

A RIGHT TO CARE

Stacey A. Tovino, J.D., Ph.D.

INTRODUCTION	186
I. MEDICARE COVERAGE.....	193
II. NON-MEDICARE COVERAGE.....	200
A. <i>Statutory and Regulatory Background</i>	200
B. <i>Research Findings</i>	205
III. A RIGHT TO CARE.....	209
A. <i>The Framework of Health Parity Law</i>	211
B. <i>An Analogy to Mandated Benefit Law</i>	215
C. <i>The Lens of Health Services Definition Law</i>	216
PROPOSALS AND CONCLUSION	218
APPENDIX	220
SECOND STATE BENCHMARK PLANS**	220

A RIGHT TO CARE

Stacey A. Tovino, J.D., Ph.D.*

INTRODUCTION

On October 7, 2016, a nationally recognized constitutional law scholar was randomly attacked and beaten by a twenty-three-year-old man.¹ First responders quickly transported Professor Leslie Griffin to Las Vegas's Sunrise Hospital and Medical Center (Sunrise), where she was diagnosed with a severe traumatic brain injury (TBI) and admitted to the intensive care unit (ICU) in critical condition.²

During her first week in the Sunrise ICU, Professor Griffin was neither aware of herself nor her environment, nor did she wake.³ That is, Professor

* Judge Jack and Lulu Lehman Professor of Law and Founding Director, Health Law Program, William S. Boyd School of Law, University of Nevada, Las Vegas. I thank Daniel Hamilton, Dean, William S. Boyd School of Law, for his generous financial support of this research project. I also thank Karen Porter, Executive Director, Center for Health, Science & Public Policy, Brooklyn Law School, and the participants of the "Measured Experience: Neuroimaging, Consciousness, and the Law Symposium" held at Brooklyn Law School on February 3, 2017, for their comments and suggestions on the ideas presented at the Symposium and in this Article. Finally, I thank Leslie Griffin, William S. Boyd Professor of Law, William S. Boyd School of Law, University of Nevada, Las Vegas, for sharing her inspirational journey of recovery with the legal, medical, and bioethics communities and for her advocacy on behalf of patients and insureds with brain injuries.

1. See Rachel Hershkovitz, *Arrest Report Indicates Attack on UNLV Law Professor Was Random*, LAS VEGAS REV. J. (Oct. 13, 2016, 6:27 PM), <https://www.reviewjournal.com/crime/arrest-report-indicates-attack-on-unlv-law-professor-was-random/> (reporting the attack and beating of Professor Leslie Griffin in Henderson, Nevada, on October 7, 2016); Kelsey Thomas, *UNLV Law Professor in Critical Condition After Brutal Attack in Henderson*, K3NEWS (Oct. 11, 2016), <https://news3lv.com/news/local/unlv-law-professor-in-critical-condition-after-brutal-attack-in-henderson> (same).

2. See Max Michor, *UNLV Law Professor Hospitalized After Attack in Henderson*, LAS VEGAS REV. J. (Oct. 11, 2016, 6:12 PM), <https://www.reviewjournal.com/crime/unlv-law-professor-hospitalized-after-attack-in-henderson/> ("Griffin was taken to Sunrise Hospital and Medical Center in critical condition."); Ricardo Torres-Cortez, *Police: Suspect in Jogger Attack Showed 'Bizarre' Behavior*, LAS VEGAS SUN (Oct. 12, 2016, 3:33 PM), <https://lasvegassun.com/news/2016/oct/12/unlv-professor-attacked-while-jogging-in-henderson/> (noting that the random attack of Professor Griffin left her in critical condition); *id.* ("In the arrest report, police called Griffin's medical prognosis 'poor,' noting she suffered two brain bleeds and hadn't regained consciousness. She was at Sunrise Hospital and Medical Center.").

3. See Rocco Salvatore Calabrò & Antonio Naro, *Diagnosing Disorders of Consciousness: The Opening of Pandora's Box!*, 13 INNOVATIONS CLINICAL NEUROSCIENCE 10, 10 (2016) (explaining that "[c]onsciousness is a multifaceted concept" consisting of awareness of self and environment as well as wakefulness); Ferris Jabr, *Does Self-Awareness Require a Complex Brain?*, SCI. AM.: BRAINWAVES (Aug. 22, 2012), <https://blogs.scientificamerican.com/brainwaves/does-self-awareness-require-a-complex-brain/> ("Consciousness is awareness of one's body and one's environment.").

Griffin had a disorder of consciousness.⁴ At the beginning of her second week in the hospital, Professor Griffin's around-the-clock visitors observed signs suggesting Professor Griffin might be regaining consciousness. Notwithstanding, a hospital case worker attempted to discharge Professor Griffin to a local nursing home at the end of the second week, stating that insurance would not cover the scholar's transfer to a specialized brain rehabilitation facility because she was not improving fast enough.⁵

The author fought the insurer, eventually obtaining coverage of air ambulance transportation to a highly specialized brain rehabilitation unit at The Institute for Rehabilitation and Research at Memorial Hermann (TIRR Memorial Hermann), a top-ranked brain rehabilitation facility located in Houston, Texas.⁶ During her two-month stay in Houston, the Yale- and

4. See Calabrò & Naro, *supra* note 3 (stating that disorders of consciousness encompass “a spectrum of cognitive dysfunction,” including mild confusional states, delirium, dementia, coma, vegetative state, minimally conscious state, and brain death); Alison K. Godbolt et al., *Disorders of Consciousness After Severe Traumatic Brain Injury*, 45 J. REHABILITATION MED. 741, 741 (2013) (explaining that severe traumatic brain injury may cause disorders of consciousness, including coma, vegetative state, and the minimally conscious state); Megan S. Wright & Joseph J. Fins, *Rehabilitation, Education, and the Integration of Individuals with Severe Brain Injury into Civil Society: Towards an Expanded Rights Agenda in Response to New Insights from Translational Neuroethics and Neuroscience*, 16 YALE J. HEALTH POL'Y L. & ETHICS 233, 240–45 (2016) (explaining that disorders of consciousness (DOC) include coma, vegetative state, and the minimally conscious state; briefly defining each DOC and discussing the importance of rehabilitation for individuals in the minimally conscious state).

5. Cf. JOSEPH J. FINS, RIGHTS COME TO MIND: BRAIN INJURY, ETHICS, AND THE STRUGGLE FOR CONSCIOUSNESS 142–45 (2015) [hereinafter FINS, RIGHTS COME TO MIND] (discussing cases in which insurers have refused coverage or discontinued coverage of rehabilitation when a patient's progress has been determined to be “too slow”); Joseph J. Fins, *Disorders of Consciousness and Disordered Care: Families, Caregivers, and Narratives of Necessity*, 94 ARCHIVES PHYSICAL MED. & REHABILITATION 1934, 1938 (2013) (considering challenges to rehabilitation for individuals with disorders of consciousness, including insurance constraints); Joseph J. Fins et al., *Whither the “Improvement Standard”? Coverage for Severe Brain Injury After Jimmo v. Sebelius*, 44 J.L. MED. & ETHICS 182, 183–84 (2016) [hereinafter Fins et al., *Whither the “Improvement Standard”*] (discussing a hypothetical case drawn from research involving a young college student who sustained a traumatic brain injury and whose insurer denied further assessment and cognitive rehabilitation after three weeks of inpatient hospital care; noting that similar patients may end up “[m]arooned in what is euphemistically described as ‘custodial care’”); Wright & Fins, *supra* note 4, at 247 (offering several reasons why patients with disorders of consciousness lack access to rehabilitation; explaining that insurers deny coverage of rehabilitation based on rigid standards, including an improvement standard that may weed out insureds who have not progressed fast enough for the insurer); *id.* at 247–48 (noting that patients diagnosed as vegetative are often discharged from hospitals to nursing homes or other chronic or custodial care facilities); *id.* at 275 (stating that it is “necessary to conduct a proper assessment to determine whether someone is actually in a permanent vegetative state prior to discharging a patient to chronic care rather than rehabilitation” (footnote omitted)). *But see* Hogland v. Town & Country Grocer of Fredericktown Mo., Inc., No. 3:14CV00273 JTR, 2015 WL 3843674, at *1 (E.D. Ark. June 22, 2015) (noting that the plaintiff, who was broadsided and seriously injured while driving, was successfully transferred to a rehabilitation hospital following an inpatient stay at an acute care hospital).

6. See *About Us*, TIRR MEMORIAL HERMANN, <http://tirr.memorialhermann.org/about-tirr-memorial-hermann/> (last visited Sept. 8, 2018) (explaining that TIRR Memorial Hermann is the best rehabilitation hospital in Texas and the second-best rehabilitation hospital in the United States; stating that TIRR Memorial Hermann offers inpatient and outpatient rehabilitation services for individuals with brain injury, spinal cord injury, stroke, and neurologic disease).

Stanford-trained law professor recovered quickly and dramatically, resuming her teaching and scholarly activities at UNLV in fall 2017.⁷

Not everyone is so lucky. Many individuals who suffer from severe brain injuries as well as other chronic, progressive, and acute health conditions such as amyotrophic lateral sclerosis, Alzheimer's disease, multiple sclerosis, paraplegia, Parkinson's disease, quadriplegia, and stroke may need some combination of skilled nursing care, physical therapy, occupational therapy, speech-language therapy, respiratory therapy, cognitive rehabilitation, neuroprosthetics, and/or other rehabilitative technologies (hereinafter skilled care and rehabilitation) to aid in their assessment and diagnosis, to improve or maintain their functioning, or to prevent or slow their deterioration in functioning.⁸ Although not all of these individuals will improve like Professor Griffin, in part because scientists have yet to discover cures for many chronic and progressive conditions, skilled care and rehabilitation can help many individuals manage disease symptoms and maintain quality of life.⁹ However, insurers frequently deny coverage of skilled care and rehabilitation in these situations.¹⁰ Without

7. See Leslie C. Griffin, *Curriculum Vitae*, UNLV WILLIAM S. BOYD SCH. OF LAW, <https://law.unlv.edu/sites/default/files/faculty/resumes/GriffinCVAug18.pdf> (last updated Aug. 2018) (stating that Professor Griffin holds a Ph.D. in Religious Studies from Yale University and a J.D. from Stanford Law School); *Fall 2017 Schedule of Classes*, UNLV WILLIAMS S. BOYD SCH. OF LAW (Aug. 30, 2017), <https://bsl.app.box.com/s/1o1fjhjstvzi0yi5j1w3zg5rflzx6mj1/file/258176081712> (listing Professor Griffin as teaching Constitutional Law II during the fall 2017 semester); Leslie C. Griffin, *Book Review: "Into the Gray Zone" by Adrian Owen*, HARV. BILL OF HEALTH (Oct. 5, 2017), <http://blogs.harvard.edu/billofhealth/2017/10/05/book-review-into-the-gray-zone-by-adrian-owen/> ("[T]he doctors predicted I would either die or live institutionalized with permanent severe brain injury. . . . [I] continue to work now, not needing any care."); *Faculty Spotlight: Leslie Griffin*, UNLV WILLIAM S. BOYD SCH. OF LAW: BOYD BRIEFS (May 11, 2017), <https://law.unlv.edu/news/publications/boyd-briefs/faculty-spotlight-leslie-griffin> (referencing several talks by Professor Griffin in which she shared her inspirational recovery with academic audiences).

8. See Gill Deford, Margaret Murphy & Judith Stein, *How the "Improvement Standard" Improperly Denies Coverage to Medicare Patients with Chronic Conditions*, 43 CLEARINGHOUSE REV. 422, 423–24 (2010) (explaining how individuals with chronic conditions frequently need one or more skilled therapies to improve their conditions, to maintain their conditions, or to prevent or slow deterioration).

9. See Rebecca G. Logsdon, Susan M. McCurry & Linda Teri, *Evidence-Based Interventions to Improve Quality of Life for Individuals with Dementia*, 8 ALZHEIMER'S CARE TODAY 309, 309–18 (2007) (reviewing evidence-based interventions that can improve quality of life for individuals with dementia); Wright & Fins, *supra* note 4, at 270–72 (discussing auxiliary aids that may assist individuals with disorders of consciousness in communicating with their caregivers and connecting with their environments).

10. See, e.g., Leighton Chan et al., *Discharge Disposition from Acute Care After Traumatic Brain Injury: The Effect of Insurance Type*, 82 ARCHIVES PHYSICAL MED. & REHABILITATION 1151, 1151–54 (2001) (finding that an association exists between type of insurance and admission to rehabilitation facilities versus nursing homes for individuals with traumatic brain injuries; concluding that efforts should be made to determine the effect this association has on clinical outcomes for TBI patients given prior, analogous studies showing better outcomes for stroke patients who were admitted to rehabilitation facilities); Douglas Katz et al., *Natural History of Recovery from Brain Injury After Prolonged Disorders of Consciousness: Outcome of Patients Admitted to Inpatient Rehabilitation with 1–4 Year Follow-up*, 177 PROGRESS BRAIN RES. 73, 76–77 (2009) (explaining that a variety of clinical and nonclinical factors influence admission to specialized brain rehabilitation facilities and noting that

insurance coverage of skilled care and rehabilitation, these individuals are pushed towards nursing homes and other custodial care settings, frequently leading to decline or death.¹¹

Prior legal scholars expressing concern for these individuals have focused on Medicare¹² coverage of skilled care and rehabilitation.¹³ These scholars have argued that Medicare should cover skilled care and rehabilitation that aims to maintain, and not just improve, the health of Medicare beneficiaries.¹⁴ Scholars interested in Medicare beneficiaries with disorders of consciousness, in particular, have elegantly and persuasively argued that public health insurance coverage of skilled care and rehabilitation is an important civil, disability, and educational right.¹⁵

health insurance is one such factor); John Whyte & Risa Nakase-Richardson, *Disorders of Consciousness: Outcomes, Comorbidities, and Care Needs*, 94 ARCHIVES PHYSICAL MED. & REHABILITATION 1851, 1851 (2013) (discussing the history of health insurance coverage of skilled care and rehabilitation for individuals with disorders of consciousness; explaining that many insurers have implemented restrictive coverage requirements, such as the requirement that the patient be “undergoing identifiable functional improvement”).

11. See, e.g., FINS, RIGHTS COME TO MIND, *supra* note 5, at 5 (“Patients not ‘showing progress’ are discharged from rehabilitation programs to nursing homes where they linger without rehabilitation or diagnostic oversight.”); Whyte & Nakase-Richardson, *supra* note 10, at 1852 (“[I]n the United States, patients with DOC are divorced from [research and rehabilitation programs] within weeks of their injuries and placed in widely distributed . . . nursing homes in which they are generally cared for by primary care clinicians with no specialized training in DOC diagnosis and comorbidities.”). *But see* Jane E. Brody, *Nursing Homes that Belie the Bad Image*, N.Y. TIMES (Oct. 5, 2009), <https://www.nytimes.com/2009/10/06/health/06brod.html> (discussing the author’s initial perception of nursing homes as places of “neglect, mistreatment, understaffing, poorly trained attendants and even corruption” but also recognizing the outstanding care provided by some nursing homes).

12. See *infra* notes 22, 34, and 37 (providing necessary background regarding the Medicare program, its statutory history, and its four parts, respectively).

13. See, e.g., Susan A. Edwards & Mary D. Van de Kamp, *The Jimmo Settlement: Is it a Milestone for Medicare Coverage?*, 7 J. HEALTH & LIFE SCI. L. 1, 35–40 (2014) (discussing how the *Jimmo* settlement and the resulting Medicare Benefit Policy Manual revisions impact Medicare-participating health care providers as well as Medicare beneficiaries); Fins et al., *Whither the “Improvement Standard,”* *supra* note 5, at 183 (“In this paper, we consider the diagnostic, therapeutic, and rehabilitative needs of [minimally conscious] patients and explore the potential impact of the *Jimmo* [v. *Sebelius*] case and settlement on Medicare policy and practice.”); Jennifer E. Gladieux & Michael Basile, *Jimmo and the Improvement Standard: Implementing Medicare Coverage Through Regulations, Policy Manuals and Other Guidance*, 40 AM. J.L. & MED. 7, 9–13 (2014) (reviewing the regulatory status of Medicare coverage of outpatient physical therapy, occupational therapy, and speech-language pathology services); Kirsten A. Lerch & Kristy L. Fischmann, *Health Law, 2010-2011 Survey of New York Law*, 62 SYRACUSE L. REV. 685, 698–704 (2012) (examining recent, successful challenges to Medicare coverage of skilled nursing care, physical therapy, and occupational therapy; noting that these challenges are “particularly significant” for Medicare beneficiaries with stable health conditions).

14. See, e.g., Christopher W. Smith, *Advising Clients on Medicare*, MICH. B.J., Nov. 2014, at 37 (noting that attorneys who represent plateaued or nonimproving Medicare beneficiaries should advocate for continued insurance coverage for their clients by arguing that the restoration potential of the beneficiary is not the deciding factor for skilled care; rather, the beneficiary may need skilled care “to prevent further deterioration or preserve current capabilities”).

15. See Wright & Fins, *supra* note 4, at 237 (“This right stems by analogy to the expectation of free public education for children and adolescents, and also by statute under the Americans with Disabilities Act and under Supreme Court jurisprudence, namely . . . *Olmstead v. L.C.* ex rel. *Zimring*.” (footnote omitted)).

Although prior scholars have suggested or assumed¹⁶ that Medicare law and policy will influence commercial and other non-Medicare¹⁷ forms of health insurance coverage, not one piece of legal scholarship has tested this assumption in the context of skilled care and rehabilitation. Prior scholars have also failed to consider the impact of President Obama's Affordable Care Act¹⁸ and President Trump's incremental health care reforms¹⁹ on

16. See, e.g., Fins et al., *Whither the "Improvement Standard,"* *supra* note 5, at 182 ("[Medicare policy] has the potential to widely influence care determinations across the country for both government funded entitlement programs as well as private payers that typically look to [Medicare manuals] for guidance."); Thomas L. Greaney, *Medicare Advantage, Accountable Care Organizations, and Traditional Medicare: Synchronization and Collision*, 15 YALE J. HEALTH POL'Y L. & ETHICS 37, 38 (2015) (stating that "Medicare payment policy strongly influences commercial insurance"); Robert J. Milligan, *Coverage and Reimbursement for Pharmacogenomic Testing*, 48 JURIMETRICS J. 137, 143 (2008) ("Because of its size, and because Medicaid and commercial payors follow Medicare's lead in many circumstances, Medicare has a great deal of influence on health care financing in the United States." (footnote omitted)).

17. See Diane Archer & Theodore Marmor, *Medicare and Commercial Health Insurance: The Fundamental Difference*, HEALTH AFFAIRS (Feb. 15, 2012), <https://www.healthaffairs.org/doi/10.1377/hblog20120215.016980/full> (explaining the difference between Medicare, a federally administered insurance program that Americans pay into throughout their working lives and enroll in after they retire or become disabled, and commercial insurance, which receives premiums that must fund members' health care costs and administrative costs while maintaining profit margins sufficient to allow borrowing in the capital markets; further explaining that commercial insurers have an incentive to exclude unhealthy individuals in order to stay in business whereas Medicare was specifically designed to attract and cover elderly individuals and individuals with permanent disabilities, whose health care costs are higher).

18. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.); Wright & Fins, *supra* note 4, at 277 ("We do not address all possible reforms to realize the right to rehabilitation, including how our argument intersects with the Affordable Care Act, as that is beyond the scope of this Article.").

19. See, e.g., Bipartisan Budget Act of 2018, Pub. L. No. 115-123, §§ 50100–53119, 132 Stat. 64, 168–313 (2018) (establishing the Advancing Chronic Care, Extenders, and Social Services (ACCESS) Act, which amends federal law governing the Medicare program and the Children's Health Insurance Program (CHIP), among other programs); Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018, Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017) (to be codified at 26 U.S.C. § 5000A) (eliminating, after December 31, 2018, the shared responsibility payment for individuals who fail to maintain minimum essential health insurance coverage); Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28,912, 28,912–64 (June 21, 2018) (to be codified at 29 C.F.R. pt. 2510) (facilitating the adoption and administration of association health plans (AHPs) and claiming to expand access to affordable health coverage for employees of small employers and certain self-employed individuals); Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16,930 (Apr. 17, 2018) (to be codified at 45 C.F.R. pt. 147, 153–58) [hereinafter 2018 Final Rule] (giving states additional flexibility regarding the ACA's essential health benefits (EHB) requirements); Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 82 Fed. Reg. 51,052 (proposed Nov. 2, 2017) (to be codified at 45 C.F.R. pt. 147, 153–58) [hereinafter 2017 Proposed Rule] (proposing changes to current federal regulations governing benchmark plans and essential health benefits); Thomas Kaplan & Alan Rappoport, *Republican Tax Bill Passes Senate in 51-48 Vote*, N.Y. TIMES (Dec. 19, 2017), <https://www.nytimes.com/2017/12/19/us/politics/tax-bill-vote-congress.html> (noting that the initial name of the 2017 Budget Reconciliation Act—the Tax Cuts and Jobs Act—was "deemed out of order" and had to be removed); Peter Sullivan, *Ryan Calls for 'Incremental' Health Reforms after Failure of ObamaCare Repeal*, THE HILL (Feb. 13, 2018, 12:09 PM), <http://thehill.com/policy/healthcare/373612-ryan-calls-for-incremental-health-reforms-after-failure-of-obamacare-repeal> (referring to the 2017

non-Medicare coverage of skilled care and rehabilitation.²⁰ This Article fills these scholarly gaps.

This Article proceeds as follows: Part I describes the history of Medicare coverage of skilled care and rehabilitation.²¹ Medicare is a federal health care program that provides health insurance benefits to individuals who are sixty-five years of age and older, certain individuals who receive Social Security Disability Insurance, and certain individuals with end-stage renal disease.²² Before 2013, Medicare frequently denied coverage of skilled care and rehabilitation in cases involving Medicare beneficiaries who were no longer improving due to the chronic or progressive nature of their conditions.²³ In January 2013, however, the U.S. District Court for the District of Vermont, in *Jimmo v. Sebelius*,²⁴ approved a settlement agreement ordering Medicare to cover skilled care necessary to prevent or slow a Medicare beneficiary's deterioration or to maintain a beneficiary at his or her maximum practicable level of function even in the absence of any expectation of improvement.²⁵ Part I explains that the *Jimmo* precedent impacts future coverage determinations involving Medicare beneficiaries but not coverage determinations involving other public health care program beneficiaries, private group health plan members, or commercial insureds.²⁶

Part II of this Article is the first piece of legal scholarship to thoroughly examine the skilled care and rehabilitation limitations of group and commercial health insurance.²⁷ A novel contribution to the health law and

Budget Reconciliation Act and the Bipartisan Budget Act of 2018 as incremental health care reforms); Victor Thuronyi, *The Law with No Name or the "2017 Budget Reconciliation Act,"* SURLY SUBGROUP (Dec. 20, 2017), <https://surlysubgroup.com/2017/12/20/the-law-with-no-name-or-the-2017-budget-reconciliation-act/> (explaining that the informal name of "2017 Budget Reconciliation Act" is as neutral and acceptable as possible).

20. See generally Stacey A. Tovino, *Disparities in Private Health Insurance Coverage of Skilled Care*, 6 LAWS 21, 31–32 (2017) (calling for additional research that will show how many states have selected Affordable Care Act–mandated benchmark plans that expressly or impliedly contain an Improvement Standard for skilled care and rehabilitation; further asking whether the Affordable Care Act should be amended to clarify that skilled care and rehabilitation without an Improvement Standard should be considered an essential health benefit in the United States). This Article responds to this call for research and answers this question.

21. *Infra* Part I.

22. See 42 U.S.C. § 1395c (2012) (explaining that Medicare provides “basic protection against the costs of hospital, related post-hospital, home health services, and hospice care” for “individuals who are age 65 or over”; “individuals under age 65 who have been entitled for not less than 24 months to [Social Security Disability Insurance] benefits”; and “certain individuals who . . . have end stage renal disease”).

23. *Infra* Part I.

24. No. 5:11-cv-17, 2011 WL 5104355 (D. Vt. Oct. 25, 2011).

25. *Infra* Part I.

26. *Infra* Part I.

27. Compare Wright & Fins, *supra* note 4, at 277 (“We do not address all possible reforms to realize the right to rehabilitation, including how our argument intersects with the Affordable Care Act, as that is beyond the scope of this Article.”), with Fins et al., *Whither the “Improvement Standard,”*

insurance law literatures, Part II and the Appendix to this Article catalogue and assess the skilled care and rehabilitation coverage limitations set forth in the fifty-one benchmark health plans currently in effect in each state and the District of Columbia.²⁸ Part II and the Appendix show that at least 84% of today's benchmark plans require demonstration of improvement, or an expectation of improvement, before coverage of some type of skilled care or rehabilitation can occur in one or more inpatient or outpatient settings. More broadly, Part II illustrates that group, individual, and other non-Medicare coverage of skilled care and rehabilitation lags significantly behind Medicare coverage, thus challenging prior suggestions and assumptions regarding the influence of Medicare law and policy on commercial insurance in this context.²⁹ Finally, Part II shows how all states but one declined the opportunity to select new benchmark plans that will go into effect in 2020.³⁰

Part III of this Article asserts a right to care—and establishes a legal basis for such care—for non-Medicare insureds who need skilled care and rehabilitation to (1) aid in their assessment or diagnosis; (2) obtain or maintain their maximum practicable level of consciousness, cognition, functioning, communication, autonomy, or independence; or (3) prevent or slow their deterioration in functioning, as appropriate.³¹ For individuals with progressive neurological conditions, such as amyotrophic lateral sclerosis, multiple sclerosis, and Parkinson's disease, this right to care includes but should not be limited to management of disease symptoms; maintenance of flexibility and mobility; avoidance of muscle contractures; minimization of fatigue; conservation of energy; and promotion of safety, function, independence, and quality of life, even without the potential for cure or improvement.³² For individuals with disorders of consciousness, by

supra note 5, at 182 (exploring the impact of *Jimmo* on Medicare policy; noting that *Jimmo* has the potential to influence private payers that may look to Medicare for coverage guidance but not assessing whether any private payers have actually followed *Jimmo*).

28. *Infra* Part II; see also Robert King, *Trump's New HHS Secretary Says He Will Enforce Obamacare if Idaho Violates Law*, WASH. EXAMINER (Feb. 14, 2018, 11:48 AM), <https://www.washingtonexaminer.com/trumps-new-hhs-secretary-says-he-will-enforce-obamacare-if-idaho-violates-law> ("President Trump's new Health and Human Services Secretary Alex Azar . . . assured Congress . . . that he is committed to enforcing Obamacare if a state violates the law."); Nathaniel Weixel, *HHS Head Says He Will Uphold ObamaCare as Law*, THE HILL (Feb. 14, 2018), <http://thehill.com/policy/healthcare/health-reform-implementation/373799-hhs-head-says-he-will-uphold-obamacare-as-law> ("The top federal health official . . . said he will uphold ObamaCare as long as it remains the law.").

29. See sources cited *supra* note 27.

30. *Infra* Part II.

31. *Infra* Part III.

32. See, e.g., NAT'L MULTIPLE SCLEROSIS SOC'Y, *NURSING HOME CARE OF INDIVIDUALS WITH MULTIPLE SCLEROSIS: GUIDELINES AND RECOMMENDATIONS FOR QUALITY CARE* 5 (Dorothy E. Northrup & Debra Frankel eds., 2010) (explaining that multiple sclerosis is a "complex, chronic disorder of the central nervous system"); *id.* at 48 (stating that individuals with multiple sclerosis should have access to "rehabilitation professionals who can assess and prescribe equipment and therapeutic

further example, this right should include neuroimaging and other technologies that can best assess or diagnose each insured's disorder of consciousness, with a focus on detecting residual consciousness. This right to care should also include care designed to maximize the insured's potential for consciousness, cognition, and environmental connection, as appropriate.³³ Again, this right to care is asserted regardless of the capacity of the insured to fully or partially recover to a pre-injury state. A conclusion proposes structure and content for a new federal regulation at 45 C.F.R. § 156.110(g) that would codify the right to care asserted in this Article.

I. MEDICARE COVERAGE

Since the statutory creation of the Medicare program in 1965,³⁴ Congress has prohibited Medicare from paying for health care items and services for Medicare beneficiaries that are “not reasonable and necessary for the diagnosis or treatment of illness or injury *or* to improve the functioning of a malformed body member.”³⁵ Although the second part of the quoted disjunctive clause (i.e., “to improve the functioning of a malformed body member”) would require a requested treatment to improve a beneficiary's health condition before Medicare coverage could occur, the

activities that address mobility needs[,] . . . feeding, communication, swallowing, and limitations in performing activities of daily living”; further stating that skilled therapists must be made available to help individuals with multiple sclerosis maximize independence, mobility, and quality of life); Salony Majmudar, Jason Wu & Sabrina Paganoni, *Rehabilitation in Amyotrophic Lateral Sclerosis: Why It Matters*, 50 *MUSCLE NERVE* 4, 4–13 (2014) (explaining that ALS is a fatal neurodegenerative disease that causes muscle weakness, wasting, fatigue, spasticity, cramps, muscle twitches, dysphagia, dysarthria, and respiratory failure; discussing rehabilitation strategies that can minimize the disease-related symptoms and maximize the independence, function, safety, and quality of life of individuals with ALS).

33. Cf. Carlo Abbate et al., *Sensory Stimulation for Patients with Disorders of Consciousness: From Stimulation to Rehabilitation*, 8 *FRONTIERS HUM. NEUROSCIENCE* 1, 1 (2014) (referencing the large body of work investigating residual cognitive functioning in patients with disorders of consciousness; referencing “neurophysiologic and functional brain imaging studies [showing] that a subset of DOC patients are able to produce some . . . responses,” suggesting residual, “high-order cognitive functioning”); Wright & Fins, *supra* note 4, at 243–45 (referencing studies showing that almost 70% of patients with TBI who receive inpatient rehabilitation regain consciousness and that just over 20% are able to be functionally independent again; also discussing the promise of neuroimaging, drugs, neuroprosthetics, and physical therapy for the assessment, diagnosis, communication, and recovery of individuals with DOCs); *id.* at 282 (discussing the importance of an accurate diagnosis for individuals with DOCs; stating, in particular, “An accurate diagnosis is what determines suitability for various rehabilitative interventions, and access to drugs, drug trials, and certain communication devices is part of an emerging standard of care for rehabilitating brain injuries”).

34. See Social Security Amendments Act of 1965, Pub. L. No. 89-97, §§ 101–22, 79 Stat. 286, 290–360 (1965) (creating the Health Insurance for the Aged Act, also known as the Medicare program).

35. *Id.* §§ 101–02, 79 Stat. at 325 (emphasis added) (also creating new § 1862(a)(1) of the Social Security Act); accord 42 U.S.C. § 1395y(a)(1)(A) (2012) (current statutory provision containing the same prohibition). See generally Hays v. Sebelius, 589 F.3d 1279, 1280–83 (D.C. Cir. 2009) (thoroughly discussing and interpreting this provision in the context of a statutory-construction dispute).

first part of the disjunctive clause only requires the requested service to be “reasonable and necessary for the diagnosis or treatment of illness or injury.”³⁶

The Department of Health and Human Services (HHS), not Congress, is responsible for determining whether particular health care items and services that are not specifically listed in the Social Security Act’s broad Medicare benefit categories³⁷ are covered by the federal health care program.³⁸ In particular, the Centers for Medicare and Medicaid Services (CMS) within HHS publishes national coverage decisions (NCDs) that determine whether Medicare will cover certain items and services nationally.³⁹ Because CMS does not have the human resources to determine whether each item or service is reasonable and necessary in every case involving a Medicare beneficiary, CMS delegates to certain contractors, called Medicare Administrative Contractors (MACs), the authority to make local coverage decisions (LCDs) to ensure that requested items and services are reasonable and necessary for particular diagnoses.⁴⁰ CMS also

36. See *In re Cardiac Devices Qui Tam Litig.*, 221 F.R.D. 318, 328 (D. Conn. 2004) (explaining that the Social Security Act allows Medicare to pay only for health care items and services that are “reasonable and necessary”); Complaint for Declaratory, Injunctive, and Mandamus Relief at 8, *Jimmo v. Sebelius*, No. 5:11-cv-17 (D. Vt. Oct. 25, 2011), 2011 WL 5104355 [hereinafter *Jimmo* Complaint] (arguing that federal law does not require a patient’s condition to improve with treatment before coverage can occur due to the preceding disjunctive language).

37. As background, Medicare has four parts. Medicare Part A is a hospital insurance program, Medicare Part B is a supplementary medical insurance program, and Medicare Part D is a voluntary prescription drug benefit program. See 42 C.F.R. § 400.202 (2017) (defining each of Medicare’s four parts, including Medicare Parts A, B, and D). Medicare Part C offers through private health plans (known as Medicare Advantage Plans) the same benefits as Medicare Parts A and B (known as original Medicare), and frequently, but not always, the benefits of Medicare Part D. The Social Security Act identifies broad categories of Medicare Part A–covered health benefits, including inpatient hospital, posthospital extended care, home health, and hospice benefits, as well as broad categories of Medicare Part B–covered health benefits, including physician services, rural health clinic services, outpatient physical therapy services, and prosthetic services. See 42 U.S.C. § 1395d(a) (listing the Medicare Part A covered benefit categories); *id.* § 1395k(a) (listing the Medicare Part B covered benefit categories). The Social Security Act also excludes certain health care benefits from coverage. See, e.g., *id.* § 1395d(b) (establishing limitations on Medicare Part A benefits after such benefits have been provided for a certain amount of time); *id.* § 1395y(a) (excluding certain items and services from Medicare coverage).

38. See, e.g., Medicare Program; Procedures for Making National Coverage Decisions, 64 Fed. Reg. 22,619, 22,620–24 (Apr. 27, 1999) (explaining the process by which HHS’s predecessor, the Health Care Financing Administration, used to make national coverage decisions (NCDs) for health care items and services); Medicare Program; Revised Process for Making Medicare National Coverage Determinations, 68 Fed. Reg. 55,634, 55,636–40 (Sept. 26, 2003) (explaining the process HHS’s Centers for Medicare and Medicaid Services (CMS) currently uses to make NCDs).

39. See 42 C.F.R. § 400.202 (defining an NCD as a decision by CMS regarding whether to cover a particular health care item or service nationally under Medicare); *id.* § 405.1060(a)(1) (defining an NCD as a determination by the Secretary of HHS regarding whether to cover a particular health care item or service nationally under Medicare).

40. See 42 C.F.R. § 400.202 (defining an LCD as a decision by a Medicare Part A fiscal intermediary or a Medicare Part B carrier, the predecessors to today’s Medicare Administrative Contractors, regarding whether Medicare should cover a particular service on an intermediary-wide or carrier-wide basis; explaining that “[a]n LCD may provide that a service is not reasonable and

issues policy guidance in the form of a Medicare Benefit Policy Manual to guide MACs in the general processing of medical claims to ensure medical necessity.⁴¹

Before January 2013, HHS, through its contracted MACs, frequently denied coverage of skilled care and rehabilitation in situations involving Medicare beneficiaries whose conditions were not expected to improve.⁴² As an illustration, a MAC named Novitas Solutions, Inc. (Novitas) made several statements in LCD 27513, effective July 11, 2008,⁴³ about not covering skilled care and rehabilitation for beneficiaries not expected to improve, such as: “Gait training is not considered reasonable and necessary when the patient’s walking ability is not expected to *improve*.”⁴⁴ The same LCD also provides: “When [physical medicine and rehabilitation services are] used in the setting of generally chronic progressive cognitive disorders, *there must be a potential for restoration or improvement*. Therapy performed repetitively to maintain a level of function is not eligible for reimbursement,”⁴⁵ and

[i]f evaluation of the patient demonstrates that the patient does not have the potential to achieve *significant improvement in, restoration of, and /*

necessary for certain diagnoses and/or for certain diagnosis codes”). Before 2005, private health insurers known as fiscal intermediaries (FIs) and carriers served as the federal government’s agents in the administration of Medicare Parts A and B, respectively. See Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. No. 108-173, § 911, 117 Stat. 2066, 2378–86 (2003). However, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required the Secretary of HHS to replace original Medicare’s FIs and carriers with Medicare Administrative Contractors (MACs). *Id.* § 911, 117 Stat. at 2378 (adding a new provision titled “Contracts with Medicare Administrative Contractors”). MACs are multistate, regional contractors responsible for administering claims under original Medicare. *What is a MAC?*, CTRS. MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/What-is-a-MAC.html> (last modified Oct. 26, 2017). The transition from FIs and carriers to MACs began in 2005, and the last FI and carrier contracts ended in September 2013. *Implementing Medicare Contracting Reform*, CTRS. MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Medicare/Medicare-Contracting/Medicare-Administrative-Contractors/Archives.html> (last modified June 29, 2018) (outlining the history of Medicare contracting reform).

41. See CTRS. MEDICARE & MEDICAID SERVS., U.S. DEP’T HEALTH & HUMAN SERVS., MEDICARE BENEFIT POLICY MANUAL PUB. NO. 100-02 (2017) (setting forth Medicare reimbursement policies for sixteen different types of health care services, including, but not limited to, inpatient hospital services, inpatient psychiatric hospital services, home health services, hospice services, ambulance services, end-stage renal disease services, comprehensive outpatient rehabilitation facility services, rural health clinic services, and federally qualified health center services).

42. See, e.g., *Fox v. Bowen*, 656 F. Supp. 1236, 1239–40 (D. Conn. 1987) (stating—in findings of fact made in 1987—that HHS had a practice of (1) granting Medicare coverage of skilled physical therapy for only some Medicare beneficiaries who demonstrated rapid recovery, and that even in those cases, coverage may be limited to two weeks; and (2) denying coverage of skilled physical therapy for individuals who needed such therapy to maintain their conditions).

43. NOVITAS SOLS., INC., LCD FOR PHYSICAL MEDICINE & REHABILITATION SERVICES, PHYSICAL THERAPY AND OCCUPATIONAL THERAPY (L27513) (eff. July 11, 2008; retired Sept. 30, 2015), <https://c.ymcdn.com/sites/aptanjanj.org/resource/resmgr/imported/DOC%20PT%205%20Novitas%20PT%20OT%20NJ%202013.pdf> (last visited Sept. 21, 2018).

44. *Id.* at 7 (emphasis added).

45. *Id.* at 8 (emphasis added).

or compensation for loss of function in a reasonable and generally predictable period of time, . . . services would not be covered because they would not be considered reasonable and necessary.⁴⁶

Similarly, a MAC named Cahaba Government Benefit Administrators, LLC (Cahaba), stated in LCD 30009, effective May 4, 2009, that, “[f]or rehabilitative therapy [to be covered by Medicare], there must be an expectation that the condition will *improve significantly* in a reasonable and generally predictable period of time based on the physician’s assessment of the patient’s rehabilitation potential.”⁴⁷ In the same LCD, Cahaba stated that

physical therapy is not covered when the documentation indicates the patient has not reached the therapy goals and *is not making significant improvement* or progress . . . [or] when the documentation indicates that a patient has attained the therapy goals or has reached the point *where no further significant practical improvement can be expected*.⁴⁸

By final illustrative example, a MAC named CGS Administrators, LLC (CGS), explained in LCD 32016, effective June 13, 2011, that physical therapy is part of a “constellation of rehabilitative services designed to *improve or restore* physical functioning following disease, injury, or loss of a body part.”⁴⁹ CGS further stated in the same LCD: “There must be an expectation that the condition will *improve significantly* in a reasonable and generally predictable period of time”⁵⁰ in order for Medicare coverage to occur.

Local coverage determinations 27512, 30009, and 32016 were not formally retired until September 30, 2015.⁵¹ However, six Medicare beneficiaries with a range of chronic health conditions, including Alzheimer’s disease, cerebral palsy, multiple sclerosis, paralysis, and Parkinson’s disease, joined forces with seven national patients’ rights organizations (collectively the Plaintiffs) to plant the seeds of change four years earlier. In 2011, the Plaintiffs sued the Secretary of HHS, alleging that HHS had adopted a clandestine coverage standard that resulted in the wrongful termination, reduction, or denial of Medicare coverage of health care items and services in cases involving Medicare beneficiaries who were

46. *Id.* at 10 (emphasis added).

47. CAHABA GOV’T BENEFIT ADMR’S, LLC, LCD FOR MEDICINE – PHYSICAL THERAPY (LCD 30009), at 4 (eff. May 4, 2009; retired Sept. 30, 2015) (emphasis added), [https://localcoverage.cms.gov/mcd_archive/pdfs_net/pdf.ashx?url=https://localcoverage.cms.gov/mcd_archive/view/lcd.aspx@@@lc dInfo\\$\\$\\$30009:72](https://localcoverage.cms.gov/mcd_archive/pdfs_net/pdf.ashx?url=https://localcoverage.cms.gov/mcd_archive/view/lcd.aspx@@@lc dInfo$$$30009:72) (last visited Sept. 13, 2018).

48. *Id.* (emphasis added).

49. CGS ADMR’S, LLC, LCD FOR PHYSICAL THERAPY – HOME HEALTH (LCD 32016), at 3 (eff. June 13, 2011; retired Sept. 30, 2015) (italicized emphasis added), [https://localcoverage.cms.gov/mcd_archive/pdfs_net/pdf.ashx?url=https://localcoverage.cms.gov/mcd_archive/view/lcd.aspx@@@lc dInfo\\$\\$\\$32016:16](https://localcoverage.cms.gov/mcd_archive/pdfs_net/pdf.ashx?url=https://localcoverage.cms.gov/mcd_archive/view/lcd.aspx@@@lc dInfo$$$32016:16) (last visited Sept. 13, 2018).

50. *Id.* at 4 (emphasis added).

51. *See supra* notes 43, 47, and 49 (stating LCD retirement dates of September 30, 2015).

not expected to improve or who had failed to demonstrate sufficient progress after an initial course of treatment.⁵²

In particular, the Plaintiffs, in *Jimmo v. Sebelius*, alleged that HHS denied coverage for skilled care and rehabilitation when there was a medical record or other evidence that a Medicare beneficiary's condition was "chronic," "medically stable," "in maintenance," "not improving," not improving fast enough, or "having plateaued."⁵³ The Plaintiffs referred to HHS's practice of denying coverage in situations in which a Medicare beneficiary's condition was not improving fast enough for HHS, or had not improved or was not expected to improve, as an Improvement Standard.⁵⁴ The Plaintiffs argued that the Improvement Standard violated the Social Security Act and its implementing regulations; the federal Administrative Procedure Act; the federal Freedom of Information Act; and the Due Process Clause of the Fifth Amendment.⁵⁵ On October 25, 2011, the U.S. District Court for the District of Vermont (Court) denied the Secretary's motion to dismiss the Plaintiffs' lawsuit for failure to state a claim.⁵⁶ The Court found "at least *some* evidence" of HHS's use of illegal presumptions and improvement rules of thumb in its Medicare coverage determinations.⁵⁷

The litigation continued until January 24, 2013, when the Court approved a settlement agreement between HHS and the Plaintiffs.⁵⁸ The settlement agreement required HHS to (1) revise several portions of the

52. *Jimmo* Complaint, *supra* note 36, at 2–3 (describing the health conditions of the individual plaintiffs and the missions of the institutional plaintiffs); *id.* at 2 ("The [practice of denying coverage to individuals who are no longer improving] amounts to a clandestine policy that is condoned and implemented by the Secretary.").

53. *Id.* at 2 (explaining that Medicare denies coverage when a Medicare beneficiary "needs 'maintenance services only,' has 'plateaued,' or is 'chronic,' 'medically stable,' or not improving").

54. *Id.* ("The shorthand term for this rule of thumb masquerading as a condition of coverage is the Improvement Standard.").

55. *Id.* at 3 ("[The Improvement Standard] violates the Medicare statute and regulations, the Administrative Procedure Act's and the Medicare statute's requirements for notice-and-comment rulemaking, the Freedom of Information Act's requirement of publication, and the Due Process Clause of the Fifth Amendment.").

56. *Jimmo v. Sebelius*, No. 5:11-cv-17, 2011 WL 5104355, at *22 (D. Vt. Oct. 25, 2011) ("[T]he court cannot conclude as a matter of law that Plaintiffs' Improvement Standard theory is factually implausible when it is supported by at least *some* evidence in each of the Individual Plaintiffs' cases and where other plaintiffs have successfully demonstrated the use of illegal presumptions and rules of thumb much like Plaintiffs allege here.").

57. *Id.*

58. See [Proposed] Settlement Agreement, *Jimmo v. Sebelius*, No. 5:11-cv-17 (D. Vt. Filed Oct. 16, 2012) [hereinafter *Jimmo* Settlement Agreement] (setting forth the terms of the Settlement); Order Granting Final Approval of Settlement Agreement and Directing Entry of Final Judgment at 2, *Jimmo v. Sebelius*, No. 5:11-cv-17 (D. Vt. Entered Jan. 24, 2013) ("Final approval of the Settlement Agreement is granted."); *Jimmo v. Sebelius Settlement Agreement Fact Sheet*, CTRS. MEDICARE & MEDICAID SERVS. (Jan. 24, 2013), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Downloads/Jimmo-FactSheet.pdf> ("On January 24, 2013, the U. S. District Court for the District of Vermont approved a settlement agreement in the case of *Jimmo v. Sebelius*, in which the plaintiffs alleged that Medicare contractors were inappropriately applying an 'Improvement Standard' in making claims determinations for Medicare coverage involving skilled care . . .").

Medicare Benefit Policy Manual governing coverage of skilled nursing facility, home health, and outpatient therapy benefits to clarify that the Improvement Standard shall not be used;⁵⁹ (2) revise one chapter of the Medicare Benefit Policy Manual to clarify that inpatient rehabilitation facility claims shall not be denied simply because a beneficiary is not expected to achieve complete independence or return to his or her prior level of functioning;⁶⁰ and (3) develop and publicize new educational materials highlighting these changes for both Medicare-participating providers and MACs.⁶¹

The settlement agreement did not end the matter, however. Three years later, on March 1, 2016, the Plaintiffs filed with the Court a motion in which they argued that the Secretary of HHS had failed to comply with the settlement agreement.⁶² On August 17, 2016, the Court granted the Plaintiffs' motion to enforce the portion of the settlement agreement relating to the Secretary's educational campaign obligations and directed the Secretary of HHS to propose corrective action for Plaintiffs' consideration.⁶³ The Court agreed with the Plaintiffs that the Secretary of HHS failed to adhere to the "letter and spirit" of the settlement agreement regarding the educational campaign.⁶⁴ In particular, the Court found that the Plaintiffs provided "persuasive evidence that at least some of the information provided by the Secretary [of HHS] in the Educational Campaign was inaccurate, nonresponsive, and failed to reflect the maintenance coverage standard."⁶⁵

On February 1, 2017, the Court further ordered the Secretary of HHS to amend HHS's corrective action plan to include a corrective statement

59. See *Jimmo* Settlement Agreement, *supra* note 58, at 8–14.

60. Compare *id.* at 14, with *DiVittore v. State Farm Mut. Auto. Ins. Co.*, 42 Pa. D. & C.3d 638, 639 (1985). *DiVittore* involved plaintiff Holly DiVittore, who had sustained a brain injury when she was hit by an automobile while she was jogging on the campus of Pennsylvania State University. *Id.* The legal issue in the case was whether the rehabilitation prescribed by Holly's physician should be covered under Pennsylvania No-fault Motor Vehicle Insurance Act's definition of "medical and vocational rehabilitation services" or whether the rehabilitation was primarily custodial and therefore not the responsibility of defendant State Farm. *Id.* In an attempt to avoid responsibility, State Farm argued that Holly's ability to adapt to her disability had "more or less plateaued" and that any "'slight improvement' in her condition from constant attendant care" was insufficient to qualify as a covered medical or vocational rehabilitative service. *Id.* at 640–41. State Farm further reasoned that it should not be responsible because Holly's physical, psychological, social, and vocational functioning would "never be restored to the point where she can become a self-supporting member of society." *Id.* If Holly were a Medicare beneficiary and needed inpatient rehabilitation, State Farm's argument would be unsuccessful in a coverage determination following *Jimmo*'s changes to the Medicare Benefit Policy Manual.

61. See *Jimmo* Settlement Agreement, *supra* note 57, at 14–19 (setting forth requirements relating to an educational campaign).

62. See *Jimmo v. Burwell*, No. 5:11-cv-17, 2016 WL 4401371 (D. Vt. Aug. 17, 2016) (deciding plaintiffs' motion for resolution of HHS's noncompliance with the *Jimmo* Settlement Agreement).

63. *Id.* at *13.

64. *Id.* at *10.

65. *Id.* at *11.

emphasizing that the Medicare program will cover skilled nursing, rehabilitation, and therapy services when an individualized assessment of the beneficiary's clinical condition demonstrates that the beneficiary needs skilled care in order to maintain function or to prevent or slow decline or deterioration.⁶⁶ One important portion of the corrective statement provided:

The *Jimmo* Settlement may reflect a change in practice for many providers, adjudicators, and contractors, who may have erroneously believed that the Medicare program pays for nursing and rehabilitation only when a beneficiary is expected to improve. The Settlement correctly implements the Medicare program's regulations governing maintenance nursing and rehabilitation in skilled nursing facilities, home health services, and outpatient therapy (physical, occupational, and speech) and maintenance nursing and rehabilitation in inpatient rehabilitation hospitals for beneficiaries who need the level of care that such hospitals provide.⁶⁷

The Court then required the Secretary of HHS to include this corrective statement on the federal agency's *Jimmo* webpage, in HHS's publicly available answers to frequently asked questions about the settlement agreement, and in the written materials and oral statements the Secretary agreed to publicize as part of the corrective action plan.⁶⁸

Of importance to this Article, the settlement agreement and the subsequent rulings in *Jimmo* establish legally binding precedent only in cases involving Medicare beneficiaries, including both original Medicare beneficiaries as well as Medicare Advantage enrollees.⁶⁹ Medicare beneficiaries make up only 14% of the U.S. population, however.⁷⁰ Of the U.S. population, 49% is covered by employer-based health insurance, 19% by Medicaid, 7% by nongroup health insurance, and 2% by other non-Medicare, public health care programs.⁷¹ In addition, 9% of the U.S. population does not have any health insurance at all.⁷² Although prior

66. *Jimmo v. Burwell*, No. 5:11-cv-17, 2017 WL 462512 (D. Vt. Feb. 1, 2017).

67. *Id.* at *6.

68. *Id.*

69. See *supra* note 37 and accompanying text (defining original Medicare and Medicare Advantage); *Frequently Asked Questions (FAQs) Regarding the Jimmo v. Sebelius "Improvement Standard" Settlement*, CTR. FOR MEDICARE ADVOC., <http://www.medicareadvocacy.org/jimmo-v-sebelius-the-improvement-standard-case-faqs/> (last visited Aug. 22, 2018) ("The *Jimmo* Settlement confirms that services by a physical therapist, occupational therapist, and speech and language pathologist are covered by Medicare, Parts A and B [original Medicare], and by Medicare Advantage Plans in skilled nursing facilities, home health, and outpatient therapy, when the services are necessary to maintain a patient's current condition or to prevent or slow a patient's further decline or deterioration.").

70. *Health Insurance Coverage of the Total Population*, HENRY J. KAISER FAMILY FOUND., <https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (last visited Sept. 8, 2018) (noting that Medicare covered 14% of the U.S. population in calendar year 2016).

71. *Id.* (providing 2016 data for insureds with employer, nongroup, Medicaid, and other public coverage, as well as data for individuals who lack health insurance altogether).

72. *Id.*

scholars have suggested or assumed that Medicare law and policy will influence coverage by the non-Medicare insurance sources listed in the previous sentence,⁷³ not one piece of legal scholarship has yet tested this assumption in the context of skilled care and rehabilitation. Prior scholars have also failed to consider the impact of President Obama's Affordable Care Act⁷⁴ and President Trump's incremental health care reforms⁷⁵ on non-Medicare coverage of skilled care and rehabilitation. Part II of this Article responds to these gaps in the literature.

II. NON-MEDICARE COVERAGE

A. *Statutory and Regulatory Background*

Some background is necessary to understand the impact of the health care reforms of both President Obama and President Trump on non-Medicare coverage of skilled care and rehabilitation. President Obama signed the Affordable Care Act (ACA) into law on March 23, 2010.⁷⁶ The ACA is perhaps best known for its individual health insurance mandate,⁷⁷ which President Trump repealed in legislation signed on December 22, 2017, effective for months beginning after December 31, 2018.⁷⁸

In provisions of the ACA not yet repealed by President Trump, the ACA continues to require certain health plans to provide ten sets of health insurance benefits called essential health benefits.⁷⁹ Specifically, a non-repealed portion of the ACA requires individual and small group health plans,⁸⁰ exchange-offered qualified health plans,⁸¹ state basic health plans,⁸² and Medicaid benchmark and benchmark-equivalent plans⁸³ to offer rehabilitative services and devices in addition to nine other categories of essential health benefits (EHBs). These nine other categories include ambulatory patient services; emergency services; hospitalization services;

73. See sources cited *supra* note 16.

74. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.); Wright & Fins, *supra* note 4, at 277 (“We do not address all possible reforms to realize the right to rehabilitation, including how our argument intersects with the Affordable Care Act, as that is beyond the scope of this Article.”).

75. See sources cited *supra* note 19 (referencing several incremental health care reforms implemented by the Trump Administration).

76. Patient Protection and Affordable Care Act, 124 Stat. at 119.

77. *Id.* § 5000A, 124 Stat. at 244.

78. See Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018, Pub. L. No. 115-97, § 11081, 131 Stat. 2054, 2092 (2017) (to be codified at 26 U.S.C. § 5000A).

79. See Patient Protection and Affordable Care Act, § 1302(b)(1)(A)–(J), 124 Stat. at 163–64.

80. See *id.* § 1201(2)(A), 124 Stat. at 154.

81. See *id.* § 1301(a)(1)(B), 124 Stat. at 162.

82. See *id.* § 1331(e), 124 Stat. at 202.

83. See *id.* § 2001(c)(3), 124 Stat. at 276.

maternity and newborn care services; mental health and substance use disorder services; prescription drugs; laboratory services; preventive and wellness services, including chronic disease management services; and pediatric services.⁸⁴ For convenience, this Article will refer to individuals who have a legal right to the EHBs listed in the previous sentence as “EHB Insureds.” Not every individual with health insurance benefits from these EHBs because the ACA exempted grandfathered health plans, large group health plans, and self-insured health plans from the requirement to provide the ten sets of EHBs.⁸⁵

For those health plans that must provide benefits within the ten EHB categories, the statutory EHB requirements were unclear as to whether particular benefits (e.g., gait therapy for individuals with neurodegenerative conditions, or functional neuroimaging for the assessment and diagnosis of residual consciousness in individuals with disorders of consciousness) were included and, if so, the extent to which they were required to be covered. As a result, HHS issued its first set of final regulations implementing the ACA’s EHB requirements on February 25, 2013 (2013 Regulations).⁸⁶ The 2013 Regulations required states to select (or be defaulted into) a benchmark plan⁸⁷ sold in 2012 that provided coverage for the ten EHB categories, including the rehabilitative services and devices category,⁸⁸ and that served as a reference plan for health plans in each state.

According to the 2013 Regulations, health plans in the state to which

84. See *id.* § 1302(b)(1)(A)–(F), (H)–(J), 124 Stat. at 163–64. The Author has reviewed the legal history of the EHBs in a number of prior articles addressing the rights of individuals with gambling disorder as well as other individuals with mental health and neurological conditions. See, e.g., Stacey A. Tovino, *Dying Fast: Suicide in Individuals with Gambling Disorder*, 10 ST. LOUIS U. J. HEALTH L. & POL’Y 159, 165–75 (2016) (invited symposium); Stacey A. Tovino, *Gambling Disorder, Vulnerability, and the Law: Mapping the Field*, 16 HOUS. J. HEALTH L. & POL’Y 163, 169–73 (2016) (invited symposium); Stacey A. Tovino, *Lost in the Shuffle: How Health and Disability Laws Hurt Disordered Gamblers*, 89 TUL. L. REV. 191, 213–24 (2014). The discussion of the legal history of the EHBs in Part II is taken with permission, and with several technical and conforming changes, from these and the Author’s other prior works in this area.

85. See Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,538, 34,562 (June 17, 2010) (to be codified at 29 C.F.R. pt. 2590) (adopting the standard from an older version of 29 C.F.R. § 2590.715–1251(a), which defines “[g]randfathered health plan coverage” as “coverage provided by a group health plan, or a health insurance issuer, in which an individual was enrolled on March 23, 2010” (emphasis omitted)); *id.* at 34,559 (explaining that Public Health Service Act § 2707 does not apply to grandfathered health plans); Sarah Rosenbaum et al., *The Essential Health Benefits Provisions of the Affordable Care Act: Implications for People with Disabilities*, COMMONWEALTH FUND 3 (2011) (“The act exempts large-group health plans, as well as self-insured [Employee Retirement Income Security Act (ERISA)] plans and ERISA-governed multiemployer welfare arrangements not subject to state insurance law, from the essential benefit requirements.”).

86. See Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834 (Feb. 25, 2013) (to be codified at 45 C.F.R. pts. 147, 155, and 156).

87. *Id.* at 12,866 (creating 45 C.F.R. § 156.100).

88. *Id.* (creating 45 C.F.R. § 156.110(a)(7)).

the EHB requirements applied were required to provide health benefits substantially equal to those provided by the state's benchmark plan, including the benchmark plan's covered benefits and excluded benefits.⁸⁹ Thus, between years 2014 and 2016, determining whether a particular health insurance policy or plan was responsible for providing particular skilled care or rehabilitation benefits required an analysis of the applicability of the ACA's EHB provision to the policy or plan, the content of the state's selected benchmark plan (sold in 2012), and the substantial similarity between the particular policy or plan and the 2012 benchmark plan.

As an illustration, New York's first benchmark plan was the Oxford Health Insurance, Inc., Exclusive Provider Organization Plan (Oxford EPO).⁹⁰ If, as written on March 31, 2012, Oxford EPO included particular skilled care or rehabilitation benefits without those benefits being subject to an Improvement Standard, then individual, small group, and other ACA-covered health plans in New York were responsible for providing substantially similar benefits to EHB Insureds in years 2014, 2015, and 2016. On the other hand, if Oxford EPO did not include coverage of particular skilled care or rehabilitation benefits on March 31, 2012, then those benefits were not considered EHBs in New York, and EHB Insureds in New York who needed those benefits would not have coverage in years 2014, 2015, and 2016 unless their health plans voluntarily included such benefits or the EHB Insureds paid out of their own pockets for such care.

In regulations published on February 27, 2015 (the 2015 Regulations), HHS required states to select a second benchmark plan, sold in 2014, that would be effective for 2017 and subsequent years (the second benchmark plan).⁹¹ The deadline for states to select a second benchmark plan was June 1, 2015.⁹² New York, for example, selected the updated version of the Oxford Health Insurance, Inc., Exclusive Provider Organization Plan as its second benchmark plan.⁹³ New York's second benchmark plan, which remains in effect today even though it was sold in 2014, defines

89. *Id.* at 12,867 (creating 45 C.F.R. § 156.115(a)).

90. See Oxford Health Insurance, Inc., *New York EHB Benchmark Plan*, CTRS. MEDICARE & MEDICAID SERVS., <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-New-York-Benchmark-Summary.pdf> (last visited Aug. 23, 2018).

91. See Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,812 (Feb. 27, 2015) (to be codified at 45 C.F.R. pts. 144, 147, 153–56, 158).

92. *E.g.*, JoAnn Volk, *States Need to Select Essential Health Benefit Benchmark Plans for 2017 Soon!*, GEO. U. HEALTH POL'Y INST. CTR. FOR CHILDREN & FAMILIES (May 7, 2015), <https://ccf.georgetown.edu/2015/05/07/states-need-select-essential-health-benefit-benchmark-plans-2017-soon/> (referencing the June 1, 2015 deadline for states to select an EHB benchmark for small employer and individual coverage available beginning 2017).

93. See Oxford Health Insurance, Inc., *Exclusive Provider Organization Plan*, OXFORD HEALTH INS., https://www.oxhp.com/secure/policy/Sample_NY_SG_Member_Handbook.pdf (last visited Aug. 23, 2018).

rehabilitation services as “[h]ealth care services [including inpatient and outpatient physical therapy, occupational therapy, and speech therapy] that help a person *keep, get back, or improve* skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled.”⁹⁴ New York’s second benchmark plan’s use of the word “keep” (versus just “get back” and “improve”) means that New York does not contain an Improvement Standard and that EHB Insureds in New York who need skilled care or rehabilitation to maintain their chronic or progressive health conditions will have coverage of such care.

In comparison, however, Nevada’s second benchmark plan states, “Benefits for rehabilitation therapy are limited to services given for acute or recently acquired conditions that . . . are subject to *significant improvement* through Short-Term therapy.”⁹⁵ This language means that EHB Insureds in Nevada who need rehabilitation therapy but who cannot demonstrate significant improvement over a short period of time will not have coverage unless their health insurers voluntarily provide coverage or the EHB Insureds pay out of pocket. Recall the experience of Professor Leslie Griffin shared in the opening of this Article. Professor Griffin’s insurer was relying on the language of Nevada’s second benchmark plan—language requiring significant improvement in the short term—in an attempt to deny her coverage of skilled care and rehabilitation.⁹⁶

These rules have changed again in light of President Trump’s incremental statutory and regulatory health care reforms. On November 2, 2017, HHS published a proposed rule that, if adopted, would allow states to select new benchmark plans or replace one or more current EHB categories in accordance with certain guidelines (2017 Proposed Rule).⁹⁷ HHS explained in the preamble to the 2017 Proposed Rule that it wanted to give states “additional choices with respect to benefits and affordable coverage” and “increase affordability of health insurance in the individual and small group markets.”⁹⁸ On April 17, 2018, HHS published a final rule giving states these additional choices (2018 Final Rule).⁹⁹

In particular, the 2018 Final Rule allowed each state, beginning on or after January 1, 2020, to change the state’s second benchmark plan by (1) selecting another state’s second benchmark plan; (2) replacing one or more categories of the state’s current EHBs with the same category or categories of EHBs set forth in another state’s second benchmark plan; or (3)

94. *Id.* at 10 (emphasis added).

95. Health Plan of Nevada, Inc., *Small Business Evidence of Coverage*, HEALTH PLAN OF NEV. 17 (emphasis added), http://doi.nv.gov/uploadedFiles/doinvgov/_public-documents/Healthcare-Reform/2017%20Evidence%20of%20Coverage.pdf (last visited Aug. 23, 2018).

96. See *supra* text accompanying notes 2–5.

97. 2017 Proposed Rule, *supra* note 19.

98. *Id.* at 51,102.

99. 2018 Final Rule, *supra* note 19.

selecting an entirely new benchmark plan so long as the new benchmark plan does not exceed the generosity of the most generous among a set of comparison plans, including the state's second benchmark plan and any of the state's options for a second benchmark plan.¹⁰⁰

With respect to these newly selected benchmark plans or replaced EHB categories, the 2018 Final Rule required the end result to balance coverage appropriately between and among the ten EHB categories—including the rehabilitative services and devices category—and would prohibit weighting towards any one category.¹⁰¹ Newly selected benchmark plans also were required to provide benefits for diverse segments of the population, including women and children as well as individuals with disabilities.¹⁰² In terms of the scope of benefits, the 2018 Final Rule also required equality relative to a defined “typical employer plan.”¹⁰³ States that failed to select a new benchmark plan pursuant to the 2018 Final Rule have been defaulted into the state's prior (i.e., second) benchmark plan.¹⁰⁴

President Trump's desired health care reforms did not end there, however. “In an effort to promote greater flexibility, consumer choice, and plan innovation through coverage and plan design options,”¹⁰⁵ the 2018 Final Rule also allowed an issuer of a plan to substitute benefits *within* the same EHB category (e.g., within the maternity and newborn care category), as had prior federal regulations, but also *between* EHB categories (e.g., from the rehabilitative services and devices category to the maternity and newborn care category), so long as the state in which the plan is offered has notified HHS that substitution between EHB categories is permitted in the state.¹⁰⁶ According to the 2018 Final Rule, all substitutions would still be required to provide (1) health insurance benefits that are “substantially equal” to the benchmark plan; (2) an appropriate balance among the EHB categories such that benefits are not unduly weighted towards any one category; and (3) benefits for diverse segments of the population including, notably, individuals with disabilities.¹⁰⁷

Interestingly, only one state (Illinois) selected a new (third) benchmark plan as permitted by the 2018 Final Rule. All other jurisdictions maintained their prior (second) benchmark plans. However, Illinois' third plan contains the same coverage standards for skilled care and rehabilitation that were set forth in its second plan, including an Improvement Standard in all categories of skilled care and rehabilitation except for a maintenance

100. *Id.* at 17,068 (creating new 45 C.F.R. § 156.111(a)).

101. *Id.* (creating new 45 C.F.R. § 156.111(b)(2)(iii)).

102. *Id.* (creating new 45 C.F.R. § 156.111(b)(2)(iv)).

103. *Id.* (creating new 45 C.F.R. § 156.111(b)(2)(i)).

104. *Id.* (creating new 45 C.F.R. § 156.111(d)(1)).

105. *Id.* at 17,020.

106. *Id.* at 17,069 (creating new 45 C.F.R. § 156.115(b)(2)(i)–(ii)).

107. *Id.* (creating new 45 C.F.R. § 156.115(b)(3)(i)–(iii)).

standard in the context of physical therapy for individuals with multiple sclerosis.

The extent to which non-Medicare health plans must provide skilled care and rehabilitation following President Obama's Affordable Care Act and President Trump's to-date incremental health care reforms is, thus, extraordinarily complex. On the one hand, nonrepealed portions of the ACA continue to require certain, but not all, health plans to offer essential health benefits, including essential rehabilitative services and devices.¹⁰⁸ This means that some individuals with brain injuries as well as some individuals with chronic and progressive health conditions will have—in legal theory—access to some skilled care and rehabilitation. However, neither the ACA nor any of President Trump's incremental health care reforms expressly state that EHB Insureds must have access to skilled care and rehabilitation without an Improvement Standard. Indeed, as discussed in more detail below, and as illustrated in the Appendix, at least 84% of current (i.e., second and third) state benchmark plans contain some type of Improvement Standard in at least one inpatient or outpatient skilled care or rehabilitation coverage category.

B. Research Findings

Subpart II.A, above, provided necessary background regarding federal law governing EHBs, including the essential rehabilitative services and devices benefit. Together with the Appendix, this Subpart provides a closer look at how states have implemented these required benefits. In particular, this Subpart examines whether current (i.e., second and third) state benchmark plans continue to incorporate an Improvement Standard that could limit access to skilled care and rehabilitation by individuals with chronic and progressive health conditions. This Subpart also illustrates how the 2018 Final Rule could have allowed non-Medicare insurers to improve their coverage of skilled care and rehabilitation in the wake of *Jimmo*, but that no states accepted this invitation.

The Appendix presents three columns of data. The first column lists each jurisdiction in alphabetical order. The second column includes the name of, and contains a hyperlink to, each jurisdiction's current (i.e., second and, in Illinois, third) benchmark plan. If the benchmark plan applies any type of Improvement Standard to any type of skilled or rehabilitative service in any inpatient or outpatient setting, a quotation from that Improvement Standard is set forth in the third column followed by the page number of the benchmark plan, in parentheses, on which the Improvement Standard appears. If the benchmark plan contains an express maintenance standard consistent with *Jimmo*, that maintenance standard is

108. See *supra* notes 80–84 and accompanying text.

also quoted in the third column.

Contrary to prior assumptions about the impact of Medicare law and policy on non-Medicare insurance, the Appendix shows that forty-three of fifty-one jurisdictions' second (and, in Illinois, third) benchmark plans (84%) contain at least one express Improvement Standard applicable to at least one category of skilled or rehabilitative care (e.g., skilled nursing care, physical therapy, occupational therapy, speech therapy, respiratory therapy, or cognitive rehabilitation) in at least one inpatient or outpatient setting (e.g., inpatient hospital, inpatient rehabilitation facility, skilled nursing facility, home health care, or outpatient facility). Only the benchmark plans of Alabama, Connecticut, New Jersey, New York, Oregon, South Carolina, Washington, and Wyoming do not contain any type of express Improvement Standard.¹⁰⁹

To illustrate the potential impact of the 2018 Final Rule, this Article will focus for the moment on two benchmark plans, one of which contains an Improvement Standard and one of which contains a maintenance standard.

In terms of an Improvement Standard, the State of Colorado's Kaiser Foundation State Employee Health Plan covers physical therapy, occupational therapy, and speech therapy in the inpatient hospital setting, skilled nursing facility setting, or through home health care, but only if, "in

109. *Infra* Appendix. New Jersey's benchmark plan defines the phrases "occupational therapy" and "physical therapy" with reference to restoration of a patient's condition (e.g., "Occupational Therapy [is] treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living."). Horizon Blue Cross Blue Shield of New Jersey, *New Jersey Benchmark Plan*, HORIZON BLUE 72 (2014) (emphasis omitted), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/BMP-Summary_NJ.zip (this provides a file with the plan included, labeled NJ 2017 BMP). However, the New Jersey plan does not specifically and expressly exclude from coverage care that does not improve or restore a patient's condition. *See id.* Similarly, Oregon's benchmark plan defines "[i]npatient rehabilitative services" as "services medically necessary to restore and improve lost body functions after illness or injury." PacificSource Health Plans, *Benchmark Sample*, PACIFICSOURCE 17 (2013) (emphasis omitted), https://dfr.oregon.gov/laws-rules/Documents/OAR/div53-0012_ex1.pdf. However, the Oregon plan does not specifically and expressly exclude from coverage care that does not improve or restore a patient's condition. *See id.* Likewise, Wyoming's benchmark plan defines "occupational therapy" with reference to rehabilitative techniques used to "improve" a patient's functional ability to achieve independence in activities of daily living. BlueCross BlueShield of Wyoming, *BLUESELECT PPO: A Silver Qualified Health Plan*, BLUECROSS & BLUESHIELD 125 (2014), https://downloads.cms.gov/cciio/2017%20Benchmark%20Summary_WY_revised.zip (this provides a file with the plan included, labeled WY 2017 BMP). However, the Wyoming plan does not specifically and expressly exclude from coverage care that does not improve a patient's functional abilities. *See id.* Finally, South Carolina's benchmark plan states that, with respect to rehabilitation services, the patient must be making "substantial progress toward set goals." BlueCross BlueShield of South Carolina, *Business Blue Employee Booklet: Group and Individual Division*, BLUECROSS & BLUESHIELD 26 (2012), <http://doi.sc.gov/DocumentCenter/View/2563/BCBSSC-HDHP-HSA?bidId>. However, there is no language specifically excluding a maintenance goal or a prevention of deterioration goal from qualifying as a set goal. *See id.* To the extent the above quoted language in the benchmark plans of New Jersey, Oregon, Wyoming, and South Carolina is interpreted by other scholars as containing an Improvement Standard, then it may be said that forty-seven of fifty-one jurisdictions (92%) have a benchmark plan containing an Improvement Standard, providing even greater support for the assertions made in this Article. *Infra* Appendix.

the judgment of a Plan Physician, significant improvement is achievable within a two-month period.”¹¹⁰ Because the quoted language in the preceding sentence requires a physician to determine that significant improvement is achievable within a certain period of time before coverage can occur, the quoted language may be classified as establishing an improvement standard.

On the other hand, the state of Washington’s Regence BlueShield Group Direct Gold+ plan covers inpatient and outpatient rehabilitation services, including physical therapy, occupational therapy, and speech therapy services, to help a person “regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to Illness, Injury or disabling condition.”¹¹¹ Because the quoted language in the preceding sentence allows coverage in situations in which a patient needs rehabilitation only to maintain the patient’s condition, or only to prevent deterioration of the patient’s condition, and does not also require the patient to demonstrate improvement of his or her condition, this language creates a maintenance standard consistent with Medicare law and policy as stated in *Jimmo*.

The opportunity made available by the 2018 Final Rule, but missed in all states, now becomes clear. That is, Colorado would have been legally permitted under the 2018 Final Rule to (1) drop its current benchmark plan and select Washington’s benchmark plan for 2019 and subsequent years, thereby dropping its Improvement Standard and implementing a maintenance standard; (2) drop its current rehabilitative services coverage and select the rehabilitative coverage of the Washington plan, thus implementing a maintenance standard; or (3) select an entirely new set of ten essential health benefits, provided that the new set of benefits, viewed in its entirety, is not more generous than the current Colorado plan. However, Colorado declined all three of these options in favor of maintaining its second benchmark plan. That is, Colorado decided not to follow developments in Medicare law and policy, including *Jimmo*.

Of interest, some jurisdictions still require more than improvement. Indeed, they require substantial, significant, or meaningful improvement. Of the forty-three jurisdictions with benchmark plans that contain at least one express Improvement Standard, seventeen (39.5%) require the improvement to be—or to be likely to be or to be expected to be—“substantial” (Maine); “significant” (Arizona, Colorado, Florida, Hawaii, Kansas, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Nevada, New Mexico, North Carolina, Pennsylvania, Rhode Island, Tennessee, and

110. Kaiser Permanente, *Evidence of Coverage*, KAISER PERMANENTE 17 (2013), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_CO-4816.zip (this provides a file with the plan included, labeled CO BMP).

111. Regence BlueShield, *Regence Direct Policy*, BLUECROSS & BLUESHIELD 18 (2017), <https://www.assets.regence.com/policy/2017/WA/Silver3000PreferredWashington-dv.pdf>.

Wisconsin); and/or “meaningful” (Hawaii, Michigan, and Rhode Island).¹¹² This “substantial,” “significant,” and “meaningful” language very much mirrors the language in Medicare LCDs 27513, 30009, and 32016 that expired in 2015.¹¹³

Of the forty-three jurisdictions with benchmark plans that contain at least one express Improvement Standard, fourteen (32.5%) also require the improvement to occur, or to be expected to occur, within a certain period of time. These time frames include “two months” (Colorado and Minnesota); sixty days (Nevada); ninety days (Michigan); a “reasonable period of time” (Idaho, Indiana, Missouri, New Hampshire, Ohio, Virginia, and West Virginia); a “reasonable and predictable [period of] time” (Delaware); or a “reasonable (and generally predictable) period of time” (Iowa and South Dakota).¹¹⁴ This Article expressly disagrees with these improvement time frames. In the context of individuals with disorders of consciousness, for example, leading experts have explained that “reimbursement standards that call for a prediction of recovery over a delineated timeline are anti-intellectual and counter to available scientific knowledge. Such standards violate evidence-based practice because brains recover by biological mechanisms—not reimbursement criteria.”¹¹⁵

In light of prior scholars’ assumptions regarding the impact of Medicare on non-Medicare coverage of rehabilitation, this Article also examined benchmark language specifically disagreeing with Medicare law and policy. Notably, the benchmark plans of two jurisdictions (the District of Columbia and Maryland) expressly state that they exclude maintenance care from coverage even though such care may be covered by Medicare.¹¹⁶

As will be discussed in more detail in Part III, some jurisdictions’ benchmark plans contain somewhat conflicting language; that is, language in one general provision suggests a maintenance standard and language in a second, more specific provision suggests an improvement standard. For example, the Minnesota benchmark plan generally defines “medically necessary” care to include care that “restores or maintains health; or . . . prevents deterioration of the member’s condition; or . . . prevents the reasonably likely onset of a health problem or detects an incipient problem.”¹¹⁷ However, a separate provision defines covered rehabilitative care only with respect to significant functional improvement; that is, “[care that] is provided for the purpose of obtaining significant functional

112. *Infra* Appendix.

113. *See supra* text accompanying notes 43–50 (summarizing LCDs 27513, 30009, and 32016).

114. *Infra* Appendix.

115. Fins et al., *Whither the “Improvement Standard,” supra* note 5, at 187.

116. *Infra* Appendix.

117. HealthPartners, Inc., *Group Membership Contract*, HEALTHPARTNERS 12 (2014) [hereinafter HealthPartners, Inc.], https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_MN.zip (this provides a file with the plan included, labeled MN BMP).

improvement, within a predictable period of time, (generally within a period of two months) toward a patient's maximum potential ability to perform functional daily living activities."¹¹⁸

The New Mexico benchmark plan is similar. The New Mexico benchmark plan generously defines rehabilitation services, including physical therapy, occupational therapy, and speech therapy services, as services that help patients "keep" their skills and functioning.¹¹⁹ Elsewhere, however, the New Mexico plan requires an expectation of significant improvement before coverage of outpatient physical therapy, occupational therapy, and speech therapy will occur.¹²⁰

III. A RIGHT TO CARE

Part II shows that the majority of current state benchmark plans (at least 84%) contain at least one express Improvement Standard in at least one category of inpatient or outpatient skilled care or rehabilitation. Part II also shows that (1) more than one-third of these benchmark plans require significant, substantial, or measurable improvement and that (2) almost one-third require improvement within a certain period of time. These criteria may be difficult or impossible for individuals with chronic and progressive conditions to meet. By definition, chronic conditions persist for a long period of time and are difficult to treat. Progressive conditions get worse over time and do not improve.

Parts I and II of this Article discussed individuals with chronic and progressive conditions generally but did not provide any specific examples that may be helpful to understanding the concerns associated with the application of the improvement standard to this population. Specific examples are appropriate now. As a first example, consider a patient who, after an acute episode that resulted in a limb amputation, is receiving skilled nursing home visits for congestive heart failure, diabetes, and several nonhealing leg and foot ulcers on the nonamputated limb.¹²¹ After three weeks of skilled nursing visits, the patient's insurer labels the patient as "chronic" and attempts to discontinue the patient's skilled nursing coverage. However, the training and clinical judgment of the skilled nurse are still medically necessary to monitor, manage, and assess the patient's

118. *Id.*

119. Presbyterian Health Plan, *SUBSCRIBER AGREEMENT AND GUIDE TO YOUR MANAGED CARE PLAN*, PRESBYTERIAN 153 (2013), https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMP-Summary_NM-4816.zip (this provides a file with the plan included, labeled "NM BMP").

120. *Id.* at 154.

121. See *Frequently Asked Questions (FAQs) Regarding the Jimmo v. Sebelius "Improvement Standard" Settlement*, CTR. FOR MEDICARE ADVOC., <http://www.medicareadvocacy.org/jimmo-v-sebelius-the-improvement-standard-case-faqs/> (last visited Aug. 22, 2018) (providing this example).

many complex conditions, which, without proper assessment and management, could deteriorate very quickly and threaten the patient's life. Although the patient will not improve to her pre-amputation functional state, skilled nursing care is necessary to maintain the patient's condition and to prevent further deterioration, including a second acute episode. This Article asserts that this patient has a right to continued coverage of skilled nursing care.

As a second example, consider a patient who, like Professor Griffin in the story that opened this Article, is involved in an accident or is the victim of a crime and suffers a severe TBI. After two weeks in the intensive care unit at a local hospital, a hospital case worker tries to discharge the patient to a nursing home, stating that insurance will not cover the patient's transfer to a specialized brain rehabilitation facility because the patient is vegetative and not improving.¹²² The patient's family, including the patient's brother who is a neurology resident, firmly believes that the patient is in the minimally conscious state and that the patient should be assessed with functional neuroimaging to detect any residual consciousness and to attempt to communicate with the patient, including to see whether the patient is in pain.¹²³ The patient's family further believes that the patient could regain consciousness and cognition with specialized brain rehabilitation. This Article asserts that this patient has a right to insurance coverage of neuroimaging and other technologies that could detect whether the patient is in the minimally conscious state as well as rehabilitation if the patient is determined to be in the minimally conscious state.

As a third and final illustrative example, consider a patient who has amyotrophic lateral sclerosis (ALS), a fatal neurodegenerative disease for which there is currently no cure.¹²⁴ Patients who are diagnosed with ALS do not improve; in fact, most die within three to five years of diagnosis.¹²⁵ However, several rehabilitative interventions, including bracing, exercise, assisted devices, and adaptive equipment, can help patients with ALS, including this hypothetical patient, manage disease symptoms, stay engaged with their environments, and otherwise maintain the quality of their lives.¹²⁶ However, the hypothetical patient's insurer does not want to cover

122. See FINS, RIGHTS COME TO MIND, *supra* note 5, at 142–45 (describing several cases in which patients with brain injuries are denied continued hospital care or transfer to specialized rehabilitation facilities and are pushed towards nursing homes instead).

123. See Wright & Fins, *supra* note 4, at 244 (“To assess whether a behaviorally nonresponsive patient is conscious or to communicate with a conscious patient who has no or limited motor function, [functional neuroimaging] scans are made of the patient while they are asked to think about performing different tasks to indicate either ‘yes’ or ‘no’ in response to questions.”).

124. See Majmudar et al., *supra* note 32, at 4–13 (describing ALS, its symptoms, and rehabilitation that can help individuals with ALS manage their disease symptoms and maintain the quality of their lives).

125. *Id.* at 4.

126. See *id.* at 4–13 (discussing these and other rehabilitation interventions).

these rehabilitation interventions because the patient is not going to improve. To the contrary, this Article asserts that this patient has a right to insurance coverage of the rehabilitative interventions.

Prior scholars expressing concern for the insurance plight of Medicare beneficiaries with chronic and progressive conditions have made several important arguments in favor of Medicare coverage of rehabilitation. In particular, Megan Wright and Joseph Fins have made an elegant analogy between the right to rehabilitation for individuals with disorders of consciousness and the right to a free public education for children and adolescents, with a focus on potentiality, not chronological age.¹²⁷ Wright and Fins have also used the lens of statutory disability antidiscrimination law, including the federal Americans with Disabilities Act. That is, they have argued that individuals with brain injuries and other chronic conditions have physical and mental impairments that substantially limit their major life activities, and they should not be subject to unfair discrimination.¹²⁸ Finally, Wright and Fins have employed the framework of Supreme Court jurisprudence relating to deinstitutionalization, including *Olmstead v. L.C. ex rel. Zimring*.¹²⁹

Building on the important work of Wright and Fins, this Article develops three additional analytical frames that support insureds' right to rehabilitation, including the frames of health parity law, mandated benefit law, and health services definition law. Each frame is discussed in more detail below.

A. *The Framework of Health Parity Law*

Health parity laws are laws that are designed to equalize insurance benefits between individuals with historically marginalized conditions, such as mental illness and substance abuse, and individuals with other health conditions. The federal government's first major health parity law was the federal Mental Health Parity Act (MHPA),¹³⁰ signed into law by President Clinton on September 26, 1996.¹³¹ As originally enacted, MHPA

127. See Wright & Fins, *supra* note 4, at 237 ("This right stems by analogy to the expectation of free public education for children and adolescents . . .").

128. See *id.* ("This right stems [from] . . . statute under the Americans with Disabilities Act . . .").

129. See *id.* ("This right stems [from] . . . Supreme Court jurisprudence, namely . . . *Olmstead v. L.C. ex rel. Zimring*." (citing *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581 (1999))).

130. See Mental Health Parity Act, Pub. L. No. 104-204, 110 Stat. 2874 (1996) (codified as amended in scattered sections of 29 U.S.C. and 42 U.S.C.).

131. The Author has carefully and thoroughly reviewed the legal history of federal and state mental health parity law in a number of prior articles. See, e.g., Stacey A. Tovino, *Lost in the Shuffle: How Health and Disability Laws Hurt Disordered Gamblers*, 89 TUL. L. REV. 191 (2014) (providing an in-depth study of federal mental health parity law); Stacey A. Tovino, *Reforming State Mental Health Parity Law*, 11 HOUSTON J. HEALTH L. & POL'Y 455 (2011) (invited symposium) (providing an in-

prohibited large group health plans that offered medical and surgical benefits as well as mental health benefits from imposing more stringent lifetime and annual spending limits on their offered mental health benefits.¹³² For example, MHPA prohibits a large group health plan from imposing a \$10,000 annual cap or a \$100,000 lifetime cap on mental health care if the plan has no annual or lifetime caps for medical and surgical care or if the plan has higher caps, such as a \$20,000 annual cap or a \$200,000 lifetime cap, for medical and surgical care.¹³³ Although MHPA contained an “increased cost” exemption, exempting health plans from compliance if the application of MHPA resulted in an increase in the cost under the plan of at least 1%,¹³⁴ only four health plans across the United States had obtained exemptions by November 1998.¹³⁵

MHPA only required parity in the context of lifetime and annual spending caps. That is, MHPA did not require parity between medical and surgical benefits and mental health benefits in terms of deductibles, copayments, coinsurance, inpatient day limitations, outpatient visit limitations, medical necessity requirements, or prior authorization requirements.¹³⁶ Because of these limitations, President George W. Bush expanded MHPA twelve years later by signing into law the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).¹³⁷ MHPAEA required that any financial requirements (including deductibles, copayments, coinsurance, and other out-of-pocket expenses)¹³⁸ as well as quantitative and nonquantitative treatment limitations (including inpatient day limitations, outpatient visit limitations, medical necessity requirements, and prior authorization requirements)¹³⁹ that large group health plans imposed on mental health and substance use disorder benefits not be more restrictive than the predominant financial requirements and treatment limitations imposed by the plan on substantially

depth study of state mental health parity law). The brief summaries of mental health parity law set forth in this Article are, subject to technical and conforming changes, taken with permission of the Author.

132. See Mental Health Parity Act § 712(a)(1)–(2), 110 Stat. at 2945.

133. See *id.*

134. See *id.* § 712(c)(2), 110 Stat. at 2947.

135. See Colleen L. Barry, *The Political Evolution of Mental Health Parity*, 14 HARV. REV. PSYCHIATRY 185, 187 (2006) (providing these numbers).

136. See Mental Health Parity Act § 712(b)(2), 110 Stat. at 2946 (“Nothing in this section shall be construed . . . as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage . . .”).

137. See Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, §§ 511–12, 122 Stat. 3765, 3881–93 (2008) (codified as amended at 29 U.S.C. § 1185a (2012) and 42 U.S.C. § 300gg-5 (2012)).

138. See *id.* § 512(a)(1), 122 Stat. at 3881 (including within the definition of “‘financial requirement’ . . . deductibles, copayments, coinsurance, and out-of-pocket expenses”).

139. See *id.* (including within the definition of “‘treatment limitation’ . . . limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment”).

all other benefits.¹⁴⁰ MHPAEA thus prohibits large group health plans from imposing higher deductibles, higher copayments, and higher coinsurance amounts, as well as lower inpatient day maximums, lower outpatient visit maximums, more stringent medical necessity requirements, and more stringent prior authorization requirements, on individuals seeking care for mental illness or substance use disorders compared to individuals seeking physical health services.¹⁴¹

Like MHPA, MHPAEA also contains an increased cost exemption for covered group health plans and health insurance coverage offered in connection with such plans, but under MHPAEA, the amount of the required cost increase went up, at least for the first year.¹⁴² That is, a covered plan that could demonstrate a cost increase of at least 2% in the first plan year and 1% in each subsequent plan year of the actual total costs of coverage for medical and surgical benefits and mental health and substance use disorder benefits would be eligible for an exemption from MHPAEA for such year.¹⁴³ MHPAEA requires determinations of exemption-qualifying cost increases to be made and certified in writing by a qualified and licensed actuary who—in good standing—belongs to the American Academy of Actuaries.¹⁴⁴

In addition to federal parity laws such as MHPA and MHPAEA, many states have also enacted parity laws designed to place insurance coverage of marginalized conditions on equal footing with other health conditions. New Jersey, for example, has a parity law that requires individual and group health insurance policies issued in the state to provide insurance coverage for biologically based mental illnesses “under the same terms and conditions as provided for any other sickness under the contract.”¹⁴⁵ North Carolina, by further example, has a parity law that requires health plans issued in the state to ensure that insurance coverage for autism screening, diagnosis, and treatment meets certain minimum dollar amounts and contains deductibles, copayments, and coinsurance amounts that are equal

140. *See id.* (requiring both financial requirements and treatment limitations applicable to mental health and substance use disorder benefits to be no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all physical health benefits covered by the plan).

141. *See, e.g.*, Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68,240, 68,286 (Nov. 13, 2013) (to be codified at 45 C.F.R. pts. 146–47) (amending 45 C.F.R. § 146.136, a federal regulation implementing MHPAEA that requires a plan’s definition of “[m]ental health benefits” and “[s]ubstance use disorder benefits” to be “consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines)” (emphasis omitted)).

142. *See* Mental Health Parity and Addiction Equity Act of 2008, § 512(a)(3), 122 Stat. at 3882 (establishing new cost exemption provisions).

143. *Id.*

144. *Id.*

145. N.J. STAT. ANN. § 17:48-6v (West 2008).

to (but not higher than) those applied to other health conditions.¹⁴⁶ The U.S. territory of Guam, by final example, requires all insurance contracts issued in Guam that provide benefits for maternity coverage to provide coverage for a minimum of (1) forty-eight hours of inpatient care following a vaginal delivery and (2) ninety-six hours of inpatient care following a cesarean section for a mother and her newly born child.¹⁴⁷ In summary, both federal and state parity laws dislike insurance plans that discriminate against individuals with marginalized health conditions vis-à-vis other individuals.

The framework of federal and state parity law is useful for thinking about insurers' treatment of individuals with chronic and progressive health conditions who need skilled care or rehabilitation to maintain their conditions. That is, insurers should not be permitted to discriminate against individuals with chronic and progressive health conditions through more stringent financial requirements or more stringent treatment limitations. For example, coverage standards that allow individuals with cancer and human immunodeficiency virus (HIV) to receive maintenance chemotherapy and maintenance HIV therapy, respectively, should apply equally to individuals with progressive conditions who need maintenance rehabilitation. Coverage standards that allow healthy individuals to receive flu shots and other preventive care, by further example, should apply equally to individuals with progressive conditions who need skilled care to prevent deterioration of their own conditions.

Recall the Minnesota benchmark plan, which generally defines medical necessity in terms of a maintenance standard but defines covered rehabilitative care with respect to an improvement standard.¹⁴⁸ The Minnesota benchmark plan thus would allow an individual with cancer or HIV to receive maintenance chemotherapy or maintenance HIV therapy, respectively; however, a Minnesotan who needs maintenance physical therapy or maintenance cognitive therapy would be subject to an improvement standard. This is not parity. Instead, this is a health insurance disparity that targets and adversely impacts individuals with chronic and progressive conditions.

Wright, Fins, and other scholars have addressed the potential cost concerns associated with adopting an equal maintenance standard for rehabilitation.¹⁴⁹ This Article adds to these rebuttals the framework

146. N.C. GEN. STAT. § 58-3-192(b)–(c), (e) (2017).

147. 10 GUAM CODE ANN. § 92104 (2018).

148. See HealthPartners, Inc., *supra* note 117.

149. Wright & Fins, *supra* note 4, at 284 (“While many may point to increased costs in providing physical rehabilitation or neuroimaging, which may have uncertain benefits, they fail to consider that patients with [disorders of consciousness] already incur great costs for health payors, costs that our proposed interventions may actually reduce.”); *id.* at 284–85 (“[W]e echo others who have noted that ‘[a]s issues relating to areas such as insurance and technology are explored, there will also be a financial cost to support those evolving rights.’ We assert that the ethical imperative of providing access to communication, which will aid in decreasing segregation and isolation and make integration into

provided by health parity law for addressing cost concerns, including federal parity law's increased cost definitions, cost exemption provisions, and actuarial requirements.¹⁵⁰ Existing health parity provisions addressing cost concerns may be useful for consideration and inclusion in new rehabilitation parity legislation.

B. *An Analogy to Mandated Benefit Law*

Parity law, discussed above, is the area of health law that requires substantially equal insurance benefits for health insurers that provide benefits for both marginalized conditions (e.g., mental health and substance use disorders) and other conditions (e.g., orthopedic conditions). A different area of health law, known as mandated benefit law, actually requires health insurers to provide or offer benefits for particular conditions. Mandated benefit law is another useful tool for thinking about rehabilitation insurance rights.

As discussed in Subpart II.A, President Obama's ACA mandates that certain health plans provide ten sets of essential health benefits, including rehabilitative services and devices.¹⁵¹ The ACA is an example of a mandated benefit law. The problem with the ACA is that it does not specify which particular rehabilitative services must be included in any particular plan. However, many states have enacted detailed mandated benefit laws that require health insurers in the state to include in their plans particular health care items, services, and supplies. According to the National Conference of State Legislatures, "there are more than 1,900 such [mandated benefit] statutes among all 50 states; another analysis tallies more than 2,200 individual statute provisions, adopted over a 30[-plus] year period."¹⁵²

For example, Virginia has a mandated benefit law that requires health insurance policies issued in the state to include insurance coverage for newborn children.¹⁵³ Kentucky has a mandated benefit law that requires health insurance policies issued in the state to cover medically necessary services and supplies for individuals with diabetes, individuals with terminal illness who elect palliative care through hospice, and individuals who need screening mammograms.¹⁵⁴ West Virginia has a mandated

community possible, is a social good that far outweighs any monetary costs that may result from changing insurance policies." (internal references and citations omitted).

150. See *supra* text accompanying notes 134 and 142 (describing the cost provisions set forth in MHPA and MHPAEA, respectively).

151. See *supra* Subpart II.A.

152. *State Insurance Mandates and the ACA Essential Benefits Provision*, NAT'L CONF. ST. LEG. (Apr. 12, 2018), <http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx>.

153. See VA. CODE ANN. § 38.2-3411(A) (2014).

154. See KY. REV. STAT. ANN. § 304.17A-096(3) (LexisNexis 2011).

benefit law that requires health insurance policies issued in the state to cover certain colon cancer screening tests and services, including an annual fecal occult blood test, a flexible sigmoidoscopy repeated every five years, a colonoscopy repeated every ten years, and a double contrast barium enema repeated every five years.¹⁵⁵ By final illustrative example, Washington has a mandated benefit law that requires health insurance policies issued in the state to cover reconstructive breast surgery for individuals who have had mastectomies following disease, illness, or injury.¹⁵⁶

One theory behind these mandated benefit laws is that individuals who need sensitive or marginalized services (e.g., reconstructive breast surgeries or colon screening services) are no less valuable than individuals who need other services (e.g., reconstructive hand surgery or hearing screening services). A second theory is that lay individuals expect that purchased health insurance includes maintenance therapy services and that they should not be surprised by noncoverage decisions when they later need those services. Again, state mandated benefit law is a useful tool for thinking about the mandated benefit needs of individuals with chronic and progressive conditions. More specifically, federal and state policymakers should consider why rehabilitation services needed by individuals with chronic and progressive conditions are not subject to mandated benefits enjoyed by other individuals.

C. *The Lens of Health Services Definition Law*

In the beginning of Part I, this Article explained that Congress permits Medicare to pay for health care items and services for Medicare beneficiaries that are “reasonable and necessary for the diagnosis or *treatment* of illness or injury.”¹⁵⁷ The state benchmark plans referenced in the Appendix to this Article contain similar provisions. For example, Massachusetts’ benchmark plan requires all covered health care services and supplies to be “medically necessary and appropriate for [members’] *health care* needs.”¹⁵⁸ A final lens that may be useful in thinking about a right to rehabilitation is health services definition law; that is, federal and state laws that define terms like “treatment” (used in Congress’s Medicare

155. See W. VA. CODE ANN. § 5-16-7a(a) (LexisNexis 2018).

156. See WASH. REV. CODE ANN. § 48.44.330 (West 2014).

157. 42 U.S.C. § 1395y(a)(1)(A) (2012) (current statutory provision containing the same prohibition) (emphasis added); see Social Security Amendments Act of 1965, Pub. L. No. 89-97, § 102, 79 Stat. 286, 325 (1965) (original Medicare legislation, enacted in 1965, creating new § 1862(a)(1) of the Social Security Act).

158. BlueCross BlueShield of Massachusetts, *Health Maintenance Organization Subscriber Certificate*, BLUE CROSS BLUE SHIELD OF MASS. HMO BLUE, INC. 40 (Jan. 1, 2013) (emphasis added, and author’s emphasis omitted), http://www.bluecrossma.com/common/en_US/ContractAndRiderInformation/pdfs/hneded2000cpaySoB-0117sng.pdf.

payment provision) and “health care” (used in Massachusetts’ benchmark plan). Many federal and state statutes and regulations that apply in a wide variety of health care contexts define these terms to include maintenance care as well as care that is designed to prevent deterioration, not just improvement care.

For example, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, a set of regulations that governs health information confidentiality at the federal level, defines “treatment” as the “provision, coordination, or management of health care.”¹⁵⁹ In turn, the HIPAA Privacy Rule defines “health care” as “[p]reventive, diagnostic, therapeutic, rehabilitative, *maintenance*, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body.”¹⁶⁰ The federal Office for Civil Rights (OCR), which authored and enforces the HIPAA Privacy Rule, is a powerful federal agency that also enforces a wide variety of laws against discrimination based on race, color, national origin, disability, age, sex, and religion by many health care and human services providers.¹⁶¹ OCR’s understanding of health care and treatment as including maintenance care is important.

State legislatures and agencies understand “treatment” and “health care” in a similar manner. For example, the Arkansas Department of Human Services defines “[b]ehavioral [h]ealth [treatments]” in its state behavioral health regulations as services that “maintain or improve” a level of functioning as well as services that “prevent deterioration.”¹⁶² The Iowa Department of Public Health defines “opioid treatment” in regulations establishing standards for opioid treatment programs to include not only detoxification treatment but also maintenance treatment.¹⁶³ The Michigan Bureau of Professional Licensing uses the phrase “restore and maintain health” in its discussion of chiropractic health care.¹⁶⁴ In statutory provisions addressing the health care of children with disabilities, the Georgia Legislature specifically defines the phrase “[c]orrect or ameliorate”—which suggest an improvement standard—to include services that “maintain a child’s health” or “prevent [a child’s condition] from worsening . . . even if treatment or services will not cure the [child’s]

159. 45 C.F.R. § 164.501 (2017) (defining treatment).

160. *Id.* § 160.103 (emphasis added) (defining health care).

161. See *Civil Rights for Individuals and Advocates*, U.S. DEP’T HEALTH & HUM. SERVS. (Oct. 28, 2015), <https://www.hhs.gov/civil-rights/for-individuals/index.html>; *HIPAA Enforcement*, U.S. DEP’T HEALTH & HUM. SERVS. (July 25, 2017), <https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/index.html>.

162. 016-06-52 ARK. CODE R. § 272.160 (LexisNexis 2018).

163. IOWA ADMIN. CODE r. 641-155.35(1) (2015).

164. MICH. ADMIN. CODE r. 338.12001(g) (2018).

overall health.”¹⁶⁵ As a final example, the Louisiana workers’ compensation carrier explains, in a regulation governing chronic pain disorder treatment, the importance of maintenance treatment:

Successful management of chronic pain conditions results in fewer relapses requiring intense medical care. Failure to address long-term management as part of the overall treatment program may lead to higher costs and greater dependence on the health care system. . . . When the patient has reached [maximum medical improvement], a physician must describe in detail the maintenance treatment.¹⁶⁶

In summary, federal and state health services definition laws frequently include the sub-concepts of maintenance and prevention of deterioration within the concepts of treatment and health care. The deviation of insurers from these common understandings seems to be self-serving rather than a true difference of linguistics opinion.

PROPOSALS AND CONCLUSION

This Article has carefully described and assessed the history of Medicare and non-Medicare coverage of skilled care and rehabilitation in the context of individuals with chronic and progressive health conditions. An important and novel contribution to the health law literature, this Article has shown that the majority of current benchmark plans (at least 84%) require demonstration of improvement, or an expectation of improvement, before coverage of skilled care or rehabilitation can occur in one or more inpatient or outpatient settings. More broadly, this Article has shown that non-Medicare coverage of skilled care and rehabilitation lags significantly behind Medicare coverage, thus challenging prior assumptions regarding the influence of Medicare law and policy on the private sector. Finally, this Article shows how states remain reluctant to follow Medicare law and policy, as exhibited by the reluctance of all states with Improvement Standards to convert to maintenance standards.

In addition, this Article has asserted a right to care for non-Medicare insureds who need skilled care and rehabilitation to (1) aid in their assessment or diagnosis; (2) obtain or maintain their maximum practicable level of consciousness, cognition, functioning, communication, autonomy, or independence; or (3) prevent or slow their deterioration in functioning, as appropriate. The only issue remaining is how and where to codify this right.

Title 45 C.F.R. § 156.110 is the current federal regulation that governs

165. GA. CODE ANN. § 49-4-169.1(1) (2013) (“‘Correct or ameliorate’ means to improve or maintain a child’s health in the best condition possible, compensate for a health problem, prevent it from worsening, prevent the development of additional health problems, or improve or maintain a child’s overall health, even if treatment or services will not cure the recipient’s overall health.”).

166. LA. ADMIN. CODE tit. 40, Pt I, § 2115(A) (2018).

the EHBs.¹⁶⁷ Section (a) of the regulation lists the ten EHB categories, while sections (b) and (c) require states to supplement benchmark plans that are missing one or more categories.¹⁶⁸ Sections (d) and (e) require nondiscrimination and balancing among the ten benefit categories, and section (f) governs habilitation services.¹⁶⁹ This Article argues that HHS should publish a new proposed rule that would add to the end of 45 C.F.R. § 156.110—following the habilitation coverage section—a new section (g) governing rehabilitation coverage.

In terms of content, new section (g) should establish a maintenance standard for coverage of skilled care and rehabilitative services in all inpatient and outpatient contexts, including the inpatient hospital setting, the inpatient rehabilitation facility setting, the skilled nursing facility setting, the home health care setting, and the outpatient facility setting. In particular, section (g) shall require non-Medicare plans to cover services necessary to maintain or prevent deterioration of an insured. Section (g) shall also expressly prohibit non-Medicare plans from requiring insureds to demonstrate improvement, restoration, or recovery before coverage shall occur. Using the standard notice-and-comment rulemaking process set forth in the federal Administrative Procedure Act, HHS's proposed rule should solicit comments from insurers, providers, and patients including, but not limited to, Medicare Administrative Contractors, Medicare-participating providers, and Medicare beneficiaries who have experience with the *Jimmo* Improvement Standard. These comments should help HHS address some of the benefits and limitations of the revisions *Jimmo* required to the Medicare Benefit Policy Manual and should aid HHS in drafting the final version of 45 C.F.R. § 156.110(g). If adopted by HHS, new 45 C.F.R. § 156.110(g) will improve the screening, assessment, diagnosis, and rehabilitation of individuals with a wide range of chronic and progressive health conditions.

167. 45 C.F.R. § 156.110 (2017).

168. *Id.*

169. *Id.*

APPENDIX

SECOND STATE BENCHMARK PLANS**

State/ DC	Benchmark Plan (Issuer/Group: Product)	Improvement or Maintenance Standard References
AL	BLUE CROSS AND BLUE SHIELD OF ALABAMA: 320 PLAN	<No Improvement Standard>
AK	PREMERA BLUE CROSS BLUE SHIELD OF ALASKA: ALASKA HERITAGE SELECT ENVOY	<u>Improvement required for coverage of inpatient and outpatient rehabilitation therapy:</u> “Benefits for [inpatient and outpatient rehabilitation therapy] are provided when such services are medically necessary to . . . restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an accidental injury, illness or surgery. . . .” (19)
AZ	THE STATE OF ARIZONA: EPO EMPLOYEE HEALTH PLAN	<ol style="list-style-type: none"> 1. <u>Speech therapy not covered when it is intended to maintain communication or will not restore communication:</u> “Speech therapy is not covered when . . . it is custodial . . . ; intended to maintain speech communication; or [is] not restorative in nature.” (59) 2. <u>Significant improvement required for care not to be classified as custodial:</u> “Custodial care is maintenance care provided by family members, health aids or other unlicensed individuals after an acute medical event when an individual has reached the maximum level of physical or mental function and is not likely to make further significant improvement.” (104) 3. <u>Home health care not covered if custodial:</u> “Home health services . . . are covered when the following criteria are met: . . . The care that is being provided is not custodial care.” (47–48)
AR	HMO PARTNERS, INC.: SMALL GROUP GOLD 1001-1	<ol style="list-style-type: none"> 1. <u>Potential to increase ability to function required for coverage of neurologic rehabilitation facilities:</u> “The Neurologic Rehabilitation Facility services are of a temporary nature with a potential to increase ability to function.” (27) 2. <u>Increase in ability to function required for coverage of skilled nursing care:</u> “The Skilled Nursing Facility services [must] increase ability to function.” (20)
CA	KAISER FOUNDATION HEALTH PLAN, INC.: SMALL GROUP HMO	<u>Acquisition or improvement of skills required for coverage of rehabilitative services:</u> “We cover Rehabilitative and Habilitative Services if . . . [t]he Services are to help you partially or fully acquire or improve skills and functioning needed to perform activities of daily living, to the maximum extent practical.” (40)
CO	KAISER FOUNDATION HEALTH PLAN OF	1. <u>Significant improvement achievable within a two-month period required for coverage of hospital</u>

** For the sake of readability, policy-specific formatting within quotes, including upper-case words, boldened text, italics, numbering, unnecessary punctuation, and bullet points, will be omitted. Page numbers are in parentheses after each quote.

	COLORADO: STATE EMPLOYEE HEALTH PLAN	<p><u>inpatient care, skilled nursing facility care, or home health care</u>: “We cover physical, occupational and speech therapy as part of your Hospital Inpatient Care, Skilled Nursing Facility and Home Health Care benefit if, in the judgment of a Plan Physician, significant improvement is achievable within a two-month period.” (17)</p> <p>2. <u>Significant improvement achievable within a two-month period required for coverage of outpatient therapy</u>: “We cover three (3) types of outpatient therapy (i.e., physical, occupational, and speech therapy) in a Plan Facility if, in the judgment of a Plan Physician, significant improvement is achievable within a two-month period.” (17)</p> <p>3. <u>Significant improvement achievable within a two-month period required for coverage of multidisciplinary rehabilitation services</u>: “If, in the judgment of a Plan Physician, significant improvement in function is achievable within a two-month period, we will cover treatment for up to two (2) months per condition per year, in an organized, multidisciplinary rehabilitation Services program in a designated facility or a Skilled Nursing Facility.” (17)</p>
CT	CONNECTICARE INSURANCE COMPANY, INC.: CONNECTICARE FLEX POS PLAN	<No Improvement Standard>
DE	HIGHMARK BLUE CROSS BLUE SHIELD DELAWARE, INC.: SMALL GROUP HEALTH PLAN SHARED COST EPO \$2000/100 PLAN	<p>1. <u>Improvement needed for coverage of inpatient occupational therapy, physical therapy, and speech therapy services</u>: “When medically necessary, we cover . . . occupational therapy . . . when needed to help your condition improve in a reasonable and predictable time, or physical therapy when needed to help your condition improve in a reasonable and predictable time, or . . . speech therapy when . . . done to improve speech impairment caused by disease, trauma, congenital defect, or recent surgery.” (17)</p> <p>2. <u>Improvement needed for coverage of outpatient occupational therapy, physical therapy, or speech therapy services</u>: “Covered care includes only . . . occupational therapy . . . when needed to help your condition improve in a reasonable and predictable time, or . . . physical therapy . . . when . . . needed to help your condition improve in a reasonable and predictable time, or speech therapy [when] needed to improve speech problems caused by disease, trauma, congenital defect, or recent surgery.” (28)</p> <p>3. <u>Maintenance home health care not covered</u>: “Care must be needed to treat or stabilize a condition. Care to maintain a chronic condition is not covered.” (30)</p>
DC	GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.: BLUE PREFERRED PPO \$1,000 – 100%/80%	<p>1. <u>Improvement needed for coverage of outpatient physical therapy, occupational therapy, and speech therapy</u>: “Coverage includes benefits for rehabilitation services including Physical Therapy, Occupational Therapy, and Speech Therapy for the treatment of individuals who have sustained an illness or injury that CareFirst determines to be subject to improvement. The goal of rehabilitation services is to</p>

		<p>return the individual to his/her prior skill and functional level.” (B-8)</p> <ol style="list-style-type: none"> 2. <u>Rehabilitation coverage not available for patients who do not improve</u>: “Coverage is not provided for . . . [r]ehabilitation services, including Speech Therapy, Occupational Therapy, or Physical Therapy, for conditions not subject to improvement.” (B-57) 3. <u>Maintenance skilled nursing facility care not covered</u>: “Benefits will not be provided for any day in a Skilled Nursing Facility that CareFirst determines is primarily for Custodial Care. Services may be deemed Custodial Care even if [the care is] [n]ecessary to maintain the Member’s present condition or [is] [c]overed by Medicare.” (B-25)
FL	BLUE CROSS AND BLUE SHIELD OF FLORIDA: BLUEOPTIONS 5462	<ol style="list-style-type: none"> 1. <u>Significant improvement needed for coverage of inpatient rehabilitation services</u>: “[Y]our Condition must be likely to result in significant improvement.” (2-8) 2. <u>Maintenance rehabilitative services not covered</u>: “Rehabilitative Therapies provided for the purpose of maintaining rather than improving your Condition are also excluded.” (3-5)
GA	HUMANA EMPLOYERS HEALTH PLAN OF GEORGIA, INC.: GEORGIA HMO PREMIER 14, COPAY OPTION 22	<ol style="list-style-type: none"> 1. <u>Restoration or improvement required for coverage of prosthetic devices</u>: “Prosthetic devices and supplies, including but not limited to limbs and eyes. Coverage will be provided for prosthetic devices to: Restore the previous level of function lost as a result of a bodily injury or sickness; or [i]mprove function caused by a congenital anomaly.” (50) 2. <u>Custodial care defined to include maintenance services</u>: “Custodial care means services given to you if . . . [t]he services you require are primarily to maintain, and not likely to improve, your condition.” (119) 3. <u>Maintenance care defined to include care that does not improve a patient’s condition</u>: “Maintenance care means services and supplies furnished mainly to: Maintain, rather than improve, a level of physical or mental function; or Provide a protected environment free from exposure that can worsen the covered person’s physical or mental condition.” (127) 4. <u>Custodial care and maintenance care excluded from coverage</u>: “Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items: . . . custodial care and maintenance care.” (81)
HI	HAWAII MEDICAL SERVICE ASSOCIATION: PREFERRED PROVIDER PLAN 2010	<ol style="list-style-type: none"> 1. <u>Significant improvement or restoration required for coverage of physical therapy and occupational therapy</u>: “The therapy is necessary to achieve a specific diagnosis-related goal that will significantly improve neurological and/or musculoskeletal function due to a congenital anomaly, or to restore neurological and/or musculoskeletal function that was lost or impaired due to an illness, injury, or prior therapeutic intervention. (Significant is defined as a measurable and meaningful increase in the level of physical and functional abilities attained through

		<p>short-term therapy as documented in the medical records.)” (30)</p> <ol style="list-style-type: none"> 2. <u>Coverage does not include maintenance physical and occupational therapy</u>: “Maintenance therapy, defined as activities that preserve present functional level and prevent regression, are not covered.” (30) 3. <u>Significant, functional improvement required for coverage of speech therapy</u>: “The therapy is used to achieve significant, functional improvement through objective goals and measurements.” (31)
ID	BLUE CROSS OF IDAHO HEALTH SERVICE, INC.: PREFERRED BLUE PPO SMALL GROUP	<ol style="list-style-type: none"> 1. <u>Measurable improvement in a reasonable period of time required for coverage of physical therapy</u>: “Payment is limited to Physical Therapy Services related to Habilitative and Rehabilitative care, with reasonable expectation that the services will produce measurable improvement in the Insured’s condition in a reasonable period of time.” (3, 52) 2. <u>Coverage does not include maintenance physical therapy services</u>: “No benefits are provided for . . . [r]ange of motion and passive exercises that are not related to restoration of a specific loss of function but are useful in maintaining range of motion in paralyzed extremities.” (52) 3. <u>Measurable improvement in a reasonable period of time required for coverage of occupational therapy</u>: “Payment is limited to Occupational Therapy Services related to Habilitative and Rehabilitative care, with reasonable expectation that the services will produce measurable improvement in the Insured’s condition in a reasonable period of time.” (3, 53) 4. <u>Measurable improvement in a reasonable period of time required for coverage of speech therapy</u>: “Benefits are limited to Speech Therapy Services related to Habilitative and Rehabilitative care, with reasonable expectation that the services will produce measurable improvement in the Insured’s condition in a reasonable period of time.” (4, 53) 5. <u>“Rehabilitation” and “rehabilitative” defined with reference to restoration</u>: “Rehabilitation (or Rehabilitative)—restoring skills and functional abilities necessary for daily living and skills related to communication that have been lost or impaired due to disease, illness or injury.” (4)
IL	BLUE CROSS BLUE SHIELD OF ILLINOIS: BLUE PPO GOLD 011	<ol style="list-style-type: none"> 1. <u>Care that does not have a clinical likelihood of improvement defined as “custodial care”</u>: “Custodial Care Service . . . means any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. . . . Custodial Care Service also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvement by you.” (11) 2. <u>Care that does not measurably improve a patient’s condition defined as “maintenance care”</u>: “Maintenance Care . . . means those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur.” (15)

		<p>3. <u>Therapy that does not measurably improve a patient's condition defined as "maintenance therapy"</u>: "Maintenance Occupational Therapy, Maintenance Physical Therapy, and/or Maintenance Speech Therapy . . . means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur." (15)</p> <p>4. <u>Coverage does not include custodial care</u>: "Expenses for the following are not covered under your benefit program: . . . Custodial Care Service." (90)</p> <p>5. <u>Coverage does not include maintenance care</u>: "Expenses for the following are not covered under your benefit program: . . . Maintenance Occupational Therapy, Maintenance Physical Therapy and Maintenance Speech Therapy, except as specifically mentioned in this Certificate" and "Maintenance Care." (90–91) (One exception covers maintenance physical therapy for patients with multiple sclerosis. (11))</p>
IN	<p>ANTHEM INSURANCE COMPANIES, INC.: LEGACY PPO, BLUE 6.0 BLUE ACCESS PPO OPTION 14, RX G</p>	<p>1. <u>Practical improvement required for coverage of physical medicine therapy services</u>: "The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time." (M-43)</p> <p>2. <u>Coverage does not include maintenance physical therapy</u>: "Non Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities . . ." (M-44)</p> <p>3. <u>Coverage does not include maintenance therapy</u>: "We do not provide benefits for . . . maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement." (M-54, M-56)</p>
IA	<p>WELLMARK, INC.: COMPLETEBLUE 2000</p>	<p>1. <u>Improvement required for coverage of physical therapy</u>: "Physical therapy services are covered when all the following requirements are met: The goal of the physical therapy is improvement of an impairment or functional limitation. . . . The expectation for improvement is in a reasonable (and generally predictable) period of time. There is evidence of improvement by successive objective measurements whenever possible." (23)</p> <p>2. <u>Coverage does not include maintenance physical therapy</u>: "Not Covered: . . . Physical therapy performed for maintenance." (23)</p>

KS	BLUE CROSS AND BLUE SHIELD OF KANSAS, INC.: COMPREHENSIVE MAJOR MEDICAL - BLUE CHOICE	<ol style="list-style-type: none"> 1. <u>“Covered rehabilitation services” defined with reference to restoration of function:</u> “Rehabilitation Services means therapies that, when provided in an Inpatient or Outpatient setting, are designed to restore physical functions following an Accidental Injury or an illness.” (6) 2. <u>Significant improvement required for coverage of rehabilitation services:</u> “Services are covered only if they are expected to result in significant improvement in the Insured’s condition. The Company, with appropriate medical consultation, will determine whether significant improvement has occurred.” (14) 3. <u>“Custodial care” and “maintenance care” defined with reference to whether patient’s physical or mental condition will be maintained:</u> “Convalescent Care, Custodial/Maintenance Care or Rest Cures means treatment or services, regardless of by whom recommended or where provided, in which the service could be rendered safely and reasonably by self, family, or other caregivers who are not Eligible Providers. The purpose of the services are [sic] designed mainly to help the patient with daily living activities, to maintain their present physical and mental condition, or provide a structured or safe environment.” (3) 4. <u>Coverage does not include custodial care or maintenance care:</u> “Covered Services do not include services . . . [w]hich are Custodial/Maintenance care. The Company has the right to determine which services are Custodial/Maintenance care.” (17)
KY	UNITEDHEALTHCARE OF KENTUCKY, LTD.: CHOICE PLUS	<ol style="list-style-type: none"> 1. <u>Coverage excludes rehabilitative services when there is no expectation of significant therapeutic improvement:</u> “Exclusions and Limitations” include “Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.” (32) 2. <u>“Custodial care” defined with reference to care that maintains, versus improves, a level of function:</u> “Custodial Care - services that are any of the following: . . . Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.” (63) 3. <u>Skilled nursing facility and inpatient rehabilitation facility coverage excludes custodial care:</u> “Benefits [for skilled nursing facility and inpatient rehabilitation facility services] are available only if . . . [y]ou will receive skilled care services that are not primarily Custodial Care.” (22) 4. <u>Coverage excludes custodial care and maintenance care:</u> “Types of Care [excluded]: . . . Custodial Care or maintenance care.” (35)

LA	LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY: GROUPCARE PPO PLAN, COPAY 80/60 \$1000	<ol style="list-style-type: none"> 1. <u>Custodial care defined with reference to the expectation that a patient will improve or recover</u>: “Custodial Care – Treatment or services . . . for a condition in a patient who is not expected to improve or recover. The Company determines which services are Custodial Care.” (11) 2. <u>Coverage excludes custodial care</u>: “Limitations and Exclusions” include “Custodial Care, nursing home or custodial home care, regardless of the level of care required or provided.” (55) 3. <u>Covered speech therapy defined with reference to improvement or restoration of speech</u>: “Speech/Language Pathology Therapy – The treatment of a speech/language impairment or a swallowing impairment to improve or restore speech language deficits or swallowing deficits.” (17) 4. <u>Improvement or Restoration of speech required for coverage of speech therapy</u>: “The therapy must be used to improve or restore speech language deficits or swallowing deficits.” (38) 5. <u>“Rehabilitative care” defined with reference to upgrading a patient’s condition</u>: “Rehabilitative Care – The coordinated use of medical, social, educational or vocational services, beyond the stage of disease or injury, for the purpose of upgrading the physical functional ability of a patient disabled by disease or injury so that the patient may independently carry out ordinary daily activities.” (17)
ME	ANTHEM HEALTH PLANS OF MAINE (ANTHEM BCBS): PPO OFF EXCHANGE, BLUE CHOICE, \$30.00, \$2,500 DEDUCTIBLE	<ol style="list-style-type: none"> 1. <u>Significant improvement required for coverage of outpatient physical and occupational therapy</u>: “We provide Benefits for short-term physical and occupational therapy on an Outpatient basis for conditions that are subject to significant improvement.” (28) 2. <u>Significant improvement required for coverage of speech therapy</u>: “We provide Benefits for short-term speech therapy on an Outpatient basis for conditions that are subject to significant improvement.” (32) 3. <u>“Custodial care” defined with reference to care that does not substantially improve a patient’s condition</u>: “[Custodial care] is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value.” (57) 4. <u>Coverage excludes custodial care</u>: “We do not provide Benefits for services, supplies or charges for Custodial Care, Domiciliary or convalescent care, whether or not recommended or performed by a Provider.” (34)
MD	CAREFIRST BLUECHOICE, INC.: BLUECHOICE HMO, HSA/HRA \$1,500	<ol style="list-style-type: none"> 1. <u>“Outpatient rehabilitation services” defined with respect to the patient’s ability to improve or return to prior level of function</u>: “Benefits will be provided for Outpatient Rehabilitative Services for the treatment of individuals who have sustained an illness or injury that CareFirst BlueChoice determines to be subject to improvement. The goal of Outpatient Rehabilitative Services is to return the individual to his/her prior skill and functional level.” (B-8) 2. <u>Custodial care defined to include care necessary to</u>

		<p>maintain the patient's condition; custodial care <u>excluded from coverage</u>: "Benefits will not be provided for any day in a Skilled Nursing Facility that CareFirst BlueChoice determines is primarily for Custodial Care. Services may be deemed Custodial Care even if . . . [n]ecessary to maintain the Member's present condition; or [c]overed by Medicare." (B-25)</p> <p>3. <u>Home health coverage excludes custodial care</u>: "Benefits are provided when . . . [t]he need for Home Health Care Services is not Custodial in nature." (B-26)</p> <p>4. <u>Skilled nursing facility and skilled rehabilitation coverage excludes custodial care</u>: "The Member must require Skilled Nursing Care or skilled rehabilitation services which are . . . [n]ot Custodial." (B-24)</p>
MA	BLUE CROSS AND BLUE SHIELD OF MASSACHUSETTS HMO BLUE, INC.: HMO BLUE NEW ENGLAND DEDUCTIBLE \$2,000	<p>1. <u>Non-covered custodial care defined with reference to patients who do not improve</u>: "Custodial care is a type of care that is not covered by Blue Cross Blue Shield HMO Blue. Custodial care means any of the following: Care that is given primarily by medically-trained personnel for a member who shows no significant improvement response despite extended or repeated treatment; or Care that is given for a condition that is not likely to improve, even if the member receives attention of medically-trained personnel; or Care that is given for the maintenance and monitoring of an established treatment program, when no other aspects of treatment require an acute level of care . . ." (30)</p> <p>2. <u>Requiring all covered services to be medically necessary and defining "medically necessary" with reference to improvement</u>: "Health services must be . . . [e]ssential to improve your net health outcome." (35)</p>
MI	PRIORITYHEALTH: PRIORITYHMO	<p>1. <u>"Rehabilitation medicine services" defined with reference to the patient's ability to improve</u>: "Rehabilitative Medicine Services . . . are [those that are] restorative in nature and result in a meaningful improvement in our ability to perform functional day-to-day activities that are significant in your life role. These services may include physical, occupational and speech therapy, cardiac and pulmonary rehabilitation, and osteopathic and chiropractic manipulations." (52)</p> <p>2. <u>Meaningful improvement required for coverage of therapy and rehabilitative medicine services</u>: "Therapy and/or Rehabilitative Medicine Services that result in meaningful improvement in your ability to perform functional day-to-day activities that are significant in your life roles, including . . . physical and occupational therapy [and] speech therapy for treatment of medical diagnoses." (18)</p> <p>3. <u>Meaningful improvement within 90 days required for coverage of therapy</u>: "Therapy is not Covered if there has been no meaningful improvement in your ability to do important day-to-day activities that are necessary in your life roles within 90 days of starting treatment." (19)</p>

		<ol style="list-style-type: none"> 4. <u>“Custodial care” defined with reference to patients who will not improve significantly:</u> “Custodial Care [is] [c]are you receive if, in our opinion, you have reached the maximum level of mental and/or physical function and you will not improve significantly more. This type of care includes room and board, therapies, nursing care, home health aides and personal care designed to help you in the activities of daily living and home care and adult day care that you receive, or could receive, from a member of your family.” (50) 5. <u>Coverage excludes custodial care, even if provided as part of inpatient care:</u> “Custodial Care is not Covered even if you receive Covered Home Health or Skilled Nursing Services . . . or other therapies along with Custodial Care.” (1–2) 6. <u>Coverage excludes maintenance care for chronic conditions:</u> “Therapy for the purpose of maintaining physical condition or maintenance therapy for a chronic condition including, but not limited to, cerebral palsy and intellectual disabilities.” (19)
MN	HEALTHPARTNERS, INC.; SMALL GROUP PRODUCT 2, HLPT-129123512	<ol style="list-style-type: none"> 1. <u>Covered rehabilitative care defined with reference to significant functional improvement:</u> “This is a restorative service, which is provided for the purpose of obtaining significant functional improvement, within a predictable period of time (generally within a period of two months), toward a patient’s maximum potential ability to perform functional daily living activities.” (12) 2. <u>Requiring all covered care to be medically necessary and defining “medically necessary” care as care that “restores or maintains health; or it prevents deterioration of the member’s condition; or it prevents the reasonably likely onset of a health problem or detects an incipient problem.”</u> (12)
MS	BLUE CROSS BLUE SHIELD OF MISSISSIPPI NETWORK BLUE	<ol style="list-style-type: none"> 1. <u>Ending coverage of physical medicine when maintenance is achieved:</u> “Benefits for Physical Medicine are limited to the number of visits per Calendar Year as specified in the Schedule of Benefits or when maintenance level of therapy is attained (whichever the Member reaches first). A maintenance program consists of activities that preserve the Member’s present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.” (40) 2. <u>Ending coverage of speech therapy benefits when maintenance is achieved:</u> “Speech Therapy as limited in the Schedule of Benefits and this section is covered up to the Benefit maximum or when maintenance level of therapy is attained (whichever the Member reaches first). A maintenance program consists of activities that preserve the Member’s present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional functional progress is apparent or expected to occur.” (51)

MO	HEALTHY ALLIANCE LIFE CO. (ANTHEM BCBS): PPO ON EXCHANGE	<ol style="list-style-type: none"> 1. <u>Improvement of function required for coverage of physical medicine therapy services, including physical therapy, occupational therapy, and speech language therapy:</u> “To be a Covered Service, the [physical medicine] therapy must improve your level of function within a reasonable period of time.” (56) 2. <u>Coverage excludes maintenance therapy, defined as care that prevents loss of function but does not result in any change for the better:</u> “Maintenance Therapy [is] [t]reatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.” (66)
MT	BLUE CROSS AND BLUE SHIELD OF MONTANA: BLUE PREFERRED GOLD PPO 007	<ol style="list-style-type: none"> 1. <u>Recommending prior authorization for therapy and rehabilitative services to ensure that they promote improvement and that the patient is progressing:</u> “Therapy services and rehabilitation services to ensure that the services or treatment continue to promote improvement and demonstrate measurable progress.” (19) 2. <u>Covered rehabilitation therapy defined with reference to improvement or restoration as well as measurable progress:</u> “Medically Necessary to improve or restore bodily function and the Member must continue to show measurable progress.” (74) 3. <u>Coverage of rehabilitation therapy does not include maintenance therapy:</u> “The Plan will not pay when the primary reason for Rehabilitation is any one of the following: . . . [m]aintenance.” (45) 4. <u>Coverage of home health care does not include maintenance visits:</u> “The plan will not pay for [m]aintenance or custodial care visits.” (36)
NE	BLUE CROSS AND BLUE SHIELD OF NEBRASKA: SG BCBSNE 2 TIER (BLUE PRIDE PLUS), BLUE PRIDE PLUS OPTION 102 GOLD	<p><u>Ending coverage for therapy services, including physical therapy, occupational therapy, and speech therapy, once maintenance has been achieved:</u> “Ongoing preventive/maintenance therapy sessions are not covered once the maximum therapeutic benefit has been achieved for a given condition and continued therapy no longer results in some functional or restorative improvement.” (21)</p>
NV	HEALTH PLAN OF NEVADA, INC.: HPN SOLUTIONS HMO PLATINUM 15/0/90%	<ol style="list-style-type: none"> 1. <u>Significant improvement required for coverage of short-term inpatient and outpatient rehabilitation services:</u> “Benefits for rehabilitation therapy are limited to services given for acute or recently acquired conditions that, in the judgment of the Member’s PCP and HPN’s Managed Care Program, are subject to significant improvement through Short-Term therapy.” (17) 2. <u>Defining “short-term” with respect to significant improvement made in 60 days:</u> “Short-Term means the time required for treatment of a condition that, in the judgment of the Member’s PCP and HPN, is subject to significant improvement within sixty (60) consecutive calendar days from the first day of treatment.” (48)

NH	ANTHEM; MATTHEW THORNTON BLUE HMO	<ol style="list-style-type: none"> 1. <u>Improvement within a reasonable period of time required for coverage of physical medicine therapy services, including physical therapy, occupational therapy, and speech therapy:</u> “Your Plan includes coverage for the therapy services described below. To be a Covered Service, the therapy must improve your level of function within a reasonable period of time.” (41) 2. <u>Defining “custodial care” with reference to patients who are not likely to improve any further:</u> “[Custodial care is care] given when you have already reached the greatest level of physical or mental health and are not likely to improve further.” (103) 3. <u>Explaining that custodial care includes care provided in a hospital or skilled nursing facility:</u> “Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility” (103) 4. <u>Skilled nursing facility coverage does not include custodial care:</u> “Custodial Care is not a Covered Service.” (38) 5. <u>Defining “maintenance therapy” with reference to patients not likely to make further gains:</u> “Maintenance Therapy [is] [t]reatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.” (52)
NJ	HORIZON HEALTHCARE SERVICES, INC.; ADVANTAGE EPO SILVER 100/50	<ol style="list-style-type: none"> 1. <u>Defining covered occupational therapy with reference to restoration of the patient’s condition:</u> “Occupational Therapy [is] treatment to restore a physically disabled person’s ability to perform the ordinary tasks of daily living.” (72) 2. <u>Defining covered physical therapy with reference to restoration of the patient’s condition:</u> “Physical Therapy [is] treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss of limb.” (72)
NM	PRESBYTERIAN HEALTH PLAN, INC.; INDIVIDUAL SILVER C HMO	<ol style="list-style-type: none"> 1. <u>Significant improvement required for coverage of outpatient physical therapy and occupational therapy:</u> “Outpatient physical and occupational therapy require that your Primary Care Practitioner or other appropriate treating Practitioner/Provider must determine in advance that Rehabilitation Services can be expected to result in Significant Improvement in your condition. . . . The treatment plans that define expected Significant Improvement must be established at the initial visit.” (63) 2. <u>Significant improvement required for coverage of outpatient speech therapy:</u> “Your Primary Care Physician must determine, in advance, in consultation with us, that speech therapy can be expected to result in Significant Improvement in your condition.” (63) 3. <u>Coverage excluded for long-term therapy and rehabilitation services:</u> “Long-term Therapy or Rehabilitation Services are not Covered. These therapies include treatment for chronic or incurable conditions

		<p>for which rehabilitation produces minimal or temporary change or relief. Therapies are considered Long-term Rehabilitation when: You have reached maximum rehabilitation potential [or] You have reached a point where Significant Improvement is unlikely to occur [or] You have had therapy for four consecutive months. Long-Term Therapy includes treatment for chronic or incurable conditions for which rehabilitation produces minimal or temporary change or relief. Treatment of chronic conditions is not Covered. Chronic conditions include, but are not limited to, Muscular Dystrophy, Down’s Syndrome, Cerebral Palsy, Autism” (81)</p> <p>4. <u>Defining “rehabilitation services” as services that help a patient keep skills and functioning:</u> “Rehabilitation Services means Health Care Services that help a Member keep, get back or improve skills and functioning for daily living that have been lost or impaired because a Member was sick, injured or disabled. These services may include physical and occupational therapy, and speech-language pathology in a variety of Inpatient and/or Outpatient settings.” (153)</p>
NY	OXFORD HEALTH INSURANCE, INC.: OXFORD EPO	<p><u>Contrary to an improvement standard, a maintenance standard is specifically incorporated into the definition of rehabilitation services:</u> “Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.” (10)</p>
NC	BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA: BLUE OPTIONS PPO	<p>1. <u>Significant clinical improvement required for coverage of short-term rehabilitative therapies, including physical therapy, occupational therapy, and speech therapy:</u> “The following therapies are covered only for treatment of conditions that are expected to result in significant clinical improvement in a Member’s condition: Occupational therapy and/or physical therapy (including chiropractic services and osteopathic manipulation) up to a one-hour session per day [and] Speech therapy.” (31)</p> <p>2. <u>Defining “maintenance therapy” with respect to therapies that preserve function or prevent regression of function:</u> “Maintenance Therapy[:] Services that preserve your present level of function or condition and prevent regression of that function or condition. Maintenance begins when the goals of the treatment plan have been achieved and/or when no further progress is apparent or expected to occur.” (65)</p> <p>3. <u>Coverage does not include maintenance therapy:</u> “Maintenance therapy [is not covered].” (41)</p>
ND	BLUE CROSS BLUE SHIELD OF NORTH DAKOTA: BLUECARE GOLD 90 500	<p>1. <u>Defining “maintenance care” with respect to patients whose conditions have stopped improving:</u> “Maintenance Care [is] treatment provided to a Member whose condition/progress has ceased improvement[.]</p>

		<p>Exception: periodic reassessments are not considered Maintenance Care.” (75)</p> <ol style="list-style-type: none"> 2. <u>Coverage of physical therapy, occupational therapy, and speech therapy does not include maintenance care:</u> “Rehabilitative Services: therapies that are designed to restore function following a surgery or medical procedure, injury or illness. Physical therapy [b]enefits are not available for Maintenance Care. Occupational therapy [b]enefits are not available for Maintenance Care. Speech therapy [b]enefits are not available for Maintenance Care.” (25–26) 3. <u>Coverage of skilled nursing facility services excludes maintenance care:</u> “Skilled nursing facility services [b]enefits are not available for Maintenance Care or Custodial Care.” (29) 4. <u>Coverage of home health services excludes maintenance care:</u> “No Home Health Care benefits will be provided for . . . maintenance care. . . .” (30)
OH	COMMUNITY INSURANCE COMPANY (ANTHEM BCBS): BLUE ACCESS (PPO) - STANDARD OPT D55	<ol style="list-style-type: none"> 1. <u>Practical improvement within a reasonable period of time required for coverage of physical medicine therapy services, including physical therapy, occupational therapy, and speech therapy:</u> “The expectation must exist that the [physical medicine] therapy will result in a practical improvement in the level of functioning within a reasonable period of time.” (M-39) 2. <u>Coverage excludes maintenance physical therapy services:</u> “Non Covered [physical therapy] Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities” (M-39) 3. <u>Coverage excludes maintenance therapy:</u> “We do not provide benefits for . . . maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.” (M-50, M-52)
OK	BLUE CROSS BLUE SHIELD OF OKLAHOMA: BLUE OPTIONS PPO GOLD 002	<ol style="list-style-type: none"> 1. <u>Improvement required for coverage of skilled nursing facility services:</u> “No Benefits are available . . . [o]nce you can no longer improve from treatment” (34) 2. <u>Coverage of home health care services excludes maintenance therapy:</u> “We do not pay home health care benefits for . . . maintenance therapy” (34–35)
OR	PACIFICSOURCE HEALTH PLANS: 3000+35/70% 0812 TIERED VALUE RX 10/50/75 0812	<p><u>Defining “inpatient rehabilitation services” with reference to a patient’s ability to improve lost body functions:</u> “Inpatient rehabilitative services medically necessary to restore and improve lost body functions after illness or injury.” (17)</p>

PA	KEYSTONE HEALTH PLAN EAST, INC.: KEYSTONE GOLD PREMIER HMO	<ol style="list-style-type: none"> 1. <u>Significant functional improvement required for coverage of outpatient therapy:</u> “Except as specifically provided . . . , no benefits will be provided for . . . maintenance of chronic conditions, injuries or illness [or] Therapy service provided for . . . [o]ngoing Outpatient treatment of chronic medical conditions that are not subject to significant functional improvement” (60) 2. <u>Improvement of management and independence required for coverage of cognitive rehabilitation therapy:</u> “Except as specifically provided . . . , no benefits will be provided for Cognitive Rehabilitation Therapy, except when provided integral to other supportive therapies, such as, but not limited to physical, occupational and speech therapies in a multidisciplinary, goal-oriented and integrated treatment program designed to improve management and independence following neurological damage to the central nervous system caused by illness or trauma (For example: stroke, acute brain insult, encephalopathy).” (60–61)
RI	BLUE CROSS BLUE SHIELD OF RHODE ISLAND: VANTAGEBLUE 100/60 1500/3000 RX 3/12/35/60/100 WOPD	<ol style="list-style-type: none"> 1. <u>Restoration or attainment of a higher level of functioning required for coverage of physical therapy and occupational therapy:</u> “Physical and occupational therapy is covered only when a program is implemented to restore or attain a higher level of independent functioning or new skills in the most timely manner possible [and] the therapy will result in significant, sustained measurable functional or skill status given your condition; and such improvement will not diminish with the removal of the therapeutic agent or environment.” (46–47) 2. <u>Defining “rehabilitation services” as those services that result in significant, meaningful improvements; noting that services must be used for restoration of function:</u> “Rehabilitative services means acute short-term therapies that . . . are used to treat functional deficiencies that are the result of injury or disease. Short-term therapies are services that result in measurable and meaningful functional improvements within sixty (60) days. The services must be . . . used to restore function.” (109) 3. <u>Covering rehabilitation services only when there is significant potential for functional recovery:</u> “The rehabilitative services must be provided as part of a defined treatment plan for an acute illness, injury, or an acute exacerbation of a chronic illness with significant potential for functional recovery.” (109)
SC	BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA: BUSINESS BLUE COMPLETE	<u>Defining “rehabilitation” with reference to rehabilitation potential and the ability to provide self-care:</u> “Rehabilitation [includes] [a]dmissions for inpatient care in a Rehabilitation Facility for taking part in a multi-disciplinary team-structured rehabilitation program following severe neurological or physical disability. . . . For these Benefits to be available, you must meet the following requirements: . . . The documentation that goes with a request for a Preadmission

		<p>Review must have a detailed patient evaluation from a Physician. This evaluation must document that, to a reasonable degree of medical certainty, the Member has rehabilitation potential, and there is belief that this Member will be able to provide self-care and carry out his or her activities of daily living. In order for Benefits to continue, all Admissions are subject to periodic review. This review will require documentation that the Member is making substantial progress toward set goals and that there continues to be significant potential for the Member to achieve these rehabilitation goals.” (27)</p>
SD	<p>WELLMARK OF SOUTH DAKOTA: BLUE SELECT PRIMARY PCP/NONPCP COPAY PLAN</p>	<p>1. <u>Improvement of impairment or function required for coverage of physical therapy</u>: “You are not covered for physical therapy performed for maintenance. . . . Physical therapy services are covered when all the following requirements are met: [1] The goal of the physical therapy is improvement of an impairment or functional limitation. [2] The potential for rehabilitation is significant in relation to the extent and duration of services. [3] The expectation for improvement is in a reasonable (and generally predictable) period of time. [4] There is evidence of improvement by successive objective measurements whenever possible. Not Covered: . . . Physical therapy performed for maintenance.” (2-3)</p>
TN	<p>BLUECROSS BLUESHIELD OF TENNESSEE: SMALL GROUP SHOP HDHP, SG GOLD 13S</p>	<p>1. <u>Defining covered outpatient therapeutic and rehabilitative services with reference to attainment of abilities or restoration or improvement of function</u>: “Medically Necessary and Appropriate therapeutic, rehabilitative, and habitative services performed in a Practitioner’s office, outpatient facility or home health setting and intended to enable a person with a disability to attain functional abilities, or to restore or improve bodily function lost as the result of illness, injury” (79)</p> <p>2. <u>Defining “maintenance care” with reference to care that does not improve function</u>: “Maintenance Care[:] Medical services (including skilled services and therapies), prescription drugs, supplies and equipment for chronic, static or progressive medical conditions where the medical services (including skilled services and therapies), drugs, supplies and equipment: (1) fail to contribute toward cure; (2) fail to improve unassisted clinical function; (3) fail to significantly improve health; and (4) are indefinite or long-term in nature.” (46-47)</p> <p>3. <u>Home health coverage does not include maintenance care or custodial care</u>: “Exclusions[:] Items such as . . . Maintenance Care or Custodial Care” (67)</p>
TX	<p>BLUE CROSS BLUE SHIELD OF TEXAS: BLUE CHOICE PPO RSH3</p>	<p>1. <u>Permitting coverage of therapy for an acquired brain injury if the goal of therapy is to maintain function or prevent or slow deterioration in function</u>: “Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.” (38)</p> <p>2. <u>Requiring restoration of function for coverage of</u></p>

		<p><u>occupational therapy</u>: “Benefits are not available for . . . [a]ny occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function, except as may be provided under the Benefits for Autism Spectrum Disorder provision in the Special Provisions Expenses portion of this Benefit Booklet.” (46)</p> <p>3. <u>Defining “custodial care” with reference to expectation of cure or improvement</u>: “Custodial Care means care comprised of services and supplies, including room and board and other institutional services, provided to a Participant primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of sickness or injury.” (53)</p> <p>4. <u>Home health coverage does not include custodial care</u>: “Benefits will not be provided for Home Health Care for . . . [s]ervices provided primarily for Custodial Care.” (29)</p> <p>5. <u>Coverage excludes custodial care</u>: “Benefits are not available for . . . any services . . . for Custodial Care.” (46)</p>
UT	<p>PUBLIC EMPLOYEES HEALTH PROGRAM: UTAH BASIC PLUS PLAN</p>	<p>1. <u>Defining “rehabilitation therapy” with reference to a patient’s ability to functionally improve</u>: “The treatment of disease, injury, developmental delay or other cause, by physical agents and methods to assist in the Rehabilitation/habilitation of normal physical bodily function, that is goal oriented and where the Member has the potential for functional improvement and ability to progress.” (16)</p> <p>2. <u>Defining “custodial care” with respect to services that maintain a patient’s condition where there is no prospect of remission or restoration</u>: “Custodial care [includes] [s]ervices, supplies, or accommodations for care rendered which . . . [m]aintain physical condition when there is no prospect of affecting remission or restoration of the Member to a condition in which care would not be required.” (11)</p> <p>3. <u>Coverage excludes custodial care and maintenance therapy</u>: “The following are exclusions of the policy: . . . Custodial Care and/or maintenance therapy.” (27)</p> <p>4. <u>Home health coverage excludes custodial care</u>: “The following are exclusions of the policy: . . . Custodial Care.” (33)</p>
VT	<p>THE VERMONT HEALTH PLAN, LLC: HMO SILVER CDHP PLAN</p>	<p>1. <u>Coverage excludes care for which there is no likelihood of improvement</u>: “General Exclusions” include “[c]are for which there is no therapeutic benefit or likelihood of improvement; Maintenance Care.” (20)</p> <p>2. <u>Coverage excludes care beyond that needed to establish or restore function</u>: “Services beyond those needed to establish or restore your ability to perform Activities of Daily Living.” (20)</p> <p>3. <u>Coverage of rehabilitation services requires progress towards functional improvement goals</u>: “Habilitation</p>

		<p>and Rehabilitation services may include respiratory therapy, Speech Therapy, Occupational Therapy and physical medicine treatments. . . . Such services are evaluated based on objective documentation of measurable progress toward functional improvement goals. Measurement methods must be valid, reliable, repeatable, and evidence-based.” (43)</p> <p>4. <u>Defining “physical rehabilitation facility” with respect to continued improvement:</u> “Physical Rehabilitation Facility: a Facility that primarily provides Rehabilitation services on an Inpatient basis. Care consists of the combined use of medical, pharmacy, social, educational and vocational services. These services enable patients disabled by disease or injury to achieve continued improvement of functional ability.” (45)</p>
VA	<p>ANTHEM HEALTH PLANS OF VIRGINIA (ANTHEM BCBS): PREMIER DIRECT ACCESS PPO</p>	<p>1. <u>Excluding from coverage maintenance therapy:</u> “Maintenance Therapy[:] Treatment given when no further gains are clear or likely to occur. Maintenance therapy includes care that helps you keep your current level of function and prevents loss of that function, but does not result in any change for the better.” (64)</p> <p>2. <u>Defining “custodial care” with respect to a patient’s likelihood of not improving:</u> “Custodial Care [includes] [a]ny type of care . . . given when you have already reached the greatest level of physical or mental health and are not likely to improve further. . . . Care can be Custodial even if it is recommended by a professional or performed in a Facility, such as a Hospital or Skilled Nursing Facility, or at home.” (103)</p> <p>3. <u>Defining “occupational therapy” with respect to restoration of a patient’s ability to do activities of daily living:</u> “Treatment to restore a physically disabled person’s ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing.” (53)</p> <p>4. <u>Requiring achievement of goals within a reasonable period of time for coverage of rehabilitation services:</u> “To be Covered Services, rehabilitation services must involve goals you can reach in a reasonable period of time. Benefits will end when treatment is no longer Medically Necessary and you stop progressing toward those goals.” (50)</p>
WA	<p>REGENCE BLUESHIELD: REGENCE GROUP DIRECT GOLD+</p>	<p><u>Rehabilitation coverage includes maintenance services:</u> “We cover inpatient and outpatient rehabilitation services (physical, occupational and speech therapy services only) and accommodations as appropriate and necessary to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury or disabling condition.” (18)</p>
WV	<p>HIGHMARK BLUE CROSS BLUE SHIELD WEST VIRGINIA: SHARED COST BLUE PPO GRP NON-X</p>	<p>1. <u>Improvement in functioning required for coverage of occupational therapy services:</u> “In order to be considered a Covered Service, [occupational] therapy must be expected to improve the level of functioning</p>

	GOLD SHARED COST PPO \$1000	<p>within a reasonable period of time.” (36)</p> <ol style="list-style-type: none"> 2. <u>Improvement in functioning required for coverage of speech therapy</u>: “Speech Therapy. The treatment for the correction of a speech impairment. In order to be considered a Covered Service, this therapy must be expected to improve the level of functioning within a reasonable period of time.” (36) 3. <u>Remediation or restoration required for coverage of rehabilitation services</u>: “Rehabilitation Services . . . [i]ncludes diagnostic tests, assessment, monitoring or Treatments which are designed to remediate a patient’s condition or to restore the patient to his or her optimal physical, medical, psychological, social, emotional, vocational and economic status.” (70) In order to get such services “[y]our Physician must certify that there is reasonable likelihood that Rehabilitation Services will correct or restore you to your optimal physical, medical, psychological, social, emotional, vocational and economic status.” (36)
WI	UNITEDHEALTHCARE INSURANCE COMPANY: CHOICE PLUS	<ol style="list-style-type: none"> 1. <u>Progress required for coverage of short-term, outpatient therapies, including physical therapy, occupational therapy, speech therapy, and cognitive rehabilitation therapy; maintenance therapy specifically excluded from coverage</u>: “Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.” (17) 2. <u>Rehabilitation coverage excludes care without an expectation of significant therapeutic improvement</u>: One benefit limitation is “[r]ehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.” (29)
WY	BLUE CROSS BLUE SHIELD OF WYOMING: BLUESELECT PPO SILVER FOR EMPLOYER GROUPS	<p><u>Defining “occupational therapy” with reference to functional improvement</u>: “Educational, vocational, and rehabilitative techniques used in order to improve a Participant’s functional ability to achieve independence in daily living.” (125)</p>