February 27, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: (CMS–9938–P) Summary of Benefits and Coverage and Uniform Glossary

Dear Acting Administrator Slavitt:

The undersigned members of the Consortium of Citizens with Disabilities (CCD) Health Task Force appreciate the opportunity to comment on the proposed rule *Summary of Benefits and Coverage and Uniform Glossary* (the Proposed Rule) issued by the Internal Revenue Service at the Department of Treasury, the Employee Benefits Security Administration at the Department of Labor, and the Centers for Medicare and Medicaid Services at the Department of Health and Human Services (collectively, the Departments). The CCD Health Task Force works on all the issues encompassed in the very broad term "health." Specific emphasis is placed on private health insurance; public programs such as Medicaid and Medicare; managed care, as well as quality assurance and enrollee education and protections.

In the Proposed Rule, the Internal Revenue Service at the Department of the Treasury, the Employee Benefits Security Administration at the Department of Labor, and the Centers for Medicare and Medicaid Services at the Department of Health and Human Services (collectively the Departments) invite comments on the proposed documents associated with the Summary of Benefits and Coverage and Uniform Glossary located at http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html. The CCD Health Task Force comments on the Uniform Glossary of Coverage and Medical Terms, the Summary of Benefits and Coverage (SBC) template, and other documents, below.

<u>Uniform Glossary of Coverage and Medical Terms</u>

A. Existing Definitions

The proposed uniform glossary of coverage and medical terms[1] contains definitions of durable medical equipment, habilitation services, and rehabilitation services. We understand the intent of the glossary terms as plain language descriptions of services meant to facilitate informed decision-making by consumers as they shop for coverage, and *not* as legally-binding definitions of covered benefits. For that reason, we distinguish between definitions intended as communications to consumers generally, from definitions as they should be understood and used by Qualified Health Plans for purposes of providing essential health benefits (EHB). For purposes of the uniform glossary of coverage and medical terms, CCD Health Task Force commends the departments for adopting the National Association of Insurance Commissioners (NAIC) definitions of durable medical equipment, habilitation services, and rehabilitation services. However, in future regulations defining coverage requirements, limitations, and exclusions of coverage benefits, CCD Health Task Force supports the Departments adopting more robust, inclusive definitions for these terms.

<u>Durable Medical Equipment (DME)</u>
CCD Health Task Force commends, for the purposes of the uniform glossary of coverage and medical terms, the definition of Durable Medical Equipment (DME), which reads: "Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics." CCD Health Task Force does not recommend a change to the uniform glossary of coverage and medical terms definition of DME.

However, for purposes of future regulations defining coverage requirements, limitations, and exclusions, CCD Health Task Force proposes that the Departments should include a more expansive definition of durable medical equipment, which would read as follows:

- <u>Durable Medical Equipment</u>: Includes but is not limited to 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 electric wheelchairs, oxygen equipment, canes, crutches, walkers, standing system chairs, blood testing supplies for people with diabetes, as well as supplies and equipment to support medically necessary devices.

Durable medical equipment, related devices and assistive technologies are critically important to people with injuries, illnesses, disabilities, and chronic conditions. These devices and technologies enable these individuals to achieve health improvement, full function, return to work and live independently when possible. An inappropriate benefits package of durable medical equipment benefits in health insurance plans will produce long-term cost-ineffective outcomes for enrollees.

[1] See http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.

Habilitation Services

For the purposes of the uniform glossary of coverage and medical terms, CCD Health Task Force commends the Departments for their definition of Habilitation Services, which reads: "Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings." CCD also commends the Department of Health and Human Services (HHS) for including the term "and devices" after health care services to its definition of habilitative services in the 2016 Notice of Benefit and Payment Parameters final rule.

CCD Health Task Force proposes that the Departments' definition for habilitation services should include a reference to devices in the uniform glossary. This could be achieved by adding the term "and devices" after "Health care services."

For the purposes of future regulations defining coverage requirements, limitations, and exclusions, CCD Health Task Force also proposes that the Departments should include a more expansive definition of habilitative services and devices, which would read as follows:

- Habilitation Services and Devices: Includes but is not limited to health care services *and devices* that are designed to assist individuals in acquiring, improving, or maintaining, partially or fully, skills and functioning for daily living. These services may include, but are not limited to, physical therapy, occupational therapy, speech-language pathology and audiology, and other services and devices for people with disabilities in a variety of inpatient and/or outpatient settings. Plans should use Medicaid coverage as a guide where there is a question of whether to cover specific habilitation benefits.

Habilitative services should be provided based on the individual's needs, in consultation with a clinician, and based on an assessment by an interdisciplinary team and resulting care plan.

Habilitative devices shall include, but not be limited to, orthotics and prosthetics, prosthetic devices, low-vision aids, Augmentative and Alternative Communication Devices (AACs), and hearing aids and assistive listening devices, as defined elsewhere in this section.

Rehabilitation Services

For the purposes of the uniform glossary of coverage and medical terms, the CCD Health Task Force commends the Departments for their definition of Rehabilitation Services, which reads: "Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings." While not explicitly adding "and devices" to rehabilitative services in the regulatory section of the 2016 Notice of Benefit and Payment Parameters final rule, the CCD Health Task Force is supportive of the Department of Health and Human Services (HHS) for including such an addition in the comments of the rule, by stating: "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."[2]

Patient Protection and Affordable Care Act (PPACA) §1302 states that "rehabilitative services and devices" are essential health benefits. The CCD Health Task Force believes that the uniform glossary of coverage and medical terms should be consistent with that statutory language. This could be achieved by adding the term "and devices" after "Health care services."

For the purposes of future regulations defining coverage requirements, limitations, and exclusions, the CCD Health Task Force also proposes that the Departments should go farther in specifying the scope and breadth of this important benefit, and should include a more expansive definition of rehabilitative services and devices, which would read as follows:

- Rehabilitation Services and Devices: Includes but is not limited to health care services *and devices* that are designed to assist individuals in improving or maintaining, partially or fully, skills and functioning for daily living. These services include, but are not limited to, physical therapy, occupational therapy, speech-language pathology and audiology, cognitive rehabilitation, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Rehabilitative devices shall include, but not be limited to, orthotics and prosthetics, prosthetic devices, low-vision aids, Augmentative and Alternative Communication Devices (AACs), and hearing aids and assistive listening devices, as defined elsewhere in this section. Rehabilitative services should be provided based on the individual's needs, in consultation with a clinician, and based on an assessment by an interdisciplinary team and resulting care plan.

B. Further Detail of Habilitative and Rehabilitative Services

Additional Services

In addition to those services listed in our recommended definitions of habilitative and rehabilitative services and devices, future regulations defining coverage requirements, limitations, and exclusions, should include many other types of services that are typically provided under these benefits, including rehabilitation medicine, behavioral health services, recreational therapy, developmental pediatrics, cardiac and pulmonary rehabilitation, cognitive and 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.

Medically Necessary

The current definition of the term "medically necessary" in the uniform glossary of coverage and medical terms reads "Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine." CCD Health Task Force proposes that the words "health care services" be replaced with

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[2] https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-03751.pdf, page 227.

"physical and mental health care services" to ensure that the public understands the breadth of health care services provided.

C. Proposed Additional Definition

Orthotics and Prosthetics
It is clear from the legislative history that durable medical equipment (DME) and orthotics and prosthetics (O&P), were intended to be covered in the essential health benefits package and we, therefore, believe that a separate definition of "orthotics and prosthetics" for purposes of comparing medical benefits across different health plans is appropriate. To define O&P care under the DME benefit would be inappropriate as these are two entirely different benefits and would result in unintended negative consequences for patients that need artificial limbs and orthopedic braces.

While the majority of DME items are largely product or commodity-based, O&P entail a high level of clinical service by educated and trained practitioners who design, fabricate and fit custom orthoses and prostheses. This is the reason why Medicare defines DME separately from O&P and uses the term "DMEPOS," (durable medical equipment, prosthetics, orthotics, and supplies).

The Congressional Record lays the foundation for the Departments to use their discretion to include a separate definition in the list of medical terms for "Orthotics and Prosthetics." House Education and Labor Committee Chairman George Miller, during passage of the ACA, explicitly stated that Congress intended to include prosthetics and orthotics in the new health care law's essential health benefits package under the term "rehabilitation and habilitation services and devices," but also intended to define prosthetics and orthotics separately from DME in the definitions section of the Affordable Care Act. "**It is my expectation 'prosthetics, orthotics, and related supplies' will be defined separately from 'durable medical equipment**,'" Miller stated. (Congressional Record, H-1882, March 21, 2010).

Therefore, the CCD Health Task Force proposes that the Departments adopt the following definition in its uniform glossary of coverage and medical conditions:

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

D. Future Regulatory Definitions

The CCD Health Task Force proposes that the Departments further define the following for purposes of future regulations defining coverage requirements, limitations, and exclusions:

1. Orthotics and Prosthetics: as defined above.

2. Habilitative Services and Devices and Rehabilitative Services and Devices: as defined above.

3. Prosthetic Devices: Includes but is not limited to 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.

4. Low-vision Aids: Includes but is not limited to 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.

5. Augmentative and Alternative Communication Devices (AACs): Includes but is not limited to 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.

6. Hearing Aids and Assistive Listening Devices: Includes but is not limited to 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.

Summary of Benefits and Coverage (SBC) Template

The CCD Health Task Force has reviewed the proposed Summary of Benefits and Coverage (SBC) template,[3] and recommends the following revisions:

- On page 1, given the primary importance of the monthly premium for the public when shopping for a QHP, the Departments add a row to the top of the chart. Under the "Important Questions" section, add "What is the monthly premium?" Under "Why this Matters," add "You can use this rate to compare plans but the amount you are charged may be different. Contact {xxx} to learn your premium amount.";

- On page 1, given the primary importance of out-of-pocket obligations for the public when shopping for a QHP, the Departments add a row to the chart. Under the "Important Questions" section, above the question "Is there an out-of-pocket limit on my expenses?" add the question "What are the out-of-pocket obligations.";

- On page 1, given the primary importance of the applicability of the deductible (in addition to the monthly premium) for the public when shopping for a QHP, the CCD

[3] See http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html.

Health Task Force further recommends that there be an "Important Question" in the final SBC template which asks "Are there any services to which the deductible does not apply?";

- Clarify how deductibles and out-of-pocket maximums apply in family plans, so that consumers have a more precise understanding of their cost-sharing obligations**.** Annual cost-sharing charges in plans covering more than one individual can be either "embedded" or "aggregate." We urge the Departments to update the SBC template so that plans are required to note whether out-of-pocket costs are "embedded" or "aggregate" and why it matters.

- Require plans to clarify how any deductible that is separate from the overall medical deductible (i.e., a prescription drug deductible) interacts with the overall medical deductible. A separate (smaller) deductible could, for example, be "nested" within the medical deductible, allowing a plan enrollee to reach copayments or coinsurance sooner for the items or services to which the separate deductible applies. A separate deductible that is not nested, on the other hand, would apply totally separately from the deductible that applies to other covered benefits. In the case of a separate drug deductible, a plan might apply it to only some drug "tiers" and not others. While the SBC template does specify the amount of any separate deductible and to what items or services it applies, the information in the "why this matters" column should be expanded to explain how any separate deductible amounts interact with the main annual deductible;

- On page 2, under "Services You May Need" column in the row "If you visit a health care provider's office or clinic," "practitioner" is not defined in the field "other practitioner office visit." The CCD Health Task Force asks that the Departments provide further clarification of what "practitioner" means in the SBC template, and define it in the Glossary of Health Terms and Medical Coverage if it is different than "Primary Care Provider" or "Provider.";

- On page 2, improve consumers' ability to determine drug cost-sharing. For people who take multiple prescription drugs, being able to compare plans based on their expected out-of-pocket cost for these drugs is very important. The current and proposed SBC needs several changes for people to more effectively compare their prescription drug costs under various plan scenarios.

    - **The language used in drug formularies to describe drug tiers should be identical to the language used in the SBC.** In most formularies the drugs are described as "Tier 1, 2, 3 and 4." But in the SBC the drug is captioned Generic, Preferred Brand, Non-Preferred Brand and Specialty. Given the likelihood that most on-line formularies will use the least amount of characters (e.g. 1, 2, 3, and 4), our suggestion is that the SBC put the phrase "usually tier 1" behind "generic," and "usually tier 2" behind "preferred brands" etc. on page 2 of the SBC.

    - **Sometimes health plans split category like "generic" or "specialty" into more than one tier,** so the Departments should require "If one of these categories of

drug is divided into more than one tier, this should be clearly indicated on the SBC."

  - One of the most significant barriers to applicants being able to calculate their projected drug costs is that many preferred brands and specialty **drugs are subject to coinsurance rather than a specific copayment.** This could be addressed by a link on the SBC to the formulary, with the formulary containing a column of the average cost-sharing paid by the plan members in the previous year, excluding silver plan members who got cost-sharing assistance;

- On page 3, the "Habilitation services" and "Rehabilitation services" items under "Services You May Need" should be renamed "Habilitation services and devices" and "Rehabilitation services and devices," respectively, to be consistent with our new proposed definitions above;

- On page 3, "Services You May Need" under "If you need help recovering or have other special health needs" should include "Orthotics and prosthetics" right below "Durable medical equipment," to be consistent with our new proposed definitions above;

- On pages 2-3, and especially for the sections regarding rehabilitation services and devices, habilitation services and devices, durable medical equipment, and orthotics and prosthetics, any quantitative limits for covered services (e.g. number of hours, days, visits covered, device exclusions) should be clearly specified in the SBC in the "Limitations & Exceptions" column;

- On page 3, rehabilitation services and devices, habilitative services and devices, durable medical equipment, and orthotics and prosthetics that are not covered should be explicitly enumerated in the "Services Your Plan Does NOT Cover" section of the SBC;

- Covered habilitative and rehabilitative services and devices should be listed somewhere in the SBC with specificity to provide optimal clarity to the public;

- On pages 3-4, the proposed SBC template no longer contains the questions "Does this Coverage Provide Minimum Essential Coverage" and "Does this Coverage Meet the Minimum Value Standard" as the current SBC template does, and the proposed Sample Competed SBC contains the question "Does this Coverage Satisfy the Individual Responsibility Requirement and Meet the Minimum Value Standard?" while the proposed SBC template does not. The CCD Health Task Force recommends that the questions "Does this Coverage Provide Minimum Essential Coverage" and "Does this Coverage Meet the Minimum Value Standard" be re-inserted into both the proposed SBC template and the proposed Sample Completed SBC to provide consumers with information as to whether or not the health plan is in compliance with the Affordable Care Act; and

- On page 4, provide information needed for Marketplace Tax Credits. Employees seeking to learn if they might qualify for premium tax credits to purchase coverage in the Marketplaces need to know their contribution to the lowest cost plan offered by their employer (among plans that meet minimum value requirements). In keeping with the goal of the law, which is to allow the public to "compare health insurance coverage and understand the terms of that coverage," the SBCs should be designed in such a way that the public can easily use this document for completing Marketplace questions about available employer-sponsored coverage.
    - To accomplish this, ***for group plans the Departments should require introductory sentences to better help the public understand the implications of their employer-sponsored coverage***. For example, the following language should be added to page 4 of the SBC: "Use this page to learn if you might be eligible for premium assistance if you buy coverage through the Marketplace instead of through your employer. Only individuals who meet certain income guidelines can get premium assistance."
    - Moreover, for group plans, we recommend the Departments to require a checkbox in the same general area that requires an employer to indicate whether the plan is the "lowest cost plan" among plans that meet the minimum value requirement. The box will only require a small amount of space, but will make it easy for the public to quickly learn if a plan that meets the minimum value is the lowest cost plan offered. The Departments should include this information in the SBC as this is the only place where the public will be able to find this information. The public is currently unprotected, as they do not have a form where employers are required to report this information.

<u>Instructions for Completing the SBC - Group Health Plan Coverage & Individual Health Insurance Coverage Documents</u>

To be consistent with the recommendations proposed to the revised SBC template, the CCD Health Task Force proposes that all references to "habilitation services" be changed to "habilitation services and devices."

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We greatly appreciate your attention to our concerns and your interest in our participation in this process. CCD further recommends the Departments to incorporate consumer testing and broader consultation on the Summary of Benefits and Coverage and Uniform Glossary, as well as associated documents, with the consumer representatives of the National Association of Insurance Commissioners (NAIC) as well as other stakeholders.

Should you have further questions regarding this information, please contact Peter Thomas or Steven Postal, CCD Health Task Force staff, by emailing Peter.Thomas@ppsv.com, Steven.Postal@ppsv.com, or by calling 202-466-6550.

Sincerely,

ACCSES
American Association on Health and Disability
American Foundation for the Blind
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Occupational Therapy Association
American Speech-Language-Hearing Association
American Therapeutic Recreation Association
Association of University Centers on Disabilities
Brain Injury Association of America
Easter Seals
Epilepsy Foundation.
Health and Disability Advocates
National Alliance on Mental Illness
National Association of State Head Injury Administrators
National Multiple Sclerosis Society
The Arc of the United States