

**STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION**

Before the Commissioner of the Office of Financial and Insurance Regulation

In the matter of:

Essential Health Benefits: Habilitative Services

Order No. 13-003-M

**Issued and entered
this 1st day of January 2013
by R. Kevin Clinton
Commissioner**

Order Requiring Coverage for Habilitative Services

The Patient Protection and Affordable Care Act (ACA) requires all non-grandfathered individual and small group health insurance plans, offered on and off the Exchange, to provide coverage in ten categories of essential health benefits (EHBs), including the category of “rehabilitative and habilitative services.” Habilitative services are defined as “health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn’t 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.”¹ Beginning January 1, 2014, any small group or individual plan must offer, at a minimum, the services covered in the state’s EHB benchmark plan. Michigan’s benchmark plan is the Priority Health HMO plan that was in effect as of March 31, 2012.

Like most health plans offered in Michigan, the Priority Health benchmark plan does not include coverage for habilitative services. In recently released proposed regulations, the Department of Health and Human Services (HHS) stated that if a state’s chosen benchmark plan “does not include coverage of habilitative services the state may determine the services included in the habilitative services category.” 77 Fed. Reg. 70650 (Nov. 26, 2012).

The Commissioner has determined that habilitative services encompasses many different types of services, including but not limited to applied behavioral analysis (ABA) for the treatment of autism spectrum disorder. ABA is defined by Michigan law as “the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation,

¹ This definition is taken from the uniform glossary that is required to be made available with every insurance plan offered on January 1, 2014, and it is substantively identical to the definition used in Medicaid laws. The Commissioner cites this definition because it is most likely to be referenced by health insurance carriers and insureds.

measurement, and functional analysis of the relationship between environment and behavior.” See MCL 500.3406s(7)(a) and 550.1416e(6)(a).


Under existing state law, treatments for autism spectrum disorder are required to be offered in all health insurance policies and certificates. See MCL 500.3406s and MCL 550.1416e. However, state law does not specifically require that such treatments be offered in health insurance policies and certificates offered on the Exchange.

THEREFORE, IT IS ORDERED that ABA treatment for autism is included in Michigan’s EHB “habilitative services” category. Any qualified health plan offered through an Exchange in Michigan is required, as a result of this Order, to include ABA treatment for autism. This will ensure that ABA treatment is available in all health insurance policies in Michigan, whether offered on or off the Exchange.

Furthermore, Michigan law allows insurers to impose annual dollar limits on coverage for autism spectrum disorder treatments. See MCL 500.3406s and MCL 550.1416e. However, these limits are not enforceable in any plan offered on or off the Exchange in Michigan because all listed treatments, including ABA, are now part of the EHB package and, according to federal guidance, cannot be subject to annual or lifetime dollar limits.

THEREFORE, IT IS ALSO ORDERED that insurance carriers must convert the applicable dollar limits to non-quantitative (e.g., scope and duration) limits for any small group or individual plan offered on or after January 1, 2014. The converted non-quantitative limits must be actuarially justified and must be included in the form and rate filings submitted through the SERFF system for Commissioner review and approval.

While the ACA does not require large group plans to offer EHBs, any EHBs that are offered by a large group plan must comply with the ACA’s provisions on annual and lifetime dollar limits. Accordingly, large group plans providing coverage for ABA should also submit any converted non-quantitative limitations for plans offered on or after January 1, 2014 to the Commissioner for review and approval.



R. Kevin Clinton
Commissioner