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Ambiguity in the Law: The Habilitative Services Regulation Under the Affordable Care Act
Lindsay Sheely*

I. Introduction

“In spite of all good intentions, the meanings of the words found in documents are not always clear and unequivocal.”¹ This certainly holds true in the context of the Department of Health and Human Service’s (DHHS) habilitative service regulation.²

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (ACA),³ which, among other things, created ten categories of benefits that individual and small group insurers are required to offer, including rehabilitative and habilitative services and devices.⁴ One of the primary purposes of healthcare reform was to expand coverage and end discrimination, specifically against the ill or disabled.⁵ To achieve this purpose, DHHS developed regulations expanding the scope of services benefiting the ill or disabled and prohibiting insurers from creating benefit designs that discriminate based on an individual’s age or disability, among other things.⁶ However, the true test of any legislation is whether or not it remedies the intended inequality, once operationalized.⁷ In this respect, despite DHHS’ good intentions, gaps still exist in the habilitative services regulation and related guidance that allow

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¹ Sanford Schane, *Ambiguity and Misunderstanding in the Law*, 25 T. Jefferson L. Rev. 167, 167 (2002).

² 45 C.F.R. § 156.115(a)(5)(i).

³ Patient Protection and Affordable Care Act. Pub. L. No. 111-148, 124 Stat. 199 (2010).

⁴ 45 C.F.R. § 156.110(a)(7).

⁵ See President Barack Obama, Remarks by the President to a Joint Session of Congress on Health Care (Sept. 9, 2009) available at <https://www.whitehouse.gov/the-press-office/remarks-president-a-joint-session-congress-health-care> (stating that the three main goals of the ACA are to provide security for those who already have insurance, provide coverage for those without it and slowing health care costs); see also Barack Obama, Remarks at the 2008 Democratic National Convention (Aug. 28, 2008) available at http://www.huffingtonpost.com/2008/08/28/barack-obama-democratic-c_n_122224.html (promising to end health insurers’ practice of “discriminating against those who are sick and need care the most.”).

⁶ 45 C.F.R. § 156.110(a); 45 C.F.R. § 156.125(a).

⁷ Ellen Weber, *Equality Standard for Health Insurance Coverage: Will the Mental Health Parity and Addiction Equity Act End the Discrimination?*, 43 GOLDEN GATE U.L. REV. 179, 184 (2013).

states and insurers to implement definitions and benefit designs that may either outright violate the regulation, or do not align with the spirit of the ACA.⁸ Additionally, although the revised regulations, including the uniform definition of habilitative services, were effectuated in 2015, state definition and insurer policies that were in place prior to the ACA have not all come into compliance with the law, leaving ample need for DHHS enforcement.⁹

This Comment will examine state definitions of habilitative services and insurer benefit designs and how the gaps left by DHHS in their guidance and enforcement may result in individuals requiring habilitative services unable to access the benefits they need. Part II will discuss the evolution of the habilitative services regulation, including the requirement that habilitative services be offered at parity with rehabilitative services, as well as the role of related regulations and policies, namely, the ACA's non-discrimination regulation and insurer medical necessity policies, in the implementation of the habilitative services regulation. Part III will analyze how the gaps and ambiguity in the DHHS habilitative services regulation can potentially cause interpretative problems and lead to states and insurers developing benefit designs that violate the plain language of the law or act as de facto discriminatory limitations. Finally, Part IV will discuss potential strategies to reduce the gaps in the law and identify areas where additional enforcement efforts are required to ensure equal access to habilitative services benefits.

II. Background Law

The goal of the ACA, generally, was to not only expand coverage to those who were uninsured, but also to ensure that individuals who were among the nation's most vulnerable

⁸ See *supra* note 5 and accompanying text.

⁹ HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,811 (Feb. 27, 2015).

populations, the sick and disabled, would have access to the care they required.¹⁰ To assist in accomplishing this goal, the ACA mandated that insurers cover services in ten categories of benefits deemed to be essential, termed Essential Health Benefits (EHBs).¹¹ Insurers must cover benefits in the categories of: “(1) ambulatory patient services, (2) emergency services, (3) hospitalization, (4) maternity and newborn care, (5) mental health and substance use disorder services, including behavioral health treatment, (6) prescription drugs, (7) rehabilitative and habilitative services and devices, (8) laboratory services, (9) preventative and wellness services and chronic disease management, and (10) pediatric services, including oral and vision care.”¹² While rehabilitative services were routinely offered by insurers as covered services, the requirement of plans to cover habilitative services and devices was a new and welcomed addition to benefit packages, especially as to the disabled and chronically ill.¹³

A. The Evolution of Habilitative Services

The original DHHS rule codifying the EHB categories did not provide a definition of habilitative services.¹⁴ Instead, DHHS allowed states to retain the flexibility to define the category themselves.¹⁵ If a state chose not to define the category, insurers could either provide

¹⁰ See President Barack Obama, Remarks by the President to a Joint Session of Congress on Health Care (Sept. 9, 2009), <https://www.whitehouse.gov/the-press-office/remarks-president-a-joint-session-congress-health-care> (stating that the three main goals of the ACA are to provide security for those who already have insurance, provide coverage for those without it, and slow rising health care costs); see also Barack Obama, Remarks at the 2008 Democratic National Convention (Aug. 28, 2008), http://www.huffingtonpost.com/2008/08/28/barack-obama-democratic-c_n_122224.html (promising to end health insurers’ practice of “discriminating against those who are sick and need care the most”).

¹¹ 45 C.F.R. § 156.110(a).

¹² *Id.*

¹³ Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12, 843 (Feb. 25, 2013) (noting that DHHS research found that many health insurance plans did not identify habilitative services prior to the ACA); see also *Ill-Defined Coverage Muddles Insurance For Developmentally Disabled*, WYO. PUB. RADIO (Jan. 14, 2014, 1:56 PM), <http://wyomingpublicmedia.org/post/ill-defined-coverage-muddles-insurance-developmentally-disabled> (noting that health insurers typically covered rehabilitative services prior to the ACA, but often excluded habilitative services).

¹⁴ Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12, 843 (Feb. 25, 2013).

¹⁵ *Id.*

habilitative services benefits at parity with rehabilitative services, or determine the scope of the category and report to DHHS which services they would cover.¹⁶ Several commenters urged DHHS to more clearly define all of the EHB categories, including habilitative services and suggested using the Medicaid definition of habilitative services as an appropriate model.¹⁷ While DHHS took note of the suggestion, they ultimately determined that the process for defining habilitative services set forth in the final rule struck the proper balance between DHHS mandates and allowing states to maintain their traditional role of regulating healthcare.¹⁸

After the regulation had been put into practice, DHHS found that the lack of definition resulted in less than adequate coverage.¹⁹ Advocates found that several states did not offer any coverage for habilitative services or did not define the term.²⁰ Other states covered habilitative services, but only for limited groups of people.²¹

In response to variations and deficiencies in coverage, DHHS adopted a uniform definition of habilitative services.²² DHHS defined habilitative services as those that help an individual “keep, learn, or improve skills and functioning for daily living.”²³ This may include

¹⁶ *Id.* at 12, 843–844.

¹⁷ *Id.*; 42 U.S.C. § 1396n(c)(5)(A) (defining habilitative services 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.”).

¹⁸ Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12, 843 (Feb. 25, 2013).

¹⁹ 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).

²⁰ See THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC., ESSENTIAL HEALTH BENEFIT BENCHMARK PLAN COVERAGE OF REHABILITATION, HABILITATION, AND AUTISM SERVICES 2, 8, 12, 35, 40, 42, 44–45, 49–50, <http://www.aahd.us/wp-content/uploads/2013/03/AOTChart0302013.pdf> (identifying Arizona, Florida, Hawaii, North Carolina, North Dakota, Pennsylvania, South Carolina, Vermont, Virginia, West Virginia, Wisconsin, and Wyoming as explicitly not offering habilitative services).

²¹ See *id.* at 5–6 (nothing that Connecticut only covers autism services and the District of Columbia only covers habilitative services for children).

²² 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).

²³ *Id.*; 45 C.F.R. § 156.115(a)(5)(i).

physical, occupational, and speech language therapy.²⁴ DHHS hoped that the uniform definition would reduce variations in habilitative services benefits among states and insurers.²⁵

Additionally, a uniform definition would clarify the difference between rehabilitative versus habilitative services.²⁶ The difference between rehabilitative and habilitative services is subtle, and the two are often only distinguishable based on the timing of when the individual acquires his condition.²⁷ As DHHS notes, habilitative services assist a person “attain, maintain, or prevent the deterioration of a skill or function never learned or acquired due to a disabling condition.”²⁸ Examples include “therapy for a child who is not walking or talking at the expected age.”²⁹ Rehabilitative services, on the other hand, are those services that help an individual regain skills that they once had, but have lost.³⁰ Rehabilitative services may include physical or occupational therapy provided to an individual to help him regain skills or movement that he may have been lost due to an injury or illness.³¹ Although two distinct categories, one factor used in determining compliance with the habilitative services regulation is whether or not habilitative services are treated in the same manner as rehabilitative services.³²

B. Parity with Rehabilitative Services

Prior to the additional DHHS guidance, parity was only relevant in instances where a state’s benchmark plan did not cover habilitative services.³³ Where a state chose not to define

²⁴ HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,811.

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*; NAT’L ASS’N OF INS. COMMISSIONERS, GLOSSARY OF HEALTH INSURANCE AND MEDICAL TERMS 2 http://www.naic.org/documents/committees_b_consumer_information_ppaca_glossary.pdf.

³⁰ HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,811.

³¹ NAT’L ASS’N OF INS. COMMISSIONERS, GLOSSARY OF HEALTH INSURANCE AND MEDICAL TERMS 3 http://www.naic.org/documents/committees_b_consumer_information_ppaca_glossary.pdf.

³² 45 C.F.R. § 156.115(a)(5)(ii).

³³ Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12, 844 (Feb. 25, 2013).

the term, a plan would still be considered in compliance with the EHB requirement if it offered habilitative services that are “similar in scope, amount, and duration to benefits covered for rehabilitative services.”³⁴ Additionally, DHHS allowed substitution of benefits within benefit categories, as long as the substitute benefits were actuarially equivalent to the benefits being replaced.³⁵ However, the guidance caused some confusion about whether the parity provision actually required a plan to cover habilitative and rehabilitative services separately, or if habilitative services could just be incorporated into the rehabilitative services category.³⁶

Following the implementation of the first habilitative services regulation, advocates noted that the benchmark plans in several states combined the coverage for habilitative and rehabilitative therapy, meaning that individuals could exhaust the total benefits offered, even if they only received services in one therapy category.³⁷ To remedy the confusion, DHHS clarified that the benefit category requires coverage of both habilitative services and rehabilitative services separately, meaning that each benefit should have separate limits.³⁸ Additionally, DHHS revised the parity provision to prohibit insurers from “imposing limits on coverage of habilitative services that are less favorable than any such limits imposed on coverage of rehabilitative services.”³⁹

C. Non-discrimination Provision

³⁴ *Id.*

³⁵ *Id.*

³⁶ AMERICAN OCCUPATIONAL THERAPY ASS’N INC., HABILITATIVE SERVICES ARE ESSENTIAL HEALTH BENEFITS: AN OPPORTUNITY FOR OCCUPATIONAL THERAPY PRACTITIONERS AND CONSUMERS 4, <https://www.aota.org/-/media/Corporate/Files/Advocacy/Health-Care-Reform/Essential-Benefits/Habilitative%20Services%20Fact%20Sheet.pdf>.

³⁷ Letter to Consumer Information and Insurance Oversight from the Habilitation Benefits Coalition 5 (Sept. 30, 2015), https://www.atra-online.com/assets/pdf/FPP_HAB15.pdf.

³⁸ HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg 10,811.

³⁹ *Id.*; 45 C.F.R. § 156.115(a)(ii).

Although DHHS specifically mandated that individuals needing habilitative services were treated equally to those needing rehabilitative services, the ACA sought to ensure equality more generally.⁴⁰ Although states and insurers retain a significant amount of flexibility in defining habilitative services and determining what services will be covered, DHHS continually reminds them that all benefit packages must comply with the ACA's non-discrimination provision, in addition to the EHB regulations.⁴¹

A non-discrimination provision was included in the ACA when it was first enacted.⁴² Under the ACA's non-discrimination provision, insurers are prohibited from discriminating against individuals on the grounds set forth under title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, or section 504 of the Rehabilitation Act of 1973.⁴³ Although out of scope for this comment, title VI of the Civil Rights Act and IX of the Education Amendments, and the corresponding implementing DHHS regulations, set forth specific actions that are, and are not, considered discriminatory.⁴⁴

The Age Discrimination Act prohibits discrimination, including being denied benefits, or having benefits limited on the basis of age.⁴⁵ DHHS has stated that an age limit is discriminatory "when applied to services that have been found clinically effective at all ages."⁴⁶ However, DHHS has made clear that an insurer will not violate the law if the action in question "reasonably takes into account age as a factor necessary to the normal operation of the achievement of any statutory objective of a program or activity."⁴⁷ The normal operation of an

⁴⁰ 42 U.S.C. § 18116.

⁴¹ HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg 10,811.

⁴² 42 U.S.C. § 18116.

⁴³ 42 U.S.C. § 18116(a).

⁴⁴ 42 U.S.C. § 2000d; 20 U.S.C. § 1681; 45 C.F.R. § 80; 45 C.F.R. § 86.

⁴⁵ 42 U.S.C. § 6102; 45 C.F.R. § 91.11.

⁴⁶ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2106; Proposed Rule, 79 Fed. Reg. 70,674, 70, 723 (Nov. 26, 2014).

⁴⁷ 45 C.F.R. § 91.13.

insurer is defined as the operation “without significant changes that would impair its ability to meet its objectives.”⁴⁸ A statutory objective is any purpose expressly stated by law.⁴⁹ DHHS has specified that an action will not be considered discriminatory if it is based on a factor other than age, “even though that action may have a disproportionate effect on persons of different ages.”⁵⁰ However, such an action may only be based on a factor other than age if the factor “bears a direct and substantial relationship to the normal operation of the program or activity or to the achievement of a statutory objective.”⁵¹

Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability or handicap.⁵² A handicapped person is one who “has a physical or mental impairment which substantially limits one or more major life activities.”⁵³ Furthermore, a “physical or mental impairment” is “any physiological disorder or condition, cosmetic disfigurement, or anatomical loss,” affecting one of the various body systems, or a mental or psychological disorder.⁵⁴ DHHS does not specifically define “major life activities,” but provides the examples “caring for one’s self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.”⁵⁵

Disabled individuals must be afforded the same opportunity to benefit from a services as those individuals without disabilities and any services provided to disabled individuals must be as effective as those provided to individuals without disabilities.⁵⁶ However, services are not

⁴⁸ 45 C.F.R. § 91.12(a).

⁴⁹ 45 C.F.R. § 91.12(b).

⁵⁰ 45 C.F.R. § 91.14.

⁵¹ *Id.*

⁵² 29 U.S.C. § 794; 45 C.F.R. § 84.4(a).

⁵³ 45 C.F.R. § 84.3(j).

⁵⁴ 45 C.F.R. § 84.3(j)(2)(i).

⁵⁵ 45 C.F.R. § 84.3(j)(2)(ii).

⁵⁶ 45 C.F.R. § 84.4(b)(ii)–(iii).

required to produce the same level of achievement between the disabled and non-disabled; insurers only have to provide the opportunity to reach the same level of achievement.⁵⁷

As the ACA and its non-discrimination statute is a fairly new law, there is limited legal precedent regarding how it should be interpreted and applied.⁵⁸ In *SEPTA v. Gilead Sciences, Inc.*, the plaintiffs claimed Gilead Sciences' pricing scheme for a Hepatitis C drug discriminated against them on the basis of disability.⁵⁹ Although the District Court of Eastern Pennsylvania recognized that only individuals with Hepatitis C would need the drugs, the court applied the standard set forth in the Rehabilitation Act and ultimately determined that the nondiscrimination provision of the ACA did not extend to "claims of disparate impact discrimination."⁶⁰ Conversely, in *Rumble v. Fairview Health Services*, decided prior to the issuance of DHHS' proposed guidance, the United States Court for the District of Minnesota ruled that Congress intended to create a new, singular standard to apply to discrimination claims, instead of using the standards in the separate laws on which the ACA's non-discrimination provision is based, but provided no guidance as to what that new singular standard would be.⁶¹

In addition to the ACA's non-discrimination provision, insurers also must comply with the EHB non-discrimination regulation.⁶² While the EHB regulation includes some of the factors that are prohibited by the ACA's provision, it focuses more on preventing discrimination based on medical or health related characteristics of an individual.⁶³ Specifically, the regulation

⁵⁷ 45 C.F.R. § 84.4(b)(2).

⁵⁸ See *Rumble v. Fairview Health Servs.*, 2015 U.S. Dist. LEXIS 31591, at *24–25 (D. Minn. Mar. 16, 2015) (noting that this was the first case that required the interpretation of the ACA's non-discrimination provision) and *SEPTA v. Gilead Scis., Inc.*, 102 F. Supp. 3d 688, 697 (E.D. Pa. 2015) (noting that "there are very few cases interpreting Section 1557 of the Affordable Care Act).

⁵⁹ *SEPTA*, 102 F. Supp. 3d at 696.

⁶⁰ *Id.* at 700.

⁶¹ *Rumble*, 2015 U.S. Dist. LEXIS 31591, at *30, 33.

⁶² 45 C.F.R. § 156.125(a).

⁶³ *Id.*

prohibited discrimination on the basis of “expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.”⁶⁴ However, DHHS clarified that the non-discrimination regulation should not be interpreted as preventing insurers from using “reasonable medical management techniques.”⁶⁵

After finalizing the non-discrimination regulation, DHHS realized that insurers were still implementing benefit designs that discouraged individuals from enrolling on the basis of age or disability.⁶⁶ Although no additional regulations were proposed, DHHS stated that insurers are not in compliance if there was a “reduction in the generosity of a benefit” that was not based on clinical indications.⁶⁷

III. Examples of Violations of the Habilitative Services Regulation

Despite the regulations and additional guidance, interpretive gaps still exist in the habilitative services regulation.⁶⁸ Even where the regulation is clear, state and insurer interpretations that run afoul of the spirit of the ACA may leave open opportunities for additional enforcement efforts by DHHS.⁶⁹

A. State Definitions of Habilitative Services

DHHS has made clear that the federal definition of habilitative services is not intended to trump state definitions, so long as the state definition allows for coverage of services that help

⁶⁴ *Id.*

⁶⁵ 45 C.F.R. § 156.125(c).

⁶⁶ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; 80 Fed. Reg. 10, 750, 10, 822–23 (Feb. 27, 2015).

⁶⁷ *Id.*

⁶⁸ *See supra* Part III.

⁶⁹ *Id.*

“keep, learn, or improve” function.⁷⁰ However, some state definitions have failed to define habilitative services, or failed to update older definitions, in such a way to comply with the minimum standards required in the federal definition or with the overall spirit of the ACA.

1. Arkansas State Definition of Habilitative Services

Arkansas defines habilitative services as those intended to help individuals “attain and maintain a skill or function that was never learned or acquired and due to a disabling condition.”⁷¹ Although the definition mirrors the federal definition in some respects, it does not appear that Arkansas insurers would be required to offer services that help individuals improve an individual’s function since it only requires services that help attain or maintain skills; therefore, Arkansas’ definition would appear to be in direct conflict with the federal definition, which does require coverage of services that help improve function.⁷²

Additionally, the Arkansas definition does not appear to require coverage of benefits intended to help keep or maintain skills that an individual once had, but lost.⁷³ Based on the plain language of the habilitative services regulation, it is unclear if Arkansas’ definition would directly violate the DHHS’ definition since the federal definition only specifies that insurers must cover services that help an individual “keep, learn, or improve skills and functioning for daily living.”⁷⁴ While the Arkansas definition may not directly violate the federal definition based on its age qualification, it would contradict the spirit and intent of the ACA.⁷⁵ One of the primary purposes of the law was to assist all of the sick and disabled; not just disabled children.⁷⁶

⁷⁰ 45 C.F.R. § 156.115(a)(5)(i); Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; 80 Fed. Reg. 10, 750, 10, 811–12 (Feb. 27, 2015).

⁷⁰ *Id.*

⁷¹ 178 ARGR 101 (Mar. 2015)

⁷² 45 C.F.R § 156.115(a)(5)(i)

⁷³ 178 ARGR 101 (Mar. 2015).

⁷⁴ 45 C.F.R § 156.115(a)(5)(i).

⁷⁵ See *supra* note 5 and accompanying text.

⁷⁶ *Id.*

Thus, until DHHS provides additional guidance on what services must be covered under the mandate and for whom, some individuals in need of habilitative services and devices will not have access to them.

The Arkansas definition of habilitative services may also run afoul of the ACA's non-discrimination provision.⁷⁷ As the definition limits services to only those with conditions that were acquired early on since, in order to be eligible for coverage, the individual must have never had the skill or function.⁷⁸ This would mean that, under the Arkansas definition, individuals with conditions contracted later in life, such as Multiple Sclerosis, would not be eligible for coverage, since they likely had the specific skill or function in question at some point in their life and then lost it due to their condition.⁷⁹ Thus, it would appear that Arkansas' definition would be discriminating on the basis of disability or handicap since it is denying individuals with certain conditions "the opportunity to participate in or benefit from the aid, benefit, or service."⁸⁰

2. District of Columbia and Illinois State Definitions of Habilitative

Both Illinois and the District of Columbia (DC) define habilitative services to only include children.⁸¹ Illinois defines habilitative services as services used to "enhance the ability of a child to function with a congenital, genetic, or early acquired disorder."⁸² Similarly, DC defines habilitative services as those services used to treat a child "with a congenital or genetic birth defect to enhance the child's ability to function."⁸³ Insurers are prohibited from denying

⁷⁷ 42 U.S.C. § 18116(a); 45 C.F.R. § 156.125.

⁷⁸ 178 ARGR 101 (Mar. 2015)

⁷⁹ *Who Gets MS?*, NAT'L MULTIPLE SCLEROSIS SOC'Y, <http://www.nationalmssociety.org/What-is-MS/Who-Gets-MS> (last visited Feb. 13, 2016) (noting most people get diagnosed with Multiple Sclerosis between the ages of twenty and fifty).

⁸⁰ 45 C.F.R. § 84.4(b)(i).

⁸¹ D.C. CODE § 31-3271(3) (2016); 215 ILL. COMP. STAT. 5/356z.15(a) (2010). This is an existing statutory definition and is not pursuant to the ACA or specific to the provision of EHBs.

⁸² 215 ILL. COMP. STAT. 5/356z.15(a) (2010).

⁸³ D.C. CODE § 31-3271(3) (2016).

individuals benefits on the basis of age.⁸⁴ As habilitative services have been found to be effective for individuals of all ages, there is not an exception for excluding individuals other than children.⁸⁵ Therefore, both Illinois' and DC's definitions would appear that the definitions would be considered discriminatory since they exclude adults from coverage of habilitative services.⁸⁶

Both Illinois and DC's definitions of habilitative services are broad, making it difficult to determine whether or not they directly violate the federal definition of habilitative services, in addition to violating the non-discrimination provision. Based on the plain language of the habilitative services regulation, it is unclear if Illinois' and DC's definitions would directly violate the DHHS' definition since the federal definition only specifies that insurers must cover services that help an individual "keep, learn, or improve skills and functioning for daily living, but not for what age of the individuals."⁸⁷ While the state definitions may not directly violate the federal definition based on its age qualification, they would contradict the spirit and intent of the ACA.⁸⁸ One of the primary purposes of the law was to assist all of the sick and disabled; not just disabled children.⁸⁹

Although the plain language of the habilitative services provides a clear outline of the coverage requirements, gaps in the guidance and state use of definitions that have not yet come into full compliance with federal definition may require additional enforcement efforts on the part of DHHS to ensure individuals have equal opportunity to receive benefits.

B. Insurer Benefit Designs

⁸⁴ 45 C.F.R. § 90.12(a).

⁸⁵ *See supra* note 46 and accompanying text.

⁸⁶ 45 C.F.R. § 90.12(a).

⁸⁷ 45 C.F.R § 156.115(a)(5)(i).

⁸⁸ *See supra* note 5 and accompanying text.

⁸⁹ *Id.*

Similar to the responsibility of defining habilitative services, the ability to determine what specific benefits are going to be covered also falls largely to the states.⁹⁰ Thus, without adequate oversight from DHHS and the states, where appropriate, insurers may develop benefit designs that do not comply with all of the regulations related to the implementation of the habilitative services regulation, including the non-discrimination provision and the parity requirement.

1. Blue Cross Blue Shield of Massachusetts

Blue Cross Blue Shield of Massachusetts (BCBSMA) is one of the state's largest health plans.⁹¹ It offers health coverage to individuals through the state's health insurance exchange, meaning that all ACA statutes and EHB regulations apply to the insurer and its products.⁹² However, despite their applicability, more than one of BCBSMA's practices and policies appear to violate the plain wording of the habilitative services definition, or run afoul of the spirit of the ACA.

One example of a practice that violates the ACA is BCBSMA's medical necessity policies. BCBSMA defines medical necessity as "the determination of whether care is required and appropriate given an individual's medical condition and general opinions of experts practicing in the field of medicine."⁹³ Based on the plain language, the definition is broad

⁹⁰ 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) (noting that DHHS did not propose any changes to the States' ability to determine services included in the habilitative services category).

⁹¹ Robert Weisman, *Earnings Rise for Largest Mass. Health Insurers*, THE BOSTON GLOBE (Nov. 15, 2014), <https://www.bostonglobe.com/business/2014/11/14/earnings-rise-for-state-largest-health-insurers/O9RqkYVV39Pn6YARnOc4RO/story.html> (noting that in 2014, BCBSMA was the state's largest insurer).

⁹² See 45 C.F.R. § 147.100 (implementing the requirements of the ACA to all insurers offering products in the group and individuals markets); CENTERS FOR MEDICARE AND MEDICAID SERVICES, MASSACHUSETTS EHB BENCHMARK PLAN, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-Massachusetts-Benchmark-Summary.pdf> (establishing BCBSMA as the state's benchmark plan for 2014-2016).

⁹³ BLUECROSS BLUESHIELD OF MASS., Glossary of Definitions, https://www.bluecrossma.com/staticcontent/glossary_content.html.

enough to allow for coverage of services to help a person “keep, learn, or improve skills and functioning for daily living.”⁹⁴ However, in a policy statement regarding reimbursement of chiropractic services, BCBSMA notes that “reasonable expectation of recovery or improvement in function” is required for continued coverage and care that is “not essential to improving the net health outcome” is not covered unless the member’s function improves.⁹⁵ The application of this policy would prevent individuals who are not expected to improve, such as an individual with cerebral palsy, from receiving the treatment they need.⁹⁶ Therefore, BCBSMA’s policy regarding chiropractic services directly violates the EHB habilitative services regulation by completing writing out the requirement to provide services that help maintain function.⁹⁷ As this specific policy was effectuated prior to the implementation of the EHB regulation, DHHS should increase enforcement efforts to ensure medical necessity policies created prior the habilitative services regulation are updated to be in compliance with the uniform definition.⁹⁸

2. Amerihealth of New Jersey and Coventry Health Care

Both Amerihealth of New Jersey and Coventry Health Plan offer health insurance products to individuals and, therefore, are subject to the ACA’s statutes and regulations.⁹⁹ Both

⁹⁴ 45 C.F.R. § 156.115(a)(5)(i).

⁹⁵ BLUECROSS BLUESHIELD OF MASS., REIMBURSEMENT POLICY AND BILLING GUIDELINES FOR CHIROPRACTIC SERVICES 1, https://www.bluecrossma.com/staticcontent/review_guidelines/Revised_BCBSMA_Chiropractic_Billing_Guidelines.pdf.

⁹⁶ HENRY T. IREYS ET AL., DEFINING MEDICAL NECESSITY: STRATEGIES FOR PROMOTING ACCESS TO QUALITY CARE FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, MENTAL RETARDATION, AND OTHER SPECIAL HEALTH CARE NEEDS 1–2 (1999), <http://www.jhsph.edu/research/centers-and-institutes/womens-and-childrens-health-policy-center/publications/cshcn-MedicalNecessity.pdf> (providing the example of an individual with cerebral palsy who is unable to obtain the necessary ongoing physical therapy to keep them walking due to a narrow definition of medical necessity).

⁹⁷ 45 C.F.R. § 156.115(a)(5)(i).

⁹⁸ BLUECROSS BLUESHIELD OF MASS., REIMBURSEMENT POLICY AND BILLING GUIDELINES FOR CHIROPRACTIC SERVICES 1, https://www.bluecrossma.com/staticcontent/review_guidelines/Revised_BCBSMA_Chiropractic_Billing_Guidelines.pdf (noting that the policy was last revised in 2007, although still available on the plan website).

⁹⁹ 45 C.F.R. § 147.100; AMERIHEALTH NEW JERSEY, https://www.amerihealthnj.com/html/individuals_families/index.html? (last visited Apr. 24, 2016); COVENTRY HEALTH CARE, <http://coventryhealthcare.com> (last visited Apr. 24, 2016).

health care insurers also impose visitation limits on habilitative services, which may violate the ACA’s non-discrimination provision and the parity requirement in the EHB regulation.¹⁰⁰

Amerihealth of New Jersey plan limits speech, physical, occupational, and cognitive therapy to thirty visits per year for each type of therapy.¹⁰¹ Similarly, Coventry Health Care beneficiaries are limited to thirty-five visits a year of physical, occupational, and speech therapy combined.¹⁰² Some advocates suggest that insurers that place limits on the number of visits that would be covered are in violation of the ACA’s non-discrimination provision on the basis of disability since some conditions would require a greater number of visits to help them maintain function or learn a skill.¹⁰³ Children’s advocates, especially, have expressed concern over arbitrary frequency limits, arguing that some children, such as those with cerebral palsy, will need habilitative services on an ongoing basis to ensure that their skills are not lost.¹⁰⁴

Based on the plain language of the ACA statute and EHB regulation, benefit designs imposing such visitation limits could potentially be discriminatory.¹⁰⁵ DHHS has stated that the specific discriminatory actions prohibited against individuals with disabilities are those prohibited by Title VI of the Civil Rights Act and Section 504 of the Rehabilitation Act.¹⁰⁶ Section 504 of the Rehabilitation Act states that insurers must not “provide a qualified handicapped person with an aid, benefit, or service that is not as effective as that provided to

¹⁰⁰ See *infra* parts II.B-II.C.

¹⁰¹ AMERIHEALTH NEW JERSEY, IHC GOLD HMO LOCAL VALUE \$15/\$30, https://www.amerihealth.com/pdfs/custom/ffm/individual/2015/316_ihc_gold_hmo_value_15-30.pdf.

¹⁰² COVENTRY HEALTH CARE, COVENTRY GOLD \$5 COPAY DUKE MEDICINE, http://www.coventryone.com/web/groups/public/@cvtv_individual_c1/documents/document/nc49158.pdf.

¹⁰³ Letter from Habilitation Benefits Coalition for the Center for Consumer Information and Insurance Oversight 1, 4 (Sept. 30, 2015), https://www.atra-online.com/assets/pdf/FPP_HAB15.pdf.

¹⁰⁴ Letter from Children’s Hospital Association for Marilyn Tavenner, Acting Administrator, Centers for Medicare and Medicaid Services, 1, 4 (Sept. 24, 2012), <http://www.regulations.gov/#!documentDetail;D=CMS-2012-0142-2062> (follow “view attachment” hyperlink).

¹⁰⁵ 42 U.S.C. § 18116(a); 42 U.S.C. § 18022(b)(4)(B) (2015); 45 C.F.R. § 156.125(a) (2016).

¹⁰⁶ See *supra* Part II.C.

others.”¹⁰⁷ Based on the regulation, Amerihealth and Coventry Health Care’s visitation limits could be in violation of the nondiscrimination provision since the offered number of visits may not be as effective for some conditions.¹⁰⁸ However, the regulations go on to say that benefits are not required to produce identical results or level of achievement as long as they “afford handicapped persons equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement.”¹⁰⁹ Based on this regulation, Amerihealth and Coventry Health Care’s benefit design would only be discriminatory if the number of visits offered did not give disabled individuals the same opportunity to achieve results.¹¹⁰ As such, DHHS should consider clarifying how to determine whether benefits allow for the same opportunity to obtain achievement in order to assist insurers in designing benefit designs that are not discriminatory in practice.

In addition to potentially violating the non-discrimination provision of the ACA, the visitation limits imposed by Amerihealth New Jersey and Coventry Health may also violate the EHB parity requirement.¹¹¹ Both Amerihealth and Coventry Health Care impose the same limitation on visits for rehabilitative services as they do for habilitative services.¹¹² Therefore, neither limitation violates the express language of the regulation since the rehabilitative treatment limitation is no less favorable than the habilitative services limitation.¹¹³ Advocates

¹⁰⁷ 45 C.F.R. § 84.4(b)(1)(iii).

¹⁰⁸ See AMERIHEALTH NEW JERSEY, IHC GOLD HMO LOCAL VALUE \$15/\$30, https://www.amerihealth.com/pdfs/custom/ffm/individual/2015/316_ihc_gold_hmo_value_15-30.pdf; COVENTRY HEALTH CARE, COVENTRY GOLD \$5 COPAY DUKE MEDICINE, http://www.coventryone.com/web/groups/public/@cvty_individual_c1/documents/document/nc49158.pdf.

¹⁰⁹ 45 C.F.R. § 84.4(b)(2).

¹¹⁰ *Id.*; see AMERIHEALTH NEW JERSEY, IHC GOLD HMO LOCAL VALUE \$15/\$30, https://www.amerihealth.com/pdfs/custom/ffm/individual/2015/316_ihc_gold_hmo_value_15-30.pdf; COVENTRY HEALTH CARE, COVENTRY GOLD \$5 COPAY DUKE MEDICINE, http://www.coventryone.com/web/groups/public/@cvty_individual_c1/documents/document/nc49158.pdf.

¹¹¹ See *infra* Part II.B.

¹¹² *Id.*

¹¹³ 45 C.F.R. § 156.115(a)(5)(ii); See AMERIHEALTH NEW JERSEY, IHC GOLD HMO LOCAL VALUE \$15/\$30, https://www.amerihealth.com/pdfs/custom/ffm/individual/2015/316_ihc_gold_hmo_value_15-30.pdf; COVENTRY

have expressed concern that this type of comparison may not result in equal treatment, as some individuals receiving habilitative services may require a greater number of visits to keep, learn, or improve the skills they need for daily living as an individual receiving the same service, but for rehabilitative purposes.¹¹⁴ However, based on the guidance DHHS has provided, limits that are equal in number would not violate the parity regulation, even if they do result in less favorable outcomes.¹¹⁵ This type of benefit design, while not in direct violation of the law, would still seem to run afoul of the spirit of the ACA.¹¹⁶ Thus, DHHS may need to provide additional guidance regarding the extent to which habilitative and rehabilitative services need to be in parity in order to fully be in compliance with the regulation.

3. Blue Cross Blue Shield of Vermont

Blue Cross Blue Shield of Vermont (BCBSVT) offers health insurance products to individuals; therefore, it is subject to the ACA statutes and EHB regulations, including the parity requirement.¹¹⁷ One of the products sold by BCBSVT requires prior authorization for all habilitative service, but only requires the same prior authorization for inpatient rehabilitative service.¹¹⁸ Based on the plain language of the requirement, it appears that BCBSVT's benefit design would violate the parity requirement since having a prior authorization requirement is less favorable than not having one.¹¹⁹ While BCBSVT could apply the prior authorization to all habilitative services and all rehabilitative services, they cannot make it harder to partake in

HEALTH CARE, COVENTRY GOLD \$5 COPAY DUKE MEDICINE,
http://www.coventryone.com/web/groups/public/@cvtv_individual_c1/documents/document/nc49158.pdf.

¹¹⁴ See *supra* notes **Error! Bookmark not defined.**–84 and accompanying text.

¹¹⁵ 45 C.F.R. § 156.115(a)(5)(ii).

¹¹⁶ See *supra* note 5 and accompanying text.

¹¹⁷ 45 C.F.R. § 147.100; BLUE CROSS BLUE SHIELD OF VERMONT, <http://www.bcbsvt.com/find-a-plan> (last visited Apr. 24, 2016).

¹¹⁸ BLUE CROSS BLUE SHIELD OF VERMONT, SUMMARY OF BENEFITS COVERAGE 1, 4 (2016), <http://www.bcbsvt.com/wps/wcm/connect/b9c95dd3-aad4-4909-a9b4-0a5ab36eba2e/1019038-silver-cdhp-2016-sbc.pdf?MOD=AJPERES>.

¹¹⁹ 45 C.F.R. § 156.115(a)(5)(ii).

habilitative services than rehabilitative services.¹²⁰ However, DHHS has not provided any guidance on how to determine what would be considered a limitation or the process for determining if a limitation is less favorable for habilitative services than rehabilitative services.¹²¹ Thus, additional clarity is needed to ensure insurer compliance with the parity requirement.

IV. Strategies to Ensure Adequate Coverage of Habilitative Service Federal and State Action

In general, both the federal and state governments have the authority to enforce the applicable provisions.¹²² The Supremacy Clause in the Constitution states that the laws of the United States are the “supreme Law of the Land;”¹²³ as such, any state law that directly conflicts with a federal law will “be without effect.”¹²⁴ DHHS could, therefore, penalize a state that defined habilitative services in such a way that it directly conflicts with the federal definition.¹²⁵ DHHS also has the authority to penalize issuers selling products in a federally-facilitated exchange for substantial non-compliance with any of the standards set forth in part 156 of title 45 of the Code of Federal Regulations, which includes both the federal definition of habilitative services, the parity provision, and the EHB non-discrimination provision.¹²⁶ This could include imposing civil monetary penalties, issuing notices of non-compliance, decertifying the plan as a qualified health plan, or suppressing enrollment into the violating plan through the exchange.¹²⁷

¹²⁰ *Id.*

¹²¹ *Id.*

¹²² See Timothy S. Jost, *Health Care Reform Requires Law Reform*, 28 Health Affairs w761 (2009), <http://content.healthaffairs.org/content/28/5/w761.full.pdf+html> (noting that health care regulation has historically been a power left to the States under their general police power); see also N.J.A.C. § 11:24A-1.1 (describing that issuers must comply with the state laws in order to operate in the state); but see U.S. Const. art. VI. cl. 2. and *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981).

¹²³ U.S. Const. art. VI. cl. 2.

¹²⁴ *Maryland v. Louisiana*, 451 U.S. 725, 746 (1981).

¹²⁵ *Id.*

¹²⁶ 45 C.F.R. § 156.805(a)(1).

¹²⁷ 45 C.F.R. § 156.805–815.

If DHHS does not or is unwilling to take action, states also have the authority to ensure compliance with the federal regulations.¹²⁸ However, in cases where interpretation of the statute or regulation is the issue, the solution may not be as straight forward as DHHS or a state enforcing the provision.

A. Defined Benefit List

To eliminate interpretive issues with the scope of services that should be offered and guarantee the minimum services needed to help individuals keep, learn, or improve function are offered, many advocates suggest that DHHS should define the scope of services that should be offered under the habilitative provision.¹²⁹ Some states and insurer advocates argue that they need to retain flexibility in order to tailor the benefits to the needs of their specific populations,¹³⁰ and DHHS appears to agree, as it has stated that it is unwilling to publish a defined list of required habilitative services.¹³¹ However, such a list would ensure that experts in the field would be defining the services, instead of insurers who likely have little experience with habilitative services as a benefit category, which would help to ensure comprehensive coverage.¹³²

¹²⁸ Jost, *supra* note 122.

¹²⁹ *See e.g.*, Letter from the Service Employees International Union (SEIU) to Centers for Medicare & Medicaid Services 1, 3 (Dec. 26, 2012), <http://www.regulations.gov/#!documentDetail;D=CMS-2012-0142-2314> (follow “view attachment” hyperlink); Letter from The Maryland Citizens’ Health Initiative Education Fund, Inc. to Department of Health and Human Services and Centers for Medicare and Medicaid Services 1, 3 (Dec. 20, 2012), <http://www.regulations.gov/#!documentDetail;D=CMS-2012-0142-2174> (follow “view attachment” hyperlink); Letter from Children’s Hospital Association for Marilyn Tavenner, Acting Administrator, Centers for Medicare and Medicaid Services, 1, 3–4 (Sept. 24, 2012), <http://www.regulations.gov/#!documentDetail;D=CMS-2012-0142-2062> (follow “view attachment” hyperlink); *see also* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,812 (Feb. 27, 2015).

¹³⁰ HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10, 750, 10,812; Letter from America’s Health Insurance Plans to Gary Cohen, Deputy Administrator and Director, Centers for Consumer Information and Insurance Oversight 1, 9 (Dec. 21, 2012), <http://www.regulations.gov/#!documentDetail;D=CMS-2012-0142-1659> (follow “view attachment” hyperlink).

¹³¹ HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10, 750, 10,812.

¹³² Letter from the Service Employees International Union (SEIU) to Centers for Medicare & Medicaid Services 1, 3 (Dec. 26, 2012), <http://www.regulations.gov/#!documentDetail;D=CMS-2012-0142-2314> (follow “view attachment” hyperlink).

The concept of a defined list of benefits has been successful in other health care programs.¹³³ For example, in the Medicare program, coverage determinations are made on a national basis.¹³⁴ The standards for National Coverage Determinations (NCDs) are adopted using research-based evidence provided by both CMS and outside experts.¹³⁵ Additionally, NCDs allow room for public participation.¹³⁶ The public can request an NCD through a formal process that involves providing sufficient supporting evidence, addressing the “relevance, usefulness, or the medical benefits of the item,” and fully explaining the “design, purpose, and method of using the item or service.”¹³⁷ Although the benefits offered are the same for every insurer participating in the Medicare program, the list is only intended to serve as a floor.¹³⁸ Therefore, a state would have the discretion to cover additional benefits.¹³⁹ Similar to CMS’ intention for NCDs, DHHS has made it clear that the uniform definition is also only intended to serve as a floor for the scope of habilitative services states and insurers have to offer.¹⁴⁰ As such, DHHS should develop a defined list of benefits, similar to that used in the Medicare context, so that states would still have the ability to tailor their benefits to their specific populations by covering services beyond what is required by the federal regulation, but guarantee the minimum amount of coverage.

B. Medical Necessity Defined

¹³³ See *Medicare Coverage Determination Process*, CMS.GOV, <https://www.cms.gov/Medicare/Coverage/DeterminationProcess/> (last visited Feb. 16, 2016).

¹³⁴ *Id.* (describing the process for developing National Coverage Determinations (NCDs)).

¹³⁵ *Id.*

¹³⁶ *How to Request an NCD*, CMS.GOV, <https://www.cms.gov/Medicare/Coverage/DeterminationProcess/howtorequestanNCD.html> (last visited Apr. 12, 2016).

¹³⁷ *Id.*

¹³⁸ *Medicare Coverage Determination Process*, CMS.GOV, <https://www.cms.gov/Medicare/Coverage/DeterminationProcess/> (last visited Apr. 12, 2016).

¹³⁹ *Id.*

¹⁴⁰ 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).

The federal definition of habilitative services specifically states that services intended to help an individual maintain skills and function must be provided.¹⁴¹ Therefore, it appears that DHHS did not intend for improvement of a skill or function to be required in order to receive coverage. However, insurers regularly impose medical necessity requirements on the services they provide.¹⁴² These medical necessity requirements often require improvement, which allows insurers to deny benefit to individuals in need of habilitative services, without directly violating the express language of the federal definition.¹⁴³ Thus, DHHS should develop a uniform definition of medical necessity in order to ensure that individuals suffering from conditions that are not likely to improve still have access to the services they require.

After the passage of the ACA, the Institute of Medicine (IOM) considered developing a uniform definition of medical necessity.¹⁴⁴ Although the public, along with the medical community, favored the idea, private insurers argued that the present system—allowing insurers to develop definitions—allowed insurers the flexibility they need to serve their beneficiaries.¹⁴⁵ While the IOM did not decide to develop a uniform definition of medical necessity, it clearly saw the benefit in having a consistent approach among insurers.¹⁴⁶ As such, DHHS should pick up where IOM left off and develop a uniform definition of medical necessity in order to ensure that state or insurer definitions of the term do not serve as de facto discriminatory limitations on habilitative services.¹⁴⁷

¹⁴¹ 45 C.F.R. § 156.115(a)(5)(i).

¹⁴² See supra notes 93–98 and accompanying text.

¹⁴³ *Id.*

¹⁴⁴ Janet L. Dolgin, *Unhealthy Determinations: Controlling “Medical Necessity,”* 22 VA. J. SOC. POL’Y & L. 435, 442 (2015).

¹⁴⁵ *Id.*

¹⁴⁶ *Id.*

¹⁴⁷ *Id.*

If DHHS chooses not to develop a uniform definition, it should make clear that definitions should not be construed to mean improvement is necessary for a benefit to be covered. As a model, DHHS should base its guidance off of the ruling in *Jimmo v. Sebelius*.¹⁴⁸ In *Jimmo*, the United States District Court of Vermont addressed this very issue a Medicare beneficiary was denied coverage after an Administrative Law Judge (ALJ) found that there had been no change in her condition.¹⁴⁹ Although the case ended in a settlement instead of a judgment, CMS agreed to update its policy to make clear that Medicare’s current policy was that when care “that is reasonable and necessary to prevent or slow further deterioration, coverage cannot be denied based on the absence of potential for improvement or restoration.”¹⁵⁰ Although the case is distinguishable from the EHB regulation since the ruling only applies to Medicare beneficiaries, DHHS should consider apply a similar standard as the resulting from *Jimmo*.¹⁵¹ Applying such a standard would reduce the likelihood that insurers could get around the maintenance requirement in the habilitative services definition using medical necessity policies.¹⁵²

Not only will an improvement standard policies ensure individuals will be able to receive services used to maintain their function, but it would also alleviate some logistical concerns. Private insurers participating in the Medicare Advantage program, which offers additional benefits to individuals who are already enrolled in Original Medicare, will already have to adhere to the policy set forth in *Jimmo* when making coverage determinations for Medicare

¹⁴⁸ See generally *Jimmo v. Sebelius*, 2011 U.S. Dist. LEXIS 123743 (D. Vt. Oct. 25, 2011).

¹⁴⁹ *Id.* at *4–5.

¹⁵⁰ CTRS. FOR MEDICARE AND MEDICAID SERVS., *JIMMO V. SEBELIUS* SETTLEMENT AGREEMENT FACT SHEET 1, <https://www.cms.gov/medicare/medicare-fee-for-service-payment/SNFPPS/downloads/jimmo-factsheet.pdf>.

¹⁵¹ *Jimmo*, 2011 U.S. Dist. LEXIS 123743 at *4–5.

¹⁵² 45 C.F.R. § 156.115(a)(5)(i).

beneficiaries.¹⁵³ This amounts to over sixteen million individuals.¹⁵⁴ Similarly, states administering the Medicaid program will have to apply the ruling to individuals who are eligible for both Medicare and Medicaid, referred to as dual-eligibles.¹⁵⁵ This accounts for an additional nine million beneficiaries.¹⁵⁶ If private insurers throughout the country are already applying the *Jimmo* policy for twenty-five million beneficiaries, as a practical matter, the policy should be applied consistently for all beneficiaries.

C. Clarification of Parity Requirement

The EHB parity provision is not the first time that there has been confusion regarding what it means to achieve parity between two different types of benefits.¹⁵⁷ DHHS also has a similar regulation for mental health benefits in relation to medical benefits.¹⁵⁸ To reduce the ability of insurers to offer benefit designs that offer rehabilitative and habilitative services that are equal in number, but unequal in outcomes, DHHS should model the habilitative services parity requirement after the mental health parity requirement.¹⁵⁹

Similar to the mental health parity regulation, DHHS should further define the relevant terms necessary to appropriately deliver care.¹⁶⁰ The mental health parity regulation defines “treatment limitation” as limits based on “frequency of treatment, number of visits, coverage,

¹⁵³ Memorandum from Peter W. Thomas, Powers Pyles Sutter & Verville PC, to Association of Academic Psychiatrists 1, 4 (Oct. 25, 2012), http://c.ymcdn.com/sites/www.physiatry.org/resource/resmgr/jimmo_v__sebelius_-_settleme.pdf (providing total Medicare Advantage enrollment in 2015).

¹⁵⁴ THE HENRY J. KAISER FAMILY FOUND., <http://kff.org/medicare/fact-sheet/medicare-advantage/> (last visited Feb. 16, 2015).

¹⁵⁵ Memorandum from Peter W. Thomas, Powers Pyles Sutter & Verville PC, to Association of Academic Psychiatrists 1, 4 (Oct. 25, 2012), http://c.ymcdn.com/sites/www.physiatry.org/resource/resmgr/jimmo_v__sebelius_-_settleme.pdf.

¹⁵⁶ THE HENRY J. KAISER FAMILY FOUND., <http://kff.org/medicaid/slide/9-million-dual-eligible-beneficiaries-are-covered-by-both-medicare-and-medicaid/> (last visited Feb. 16, 2015).

¹⁵⁷ Weber, *supra* note 7, at 206–07.

¹⁵⁸ 45 C.F.R. § 146.136.

¹⁵⁹ Compare 45 C.F.R. § 146.136, with 45 C.F.R. § 156.115(a)(5)(2).

¹⁶⁰ 45 C.F.R. § 146.136(a).

days in waiting period, or other similar limits on the scope or duration of treatment.”¹⁶¹ The regulations also specify that both quantitative and non-quantitative treatment limitations are included in the general definition of “treatment limitation.”¹⁶² Quantitative limitations are described as those that are expressed numerically, such as number of visits covered per year, and non-quantitative limitations are those that “otherwise limit the scope or duration of benefits.”¹⁶³ An insurer cannot impose a non-quantitative treatment limitation unless “any processes, strategies, evidentiary standards,” applied to mental health benefits are no more stringently applied to medical benefits.¹⁶⁴ Examples of non-quantitative treatment limitations include “medical management standards limiting or excluding benefits based on medical necessity,” “refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective,” and “exclusions based on failure to complete a course of treatment.”¹⁶⁵

Applying the mental health parity requirement to habilitative services would clarify which types of benefit designs would constitute a violation of the parity requirement. For example, BCBSVT would no longer be able to require a prior authorization for habilitative services and not for rehabilitative services.¹⁶⁶ A prior authorization is a non-quantitative treatment limitation, constituting a medical management standard that limits benefits.¹⁶⁷ Thus, BCBSVT’s benefit design would impose a treatment limitation on habilitative services that is less favorable than the limitation on rehabilitative services.¹⁶⁸

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ *Id.*

¹⁶⁴ 45 C.F.R. § 146.136(c)(4)(i).

¹⁶⁵ 45 C.F.R. § 146.136(c)(4)(ii).

¹⁶⁶ *See supra* note 118.

¹⁶⁷ 45 C.F.R. § 146.136(c)(4)(ii); *see also* 45 C.F.R. § 146.136(c)(4)(iii) (providing an example of a violation of the mental health parity requirement that involves a prior authorization).

¹⁶⁸ 45 C.F.R. § 156.115(a)(5)(2).

Insurers that impose visitation limits on habilitative and rehabilitative services would also not be immune from the rule, just because the limits are numerically equal.¹⁶⁹ For example, Amerigroup New Jersey and Coventry Health both impose numerically equal visitation limits on rehabilitative and habilitative services.¹⁷⁰ However, under parity regulations similar to the mental health parity regulations, this would not necessarily result in compliance with the provision.¹⁷¹ Both insurers would have to demonstrate that the medical management techniques used to determine the visitation limits applied habilitative services are comparable to, and no less stringent, than those applied to rehabilitative services benefits for them to actually satisfy the regulation.¹⁷² DHHS has made clear that all non-quantitative treatment limitations should be based on medically appropriate evidentiary standards, even though the application “may not result in similar numbers or visits, days of coverage, or other benefits.”¹⁷³ As such, both insurers would also have to prove that the numerically equal treatment limitation was the result of medically appropriate management techniques in order to comply with the regulation.

Although modeling the habilitative services parity regulation after the mental health parity regulation may not result in complete equality, the additional guidance would bring more clarity to what would, and would not be, a violation of the habilitative services parity requirement.¹⁷⁴ With clearer standards in place, DHHS may then have the ability to enforce compliance and impose penalties, if necessary.¹⁷⁵

V. Conclusion

¹⁶⁹ See *supra* note 101–95 and accompanying text.

¹⁷⁰ *Id.*

¹⁷¹ 45 C.F.R. § 146.136(c)(4)(i).

¹⁷² *Id.*

¹⁷³ 45 C.F.R. § 146.136(c)(4)(iii) (providing example 4, which involves the process for developing medical management standards).

¹⁷⁴ Weber, *supra* note 7 at 235 (describing the issues that still exist, even after the passage of the Parity Act).

¹⁷⁵ See *supra* note 122–127.

A century ago, Theodore Roosevelt called for health care reform, and, ever since, it has been a topic of debate for every politician.¹⁷⁶ The passage of sweeping reform signaled the end of insurers being able to reject potential enrollees because of costly preexisting conditions or rescinding the policies of individuals who are a higher cost to the insurer, such as those with chronic conditions and disabilities.¹⁷⁷ While DHHS has made strides with the passage of the habilitative services definition to ensuring that many individuals with disabilities will receive coverage, the definition also allows the health insurance industry to retain much of the power in the way of administering benefits to consumers.¹⁷⁸ As a result, individuals may not always receive comprehensive coverage of habilitative services.¹⁷⁹ Insurers regularly implement medical necessity policies that prevent individuals from receiving maintenance services.¹⁸⁰ Additionally, some state or insurer policies directly or indirectly violate the federal definition of habilitative services or the related regulations.¹⁸¹ In order to realize the promise of the habilitative services definition, additional guidance and enforcement efforts are needed from DHHS.¹⁸²

While sweeping reform is unlikely, smaller revisions to the regulations can and should be made. DHHS should consider defining the scope of habilitative services that are required to be covered, similar to how NCDs are used in the Medicare program.¹⁸³ This method would ensure

¹⁷⁶*A Brief History: Universal Health Care Efforts in the US*, PHYSICIANS FOR A NAT'L HEALTH PROGRAM, <http://www.pnhp.org/facts/a-brief-history-universal-health-care-efforts-in-the-us> (date last visited). *See also* President Barack Obama, Remarks by the President to a Joint Session of Congress on Health Care (Sept. 9, 2009), <https://www.whitehouse.gov/the-press-office/remarks-president-a-joint-session-congress-health-care>.

¹⁷⁷ U.S. DEP'T OF HEALTH & HUMAN SERVS., PRE-EXISTING CONDITIONS, <http://www.hhs.gov/healthcare/about-the-law/pre-existing-conditions/index.html> (Apr. 12, 2016); U.S. DEP'T OF HEALTH & HUMAN SERVS., CURBING INSURANCE CANCELLATIONS, <http://www.hhs.gov/healthcare/about-the-law/cancellations-and-appeals/curbing-insurance-cancellations/index.html> (Apr. 12, 2016).

¹⁷⁸ Dolgin, *supra* note 144 at 475, 488–89.

¹⁷⁹ *See supra* Part II.A–B.

¹⁸⁰ *See supra* notes 93–98 and accompanying text.

¹⁸¹ *See supra* Part II.A–B.

¹⁸² *Id.*

¹⁸³ *See supra* notes 133–137 and accompanying text.

that insurers offer services intended to help individuals keep, learn, or improve skills, while still allowing states to retain the ability to tailor their benefits to fit their population's needs by supplementing the standard benefit design with additional benefits.¹⁸⁴ Additionally, DHHS should provide additional guidance regarding the policies affecting how the habilitative services definition operates in practice, such as policies regarding medical necessity definitions and parity between habilitative and rehabilitative services.

In sum, healthcare regulation has long been the responsibility of the individual states. Although DHHS attempted to limit some of the states' power by implementing a minimum standard for habilitative services, the regulation will have a lesser benefit if it is not adequately enforced and all related regulations are not clear. As such, DHHS should focus enforcement efforts to instances of direct violations of the habilitative services definition or any of the related regulations, and provide additional guidance where necessary to ensure individuals have access to services that will help them keep, learn, or improve the skills they need to function in their daily lives.

¹⁸⁴ *Id.*