



February 16, 2016

Affordable Care Act (ACA) Notice of Benefit and Payment Parameters for 2016 *Final Rule*

On February 27, 2015, the Department of Health and Human Services (HHS) released the Affordable Care Act (ACA) Notice of Benefit and Payment Parameters for 2016 Final Rule. In the rule, HHS finalizes a number of standards relating to essential health benefits (EHBs), including a definition of habilitative services, as well as coverage of pediatric services and prescription drugs. This final rule also provided examples of discriminatory plan designs and amended requirements for essential community providers (ECPs).

The final rule contains specific victories for habilitation and rehabilitation providers and beneficiaries by directing EHBs to be equal in scope to the benefits covered by a typical employer plan and mandating that they cover habilitation and rehabilitation services and devices specifically, among the 10 general categories defined in EHBs. Other services covered include: ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. The final rule also clarifies the difference between habilitative and rehabilitative services and specifies that plans cannot count habilitative service visits towards the same limits imposed for rehabilitative services as they are separate and distinct EHBs.

Key Provisions of Essential Health Benefits (EHB) (§156.115)

- §156.115 which states ‘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 § 023.110(a)(10), provide coverage for enrollees until at least the end of the month in which the enrollee turns 19 years of age.

Network Adequacy Standards (§ 156.230)

- *General requirement.* Each Qualified Health Plan (QHP) issuer that uses a provider network must ensure that the provider network consisting of in-network providers, as available to all enrollees, meets the following standards:

(b) *Access to provider directory.* (1) A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from HHS and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.

(2) For plan years beginning on or after January 1, 2016, a QHP issuer must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS and the Office of Personnel Management (OPM). A provider directory is easily accessible when—

(i) The general public is able to view all of the current providers for a plan in the provider directory on the issuer's public Web site through a clearly identifiable link or tab and without creating or accessing an account or entering a policy number; and

(ii) If a health plan issuer maintains multiple provider networks, the general public is able to easily discern which providers participate in which plans and which provider networks.

(c) *Increasing consumer transparency.* A QHP issuer in a Federally-facilitated Exchange must make available the information described in paragraph (b) of this section on its Web site in an HHS specified format and also submit this information to HHS, in a format and manner and at times determined by HHS.

Language Provision Guidance for EHBs (§ 156.115)

- HHS believes 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.
- HHS also proposes 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, HHS interprets the statute to require coverage of each. Therefore, issuers that previously excluded habilitative services, but subsequently added them, would be required under this 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 HHS proposed to establish a uniform definition of habilitative services in new §156.115(a)(5)(i), it was 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 it was 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).

- HHS is finalizing this 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. HHS is thereby codifying this final policy in revised §156.115(a)(5) and removing §156.110(c)(6).
- HHS is 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 preempted so long as they do not prevent the application of the Federal definition.

Comments and Responses

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: *HHS is 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: *HHS originally omitted devices because the term is already included in the statutory description of this category of EHB. In response to comments, however, “devices” has been added to the regulatory definition. HHS reminds issuers that the statute requires coverage of devices for both rehabilitative and habilitative services.*

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: *HHS is 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 issuers are encouraged to cover additional services and devices beyond those covered by the benchmark plan.*

Other Considerations:

HHS considered for the 2016 benefit year requiring issuers to separate visit limits for rehabilitative and habilitative services and devices. However, we determined that issuers’ claims systems are unable to distinguish rehabilitative and habilitative services and devices at this time. Therefore, they determined that this requirement should not be effective until 2017 to allow issuers to modify their claims systems.