**[Insert date]**

The Honorable Sylvia Mathews Burwell
Secretary
United States Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Burwell:

The **[insert state association name]** is a professional society composed of doctors of chiropractic (DC) whose goal is to promote the highest standards of ethics and essential patient care, contributing to the health and well being of thousands of patients. The **[insert state association name]** appreciates the Department of Health and Human Services' (HHS) effort to gather stakeholder input regarding the establishment of the 2017 benchmark plans for the states. This is a critical and important task.

The **[insert state association name]** commends HHS' approach to provide states the flexibility and freedom to design and adopt an essential health benefits package. We believe that in order to ensure the goal of balancing comprehensiveness and affordability of coverage is met, state input should be respected and recognized. At the same time, we also believe strongly that while allowing the states to identify "benchmarks" to determine what benefits must be included in plans offered in the state exchanges, HHS must maintain oversight of what may otherwise become a patchwork of standards across the country. States may know what works best for their own citizens, but there must be continued federal interaction on this vital component of the Patient Protection and Affordable Care Act (PPACA). Anything less may result in the unintended consequence of patients losing important benefits.

It is estimated that 29 million Americans will purchase health insurance in the exchange market by 2019. To ensure that these people are afforded the right to choose the type of provider they obtain services from, it is vital for HHS and the states to be aware of, and adhere to, provisions in PPACA that protect these patient rights. It is also critical to deter insurance issuers, especially those who have plans available in the exchanges, from limiting the patient's provider choice by discriminating against certain provider types. Section 2706 of the Public Health Service Act as enacted under Section 1201 of PPACA addresses this inequity by specifically preventing insurance issuers from arbitrarily excluding the participation of providers in their health care plans. Section 2706 applies to insured plans available in the exchanges, and we urge HHS to take all steps necessary to ensure that this provision is not diminished in any way.

It has been previously noted that some insurers have referenced the FAQ document issued by HHS, DOL, and the Department of Treasury on April 29, 2013 to exclude from participation whole categories of providers operating under a State license or certification and to discriminate in reimbursement rates based on broad "market considerations". We strongly urge HHS to consider the recently reissued FAQ of May 26, 2015 (that supersedes the 2013 FAQ) when reviewing the benchmark plans for the states. The new FAQ reinforces the law and congressional intent of Section 2706 (a) to ensure that patients have the right to access covered health services from the full range of providers licensed and certified in their State

The **[insert state association name]** believes much misinformation remains regarding the issue of mandates, especially as it applies to insurance equality laws, currently found in the majority of states. Insurance equality laws do not constitute mandated benefits. In the instances where these laws – which exist in over 40 states – impact the chiropractic profession, it is only when an employer, of his or her own free will, has already decided to include a certain service in that company's employee benefit package. At that point, the insurance equality laws stating that *no discrimination can be directed at any provider licensed to provide the service at issue* are applied. This is entirely different than a true mandate where the employer has decided not to include a specific service, such as acupuncture, mammography, or ambulance services, as part of their benefit package, but is required by the State to do so.

With an insurance equality law, if an employer's health benefit package included "treatment of back injuries" in its offerings, the enrollee has the choice to go to any licensed provider who can deliver that service. Once a decision regarding covered services is made, neither an employer nor an insurer should have the right to determine which licensed provider will deliver those services. These insurance equality laws increase competition among providers, ensure freedom of choice and improve access for patients, and are critical to improving patient-centered health care and for bringing down costs of care. In addition, insurance equality laws are congruent with Section 2706 of the Public Health Service Act--nondiscrimination in health care.

As coverage under the benchmark plans are further refined, HHS should guard against the possibility of essential benefits being denied by insurers. To protect patients' access to these benefits, determinations cannot solely be left to individual or group health plans. Providing access to a provider of choice for essential benefits provides transformational options for patients and will end some significant and costly discriminatory practices in health care. If essential benefits are denied, patients should have the right to an independent, third-party review of their claim. This process could be similar to the regulations for all group health plans, which must have a straightforward and independent appeals process.

**[Insert state specific information here. Please find your proposed benchmark plan and compare it to what is now the benchmark in your state.]**

With regard to HHS' effort to best meet the dual goals of comprehensiveness of coverage included in essential health benefits and affordability of coverage, it is essential for HHS and the states to ensure that each state's benchmark plan includes coverage for cost-effective, low-risk interventions offered by doctors of chiropractic and other conservative health care providers. Too often for common conditions like highly prevalent back pain, patients are directed to higher risk and higher cost interventions like prescription drugs or surgery to address the condition that could have been treated in a more cost-effective and conservative manner. Ensuring coverage for the conservative, primary care, portal of entry interventions that doctors of chiropractic provide, such as spinal adjustment/manipulation, physical medicine procedures, counseling on risk avoidance, health promotion, prevention, wellness and other physician services, would help to keep healthcare costs down and increase access to necessary services. In clear support of this type of approach is a 2010 study of Blue Cross Blue Shield of Tennessee claims data which found that for low back pain, care initiated by a Doctor

of Chiropractic saves up to 40 percent on health care costs for certain low back diagnoses when compared with care initiated through a medical doctor.[1]

Additionally, much research over the last several years has demonstrated that chiropractic care is a safe, effective, and therefore viable treatment option for the millions of Americans who seek insurance coverage through the exchanges. For example, a study published in the January 2012 issue of the *Annals of Internal Medicine* found that spinal manipulative therapy (SMT) and exercise was more effective at relieving neck pain than pain medication. The majority of study participants (57%) that received SMT from a Doctor of Chiropractic,. reported at least a 75 percent reduction in pain, compared to 33 percent of those study participants who received pain medication group. After one year, approximately 53 percent of those who received SMT still reported at least a 75 percent reduction in pain; compared to just 38 percent pain reduction among those who took medication. The study also found that despite experiencing limited pain relief, people in the drug group continued using a higher amount of medication more frequently throughout the follow-up period.[2] The research reinforces the use of conservative care options as a first line of defense against pain. Further research findings include:

- A recent systematic review revealed that spinal manipulative therapy more effectively treated chronic low back pain (cLBP) than sham or an ineffective control intervention and had a similar treatment effect when compared to analgesics, exercise, or medical care.[3]
- Chiropractic care provides an alternative to more invasive treatments that are increasingly used and may have severe drawbacks.
    - Medicare spending on various invasive treatments for back pain increased substantially over the decade. According to an article published in 2009, a review of the literature found that over approximately a decade, epidural steroid injections increased by 629% and spinal fusions, by 220%; however, these increases were not accompanied by improvements in patient outcomes or reductions in disability rates.[4] Indeed, several recent articles have documented the potential negative impacts of spinal fusion.[5, 6, 7] During that same period, opiate use increased by 429% and recent studies have documented high utilization rates of opiate use among younger, disabled Medicare beneficiaries. Opiates are expensive, addictive, and present health risks that may result in downstream treatment costs.[8]

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[1] Cost of Care for Common Back Pain Conditions Initiated With Chiropractic Doctor vs. Medical Doctor/Doctor of Osteopathy as First Physician: Experience of One Tennessee-Based General Health Insurer," *Journal of Manipulative and Physiological Therapeutics (JMPT), 2010*.

[2] Bronfort G, Evans R, Anderson AV, Svendsen KH, Bracha Y, Grimm RH. Spinal manipulation, medication, or home exercise with advice for acute and subacute neck pain. A randomized trial. Ann Intern Med. 2012; 156:1-10.

[3] Rubinstein SM, Terwee CB, Assendelft WJ, de Boer MR, van Tulder MW. Spinal manipulative therapy for acute low back pain: an update of the cochrane review. Spine (Phila Pa 1976). 2013;38(3):E158-77. Epub 2012/11/22. PMID: 23169072.

[4] Deyo, Richard, "Overtreating Chronic Back Pain: Time to Back Off?," Journal of the American Board of Family Medicine, 2009: 22(1): 62-68

[5] Marquez-Lara A, Nandyala SV, Fineberg SJ, Singh K. "Cerebral Vascular Accidents Following Lumbar Spine Fusion." Spine (Phila Pa 1976). 2013 Dec 30. [Epub ahead of print]

[6] Fineberg SJ, Nandyala SV, Kurd MF, Marquez-Lara A, Noureldin M, Sankaranarayanan S, Patel AA, Oglesby M, Singh K. "Incidence and risk factors for postoperative ileus following anterior, posterior, and circumferential lumbar fusion." Spine J. 2013 Oct 31. pii: S1529-9430(13)01610-0. doi: 10.1016/j.spinee.2013.10.015. [Epub ahead of print]

[7] Martin BI, Mirza SK, Franklin GM, Lurie JD, MacKenzie TA, Deyo RA. "Hospital and surgeon variation in complications and repeat surgery following incident lumbar fusion for common degenerative diagnoses." Health Serv Res. 2013 Feb;48(1):1-25. doi: 10.1111/j.1475-6773.2012.01434.x. Epub 2012 Jun 20.

[8] Wolters Kluwer Health: Lippincott Williams and Wilkins, High Prevalence of opioid use by social security disability recipients, Science Daily, August 14, 2014.

In short, research has shown the chiropractic care is a conservative treatment option that lowers overall costs for the health care system at large, benefitting not only patients, but also reducing downstream costs for insurance issuers, and potentially reduces the burden on other health care providers by reducing dependence on more costly options such as surgery and prescription drugs on a system struggling to control skyrocketing costs and drug addiction.

The **[insert state association name]** strongly encourages HHS to ensure that states avoid placing arbitrary limits on coverage of essential benefits as a way to limit the cost of the package. As we have noted above, some benefits, such as the services doctors of chiropractic provide, can actually reduce expenditures and patients should not be denied health care services arbitrarily. Essential benefit health services should be covered regardless of the provider performing the services, so long as that provider is trained and licensed to provide those essential benefit services. Furthermore, the inclusion of specific health services as essential benefits (e.g. manipulation & physical medicine and rehabilitation services) should be based on evidence of effectiveness, safety, clinical outcomes, patient satisfaction and patient preference. This will ensure true health care reform, increasing patients' choice of health provider, treatment options and appropriate access to care.

Again, the **[insert state association name]** appreciates the opportunity to provide comment on the important work of HHS to further develop and refine affordable essential health benefits packages that guarantee patient access to needed care. We believe that looking at benefits from the standpoint of both effectiveness and cost-effectiveness (factoring relative risk into each) will enable states to ensure that patients receive high quality care that is responsive to their needs and preferences, at a cost both they and the government can afford.

Sincerely,

**[insert signature, name and title of state official]**