HEALTH POLICY PERSPECTIVES

What Is Essential in the Essential Health Benefits? And Will Occupational Therapy Benefit?

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- health planning
- insurance benefits
- Patient Protection and Affordable Care Act
- state health plans

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The Patient Protection and Affordable Care Act of 2010 (ACA; Pub. L. 111–148) holds great challenges and opportunities for occupational therapy. The law seeks to strengthen existing health insurance access, choice, cost, and coverage as well as expand coverage to an estimated 32 million uninsured Americans. At this writing, the U.S. Supreme Court is considering constitutional challenges to the law, with a decision expected in summer 2012.

One significant aspect of the law is the creation of a package of essential health benefits—10 categories of benefits that all private insurance companies participating in state-based health insurance purchasing exchanges must cover beginning in 2014:

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. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care (§1302(b)(1); 42 USC §18022(b)(1)).

Although many stakeholders would like to see strong federal direction for states on essential health benefits and other implementation questions to achieve consistency and fairness for consumers across the states, others criticize the ACA for being too federally directed:

Obamacare has increased government control of Americans' health care choices and limited consumer choice. The recent controversy over the preventive care benefit mandates are a good indication of things to come. The fundamental structure of Obamacare is based on centralizing the financing, delivery, and management of health care and is completely incompatible with patient-centered, market-based reforms. (Owcharenko & Nix, 2012)

It is becoming increasingly clear that strong federal guidance on the exchanges and essential health benefits will not be forthcoming. Significant flexibility will be left to the states to determine the scope and nature of coverage under these required categories and how to address other implementation issues. This article focuses on the implications and promise of the essential health benefits as the ACA is implemented.

Benchmarking

One process that will play a key role in determining coverage details for these categories is the statutory requirement for benchmarking. States must establish
a baseline of coverage, or a benchmark, of what is currently covered in existing health plans. Benchmarking is intended to simplify the process and ensure affordability; is an easy way for states to determine what benefits plans must cover; and avoids the political firestorm of developing benefit packages from scratch, allowing states to use existing insurance products as the parameters for their decisions. Benchmarking also serves to ensure affordability and help make certain that coverage expansions do not shift premiums beyond the point of accessibility for consumers.

Benchmarking has been used for years by both private and public payers to help set an acceptable scope of health plan coverage. For example, many states use private plans as benchmarks to inform the benefits made available under Medicaid and Children’s Health Insurance Program plans.

The U.S. Department of Health and Human Services (HHS) has issued guidance that would require states to choose one of the following health insurance plans as the official state benchmark plan:

- One of the three largest small-group plans in the state by enrollment
- One of the three largest state employee health plans by enrollment
- One of the three largest federal employee health plan options by enrollment
- The largest HMO plan offered in the state’s commercial market by enrollment.

If a state does not choose a benchmark plan, the default benchmark plan would be the largest small-group plan (HHS, 2011). This approach provides significant flexibility to the states but is problematic for the practice of occupational therapy because so much variation exists for coverage of therapy under these plans both within and across the states.

Under the department’s proposed approach, when a state chooses a benchmark plan, that plan’s limits on specific benefits would apply. However, it is not clear that the limits on specific benefits are substantially similar among the Federal Employees Health Benefits Program (FEHBP), small employer plans, and state employee plans. Substantial review and oversight is therefore needed to ensure that no benchmark plans—in particular, small employer plans—impose limits that are inconsistent with medical practice or that undermine the ACA’s important consumer protections. (Spiro, 2012)

One benchmark available to all states (as one of the “three largest federal employee health plan options by enrollment”) is the FEHBP. This program is often touted as a model for health care reform, but the benefits are widely variable, because the federal Office of Personnel Management (OPM) establishes contracts with different insurance companies to offer plans to federal employees, and the guidelines for what needs to be included in the offerings stem from very weak legislative language:

1) Service Benefit Plan. (A) Hospital benefits. (B) Surgical benefits. (C) In-hospital medical benefits. (D) Ambulatory patient benefits. (E) Supplemental benefits. (F) Obstetrical benefits.
2) Indemnity Benefit Plan. (A) Hospital care. (B) Surgical care and treatment. (C) Medical care and treatment. (D) Obstetrical benefits. (E) Prescribed drugs, medicines, and prosthetic devices. (F) Other medical supplies and services. (ACA, 5 USC § 8904(a))

With this broad language, plans can vary widely. Looking at an overview of the various plans, occupational therapy is likely covered in every FEHBP plan, as it is in most private insurance plans. This trend in private insurance and FEHBP can be traced in some ways to the American Occupational Therapy Association’s (AOTA’s) successful addition of occupational therapy as a freestanding Medicare benefit in 1987.

At this point, the benchmark plan expected to be chosen by many states is the largest small-group plan in the state. Although occupational therapy is widely covered under current private insurance plans, we anticipate instances in which occupational therapy may not be a covered benefit under a chosen benchmark plan. Targeted advocacy at the federal and state levels is going to continue to be critical in taking advantage of all possible opportunities for increased coverage of occupational therapy.

**Balance**

Qualified insurance plans participating in the exchanges must strike an appropriate balance of the 10 essential health benefit categories. This statutory requirement also presents an opportunity to advocate for expanded coverage of occupational therapy in several of the categories (see below).

In addition, the 10 essential health benefit categories listed in the statute must be covered by all qualified plans participating in the exchanges, even if the benchmark plan does not include existing coverage for one (or more) of the essential categories. The coverage gaps most likely to arise are the categories of mental health and substance abuse and habilitative services as well as pediatric dental care.

If the benchmark plan inadequately covers mental health or habilitative services, states must supplement coverage of those essential benefits to meet the balance requirement. The danger here is that the additional coverage will not simply be added on to the plan, but in fact other benefits will be proportionately reduced to ensure that the actuarial or total value of the plan remains equal to the benchmark plan. These processes for determining coverage together chart an advocacy path forward for the profession: benchmarking, balancing, and ensuring statutorily required coverage in each category present challenges and opportunities for AOTA, the affiliated state associations, and the profession of occupational therapy in the next phase of health reform.

Habilitation and mental health benefits are particularly threatened by the benchmark process. In comments to the HHS, the National Alliance on Mental Illness (NAMI; 2012) stated:

Of particular concern to NAMI are some of the options available to states for selecting a benchmark plan for Essential Health Benefits.
While adherence to parity will be a critical feature, it is worth noting that in many states, the largest small employer plan may still contain gaps in coverage that parity cannot resolve.

NAMI went on to emphasize the requirement to provide mental health coverage created by inclusion of that category in the list of essential benefits, and habilitation proponents can fall back on that category’s inclusion as well.

States will thus have multiple ways in which they may approach the development of their own required benefit packages. Each category can be framed broadly or narrowly. Indeed, the ACA itself requires that HHS obtain information and opinions from multiple sources about how to define these benefits.

How the Pieces Came Together

Section 1001(5) of the ACA directs HHS, the U.S. Department of Labor, and the U.S. Department of the Treasury to consult with the National Association of Insurance Commissioners (NAIC) to develop a summary of benefits and coverage (SBC) template as well as a uniform glossary for use by individual and group health plans. As part of this required consultation, the NAIC convened a consumer information subgroup, which drafted documents, held open meetings, and hosted public conference calls. AOTA participated closely in the process and filed formal comments in response to NAIC draft documents.

The Institute of Medicine also held several hearings on the issue to prepare the report it was mandated to prepare. AOTA (2010) signed on to testimony with the Consortium for Citizens with Disabilities (2010) to testify with the report it was mandated to prepare. AOTA participated closely in the process and filed formal comments in response to NAIC draft documents.

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With all this input, the subregulatory, preliminary guidance on this issue released thus far has been thin in details (HHS, 2011).

Defining the Essential Health Benefits

Even in light of the limited federal guidance, states will have to look at the benefit definitions used in existing insurance. Information follows on a selection of categories that will have the greatest impact on the occupational therapy profession (see also the Appendix).

Hospitalization

The hospitalization category requires coverage of inpatient hospital services. Under current private insurance coverage, most services are bundled together and billed to the consumer on the basis of predetermined cost sharing for covered services received as part of the inpatient stay. Occupational therapy, when medically necessary, is currently a covered service for inpatient care under private insurance. AOTA is working to ensure that continued access to occupational therapy will be available under hospitalization as well as the new rehabilitative and habilitative services and devices category that is seen to most directly relate to occupational therapy services.

Prescription Drugs

The inclusion of the prescription drugs category is critical to the health and quality of life for millions of beneficiaries. Increases in prescription drug costs outpace other categories of health care spending and are projected to exceed the growth rates for hospital care and other professional services through 2019 (Truffer et al., 2010). Medications such as those to address pain, high blood pressure, depression, and schizophrenia are truly essential to quality comprehensive health care. Although the details of coverage remain undefined, the coverage criteria and formulary are expected to be developed through the benchmarking process, as with the other categories.

Rehabilitative and Habilitative Services and Devices

Of the 10 categories of required essential benefits under the ACA, the rehabilitative and habilitative services and devices category is the most critical to occupational therapy. The inclusion of this category in the law was a direct result of work done by AOTA with the Senate Finance Committee to ensure that there would be an appropriate focus on these issues in the law. Initially, occupational therapy was likely to be covered only under the broad categories of hospital and outpatient services, but AOTA advocacy secured the inclusion of a more focused and protective category.

This was a significant victory, but it was only the first of several steps necessary to make certain that the opportunities for the profession created by the legislation are maintained throughout...
the implementation and regulatory processes. A few competing factors related to how the categories will be defined make the ongoing work related to fine-tuning and establishing the essential health benefits both a challenge and an opportunity for occupational therapy.

Although the list of 10 categories is now statutorily mandated, much about how it will be implemented remains unclear: “There are significant unknowns in the ACA as well. One of these unknowns is what will be covered given that the mandate is to reduce cost” (Ulicny, 2012).

One indicator of how this benefit category will be defined is the glossary of medical terms developed by NAIC (2011). AOTA participated in the definition development process and focused heavily on rehabilitation and habilitation, and it was successful in influencing those definitions so that both explicitly list occupational therapy as an example of the covered services under each term.

**Habilitation Services**

Health care services that help a person keep, learn, or improve skills and functioning for daily living are habilitation 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 services, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

**Rehabilitation Services**

Rehabilitation services are health care services that help a person keep, regain, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings. (NAIC, 2011)

Note that the definitions of both habilitation and rehabilitation services reference maintenance of function (“keep...skills”), language that indicates flexibility as to how the benefit may be used to meet beneficiary needs.

This glossary was designed by NAIC to inform consumers of what services and benefits they can expect related to these terms, and the glossary was approved by HHS. The explicit inclusion of occupational therapy in these sanctioned definitions aids greatly in ongoing and future advocacy efforts (NAIC, 2011; U.S. Departments of Labor, Treasury, and Health and Human Services, 2012).

Taken together, the ACA principles of benchmarking and balancing also provide a sense of what will be covered under exchange plans. It is fairly clear at this point that there will be limits to essential benefits within each category. Specifically, it is expected that visit limits will exist for the rehabilitative and habilitative services and devices category. What is not known are the exact details about the nature of those limits and how the benefit will be designed.

While AOTA continues to work with Congress and federal agencies in search of improved federal guidance, it is becoming clear that significant decisions will be left to the states. AOTA is working closely with affiliated state associations to prepare them to take up the advocacy effort at the state level. AOTA is using its experience and advocacy expertise to help state associations successfully take advantage of the opportunities created by the inclusion of rehabilitative and habilitative services and devices in federal law as it pertains to health care reform.

**Mental Health and Substance Use Disorder Services, Including Behavioral Health Treatment**

Several provisions in the ACA may have a major impact on mental health, substance use, and behavioral health services, notably the inclusion of these services as one of the 10 required categories of essential health benefits.

It is estimated that 3.7 million more people with severe mental illnesses (SMIs) will gain access to mental health care (Mechanic, 2012). This access will be achieved in part by the expansion of Medicaid provided for by the ACA. Expanding Medicaid to all individuals at or below 133% of the Federal Poverty Level will allow adults with mental illness to be eligible for Medicaid on the basis of their income, rather than on the basis of additional eligibility criteria such as receiving Supplemental Security Income (ACA, §2001). Other coverage expansions are likely to stem from the individual mandate and income-based subsidies for individuals and families to purchase private insurance within the exchanges.

Additional improvements in access to mental health services could be accomplished through the state health insurance exchange programs (Garfield, Zuvekas, Lave, & Donohue, 2011). However, in the absence of further regulation or meaningful guidance by HHS, states that choose benchmark plans with limited benefits may cover a limited range of mental health services such as hospitalization stays, limited clinic visits, and medications. More comprehensive community services such as rehabilitation services may not be covered (Bazelon Center for Mental Health Law, 2010).

Although coverage for substance abuse services may be expanded, the form those services take under the ACA may change significantly. The coordinated and integrated health care approach encouraged under the ACA may lead to opportunities for early identification and treatment and also greater “medicalization” of substance abuse interventions by more primary care providers with limited substance abuse specialization (Buck, 2011).

The ACA also requires that all benchmark and benchmark-equivalent state Medicaid plans must comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (part of Pub. L. 110–343). Moreover, the previous requirements are extended to ensure that all plans cover mental health and substance abuse services (Bazelon Center for Mental Health Law, 2010). Note, however, that small businesses (50 or fewer employees) continue to have an exemption (Sarata, 2011).

People with SMI and/or substance abuse disorders who have previously been denied insurance coverage because of their...
illness should benefit from the ACA’s prohibition on denial of coverage on the basis of preexisting conditions (Mechanic, 2012). Adults with SMI and substance abuse disorders may also benefit from the ACA’s promotion of more efficient coordination of health care through the development of medical or health homes and accountable care organizations and coverage for other care coordination services that have not been traditionally covered. This promotion of coordinated care may help facilitate more comprehensive coordination of mental health care and substance abuse services as well as better utilization of other health care services. For adults with SMI, the rising rates of metabolic syndrome and existing difficulties in accessing primary health care make any improvements in coordination and integration of mental health and primary health care resulting from ACA implementation increasingly critical.

Children and adults with autism spectrum disorders (ASDs) should benefit from the ACA in several ways. The ACA’s prohibition on lifetime caps, annual limits, and denial of coverage on the basis of preexisting conditions have been in place since 2010. Still, it is estimated that 2.8% of children with ASD are uninsured, and the rate for adults is considered to be much higher. Expanding coverage will occur through a variety of provisions under the ACA. First, young adults up to age 26 are eligible for coverage under their parents’ insurance plan. Second, the insurance industry’s practice of ending coverage for individuals with high claim rates by identifying errors in the original application for insurance, a practice called rescission, is prohibited by the ACA. Third, states with insurance mandates requiring coverage of autism services will be included as mandates in that state’s benchmark plans.

The definition and coverage of habilitation services by the states’ benchmark plans, as well as any further regulation or guidance by HHS, will be very important to individuals with ASD, their families, and service providers such as occupational therapy practitioners. The definition and administration of medical necessity standards, including evidence-based materials, will also play an important role in the extent to which ASD services are covered (Association of Maternal and Child Health Programs, 2012).

Conclusion

The ways in which the essential health benefits categories contained in the ACA are interpreted and defined are extremely important for the practice of occupational therapy going forward. HHS has made clear that it intends to provide states with a great deal of flexibility in designing their benefit packages. Therefore, providers, consumers, and other advocates of the profession must work together to ensure that the opportunities for occupational therapy practitioners and patients under the ACA are maximized and that the practice is fully recognized in each state’s benchmarked and balanced essential health benefits package.

AOTA’s advocacy efforts during the legislative phase of the ACA have been successful, but the implementation phase presents several opportunities and challenges. Our work, particularly in the area of essential health benefits, is far from done. ▲

References


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## Appendix. Definitions of Key Medical Terms for Health Care Reform

<table>
<thead>
<tr>
<th>Medical Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs, crutches or blood testing strips for patients with diabetes.</td>
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<tr>
<td>Habilitation Services</td>
<td>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.</td>
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<tr>
<td>Hospitalization</td>
<td>Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.</td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.</td>
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<tr>
<td>Preauthorization</td>
<td>A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost.</td>
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<tr>
<td>Primary Care Provider</td>
<td>A physician (MD, medical doctor, or DO, doctor of osteopathic medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.</td>
</tr>
<tr>
<td>Provider</td>
<td>A physician (MD, medical doctor, or DO, doctor of osteopathic medicine), health care professional or health care facility licensed, certified or accredited as required by state law.</td>
</tr>
<tr>
<td>Rehabilitation Services</td>
<td>Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech–language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.</td>
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<tr>
<td>Skilled Nursing Care</td>
<td>Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.</td>
</tr>
<tr>
<td>Specialist</td>
<td>A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A nonphysician specialist is a provider who has more training in a specific area of health care.</td>
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