CAMBIA HEALTH SOLUTIONS

Testimony on SB 669: Sports Prosthetics and Orthotics

January 31, 2025

Chair Patterson and Members of the Committee,

I am the Director of Government Relations at Cambia Health Solutions, which operates Regence BlueCross BlueShield of Oregon. As the state's largest health insurer, Regence is committed to addressing both persistent and emerging health needs for the nearly one million Oregonians we serve. In keeping with our values as a tax paying nonprofit, nearly 89% of every premium dollar goes to pay our members' medical claims and expenses.

As an insurer, Regence has been at the forefront of ensuring that Oregonians have access to safe, affordable healthcare. We recognize and understand the goal of SB 699 to provide access to prosthetic and orthotic devices for sports. Our testimony is intended to help the committee understand the impacts of the coverage mandate on Oregonians so that you can determine whether moving forward is in the best interest of the state and its residents. We also offer specific feedback that can ensure access while limiting the potential for poor outcomes for our members.

Scope of Coverage

There are several types of health insurance in Oregon, including private insurance, Medicare, and Medicaid. Within the private insurance market, there are self-insured plans (where the employer pays the full cost of member care) and fully insured plans (where members pay a premium to the insurer and risk is spread among members). Fully insured plans include the large group, small group, and individual market plans, and are the subset of insurance that the state regulates directly. About 53% of Oregonians are on private insurance, but about 58% of those are on a self-insured plan, which are exclusively federally regulated. This means that there is only about 23% of the population on a plan that is regulated by the state and that would be impacted by this mandate. Conversely, about 30% of all Oregonians (and 57% of Oregon children) are on Medicaid, which is currently not covered by this mandate, but could be written into the bill. Similarly, the Oregon Educators Benefit Board and the Public Employees Benefit Board plans are currently excluded from the mandate, but could be written into the bill.

While we understand that the state would have to allocate resources to expand coverage to Medicaid and OEBB/PEBB, the result would be much more equitable to Oregonians and ensure that the intent of the legislation is truly realized. If the legislature believes that coverage for sports prosthetics and orthotics is important enough that it should be built into private premiums, then the state should also allocate resources to expand coverage to Medicaid and OEBB/PEBB plans.

Medical Necessity Review

Premium costs directly reflect the cost of care in the state. While pharmacy costs and hospital costs drive the largest share of premium growth annually, insurance coverage mandates are directly reflected in insurance premiums and impact the cost of health care for our members. As such, the legislature should be aware of the financial impact of any mandate considered for the private market, particularly given our state's desire to limit annual health care cost growth to 3.4% annually. Most critically, there are ways to limit the cost of mandates while still ensuring access to the care covered by the mandate, including ensuring medical necessity review is allowed and the mandate provides clear standards for coverage.

As an insurer, we have an obligation to ensure that our members are receiving care at the right time, at the right place, and at an affordable price point. As drafted, this bill would severely impact our ability to do that for all prosthetic and orthotic devices, because it removes existing medical necessity review for everyday prosthetics and requires coverage for sports prosthetics and orthotics without medical necessity review. Medical necessity review is important for prosthetics and orthotics because it helps ensure that patients receive the right device at the right time, while also controlling costs and preventing unnecessary care. There are several purposes to medical necessity review:

- Ensures proper fit and function: Medical necessity review helps ensure that the prosthetic or orthotic device is properly fitted and functions correctly, which is critical for patient safety and optimal outcomes. If someone gets a device that is not fitted correctly or is not the right device for the activity and ability level, they won't use it and it will be unnecessary cost with no benefit to the member. This cost would accrue both to the member in the form of cost share, and to all members in the premium increase associated with incredibly expensive devices.
- Prevents unnecessary utilization: Medical necessity review helps prevent prescribing prosthetic and orthotic devices where they are not appropriate or necessary, which can help control costs and reduce waste.

- Improves patient outcomes: Medical necessity review can help improve patient outcomes by ensuring that patients receive the right device at the right time, which can improve their quality of life and functional ability.
- Supports evidence-based practice: Most critically, medical necessity review is based on evidence-based practice guidelines, which helps ensure that patients receive care that is consistent with the latest research and clinical evidence.

Medical necessity review allows for an important conversation to happen between the doctor prescribing the device and experts within our company, who can help ensure that the device prescribed is supported by evidence, recommended for the patient's condition, and able to support the patient's needs. There is also an appeals process if the doctor or patient disagrees with the insurer assessment.

Ensuring that insurers can complete a medical necessity review is an important mechanism to prevent unnecessary care, prescription of costly devices that don't meet the needs of the insured, and to ensure that doctors are following the latest evidence-based recommendations, and it should be restored in SB 699.

Clarity of Standards

As drafted, the bill requires coverage of devices that are "the most appropriate model" that meets the medical needs of the insured, and that "maximizes the insured's whole-body health." These terms are not well defined within the bill. As we read them, we understand that this section does not require coverage of the most expensive or highest caliber device for every sport, but rather for a model that meets the needs of the insured for the specific sport and allows the insured to participate within their existing abilities. For example, the bill does not require coverage of a tech-assistive device that would enhance the insured's ability to participate, but rather a device that allows participation within the insured's fitness level and abilities.

Effective Date

As currently drafted, the bill has an emergency clause that would make it effective upon passage. With mandates, we need an opportunity to build them into medical policies, ensure that coverage is in our booklet, and build them into our pricing model for future premiums, all of which cannot happen once a plan is issued for the year. In addition to these operational challenges, under the Affordable Care Act we cannot modify the individual and small group plans already filed and in use for 2025. As such, it's critical that mandates do not take effect until the plan year following the current year. As such, we ask for removal of Section 3 so that the bill will be effective January 1, 2026 and we can build it into our plans for next year.

Thank you for the opportunity to submit testimony and let me know if you have any questions.

Sincerely,

Mary Anne Cooper
Director of Government Relations
Cambia Health Solutions