



March 6, 2018

VIA ELECTRONIC SUBMISSION

The Honorable R. Alexander Acosta
Secretary, U.S. Department of Labor
200 Constitution Ave NW
Washington, DC 20210

RE: Public Comments on Association Health Plans and the Definition of “Employer” under Section 3(5) of ERISA (RIN 1210-AB85)

Dear Secretary Acosta:

The undersigned members of the Habilitation Benefits (HAB) Coalition Steering Committee would like to comment on the Department of Labor (DOL) proposed rule entitled *Definition of “Employer” under Section 3(5) of ERISA – Association Health Plans*¹ (the Proposed Rule). This rule has the potential to significantly alter the dynamics of the existing individual and small group markets and, as such, the HAB Coalition must express our very significant concerns with the expected effect this rule will have on access to essential health benefits, particularly habilitation services and devices.

The HAB Coalition is a group of national nonprofit consumer and clinical organizations focused on securing and maintaining appropriate access to, and coverage of, habilitation benefits within the category known as “rehabilitative and habilitative services and devices” in the Essential Health Benefits (EHB) package under existing federal law.²

We share the Department’s goal of increasing access to affordable health care, but we believe the proposed rule would leave children and adults, particularly those with developmental disabilities and chronic/progressive conditions, with less comprehensive coverage and higher out-of-pocket costs. We believe that insurance coverage, whether through an employer, a plan purchased on the exchange, or an association health plan (AHP), must ensure access to timely, affordable, high-quality health care that meets the needs of individuals with disabilities.

¹ Definition of “Employer” Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 614 (Jan. 5, 2018). Available at: <https://www.gpo.gov/fdsys/pkg/FR-2018-01-05/pdf/2017-28103.pdf>.

² Patient Protection and Affordable Care Act (ACA), Section 1302.

The proposed rule may reduce the short-term cost of coverage through AHPs, but we expect AHPs described in the proposed rule to primarily attract relatively younger and healthier consumers, leaving older and less healthy people in the individual and small group marketplaces. According to the proposed rule, AHP consumer protections are not nearly as strong and benefit packages are not nearly as comprehensive as plans in the current marketplaces. Expansion of AHPs will therefore lead to adverse selection that will force marketplace plans to raise premiums even more than under existing law. AHPs will have the net effect of driving insurance costs higher for current marketplace plans as the insurance pool is skewed, while AHP enrollees will be exposed to non-covered services and increased out-of-pocket costs when the bare bones benefit packages they purchase will be more likely to fail to meet their needs when needed most.

For these reasons, we urge DOL to seriously reconsider the proposed rule and, if it moves forward with AHPs, ensure that the final regulations require these plans to comply with the same consumer protections and cover the same minimum essential health benefits as exchange-based health plans, especially the category of benefits known as “rehabilitation and habilitation services and devices.”

I. Access to Essential Health Benefits

Under the Proposed Rule, AHPs would be regulated as group health plans under ERISA. As a result, AHPs would not be subject to the ACA’s requirement to cover all ten categories of EHBs. This would have a significant impact on individuals who have a disability or chronic condition and require habilitation services and devices to improve, maintain, or prevent the loss of their health and functional ability. These same individuals also have a need for other essential health benefits such as prescription drugs, behavioral and mental health services, chronic disease management, and other benefits.

We are especially concerned that AHPs could decide not to cover rehabilitative and habilitative services and devices or significantly limit the scope of these benefits. The inclusion in the ACA of the category of rehabilitative and habilitative services and devices was a major milestone for the disability community in that Congress recognized the importance of these benefits to improving the health and functioning of the American people. The passage of the ACA and its implementation represented significant gains for consumers of rehabilitation and habilitation services and devices.

Prior to the ACA, most health plans did not cover habilitation services and devices and only three States (Illinois, Maryland, and Oregon) had adopted a habilitative services mandate in the individual market. This lack of coverage contributed to significant downstream costs to the health care system for unnecessary disability and dependency. Enactment of the essential benefits package dramatically impacted access to habilitation for children and adults in need of these services and devices. Coverage gains for habilitation services and devices were hard fought but necessary to meet the needs of a wide variety of children and adults with autism, cerebral palsy, congenital deficits, disabilities, and other chronic and progressive conditions.

This benefit category was clarified through federal regulations, perhaps more so than any other essential health benefit. In the February 2015 Notice of Benefit and Payment Parameters Final Rule, the Centers for Medicare and Medicaid Services (CMS) defined “habilitation services and devices” as follows:

Habilitation services and devices—Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not 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.

For the first time, this definition established a uniform, understandable federal definition of habilitation services and devices that became a standard for insurance coverage. This definition has become a floor for both individual and small group health plans. It has also been adopted by States that chose to expand their Medicaid programs. Importantly, the definition includes both services *and* devices. The adoption of a federal definition of habilitation services and devices has minimized the variability in benefits across States and the uncertainty in coverage for children and adults in need of these services.

II. Habilitation Services and Devices

Habilitation services and devices are necessary for individuals with many types of developmental, cognitive, physical and mental conditions that, in the absence of such services, prevent individuals from acquiring certain skills and functions over the course of their lives, particularly in childhood. Habilitation services are closely related to rehabilitation services although there are key differences between the two. Whereas *rehabilitation services* are provided to help a person regain, maintain, or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition, *habilitation services* are provided in order for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

The types of habilitation services and devices include, but are not limited to, behavioral health services, recreational therapy, developmental pediatrics, psychiatric services, and psycho-social services provided in a variety of inpatient and/or outpatient settings. Habilitation and rehabilitation services:

- Improve long-term function and health status and improve the likelihood of independent living and quality of life;
- Halt or slow the progression of primary and secondary disabilities by maintaining function and preventing further deterioration of function;
- Enable persons with developmental, intellectual, physical or cognitive impairments to improve cognition and functioning through appropriate therapies and assistive devices;

- Speed recovery by achieving better outcomes and enhancing the likelihood of discharge from the hospital to one's home, increase lifespan, and help individuals attain a higher level of function post injury or illness; and
- Reduce the likelihood of relapse and readmission to the hospital, while facilitating return to work in appropriate circumstances.

The following vignettes demonstrate just a few examples of real-life instances where access to habilitation services and devices has maximized the health, function, and independence of those who have been able to access these services:

- *Cleft Palate.* Jessica is a 2-year-old child with a bilateral cleft palate that was surgically repaired at 11 months of age. She presented with speech sound production errors and excessive nasality that impaired her ability to communicate. Jessica's care is coordinated by a cleft palate/craniofacial team that includes a plastic surgeon, an orthodontist, a speech-language pathologist (SLP), a pediatrician, and additional providers. With appropriate speech language treatment, Jessica will learn techniques to improve her speech intelligibility, allowing her to communicate with others at an age-appropriate level. Professional collaboration with the craniofacial team and a coordinated care plan ensure that Jessica achieves maximum functional communication.
- *Muscular Dystrophy.* Adam is a 14-year-old boy with Duchenne Muscular Dystrophy. He has recently experienced a significant decrease in his trunk and arm strength. After conducting an occupational profile and evaluating Adam's current performance skills, the occupational therapist adapted Adam's computer keyboard in order for him to continue to be able to use the computer and keyboard for schoolwork and entertainment. She teaches Adam compensatory strategies and modifies his silverware so that he may continue to feed himself without assistance, and teaches him and his family strategies for dressing with minimal assistance from his caregivers. The occupational therapist also teaches Adam stretches for his shoulders and upper arms to help maintain flexibility and prevent the development of muscle contractures. Finally, she teaches Adam new strategies for relieving pressure on his buttocks in his wheelchair, as he can no longer perform wheelchair pushups. She works with Adam to build these techniques into his daily routine so he does not forget, since forgetting could result in the development of additional pressure sores.
- *Cochlear Implants.* Raul was diagnosed with congenital hearing loss as a young child, but did not have access to hearing aids until age ten. He attended a school for the deaf and hard of hearing, and his primary language is American Sign Language. As an adult, Raul decided to undergo cochlear implant surgery and learn spoken language. He works with an audiologist and SLP on open-set speech recognition with amplification. The prognosis from the interdisciplinary cochlear implant team—based on Raul's motivation, progress in therapy, and use of lip-reading and technology—is fair for receptive language abilities. His cochlear implant and related new skills will assist him with communication in the workplace and community.

- *Down Syndrome.* Jill is a 5-month-old girl with Down syndrome (DS). Jill's parents were aware of the diagnosis before her birth, and they have always sought optimal care for her. Jill has had difficulty drinking from a bottle, and her physical therapist has worked with other health professionals to assist the parents with the feeding program best suited for her. The pediatric physical therapist has helped her family learn how to teach Jill to hold her head upright when she is supported when sitting, and how to teach Jill to roll over from her stomach to her back and from her back to her stomach. As Jill continues to develop during her early years of life, the physical therapist will encourage progression of motor activities such as crawling, walking, climbing stairs, and running. An orthotics (orthotic braces for the foot and ankle) assessment will be completed once Jill begins to initiate weight-bearing activities at 7-9 months. Infants with DS are at high risk for delayed standing due to low muscle tone and joint instability, which may result in foot deformity and lifelong mobility impairments. Therefore, an orthotics assessment will be particularly beneficial in her first year of life, to prevent future complications.

Individuals and families have come to rely on coverage of habilitation services and devices by their plans. Expanding access to AHPs that can choose not to offer these necessary benefits would negatively impact patient access to comprehensive care. It is of utmost importance that AHPs do not provide a false sense of health insurance coverage when, in reality, they only offer minimal benefit coverage in exchange for lower premiums.

Limiting access to habilitation for children and adults with disabilities or chronic/progressive conditions is not cost-effective in the long term as it often results in further complications and avoidable hospital admissions and readmissions. In addition, it should be noted that reducing coverage is not likely to significantly reduce the cost of coverage in the first place. This is particularly true for coverage of rehabilitative and habilitative care which accounts for just 2% of total premium dollars. Reducing coverage of these services would not significantly decrease the cost of insurance packages overall, but would lead to very high increases in out-of-pocket costs for children, families, and adults who need these services.

Both habilitation and rehabilitation services and devices are highly cost-effective and decrease downstream costs to the health care system and society at large for unnecessary disability and dependency. For these reasons, it is essential that any regulatory change to the individual or small group market, including AHPs, maintain access to the full continuum of rehabilitation and habilitation care. We, therefore, urge the Department of Labor to rewrite this AHP rule to ensure access to and coverage of essential health benefits.

III. Nondiscrimination Protections

The nondiscrimination protections in the Proposed Rule are similar, although not identical, to those applicable to group health plans under the Health Insurance Portability and Accountability Act (HIPAA), as amended by the ACA. We support that, under the Proposed Rule, AHPs are prohibited from conditioning membership based on a health factor, including

disability. While this is an important provision of the proposed regulation and must be retained in the final rule, it does not go far enough to prevent potentially discriminatory benefit design or premium rating that approximates health status rating. In short, the rule should apply the same non-discrimination protections to consumers of AHPs that apply to those in the individual and small group markets.

IV. Annual and Lifetime Limits

We share the Department's concerns regarding the affordability of coverage, but remind DOL of the importance of protecting families from potentially-bankrupting out-of-pocket costs. Enrollment in an AHP not subject to the prohibition of annual and lifetime limits on the cost of benefits could financially overwhelm an individual who requires extensive health care services or medications. In addition, annual and lifetime caps are currently tied to essential health benefits. We seek confirmation from DOL of the application of this important provision to AHPs and how these provisions would operate if the Department does not require coverage of essential health benefits under AHPs.

V. Oversight of AHPs

Under the Proposed Rule, there is a lack of clear oversight over AHPs, including confusion over whether it is the state or the federal government's responsibility to regulate AHPs. We strongly recommend further clarity on the role of states in the regulation of fully insured AHPs. Historically, some AHPs have demonstrated a pattern of insolvency and unpaid claims. In the past, ambiguity regarding distinctions between federal and state authorities governing AHPs left individuals and their families with unpaid benefits and large financial obligations. We are concerned that the Proposed Rule will result in a return to that complex patchwork of AHP requirements and state and federal oversight responsibilities, which will undermine coverage and access to care.

On its own, DOL lacks the resources to effectively regulate and oversee AHPs. Filing a federal lawsuit is the key enforcement protection under current ERISA law and this is out of reach for most individuals who need to challenge coverage denials. Therefore, it is critical that the final rule specifically affirm the state's role in regulating AHPs. As such, states should be allowed to apply the same standards to AHPs as they apply to other commercial group plans, including essential health benefits, network adequacy requirements, rate review and other consumer protections.

In sum, we ask that you seriously reconsider this proposed rule and revise it to ensure it meets the needs of children and adults with disabilities and chronic/progressive conditions by ensuring access to a national coverage standard of habilitation services and devices.

The HAB Coalition membership greatly appreciates your attention to our concerns involving this important proposed rule. Should you have further questions regarding this information, please contact Peter.Thomas@powerslaw.com or call at 202-466-6550.

Sincerely,

HAB Steering Committee Organizations

American Academy of Physical Medicine and Rehabilitation

American Occupational Therapy Association

American Speech-Language-Hearing Association

The Arc of the United States

Children's Hospital Association