Opportunity Now to Define Habilitative Services in State EHB Benchmark Plans

On November 26, 2012, The Centers for Medicare & Medicaid Services, Center for Information & Insurance Oversight released a proposed rule on Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation (summary here). Each state’s benchmark plan is also available for comment here. To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. Eastern Standard Time (EST) on December 26, 2012.

AMCHP encourages its members to comment on the proposed rule citing experience, expertise and data “from the field” especially in areas where gaps in covered services could be perpetuated in regards to habilitative services – an area that has been noted due to the lack of clear definition or even inclusion in “typical employee plans” that are used as the benchmark for these essential health benefits by states.

In this regard, states are encouraged to promote benefit package design in benchmark plans whereby habilitation services and devices are covered in parity with rehabilitation services and devices. This recommendation is consistent with national efforts to promote parity for habilitative services. In making this recommendation, states can look to the definition of “habilitation” offered by the NAIC as “health care services 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” and augment this definition with consideration of habilitation services and devices provided under the Medicaid program.

There is an array of issues for stakeholders to consider in this proposed rule. However, AMCHP is highlighting the particular opportunity for state leaders to defining the portion of the proposed rule related to habilitative services because of its significance for children and youth with special health care needs (CYSHCN). In the area of habilitative services, there remains lots of question for advocates and those working at the state level. In response to the requests made by our members, AMCHP created this short memo to help our members evaluate the proposed rule in regards to the means of defining habilitative services included in the states’ proposed EHB benchmark plan, especially in terms of how it might affect MCH populations and CYSHCN.

Background

As you may know, this proposed rule does not differ much from the preliminary guidance issued by HHS in late 2011 and early 2012 that proposed that states select their own EHB “benchmark” plan from a range of options. The initial guidance outlined the 10 major categories of benefits that must be covered in the individual and small-group markets – both inside and outside of the new health insurance exchanges – including rehabilitative services, habilitative services and devices.

This rule keeps with the Administration’s approach to provide flexibility to states in the implementation of EHB and specifically habilitative services, it is important for those working in the states have what they need to work toward getting the best possible set of services for their populations that need it.
This benchmark method is meant to mirror a “typical employer plan.”

The rule also states that all plans that cover EHB must offer benefits that are substantially equal to the benefits offered by the benchmark plan.

The rule also clarifies that in the event a state does not make a selection, HHS will select as the default benchmark the largest small group product in the state.

- Notably, HHS proposes: “that in order to define EHB, if the base-benchmark plan does not include coverage of habilitative services the state may determine the services included in the habilitative services category. We believe that this transitional policy—which provides states with additional flexibility beyond what was initially outlined in the EHB Bulletin will provide a valuable opportunity for states to lead the development of policy in this area and welcome comments on this proposed approach to providing habilitative services. If states choose not to define the habilitative services category, plans must provide these benefits as defined in §156.115.”

- As an alternative transitional approach, HHS proposes: some states may prefer to provide issuers with the opportunity to define the specific benefits included in the habilitative services category if it is missing from the base-benchmark plan. Accordingly, we are proposing that a state may allow issuers time and experience to define these benefits. Specifically, in paragraph (a)(4), we propose that if the EHB-benchmark plan does not include coverage for habilitative services and the state does not determine habilitative benefits, a health insurance issuer must either: (1) Provide parity by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services; or (2) Decide which habilitative services to cover and report on that coverage to HHS.

- With regard to option (2), HHS intends to evaluate the habilitative services reported and further define habilitative services in the future. The issuer only has to supplement habilitative services when there are no habilitative services at all offered in the base benchmark plan and the state has not exercised its option to define habilitative services under §156.110(f). We believe that this alternative approach would provide a valuable window of opportunity for review and development of policy in this area and welcome comments on this proposed approach.”

For any questions related to this memo, please contact Carolyn McCoy (cmccoy@amchp.org)

The Center for Consumer Information & Insurance Oversight (CCIIO) at the Centers for Medicare and Medicaid (CMS) provided a Guide to Reviewing Proposed State EHB Benchmark Plans.

How to comment:
In commenting, please refer to file code CMS–9980–P

You may submit comments in one of three ways (please choose only one of the ways listed. For hand delivery, please see instructions in proposed rule):

1. Electronically. You may submit electronic comments on this regulation to http://www.regulations.gov. Follow the “Submit a comment” instructions.
2. **By regular mail.** You may mail written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9980–P, P.O. Box 8010, Baltimore, MD 21244–8010

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. **By express or overnight mail.** You may send written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9980–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.