September 30, 2015

Submitted electronically via: FFEcomments@cms.hhs.gov

To: Center for Consumer Information and Insurance Oversight (CCIIO)

RE: 2017 Essential Health Benefits (EHB) Benchmark Health Plan Comments

Dear CCIIO Official and State Insurance Commissioner:

Thank you for the opportunity to comment on your state's 2017 benchmark benefits plan pursuant to Section 1302 of the Patient Protection and Affordable Care Act (ACA). The undersigned members of the Independence Through Enhancement of Medicare and Medicaid Coalition (ITEM Coalition) would like to offer our comments on the definitional and coverage issues involving the statutory Essential Health Benefits (EHB) category of "rehabilitative and habilitative services and devices," with an emphasis on device coverage.

The ITEM Coalition appreciates the opportunity to comment on the above-referenced proposed rule. ITEM is a coalition of national organizations dedicated to raising awareness and building support for policies that will improve access to assistive devices, technologies and services for people of all ages with disabilities and chronic conditions.

Given the short timeframe for comments, the ITEM Coalition examined a number of proposed state EHB benchmark plans and found several common themes where we believe that coverage for rehabilitative and habilitative services and devices is not in compliance with federal law. To the extent that these arguments and examples apply to individual states, we request that you seriously consider our views and alter your benchmark plans to bring them into compliance with the ACA.

I. ACA Requirements Applicable to All State EHB Benchmark Plans

In establishing the 2017 benchmark health plans, all states must explicitly adopt a rehabilitative and habilitative benefit that complies with the newly-issued federal regulations for this benefit category under the ACA. By recognizing these regulations, every state will be clarifying

coverage of this benefit category consistent with the Centers for Medicare and Medicaid Services' (CMS') February 27, 2015 final rule (The Rule).[1]

Specifically, under this federal regulation, every state's EHB plan must:

- **Adopt the Rule's definition of rehabilitative (and habilitative) services and devices as the floor for individual and small employer health insurance plans beginning in 2016.** The ITEM Coalition believes that adopting the uniform federal definition of rehabilitation services and devices minimizes the variability in benefits and uncertainty involving the rehabilitation benefit. The federal definition appears in the preamble of the federal rule as follows:

  > "Rehabilitation services and devices—Rehabilitative services, including devices, on the other hand, are provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition." See §156.115(a)(5), page 10811 of The Rule.

  We stress that this definition is a floor for coverage and includes both rehabilitative *services* and rehabilitative *devices* that may be required to meet this standard. The services and devices covered by the rehabilitation benefit should not be limited to certain specific therapies but include a wide array of rehabilitation therapies and devices described in more detail below.

  Examples of these types of services typically provided under this benefit include rehabilitation medicine (including inpatient hospital rehabilitation and rehabilitation physician services), behavioral health services, recreational therapy, developmental pediatrics, cardiac and pulmonary rehabilitation, psychiatric rehabilitation, and psycho-social services provided in a variety of inpatient and/or outpatient settings. These services should be provided based on the individual's needs, prescribed in consultation with a clinician, and based on the assessment of an interdisciplinary team and resulting care plan.

- **Not impose arbitrary caps on coverage.** Caps on coverage can easily serve as de-facto annual monetary caps on coverage, which violate ACA requirements. In the event that states impose coverage caps based on visit or service limits, the ITEM Coalition believes that such caps should not be arbitrary, but rather, should be grounded in medical necessity and based on clinical and medical evidence. Further, the ITEM Coalition believes that EHB plans that do not include an exceptions process for patients with greater-than-average needs violates the ACA's plan design requirements that prohibit discrimination based on disability. All EHB plans should, therefore, have an exceptions process in place if they decide to establish arbitrary caps in benefits.

[1] *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016 – Final Rule*, 80 Fed. Reg. 10811, 10871 (February 27, 2015). Available at: http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf.

- **Not impose limits on coverage of rehabilitative services that are less favorable than any such limits imposed on coverage of habilitative services.** If a state's EHB plan imposes arbitrary limits not based on medical necessity, this provision of the federal regulations requires that rehabilitation service limits are not less generous than habilitative service limits.

- **Not impose combined limits on rehabilitative and habilitative services and devices.** If a state chooses to impose limits on these benefits, the federal regulations require separate limits for rehabilitation and habilitation benefits after January 1, 2017. This is to ensure that individuals requiring both sets of benefits—rehabilitative and habilitative services and devices—do not exhaust their benefits under the same overall limit. In other words, if service limits are imposed, there must be a separate limit for rehabilitative services and a separate limit for habilitative services in order to meet the needs of individuals receiving these services.

- **Not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.** These nondiscrimination protections are included in the ACA statute at Sections 1302 and Section 1557 and form the basis for plan benefit design that is equitable and meets the needs of diverse populations. We recommend that states further consider these nondiscrimination issues by examining the document found at: http://www.insurance.ohio.gov/Company/Documents/2015_Non-Discriminatory_Benefit_Design_QHP_Standards.pdf.

- **Explicitly include coverage of rehabilitative and habilitative *devices*, as required by federal regulations.** We request that states provide a list of rehabilitative *devices* and habilitative *devices* for illustrative purposes in their EHB benchmark plans and make clear that this is not an exhaustive list. For instance, "rehabilitative devices" and "habilitative devices" typically include, but are not limited to, the following:

    - ***Durable Medical Equipment (DME)*** including:
        - Equipment and supplies ordered by a health care professional for everyday or extended use to improve, maintain or prevent the deterioration of an individual's functional ability. Examples of DME include, but are not limited to, manual and power wheelchairs, home oxygen equipment and services, canes, crutches, walkers, standing system chairs, blood testing supplies for people with diabetes, as well as supplies and equipment to support medically necessary devices;

    - ***Orthotics and Prosthetics*** including:
        - Leg, arm, back, and neck braces, artificial legs, arms, and eyes, and external breast prostheses incident to mastectomy resulting from breast cancer. Covered services include adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition;

- ***Prosthetic Devices*** including:
    - Devices that replace all or part of an internal body organ or all or part of the function of a permanently inoperative or malfunctioning internal body organ. Examples of prosthetic devices include, but are not limited to joint replacements, colostomy care, and implanted breast prostheses incident to mastectomy resulting from breast cancer, cochlear implants, and osseointegrated implants to replace middle ear or cochlear function. Covered services include maintenance, adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition;

- ***Low Vision Aids*** including:
    - Devices that help correct for the partial loss of eyesight, making it possible for an individual with impaired vision to accomplish everyday tasks, including reading, writing, driving a car or recognizing faces. Examples of low vision aids include, but are not limited to, devices which magnify, reduce glare, add light or enlarge objects as to make them more visible;

- ***Augmentative and Alternative Communication Devices (AACs)*** including:
    - Specialized devices ordered by a health care professional which assist individuals with severe speech or language problems to supplement existing speech or replace speech that is not functional. Examples of AAC devices include, but are not limited to, picture and symbol communication boards and electronic devices; and

- ***Hearing Aids and Assistive Listening Devices*** including:
    - Medical devices which amplify sound and/or counter the negative effects of environmental acoustics and background noise to assist individuals who have been diagnosed with a hearing loss by a physician and/or hearing health professional.

II. Common Themes of 2017 Draft EHB Plans that Must be Corrected

The ITEM Coalition has surveyed the proposed 2017 EHB benchmark plans of the 50 states and Washington, DC, and has found several common themes where EHB benchmarks violate ACA requirements and, therefore, must be amended before being adopted by those states. The themes that pertain to coverage of assistive devices and technologies include the following:

Limits on Durable Medical Equipment

- $5000 limit for non-EHB DME: Oregon
- Purchases are limited to a single purchase of a type of DME, including repair and replacement, every three years: Nevada

- DME over $750, rentals, that exceed 60 days, or as indicated in Appendix A of the Master Policy require Pre-authorization: Utah
- Prior approval is required for equipment amounting to more than $500: Vermont
- $2500 limit per year. Benefits are limited to a single purchase of a type of DME (including repair/replacement) every three years: Wisconsin
- DME not provided for Home Health Care: Texas
- As an exclusion: "Reasonable quantity limits on Durable Medical Equipment items and we will determine supplies": Louisiana
- Not covered if out-of-network services are used: Mississippi
- Lack of clarity as to what constitutes covered DME as EHBs
    - This is important in order to determine which benefits are permitted to have dollar/lifetime limits and which ones cannot
    - Members need to call a phone number to find out whether a particular item is included in the plan's DME formulary/list of covered DME: California, Vermont
        - This does not clarify which exact DME items are EHBs. Members may only be able to find out which items are EHBs once they need it.

- *Recommendation*: Outright dollar caps in benefits are prohibited under the ACA and, therefore, these caps in benefits must be removed under the EHB benchmark plans for 2017. Policies that serve to delay access to DME benefits should be narrowly prescribed so enrollee access to care is not compromised. Use of prior authorization, while permissible, should still ensure timely access to care. Provisions describing DME coverage and exclusions in EHB benchmark plans must be clear and specific enough to ensure that enrollees do not incur unexpected out-of-pocket costs for DME that they thought would be a covered benefit due to vague coverage policies. A number of the DME coverage provisions cited above should be clarified to ensure timely access to and coverage of DME.

Limits on Prosthetic Devices

- No coverage for prosthetic devices (i.e., artificial limbs): Utah
- Only one prosthetic device, per limb, per lifetime is covered: New York
- One item per year is covered: New Mexico
- Purchases are limited to a single purchase of a type of Prosthetic Device, including repair and replacement, every three years: Nevada
- $2500 limit per year for prosthetic devices. Benefits are limited to a single purchase of each type of prosthetic device every three years. Once this limit is reached, Benefits continue to be available for items required by the Women's Health and Cancer Rights Act of 1998: Wisconsin
- $5,000 lifetime limit for benefits related to the temporomandibular/craniomandibular joint (includes prosthetic appliances): Mississippi
- Coverage excludes interim prosthetic devices, fixed or removable and not part of a permanent or restorative prosthetic service: Washington, DC

- Prior approval is required. Benefits are not available for Prosthetic Limbs or components required for work-related tasks, leisure or recreational activities or to allow a member to participate in sport activities: North Dakota.
- Exclusions include orthopedic shoes that are not attached to braces: West Virginia
- Some items require Pre-Certification: Wyoming

- *Recommendation*: Outright dollar caps in benefits are prohibited under the ACA and, therefore, caps such as the $2,500 per year cap in Wisconsin violates the ACA and must be removed. Lifetime monetary caps are also prohibited and, therefore, Mississippi's $5,000 lifetime cap directly violates the ACA and must be removed from the state's EHB benchmark plan. The use of prior authorization, while permissible, should still ensure timely access to care. Failure to cover rehabilitative and habilitation devices (e.g., prosthetic limbs) is a direct violation of the ACA statute and federal regulations. Therefore, EHB plans in states such as Utah must reinstate coverage of prosthetic limbs for 2017. In addition, the "one limb, per limb, per lifetime" policy in New York violates the ACA regulations which establish that rehabilitation "devices" are covered under the rehabilitation and habilitation services and devices benefit. New York State's Exchange Commissioner admitted this in writing for purposes of coverage of prosthetic limbs including replacements earlier this year for plan year 2016. As a result, New York must also strike the "one limb per life" policy from its 2017 EHB benchmark plan.

Limits on Hearing Aids

- No coverage for hearing aids: Alabama, Alaska, Arkansas, California, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Michigan, Mississippi, Montana, Nebraska, North Dakota, Ohio, Pennsylvania, South Carolina, South Dakota, Utah, Vermont, Virginia, Washington State, Washington, DC, West Virginia, Wyoming
- Covers hearing aids only for children, while denying coverage for adults: Colorado, Connecticut, Delaware, Illinois, Kentucky, Louisiana, Massachusetts, Maryland, Maine, Minnesota, Missouri, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, Tennessee, Texas, Wisconsin

- *Recommendation*: Hearing aids and similar technologies are "rehabilitative or habilitative devices" and, as such, must be covered under every state's EHB benefit package for 2017. Failure to cover hearing aids and similar technologies violates both the ACA's statute and regulations. Coverage of hearing aids for children only and not for adults also violates the ACA prohibition against discrimination in plan design based on age. For these reasons, hearing aids are required EHB benefits and must be covered in 2017 regardless of age.

Limits on Aural Rehabilitation

- Covers cochlear implants, but no mention of audiology as an eligible provider for habilitation and/or rehabilitation (i.e., the device is covered but not aural rehabilitation to learn how to function with the device): Virginia and Ohio

- *Recommendation*: Aural rehabilitation in connection with cochlear implantation is a critical service necessary to effectuate the proper functioning of and adaptation to the device. Aural rehabilitation to an individual with cochlear implantation is no different than physical therapy for an individual with a hip replacement. The ACA statute and regulations establishes explicit coverage for rehabilitation and habilitation services and devices and, therefore, aural rehabilitation must be covered under the 2017 EHB packages in Virginia, Ohio, and any other state that seeks to restrict coverage of these services.

We appreciate the opportunity to provide comments on this important topic. Should you have further questions regarding this information, please contact Sara Rosta, ITEM Coalition Coordinator at Sara.Rosta@ppsv.com or by calling 202-349-4246.

Sincerely,

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