



OPEN LETTER TO STATES ON UPDATING THE ESSENTIAL HEALTH BENEFITS PACKAGE UNDER THE AFFORDABLE CARE ACT

**RE: TECHNICAL ASSISTANCE FOR STATES TO UPDATE THE DESIGN OF THEIR ESSENTIAL HEALTH BENEFITS PACKAGES FOR “REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES”**

Dear State Insurance Commissioners and Other Interested Parties:

As you review your state’s essential health benefits (EHB) benchmark plan design, the undersigned members of the Habilitation Benefits (HAB) Coalition appreciate this opportunity to provide state leadership with this guidance. This technical assistance document focuses solely on the EHB category referred to in the Affordable Care Act (ACA) as “rehabilitative and habilitative services and devices.” This document is a follow-up to the technical assistance document that the HAB Coalition previously provided in 2020.

In light of additional flexibility and options for states to select new EHB benchmark plans following the 2019 Notice of Benefit and Payment Parameters final rule, we hope you find this technical assistance useful in selection—as well as enhancement—of your states’ EHB package. We also hope you find this to be a useful resource as you refine your EHB package in the years to come.

The HAB Coalition is a group of national nonprofit 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. The HAB Coalition has worked hard over the past several years to ensure full and appropriate implementation of the ACA’s reforms at the federal and state levels with the ultimate goal of eliminating decision-making based on health status in the individual and small group markets, which disproportionately impacts people with disabilities and chronic conditions. For additional information about the HAB Coalition, please visit our website at: <https://habcoalition.wordpress.com/>.

As you are well aware, Section 1302 of the ACA lists ten benefit categories that must be covered as essential by new individual and small group plans. In advance of regulating the EHB package, the U.S. Department of Health and Human Services (HHS) released guidance instructing states to choose an existing plan as a benchmark for their EHB package. The HHS guidance directed states to enhance that plan where it does not adequately cover all 10 of the required benefit categories. In 2018, HHS provided states with new options for setting their EHB benchmark plans.

Though the mandate for coverage of habilitation (and rehabilitation) services and devices has been in effect for almost a decade, we have unfortunately found that many states have yet to consistently provide practical and accessible information about the scope of benefits covered by plans that is necessary for beneficiaries to understand the rehabilitation and habilitation benefit. The American Occupational Therapy Association (AOTA), an active member of the HAB Coalition, completes a periodic review of Marketplace plans available under the ACA, most recently examining all silver-level plans available in 24 states and the District of Columbia, to examine the availability of such information. This 2019 report, available [here](#), found that fewer than half of the Summaries of Benefits and Coverage (SBCs) provided by these plans include enough information for people to understand the rehabilitation and habilitation benefit. Furthermore, habilitation still lags behind rehabilitation when it comes to presenting clear and consistent information about its coverage. This analysis only underscores the need for clearer understanding by providers and regulators of the full scope of services that are critical for inclusion in a robust rehabilitation and habilitation benefit.

We hope to offer guidance as states consider embarking on this new EHB benchmark plan selection process. Although a number of EHB categories listed in the ACA include services beneficial to people with disabilities and chronic conditions, such as mental and behavioral health services and chronic disease management, this Technical Assistance (TA) document focuses on a single category of benefits: “rehabilitative and habilitative services and devices.”

**Rehabilitative and habilitative services and devices** encompass a wide range of benefits critical to individuals with injuries, illnesses, disabilities and chronic conditions. These services and devices are provided by appropriately credentialed (licensed, accredited, and certified) providers and suppliers. Rehabilitation and habilitation services and devices include, but are not limited to, rehabilitation physician services; rehabilitation nursing; physical therapy; occupational therapy; speech, language and hearing therapies; recreational therapy; music therapy and cognitive therapy for people with brain injuries and other conditions; psychiatric, behavioral and other developmental services and supports; durable medical equipment (DME), including complex rehabilitation technologies; orthotics and prosthetics; low vision aids; hearing aids, cochlear implants, and augmentative communication devices; and other assistive technologies and supplies.

These services and devices are provided in an array of settings, such as inpatient rehabilitation hospitals and other inpatient or transitional rehabilitation settings, outpatient therapy clinics, community provider offices, at a person’s home, and at various levels of intensity, duration and scope, depending on the severity of the condition and the functional impairment presented by the particular individual.

This TA document is intended to aid your state in updating your EHB package in order to appropriately cover rehabilitative and habilitative services and devices, consistent with the intent of the ACA and guidance issued by HHS. As such, we provide the following recommendations and guidance within this document:

- [Overview: The State’s Role in Defining Essential Health Benefits](#)
- [Explanations and Definitions of Rehabilitative and Habilitative Services and Devices](#)
- [Enhancing Benchmark Plan Coverage of Rehabilitative and Habilitative Services and Devices](#)
- [Incorporating State Mandates for Rehabilitative and Habilitative Services and Devices](#)
- [Establishing Limits on Rehabilitative and Habilitative Services and Devices](#)
- [Rehabilitative and Habilitative Services and Devices Evaluation Chart](#)

Thank you for your consideration. If you have any questions, please contact Peter Thomas at [Peter.Thomas@PowersLaw.com](mailto:Peter.Thomas@PowersLaw.com) or call at 202-872-6730.

Sincerely,

**HAB Coalition Members**

ACCSES

American Academy of Physical Medicine and Rehabilitation

American Association on Health and Disability

American Cochlear Implant Alliance

American Music Therapy Association

American Occupational Therapy Association

American Physical Therapy Association

American Speech-Language-Hearing Association

American Therapeutic Recreation Association

Brain Injury Association of America

Children’s Hospital Association

Christopher & Dana Reeve Foundation

Lakeshore Foundation

National Association of Councils on Developmental Disabilities

National Association of Social Workers

## **Overview: The State’s Role in Defining Essential Health Benefits**

Section 1302 of the ACA lists ten benefit categories that must be covered as essential by new individual and small group plans as of 2014. These 10 benefit categories describe the “essential health benefits package,” which includes services essential for all Americans, including people with disabilities and chronic conditions. Some of these benefits were not consistently covered in insurance market plans prior to 2014. States have the opportunity to greatly enhance health care insurance coverage for individuals with disabilities and chronic conditions by establishing EHB packages that adequately and appropriately cover health care benefits, without discriminating against individuals based on health or disability status.

In advance of regulating the EHB package, HHS released guidance in December 2011 instructing states to (a) choose an existing plan as a benchmark for their EHB package and (b) enhance that plan where it does not adequately cover all 10 of the federally required benefit categories.

In the parameters that HHS provided for choosing a benchmark package, States were given four options for their starting benchmark plan:

- (1) The largest plan by enrollment in any of the three largest small group insurance products in the State’s small group market;
- (2) Any of the largest three State employee health benefit plans by enrollment;
- (3) Any of the largest three national FEHBP plan options by enrollment; or
- (4) The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State.

Once a state selected a benchmark plan, it was required to “plus up” that package with benefits required under the ACA that may not have been covered under the selected benchmark plan. For example, some individual and small group plans may not have covered habilitation benefits or pediatric dental and vision benefits, but these benefits are explicitly required by the ACA to be included in EHB as of 2014.

In the 2019 Notice of Benefit and Payment Parameters final rule, HHS finalized options for states to select new EHB benchmark plans beginning with the 2020 plan year. Under 45 C.F.R. § 156.111, a state may modify its EHB benchmark plan by:

- (1) Selecting the EHB benchmark plan that another state used for the 2017 plan year;
- (2) Replacing one or more EHB categories of benefits in its EHB benchmark plan used for the 2017 plan year with the same categories of benefits from another state’s EHB benchmark plan used for the 2017 plan year; or
- (3) Otherwise selecting a set of benefits that would become the state’s EHB benchmark plan.

HHS intends these options to provide states with more flexibility in the selection of their EHB benchmark plans. HHS specifically encourages states to consider the potential impact on

vulnerable populations as they select their new EHB benchmark plans. States must also engage in a public comment period prior to submitting proposed EHB benchmark plan changes to HHS.

When making changes to their EHB benchmark plans, it is important that states conduct a thorough review of the contents of their selected benchmark benefit package in every category required under the ACA and consider adding coverage of benefits. Benefit design must also be measured—among other things—against the non-discrimination protections in Section 1302(b)(4) of the ACA which prohibits discrimination in benefit design based on disability status and mandates that benefit coverage is appropriately balanced among the categories of covered benefits.

## **I. Explanation and Definitions of Benefits**

For many people with disabilities and chronic conditions, rehabilitative and habilitative services and devices are equivalent to the provision of antibiotics to a person with an infection—both are essential medical interventions. Thus, this benefit category is an integral component of health care, especially for persons with disabilities and chronic conditions. This is perhaps one reason why Congress chose to include this benefit category as one of only ten categories in the ACA statute that are required to be covered. Congress intended the essential health benefits package to be more than a typical major medical, acute care health plan. By including coverage for rehabilitative and habilitative services and devices, Congress clearly signaled its intent to accommodate the health care needs of those with functional limitations following illness, injury, disability and chronic condition.

With respect to an individual with such a condition, rehabilitative and habilitative services and devices:

- Speed recovery by achieving better outcomes and enhancing the likelihood of discharge from the hospital to one's home, living longer, and retaining a higher level of function post injury or illness;
- Improve long-term functional and health status and improve the likelihood of independent living and high quality of life;
- Reduce the likelihood of relapse and rehospitalization;
- Halt or slow the progression of primary and secondary disabilities by maintaining function and preventing further deterioration of function; and
- Facilitate return to work in appropriate circumstances.

For example, medically necessary rehabilitative and habilitative services and devices:

- Enable persons with spinal cord injuries to recover and regain functions through intensive rehabilitation services and the use of appropriate wheeled mobility;
- Enable persons born with congenital conditions or developmental disabilities to acquire skills and abilities through habilitation therapies and assistive devices;

- Enable amputees to walk, run, work and fully function using an artificial limb;
- Enable persons with a traumatic brain injury to improve cognition and functioning through appropriate therapies and assistive devices.

Additionally, rehabilitative and habilitative care account for a small fraction of overall health care spending. A [study of “silver” marketplace plans](#) found that these services represent only one percent of an average premium cost (approximately \$84 annually) but provide return to function, productivity, and health. Financing that care separately would cost \$2,530 per user on average.

Essential rehabilitation and habilitation care must include services and devices that improve, maintain, and lessen the deterioration of a patient’s functional status over a lifetime and on a treatment continuum. This implies coverage of a spectrum of rehabilitation care, from immediate post-operative, intensive, inpatient hospital rehabilitation to outpatient rehabilitation therapies provided in a variety of settings. It also includes, under the term “habilitation,” ongoing, medically necessary, therapies provided to individuals with developmental disabilities and similar conditions who need habilitation therapies to achieve functions and skills never before acquired. These skills acquired through habilitation often serve as important developmental building blocks that lead to significant gains in function during the lifespan of the individual, thereby decreasing long term dependency costs.

### *The Habilitation Benefit*

Habilitation services and devices are appropriate for individuals with many types of developmental, cognitive, and mental conditions that, in the absence of such services, prevent them from acquiring certain skills and functions over the course of their lives, particularly in childhood. Many people are already familiar with a wide range of rehabilitation services and devices, such as therapies and supports, including physical therapy, occupational therapy, speech-language pathology and audiology services, and other services that improve function and support independent living within the community, as well as durable medical equipment, prosthetic limbs, orthopedic braces, and augmentative communication devices. As discussed below, habilitation services are very similar to rehabilitation in this respect but are focused on those who have never attained certain skills due to disability, not on those who have lost the ability to perform certain skills or functions due to disability.

A few states mandate coverage of habilitation services and devices. Of interest, the state of Maryland [found](#) that its habilitation mandate (which covers individuals up to the age of nineteen) **costs 0.1% of the total premium cost** in the private insurance market, and expanding the mandate to individuals with congenital or genetic birth defects regardless of age would increase state plan expenditures by 2%. If habilitation benefits were provided until age 25, responses from four insurance carriers in the state suggest that premiums would increase between 0% and 1.1%.

Medicaid programs across the country generally have greater experience with the habilitation benefit than private insurance plans. The Medicaid statute, for instance, defines habilitation as:

“Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings.” Social Security Act, Section 1915(c)(5)(A).

While different states cover habilitation to different degrees, habilitation under Medicaid consists of an expansive range of skilled therapies, services, and devices provided by a wide variety of providers. Habilitation services in the Medicaid context are provided to people who would require the level of care provided in a hospital, a nursing facility, or intermediate care facility for people with intellectual disabilities or related conditions (primarily “intellectual disability,” cerebral palsy, epilepsy, and autism), but who, with habilitation services and devices, are able to live in home- and community-based settings. For children, Medicaid provides for comprehensive coverage of habilitative services under its Early and Periodic Screening, Diagnosis and Treatment (EPSDT) mandate.

The Congressional Record clearly signals Congress’ intent in the form of Congressman George Miller’s floor statement offered at the time of passage of the bill in the House. Congressman Miller, Chairman of the House Committee on Education and Labor, a committee with primary jurisdiction over the House health reform bill, explained that the term rehabilitative and habilitative services:

“...includes items and services used to restore functional capacity, minimize limitations on physical and cognitive functions, and maintain or prevent deterioration of functioning. Such services also include training of individuals with mental and physical disabilities to enhance functional development.” 111 Cong. Rec. H1882 (daily ed. Mar. 21, 2010) (statement of Rep. George Miller).

Congressman Bill Pascrell, a co-chair of the Congressional Brain Injury Task Force, included similar comments in the Congressional Record during this same debate.

The federal definition provided below is important in establishing the foundation of an appropriate and affordable habilitation benefit under the EHB package that all small group and individual health plans both inside and outside of the State exchanges must cover as of 2014.

### ***Distinction between Rehabilitation and Habilitation***

Rehabilitative services help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because of sickness, injury, or disability. In contrast, habilitative services and devices help a person keep, learn, or improve skills and functioning for daily living. In other words, an important difference between rehabilitation and habilitation services and devices is the fact that *habilitation* services are provided in order for a person to ***attain***, maintain or prevent deterioration of a skill or function never learned or acquired. *Rehabilitation* services and devices, on the other hand, are provided to help a person ***regain***, maintain or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.

Examples of the comparison between rehabilitation (where the individual *regains*, maintains, or prevents deterioration of a function or skill) and habilitation (where the individual *attains*, maintains, or prevents deterioration of a function or skill) are as follows:

- A speech-language pathologist providing speech therapy to a 3-year old with autism who has never acquired the ability to speak would be considered habilitation but providing speech therapy to a 3-year old to regain speech after a traumatic brain injury would be considered rehabilitation.
- A child born with severe to profound hearing loss fit with hearing aids receives audiologic habilitation to develop speech and language skills; an adult with hearing loss and tinnitus fit with hearing aids equipped with sound generators receives audiologic rehabilitation to improve listening skills and to cope with tinnitus.
- An occupational therapist teaching children who have had a stroke *in utero* or children or adults with developmental disabilities the fine motor coordination required to groom and dress themselves is considered habilitation, whereas teaching children or adults who have had a stroke the fine motor skills required to re-learn how to groom and dress themselves would be rehabilitation.
- An orthotist or therapist fitting hand orthoses for a child or an adult with a congenital condition to correct hand deformities would be habilitation, while fitting orthoses for a child or adult who has had hand surgery for a torn tendon repair would be rehabilitation.
- A physical therapist who teaches a child how to improve a congenital walking abnormality would be providing habilitation, while a physical therapist who teaches a child to regain the ability to walk following a car accident would be providing rehabilitation.

The services and devices used in habilitation are often the same or similar as in rehabilitation, as are the professionals who provide these services, the settings in which the services and devices are provided, the individuals receiving the services, the functional deficits being addressed, and the improvement in functional outcomes that result from treatment. The only meaningful difference is the reason for the need for the service; whether a person needs to attain a function from the outset or regain a function lost to illness or injury. There is a compelling case for coverage of both rehabilitation and habilitation services and devices in persons in need of functional improvement due to disabling conditions. This case includes the fact that both habilitation and rehabilitation services and devices are highly cost-effective and decrease downstream costs to the health care system for unnecessary disability and dependency.

### ***Coverage of Habilitation in “Parity” with Rehabilitation Benefits***

The extent of coverage of habilitation services and devices should at least be in parity with rehabilitation coverage. In other words, regardless of the diagnosis that leads to a functional deficit in an individual, the coverage and medical necessity determination for rehabilitative and habilitative services and devices should be recommended based on clinical judgment of the



effectiveness of the therapy, service, or device to address the deficit. Such judgments should be made on a periodic basis to ensure the individual continues to benefit from the rehabilitative or habilitative intervention.

If service caps in benefits are employed, there must be separate caps for habilitation and rehabilitation benefits. 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 would seriously undermine the ACA's habilitation mandate. Habilitation benefits are defined as services that help individuals attain functions and skills they never have had. 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, states should consider habilitative services independently from rehabilitative services. The 2016 Notice of Benefit and Payment Parameters final rule prohibited combined limits on habilitation and rehabilitation and clarified that plans cannot impose any limits on habilitation that are less favorable than those imposed on rehabilitation. On January 1, 2018, new modifiers (96 and 97) went into effect to allow insurance companies to distinguish between habilitation and rehabilitation.

### ***Definitions of Rehabilitation and Habilitation Services***

The term "rehabilitative and habilitative services and devices" that appears in Section 1302 of the ACA refers to a broad category of benefits, and the term itself did not typically appear in private health plan documentation prior to the ACA. Rather, most health plan benefit packages were more specific with respect to the benefits covered by this category. In the Notice of Benefit and Payment Parameters Final Rule for 2016, HHS defined "rehabilitation services and devices" and "habilitation services and devices" as follows:

"Rehabilitation services and devices—Rehabilitative services, including devices, on the other hand, are provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition." Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,811 (Feb. 27, 2015).

"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." *Id.* at 10,871.

For the first time, these regulations established a uniform definition of rehabilitation and habilitation services and devices that states could understand and consistently implement. This definition has become a standard for private insurance coverage, a floor of coverage for individual insurance plans sold on the exchanges. Importantly, the definitions include both rehabilitative and habilitative *services* and rehabilitative and habilitation *devices*. The adoption of federal definitions of rehabilitation and habilitation services and devices has minimized the

variability in benefits across states and the uncertainty in coverage for children and adults in need of these vital services.

### ***Rehabilitative and Habilitative Devices***

Rehabilitative and habilitative devices include DME, orthotics, prosthetics, low vision aids, hearing aids, augmentative communication devices that aid in hearing and speech and other assistive technologies and supplies. States should define “rehabilitative and habilitative devices” to explicitly include devices that *maintain* as well as *improve* function, consistent with the definitions adopted by HHS in the Notice of Benefit and Payment Parameters Final Rule for 2016. *See Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. at 10,811, 10,871.*

Based on extensive analysis of multiple health care programs and plans, we believe that states should specifically define each of the following devices:

The definition of ***Durable Medical Equipment (DME)*** should read:

Equipment and supplies ordered by a health care professional for everyday or extended use to improve, maintain or prevent the deterioration of an individual’s functional ability. Examples of DME include, but are not limited to, manual and electric wheelchairs, oxygen equipment, canes, crutches, walkers, standing system chairs, blood testing supplies for people with diabetes, as well as supplies and equipment to support medically necessary devices.

The definition of ***Orthotics and Prosthetics (O&P)*** should read:

“Orthotics and Prosthetics” are leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes, and external breast prostheses incident to mastectomy resulting from breast cancer. Covered services include adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.

The definition of ***Prosthetic Devices*** should read:

“Prosthetic Devices” are devices that replace all or part of an internal body organ or all or part of the function of a permanently inoperative or malfunctioning internal body organ. Examples of prosthetic devices include joint replacements, colostomy care, and implanted breast prostheses incident to mastectomy resulting from breast cancer, cochlear implants, and osseointegrated implants to replace middle ear or cochlear function. Covered services include adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.

The definition of *Low Vision Aids* should read:

“Low Vision Aids” help correct for the partial loss of eyesight, making it possible for an individual with impaired vision to accomplish everyday tasks, including reading, writing, driving a car or recognizing faces. Examples of low vision aids include devices which magnify, reduce glare, add light or enlarge objects as to make them more visible.

The definition of *Augmentative and Alternative Communication Devices* (AACs) should read:

“Augmentative and Alternative Communication Devices” are specialized devices ordered by a health care professional which assist individuals with severe speech or language problems to supplement existing speech or replace speech that is not functional. Examples of AAC devices include, but are not limited to, picture and symbol communication boards and electronic devices.

The definition of *Hearing Aids and Assistive Listening Devices* should read:

“Hearing aids and Assistive Listening Devices” are medical devices which amplify sound and/or counter the negative effects of environmental acoustics and background noise to assist individuals who have been diagnosed with a hearing loss by a physician and/or hearing health professional.

### ***Additional Considerations Involving Coverage of Devices***

In implementing the EHB provisions of the ACA, it is important that policy-makers and regulators understand the differences between the types of rehabilitative and habilitative devices listed above. For instance, basic benefits such as O&P differ significantly from DME and should be treated differently for coverage purposes by health plans. It is not sufficient for only DME to be listed under rehabilitative and habilitative devices within the EHBs. There is abundant evidence that health plans often treat these benefits separately, as does Medicare and other publicly supported payers. O&P, as well as a number of the types of devices listed above, should be specifically enumerated under the definition of “devices” for the purposes of EHB packages in the states. There is compelling legislative history to support this position.

1. During passage of the ACA, House Education & Labor Committee Chairman George Miller stated on the floor of the House of Representatives:

“The term “rehabilitative and habilitative devices” includes durable medical equipment, prosthetics, orthotics, and related supplies... It is my expectation ‘prosthetics, orthotics, and related supplies’ will be defined separately from ‘durable medical equipment.’” 111 Cong. Rec. H1882 (daily ed. Mar. 21, 2010) (statement of Rep. George Miller).

2. A February 2011 study conducted by the Society of Human Resource Management (“SHRM”) surveyed employers from across the United States to examine whether they

offered coverage for O&P services and devices. SHRM received responses from 1,115 employers. The data showed that 70-75% of employers provide coverage for O&P.

3. All federally supported health programs include coverage of O&P care. Medicare Part B covers O&P, including artificial limbs and eyes; braces for the arm, leg, back, and neck; and breast prostheses and related supplies following a mastectomy. All state Medicaid plans cover O&P care for children and many states cover this same benefit for adults. The Department of Defense and the Department of Veterans Affairs offer robust O&P coverage for returning service members and all veterans with injuries, disabilities, or other conditions requiring O&P care. The Federal Employee Health Benefits Program (“FEHBP”) covers O&P care under its standard and preferred benefit packages. DME is also covered under these plans but is covered under a separate benefit.

Appropriate DME and O&P care, as well as coverage of assistive devices defined herein, enable an individual to live a life of full function, self-sufficiency, and independence. Inclusion of these devices and related services in the EHB package will determine whether insured persons have their needs met when confronted with an illness, injury, disability, or other health condition. Inclusion of these benefits will also allow an affected person to recover more fully, improve functioning, live more independently and return to work. Alternatively, a lack of coverage of these devices will lead to individuals being forced to pay out-of-pocket for needed care, go without needed care, or ultimately exit the private market altogether with no choice but to enter the publicly supported programs such as Medicare and Medicaid, as many children, adults, and seniors with disabilities do today.

## **II. Enhancing State Benchmark Plans to Meet Essential Health Benefits Requirements**

When updating EHB packages, States must ensure that their plan’s coverage decisions, reimbursement rates, incentive programs, and benefit design avoids discrimination against individuals because of, among other things, disability. *See* Section 1302(b)(4)(B) of the ACA. In addition, health benefits established as essential cannot be subject to denial to individuals against their wishes on the basis of the individual’s present or predicted disability, degree of medical dependency or quality of life. *See* Section 1302(b)(4)(D) of the ACA.

Non-discrimination provisions under the ACA, as well as guidance from HHS, dictate that states enhance benchmark plans to adequately cover mandated EHBs, such as habilitation. In addition, states should ensure that plans are not arbitrarily restricting certain essential benefits or covering them in a manner that is not balanced across the categories of covered benefits. *See* Section 1302(b)(4) of the ACA. States must ensure that limitations they impose on certain benefits do not violate the non-discrimination provisions of the ACA by failing to accommodate the rehabilitative needs of persons with particularly disabling diagnoses or conditions.

States must also be careful not to discriminate against persons with certain conditions by limiting or omitting coverage for certain treatments that are only relevant to people with that particular condition. For example, failing to include coverage of dialysis treatments clearly discriminates against people with kidney failure. Failing to include coverage of prosthetic limbs discriminates against people with limb loss. States must develop certain process protections to ensure that they

fully examine the final EHB package they adopt to ensure that it conforms to the letter and spirit of the ACA.

With respect to states that do not proactively adopt an EHB package but simply default to the state's largest small group insurance plan, it is critical that these states ensure that a relevant and appropriate state agency engage in the process of assessing that plan to ensure it covers all 10 categories of benefits required by the ACA. The state agency must also conduct the non-discrimination analysis discussed above. Even if the federally facilitated exchange implements that state's EHB package, the state must still be accountable to ensure that the EHB package complies with federal law. In the alternative, HHS, through the authority granted to the federally facilitated exchange, should have the responsibility to complete the EHB design process before permitting federal subsidies to flow into that state.

When exercising the new options for selecting EHB benchmark plans under the 2019 Notice of Benefit and Payment Parameters final rule, it is critical that states consider the potential impact on vulnerable populations and ensure compliance with the nondiscrimination protections of the ACA as they select their new EHB benchmark plans. As described in Section 1302(b)(4) of the ACA, EHB packages may not be designed to discriminate against individuals because of their age, disability, or expected length of life. In addition, states must take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups.

### **III. Incorporating State Mandates for Rehabilitative and Habilitative Services and Devices**

In the 2019 Notice of Benefit and Payment Parameters final rule, HHS finalized options for states to select new EHB benchmark plans beginning with the 2020 plan year. Under 45 C.F.R. § 156.111, a state may modify its EHB benchmark plan by:

- (1) Selecting the EHB benchmark plan that another state used for the 2017 plan year;
- (2) Replacing one or more EHB categories of benefits in its EHB benchmark plan used for the 2017 plan year with the same categories of benefits from another state's EHB benchmark plan used for the 2017 plan year; or
- (3) Otherwise selecting a set of benefits that would become the state's EHB benchmark plan.

For each of these three benchmark plan options, states must still comply with HHS's policy on additional state benefit mandates. Under this policy, states are not required to defray the cost of a benefit mandated prior to or on December 31, 2011, but are required to defray the costs of benefits after that date. Under the new options above, if a state selects another state's benchmark plan or category of benefits that includes benefits mandated by the originating states that are EHBs, those benefits will be incorporated into the selecting state's EHB benchmark plan. Additionally, if a State supplements the selected benchmark plan with additional habilitative services not covered in the plan, the State will *not* need to defray these costs if those additional services are required under the ACA or another federal requirement. For example, such

additional services not requiring defrayal could include requirements to provide benefits and services under the ten essential health benefit categories, requirements to cover preventive services, or requirements to comply with federal legislation such as the Mental Health Parity and Addiction Equity Act.

In this scenario, the state would not be required to defray the costs related to the other state's mandated benefits, provided that the selecting state does not have its own mandate with the same benefits that were adopted after December 31, 2011. Due to the "generosity test" imposed by HHS on states selecting new EHB benchmark plans, however, states are somewhat limited in their ability to select a new EHB benchmark plan that incorporates another state's benefit mandates. Under this test, states cannot select an EHB benchmark plan that is more generous than the most generous comparison plan (i.e., the state's 2017 EHB benchmark plan and any of the state's three largest small group health plans by enrollment).

#### **IV. Establishing Limits on Rehabilitative and Habilitative Services and Devices**

When evaluating coverage limitations on and exclusions of rehabilitative and habilitative services and devices, states should ensure these decisions are evidence based and not arbitrarily imposed to reduce short term cost to the health plan.

States must carefully evaluate both quantitative and non-quantitative limits on services and devices to ensure such limits do not restrict access to EHBs and violate the nondiscrimination requirements of the ACA. Patients' individual needs should be the foundation of coverage decisions. Additionally, states 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.

##### ***Nondiscrimination and Medical Necessity***

The ACA does not require the HHS Secretary to establish a uniform definition of medical necessity, but the nondiscrimination provisions mentioned above provide strong protections for people with disabilities and chronic conditions with respect to coverage of benefits under the EHB. Additionally, the federal government has largely deferred to states as primary regulators of nondiscrimination, and states are considered a first line of defense to implement these protections. To ensure plan limits and coverage decisions are in compliance with the nondiscrimination requirements for EHBs and do not restrict patients' access to evidence based, individualized care, states should consider the following:

- The focus of many benefits for people with disabilities and other chronic conditions is to improve a patient's health status through improvement in their ability to function in daily life. The focus is not on "curing" the condition but rather on enabling, improving, maintaining, or preventing deterioration of a patient's capacity to function. Coverage decisions, therefore, must include consideration of an individual's functional needs.
- Coverage decisions must refer to the individualized care needs for a particular patient, and hence entail an individual assessment rather than a general determination of what

works in the ordinary case. This is critical for people with disabilities whose conditions (or combinations of conditions) often affect individuals in very different ways. *See Defining Medical Necessity*, Janet L. Kaminski, Attorney <http://www.cga.ct.gov/2007/rpt/2007-r-0055.htm>.

- Evidence based medicine or comparative effectiveness research should be applied in a manner that does not lead to inappropriate restrictions in coverage of and access to therapies, treatments, medications, assistive devices and long-term services and supports for people with disabilities and chronic illnesses. Use of the best evidence available should be the standard. A *lack* of Level I medical evidence does not prove the service or device ineffective or unnecessary. This is particularly important with treatments that address low prevalence conditions or conditions that are difficult to assess and treat, such as traumatic brain injury and other similar conditions.

Health plans should not use arbitrary visit limits or other limitations or exclusions to impede or intrude on the patient and physician relationship, interfere with communication regarding the treatment options between the patient and physician, prevent access to rehabilitation or habilitation altogether, or stop rehabilitation or habilitation prematurely.

The complex nature of disabilities and chronic diseases often leads to a wide breadth of treatment from a range of providers. Services are often considered appropriate as long as:

- Separate and distinct goals are documented in the treatment plans of physicians, nurses and therapists providing concurrent services;
- The specific services are non-overlapping; and
- Each discipline is providing some service that is unique to the expertise of that discipline and would not be reasonably expected to be provided by other disciplines.

States 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.

Health care interventions should enhance, maintain, and prevent deterioration of cognitive and physical functioning to enable individuals with disabilities and other chronic conditions to live as independently as possible, to attain and maintain employment, avoid homelessness, avoid medical indigence, reduce lifetime cost of care, reduce caregiver burden and attendant care requirements, improve overall health and quality of life, and participate in the community to the maximum extent of their abilities and capabilities. In addition, it is important to note that the rate of progress across time and developmental expectations for the growing child are also highly variable and specific to the individual. Recovery is often divergent qualitatively and quantitatively, and as such is not always predictable.

## **APPENDIX 1: REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES EVALUATION CHART**

The next few pages contain a simple chart intended to assist states in their evaluation and enhancement of benchmark plan coverage for rehabilitative and habilitative services and devices. The chart lists typical rehabilitative and habilitative benefits across the left side and coverage qualifiers across the top. With information about their benchmark plans, state leaders can complete the chart and use it to help assess the level of coverage for these benefits and identify necessary improvements to bring the plan into compliance with the ACA.

If you have any questions about the chart or other sections of this document, please contact Peter Thomas of the Powers Law Firm, at 202-872-6730, or via email at [Peter.Thomas@PowersLaw.com](mailto:Peter.Thomas@PowersLaw.com). He can direct your questions to our coalition specialists on rehabilitation and habilitation services and devices.



	<b>Benefit</b>	<b>Inpatient</b>	<b>Outpatient</b>	<b>Quantitative Limits</b>	<b>Non-Quantitative Limits</b>	<b>Minimum Stay</b>	<b>Exclusions</b>
		Inpatient Benefit Covered or Not Covered?	Outpatient Benefit Covered or Not Covered?	Explain limits, if any	Describe Limits, if any (prior authorization, referral required)	If applies, please enter the Minimum Stay (in hours) as a whole number	Enter any Exclusions for this benefit
	<b>Rehabilitation Benefits</b>						
	Physician Services						
	Inpatient Rehabilitation Hospital Services						
	Rehabilitation Nursing Services						
	Physical Therapy						
	Occupational Therapy						
	Speech-Language Pathology and Audiology						
	Cognitive Therapy						
	Psychiatric Rehabilitation						
	Recreational Therapy						
	Respiratory Therapy						

	<b>Benefit</b>	<b>Inpatient</b>	<b>Outpatient</b>	<b>Quantitative Limits</b>	<b>Non-Quantitative Limit</b>	<b>Minimum Stay</b>	<b>Exclusions</b>
	Music Therapy						
	Orthotics and Prosthetics						
	Prosthetic Devices						
	Durable Medical Equipment						
	Low Vision Aids						
	Hearing Aids and Assistive Listening Devices						
	Cochlear Implants and Related Servicing						
	Augmentative Communication Devices						
	Other services and devices that are medically necessary and prescribed by a practitioner as part of a plan of care						

	<b>Benefit</b>	<b>Inpatient</b>	<b>Outpatient</b>	<b>Quantitative Limits</b>	<b>Non-Quantitative Limit</b>	<b>Minimum Stay</b>	<b>Exclusions</b>
		Inpatient Benefit Covered or Not Covered?	Outpatient Benefit Covered or Not Covered?	Explain limits, if any	Describe Limits, if any (prior authorization, referral required)	If applies, please enter the Minimum Stay (in hours) as a whole number	Enter any Exclusions for this benefit
<b>Habilitation Benefits</b>							
	Physician Services						
	Inpatient Hospital Services						
	Nursing Services						
	Physical Therapy						
	Occupational Therapy						
	Speech-Language Pathology and Audiology						
	Cognitive Therapy						
	Developmental Services						
	Recreational Therapy						
	Respiratory Therapy						
	Music Therapy						

	<b>Benefit</b>	<b>Inpatient</b>	<b>Outpatient</b>	<b>Quantitative Limits</b>	<b>Non-Quantitative Limit</b>	<b>Minimum Stay</b>	<b>Exclusions</b>
	Orthotics and Prosthetics						
	Prosthetic Devices						
	Durable Medical Equipment						
	Low Vision Aids						
	Hearing Aids and Assistive Listening Devices						
	Cochlear Implants and Related Servicing						
	Augmentative Communication Devices						
	Other services and devices that are medically necessary and prescribed by a healthcare practitioner as part of a plan of care						

