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# Issue Brief

May 2013

## **Habilitative Services Coverage for Children Under the Essential Health Benefit Provisions of the Affordable Care Act**

*by Sara Rosenbaum, George Washington University School of Public Health and Health Services*

### **Executive Summary**

Habilitative services are defined by the National Association of Insurance Commissioners as “health care services that help a person keep, learn or improve skills and functioning for daily living.” Whether health insurance covers habilitative services is a matter of great importance in child health policy, because of the prevalence of developmental disabilities among children. In 2008, nearly one in seven U.S. children experienced a physical or mental health condition that led to some level of developmental disability, a figure 17% higher than a decade earlier.

The Affordable Care Act’s essential health benefit (EHB) provisions establish coverage standards for the individual and small group health insurance markets, and habilitative services and devices are included in the EHB

**Whether health insurance covers habilitative services is a matter of great importance in child health policy.**

definition. The implementation approach taken by the Obama Administration makes state law the primary source of regulatory policy in defining EHBs.

In the absence of state standards, the Administration has elected to give broad deference to the health insurance industry to

define the level of habilitative services coverage. Under federal regulations issued in February 2013, insurers will be permitted not only to define the benefit but also to engage in “substitution” of greater rehabilitative services for adults in favor of lesser habilitative services for children.

Establishing state standards for health insurance plans sold in the individual and small group markets (including Qualified Health Plans [QHP] sold in the Health Insurance Marketplace) thus becomes key to health policy for children with disabilities. The evidence suggests that to date, only some states have addressed this issue. Key regulatory issues encompass coverage definition, permissible limitations and exclusions, medical necessity evaluation, the permissibility of substitution, and the interaction between habilitative services and mental health parity.

### **Introduction**

This analysis examines coverage of habilitative services for children under the essential health benefits (EHB) provisions of the Affordable Care Act (ACA). The issue of habilitative services coverage is of major importance in child health policy because of the prevalence of

developmental disabilities among children. In 2008, nearly one in seven U.S. children experienced a physical or mental health condition that led to some level of developmental disability.<sup>1</sup> This figure represents a 17 percent increase over the proportion of children experiencing such disabilities a decade earlier. Considerable evidence shows that intervention at the earliest time with a range of therapies aimed at developing physical, mental, cognitive, and socialization skills can be effective in reducing the severity and scope of developmental delays.<sup>2</sup>

Because of the complex manner in which the EHB provisions of the law interact with various sources of health insurance, the analysis focuses on several distinct health insurance markets: (1) Medicaid and separately administered CHIP programs; (2) the individual and small group (under 100 employees) health insurance markets; and (3) the large group market, whether fully insured or self-insured. In addition, the analysis touches on the relationship of the EHB provisions to health plans that maintain “grandfathered” status.

This analysis finds that the essential health benefits provisions of the ACA have significantly advanced access to habilitative services coverage for children in the individual and small group markets. However, it also finds that final federal EHB regulations, issued by the United States Department of Health and Human Services in February 2013, may actively

<sup>1</sup> C. Boyle et al., “Trends in the Prevalence of Developmental Disabilities Among U.S. Children, 1997-2008,” *Pediatrics* (published online, May 23, 2011) [accessed online at Centers for Disease Control and Prevention, *Developmental Disabilities Increasing in the U.S.*

[http://www.cdc.gov/features/dsdev\\_disabilities/index.html](http://www.cdc.gov/features/dsdev_disabilities/index.html) (May 10, 2013)]

<sup>2</sup> Id.

incentivize EHB-governed health plans to reduce habilitative services for children in favor of more comprehensive rehabilitative services for adults. Because of the primary role played by states in defining the scope of EHB coverage, state health policy becomes extremely important to the strength of habilitative services coverage for children.

This analysis begins with a background that reviews the habilitative services coverage landscape prior to passage of the ACA. It then describes the EHB amendments and the course of federal agency implementation. The analysis concludes with a discussion of issues that arise as the amendments are translated into coverage in state markets.

## Background: Pre-ACA Coverage of Habilitative Services for Children

### *Private insurance, employer-sponsored plans*

The National Association of Insurance Commissioners (NAIC), whose model laws and policies are considered authoritative in the field of insurance regulation, defines the term “habilitative services” as “health care services that help a person keep, learn or improve skills and functioning for daily living.”<sup>3</sup> Prior to enactment of the ACA, coverage of habilitative services, whether for children or adults, was effectively confined to the Medicaid program. To be sure, strong advocacy in recent years led to measurable gains in standards governing habilitative services coverage under private insurance in the case of children with autism spectrum disorders. Indeed, as of August 2012,

<sup>3</sup> National Association of Insurance Commissioners, Glossary of Health Insurance Terms [http://www.naic.org/documents/committees\\_b\\_consumer\\_information\\_ppaca\\_glossary.pdf](http://www.naic.org/documents/committees_b_consumer_information_ppaca_glossary.pdf) (Accessed online May 4, 2013)

37 states reported at least some insurance coverage of applied behavioral therapy for children with a covered diagnosis related to autism spectrum disorders.<sup>4</sup> Inevitably, as with state insurance benefit mandate laws generally, state laws governing habilitative services coverage may vary considerably in terms of the level of diagnosis necessary to trigger coverage, the amount, duration and scope of coverage available, permissible types of treatment limitations and exclusions, and permissible cost-sharing. Moreover, as state laws related to autism treatment coverage underscore, state coverage law advances may be limited to certain specific diagnoses.

In its 2011 report on the ACA's EHB provisions,<sup>5</sup> the Institute of Medicine (IOM) noted that habilitative services are distinct from rehabilitative care, since they are designed to

**Insurers and health plans have used an array of techniques to exclude coverage of treatments and therapies when needed for habilitative reasons.**

help a person attain a particular function as opposed to restoring a prior level of functioning. Recognizing the extremely limited nature of commercial insurers' experience with habilitative services

coverage, the IOM also pointed out that insurers and health plans have extensive experience with coverage of rehabilitative services, which consist of similar physical, cognitive, and mental health therapies, although carried out for a different purpose.

Despite the similarities between rehabilitative and habilitative treatments, as the IOM noted, insurers and health plans traditionally have used an array of techniques to exclude coverage of the treatments and therapies when needed for habilitative reasons, despite the fact that the only major difference between the provision of such therapies to a child is the triggering set of factors for their provision (i.e., attainment and maintenance, versus restoration, of function). The result of these exclusionary techniques has been denial of access to otherwise-covered therapies in the case of children (and adults) who need treatment to attain and maintain health and avert functional loss.

Numerous exclusionary tools come into play; typically these tools are used in combination with one another. One type of tool is to embed treatment exclusions directly into the contractual terms of coverage. For example, health plan documents might define speech therapy as care furnished by a licensed speech therapist when medically necessary to "restore" speech.<sup>6</sup> Another tool involves the exclusion of certain treatment settings from coverage; an example would be to insert a contractual "educational" exclusion that bars otherwise-covered treatments when furnished in school or child care settings as part of an overall child development program,<sup>7</sup> even in cases in which the treatment is furnished by a licensed health care professional. A third type of exclusionary technique would be use of a medical necessity

<sup>4</sup> National Conference of State Legislatures, *Insurance Coverage for Autism* (August 2012) <http://www.ncsl.org/issues-research/health/autism-and-insurance-coverage-state-laws.aspx> (Accessed online, May 4, 2013)

<sup>5</sup> Institute of Medicine, *Essential Health Benefits: Balancing Coverage and Costs* (National Academy Press, 2011), p. 61.

<sup>6</sup> See, e.g., *Bedrick v Prudential Insurance Co.* 137 F. 3d 1253 (4<sup>th</sup> Cir., 1994) (speech therapy limited to treatments necessary to "restore" speech and therefore denied to child with cerebral palsy)

<sup>7</sup> See, *Mondry v American Family Mutual Ins. Co.* No. 07-1109 (7<sup>th</sup> Cir., 2009). In 1984, Medicaid was amended to stop this type of service denial in the case of children receiving covered therapies as part of individualized plans under the Individuals with Disabilities Education Act (IDEA)

standard that allows payment for covered therapies only in cases in which the purpose of the treatment is to recover lost function.<sup>8</sup> A fourth type of tool is the use of internal practice guidelines, which guide individual determinations of medical necessity in particular cases, that advise against interventions in the case of children with developmental disabilities, for whom such interventions are to be considered educational in nature, with no hope of health improvement.<sup>9</sup>

### *Medicaid and CHIP*

As a program designed for impoverished families, and children and adults with disabilities, Medicaid historically has operated in a fashion completely distinct from the principles that guide the types of exclusions of long term treatments for chronic physical and mental conditions that characterize commercial coverage. For this reason, Medicaid's distinct qualities are apparent not only in the populations entitled to coverage but in the level of coverage to which beneficiaries are entitled, especially in the case of children.

Medicaid consists of both required and optional services, and as a general matter, federal law bars states from discriminating on the basis of diagnosis in coverage of required services.<sup>10</sup> This means that Medicaid prohibits states from withholding otherwise covered treatments that fall within required services classes simply because a condition was present at birth as opposed to developing later in life.

Moreover, where children are concerned, no service class falling within the federal definition

of "medical assistance" is classified as optional; instead, all services are required services. This special coverage standard is the result of Medicaid's special early and periodic screening, diagnosis and treatment (EPSDT) benefit, which covers individuals from birth to age 21. Part of Medicaid since 1967 and expanded significantly by Congress in 1989, EPSDT offers not only broad preventive benefits but also coverage of all medically necessary treatments and services falling within any of the covered classes of services that together define the concept of "medical assistance." Furthermore, the definition of EPSDT itself adds to the power of its coverage requirements, since the term "early" in the EPSDT statute modifies not only "screening" but also "diagnosis and treatment."<sup>11</sup>

As a result, EPSDT effectively creates a singular coverage standard that entitles children to the broadest possible range of treatments and services (without cost-sharing) at the earliest possible point at which the need for treatment is determined. Finally, EPSDT establishes a medical necessity test that turns on whether a treatment is necessary to "ameliorate" any "physical or mental health condition," thereby eliminating any distinction between physical and mental conditions or between conditions that are present at birth or early infancy as opposed to being subsequently acquired.

In 2006, Congress amended Medicaid to enable states to substitute a more limited "benchmark" benefit design (pegged to the commercial insurance market) in place of traditional Medicaid coverage for certain populations.<sup>12</sup>

<sup>8</sup> See *Bedrick*, supra, note 4.

<sup>9</sup> *Id.*

<sup>10</sup> 42 C.F.R. §440.230(b)

<sup>11</sup> 42 U.S.C. §§1396d(a)(4)(B) and (r)

<sup>12</sup> §1937 of the Social Security Act, added by the Deficit Reduction Act of 2005.

(The 2006 benchmark amendment reflects both a state option to adopt a commercially oriented benefit design as well as state flexibility to buy such commercial designs from sellers of “benchmark plans.”) The 2006 benchmark amendments thus were designed to pave the way to a revision of Medicaid’s traditional benefit design in ways that would pull it closer to commercial norms, with their limited coverage of long term treatments for chronic physical, mental, and developmental conditions. At the same time however, the 2006 amendments also preserved the full EPSDT benefit package for children enrolled in benchmark plans.<sup>13</sup> Thus, even in the case of children enrolled in Medicaid benchmark plans, the full EPSDT benefit package remains the coverage standard.

The Children’s Health Insurance Program affords states far greater discretion in defining the amount, duration, and scope of covered services. Under CHIP, habilitative services coverage remains a state option in the case of separately administered CHIP plans. Because the EHB provisions do not apply to state CHIP plans, habilitative services remain a state CHIP option in the wake of the ACA.

### The Affordable Care Act

The Affordable Care Act transforms the market for private health insurance. However, the scope of the transformation varies depending on which segment of the insurance market is in focus. Certain ACA amendments apply to the private coverage market as a whole, while others, such as the EHB provisions, target the state-regulated individual and small group health insurance market. Furthermore, as discussed below, the

<sup>13</sup> §1937(a)(1)(A)(ii)

ACA cross-walks (that is, applies) the EHB provisions to the Medicaid benchmark statute in order to ensure going forward that states’ benchmark plans meet all EHB requirements.

Of course, the ACA’s EHB provisions are of special importance to the Health Insurance Marketplace (formerly termed Exchanges, consistent with the Act’s statutory terminology). This is because in order to be certified as “Qualified Health Plans” (the type of plan sold in the Marketplaces), issuers must demonstrate that their QHPs cover all essential health benefits in accordance with federal and state requirements. The ACA exempts “grandfathered” plans<sup>14</sup> from nearly all of the general market reforms, as well as the EHB coverage requirements. But the test of grandfathered status is sufficiently stringent so that the proportion of plans that fall into this special exemption category is expected to decline significantly with time.<sup>15</sup>

### *Key market reforms generally applicable to all non-grandfathered plans sold in the individual or group markets, whether fully insured or self-insured*

Certain of the ACA’s general market-wide insurance reforms are especially relevant to a discussion of the EHB provisions because they address the basic question of access to coverage among children and adults with disabilities:

- *A bar against lifetime and annual coverage limits.* The Act bars lifetime and annual limits on coverage.<sup>16</sup> Prior to 2014, the Act

<sup>14</sup> PPACA §1251

<sup>15</sup> Healthcare.Gov offers a clear explanation of which protections do and do not apply to grandfathered plans. <http://www.healthcare.gov/law/features/rights/grandfathered-plans/> (Accessed online May 5, 2013)

<sup>16</sup> PHS §2711 as added by PPACA §1001

allows certain restricted annual limits on benefits and services falling within the “essential health benefits” category.<sup>17</sup> Thus, to the extent that a health plan of any size offers habilitative services, coverage cannot be subject to either annual or lifetime limits. (Grandfathered plans are subject to the bar against lifetime limits.)

- *Coverage of preventive services.* The Act requires coverage of certain preventive services including services for infants, children and adolescents that are “evidence-informed preventive care and screenings provided for in comprehensive guidelines” issued by the Health Resources and Services Administration (HRSA).<sup>18</sup> HRSA guidelines<sup>19</sup> encompass 26 separate preventive services including numerous screening procedures used to identify children whose health conditions make them candidates for habilitative treatment.
- *Uniform explanations of coverage.* The Act requires all health plans to use uniform explanation of coverage documents and standardized definitions.<sup>20</sup> The Act’s uniform explanation of coverage documents do not bind any plan to coverage of the subject matter as described; (in other words, actual coverage still depends on the terms of the plan itself). Nonetheless, the uniform explanation of coverage materials incorporate the NAIC habilitative services definition described earlier (“health care services that help a person keep, learn or

improve skills and functioning for daily living”).

- *Guaranteed issue and renewal, and a bar against pre-existing condition exclusions or discrimination based on health status.* The Act requires all plans to make coverage available regardless of health status.<sup>21</sup> Furthermore the Act bars the use of pre-existing condition exclusions<sup>22</sup> or other forms of discrimination (such as pricing) that are based on health status.<sup>23</sup>

### *The EHB Requirements*

The EHB provisions of the ACA designate 10 mandatory benefit classes, one of which is “rehabilitative and habilitative services and devices.”<sup>24</sup> As noted, the EHB provisions apply to all insurance products sold in the individual and small group markets. The provisions also apply to Medicaid “benchmark” plans (renamed “Alternative Benefit Plans [ABPs]” by the Centers for Medicare and Medicaid Services in proposed rules issued in January 2013). As a result, the EHB amendments effectively raise the bar not only for private insurance but also for Medicaid benchmark plans (now renamed ABPs) that will enroll newly eligible adults ages 21 and older<sup>25</sup> as well as certain children, at state option. (Recall, as previously discussed, however, that individuals enrolled in benchmark

<sup>21</sup> PHS §2702, added by PPACA §1201

<sup>22</sup> PHS §2704, added by PPACA §1201

<sup>23</sup> Id.

<sup>24</sup> The 10 categories consist of ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care. PPACA §1302(b)(1)

<sup>25</sup> 78 Fed. Reg. 4594-4724. See discussion of EHB coverage through alternative benefit plans, 78 Fed. Reg. 4629-4631.

<sup>17</sup> PHS §2711(a)(2) as added by PPACA §1001

<sup>18</sup> PHS §2713(a)(3)

<sup>19</sup> <http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html#CoveredPreventiveServicesforChildren>

<sup>20</sup> PHS §2715, added by PPACA §1001

plans and under age 21 remain entitled to the full EPSDT benefit, a coverage guarantee that the ACA does not alter. It is also important to note that young adults entitled to Medicaid on the basis of their status as former foster care children remain exempt from the arguably more limited benchmark rules and entitled to traditional Medicaid coverage, which may include richer benefits for serious and chronic physical and mental health conditions).<sup>26</sup>

Thus, as the Table below illustrates, children who are entitled to Medicaid remain fully entitled to EPSDT, regardless of whether their coverage is effectuated through traditional fee-for-service arrangements, traditional Medicaid managed care arrangements, or through benchmark/ABP arrangements, or even through enrollment in a Qualified Health Plan (QHP) purchased by a state Medicaid program in the Health Insurance Marketplace.<sup>27</sup> For this reason, the habilitative coverage component of the EHB requirement does not directly affect Medicaid-enrolled individuals under 21.

But in the case of private health insurance, the EHB requirement is far-reaching for the millions of children expected to be enrolled in

<sup>26</sup> Social Security Act §1937(a)(2)(B)(viii), as amended by PPACA §2004

<sup>27</sup> Since Medicaid's enactment, states have had the option to cover beneficiaries by buying private insurance coverage. This option is now codified at §1905 of the Social Security Act. Some states, such as Arkansas, are considering using the purchase of Qualified Health Plans sold in the Marketplace to cover some portion of their newly eligible population. Although the Arkansas model appears at this point to be limited to adults, there is no reason why a state could not also buy QHP coverage for families with children. See CMS, Medicaid and the Affordable Care Act: Premium Assistance <http://www.healthreformgps.org/wp-content/uploads/medicaid-premium-assistance-3-29.pdf> (March 29, 2013). See generally, Sara Rosenbaum for Healthreform GPS for a discussion of Medicaid premium support <http://www.healthreformgps.org/resources/using-medicaid-funds-to-buy-qualified-health-plan-coverage-for-medicaid-beneficiaries/> (Accessed online May 5, 2013)

plans sold in the individual and small group markets, particularly those plans (i.e., certified Qualified Health Plans) sold inside the Health Insurance Marketplace. Particularly great interest has been shown in the question of how the EHB requirements will affect coverage obtained through the Health Insurance Marketplace, since it is this segment of the insurance market in which individuals and families, as well as small low-wage employers, will qualify for subsidization through premium tax credits (and cost-sharing assistance in the case of individuals and families).

### *The EHB Statutory Provisions*

As noted, the EHB statute sets forth 10 broad benefit categories, including habilitative and rehabilitative services and devices, and directs the Secretary to define the EHB package. The statute further provides that in carrying out her implementation responsibilities, the Secretary must take into account certain “considerations,” three of which bear directly on habilitative services coverage: First, in fashioning the package, the Secretary must balance the health care needs of a “diverse” population, including children. Second, the Secretary must “not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life.” Third, the Secretary must ensure that health benefits established as essential [will] not be subject to denial . . . on the basis of individuals' present or predicted disability. . . .”<sup>28</sup>

In addition to describing certain covered EHB classes and establishing certain

<sup>28</sup> PPACA §1302(b)(4)

“considerations,” the statute also defines EHBs in terms of their actuarial value. This definition of EHBs in relation to their actuarial value as well as their specific terms of coverage is significant, as discussed below, because of its implications for the practice of benefit substitution.

Another key matter in examining the implementation of the habilitative services component of the EHB package is its interaction with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Federal regulations implementing MHPAEA<sup>29</sup> interpret the Act as applying to both quantitative (e.g., the number of allowable visits) and non-quantitative (e.g., medical necessity, medical management practices) treatment limits. MHPAEA applies to all employer group plans with 50 or more full-time employees, as well as to QHPs of any size sold in the Health Insurance Marketplace.<sup>30</sup> As a result, understanding how MHPAEA relates to any particular EHB class becomes a significant factor in regulating the practices of both QHPs as well as health plans sold in the small group market.

### *The Secretary’s Approach to Implementation*

In implementing the EHB provisions, the Secretary has elected to delegate the power to define EHBs to both states and insurers, at least in the initial implementation years. Recognizing the extent to which U.S. law emphasizes the role of states in the regulation of insurance – an emphasis that has long distinguished the U.S. insurance market and that continues under the ACA – the Secretary has taken an exceptionally broad approach to defining the meaning and

scope of EHBs. The EHB regulations effectively delegate the key decisions to states and to the health insurance industry itself, which has long enjoyed considerable discretion to shape coverage design.<sup>31</sup>

The final rules, released in February 2013,<sup>32</sup> were presaged by an *Essential Health Benefits Bulletin* released in December 2011,<sup>33</sup> which laid out a highly deferential approach to implementing the provisions. The deferential approach set forth in the *Bulletin*, and carried over into the final rules, reflects the Administration’s view that the concept of keeping and maintaining functioning is “virtually unknown in commercial insurance...” Thus, despite the fact that the same collection of therapies used in rehabilitative treatment (with which, as the *Bulletin* acknowledged, insurers have extensive experience) form the basis of the therapeutic approaches used in habilitative treatment, the *Bulletin* instead focused on the fact that where habilitative care is concerned, the focus is “on creating skills and functions” as opposed to “restoring skills and function” in the case of rehabilitation.<sup>34</sup> For this reason, the *Bulletin* concluded, issuers needed exceptionally broad latitude where implementation of habilitative coverage is concerned.

Employing this “virtually unknown” rationale, the *Bulletin* lays out two options to covering habilitative services in cases in which a state elects not to define the scope of the term. Under the first option, insurers may offer habilitative

<sup>31</sup> See, generally, Sara Rosenbaum and David Frankford et al., *Law and the American Health Care System* (2d ed., 2012) (Foundation Press, NY, NY)

<sup>32</sup> 78 Fed. Reg. 12834 (February 25, 2013)

<sup>33</sup> [http://cciio.cms.gov/resources/files/Files2/12162011/essential\\_health\\_benefits\\_bulletin.pdf](http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf) (accessed online, May 5, 2013)

<sup>34</sup> *Essential Health Benefits Bulletin* at p. 11.

<sup>29</sup> 75 Fed. Reg. 5410-5451 (Feb 10, 2010)

<sup>30</sup> PPACA §1311(i)

services “at parity” with rehabilitation; that is, they may elect to cover the same range of physical, mental, cognition, and other therapies available through rehabilitative coverage, simply substituting a habilitative-related test of coverage (i.e., coverage is available when the treatments are necessary to attain and maintain functional skills as opposed to restoring them). Alternatively – and highly significantly – the *Bulletin* permits issuers on a “transitional basis” to “decide which habilitative services to cover” and report their coverage to HHS.<sup>35</sup>

The final EHB rule preserves the *Bulletin*'s construct, by establishing a multi-pronged approach to habilitative services coverage in the EHB-governed market. As a threshold matter – and reflecting the deferential standard that succeeding Administrations have taken to state regulation of insurers ever since the 1996 enactment of the Health Insurance Portability and Accountability Act (HIPAA) – the regulations provide that states “may” determine the meaning and scope of habilitative services if their “base benchmark plan” (which is the starting point for building the essential health benefits package) does not already contain a definition.<sup>36</sup>

The regulations then proceed to lay out what might be thought of as the federal default approach in the event that the state's final EHB benchmark does not include a definition of habilitative services. Under this “default” approach, the two coverage options presented in the *Bulletin* are incorporated into the rules. That is, an issuer either may use a “parity” approach to habilitative coverage or it may determine the

meaning and scope of habilitative coverage and report it to HHS.<sup>37</sup>

At this point, two other crucial aspects of the final EHB rule come into play. The first is how the final rule implements the bar against discrimination against persons with disabilities, as well as the requirement that the final package reflect the needs of a diverse population. The final rule<sup>38</sup> simply repeats the terms of the statute and does not amplify on their meaning or apply the considerations to specific cases (such as how the Administration expects that issuers are to balance coverage of rehabilitative services for adults with habilitative services for children and adults with developmental disabilities).

The second crucial aspect of the final EHB rule has to do with the issue of substitution, that is, the discretion of insurers to substitute one set of covered items and treatments for another, as long as the package containing the substituted benefits is the actuarial equivalent of the EHB benchmark. The final rule allows states to bar substitution. But in the absence of a state bar, the rule permits issuers to substitute services but only within the same benefit class. Since rehabilitative and habilitative services fall within the same benefit class,<sup>39</sup> this presumably means that in selecting between the two habilitative services coverage options under the rule (i.e., parity versus insurer-defined level of coverage), insurers may offer a lesser scope of habilitative coverage in favor of a richer rehabilitative benefit package. Such a coverage design strategy may be highly desirable in a QHP marketplace that is expected to attract millions of older adults in poor health.

<sup>35</sup> Id.

<sup>36</sup> 45 C.F.R. §156.110(f)

<sup>37</sup> 45 C.F.R. §156.115 (a)(5)(i) and (ii)

<sup>38</sup> 45 C.F.R. §156.125(a)

<sup>39</sup> PPACA §1302 groups habilitative and rehabilitative services together into a single benefit grouping.

Finally, it is important to note that in the context of non-discrimination, the final EHB rule does not address the interaction of habilitative coverage under the EHB package with MHPAEA.

In sum, the EHB regulations establish a tiering approach to habilitative services coverage policy. In the first tier, the federal government, deferring to the primary role of states in the regulation of insurance, will look to state law. If a state standard is absent – that is, if the state elects not to define the meaning and scope of habilitative coverage, then the second tier commences. Under this tier, insurers would be free to use one of two approaches under the federal default standard as laid out in the final EHB rules. Under the first approach the insurer would offer habilitative coverage at parity with rehabilitative coverage. Under the second, the issuer would fashion a habilitative benefit and report on it. Under the substitution rule, and in the absence of a state prohibition to the contrary, the habilitative benefit could be lessened in favor of a richer rehabilitative services benefit.

A series of blog posts<sup>40</sup> at the Statereforum® website maintained by the National Academy for State Health Policy suggest that some states have begun to develop approaches to habilitative services coverage. As one might expect, these approaches run the gamut, from parity to complete or partial deference to issuers (for example, allowing issuers to design habilitative services coverage generally but requiring them to cover at least some level of habilitative services for children with autism

spectrum disorders, presumably reflecting underlying state benefit mandates).

### *The Approach Taken by the Office of Personnel Management to Essential Health Benefits*

The federal Office of Personnel Management (OPM) oversees the QHP certification process in the case of multi-state QHPs. In the case of habilitative services, OPM has taken a strikingly different approach that suggests far less deference to the insurance industry. As is the case with the HHS regulations, OPM will require issuers to follow a state’s definition of habilitative services where the state provides a definition. But where the state does not define the coverage, the OPM rule indicates that the agency “may determine what habilitative services and devices are to be included in that EHB-benchmark plan.”<sup>41</sup> Thus, unlike HHS, OPM leaves the door open to a potentially more directive approach to defining habilitative services. With respect to the issue of benefit substitution, OPM specifies that an issuer must “comply with any state standards relating to substitution of benchmark benefits or standard benefit designs.”<sup>42</sup> Whether, in the absence of a state bar against substitution, OPM in fact will permit substitution within the habilitative/rehabilitative coverage class is not clear.

The interaction of the EHB regulations across public and private insurance markets can be seen in the Table below.

## Discussion

This analysis underscores that states remain the

<sup>40</sup> <http://www.statereforum.org/search/solr/habilitative%20benefits> (Accessed online May 5, 2013)

<sup>41</sup> 5 C.F.R. §800.105(c)(3)

<sup>42</sup> 5 C.F.R. §800.105(b)(3)

first-level decision point where defining the meaning and scope of EHBs is concerned. As such, two possible avenues to a state definition exist. The first is state benefit mandates in effect as of December 31, 2011, which the federal regulation incorporates into the final EHB rule. To the extent that states mandated one or more types of habilitative treatment coverage as of that date, the mandate presumably would apply unless amended or altered in state law. But in many states, the benefit mandate may be limited to certain diagnoses and certain treatments, in contrast to rehabilitative coverage, which typically pertains to a wide array of physical and mental health/addiction disorder conditions for which treatments aimed at aiding recovery are appropriate.

At the same time, as the federal regulations underscore, states retain the primary role in defining the meaning of the federal habilitative services coverage standard, regardless of their own, separate state mandates. As the Statereforum® materials suggest, at least some states are moving to implement the habilitative coverage provisions of the EHB amendments separate and apart from whatever their pre-existing state law benefit mandates may specify. For example, some states already have indicated that they expect issuers to maintain a “parity” approach where habilitative/rehabilitative services are concerned. Other states already have indicated that in the absence of a specific state benefit mandate, issuers will have the discretion to define the habilitative benefit. In the absence of a bar against benefit substitution, this would permit a state issuer to use a more restrictive approach to habilitative treatment coverage, limiting coverage to certain conditions, certain treatment settings, and certain therapies that collectively offer a

narrower range of coverage than that available when the focus is on rehabilitation as opposed to habilitation.

In states that are considering defining habilitative treatment coverage rather than defaulting to the federal standard or parity or issuer definition, a number of considerations arise.

*Defining habilitative treatment.* The NAIC definition (“health care services that help a person keep, learn or improve skills and functioning for daily living”) offers the important benefit of having been adopted and endorsed by the NAIC, whose model laws and policies, as noted above, are considered authoritative in the field of insurance regulation. The definition implicitly, yet importantly, reflects a consensus by an authoritative body that such a definition can be implemented by the industry in terms of coverage design, coverage determination, and coverage pricing, all key considerations.

*The applicable medical necessity standard and medical management considerations.* Under the NAIC definition, a treatment or service would be considered medically necessary if the intervention is necessary to help the individual keep, learn, or improve skills and functioning for daily living. This scope appears to be consistent with the clinical underpinnings of habilitative services. Coverage would not be confined to “attainment” situations (i.e., learn) but would also preserve access to coverage where the intervention is needed to maintain (i.e., keep) skills and functions. The one notable consideration that does not fit neatly into the NAIC definition but that would be relevant to coverage decision-making is whether the treatment is needed to avert deterioration,

although even here, the concept of “keep” arguably encompasses both maintaining and averting loss. Adoption of the NAIC definition of habilitative services with appropriate accompanying indications of policy intent presumably would ensure that the term “keep” is understood as addressing not only maintenance but also the avoidance of loss of functioning.

*Limitations and exclusions.* An important issue in habilitation is the treatment settings in which otherwise covered services will be recognized. In the case of adults receiving either habilitative or rehabilitative services, the location of care may be either an inpatient or outpatient clinical setting. In the case of children, the service location might be a comprehensive day program or school setting, where, during the day of education or child care, a child in need of habilitative treatments receives additional or extra therapies by licensed clinical health professionals. In these situations an important consideration is whether, as long as the health care professional meets applicable state licensure and certification requirements and is furnishing a covered benefit (e.g., speech therapy, physical therapy, therapy to improve cognition or socialization), issuers will have the discretion to exclude otherwise covered treatment because it is received in an educational or social setting.

*Substitution versus parity.* As the federal regulations underscore, substitution is not uncommon in the commercial insurance market. Because habilitative and rehabilitative services arguably fall within a single benefit class, it would be possible for an insurer to limit habilitative coverage in order to expand rehabilitative coverage. If this result is not

desired, then state law would need to explicitly bar substitution within the benefit classes, as so indicated by the federal rule.

*Interaction with mental health parity requirements.* As noted, mental health parity requirements apply to both QHPs sold in Health Insurance Marketplaces and to small group plans sold outside the Marketplace and covering 50 or more full-time employees. In order to clarify the relationship between the MHPAEA requirements and habilitative services, it would be helpful for a state’s habilitative coverage policy to specify the application of MHPAEA in the habilitative treatment context, with respect to both quantitative and non-quantitative treatment limits. By specifying the application of MHPAEA, state habilitative coverage policy would underline the fact that on matters having to do with coverage design or management, MHPAEA prohibits insurers from treating children with mental disabilities in a manner different from those with physical disabilities. Examples of key design and management aspects of insurance where MHPAEA could make a decisive difference would be differentials in the use of treatment plans that require ongoing insurer re-certification, the use of fixed practice guidelines that specify absolute coverage limits (as opposed to softer limits that defer to clinical judgment), differentials in quantitative treatment limits, or differential cost-sharing requirements.

## Conclusion

Ultimately, the federal government may use the results of the information it gains in overseeing the EHB coverage market – both inside and outside the Health Insurance Marketplace – to move in the direction of a more uniform

national standard. Because the information on habilitative services coverage proposed by QHP bidders is not public, it is not possible to know with certainty how many issuers are proposing to use a parity approach as opposed to an alternate approach that also allows substitution within the habilitative/rehabilitative benefit class. As QHPs come on line in both federally administered and state-based Marketplaces, the task of understanding the current state of habilitative coverage in the EHB market will be eased. It also will be important to determine whether coverage differences emerge in that portion of the EHB market that lies outside of the Health Insurance Marketplace and that involves direct sales by agents and brokers. Also

of importance will be how OPM approaches the question of habilitative services coverage in the case of issuers that do not operate under state coverage standards. The OPM regulations at least hint at the notion that the agency is considering more decisive and uniform habilitative coverage standards in its negotiations with issuers, but, of course, it is still too early to tell. In the meantime, state EHB coverage policy offers the crucial starting point for habilitative services coverage.

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**Table 1: Coverage of Habilitative Services for Children Across Multiple Insurance Markets and Plan Types**

Market and Plan Type	Habilitation Coverage Standard
<b>Medicaid and CHIP</b>	
<b>Fee-for-service</b>	Under EPSDT, children are entitled to all federally recognized Medicaid benefits necessary to diagnose and ameliorate physical and mental health conditions
<b>Traditional managed care<sup>43</sup></b>	Same coverage standard
<b>Alternative benefit plans<sup>44</sup></b>	Same coverage standard
<b>Premium assistance for qualified health plan (QHP) coverage<sup>45</sup></b>	Same coverage standard
<b>Separately administered CHIP plans</b>	State defines coverage
<b>Essential Health Benefit (EHB)-Governed Markets (Individual policies and Small Group Plans)</b>	
<b><u>Inside the Health Insurance Marketplace for Qualified Health Plans (QHPs)<sup>46</sup></u></b>	
<b>State-based Marketplaces</b>	State sets the standard or default to federal standard at state option <sup>47</sup>
<b>Federally facilitated Marketplaces</b>	State standard applies; if none, then default to federal standard (habilitation/rehabilitation parity or issuer-designed standard) <sup>48</sup>
<b>OMB-certified multi-state QHPs</b>	State standard applies; if none, then OPM negotiates with the QHP issuer.
<b><u>Outside the Health Insurance Marketplace</u></b>	State sets the standard; if none, federal default standard applies
<b>Large Employer Groups, Insured or Self-Insured</b>	
At the discretion of the group sponsor and the issuer or plan administrator: EHB standard does not apply	

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<sup>43</sup> Social Security Act §1932

<sup>44</sup> Social Security Act §1937

<sup>45</sup> Social Security Act §1905, with or without an accompanying §1115 demonstration waiver

<sup>46</sup> Formerly termed Exchanges

<sup>47</sup> 45 C.F.R. §156.110(f)

<sup>48</sup> 45 C.F.R. §156.115(a)(5)(i) and (ii)