

## THE BILL

### OVERVIEW

#### The Bill Sponsor

One of the most important elements of passing legislation is deciding which legislator to ask to carry your bill. Colorado was very successful because they were able to have the majority party in the House and Senate sponsor the bill. The best scenario is to have a person in a leadership position as the primary sponsor. Legislators who control the committee that your bill will move through are also good candidates.

If you hire a lobbyist, the lobbyist can assist you in determining who to ask to sponsor your bill. You may need to have the committee meet the legislator or visit with an individual in your group who has been affected by lack of parity in your state.

You will also need to build cosponsors for your bill. Cosponsors are legislators who sign on in support of the bill. It is always good to have a lengthy list of cosponsors before the bill is introduced. You will want to show broad-based support with cosponsors from both political parties, different geographic regions of your state, and members who sit on key committees.

#### Bill Language

The ACA worked with Powers Pyle Sutter & Verville to develop a model bill. The bill is focused on prosthetic coverage. Many states are also working to ensure access to orthotics.

If you are looking for assistance in drafting a bill, please contact the Advocacy staff directly at: [appl@amputee-coalition.org](mailto:appl@amputee-coalition.org).

#### Negotiating

At some point in the process, amendments may be offered by legislators or suggested by the insurance companies. It is important to figure out what your bottom line is.



See: *"Model Bill"* and *"Negotiating Principles."*

### MODEL BILL

1. Any health benefit plan, except supplemental policies covering a specified disease or other limited benefit that provides hospital, surgical, or medical expense insurance and is delivered, issued, executed, or renewed in this State shall provide coverage for benefits for prosthetics that, at a minimum, equals the coverage provided for under the federal Medicare program pursuant to 42 U.S.C. secs. 1395k, 1395l, and 1395m and 42 CFR 414.202, 414.210, 414.228, and 410.100, as applicable to this subsection (14).
2. For the purposes of this section, “prosthetics” means artificial legs, arms and eyes, including replacements if required because of a change in the patient's physical condition, as set forth at 42 U.S.C. sec. 1395x(s)(9). The term “prosthetics” is synonymous with “prosthesis” and “prostheses.”
3. A health benefit plan may require prior authorization for prosthetics in the same manner that prior authorization is required for any other covered benefit.
4. A health benefit plan may impose copayment and/or coinsurance amounts on prosthetics, not to exceed the copayment and/or coinsurance amounts imposed under Part B of the Medicare fee-for-service program. A health benefit plan shall reimburse for such prosthetics at no less than the fee schedule amount for such prosthetics under the federal Medicare reimbursement schedule.
5. Covered benefits are limited to the most appropriate model that adequately meets the medical needs of the patient as determined by the insured's treating physician.
6. Coverage under this section must also be provided for repair or replacement of prosthetics if repair or replacement is determined appropriate by the insured’s treating physician.
7. A health benefit plan shall not impose any annual or lifetime dollar maximum on coverage for prosthetics other than an annual or lifetime dollar maximum that applies in the aggregate to all terms and services covered under the policy.

### LEGISLATIVE NEGOTIATING PRINCIPLES

**Negotiable Issues (Minor Impact):** Changes that can be readily made in order to address insurance lobby concerns. Examples include:

- Inclusion of eyes in the definition of prosthetics
- Language may be added to address managed care organizations:

*“If coverage under this section is provided through a managed care plan, such plan may require that prosthetics be furnished by a prosthetist with which the plan has a contract (i.e., a participating provider). Notwithstanding the above, the insured shall have access to medically necessary clinical care, prosthetic services, and prosthetic components/technology from a nonparticipating prosthetist to the same extent that the managed care plan provides for out-of-network services for other covered benefits. Payment rates for such out-of-network services shall be at no less than the fee schedule amount for prosthetics under the federal Medicare reimbursement schedule.”*

**Negotiable Issues (Major Impact):** Changes that should only be made if absolutely necessary. Examples include:

- Drop the sentence fixing the payment rate to the Medicare fee schedule amount (second sentence of section 4).
- Provide for a functional limit test for medical necessity, as found in the Medicare local coverage determinations for lower-limb prostheses:

*“Coverage of prosthetics is limited to medically necessary clinical care, prosthetic services, and prosthetic components/technology, based on the patient's potential functional abilities. The potential functional ability of the insured is determined by the treating physician, in consultation with the prosthetist and the insured, considering factors including, but not limited to:*

- a) The insured's past history (including prior prosthetic use, if applicable);*
- b) The insured's current condition, including the status of the residual limb and the nature of other medical problems; and*
- c) The insured's desire to ambulate (with respect to lower-limb prosthetics) or maximize upper-limb function (with respect to upper-limb prosthetics).”*

**Non-Negotiable Issues:** Alterations that will alter the bill in such a way that it no longer meets our mission. These are deal-breaking points.

- Do not allow insurer to define or limit medical necessity/appropriateness.
- Do not permit caps or lifetime maximums.
- Do not permit specific exclusions (e.g., microprocessors and myoelectric devices).
- Do not increase or eliminate coinsurance limits (i.e., do not permit insurer to raise coinsurance amounts to greater than the Medicare amount of 20 percent).