National Office: Suite 1540, 1700 N. Moore Street, Arlington, VA 22209-1903
703/524-6686, Fax: 703/524-6630, TTY: 703/524-6639
Website: www.resna.org

December 26, 2012

Mr. Gary Cohen, Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

RE: (CMS-9980-P) ACA Standards Related to Essential Health Benefits, Actuarial Value and Accreditation of Qualified Health Plans

Dear Director Cohen:

RESNA, the Rehabilitation Engineering and Assistive Technology Society of North America, is the premier professional organization dedicated to promoting the health and well-being of people with disabilities through increasing access to technology solutions. RESNA advances the field by offering certification, continuing education, and professional development; developing assistive technology standards; promoting research and public policy; and sponsoring forums for the exchange of information and ideas to meet the needs of our multidisciplinary constituency.

RESNA appreciates the opportunity to comment on the proposed rule *ACA Standards Related to Essential Health Benefits, Actuarial Value and Accreditation of Qualified Health Plans*. For healthcare reform to work for individuals with disabilities, the Affordable Care Act's (ACA) mandated benefit categories and non-discrimination provisions must be the foundation of the essential health benefits (EHB) packages that Americans in the individual and small group markets will depend upon starting in 2014. Appropriate, medically necessary devices are a basic and essential part of life for many individuals with a disability.

To ensure Americans with disabilities' full availability of and equal access to EHB packages, we affirm our support for enforcement of Section 1557 of the ACA (42 U.S.C. 18116), which provides that an "individual shall not be excluded from participation in, be denied the benefits of, or be subjected to discrimination on the grounds prohibited under…Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. 794 (disability). We believe strongly that the federal government must play a significant role in establishing and enforcing the ACA's nondiscrimination standards. RESNA has signed onto letters submitted by the Consortium for Citizens with Disabilities (CCD) and Hearing Access Program (HAP) in response to the same proposed rulemaking.

RESNA recommends that HHS specify in the final rule that EHB base-benchmark plans must cover, at a minimum, all of the benefits within categories of care that list more than one benefit. For example, a plan should not be considered an EHB-benchmark plan unless it covers *as three distinct benefits* rehabilitation, habilitation, and devices, as opposed to only covering rehabilitation or only covering devices. Each of these benefits is integral for meeting the health and wellness needs of Americans with disabilities, and they cannot be substituted for one another. Availability of benefits will also serve the prevention and cost savings objectives of the ACA.

We suggest that clarification is needed to ensure that the "rehabilitation" benefit includes both *rehabilitation services and devices*, and "habilitation" benefit includes both *habilitation services and devices*. Occasionally there are situations when devices may be needed without the need for rehabilitation services or habilitation services; however, this is not typical. For example, a person with a disability who is an experienced wheelchair user may not require rehabilitation services when a replacement wheelchair becomes medically necessary. However, they may require rehabilitation services for an evaluation and documentation of medical necessity for an appropriate replacement wheelchair as required in policy by many third-party payors.

In order to realize these recommendations, RESNA offers the following specific guidance:

First, there are multiple places in the proposed standards where clarification is needed. At mentions of "services" (excluding those mentions of "benefits") the phrase "and devices" should be added to specify that devices are independent of services and equally valid for consideration in the proposed regulations.

For example:

"As an alternative to the transitional approach outlined in Sec. 156.110(f), some states may prefer to provide issuers with the opportunity to define the specific benefits included in the habilitative services **and devices** category if it is missing from the base-benchmark plan. Accordingly, we are proposing that a state may allow issuers time and experience to define these benefits. Specifically, in paragraph (a)(4), we propose that if the EHB-benchmark plan does not include coverage for habilitative services **and devices** and the state does not determine habilitative benefits, a health insurance issuer must either: (1) Provide parity by covering habilitative services **and devices** benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services; or (2) Decide which habilitative services **and devices** to cover and report on that coverage to HHS. With regard to option (2), HHS intends to evaluate the habilitative services **and devices** reported and further define habilitative services **and devices** in the future. The issuer only has to supplement habilitative services **and devices** when there are no habilitative services **and devices** at all offered in the base benchmark plan and

the state has not exercised its option to define habilitative services **and devices**…"

Second, we recommend that HHS consider the adoption of a category-specific, non-exhaustive list of "rehabilitative and habilitative devices" to guide providers in their provision. Here, we reference the CCD's "Open Letter to the States on Defining Essential Health Benefits Package" from September 2012 (see http://www.resna.org/aboutUs/documents/EssentialHealthBenefits_TAonRehab%26Hab092012.pdf). The technical assistance in this letter expounded upon and clarified durable medical equipment (DME), orthotics and prosthetics, prosthetic devices, low vision aids, augmentative and alternative communications devices (AACs), and hearing aids and assistive listening devices. We further recommend this list include complex rehabilitation technologies (CRT) as part of the EHB.

Complex rehabilitative technologies are devices such as complex rehabilitation power wheelchairs, highly configurable manual wheelchairs, adaptive seating and positioning systems, and other specialized equipment that enable individuals to maximize their function and minimize the extent and costs of their medical care. Many of these devices must meet stringent, internationally accepted testing criteria set forth by the RESNA Technical Standards Board. These items serve individuals with permanent disabilities and progressive or serious medical conditions that require a broader range of services and specialized personnel, such as those credentialed by the RESNA Professional Standards Board, than what is required for standard DME.

Any definition for "rehabilitative and habilitative devices" should consider how they might *maintain* as well as *improve* function. This would be consistent with definitions by the National Association of Insurance Commissioners (NAIC) and HHS in the proposed rule on the definition of medical and insurance terms for purposes of comparing health plans in the state exchanges (76 FR 52442 and 76 FR 52475). In addition, we recommend consideration be given to how rehabilitative and habilitative devices may minimize or prevent further loss of function and/or secondary medical complications and include this in the final definition.

Third, RESNA recommends that HHS consider taking a patient-oriented approach that streamlines and simplifies the benefits process for individuals disadvantaged historically in the provision of healthcare. Americans with disabilities have faced inaccessibility and exclusion in the insurance coverage market. To ensure their ability to participate, HHS might consider:

- Establishing a process for participants to request and receive coverage for benefits, including devices, not conventionally covered by the plan.
- Developing a process that allows an enrollee to request clinically appropriate benefits, including devices, not covered by the health plan and in line with the prescription drug benefit.

- Providing a process for participants to request and receive coverage for benefits, including devices, beyond the limits set by the plan when medically necessary and appropriate.

Incorporating flexibility into the program is vital to ensuring that citizens who may be disadvantaged will receive consideration for their benefits, including Americans with disabilities reliant upon rehabilitation devices and habilitation devices. As HHS develops this we respectfully request the opportunity to work with the agency on further defining the above recommendations for inclusion in the final rule.

RESNA appreciates the opportunity to offer its comments and hopes that HHS's rules will take into account Americans with disabilities who utilize rehabilitation devices and habilitation devices, among other technologies, to enable access and inclusion within society. We stress the need that this rulemaking should consider the importance of equity and the potential of these rules to redress historical discrimination against Americans on the basis of disability or chronic health conditions.

RESNA would be pleased to offer HHS data about the role devices play in improving and maintaining function, as well as examples of cases where unintended lack of clarity in public and private health insurance language has led to needed devices being denied.

Respectfully submitted,

Alex Mihailidis, Ph.D. P.Eng.
RESNA President

Nathan W. Moon, Ph.D.
Chair, RESNA Government Affairs Committee