March 13, 2026

SUBMITTED ELECTRONICALLY www.regulations.gov

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Joint CPR/HAB Coalition Comments in Response to the HHS Notice of Benefit and Payment Parameters for 2027 Proposed Rule (CMS-9883-P)

Dear Administrator Oz:

The undersigned members of the Coalition to Preserve Rehabilitation ("CPR") and the Habilitation Benefits ("HAB") Coalition appreciate the opportunity to jointly comment on the *HHS Notice of Benefit Payment Parameters for the 2027 Plan Year* proposed rule ("proposed rule"), which was published in the Federal Register on February 11, 2026. These joint comments focus on key proposals related to enrollees in need of the essential health benefit ("EHB") category of "rehabilitation and habilitation services and devices." We first address historical identification of these benefits as EHBs and discuss our recommendations to eliminate caps in therapy benefits. We then proceed to address our concerns with the proposed expansion of catastrophic plans that do not require EHB coverage, followed by the proposed rule's reversal of policy involving state defrayal of EHB benefits.

CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to *rehabilitative* care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain their maximum level of health and independent function. The HAB Coalition membership includes national non-profit consumer and clinical organizations focused on securing and maintaining appropriate access to, and coverage of, *habilitation* benefits within the category known as "rehabilitative and habilitative services and devices" in the EHB package under existing federal law.[1]

[1] Patent Protection and Affordable Care Act ("ACA"), Section 1302.

I. The Importance of Rehabilitative and Habilitative Services and Devices

Rehabilitation services are provided to help a person regain, maintain, or prevent deterioration of a skill, condition, or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition. Rehabilitation services are essential to enable people with injuries, illnesses, and disabilities to:

- Improve, maintain, or slow deterioration of health status;
- Improve, maintain, or slow deterioration of functional abilities;
- Live as independently as possible;
- Return to work, family, and community activities as much as possible;
- Avoid unnecessary and expensive re-hospitalization and nursing home placement; and
- Prevent secondary medical conditions.

Habilitation services, which focus on skills, conditions, and functions that were never acquired due to a wide range of disabling or developmental conditions. Habilitation services and devices are provided by appropriately credentialed (licensed, accredited, and certified) providers to individuals with many types of developmental, cognitive, physical, and mental health conditions that, in the absence of such services, prevent those individuals from acquiring certain skills and functions over the course of their lives. Habilitation services:

- Improve long-term function and health status and improve the likelihood of independent living and quality of life;
- Halt or slow the progression of primary disabilities by maintaining function and preventing further deterioration of function; and,
- Enable persons with developmental, intellectual, physical or cognitive impairments to improve cognition and functioning through appropriate therapies and assistive devices.

There is a compelling case for coverage of both rehabilitative and habilitative services and devices for persons in need of functional improvement due to disabling conditions. These services and devices are designed to maximize the functional capacity of the individual, which has profound implications on the ability to perform activities of daily living in the most independent manner possible. Both rehabilitative and habilitative services and devices are highly cost-effective and decrease downstream costs to the health care system for unnecessary disability and dependency.

In addition to our comments below on specific provisions in this proposed rule, we outline several areas where additional policy changes are needed. These will help ensure that individuals with disabling conditions have access to the full rehabilitative and habilitative services and devices benefit.

Defining Habilitative and Rehabilitative Services in Regulation

In the February 2015 Notice of Benefits and Payment Parameters final rule, the Centers for Medicare and Medicaid Services ("CMS") defined "habilitation services and devices" using the definition of "habilitation services" from the National Association of Insurance Commissioners' Glossary of Health Coverage and Medical Terms and explicitly added habilitation devices, as follows:

> *"Habilitation services and devices— Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings."*

For the first time, this definition established a uniform, understandable federal definition of habilitation services and devices that became a national standard for commercial insurance coverage. Despite this definition and the requirement that it be covered as an essential health service, there has been limited adoption of the full scope of habilitation benefits across the country.

Nonetheless, the CPR and HAB Coalitions support the preservation of the regulatory definition of habilitative services and devices and related interpretations that have been duly promulgated and believe that this should be the *baseline* for all states in their implementation of EHBs. We urge CMS to work with the states to enhance implementation and enforcement of habilitation coverage.

To provide further clarity between what services and devices habilitation covers versus what rehabilitation covers, we also ask CMS to provide a definition in regulation of "rehabilitation services and devices." We view as an oversight the fact that CMS codified a habilitation benefit definition in regulation but did not do so for rehabilitation services and devices. This inconsistent regulatory treatment makes it more difficult to effectuate either benefit. While many services and devices between habilitation and rehabilitation are similar, there is a clear difference in the reason each service is being provided. To ensure accurate implementation of both habilitation and rehabilitation coverage, we believe there must be a regulatory definition for both. Therefore, the CPR and HAB Coalitions recommend that CMS include the following definition, as is outlined in the Glossary of Health Coverage and Medical Terms, into regulation in its ACA regulations:

> *"Rehabilitative services and devices – 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 may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings."*

II. Sufficiency of Current Coverage and Limits for Rehabilitative and Habilitative Services and Devices

The CPR and HAB Coalitions have shared our recommendations with CMS and the Center for Consumer Information and Insurance Oversight ("CCIIO") over the past several years both in-person and virtually regarding the importance of separating and limiting the impact of the therapy caps associated with the rehabilitative and habilitative benefits. Both Coalitions have also submitted extensive written comments on this specific topic in response to previous annual

Notice of Benefit and Payment Parameters proposed rules. Furthermore, both Coalitions also jointly responded to CMS' Request for Information ("RFI") on EHBs in January 2023 stressing similar points.

As recently as December 2025, both Coalitions met with senior officials at CCIIO to discuss solutions to overcome the impact of therapy caps in state-regulated ACA plans and we left that meeting feeling hopeful that CMS would address some of our concerns mentioned during the meeting, or in response to the EHB RFI, in this proposed rule. However, we are disappointed that, once again, this issue has not yet been addressed in any written regulatory guidance or a Request for Information. We reiterate our concerns below in hopes that CMS will adopt these recommendations as soon as possible.

A. Restatement of the Problem

The ACA prohibits annual and lifetime dollar limits on EHBs, but it does not explicitly prohibit the imposition of caps on the number of visits or services a person can receive. Insurers can still impose visit limits on certain types of care, such as outpatient "rehabilitative and habilitative services and devices," one of the EHB categories explicitly listed in the statute. Visit limits can vary depending on the type of service and how insurers define EHBs within the framework of the ACA. Typically, it is common to see ACA plans limit rehabilitative and habilitative services and devices to an arbitrary number of visits per episode, per year (e.g., 20 visits).

Caps and limitations in therapy benefits are not—and have never been—evidence-based. They are imposed by health plans to save money, plain and simple, regardless of medical necessity. Therapy caps as restrictive as 20 visits per episode of care are largely based on the typical orthopedic patient who may find this narrow scope of therapy benefit sufficient. But individuals with any significant injury, illness, disability or chronic condition, such as brain injury, spinal cord injury, multiple traumas, neurological conditions, and other significant disabilities find these therapy caps completely inadequate to meet their medically necessary needs. These caps are nearly universal in private insurance and systematically underserve ACA plan enrollees, requiring individuals in need to endure an exhausting appeals process, pay out of pocket, or go without the services entirely—resigning themselves to accept a less functional life and lifestyle for themselves and their loved ones.

B. Restated Recommendations

We strongly recommend that CMS interpret the nondiscrimination provisions of the ACA to prohibit therapy caps in ACA plans across the board. In the event that caps continue to be allowed, CMS and CCIIO should move forward with a requirement for all ACA plans that they adopt an exceptions process similar to the process established under the Medicare program. In that way, ACA plan enrollees would receive appropriate access to critical therapy services when they are determined by their treating practitioner to continue to be medically necessary.

In addition, if service caps in benefits continue to be permitted under ACA plans, the CPR and HAB Coalitions strongly encourage CMS ensure that **any such benefit caps separately apply**

to rehabilitation and habilitation benefits. Beginning in 2017, CMS interpreted the ACA as mandating that all individual and small-group, non-grandfathered health plans utilizing visit limits must establish separate limits for habilitative and rehabilitative services, where clinicians need to identify whether a provided service is habilitative or rehabilitative for purposes of the caps. However, simply importing the limits and exclusions that may exist under a plan's rehabilitation benefit and applying those same limits and exclusions to the habilitation benefit seriously undermines the ACA plan enrollees' access to both rehabilitation and habilitation services and devices.

As already stated, rehabilitation therapy caps were created with the typical orthopedic adult in mind. For instance, a joint replacement or other common orthopedic procedure typically requires outpatient therapy of moderate duration, intensity, and scope. However, habilitation benefits are more typically provided to young children who may have serious delays in achieving certain functional milestones that must be achieved before progressing to the next set of skills in preparation for adolescence and adulthood. A three-year-old with developmental disabilities and functional deficits has fundamentally different needs than a 65-year-old tennis player who requires a knee replacement. All ACA plans that employ the use of rehabilitation and habilitation caps in benefits must recognize these differences and should tailor their limits accordingly (e.g., through an exceptions process), in a manner that ensures access to medically necessary care. No ACA beneficiary with habilitation needs should be denied services or devices based on the typical needs of orthopedic rehabilitation patients.

Furthermore, the CPR and HAB Coalitions recommend that, if ACA plans employ the use of benefit caps or limits, the plans should be required to use separate visit caps for PT, OT, and SLP. This would ensure that patients with multiple co-occurring or unrelated conditions will be able to access sufficient therapy. For example, a child born with Down Syndrome may need help through physical therapy to gain core strength due to atlantoaxial instability and speech language therapy to help improve their communication skills. If combined under one therapy benefit cap for the entire year, that same child will quickly exceed his or her benefit limit. Therefore, there should be clear and separate caps that are applied for each type of therapy per condition per benefit period, along with an exceptions process to ensure appropriate access to medically necessary care.

As we have articulated in our various precious communications with CCIIO, the elimination of arbitrary therapy caps under the ACA and private plans across-the-board for medically necessary rehabilitative and habilitative services and devices is imperative. However, given the ACA's statutory allowances of non-dollar caps in benefits, and in light of our previous advocacy efforts with CCIIO on this issue that have not generated regulatory interest in this approach, we believe an exceptions process similar to the one imposed by Congress on the Medicare program is a meaningful alternative worthy of serious consideration for ACA plans. We urge the Agency to move forward with addressing this issue, and our recommendations, as expeditiously as possible.

Lastly, it is important to note that CPR and HAB Coalition members rarely hear from enrollees who have minor or modest rehabilitation therapy needs as the therapy caps do not typically prevent medically necessary care from being delivered to these patients. It is the enrollees with extensive needs who routinely exceed the therapy caps and visit limits, resulting in negative outcomes and creating unnecessary disability, lack of function, and ultimately, increased long

term costs. Given the enormous impact that these therapy caps have on the enrollees who need the most extensive care, we urge CCIIO to increase its enforcement and compliance to ensure nondiscrimination in benefit design for EHBs. This increased enforcement and compliance would pressure-test some of these plans to make sure they are meeting patient needs, especially in light of the pervasive lack of clinical evidence for therapy caps.

III. Proposed Expansion of Eligibility for Catastrophic Plans

CPR and the HAB Coalition strongly oppose the proposed changes to catastrophic and bronze plans under this proposed rule. We believe that these proposals not only exceed statutory authority under the ACA, but also weaken core consumer protections and threaten meaningful access to habilitative and rehabilitative services that Congress designated as EHBs.

A. Expansion of Catastrophic Coverage Puts Patients at Financial Risk

Section 1302(e)[2] of the ACA narrowly limits catastrophic plan eligibility to individuals under age 30 and those who qualify for hardship or affordability exemptions. Congress designed catastrophic plans as a narrow, short-term option—not as a mainstream alternative to bronze coverage.

The proposed rule would dramatically expand eligibility to catastrophic plans by allowing individuals of any age to enroll in catastrophic coverage based solely on income**. CPR and the HAB Coalition believes that this change will likely draw healthier individuals into high-deductible plans with extremely limited upfront coverage, increasing risk segmentation in the individual market and shifting higher costs onto those with ongoing medical needs.** More importantly, catastrophic plans provide virtually no coverage—other than preventive services and three primary care visits per year—until an enrollee reaches the annual maximum out-of-pocket ("MOOP") limit. For 2027, that exposure could exceed $15,000 for an individual under this proposal. For many families, that amount represents an insurmountable financial barrier to care.

For individuals recovering from stroke, spinal cord injury, traumatic brain injury, amputation, or managing progressive neurologic diseases, early and consistent access to rehabilitation is medically necessary and time intensive. Similarly, individuals who require habilitation services—including children with developmental disabilities and adults with lifelong conditions—depend on regular therapies and supports to develop, maintain, or improve functional skills necessary for daily living and independence. We believe that a coverage design that requires patients to spend tens of thousands of dollars before services are covered is not meaningful insurance—it is a system that places enrollees at serious risk of delayed access to care.

Congress intentionally limited eligibility for catastrophic coverage, and we believe that expanding it broadly without congressional authorization risks steering patients into plans that appear affordable on the front end but leave them exposed to severe financial hardship when health needs arise.

[2] 42 U.S.C. § 18022(e)

B. Raising Out-of-Pocket Limits Undermines Financial Protection and Access to Care

The ACA established annual limits on cost-sharing to protect patients from catastrophic medical debt, and those limits are central to the law's consumer protection framework. The proposed rule would allow bronze plans to exceed statutory MOOP limits and require catastrophic plans to delay coverage until patients reach 130 percent of the MOOP. In practice, this means some enrollees would need to spend more than $15,000—or far more for families—before coverage meaningfully begins.

This is particularly concerning for patients who rely on habilitative and rehabilitative services, which are included in the ACA's list of EHBs. These services are not optional or discretionary. In fact, they enable children to develop speech and motor skills, allow adults to regain mobility after injury, and help individuals with disabilities maintain independence and avoid unnecessary institutionalization. High upfront cost-sharing forces patients to delay or forgo medically necessary habilitation and rehabilitation therapy. Missed or delayed habilitation or rehabilitation therapy often results in permanent functional decline, preventable complications, and higher long-term costs in both Medicare and Medicaid. **CPR and the HAB Coalition believes that these proposed changes would shift financial risk to patients at precisely the moment they are medically vulnerable, and they or their families are in crisis.**

C. Multi-Year Catastrophic Plans Reduce Consumer Flexibility and Increase Patient Risk

HHS is proposing to allow multi-year catastrophic plans of up to ten consecutive years. CPR and HAB Coalition members believe this raises serious concerns for patients whose health status changes over time as health needs are unpredictable. For instance, a person who enrolls in catastrophic coverage while healthy may be diagnosed with cancer, experience a stroke, spinal cord injury, traumatic brain injury, or develop another disabling condition during the course of a multi-year contract. Under HHS's proposed framework, individuals could remain locked into high-deductible coverage with limited ability to reassess options on an annual basis.

The ACA's market reforms, including guaranteed availability and annual cost-sharing protections, are structured around annual enrollment cycles for a reason. Annual reassessment allows consumers to adjust coverage as their medical needs evolve. The suggestion that insurers could vary cost-sharing over time or structure higher out-of-pocket exposure in early years to incentivize long-term enrollment is particularly troubling. Such flexibility risks creating benefit designs that disadvantage individuals once they become high-cost or chronically ill. Patients with multi-year habilitation or rehabilitation needs—such as those undergoing treatment for cancer, stroke, or recovering from serious injury—could face especially high early financial burdens. **The CPR and HAB Coalitions strongly believe that value-based insurance design should promote access to effective care, not create new barriers to medically necessary services.**

D. Disproportionate Impact on Individuals with Disabilities and Chronic Conditions

Taken together, expanded catastrophic plan eligibility, higher out-of-pocket limits, and multi-year flexibility would disproportionately impact individuals who require ongoing habilitation and

rehabilitation services. These patients often require consistent therapy over months or years. Interruptions in care are not benign; they can lead to regression, loss of function, avoidable hospitalizations, and long-term institutional care. CPR and HAB Coalition members believe that high-cost sharing requirements deter early intervention and undermine recovery—especially for individuals with disabilities and chronic conditions.

The ACA's inclusion of rehabilitative and habilitative services as EHBs reflected a clear recognition that maintaining function is as important as treating illness. **The CPR and HAB Coalitions believe policies that delay access until patients meet high spending thresholds undermine that principle. For these reasons, we respectfully urge HHS to withdraw these proposals and preserve the ACA's core promise: that health coverage should provide real protection when patients need care the most.**

IV. Proposed Changes to EHB Standards

The CPR and HAB Coalitions strongly oppose the proposed revisions to EHB standards in this proposed rule. **These proposals would reverse CMS policy on EHBs and would create financial instability for states. In addition, they would reduce coverage protections for patients as well as jeopardize access to critical rehabilitative and habilitative services that individuals with disabilities and chronic conditions rely upon every day.**

The ACA established EHBs to ensure that health coverage in the individual and small group markets includes meaningful, comprehensive benefits. Congress required that plans cover ten categories of services, including "rehabilitation and habilitative services and devices," and looked to states to defray the costs of additional benefit mandates states chose to adopt. Over time, the benchmark plan framework has allowed states to modernize and strengthen the EHB packages offered to enrollees to reflect evolving standards of care, particularly—for purpose of our coalitions—in areas such as hearing services and durable medical equipment.

For years, states relied on longstanding federal guidance confirming that benefits included in a state EHB-benchmark plan are treated as EHB and therefore not subject to defrayal, even if the state separately mandates that same benefit under state law. As recently as CY 2025, CMS explicitly stated:

> "We are finalizing the amendment to § 155.170(a)(2) to codify that benefits covered in a State's EHB benchmark plan will not be considered in addition to EHB, even if they had been required by State action taking place after December 31, 2011, other than for purposes of compliance with Federal requirements. *Under this policy, there would be no obligation for the State to defray the cost of a State mandate enacted after December 31, 2011, that requires coverage of a benefit if that benefit is included in the State's EHB-benchmark plan.* Benefits that are covered under a state's EHB benchmark plan will not be considered in addition to EHB and will remain subject to the various rules applicable to the EHB, including the prohibition on discrimination in accordance with Section 156.125, limitations on cost sharing in accordance with Section 156.130, and restrictions on annual or lifetime dollar limits in accordance with Section 147.126. We believe that this

> change would promote consumer protections and facilitate compliance with the defrayal requirement by making the identification of benefits in addition to EHB more intuitive.[3] [Emphasis added.]

Many states updated their benchmark plans to improve coverage for services directly affecting individuals with disabilities and chronic conditions. Patients and families have come to rely on those coverage expansions, which often addressed gaps in access to hearing aids, autism therapies, rehabilitation and habilitation services, certain types of prosthetic limbs and orthotic braces, and related supports and devices.

The proposed rule would reverse this current policy and require states to defray the cost of benefits that are already included in their EHB-benchmark plan if those benefits are also required by post-2011 state action. Beginning in 2027, states could face substantial and unexpected financial obligations unless those states repeal or narrow those mandates as applied to qualified health plans. Faced with new fiscal burdens, states may have little practical choice but to eliminate or scale back coverage requirements that patients currently depend on.

From the CPR and HAB Coalition perspective, there is no justification to reverse this policy, and we strongly urge CMS to withdraw this aspect of the proposed rule. This proposal creates two immediate risks. First, it destabilizes coverage gains that states have lawfully implemented, and patients have relied upon for years. To do otherwise would lock in a 15-year-old benefit design to current insurance coverage without any recognition of advances made in medical treatment, technology, and related care. Second, it increases the likelihood that important benefits will be abruptly reclassified as non-EHB. This distinction is critical. ACA protections—including the prohibition on annual and lifetime dollar limits, application of the annual maximum out-of-pocket cap, and eligibility for premium tax credits—apply to EHBs. When a service is treated as non-EHB, consumers can face higher net premiums, greater out-of-pocket exposure, and reduced financial protection.

For individuals requiring rehabilitation following stroke, spinal cord injury, traumatic brain injury, amputation, or progressive neurological disease, these protections are not abstract. Access to medical rehabilitation and habilitation therapy services, assistive devices and technologies, and durable medical equipment often determine whether a person can return to work, remain in their home and avoid institutional care. Similarly, children who require habilitative therapies—such as speech, occupational, or behavioral therapy—depend on stable coverage to achieve developmental milestones. Reclassifying benefits as non-EHB exposes these patients to financial barriers that can interrupt care and produce lifelong consequences.

CPR and the HAB Coalitions are also deeply concerned about the Department's decision to pause review of pending EHB-benchmark plan applications while conducting a broader reconsideration of Section 1302 and EHB standards. States such as California have sought to strengthen coverage for durable medical equipment, and hearing aids and hearing exams—benefits that directly affect individuals with disabilities and functional limitations. Delaying or halting these improvements sends a troubling signal that modernization of essential benefits may

[3] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2025, 89 Fed. Reg. 26218 (Apr. 15, 2024)

be curtailed at a time when advancements in treatment and assistive technology are improving patient outcomes.

Finally, the proposed clarification regarding state defrayal obligations and state laws tied to federal determinations introduces additional uncertainty into the regulatory environment. States and insurers require clear, stable guidance to design benefit packages, and patients require predictability in coverage. Abrupt shifts in policy, particularly after states have relied on prior federal interpretations, undermine that stability and erode trust in the regulatory framework.

EHBs are the foundation of meaningful coverage in the individual and small group markets. Weakening EHB standards, expanding defrayal obligations in a way that pressures states to repeal coverage requirements, and increasing the likelihood that critical services are treated as non-essential would disproportionately harm individuals with disabilities and chronic conditions who rely on medical rehabilitation and habilitation services and devices to live independently and participate fully in their communities.

For these reasons, the **CPR and the HAB Coalitions respectfully urge HHS to withdraw the proposed changes to EHB standards in this rule. Doing so would maintain the longstanding treatment of benefits included in state EHB-benchmark plans as EHBs and preserve the ACA's financial protections for patients who depend on these services every day.**

****

We greatly appreciate your consideration of our comments in response to the *HHS Notice of Benefit Payment Parameters for the 2027 Plan Year* proposed rule. Should you have any further questions regarding this information, please contact Peter Thomas or Michael Barnett, coordinators for CPR and the HAB Coalitions, by e-mailing Peter.Thomas@PowersLaw.com or Michael.Barnett@PowersLaw.com, or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the CPR and HAB Coalitions

ACCSES*
ADVION
ALS Association
American Academy of Physical Medicine & Rehabilitation (AAPM&R)
American Association of People with Disabilities (AAPD)
American Association on Health and Disability
American Cochlear Implant Alliance
American Occupational Therapy Association*
American Physical Therapy Association*
American Speech-Language-Hearing Association (ASHA)*
American Spinal Injury Association
American Therapeutic Recreation Association*
The Arc of the United States*

Brain Injury Association of America*
Center for Medicare Advocacy*
Child Neurology Foundation
Children's Hospital Association*
Disability Rights Education and Defense Fund (DREDF)
Epilepsy Foundation of America
Falling Forward Foundation*
Lakeshore Foundation
Muscular Dystrophy Association
National Association of Rehabilitation Providers and Agencies
National Association of Social Workers (NASW)
National Athletic Trainers' Association
National Clinician Task Force
National Multiple Sclerosis Society*
RESNA
Spina Bifida Association
United Cerebral Palsy
United Spinal Association*

****Member of the CPR or HAB Coalition Steering Committee***