



November 9, 2015

VIA ELECTRONIC SUBMISSION

Ms. Jocelyn Samuels
Director
U.S. Department of Health and Human Services
Office for Civil Rights
Attn: 1557 NPRM (RIN 0945-AA02)
Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

RE: Public Comments on Affordable Care Act Section 1557 Notice of Proposed Rulemaking (RIN 0945-AA02)

Dear Director Samuels:

The undersigned members of the Coalition to Preserve Rehabilitation appreciate the opportunity to comment on the proposed rule [Nondiscrimination in Health Programs and Activities](#),¹ (the Proposed Rule) to implement [Section 1557](#) of the Patient Protection and Affordable Care Act (ACA),² which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities.³ The Office for Civil Rights (OCR)'s Proposed Rule aims to further provide safeguards in health programs and activities against these types of discrimination. CPR is a coalition of national consumer, clinician, and membership organizations that advocates for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions can regain and/or maintain their maximum level of health and independent function. As such, this comment letter focuses on non-discrimination based on disability and, to a lesser extent, age, due to the fact that there is a high correlation between aging and disability status.

¹ Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

² 42 U.S.C. § 18116 (2010).

³ Health programs and activities include "the provision or administration of health-related services or health-related insurance coverage and the provision of assistance to individuals in obtaining health-related services or health-related insurance coverage." Nondiscrimination in Health Programs and Activities, 80 Fed. Reg. 54,172, 54,216. The term also includes all operations of a State Medicaid program and all operations of an entity principally engaged in providing or administering health services or health insurance coverage, unless otherwise stated in the Proposed Rule. *Id.*

We applaud OCR for finally issuing this important proposed rule and strongly urge OCR and the Department of Health and Human Services to prioritize this rule for publication in final form before the transition to the next Administration. We believe that full implementation of Section 1557 of the Affordable Care Act is critical to meeting the needs of diverse segments of the population. There are numerous provisions in the proposed rule that will advance a non-discriminatory health care environment. With respect to the impact on people with disabilities, CPR would like to mention the importance of the provisions relating to effective communication for individuals with disabilities, accessibility standards for medical facilities and equipment, as well as modifications to procedures, policies, and practices by health care programs and activities.

CPR's comments, however, will focus on prohibitions against discrimination in connection to health-related insurance and other health-related coverage.

Non-Discrimination Based on Disability and Age in Health Plan Benefit Design

We are grateful to the OCR for recognizing the connection between Section 1557 (codified at [42 U.S.C. § 18116](#)) and discriminatory health plan benefit designs. CPR believes that this is perhaps one of the most important applications of this section of the Affordable Care Act. Section 1302 of the ACA contains more specific prohibitions against disability and age-based discrimination in health plan design. [42 U.S.C. § 18022\(b\)\(4\)](#) For instance, Section 1302 of the ACA prohibits discrimination 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 grounded in nondiscrimination based on disability status and age.

CPR strongly encourages the HHS Secretary to move forward with further regulation of Section 1302 as a critical adjunct to the regulations being proposed under Section 1557. To be clear, there have been regulations issued to implement Section 1302 (the essential health benefit (EHB) requirements generally) and 45 CFR 156.125, which is the current regulation that is intended to implement Section 1302(b)(4) of the ACA, the specific prohibitions against discrimination in the essential health benefits package. However, the CPR does not believe that 45 CFR 156.125 goes far enough in laying out specific types and examples of discriminatory benefit design, nor do we believe that HHS and the states have gone far enough in their enforcement of the non-discrimination protections of Section 1302. While health care consumers await further regulation by HHS of the non-discrimination protections of Section 1302, we believe that HHS should issue strong regulations under Section 1557 that further illustrate and elaborate on discriminatory health plan design, especially from a disability and aging perspective.

The Rehabilitation Act of 1973 and the Americans with Disabilities Act were seminal federal laws that addressed disability discrimination in a variety of settings, including to a limited extent, the provision of health insurance and health coverage. Section 504 of the Rehabilitation Act applies to the terms and conditions of insurance policies, and not simply to whether or not an individual is afforded insurance coverage. See, e.g., 28 C.F.R. Part 36, App. B, § 36.212 (Department of Justice regulations implementing Title III of the ADA, stating that "[l]anguage in the [ADA] committee reports indicates that Congress intended to reach insurance practices by prohibiting differential treatment of individuals with disabilities in insurance offered by public accommodations unless the differences are justified;" 29 C.F.R. Part 1630, App., § 1630.16(f) (EEOC interpretive guidance for regulations implementing Title I of the ADA, stating that a covered entity cannot deny a qualified individual with a disability equal access to insurance or subject a qualified individual with a disability to different terms or conditions of insurance based on disability alone if the disability does not pose increased risks).

Section 504 prohibits all disability-based distinctions in insurance coverage that are not justified by legitimate actuarial data or actual or reasonably anticipated experience. 29 C.F.R. Part 1630, App., § 1630.16(f). Such data or experience cannot be based on generalized information about the cost of covering individuals with a particular condition or covering particular services. CPR believes that many of the exclusions of benefits, limitations, and arbitrary caps that appear in present-day EHB plan designs are not based on actuarial data and risk violation of these federal nondiscrimination laws. We urge the OCR to clearly state in the text of the final rule that, Section 1557 incorporates prohibitions against this form of discrimination.

We also urge the Department to provide additional guidance in the final rule concerning what constitutes disability-based discrimination in health insurance, including discriminatory benefit design, discriminatory payment structures, discriminatory network design, and discriminatory coverage decisions. The bare statement in the proposed rule that Section 1557 prohibits discriminatory benefit design offers no information to beneficiaries about their rights under Section 1557 and no information to plan administrators, Medicaid officials, and others about their obligations under Section 1557. In order for Section 1557 to be implemented effectively, covered entities and protected individuals must have more guidance concerning the meaning of disability-based discrimination in health insurance.

This additional guidance is crucial because insurance companies discriminate against people with disabilities in a variety of ways, including through drug formularies, narrow networks, increased cost-sharing, inappropriately designed wellness programs, utilization management programs, and by imposing limitations or caps on certain services. These discriminatory practices are often driven by a desire to reduce short-term costs. However, limiting access to health care for people with disabilities or chronic conditions is not cost-effective in the long term as it often results in further complications and avoidable hospital admissions and readmissions.

In the proposed regulatory language, Section 92.207(b)(1) prohibits a covered entity from limiting a health insurance plan, policy or other health coverage, or limiting coverage of a claim, or imposing limitations on the basis of an enrollee's disability. Section 92.207(b)(2) prohibits a covered entity from employing marketing practices or benefit designs that discriminate on the basis of disability. OCR should finalize these regulations and then issue guidance describing this discrimination and offering illustrations to highlight how these provisions impact commonly accepted insurance practices, especially with respect to the category of essential health benefits known as "rehabilitative and habilitative services and devices."

CPR continues to survey its members and study essential health benefit (EHB) benchmark plans selected by states to determine whether such plans discriminate based on disability and age, with a focus on rehabilitative and habilitative services and devices. This benefit category is mandated by 1302 of the ACA and has been regulated more than most required benefit categories. For instance, under the February 2015 final rule *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016*, plans must:

- 1) Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services) (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);

- 2) Not impose limits on coverage of habilitative services and devices that are less favorable than any such limits imposed on coverage of rehabilitative services and devices; and,
- 3) For plan years beginning on or after January 1, 2017, not impose combined limits on habilitative and rehabilitative services and devices.⁴

We encourage the OCR to hold states and QHP issuers accountable for their violations of the ACA's anti-discrimination provisions, specifically as they relate to EHB benefit design. Specific examples of discriminatory benefit designs include the following:

- **Limitations or caps on coverage of services.** Imposing 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, federal law requires that such caps do not rely on disability-based distinctions and must be justified by legitimate actuarial data or actual or reasonably anticipated experience. Further, the CPR Coalition believes that EHB plans that do not include an *exceptions process* for patients with greater-than-average needs after a cap has been exceeded risk violation of 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 caps in benefits. Limitations on the number of covered visits without regard for medical necessity, best medical practices, or the extent of therapy prescribed to the individual discriminates against people with more significant disabilities who need this extensive habilitation or rehabilitation in order to gain, regain, or maintain functioning. CPR strongly encourages OCR to include in the final rule a statement that plans that discontinue benefits to patients with disabling conditions after a one-size-fits-all service cap has been reached, without individual consideration of a patient's medical needs, are at serious risk of violating Section 1557.
- **Limitations and exclusions of certain devices.** Imposing monetary caps in coverage of durable medical equipment, prosthetics, orthotics, and other devices under ACA plans is expressly prohibited. But many EHB benchmark plans impose other types of limitations and exclusions that are premised on disability-based distinctions and are not based on actuarial data. For instance, coverage exclusions of certain types of modern prosthetic limb technologies are applicable to only one disability group, individuals with limb loss. No coverage for hearing technologies or vision aids similarly impact one disability group and thereby can be considered disability-based distinctions. The OCR should provide additional guidance on these forms of discriminatory plan design so that plans and participants understand what types of benefit limitations and exclusions are not permissible.
- **Related Discriminatory Treatment of Covered Benefits.** CPR is further concerned that brain injury services might not be covered in both EHB plans and QHPs when the reason for the brain injury is related to an attempt of suicide. Coverage for EHB benefits should not be dependent on the reason or origin of the injury or condition. This clearly presents a slippery slope where health plans could deny coverage for treatment based on a wide variety of reasons. CPR is also concerned that EHB plans and QHPs continue to discriminate based on mental health conditions. The OCR should clarify in the final rule that this type of discrimination is

⁴ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10750, 10871 (February 27, 2015).

impermissible under Section 1557 of the ACA and that EHB benchmark plans and QHPs that include these policies must modify them accordingly.

Examples of Discriminatory Plan Design Taken From EHB Benchmark Plans

In September 2015, the CPR Coalition examined a number of proposed state EHB benchmark plans and found several common themes where we believe coverage for rehabilitative and habilitative services and devices is not in compliance with federal law. Within this category, people with disabilities experience discrimination on the basis of age, disability, and the type or severity of their disability. We have provided several examples below that the OCR should include as illustrations of impermissible discrimination under Section 1557, and through future rulemaking on Section 1302.

Limits on Rehabilitative Services

- Up to 20 visits per calendar year for outpatient rehabilitative services: Idaho, Wyoming
- Up to 20 visits per beneficiary period for outpatient rehabilitation services: Missouri

Recommendation: Failure to cover rehabilitative services under the EHB benchmark is an outright violation of the statutory provisions of the ACA. In addition, states with severe restrictions in coverage for as few as 20 visits per year or per beneficiary period—coupled with no exceptions process for those with much greater medically necessary needs—violate the non-discrimination provisions of the ACA on the basis of disability. We recommend that the OCR clarify in the final rule that states with severe coverage limitations such as these must revise their EHB benchmark plans, and QHPs must revise their plans' coverage limits, accordingly.

Limits on Habilitative Services

- No coverage for habilitative services: Arizona, Florida, Louisiana, Mississippi, South Carolina, Vermont, Wisconsin
- Up to 20 visits per calendar year for habilitative services: Missouri, Tennessee, Wyoming
- Limits habilitation to one condition: Alabama, Arkansas, Wisconsin

Recommendation: CPR believes that these provisions violate key statutory and regulatory requirements of the ACA with regard to EHB benchmark plan offerings. Failure to cover habilitation services under the EHB benchmark is an outright violation of the Section 1302 of the ACA. With respect to any state that offers coverage for as few as 20 visits per year for habilitation, we believe this severe limitation—coupled with no exceptions process for those with much greater medically necessary needs—violates the non-discrimination provisions of the ACA on the basis of disability under both Sections 1557 and 1302. We recommend that the OCR require in the final rule that states revise their EHB benchmark plans, and QHPs revise their plans, accordingly.

Limits on Rehabilitative and Habilitative Therapy

- 60 visits per year, combined, for rehabilitative speech therapy, occupational therapy, and physical therapy: Arizona, Maine
- 45 visits per year, combined, for rehabilitative speech therapy, occupational therapy, physical therapy, and chiropractic or osteopathic physiotherapy: Nebraska
- 30 visits per year, combined, for speech therapy, occupational therapy, and physical therapy: Alabama, Arkansas

- 25 visits per benefit period for each of habilitative speech therapy, occupational therapy and physical therapy, and rehabilitative speech therapy, occupational therapy and physical therapy: Kentucky
- 20 visits per benefit period for each of rehabilitative speech therapy, occupational therapy and physical therapy: Colorado, Indiana, Mississippi, Ohio, Tennessee

Recommendation: CPR believes that if states choose to impose caps in rehabilitation or habilitation therapy services, they must not rely on disability-based distinctions and must be justified by legitimate actuarial data or actual or reasonably anticipated experience. In addition there must be an exceptions process to meet the needs of individuals who require more therapy than the cap allows for the person with average therapy needs. Although not required by federal regulations on the rehabilitative and habilitative services and devices benefit under the ACA, we believe that any therapy caps established under EHB benchmark plans should apply to different types of therapy services. For instance, if states adopt therapy caps, EHB benchmark plans should apply separate caps for physical therapy, occupational therapy, and speech therapy and each such cap must ensure access to a sufficient amount of therapy under EHB plans to meet the needs of enrollees. Of course, federal EHB regulations already require that caps in therapy benefits must be applied separately for rehabilitation and habilitation services. Finally, chiropractic services are not considered rehabilitative or habilitative services under therapy cap regulations and should be treated separately for purposes of coverage limits. We recommend that the OCR clarify in the final rule that states must revise their EHB benchmark plans, and QHPs revise their plans, accordingly, in order to comply with Section 1557.

Limits on Prosthetic Limbs

- 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: Wisconsin
- \$5,000 lifetime limit for benefits related to the temporomandibular/craniomandibular joint (includes prosthetic appliances): Mississippi

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 by the ACA and, therefore, Mississippi's \$5,000 lifetime cap directly violates the ACA. Failure to cover rehabilitative and habilitation devices (e.g., prosthetic limbs, as in Utah) is a direct violation of the ACA statute and federal regulations. 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. This limitation is also a disability-based distinction as the limitation applies only to individuals with limb loss and, therefore, violates Section 1557. We recommend that the OCR clarify in the final rule that states with coverage limitations such as these must revise their EHB benchmark plans, and QHPs must also revise their plans, accordingly.

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 constitutes a disability-based distinction as these benefits only apply to individuals with hearing loss and, therefore, this violates both Section 1302 and Section 1557 of the ACA. Coverage of hearing aids for children only—and not for adults—also violates the ACA prohibition against discrimination in plan design based on age under both Sections 1302 and 1557. For these reasons, hearing aids are required EHB benefits and must be covered regardless of age. We recommend that the OCR clarify in the final rule that states with such limitations and exclusions must revise their EHB benchmark plans, and QHPs must also revise their plans, accordingly.

We greatly appreciate your attention to our concerns and your interest in our participation in this process. Should you have further questions regarding this information, please contact Peter Thomas or Steven Postal, CPR staff, by emailing Peter.Thomas@ppsv.com or Steven.Postal@ppsv.com, or by calling 202-466-6550.

Sincerely,

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Supporting Organizations

ACCSES
American Academy of Physical Medicine and Rehabilitation
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
American Therapeutic Recreation Association
Amputee Coalition
The Arc of the United States
Association of University Centers on Disabilities
Brain Injury Association of America
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Child Neurology Foundation
Christopher and Dana Reeve Foundation
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Epilepsy Foundation
Falling Forward Foundation
Lakeshore Foundation
National Association for the Advancement of Orthotics and Prosthetics
National Association of State Head Injury Administrators
National Disability Rights Network
National Multiple Sclerosis Society
National Rehabilitation Association
National Stroke Association
Paralyzed Veterans of America
Parkinson's Action Network
United Cerebral Palsy
United Spinal Association