Lucile Packard Foundation for Children's Health

Fact Sheet

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Habilitative Services Under the ACA: What States Should Consider

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." It is often difficult to determine the appropriate intensity and duration of habilitative services, which means that they can be both extensive and expensive. Whether health insurance covers habilitative services is a matter of special importance in child health policy, because of the large number of children with developmental disabilities. In 2008, nearly one in seven children experienced a physical or mental health condition that led to some level of developmental disability. Many of these children might benefit from habilitative services.

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 definition. The implementation approach taken by the Obama Administration makes state law the primary source of regulatory policy in defining EHBs, meaning that states determine the extent of covered habilitative services. Establishing state standards for health insurance plans sold in the individual and small group markets thus becomes key to health policy for children with disabilities.

Under the ACA implementation, states determine the extent of covered habilitative services.

States retain the primary role in defining the meaning of the federal habilitative services coverage standard, regardless of their own, separate, state mandates. 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.

Issues for States to Consider

Defining habilitative treatment: The NAIC definition offers the important benefit of having been adopted and endorsed by the NAIC, whose model laws and policies 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. Some children might receive habilitation services in the home. In these situations an important question 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: Mental health parity requirements apply to both Qualified Health Plans 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 mental health parity requirements and habilitative services, it would be helpful for a state's habilitative coverage policy to specify the application of mental health parity 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.

Conclusion

Ultimately, the federal government may use the results of the information it gains in overseeing the EHB coverage market to move in the direction of a more uniform national standard. As Qualified Health Plans 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 the federal Office of Personnel Management approaches the question of habilitative services coverage in the case of issuers that do not operate under state coverage standards. Existing regulations at least hint at the notion that the agency is considering more decisive and uniform habilitative coverage standards in its negotiations with issuers. In the meantime, state EHB coverage policy offers the crucial starting point for habilitative services coverage.

See a full report on habilitative services by Sara Rosenbaum, JD, George Washington University School of Public Health and Health Services.