

May 13, 2015

Commissioner Al Redmer, Jr.  
Maryland Insurance Administration  
200 St. Paul Place, Suite 2700  
Baltimore, MD 21202

Dear Commissioner Redmer:

Thank you for the opportunity to submit recommendations on Maryland's selection of its benchmark plan for 2017 to the Maryland Insurance Administration (MIA). We have reviewed the three potential benchmark plans, and we have found that their benefit structure for habilitative services is identical. Therefore, we are not recommending a specific plan to be used as benchmark.

However, we are recommending several actions related to the new federal rule (see attached rule) on habilitative services and devices in the Essential Health Benefits package (EHB). With the exception of one provision, the new rule should be implemented in the 2016 plan year.

#### **Recommendation 1**

For the 2016 plan year, carriers should incorporate the new uniform federal definition of habilitative services and devices into their plans, as follows: "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." This definition, under CFR §156.115(a)(5)(i), will clarify coverage in two key areas:

- Under Health Insurance § 15-835, Maryland's habilitative services mandate for children is limited to a child with a "congenital or genetic birth defect." With the new uniform federal definition, all children up to age of 19-years will be eligible for habilitative services. There will no longer be the qualifier that the child has a "congenital or genetic birth defect."
- "Devices" will be included under the definition of habilitative services. This is an important clarification.

#### **Recommendation 2**

In CFR §156.115(a)(5)(iii), the federal rule prohibits carriers from imposing combined limits on habilitative and rehabilitative services and devices in plan year 2017. While we did not see any evidence of combined limits in the three benchmark plans options, we understand that this is an

operational issue, rather than an issue in the benefits structure. In the attached federal rule on page 226, CMS acknowledged the public comment that carriers “do not have operational capacity to differentiate between habilitative services and rehabilitative services and devices based on enrollee diagnosis or whether the enrollee is seeking to maintain or achieve function.” CMS’ response states that the rule is not going into effect until 2017 “to provide issuers with the opportunity to resolve operational issues with their claims systems.”

The Workgroup on Access to Habilitative Services Benefits, facilitated by the MIA, acknowledged this same operational issue in distinguishing between habilitative and rehabilitative services. In its final report in October 2013, the Workgroup recommended that “carriers should distinguish between rehabilitative and habilitative services in their claims systems.”

Given the Workgroup’s recommendation and the final federal rule, we recommend that the MIA follow-up with carriers on their progress in operationalizing the new federal rule. We would appreciate if the MIA could share a summary of their findings with the Workgroup, as it would demonstrate how the Workgroup’s recommendation has been implemented.

### **Recommendation 3**

The new federal rule, under CFR §156.115(a)(6), clarifies that pediatric habilitative coverage is required for “enrollees until at least the end of the month in which the enrollee turns 19 year of age.” The Department of Health and Human Services in its final comments stated that it encouraged plans to provide coverage until the end of plan year under which an enrollee turns 19 years of age.

In the plan documents that we have reviewed, carriers generally specify that habilitative coverage will be provided up to age 19 as opposed to the end of the month in which the enrollee turned 19. Carriers should operationalize this new federal rule by the 2016 plan year.

### **Recommendation 4**

While the MIA can incorporate all of our recommendations into the EHB in 2017 by supplementing the benchmark plan selection, this action will not address the need to implement the new uniform federal rule and the “end-of-the-month” provision in the 2016 plan year. Therefore, our final recommendation is that the MIA issue a bulletin regarding the need to adopt these provisions in the 2016 plan year. We would request that the bulletin also direct the carriers to ensure that they update all benefits information to consumers.

## **Conclusion**

Thank you for your consideration of our comments. If you have any question or need any follow-up information, please contact Robyn Elliott at (443) 926-3443 or [relliott@policypartners.net](mailto:relliott@policypartners.net). Ms. Elliott is a public policy and governmental affairs consultant to the Maryland Occupational Therapy Association. She will coordinate communications amongst the signatories to this letter.

Maryland Occupational Therapy Association  
Maryland Developmental Disabilities Council  
The Arc Maryland  
The Parents' Place of Maryland  
Pathfinders for Autism

## 2. Essential Health Benefits Package

### a. State selection of benchmark (§156.100)

We proposed to amend paragraph (c) of §156.100 to delete the language regarding the default base-benchmark plan in the U.S. Territories of Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands. The change reflects HHS's determination, described in more detail in section III.A.1.b of this final rule, that certain provisions of the PHS Act enacted in title I of the Affordable Care Act that apply to health insurance issuers are appropriately governed by the definition of "State" set forth in that title. Therefore, the rules regarding EHB (section 2707 of the PHS Act) do not apply to health insurance issuers in the U.S. Territories. We also proposed to make a technical change to this section by replacing "defined in §156.100 of this section" with "described in this section." We note that this has no effect on Medicaid and CHIP programs and that Alternative Benefit Plans will still have to comply with the essential health benefit requirements.

We did not receive any comments regarding this proposal. We are finalizing the provisions as proposed.

### b. Provision of EHB (§156.115)

#### (1) Habilitative Services

One of the 10 categories of benefits that must, under section 1302(b)(1)(G) of the Act, be included under the Secretary's definition of EHB is rehabilitative and habilitative services and devices. If a benchmark plan does not include habilitative services, §156.110(c)(6) of the current EHB regulations requires the issuer to cover habilitative services as specified by the State under §156.110(f) or, if the State does not specify, then the issuer must cover habilitative services in the manner specified in §156.115(a)(5). Section 156.115(a)(5) states that a health plan may

provide habilitative coverage by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services or otherwise determine which services are covered and report the determination to HHS. In some instances, those options have not resulted in comprehensive coverage for habilitative services. Therefore, we proposed amending §156.115(a)(5) to establish a uniform definition of habilitative services that may be used by States and issuers. In addition, we proposed to remove §156.110(c)(6) because that provision gives issuers the option to determine the scope of habilitative services.

We believe that adopting a uniform definition of habilitative services would minimize the variability in benefits and lack of coverage for habilitative services versus rehabilitative services. Defining habilitative services clarifies the difference between habilitative and rehabilitative services. Habilitative services, including devices, are provided for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition. 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.

We proposed adopting the definition from the Glossary of Health Coverage and Medical Terms:<sup>45</sup> 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.

We did not propose any changes to §156.110(f), which allows States to determine services included in the habilitative services and devices category if the base-benchmark plan

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<sup>45</sup> <http://www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf>

does not include coverage. Several States have made such a determination following benchmark selection for the 2014 plan year, and we wish to continue to defer to States on this matter as long as the State definition complies with EHB policies, including non-discrimination. If the State does not supplement missing habilitative services or does not supplement the services in an EHB-compliant manner, issuers should cover habilitative services and devices as defined in §156.115(a)(5)(i).

We also proposed to revise current §156.115(a)(5)(ii) to provide that plans required to provide EHB cannot impose limits on coverage of habilitative services that are less favorable than any such limits imposed on coverage of rehabilitative services. Since the statutory category includes both rehabilitative and habilitative services and devices, we interpret the statute to require coverage of each. Therefore, issuers that previously excluded habilitative services, but subsequently added them, would be required under our proposal to impose separate limits on each service rather than retaining the rehabilitative services visit limit and having habilitative services count toward the same visit limit. Because we proposed to establish a uniform definition of habilitative services in new §156.115(a)(5)(i), we also proposed to delete §156.110(c)(6), which would remove the option for issuers to determine the scope of the habilitative services. In §156.110 we proposed to make a technical change to amend the list structure of paragraph (c) by replacing the “and” in (c)(5) with a period and adding an “and” at the end of (c)(4).

We are finalizing our policy as proposed, adopting the definition of habilitative services from the Uniform Glossary in its entirety, to be effective beginning with the 2016 plan year and requiring separate limits on habilitative and rehabilitative services beginning with the 2017 plan year. We are codifying this final policy in revised §156.115(a)(5) and removing §156.110(c)(6).

Comment: Several commenters requested more State flexibility, even in cases where the benchmark plan includes habilitative services; they sought assurance that a Federal definition will not supersede a State law, and that State-required benefits that could be considered habilitative services would be treated as EHB.

Response: States are required to supplement the benchmark plan if the base benchmark plan does not include coverage of habilitative services as defined in this final rule. We are codifying the definition of habilitative services as a minimum for States to use when determining whether plans cover habilitative services. State laws regarding habilitative services are not pre-empted so long as they do not prevent the application of the Federal definition. State laws enacted in order to comply with §156.110(f) are not considered benefits in addition to the EHB; such laws ensure compliance with §156.110(a) which requires coverage of all EHB categories. Therefore, there is no obligation to defray the cost of such State-required benefits.

Comment: Several commenters objected to imposing separate limits on rehabilitative and habilitative services and devices, claiming issuers do not have operational capacity to differentiate between habilitative and rehabilitative services and devices based on enrollee diagnosis or whether the enrollee is seeking to maintain or achieve function.

Response: We are finalizing the requirement to ensure coverage of each with separate limits, but the requirement will not become effective until 2017. This delay is intended to provide issuers with the opportunity to resolve operational issues with their claims systems.

Comment: Several commenters asked that “devices” be included in the definition of habilitative services.

Response: We originally omitted devices because the term is already included in the statutory description of this category of EHB. In response to comments, however, we have

added “devices” to our regulatory definition. We remind issuers that the statute requires coverage of devices for both rehabilitative and habilitative services.

Comment: Several commenters requested that we require issuers to have an exceptions process similar to the process required by OPM for multi-State plans, in case a patient needs treatment that exceeds the visit limits allowed by the plan.

Response: Enrollees wishing to appeal an adverse benefit determination, including denial of habilitative services, should follow the process established in §147.136, which implements section 2719 of the PHS Act for internal claims and appeals and external review processes.

Comment: Commenters offered many suggestions for specific services and devices, such as orthotics and prosthetics, which they stated should be required to be covered as habilitative services and devices by all issuers.

Response: We are not codifying such a list at this time, as we continue to allow States to maintain their traditional role in defining the scope of insurance benefits, but we encourage issuers to cover additional services and devices beyond those covered by the benchmark plan.

## (2) Pediatric Services

In the preamble of the EHB Rule, we stated that pediatric services should be provided until at least age 19 (78 FR 12843). States, issuers, and stakeholders requested clarification on this standard. To provide this clarification, we proposed amending §156.115(a) to add paragraph (6), specifying that EHB coverage for pediatric services should continue until the end of the plan year in which the enrollee turns 19 years of age. This was proposed as a minimum requirement.

41. Section 156.115 is amended by revising paragraphs (a)(5)(i) and (ii) and adding paragraphs (a)(5)(iii) and (a)(6) to read as follows:

**§156.115 Provision of EHB.**

(a) \* \* \*

(5) With respect to habilitative services and devices –

(i) Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). 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;

(ii) Do not impose limits on coverage of habilitative services and devices that are less favorable than any such limits imposed on coverage of rehabilitative services and devices; and

(iii) For plan years beginning on or after January 1, 2017, do not impose combined limits on habilitative and rehabilitative services and devices.

(6) For plan years beginning on or after January 1, 2016, for pediatric services that are required under §156.110(a)(10), provide coverage for enrollees until at least the end of the month in which the enrollee turns 19 years of age.

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42. Section 156.120 is added to read as follows:

**§156.120 Collection of data to define essential health benefits.**

(a) Definitions. The following definitions apply to this section, unless the context indicates otherwise:

Health benefits means benefits for medical care, as defined at §144.103 of this