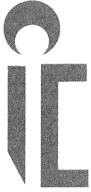


STATE OF WEST VIRGINIA

Offices of the Insurance Commissioner

Earl Ray Tomblin
Governor

Michael D. Riley
Insurance Commissioner

MARCH 2013

WEST VIRGINIA INFORMATIONAL LETTER

NO. 184

TO: All Insurance Companies Authorized to Sell Health Insurance Plans in West Virginia's Small Group and Individual Markets

RE: "Habilitative Benefit" Category of Essential Health Benefits

In March 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 were signed into law. The two laws are collectively referred to as the Affordable Care Act (ACA). The ACA requires all health care plans sold in the United States in the small group or individual markets to include "essential health benefits" (EHB), defined as ten (10) categories of benefits. *See* ACA §2707 (codified at 42 USC §300gg-6 & ACA §1301 (codified at 42 USC §18021).

Aside from the ten basic categories, discretion on how to define EHB was left to the US Department of Health and Human Resources which ultimately used a "benchmark" approach, permitting each state to select a "benchmark plan" from among 7 plans offered in the state and 3 federal plans. Because West Virginia did not select a benchmark, the largest small group plan offered in the state, the "Highmark Blue Cross BlueShield West Virginia Super Blue PPO Plus 2000 1000 Ded" became the benchmark plan. *See* 45 CFR §§147, 155 & 156.

One EHB category that traditionally has not been provided by most health insurance carriers in states is "habilitative benefits". Therefore, most states' benchmarks do not include habilitative benefits. Further, this category of EHB is not defined in federal statute, law or guidance. As such, the U.S. Department of Health and Human Services (HHS) has provided the states discretion to define this category for purposes of EHB. Specifically, 45 CFR §156.110(f) states:

> (f) Determining habilitative services. If the base-benchmark plan does not include coverage for habilitative services, the State may determine which services are included in that category.

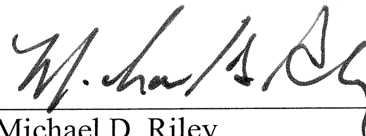
Additionally, language in the above-referenced federal rule indicates that one preferred approach is to make the habilitative benefits offered in the policy to be in parity with the rehabilitative benefits offered in the policy. See 45 CFR §156.110(f).

West Virginia defines "habilitative services" as follows:

> Medically necessary services that help a person gain, keep, or improve skills for daily living. Some examples include physical and occupational therapy, speech-language pathology, and other needed services.

Therefore, to meet the requirement to provide habilitation services, carriers should provide them: (1) as defined above; and (2) in *parity* with the rehabilitative services offered under the plan.[1] For example, if the plan offers up to 50 physical therapy visits per year for rehabilitation benefits, the same amount would have to be offered for habilitative benefits pursuant to the definition above ("needed to help a person gain, keep, or improve skills for daily living").

Questions regarding this informational letter should be directed to Jeremiah Samples, Director of Health Policy for the OIC, at 304-558-6279 ext. 1131 or jeremiah.samples@wvinsurance.gov.



Michael D. Riley
Insurance Commissioner

[1] Rehabilitative services are also an EHB "sub-category" under the ACA along with habilitative, so every plan that has to provide habilitative pursuant to EHB requirements will also provide rehabilitative. Further rehabilitative benefits *are* part of West Virginia's benchmark plan so all EHB carriers will have a point of reference for purposes of establishing rehabilitative benefits in their plan.