

# Habilitative Services: An Essential Health Benefit and an Opportunity for Occupational Therapy Practitioners and Consumers

## MeSH TERMS

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Most provisions of the Patient Protection and Affordable Care Act of 2010 (ACA; Pub. L. 111–148) are now in effect. The regulatory environment for health insurance has changed dramatically as a result. One of the most significant provisions of the ACA for the profession of occupational therapy is the requirement that certain services be covered for most of the newly insured population. The law identifies these services as *essential health benefits* (EHBs).

One of the 10 categories of EHBs includes *habilitative services*, which itself presents a unique opportunity. Most private health insurance policies have not identified habilitative services as a covered benefit in the past, but beginning this year, millions of newly insured people will have access to these services as a result of the EHB requirements. In most cases, it is expected that occupational therapy practitioners will be covered providers under plans' habilitation benefits. This article describes the EHB implementation process with a focus on the habilitation benefit and explores the related implications for occupational therapy practitioners and consumers.

## ACA Statutory Requirements for the Essential Health Benefits

The language in the ACA establishing the EHB requirements is only about two pages long. It specifies that the U.S. Department of Health and Human Services (HHS) shall define the EHBs and that

they must include at least the following 10 categories of benefits:

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)).

The ACA also directs HHS to “ensure that the scope of the essential health benefits . . . is equal to the scope of benefits provided under a typical employer plan” (§ 1302(b)(2)). In addition, the law indicates criteria that HHS must consider when defining the EHBs, including the following: an “appropriate balance among the [benefit] categories,” a nondiscriminatory benefit design, and consideration of the diverse needs of the population (§ 1302(b)(4)). The ACA also stipulates that the EHB requirements apply to all health plans sold to individuals and small groups, as well as the Medicaid expansion population and other benchmark coverage<sup>1</sup> (Center for Consumer Information and Insurance Oversight [CCIIO], 2011).

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Congress's intent when passing legislation is often a matter for debate; however, some level of consensus exists as to what Congress's purpose was in including the EHB requirements in the ACA. A bipartisan panel of congressional staff testified before an Institute of Medicine (IOM) committee that the intent was generally to ensure that both a minimum and a maximum level of benefits would be offered by plans subject to the EHB requirements (IOM, 2011b). The minimum constraint was established by the specification of the 10 categories of benefits that must be covered, and the maximum constraint was established by the requirement that the EHB package reflect the benefits included in a typical employer plan.

By creating these guidelines for HHS, presumably Congress intended for a balance to exist between comprehensiveness and cost of coverage. As an IOM report stated, "If the package of benefits is too narrow, health insurance might be meaningless; if it is too broad, insurance might become too expensive" (IOM, 2011a, p. xi). It also seems fair to assume that Congress intended that the EHB would provide a consistent package of benefits (IOM, 2011a) so that consumers could compare qualified health plans on the basis of price, network adequacy, and quality ratings instead of the fine print governing coverage and exclusions. Finally, it seems reasonable to deduce, as an IOM committee did, that "Congress sought to remediate what it saw as shortcomings in current coverage by pulling out certain categories to ensure that they were covered, such as . . . habilitative services" (IOM, 2011a, p. 61).

The highly general nature of the ACA's requirements related to the EHBs, and the assignment of the development of detailed requirements to HHS, foretold the lengthy regulatory process that was

forthcoming. Indeed, it took HHS almost 3 years after passage of the ACA in 2010 to develop final regulations governing EHB implementation, and the expectation remains that HHS will revisit and revise EHB regulations in the near future.

The American Occupational Therapy Association's (AOTA's) congressional lobbying efforts were instrumental in obtaining the inclusion of habilitative services in the ACA's EHB requirements to reduce the likelihood that insurance carriers could continue to exclude habilitative occupational therapy services from coverage under their health plans. Although the ultimate effect of the inclusion of that language still is not fully known, having it in the law was a critical first step to improving access to habilitative occupational therapy services. Indeed, as a former congressional staffer mentioned in testimony to an IOM committee, although most of the EHB categories remained static during congressional debate on the ACA, the habilitation benefit was an important addition later in the process (IOM, 2011b).

### Institute of Medicine's Committee on Defining an Essential Health Benefits Package

Because the statutory EHB language contains a certain tension between competing goals (i.e., comprehensiveness vs. affordability), and because HHS was tasked with resolving and building a regulatory framework based on the statute, HHS commissioned the IOM to provide recommendations as to how it should proceed. The IOM formed the Committee on Defining and Revising an Essential Health Benefits Package for Qualified Health Plans (referred to here as "the Committee"), and its work began in late 2010 with an opportunity for the public to submit comments online. In addition, the Committee invited experts and stakeholders to present at two public workshops in early 2011 (IOM, 2011b). Ultimately, the Committee developed and disseminated two reports summarizing its activities and recommendations.

Although the Committee evaluated myriad topics, not surprisingly it spent

a substantial amount of time focused on the question of how to develop an EHB package that balances generosity of health plan benefits with affordable premiums for those same plans (IOM, 2011a). In particular, it sought to identify what should be considered a *typical employer plan* because that term was a critical element of the statute's constraint on the generosity of the EHBs. The Committee considered opinions that ran the gamut in addressing its charge. Of note, one insurance industry expert observed that even the health plans typically offered by large employers, which are usually more comprehensive than those of small employers, do not typically cover habilitative services (IOM, 2011b). This statement was indicative of a question that came up again and again during development of EHB regulations—that is, how to define coverage of habilitative services, an EHB that was almost completely absent from the existing market. In the end, the Committee decided for the purpose of the EHBs that a *typical employer plan* should be based on a small employer plan (IOM, 2011a).

Because certain EHB categories presented unique challenges for regulators, the Committee explored two benefit categories in greater detail than others. One of those was *rehabilitative and habilitative services and devices* (IOM, 2011b), the category of greatest importance to occupational therapy practitioners and consumers. One factor in determining congressional intent, although not a definitive one, was the floor statements of members of Congress. The most relevant statement on this subject came from Representative Bill Pascrell (D-NJ), cochair of the Congressional Brain Injury Task Force, who stated,

The term *rehabilitative and habilitative services* includes items and services used to restore functional capacity, minimize limitations on physical and cognitive functions, and maintain or prevent deterioration of functioning as a result of an illness, injury, disorder or other health condition. Such services also include training of individuals with mental and physical disabilities to enhance

<sup>1</sup>The ACA does exempt certain plans from the EHB requirements that maintain grandfathered status. The law defines *small groups* as those with 100 or fewer persons; however, it permits states to define the small group market as 50 or fewer. In addition to the Medicaid expansion population, benchmark coverage for which the EHB requirements apply includes basic health plans, another construct of the ACA that states may create to bridge coverage between Medicaid and the exchanges (Kaiser Family Foundation, 2013).

functional development. (IOM, 2011b, p. 77, italics added)

Peter Thomas, on behalf of the Consortium for Citizens with Disabilities (CCD), a coalition of which AOTA is a member, testified before the Committee and provided his own definitions for rehabilitation and habilitation.<sup>2</sup> Thomas made some important points, including the following: that the rehabilitation and habilitation benefit category should include services to maintain and prevent the deterioration of function, that rehabilitation and habilitation are distinct benefits, that people with disabilities in need of these services have greater than average needs, and that trying to identify typical employer coverage of these benefits may be difficult and inadequate (IOM, 2011b).

Other presenters also contributed valuable statements to the record. Gary Ulicny, a hospital executive and president of the American Congress of Rehabilitation Medicine, pointed out that patients needing rehabilitative and habilitative services present with a wide variety of needs and are not served well by benefits with arbitrary limitations. Marty Ford, also a representative of CCD, mentioned the federal Medicaid definition of habilitative services<sup>3</sup>—that habilitative services include occupational therapy and other services that could help prevent the need for more costly interventions, and she aptly described how rehabilitative and habilitative services are distinct, as well as the arbitrary basis under which coverage of habilitative

services has commonly been denied by insurers in the past. Ford also noted that a number of states have adopted laws that require coverage of certain habilitative services, in some cases specifically mentioning occupational therapy as a habilitative service (IOM, 2011b).

Andrew Racine, testifying on behalf of the American Academy of Pediatrics, cautioned that “health plans have denied habilitative services on the grounds that [the effectiveness of] occupational therapy for children with cerebral palsy is not supported by evidence” (IOM, 2011b, p. 95). Racine was not supporting that position about the efficacy of occupational therapy. Instead, he made that statement in the context of pointing out that large-scale randomized controlled trials often are not available to evaluate services for children, and in the absence of such evidence, insurance companies should rely on “observational studies, professional standards of care, and the consensus of pediatric experts” instead of just denying coverage (IOM, 2011b).

AOTA submitted written comments to the Committee in December 2010. In reference to habilitation and rehabilitation, AOTA’s comments asserted that “medical necessity criteria should allow for coverage to: (1) develop skills or functioning; (2) maintain skills or functioning; (3) restore skills or functioning; and (4) prevent the loss of skills or functioning” (AOTA, 2010, p. 9).

Not all the testimony received was supportive of comprehensive coverage of habilitative services. For example, Carolyn Ingram of the Center for Health Care Strategies and Cindy Ehnes of the California Department of Managed Health Care expressed concerns that extensive coverage of habilitative services could result in unacceptably high increases in costs (IOM, 2011b). As will become apparent later in this article, all of the testimony raised issues that were discussed extensively by stakeholders and decision makers in the ensuing 2 years as EHB regulations were developed.

Another issue the Committee considered was the extent to which states should be given flexibility to develop their

own EHB requirements. The expectation of the Committee was that HHS would interpret the EHB statute as requiring the development of a national EHB package and perhaps would allow states some flexibility to diverge from that national standard. In fact, the Committee recommended that HHS do just that (IOM, 2011a). In the end, HHS gave states much more flexibility than the Committee probably imagined. Although the Committee did recommend that states operating their own health insurance exchanges be given leeway to develop their own EHB packages, provided they meet certain standards (IOM, 2011a), the flexibility granted states by HHS’s final regulations was even more deferential.

Also of importance as the EHB regulations evolve, the Committee recommended requiring a sufficiently detailed description of benefits to ensure that consumers are protected from exclusions carriers may try to obscure in the fine print of coverage documents. It also suggested that a framework be developed to gather and analyze data about the specific effects of EHB implementation, including any problems consumers may have obtaining benefits (IOM, 2011a).

In addition, the Committee explored what various employer coverage included to determine which benefits listed in the ACA may have to be added to that coverage to meet the statutory requirements. Although one report the Committee cited indicated that occupational therapy services are covered by 92% of employer plans, not surprisingly habilitative services were typically not covered by existing plans unless a state had enacted a benefit mandate, and even then, the benefit usually included condition- or age-based limitations (or both). As a result, the Committee wrestled with how the EHB requirement for coverage of habilitation should be defined. In doing so, it considered the difficulty of establishing boundaries between medical care and social and educational services. It explored the possibility of using Medicaid as a model but was concerned that Medicaid coverage determinations were too dissimilar to those of a typical employer plan.

<sup>2</sup>“Rehabilitation therapies are provided from a continuum of accredited programs and treatment settings based on the intensity of service that helps *improve, maintain, and prevent deterioration* of function (settings include inpatient rehabilitation hospitals, long-term acute care hospitals, skilled nursing facilities [SNFs], long-term residential transitional rehabilitation programs, outpatient therapy, home care, and community-based programs). Habilitation therapies are services or supports that enable a person with a significant disability to *acquire, retain, improve or prevent deterioration* of activities of daily living (ADLs) or instrumental activities of daily living (IADLs) over time” (IOM, 2011b, p. 77).

<sup>3</sup>“Medicaid defines habilitative services as those services designed to assist participants in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings” (IOM, 2011b, p. 80).

Ultimately, the Committee did not make a recommendation about how habilitation should be dealt with, aside from acknowledging that some of the EHBs, such as habilitation, are not typically found in employer plans but still must be incorporated into the EHB package (IOM, 2011a). In sum, although many of the recommendations the Committee made did not make it into HHS's final regulations, the Committee's reports provide some useful insights that may support future advocacy efforts to improve the EHB regulations.

## National Association of Insurance Commissioners Summary of Benefits and Coverage Glossary

The ACA directed several federal agencies (i.e., HHS and the U.S. Departments of Labor and Treasury) to develop standards for the creation of a summary of benefits and coverage (SBC), which was to include a glossary defining terms often used to describe health insurance. The purpose was to "help consumers understand and compare the terms of coverage and the extent of medical benefits" (U.S. Department of the Treasury, U.S. Department of Labor, & HHS, 2012, p. 8678) in health insurance policies. In doing this, the agencies were required to consult with the National Association of Insurance Commissioners (NAIC). NAIC developed recommendations through a public deliberative process, and the agencies largely adopted these recommendations in their final regulations. Among those recommendations were to include the following definitions of rehabilitation and habilitation services in the SBC glossary (U.S. Department of the Treasury et al., 2012):

Rehabilitation Services—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.

Habilitation 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. (National Association of Insurance Commissioners, 2011)

AOTA advocated with the NAIC to ensure that the definitions of rehabilitation and habilitation both included explicit mention of occupational therapy. The adoption of these definitions in federal regulations has proven useful in support of advocacy efforts related to the EHBs. AOTA and allied stakeholders have often cited the NAIC definition of habilitation as a model that states or the federal government should adopt as the basis to define coverage requirements for insurers, as opposed to merely as a generic description of coverage for consumers.

## HHS Guidance and Regulations

### *Essential Health Benefits Bulletin*

After the release of the IOM Committee's final report in October 2011, HHS conducted 10 listening sessions throughout the country, during which members of the public communicated their views regarding the EHBs to HHS officials. The last of those sessions was held in November 2011 (Bagley & Levy, 2013). AOTA policy staff developed a template for comments and worked with state occupational therapy leaders to identify members to provide testimony based on the AOTA model in New York City, Atlanta, San Francisco, Seattle, and Denver. The testimony provided at these hearings by occupational therapy practitioners endorsed the NAIC definitions for rehabilitation and habilitation and went on to state,

Clearly the rehabilitation and habilitation benefits required under the ACA must include full coverage of occupational therapy. . . It is essential

to the effectiveness and quality of a reformed health care system to ensure that beneficiaries receive comprehensive care from acute to post-acute and from prevention to rehabilitation. Occupational therapy is a key part of the health care solution because it is a critical link between acute, post-acute, rehabilitative and preventive care. (AOTA, 2011, p. 2).

A few weeks later, HHS released its first guidance document, titled *Essential Health Benefits Bulletin* (referred to hereafter as "the *Bulletin*"), describing a possible implementation framework that would later be established in formal regulations. That framework diverged substantially from the IOM Committee's recommendations. First, the *Bulletin* summarized the information on which HHS was basing its proposed regulatory approach. It acknowledged the conflict inherent in the EHB requirements in terms of stakeholder views—that is, advocates for consumers and providers generally wanted the emphasis to be on comprehensiveness, whereas advocates for employers and insurers generally wanted flexibility in the name of affordability. The *Bulletin* also surveyed the resources that had been developed to inform its decision making to that point, in particular the IOM Committee reports, a survey of employer-sponsored insurance conducted by the U.S. Department of Labor (2011), and various other data sets HHS had collected, including input it had received at the listening sessions.

The conclusions HHS drew from this information include the following: Most existing employer-sponsored health plans cover services falling into each of the 10 EHB categories, plans differ primarily in terms of cost-sharing design, occupational therapy is consistently covered by a range of plans in different markets, and some EHBs (e.g., habilitative services) are inconsistently covered (CCIIO, 2011).

The *Bulletin* did explore those benefit categories it determined were inconsistently covered in greater detail, including habilitative services. HHS revealed an apparent conflict in its thinking on this issue. The *Bulletin* states, "There is no generally accepted definition of habilitative

services among health plans, and in general, health insurance plans do not identify habilitative services as a distinct group of services” (CCIIO, 2011, p. 6). Confusingly, it later indicates

that about 70 percent of small group products offer at least limited coverage of habilitative services. Physical therapy (PT), occupational therapy (OT), and speech therapy (ST) for habilitative purposes may be covered under the rehabilitation benefit of health insurance plans. (CCIIO, 2011, p. 6)

Note that HHS was drawing the conclusion about coverage of habilitative services in the small-group market on the basis of a limited, and possibly unrepresentative, data set. Nonetheless, the apparent conflict in terms of the information HHS was relying on, and the conclusions it drew from that information, is important to recognize in order to understand the regulatory framework it ultimately developed.

The *Bulletin* reiterated the EHB statutory requirements, mentioned the issue of balancing comprehensiveness with affordability, and implied that it was basing its proposed regulatory approach on the IOM Committee’s recommendations. However, HHS chose to go far beyond IOM’s recommendations in terms of the degree it intended to involve states in EHB implementation and the flexibility states would be given. HHS chose benchmarking as the foundation of its EHB regulatory approach. In other words, states would be required to select an existing health plan to serve as the model of covered services and limitations, called a *benchmark plan*, for the EHBs in that state. HHS was familiar with this process, which was used for the Children’s Health Insurance Program and for certain Medicaid populations (CCIIO, 2011). It likely was appealing for that reason because HHS was tasked with implementing many provisions of the ACA within a limited timeframe.

The specific benchmark approach the *Bulletin* described included several elements. HHS identified 10 benchmark options in each state, to include the three largest small-group plans, the three largest state employee plans, the three largest federal employee plans, and the largest

commercial health maintenance organization. Each state had the option to choose one of those plans as its benchmark on the basis of those plans as they existed in 2012. An October 1, 2012, deadline was indicated, after which states that had not chosen a benchmark would default to have the largest small-group plan serve as their state’s model.<sup>4</sup> Benchmark plans that did not include services for all EHB categories would have to be supplemented to cover all required benefits by modeling the benefits from other benchmark options. Starting in 2014, when the EHB requirements took effect, health plans subject to the EHB requirements would be required to have benefit designs that were “substantially equal” to the benchmark plan in a given state, as supplemented to cover all EHB categories (CCIIO, 2011).

HHS acknowledged that some benefits, such as habilitative services, might not be included in any benchmark plan options and would need an alternative method to supplement them. The *Bulletin* addressed this issue by indicating that HHS was considering different options to define coverage requirements for habilitative services (CCIIO, 2011). It mentioned the definition NAIC had developed, as well as the Medicaid definition, and noted that both of those definitions included coverage of maintenance of function. HHS requested comment on whether to include maintenance of function in the definition of coverage of habilitation, and AOTA submitted a letter strongly supporting that approach. The *Bulletin* also identified the following two specific options it was considering in the event a benchmark plan did not provide coverage of habilitative services:

Habilitative services would be offered at parity with rehabilitative services—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; or [a]s a transitional approach, plans would decide which habilitative services to cover, and would report on that coverage to HHS. HHS would evaluate those decisions, and further define habil-

itative services in the future (CCIIO, 2011, p. 11).

Note that the *Bulletin* described HHS’s proposed regulatory approach as a transitional approach applying only in 2014 and 2015, to be revisited for 2016 and beyond (CCIIO, 2011).

The last significant component of the regulatory approach described in the *Bulletin* suggested that HHS was considering permitting health plans to have flexibility that would allow them to substitute benefits within, and possibly between, EHB benefit categories. In other words, plans might be permitted to reduce coverage for some benefits in exchange for increasing coverage of others, so long as the actuarial value of the benefits in total stayed the same (CCIIO, 2011). AOTA expressed concern with this approach in its comments to HHS, noting that it might lead to arbitrary or absolute limits that deny consumers access to coverage.

The *Bulletin*’s proposed regulatory approach included elements that alternatively were cause for optimism and concern. The data HHS relied on indicated broad coverage of occupational therapy services in general, which suggested that a benchmark approach would be sure to include them in most cases. In addition, HHS expressed interest in including maintenance of function therapy within the definition of coverage of habilitative services. However, the possibility that insurers might be permitted to define habilitation coverage and to substitute EHB benefits within or between categories caused concern that the very protections the EHB requirements were intended to provide might be undermined.

Especially in retrospect, the *Bulletin*’s proposed regulatory approach was not surprising. In particular, it reduced the implementation burden on HHS to some degree. By shifting the responsibility to states to develop their own EHB packages, HHS avoided having to create a national standard. Because HHS was responsible for implementing a huge array of provisions of the ACA, it was logical for it to seek ways to reduce that burden. It also provided the opportunity to collect data from a variety

<sup>4</sup>Ultimately, HHS ignored this deadline.

of models to inform future revisions. The benchmark approach as described in the *Bulletin* also addressed the conflicting statutory demands of covering the 10 categories of benefits while maintaining a scope of benefits equal to a typical employer plan. Finally, a fairly obscure, but nonetheless significant, issue was temporarily resolved by this approach. The ACA requires states to defray the cost of state-specific insurance benefit mandates that exceed the requirements of the EHB (HHS, 2013). By allowing states to select a benchmark plan subject to, and therefore inclusive of, its insurance benefit mandates, the benchmark approach postponed the need for HHS to calculate and collect payments from states.

### *Essential Health Benefits Bulletin Frequently Asked Questions*

Soon after the public comment deadline for the *Bulletin*, HHS released a document titled *Frequently Asked Questions on Essential Health Benefits Bulletin* (CMS, 2012). The document addressed several important issues. It clarified that whatever approach HHS ultimately took to address the potential absence of coverage of habilitative services in a state's benchmark plan, "a plan would be required to offer at least some habilitative benefit" (CMS, 2012, p. 2). The document also provided an example of how HHS envisioned benefit substitution working:

For example, 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 and the other criteria are met. (CMS, 2012, p. 3)

Finally, the document made clear that states may not design unique EHB packages but must adhere to the approach outlined in the *Bulletin* of selecting a benchmark plan (CMS, 2012).

### *Data Collection Rule*

In June 2012, HHS released its first formal proposed rule related to the EHBs. It was

limited in scope, however, and focused primarily on establishing small-group health plan data collection requirements to aid insurance carriers in the development of products that comply with the EHB requirements (HHS, 2012). AOTA submitted comments requesting that information be collected from sources other than small-group plans (e.g., from Medicaid) to increase the likelihood that data were captured that would aid in the definition of benefits that were often excluded from the small-group market, such as habilitation. When the final rule was issued the following month, HHS did not adopt AOTA's position. Instead, it implied that the data collection was primarily for the purpose of defining the benefits in default benchmark plans, which are small-group market plans (HHS, 2012). However, this final rule contained a critical revelation: HHS indicated that it would not collect information on benchmark plans' nonquantitative limits (e.g., prior authorization requirements), stating, "Nonquantitative limits are not necessary for benchmark plan purposes" (HHS, 2012, p. 42660). In other words, plans subject to the EHB requirements would not have to emulate the nonquantitative limits of the benchmark plan.

### *Essential Health Benefits Rule*

HHS did not release a comprehensive formal proposed rule for the EHB requirements until late November 2012, with the final rule published in late February 2013. Because the *Bulletin* had established a deadline for states to select and supplement a benchmark plan almost 2 months before the proposed rule was published, it was a confusing time for stakeholders and state officials. Because a variety of ACA regulations seemed to be delayed, it was believed by many that HHS had been instructed to wait until after the election cycle had ended to reduce the chance that proposed regulations would fuel political criticism. When the proposed rule was released, the regulatory framework it created was similar in many respects to that laid out in the *Bulletin*.

The proposed EHB rule maintained the benchmarking structure established by the *Bulletin*, as did the final rule. In fact,

the proposed and final rules were identical in most relevant respects. The process described in the *Bulletin* allowing states to select benchmark plans and requiring that they be supplemented to cover all categories of EHB remained the same. However, some important additions were made to the regulatory framework. HHS established that the October 1, 2012, deadline for states to select a benchmark plan was encouraged, but not required, and that states had additional time. Instead of the benchmark approach being transitional in nature and applicable only in 2014 and 2015, the EHB rule indicated that it would apply for "at least" 2014 and 2015.

Of note, HHS stated that enforcement of the EHB requirements would be left to the states unless they were unwilling or unable to do so. The rule clarified that states would not be required to pay for the incremental cost of insurance benefit mandates that exceed the requirements of the EHBs, so long as those mandates were enacted before 2012. In addition, HHS specified that substitution of benefits would be permitted only within EHB benefit categories, not between them. Furthermore, the rule allowed states to further restrict or completely prohibit substitution of benefits (HHS, 2013).

Of greatest importance to occupational therapy practitioners and consumers, the rule described in greater detail how HHS intended to address habilitation as an EHB. Crucially, it indicated that states had permission to define habilitation as they saw fit. It also established a default process that would take effect if the state failed to define the benefit. That process allowed insurers to define coverage of habilitative services either at parity with rehabilitation (i.e., providing benefits for habilitation similar in scope, amount, and duration to rehabilitation) or in some other manner that would have to be reported to HHS. Unfortunately, the rule indicated that EHB-compliant health plans need to provide supplemental habilitative services only if the benchmark plan includes no habilitative services (HHS, 2013). That language is likely to have the impact of allowing plans to meet the EHB habilitation requirements by covering services

limited by age or health status, despite the fact that benefit designs based on those factors seem to be prohibited by the ACA. On a positive note, the rule stated that its regulatory approach for habilitation was transitional, that HHS intended to carefully monitor coverage of habilitative services, and that the agency intended to “assess the need for future regulatory action” (HHS, 2013, p. 12843).

AOTA submitted extensive comments on the EHB proposed rule advocating for a variety of changes. Supplemental information referenced in the proposed EHB rule suggested that HHS’s and states’ evaluations of benchmark plans led to determinations that those plans covered habilitative services at a far greater rate than seemed likely. The apparent cause of that anomaly seemed to be a failure to distinguish between rehabilitative and habilitative services, even though the EHB statutory language clearly requires coverage of both. Therefore, AOTA made the argument that the EHB rule should require distinct coverage of rehabilitative and habilitative services. Another important issue AOTA addressed was the risk that the rule’s language would allow for coverage of habilitative services that was limited to pediatric populations, which also seemed contrary to the statute’s intent. The other key argument AOTA made was for parity of coverage between rehabilitative and habilitative services to be the default requirement absent state action to define the benefit instead of an option for insurers to choose.

Although AOTA’s comments included positions not described here, the unfortunate reality is that HHS released its formal proposed rule so closely to the time that the requirements needed to be in place that it was nearly impossible for it to change direction in response to stakeholder advocacy. States had in many cases been compelled to develop their own requirements for insurance carriers before the release of the EHB final rule to enable those carriers to develop and submit health plan documents on time for approval, as required by many states’ laws. HHS’s EHB regulatory approach was not directly in line with what AOTA had advocated for,

but all was not lost. The flexibility given to states to make a variety of their own decisions regarding the EHBs, including defining the habilitation benefit, allowed AOTA to partner with state occupational therapy associations to engage in some successful advocacy efforts. In addition, HHS maintained its position that EHB regulations, including those regarding habilitation, will be revisited and potentially revised in the near future. AOTA will continue to advocate for positive changes when those opportunities arise.

### Essential Health Benefits for Medicaid and the Multi-State Plan Program

The focus of this article has been the EHB regulatory process as it affects private insurance benefits, largely because the majority of regulatory documents and activities are focused on that aspect as well. However, the EHB requirements apply to new beneficiaries of Medicaid made eligible by the ACA, as well as to multistate plans that will eventually be sold on every state’s health insurance exchange, and will be administered by the U.S. Office of Personnel Management. Space does not permit a full explanation of EHB regulations for Medicaid and the Multi-State Plan Program, and AOTA’s advocacy efforts related to them, but many of the issues and requirements discussed in this article apply to those programs as well.

### Partnering on Advocacy in the States

Although advocacy at the national level to develop strong standards for coverage of habilitative services met with limited success, AOTA partnered with state occupational therapy associations to positively influence a variety of state-specific definitions. States responded in varied ways to the guidance provided by HHS related to EHB implementation. Some states enacted legislation in 2012 in the wake of the issuance of the EHB *Bulletin* and began the process of selecting an EHB benchmark plan. However, in many cases, state officials seemed to be waiting for the outcome

of the U.S. Supreme Court case challenging the constitutionality of the ACA before proceeding. Even after the Court largely upheld the ACA in June 2012, some states were hesitant to take action without formal regulations to guide them or without knowing the outcome of the 2012 elections, which also were seen as a potential threat to the ACA’s continued existence. In most states that actively engaged in EHB implementation, decisions were made outside the states’ legislatures, either by state agencies or ad hoc committees.

Ultimately, as mentioned earlier, HHS issued formal EHB regulations in November 2012. Those regulations maintained, and in some ways expanded, state flexibility in terms of influencing the development of state-specific EHBs. AOTA monitored state activities continuously, kept state occupational therapy associations informed, and advocated extensively, in particular to influence definitions of habilitative services. The following descriptions are of advocacy activities, and the outcomes of those activities, in select states.

#### Washington

Washington State took early action on EHB implementation. The state legislature passed House Bill 2319 in 2012 identifying the state’s EHB benchmark plan. Soon thereafter, the Washington Office of the Insurance Commissioner (OIC) began development of EHB regulations. A variety of public meetings were held, and the creation of a work group to address the definition of habilitative services was initiated. AOTA consulted with the Washington Occupational Therapy Association (WOTA) on these activities and assisted in the development of an advocacy strategy. WOTA communicated with the OIC, obtained a seat on the habilitative services work group, and partnered with the Washington physical and speech therapy associations to submit comments on proposed regulations.

In the end, Washington State developed EHB regulations that included a relatively good definition of coverage of habilitative services. The definition identified habilitative services as being distinct from rehabilitative services and required that they

be covered at parity. In addition, it explicitly identified occupational therapy as within the habilitation benefit (Washington OIC, 2013).

### *Michigan*

Michigan, in contrast to Washington State, issued an administrative order through its Office of Financial and Insurance Regulation (OFIR) that defined coverage requirements for habilitative services (Michigan Department of Licensing and Regulatory Affairs OFIR, 2013). The order required coverage of applied behavioral analysis (ABA) under the habilitation benefit. It acknowledged that habilitative services include other services and cited the NAIC definition (which includes mention of occupational therapy), but it was ambiguous as to whether a health plan could fulfill the requirement to cover habilitation as an EHB by *only* covering ABA.

There was no public notice and opportunity for comment; however, AOTA learned of the order, informed Michigan's Occupational Therapy Association (MiOTA) about it, and identified a contact at OFIR. AOTA assisted MiOTA in drafting a letter to OFIR making the argument that habilitation coverage should not be deemed adequate if it included only ABA. MiOTA submitted the letter in partnership with Michigan's speech-hearing association. Several weeks later, MiOTA received a response from OFIR indicating that habilitation coverage would have to include the services listed in the NAIC definition in addition to ABA to be considered adequate.

### *District of Columbia*

In the District of Columbia (DC), the Health Benefit Exchange Authority (referred to hereinafter as "the Exchange") created work groups to make recommendations to the Exchange Board about a variety of ACA implementation issues, one of which was how to define habilitative services. DC is somewhat unique in that it has an existing insurance benefit mandate that requires coverage of habilitative services, including occupational therapy, for children with certain conditions. The problem this man-

date created was that without action by DC's Exchange, the existing definition would likely become the definition for EHB purposes—that is, habilitative services would be required only for children with certain conditions. AOTA provided background information to a member of the leadership team of the DC Occupational Therapy Association that enabled him to advocate for a preferred definition of habilitation at work group meetings.

Ultimately, the Exchange Board adopted the work group's recommended definition, which was a modified version of the NAIC definition (District of Columbia Health Benefit Exchange Authority, 2013). As a result, DC's habilitation benefit will not be limited by age or health status.

## Vision for the Future

Although development of EHB regulations and standards for coverage of habilitative services, as well as AOTA's advocacy efforts on these issues, has been ongoing for years, the journey to ensure that consumers have access to habilitative occupational therapy services is not at an end. Success was achieved by obtaining the inclusion of habilitative services as an EHB in the ACA and having the NAIC develop a definition of the benefit for the consumer glossary that explicitly mentions occupational therapy. Yet efforts to influence HHS during the federal regulatory process produced mixed results because HHS elected to give states substantial flexibility instead of developing rigorous national standards. However, that flexibility provided to the states created opportunities that led to positive outcomes that can be used as examples during future advocacy activities. There are far more examples than described in this article. Arkansas, Colorado, Maryland, Rhode Island, and West Virginia are among the states that also adopted positive definitions of habilitation that can be cited, and the capacity of state occupational therapy associations to advocate on issues related to ACA implementation was enhanced. Nonetheless, there is more to do.

Of the utmost importance is educating occupational therapy practitioners and consumers about the existence of the EHBs and the inclusion of habilitative services within them. If consumers are unaware that their health insurance is required to cover this benefit, which has often been denied coverage in the past, then the intent of including it will not be achieved. In Maryland, a limited mandate to cover habilitative services has been in effect for many years, and evidence indicates that fewer people have accessed those services than had been expected, potentially because consumers were unaware of the benefit.

Equally important is educating decision makers within insurance companies, health insurance exchanges, state departments of insurance, and other venues about the difference between rehabilitative and habilitative services and about the fact that occupational therapy practitioners are skilled providers of both. As a result of the myriad changes to the health insurance regulatory environment that have come with implementation of the ACA, many people affiliated with these entities will not have familiarized themselves with all of the EHBs. In addition, because HHS has indicated that states will be primarily responsible for enforcement of the EHB requirements, it will be important for occupational therapy practitioners and consumers to know and assert their rights with insurers and regulators. It will likely be necessary in many cases to file appeals with insurance companies and potentially to file complaints with health insurance exchanges or state departments of insurance to ensure that the EHB requirements are fully complied with.

Because HHS indicated that it intends to revisit and potentially revise the EHB requirements, and the coverage standards for habilitation specifically, it will be important to gather as much information as possible on how the EHBs are being covered in each state to inform future advocacy efforts. To do that, it may be necessary to partner with allied organizations to share information. State occupational therapy associations are on the frontlines of these efforts and should seek to develop lines of communication



with state physical and speech therapy associations and with organizations that advocate for the rights of occupational therapy consumers (e.g., state chapters of Easter Seals, The Arc, United Cerebral Palsy). In addition to sharing resources to monitor implementation of the EHBs, these relationships can facilitate partnerships when advocacy opportunities arise, as they inevitably will.

AOTA will seek to maintain a leadership role in terms of advocating for and educating occupational therapy practitioners and consumers about the EHBs and habilitative services. An active professional membership and established alliances will increase the likelihood of achieving the previously mentioned goals of educating practitioners and consumers about habilitation as an EHB, educating decision makers about the difference between rehabilitation and habilitation and occupational therapy practitioners' expertise in both, and monitoring coverage of habilitation to inform future advocacy efforts. ▲

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