AOTA BULLETIN FOR STATES: ESSENTIAL HEALTH BENEFITS IN THE AFFORDABLE CARE ACT

Background

The Patient Protection and Affordable Care Act of 2010 (ACA)[1] seeks to strengthen existing health insurance coverage and expand coverage to an estimated 32 million uninsured Americans, in part through an "individual mandate," which will require everyone to have some type of coverage beginning in 2014. The expected advantage of this approach is that there will be a much larger pool of consumers to share the risk of getting sick or injured, which will result in lower individual health care costs. The mandate is central to expanding coverage but it is controversial. The constitutionality of this mandate will be decided by the U.S. Supreme Court this summer.

Some of the problems in the health insurance market will currently be addressed by the establishment of easier ways for consumers to purchase insurance. In order to facilitate this and help improve insurance access, choice, cost, and coverage, the ACA calls for the establishment of state-based health insurance purchasing "exchanges." Exchanges are intended to be competitive marketplaces for individuals and employers to directly compare and purchase health insurance plans on the basis of price, quality, covered services, and other factors. The premise is that "one stop shopping" will make the process easier for consumers to find and purchase health care coverage. In order to set up an exchange, a state must complete a number of tasks, including:

- Passing legislation to establish an exchange
- Evaluating existing insurance plans in the state
- Selecting a benchmark plan
- Addressing cost issues such as premiums and co-payments.

If a state does not set up its own exchange, then the federal government will establish one for that state. Most states will need to pass legislation to establish the exchange, so state occupational therapy associations and advocates should monitor developments on the legislative front. At this point, very few states have begun to set up exchanges. Some are moving toward establishment, but others are waiting to see how the Supreme Court rules.

This bulletin addresses the issue of establishing the health care services and devices that must be included in any plan under the exchanges: essential health benefits (EHB). The role of states and state decision makers is critical, and state occupational therapy associations will thus be on the front lines of protecting and enhancing the way occupational therapy is addressed under the new insurance system.

Essential Health Benefits

Insurance plans participating in the exchanges are required by the ACA to meet certain quality standards and cover, at a minimum, a package of 10 EHB:

- 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
- Pediatric services, including oral and vision

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In December 2011, the U.S. Department of Health and Human Services (HHS) released a Bulletin[2] outlining, among other things, the agency's intended regulatory approach to defining EHB. Under the proposed plan, states would have the flexibility to select an existing health plan to set the "benchmark" for the items and services included in the EHB package. All 10 mandated categories must be included but there are various ways in which they could be packaged. States can choose a benchmark from among the following four options:

- Any of the three largest state employee health benefit plans by enrollment
- Any of the three largest national Federal Employees Health Benefits Program (FEHBP) plans by enrollment
- The largest plan by enrollment in any of the three largest small group insurance products in the state
- The largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.

AOTA provided comments[3] on the Bulletin focusing on habilitative services, maintenance of function, the importance of limiting coverage to qualified providers, and other issues of importance to occupational therapy.

HHS has also released an Illustrative List of the Largest Three Small Group Products by State[4] in response to questions about the existing insurance plans that could serve as benchmarks. The list focuses on the plans with the three largest enrollments in the small group market in each state and includes information on the top three nationally available FEHBP plans based on enrollment; it does not provide information on state employee plans or the largest commercial non-Medicaid HMO operating in each state. Although limited, the list could be useful to occupational therapy practitioners and advocates working with state officials to design an expansive plan.

The Institute of Medicine, the National Association of Insurance Commissioners, and other entities also have influenced HHS work in this area.

Occupational Therapy Advocacy

The EHB package is extremely important for the practice of occupational therapy. An expansive package of benefits designed to meet individual needs would be a positive outcome for occupational therapy practitioners and consumers. HHS has made clear that it intends to provide states with a great deal of flexibility in designing their benefit packages. This means that providers, consumers, state associations, and state legislators must work together at the state level to ensure that occupational therapy is fully recognized in the EHB package. State associations can participate in state conversations on EHB and benchmarks and advocate for the following:

- Consumer access to both rehabilitative and habilitative services, and access to comprehensive mental and behavioral health services for both children and adults
- Requirements that therapy services be provided by qualified providers (e.g., OTs, PTs, and SLPs)
- Appropriate and transparent limits to coverage of therapy services that are not arbitrary or restrictive
- Medical review of therapy claims completed by peers in the same profession
- Establishment of a fair and straightforward appeals process for consumers.

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[1] The Patient Protection and Affordable Care Act (2010), Pub. L. 111–148, § 3502, 124 Stat. 119, 124.

[2] HHS, Center for Consumer Information and Insurance Oversight (CCIIO), *Essential Health Benefits Bulletin* (2011) available at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf.

[3] AOTA, Comments on the *Essential Health Benefits Bulletin* (2012) available at http://www.aota.org/News/AdvocacyNews/AOTA-Comments-on-HHS-EHB-Jan-12.aspx?FT=.pdf.

[4] HHS, CCIIO, *Illustrative List of the Largest Three Small Group Products by State* (2012) available at http://cciio.cms.gov/resources/files/Files2/01272012/top_three_plans_by_enrollment_508_20120125.pdf.