



**American Orthotic &
Prosthetic Association**

March 6, 2018

The Honorable R. Alexander Acosta
Secretary, U.S. Department of Labor
Submitted electronically via www.regulations.gov (RIN 1210-AB85)

Re: Public Comments from AOPA Regarding Proposed Changes to the Definition of
“Employer” Under Section 3(5) of ERISA

Dear Secretary Acosta:

We are writing to provide comments on the proposed rule entitled *Definition of “Employer” Under Section 3(5) of ERISA-Associated Health Plans*. This proposed rule was published in the January 5, 2018 *Federal Register*.

The American Orthotic & Prosthetic Association (AOPA), founded in 1917, is the largest national orthotic and prosthetic trade association with a membership that draws from all segments of the field of artificial limbs and customized bracing for the benefit of patients who have experienced limb loss, or limb impairment resulting from a trauma, chronic disease or health condition. These include patient care facilities, manufacturers and distributors of prostheses, orthoses and related products, and educational and research institutions.

AOPA’s comments relative to this proposed rule will be limited to those that address Essential Health Benefits, specifically the provisions of the proposed rule that would potentially impact access to quality orthotic and prosthetic care for patient’s covered under newly define association health plans.

Essential Health Benefits

As part of the Affordable Care Act (ACA), Congress identified several categories of health benefits services and services that were considered “essential” when discussing coverage by health care plans. Among these categories of essential health benefits was habilitative and rehabilitative services, a subset of which includes orthotic and prosthetic devices. The ACA definitions associated with rehabilitative services established, for the first time, uniform definitions that created a baseline for coverage by insurers nationwide and minimized the variability of coverage for orthotic and prosthetic services within each of the states. The recognition of orthotic and prosthetic services and devices as essential health benefits

significantly reduced the ability of health plans to not include coverage of these important, cost effective, and restorative devices as part of their benefit package.

In December 2014, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule that would delegate authority on coverage of essential health benefits to individual states. At that time, AOPA expressed its concern relating to the delegation of excessive authority regarding coverage of essential health benefits to the states, through creating the concept of benchmark plans. AOPA pointed out that this was clearly not the original intent of the Patient Protection and Affordable Care Act (PPACA) which was enacted with the purpose of creating consistency in health care coverage on a national level via a reliable national package of essential health benefits.

Many members of Congress at the time of the 2014 proposed rule, including the then Chairs of the six House Committees and sub-committees that had jurisdiction at the time the PPACA was implemented articulated in a letter to top officials of HHS and CMS that it was clearly Congress' intent that HHS would establish a national policy on what are and are not "essential health benefits." These members were troubled with the approach initially proposed in the Dec. 16, 2011 EHB bulletin, where HHS errantly passed a substantial component of the power to determine Essential Health Benefits to the states, which created state-by-state differences in what is an essential health benefit.

CMS subsequently issued another proposed rule on November 2, 2017 that would further expand the authority of individual states in defining essential health benefits relative to their inclusion in state "benchmark" plans. AOPA again expressed its concern, through submission of public comments, that the intent of the ACA was to create a national standard regarding essential health benefits and to not simply delegate that authority to the individual states.

AOPA Concerns Regarding the Proposed Change in Definition of the Term "Employer"

AOPA understands the goal of increasing access to affordable health care and recognizes the value that re-defining the term "employer", as it relates to association based health plans, may afford when negotiating rates, but is concerned that the revised definition may have significant impact on access to orthotic and prosthetic care. The requirements for coverage of essential health benefits as outlined in the ACA are much more significant for small group and individual health plans. AOPA is concerned that redefining the definition of the term employer will shift the role of association health plans from that of a conglomerate of small group health plans to a single large group health plan. This shift may reduce the requirements of these plans to offer essential health benefits, including prosthetic and orthotic services, as part of their overall package of covered services, resulting in less comprehensive coverage and higher out of pocket costs for individuals with limb loss and mobility impairment.

While the proposed rule may offer a short term reduction in overall healthcare costs through the creation of association health plans, the reduction in benefits may force individuals who require prosthetic and orthotic care into higher cost individual and small group plans in order to maintain access to the care they need to function on a daily basis.

Recent studies by both the RAND Corporation and the health economics firm Dobson DaVanzo have conclusively shown that the provision of orthotic and prosthetic devices actually saves money over time as a result of increased patient activity, fewer falls, and fewer co-morbidities leading to additional health care costs. AOPA is concerned that association health plans may not appreciate the value of orthotic and prosthetic care as a preventative measure and simply eliminate them as high cost, low volume services.

Annual and Lifetime Limits

In addition to defining essential health benefits, the ACA also addressed both annual and lifetime limits for benefits provided by insurers. AOPA is encouraged by the provision in the proposed rule that would maintain the ACA restriction on annual and lifetime limits for association based health plans. The ability for individuals with limb loss or mobility impairment to have access to more than one device over a period of time or a lifetime to accommodate either changes in condition or growth is crucial to ensuring that they have access to high quality, clinically appropriate orthotic and prosthetic care. AOPA remains concerned however that since restrictions on annual or lifetime limits are tied to essential health benefits in the ACA, and association based health plans may have greater discretion in coverage of these benefits, the restriction on annual or lifetime limits may become irrelevant if the services are not covered in the first place.

The Patient is the Biggest Concern

AOPA's interest in this proposed rule is limited only to our concern that prosthetic and orthotic patients retain the right to reasonable coverage of the devices that have literally transformed their lives. Prior to the passage of the Affordable Care Act, amputees and those with mobility impairment were often unable to obtain insurance coverage for the devices that restored their functionality. When there was coverage available, it was often grossly inadequate, with significant restrictions due to annual and/or lifetime limits that provided no coverage for replacement devices that were either worn out or no longer met the medical needs of the patient. With the passage of the Affordable Care Act and the establishment of rehabilitative services as an essential health benefit, new coverage opportunities became available for users of prosthetic and orthotic devices. Patients could no longer be told that prostheses and orthoses were simply not included in the plan or that it didn't matter if your prosthesis no longer fit because your lifetime limit had been reached. Patients were no longer faced with the decision whether to pay their bills or have their prosthesis fixed. Any proposal that reduces access to high quality, clinically appropriate care should be considered universally unacceptable even if the intent of the proposal is not to directly deny access to needed healthcare services. The positive and negative impact on patients must be paramount before any regulation is finalized.

Conclusion

In closing, AOPA appreciates the opportunity to submit comments on the proposed rule that would change the definition of the term employer under section 3(5) of ERISA and reiterates its overall concern that coverage of orthotic and prosthetic services remain an essential health

benefit regardless of how an insurance plan is classified. Millions of individuals with limb loss and mobility impairment rely on insurance coverage to allow them to maintain functional lives within today's society.

If you have any questions or need any additional information, please contact myself, at (571) 431-0876 or tfise@aopanet.org, or Joseph McTernan, Director of Coding and Reimbursement Services, Education and Programming at (571)431-0811 or jmcternan@aopanet.org.

Sincerely,

A handwritten signature in black ink, appearing to read "T. F. Fise". The signature is written in a cursive style with a large initial "T" and "F".

Thomas F. Fise, JD
Executive Director