DRAFT Bulletin to Insurers

Date: March x, 2013
To: All Insurers Writing Individual and Group Health Insurance
From: Theodore K. Nickel, Commissioner of Insurance
Subject: Essential Health Benefits – Habilitative Services

On February 20, 2013, the United States Department of Health and Human Services issued a final rule establishing Essential Health Benefits that must be covered beginning January 1, 2014 by individual and small group plans. The final rule requires coverage for habilitative services and devices. HHS recognized that many health insurance plans do not identify habilitative services as a distinct group of services. The final rule includes a transitional policy for coverage of habilitative services that would provide states with the opportunity to define these benefits if they were not included in the base-benchmark plan.

Wisconsin's federally approved benchmark plan - UnitedHealthcare Choice Plus Definity HSA Plan A92NS – does not include habilitative services. The federal rule indicates that in the absence of habilitative services from a state's benchmark plan a state is permitted to determine the services included in the habilitative services category. If a state does not define the habilitative services category, plans are still required to provide these benefits as defined in §156.115(a)(4). HHS intends to carefully monitor coverage of habilitative services across the individual and small group markets.

Final Regulation on Habilitative Services:

> 45 C.F.R. §156.115 Provision of EHB.
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> (5) If the EHB-benchmark plan does not include coverage for habilitative services, as described in §156.110(f) of this subpart, include habilitative services in a manner that meets one
> of the following—
> (i) Provides parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services; or
> (ii) Is determined by the issuer and reported to HHS.

Final rules on EHB: http://www.ofr.gov/OFRUpload/OFRData/2013-04084_PI.pdf)

Habilitative Services Considerations for Wisconsin Insurers

Option #1 – Providing Parity.
Parity between rehabilitation coverage and habilitation coverage refers to parity to the availability of coverage of services to treat an underlying condition. In other words, the coverage of therapy services and devices to treat a functional deficit in a child or adult should not turn on whether the condition that led to that functional deficit was acquired before/near birth or was acquired after birth through illness, injury, or other reason. In this respect, availability of coverage of habilitation services to address a functional deficit should be on par with the

availability of coverage of rehabilitation services. The underlying condition that causes the functional deficit should not impact coverage of services to address that deficit.

Option #2 – Insurer Determination.
Habilitation benefits are defined as services that help individuals attain functions and skills they have never had due to a disabling condition. This may entail major variations in amount, duration, and scope of needed services in comparison to the typical rehabilitation patient. Therefore, when assessing limits on habilitation coverage, insurers should consider habilitative services independently from rehabilitative services.

Sample Coverage of Habilitative Services

Habilitative Services means health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't 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. (National Association of Insurance Commissioners proposed definition http://www.naic.org/documents/committees_b_consumer_information_ppaca_glossary.pdf).

1. These services may include physical therapy, occupational therapy, speech-language pathology and audiology, mental health and other services for people with disabilities in a variety of inpatient and/or outpatient settings. Services must be performed by an appropriate registered therapist licensed by the appropriate state licensing board and must be furnished under the direction and supervision of a physician (doctor of medicine or doctor of osteopathy) or an advanced practice nurse in accordance with a written treatment plan established or certified by the treating physician or advanced practice nurse. It is understood that the issuer will determine the number of therapy sessions, but at a minimum therapy for habilitation will be on parity with therapy for rehabilitation.

2. Habilitative devices and equipment include durable medical equipment (DME), orthotics, prosthetics, low vision aids, hearing aids, augmentative communication devices that aid in hearing and speech and other assistive technologies and supplies. This includes devices that maintain as well as improve function. Habilitative devices and equipment when prescribed by a physician (doctor of medicine or doctor of osteopathy) or an advanced practice according to the guidelines specified below.
    a. Habilitative devices and equipment are equipment which (1) can withstand repeated use; and (2) are primarily and customarily used to serve a medical purpose; and (3) generally are not useful to a person in the absence of an illness or injury; and (4) are appropriate for use in the home.
    b. Durable Medical Equipment delivery or set up charges are included in the Allowance or Allowable Charge for the Durable Medical Equipment.
    c. Replacement of DME is covered when necessitated by normal growth or when it exceeds its useful life. Usual and customary maintenance and repairs are covered unless resulting from misuse or abuse by the Covered Person.

d. When it is more cost effective, the Company in its discretion will purchase rather than lease equipment. In making such purchase, the Company may deduct previous rental payments from its purchase Allowance.

Establishing Limits on Rehabilitative and Habilitative Services and Devices

Section 1302(b)(4)(B) of the Affordable Care Act explicitly prohibits EHB coverage decisions and benefit designs that discriminate against individuals based on disability. Section 1302(b)(4)(D) further prohibits any service established as essential from being subject to denial based on disability.

Insurers must carefully evaluate both quantitative and non-quantitative limits on services and devices to ensure such limits do not restrict access to essential health benefits and violate these nondiscrimination requirements. Additionally, insurers must ensure an appropriate balance of coverage between categories of benefits under the ACA, meaning that coverage for rehabilitative and habilitative benefits should be no more restrictive than other benefit categories in the state's EHB package.

Insurers should review plans' proposed limits and exclusions to ensure coverage decisions focus on the individualized health care needs of each particular patient and comply with all nondiscrimination requirements set forth under the law. Evaluation of plans' limits and exclusions should consider more than just physical health but also a person's ability to function in his or her environment.

Substitutions within Habilitative Services

Section 156.115(b) of the Final Rule allows for benefit substitution. Insurers may substitute benefits, or sets of benefits, that are actuarially equivalent to the benefits being replaced within benefit categories, not between different benefit categories. Through such a substitution, insurance policies would have more flexibility to better meet the medical needs of an individual consumer. For example, this could permit 30 visits for OT and 10 visits for PT even though the benefit describes 20 visits for each.