Navigating the Brave New World of Health Insurance Coverage for Amputees and Their Families

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Health insurance coverage has always been a complex topic, even without all the recent changes being ushered in with implementation of the Affordable Care Act. Now the challenges are even greater. But the first rule is that you have to be at the table. There is an advertising axiom for a clothing store—"The Educated Consumer is Our Best Customer." Well, the same should apply to health insurance. A recent Kaiser Family Foundation report indicated, for example that only 60% of Medicare beneficiaries said they review their insurance coverage options each year (one-fourth say they never or rarely review their options). For most families, health insurance is one of the largest annual expenditures they make, yet it may be the one they understand the least.

Before we get to the ACA, let's start with the basics—the groundrules that have always been good advice.

1. Get and retain a copy of your health insurance policy, and read it. Specifically, check and make sure that the policy includes a specific provision stating prosthetic coverage.
2. Beware of anything that refers to annual or lifetime limits or caps. This could be in dollars, or it could be in terms like "one prosthesis per lifetime," or the policy will cover only one prosthesis, or cover the cost of the prosthesis up to a limit of $XXXX. (You may say, I thought Obamacare assured that there would be no lifetime caps—true in principle, but you'll want to read below).
3. Be tuned in to where in the policy the reference to prosthetics appears. For example, the policy might indicate that prosthetics, or orthotics and prosthetics is considered to be durable medical equipment. You'd better read on, because many policies provide further that the policy does not include coverage for durable medical equipment—the combination of those two provisions means that the policy does not offer any coverage for orthotics and/or prosthetics.
4. Look carefully at exclusions. This is an out clause—it could reference acts of terrorism, acts of God, ultra-hazardous activities (like flying in helicopters or single wing aircraft, or riding a motorcycle)—this is more common in other types of insurance, less common in health, but still worth giving this exclusion section a careful read.
5. Be tuned in to the premium due date. You have a vested interest in keeping your policy paid and in force. If you lose that coverage because you paid too late (beyond any grace period), you could have difficulty finding another policy that provides comparable prosthetics coverage.
6. Be honest, but aware, as you answer questions on any application for any type of insurance. You must answer the question as it is asked, but you do not need to volunteer information. Privacy is largely a thing of the past. Formerly, there was an institute in Hartford, CT that ***was*** the database—if you told something to any insurer, or that insurer paid any claim, all insurers had access to it. People used to be able to pay for a medical test, or for a medication out of pocket, not using their insurance, and insurers were not aware. The shift toward electronic medical records, as well as several new companies/services that track ALL medical services in your name, regardless of how they are paid for have greatly narrowed these patient options to avert disclosure of health information. But be aware of what information you have

provided elsewhere, and what is in your physician and hospital records because you will sign a form that gives the health insurer access to that.

The New Post-ACA World

In principle, the Affordable Care Act is supposed to address and fix some of the more significant insurance impediments that amputees, and others with chronic health conditions face. However, the law is far from perfect, both in how it was written and how it is being implemented, so it changes the insurance playing field, and creates some new challenges.

The Law Itself

The heart of the ACA (and of some of the insurance cancellation problems that have plagued it) revolve around its provisions relating to essential health benefits. The statute itself establishes ten categories of benefits which, in theory, must be covered by every insurance plan that is going to receive any federal money. These ten categories are: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; **(7) rehabilitative and habilitative services and devices;** (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

Most members of Congress believed that the "rehabilitative and habilitative services" category would cover prosthetics and orthotics. Several members of Congress, including Reps. George Miller (D-CA) and Bill Pascarell (D-NJ) have stated this in the ***Congressional Record***. House Members also believed that HHS would write rules to establish a single, clear essential health benefits package that would be recognized across the country as the law of the land, and the six Democrats who were Chairs of the major Committees and Subcommittees that wrote, refined and enacted the law wrote a strong letter to HHS Secretary Sebelius expressing their disappointment when HHS refused to do just that.

Essential Health Benefit Regulations

Instead, HHS 'punted' the job of defining essential health benefits to the states, albeit within some strong federal boundaries. To be eligible for federal support and participation in the new exchanges—the marketplace for purchasing insurance—a plan must provide some type of benefit in all the ten areas above, stated in the law. HHS also set up a process of setting out several 'benchmark' plans in each state. The criteria for these benchmark plans are: (1) the largest plan by enrollment in any of the three largest small group insurance products in the State's small group market; (2) any of the largest three State employee health benefit plans by enrollment; (3) any of the largest three national Federal Employees Health Benefit Program (FEHBP) plan options by enrollment; or (4) the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State. The state could select one of these benchmark plans, so long as it provides for benefits *of some kind* in all ten statutory areas, as defining what 'essential health benefits' means in that state.

While it might have been mildly popular to some states rights advocates, this created at least three major problems: (1) there is not absolute consistency in essential health benefits from one state to another; (2) the state benchmark plan can 'cut a corner' by offering some benefit in all ten areas—even if that stated benefit is quite deficient--that can still meet the federal EHB standard; and (3) it compromises portability—if you move from Maryland to Utah, things that your federally-subsidized ACA plan provided in Maryland may not be available to you in

Utah. So, as a consumer you still have to very carefully read and understand what the insurance plans sold (and where eligible -- subsidized) via the federally-sanctioned exchanges provide as to prosthetics and orthotics coverage.

Other Potential Problem Areas with ACA Sanctioned Plans

Roughly half of the states exercised their options to select one of the benchmark plans. In the remaining states which did not select one of their benchmark plans, the EHB rules designate the largest small group market plan in the State as the default benchmark plan.

While prosthetics and artificial limbs are included in coverage under the EHB benchmark plan in every State, the EHB benchmark plans employ a variety of restrictions on coverage. Seven EHB benchmark plans require some form of prior authorization and approval for coverage of prosthetic devices. Four EHB benchmark plans establish some form of cap on the annual or lifetime dollar amount of coverage for either durable medical equipment (DME) in general or prosthetics specifically. Six EHB benchmark plans established coverage exclusions for certain classes of prosthetic devices, including exclusions for "deluxe prosthetics," robotic prosthetics, bioelectric or computer-programmed prosthetics, and biomechanical devices. Another three EHB benchmark plans established coverage exclusions for fitting, adjustment, or repairs of prosthetics. Finally, four EHB benchmark plans place a limit on the number of prosthetic devices that may be covered per lifetime of an enrollee.

Although section 2711 of the Public Health Service (PHS) Act, as added by section 1001 of the ACA, prohibits "Qualified Health Plans" or QHPs from applying the dollar-value caps on annual and lifetime coverage for prosthetics even if those limits are included in the various EHB benchmark plans noted above, QHPs will be allowed to convert the dollar-value annual and lifetime limits to actuarially equivalent limits on devices per year, or per lifetime. HHS guidance provides that if a benefit included within a State-selected EHB benchmark plan was to have a dollar limit, that benefit would be incorporated into the EHB definition **without the dollar limit, but plans would be permitted to make actuarially equivalent substitutions** within statutory categories. Therefore, plans would be permitted to impose non-dollar limits, consistent with other guidance, that are at least actuarially equivalent to the annual dollar limits.

A Look to the Future

Health costs may have moderated in the past couple of years, but they continue to rise, and so has the cost of health insurance. Largely independent of ACA, a substantial number of employers have sought to limit their exposure to greater health insurance costs. They have looked to the changes that occurred in pension plans—moving from defined benefit retirement plans (so much per month for life) to defined contribution plans (money goes into a retirement or 401(k) type plan which is invested, and whatever the proceeds are become available for the retiree's use)—as the model. Most people have heard of a voucher system, and some may have heard about 'consumer-driven health care plans.' These are nice names for employers shifting out of providing a health insurance plan, to instead saying: "we'll contribute this much to help you purchase health insurance, but any costs above that (now or in the future) you're on your own for those costs—you choose what you want and how to apply this employer contribution." Proposals to shift Medicaid or Medicare to a voucher system are variations of this same concept of limited health benefits.

All of this underscores the increasing importance of being an educated and vigilant consumer in making your choices about health insurance, and protecting it. We hope this article helps you with your understanding and decisions.