American Orthotic & Prosthetic Association

Members of Congress Need to be Reminded that Orthotics and Prosthetics Were Intended to Be Covered as an Essential Benefit in the Patient Protection and Affordable Care Act and that HHS Actions Delegating the Definition of Essential Benefits by the States Causes Uncertainty and Risk to Patients with Limb Loss and Limb Impairment.

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I. Legislative History supports inclusion of O&P under Rehabilitation and Habilitation Category

Congressional intent is clear that orthotics and prosthetics (O&P) fall under the Rehabilitation and Habilitation category, which is one of the ten statutorily defined EHB categories for which plans must provide coverage. To its credit, HHS noted that some of the benchmark plans did not include 'habiliitative' benefits, and so made provision that content on rehabilitative services would need to be added to any benchmark plan that did not already include it in order to assure compliance with the federal standard. This is supported by the legislative history, which is replete with statements by leading legislators clarifying that this term was indeed intended to include orthotics and prosthetics.

Rep. George Miller, the Chair of the House Energy and Commerce Committee, and as such a key author of the bill, stated:

> "I am pleased that the essential benefits in the Patient Protection and Affordable Care Act include rehabilitative and habilitative services and devices, as these benefits are of particular importance to people with disabilities and chronic conditions...
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> The term 'rehabilitative and habilitative devices' includes durable medical equipment, prosthetics, orthotics, and related supplies. It is my understanding that the Patient Protection and Affordable Care Act requires the Secretary of Health and Human Services to develop, through regulation, standard definitions of many terms for the purposes of comparing benefit categories, from one private health plan to another. It is my expectation 'prosthetics, orthotics, and related supplies' will be defined separately from 'durable medical equipment.'"

Congressional Record, p.H1882 (March 21, 2010).

In parallel, another legislator, Rep. William Pascarell, a member of the House Ways and Means Committee, the House Committee of jurisdiction at the time the Affordable Care Act was enacted, has re-stated the identical standard:

> "The term 'rehabilitative and habilitative devices' includes durable medical equipment, prosthetics, orthotics, and related supplies. It is my understanding that the Patient Protection and Affordable Care Act requires the Secretary of HHS to develop, through regulation, standard definitions of many terms, including durable medical equipment for purposes of comparing benefit categories from one private health plan to another. It is my expectation 'prosthetics, orthotics, and related supplies' will be defined separately from 'durable medical equipment' and the Secretary is not to define durable medical equipment for purposes of 'in-home" use only.'"

Congressional Record, p.E462 (March 23, 2010).

As demonstrated above, there is clear congressional intent that O&P falls under the statutorily defined EHB category of Rehabilitative and Habilitative services.

II. Dec. 16 EHB Bulletin considers O&P as consistently covered benefits

On December 16, 2011 HHS released an EHB Bulletin that outlined HHS' intended approach to EHB. As expressed in the Bulletin, HHS proposed that EHB be defined by each state selecting one plan from among four benchmark plan categories (representing up to 8 potential benchmark plans), which meet criteria set out in the Bulletin. This benchmark plan would serve as a reference for the state and be supplemented as needed to cover the 10 essential health benefits categories and any state required mandates. This "benchmark approach" to defining EHBs, in essence, delegates the decision of defining what benefits constitute covered services to the states.

While AOPA remains concerned with the "benchmark approach," we do want to underscore, endorse and state our rock-solid agreement with the only direct reference to orthotics and prosthetics in the EHB Bulletin. On the carry-over paragraph from page 4 to page 5 it is stated:

> "For example, across the markets and plans examined, it appears that the following benefits are consistently covered: physician and specialist office visits, inpatient and outpatient surgery, hospitalization, organ transplants, emergency services, maternity care, inpatient and outpatient mental health and substance use disorder services, generic and brand prescription drugs, physical, occupational and speech therapy, durable medical equipment, **prosthetics and orthotics**, laboratory and imaging services, preventive care and nutritional counseling services for patients with diabetes, and well child and pediatric services such as immunizations. As noted in a previous HHS analysis, variation appears to be much greater for cost-sharing than for covered services."
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> [Emphasis added].

This decision, in stating that O&P is among services, like physician visits, as benefits that "are consistently covered," is a critically important benchmark for all O&P patients. On the positive side, it doesn't get much better than being grouped with physician office visits, in terms of being essential. It is unfortunate that this clarity on the importance of including O&P services within EHBs is not sustained throughout other aspects of the EHB bulletin.

III. Concern regarding delegating EHB decision to states

a. Delegation of EHB Decision to States not what Congress intended

Many members of Congress, including the then Chairs of the six House Committees and sub-committees that had jurisdiction at the time the PPACA was adopted felt HHS would be setting a national policy on what are and are not "essential health benefits." This setting of a national policy would result in an immense value of having one well-understood national policy. These members were troubled with the approach initially proposed in the Dec. 16 EHB bulletin, passing a substantial component of the power to determine Essential Health Benefits to the states, an approach now largely reflected in the proposed rule.

In a letter to Secretary Sebelius, dated Feb. 6, 2012, key committee members (Rep. Waxman, Rep. Levin, Rep. George Miller, Rep. Pallone, Jr., Rep. Stark, Rep. Andrews and Rep. Dingell) expressed their concerns regarding the delegation of EHB to the states. The members stated that:

> "When creating the EHB package, we intended this to be a federal decision. We had not anticipated your decision to delegate the definition of the EHB package to states. While we understand the goal of balancing comprehensiveness and affordability, and ensuring an appropriate role for state input, we would reiterate that one of the primary goals of the Affordable Care Act was to create a consistent and comprehensive level of coverage for people across the country. Without very careful protections, we have serious concerns about delegating the decision for EHB to the States and providing even further discretion to insurers."

Part of the members' concern that "all stakeholders should have the opportunity to understand and comment on what an actual EHB package may be in a state," mirrors AOPA's concerns regarding the nebulous nature

of what actual benefits will be covered for each state. Unfortunately, when HHS published the final regulation on Essential health Benefits last month, they maintained the 'state option' so that these uncertainities remain in the final rule. This lack of clarity undercuts the intent of PPACA and makes it very challenging for stakeholders to fully understand and comment on what the specific EHB benefits are that will be covered within their state's EHB package.

b. Lack of clarity remains for stakeholders

When Congress enacted this law, it fully expected that HHS would publish a rule, presumably a statement that could be accessed in the Code of Federal Regulations that each citizen could consult to determine what is, and is not covered under an acceptable federal plan.

HHS, by deferring to the states on Essential Health Benefits, has undercut the very purpose of PPACA to establish a national health care policy and benefits package. Under the proposed disjointed approach when a patient with a chronic health condition, for example, an amputee or a patient with multiple sclerosis who has restored mobility through an artificial limb or customized orthopedic bracing is considering relocating (for employment or other reason) from one state to another, they will need to investigate and shape their decision around whether the PPACA health benefit assured in their new state (e.g. Utah) is different in this key area from the PPACA health benefit afforded in their current state of residence (e.g. New York). So, in the face of the struggles of differing benefits from a current employer to a potential new employer, or the Catch-22 of pre-existing conditions, that PPACA has gone a long way toward remedying, HHS itself has substituted a new uncertainly and confusion by endorsing non-equivalent Essential Health Benefits packages in each of the 50 states. Sadly, HHS, to date, has failed to carry out the job assigned to it by the Congress in PPACA.

c. Challenges remain to constructively comment on the actual EHB plan within state

The lack of clarity for stakeholders makes it very challenging for stakeholders to be able to comment on the actual EHB benefits that will be covered within a state. Currently, states may choose between four benchmark categories, representing up to 8 potential plans, which the state may then supplement categories from any of the other potential base-benchmark plans if the chosen base-benchmark does not cover any items or services within an EHB category. HHS has proposed a rule which for insurers to substitute benefits, or sets of benefits, that are actuarially equivalent to the benefits being replaced. The proposed rule does note that states have an option to enforce a stricter standard on benefit substitution or prohibit it completely. Nonetheless, this reported flexibility for states leaves stakeholders without a clear picture of the actual benefits that will be covered under the Essential Health Benefits package within their state.

VI. Conclusion

In conclusion, AOPA wants to reinforce that there is strong evidence of Congressional intent for O&P services to be included under the Rehabilitation and Habilitation Services statutorily defined EHB category. Further, HHS' Dec. 16 EHB Bulletin groups O&P services along with physician visits as services typically covered under health insurance plans. AOPA reiterates the concern with delegating the determination of specific EHB benefits to the state given this approach was not intended by Congress and undermines the PPACA goal of creating a consistent and comprehensive level of coverage for people across the country. The proposed benchmark approach leaves stakeholders struggling to understand what benefits may or may not fall under each state's EHB benchmark plan. AOPA believes that patients generally, and particularly patients with disabilities would have been better served if, in the final rule, HHS had more clearly defined EHB, to include unambiguously requiring the provision of O&P services for **all** plans required to cover the EHB package.

For more information contact the American Orthotic & Prosthetic Association (AOPA) at (571) 431-0876 or www.AOPAnet.org.

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