

Habilitative Services are Essential Health Benefits: An Opportunity for Occupational Therapy Practitioners and Consumers

What are essential health benefits or EHBs?

The Affordable Care Act (ACA) identifies 10 broad categories of services¹ that it requires certain health insurance plans to cover. Those services are called *essential health benefits* (EHBs). One of the categories of EHBs is rehabilitative and habilitative services and devices. The federal government allowed states to adopt an existing health plan as the model for coverage of EHBs, which it called a *benchmark plan*. A state’s benchmark plan serves as the model for the types of services that must be covered, as well as any quantitative limits on those services, such as visit limits. Therefore, each state’s EHBs can vary in terms of the particulars, such as what services are included under the rehabilitative services category and how many visits are permitted. To the extent that a state’s benchmark plan did not include all the EHBs, the state had to supplement it to ensure coverage of all services in each of the 10 categories. Because habilitative services were often excluded from health insurance coverage in the past, many benchmark plans did not reference them. In those cases, states were permitted to define coverage requirements for habilitation. In cases where states did not do so, insurers have to supplement benchmark plans to include coverage of habilitative services.

What health plans are subject to the EHB requirements?

The ACA requires all nongrandfathered individual and small group market plans to cover the EHBs.² In addition, the EHBs must be covered for newly eligible populations³ in states that expand Medicaid eligibility pursuant to the ACA.

How are habilitative services defined?

The ACA did not define habilitative services. Neither did the federal regulations adopted to implement the ACA. The National Association of Insurance Commissioners (NAIC) adopted a definition for the consumer glossary of insurance terms created pursuant to the ACA (see chart below). AOTA has advocated for the wide adoption of NAIC’s definition. States were permitted to define habilitative services, and some did, often adopting a modified version of the NAIC definition. However, many states did not define the benefit, and in those cases, federal regulations require health plans subject to the EHB requirements to either cover habilitative services at parity with rehabilitative services,⁴ or cover habilitative services in some other manner and report the parameters of that coverage to the U.S. Department of Health & Human Services (HHS). In virtually all cases when types of therapies are explicitly mentioned in a state’s or health plan’s definition of habilitative services, occupational therapy (OT) services are included.

Examples of Definitions of Habilitative Services

NAIC	Habilitative Services: 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.
Arkansas	Services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition. Subject to permissible terms, conditions, exclusions and limitations, health benefit plans, when required to provide essential health benefits, shall provide coverage for physical, occupational and speech therapies, developmental services and durable medical equipment for developmental delay, developmental disability, developmental

	speech or language disorder, developmental coordination disorder and mixed developmental disorder.
California	Habilitative services means medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Examples of health care services that are not habilitative services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy.
Colorado	Habilitative services are services that help a person retain, learn, or improve skills and functioning for daily living that are offered in parity with, and in addition to, any rehabilitative services offered in Colorado's EHB benchmark plan. Parity in this context means of like type and substantially equivalent in scope, amount, and duration.
West Virginia	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. 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).

What coverage limits are placed on habilitative OT services?

Each state's benchmark plan establishes the quantitative limits for EHBs, such as the number of visits allowed. However, federal regulations allow health plans to substitute benefits within EHB categories unless a state prohibits or restricts such substitution, as long as the overall actuarial value of the benefits remains the same. Most states have not prohibited benefit substitution. Therefore, a health plan in those states could increase coverage of some services included in a state's benchmark plan in exchange for decreasing coverage of other services.⁵ In addition, each health plan can establish its own nonquantitative limits on benefits, such as preauthorization requirements. It should be noted that AOTA has identified plans that appear out of compliance with these regulatory requirements, because they neither cover the number of visits for therapy services that the benchmark plan does, nor have they seemed to engage in permissible benefit substitution.⁶

Examples of Coverage Limits for Habilitative OT Services

Colorado (Kaiser silver plan) ⁷	40 annual visits for OT for both rehabilitative and habilitative services (therapy services for the treatment of autism spectrum disorders do not count towards the visit limit)
Connecticut (Blue Cross silver plan)	40 annual visits combined for OT/PT/SLP for both rehabilitative and habilitative services (medically necessary early intervention services from birth to age 3 and therapy services for the treatment of autism spectrum disorders do not count towards the visit limit)
North Carolina (Blue Cross silver plan)	30 annual visits combined for OT/PT/chiropractic for both rehabilitative and habilitative services

What is the cost-sharing imposed on habilitative OT services?

The ACA does not standardize cost-sharing,⁸ although it does establish out-of-pocket maximums⁹ and prohibits annual and lifetime dollar limits on coverage of EHBs. The ACA also establishes *metal levels*¹⁰ for *qualified health plans* (QHPs), which are plans sold on states' health insurance marketplaces. Each metal level represents an overall value of the services paid for by the plan, which is directly related to a

plan's cost-sharing. Some states have elected to standardize cost-sharing for all QHPs. Even in those states, cost-sharing will vary for each metal level. In many states, multiple insurance carriers are offering a range of health plans with a variety of cost-sharing parameters.

Examples of Unsubsidized Cost-Sharing for Habilitative OT Services¹¹

California (silver plan – standardized cost-sharing across metal levels)	\$45 copay, not subject to deductible
Colorado (Kaiser silver plan)	\$30 copay in-network, not subject to deductible/not covered out-of-network
Connecticut (Blue Cross silver plan)	\$30 copay in-network, not subject to deductible/40% coinsurance out-of-network after \$6,000 individual or \$12,000 family deductible
North Carolina (Blue Cross silver plan)	\$50 copay in-network after \$3,500 individual or \$7,000 family deductible/60% coinsurance out-of-network after \$7,000 individual or \$14,000 family deductible

What actions can OT practitioners take to ensure the greatest benefit for the profession and its clients?

- Become familiar with your state's EHB benchmark coverage requirements, and in states that have defined habilitative services, your state's definition.¹²
- Share your knowledge about these new regulatory requirements for coverage of habilitative services with other OT practitioners, clients, and referral sources.
- Offer to provide assistance to clients who have experienced denials of coverage of habilitative services by helping them to determine if their plan is subject to the EHBs and whether their plan's coverage is in compliance with the state's benchmark, and if applicable, the state's definition of habilitative services.
- Encourage consumers to file appeals with insurers or complaints with the state health insurance marketplace or department of insurance in cases when health plans seem to be out of compliance. Also, communicate with your state OT association and AOTA about these instances to inform current and future advocacy efforts.
- Educate decision makers (e.g., your state legislators and insurance regulators) about the difference between rehabilitative and habilitative services and the fact that OT practitioners are skilled providers of both.
- Keep yourself informed and prepare to assist with grassroots advocacy efforts by becoming a member of your state OT association and AOTA, and by developing relationships with potential allies, such as speech therapists and organizations that advocate for people with disabilities.

Where can I find more information?

AOTA's website has a page dedicated to EHBs with information about habilitative services: <http://www.aota.org/Advocacy-Policy/Health-Care-Reform/Essential-Health-Benefits.aspx>

AOTA's Health Care Reform Blog contains the most recent information about implementation of the ACA: http://otconnections.aota.org/aota_blogs/b/healthcarereform/default.aspx

The Mar. 2014 issue of the American Journal of Occupational Therapy includes a Health Policy Perspectives column written about habilitative services: <http://ajot.aotapress.net/content/68/2/130.full>

AOTA Policy Staff can be contacted at stpd@aota.org.

¹ The 10 EHB categories are as follows: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

² Grandfathered plans are those that existed at the time the ACA became law and have since been modified in limited ways permitted under the law. In states that allowed the continuation of non-ACA-compliant nongrandfathered plans pursuant to federal administrative action in late 2013, some plans that don't meet the ACA's definition of grandfathered are effectively grandfathered through 2014, and perhaps longer if the federal government extends the deadline to fully comply. Individual market plans are those sold directly to individuals or families. Small group market plans are defined in most states as those available to employer groups with 50 or fewer eligible employees.

³ The ACA expanded Medicaid eligibility, but due to a 2012 U.S. Supreme Court ruling, the expansion is optional for states. As of 2014, about half the states have opted-in. In states that adopted the expansion, all citizens with incomes below 138% of the federal poverty level will be eligible. Because states had different eligibility criteria prior to expansion, the demographic characteristics of newly eligible individuals will vary from state to state.

⁴ HHS described parity in this context as follows: "a plan covering services such as PT, OT, and ST for rehabilitation must also cover those services in similar scope, amount, and duration for habilitation...." The ambiguity of this description has left open whether parity requires habilitative services to be covered *in addition to* rehabilitative services, or whether a plan can comply simply by covering habilitation *within* its rehabilitation benefit.

⁵ HHS described benefit substitution as follows: "a plan could offer coverage consistent with a benchmark plan offering up to 20 covered physical therapy visits and 10 covered occupational therapy visits by replacing them with up to 10 covered physical therapy visits and up to 20 covered occupational therapy visits, assuming actuarial equivalence...."

⁶ AOTA is working with state associations to advocate for enhanced enforcement of the regulatory requirements in these cases. Nonetheless, if and when practitioners identify apparently noncompliant plans, bringing that to the attention of AOTA policy staff would be appreciated.

⁷ Colorado is one of the states where not all plans appear to have adhered to the benchmark standard, but Kaiser plans do seem to comply with the standard.

⁸ Cost-sharing parameters include deductibles, coinsurance, and copays.

⁹ The ACA limits out-of-pocket spending for in-network EHBs to \$6,350 for an individual and \$12,700 for a family annually. Therefore, after beneficiaries of a plan have spent that amount in the form of any cost-sharing in a given plan year, the plan must cover 100% of the cost of services for the remainder of the plan year.

¹⁰ There are 4 metal levels: platinum (90%), gold (80%), silver (70%), and bronze (60%), each of which corresponds to the actuarial value in parentheses, or the percent of costs the plan is designed to cover on average. There is also a catastrophic plan available to certain cohorts, which has an actuarial value slightly lower than bronze plans.

¹¹ Cost-sharing for beneficiaries of silver plans could be lower if the beneficiaries qualify for cost-sharing reductions, which the ACA provides to individuals and families purchasing silver plans with incomes below 250% of the federal poverty level. Those cost-sharing reductions increase the actuarial value of silver plans to higher than 70%; for the lowest income beneficiaries, their plans essentially become more generous than platinum plans.

¹² AOTA has compiled a chart summarizing each state's benchmark coverage for rehabilitative and habilitative services, as well as states' definitions of habilitative services.