Joint Habilitation/Rehabilitation Benefit Coverage Statement:
Guide to Assessing Adequacy of Benefits

Appropriate coverage of habilitative and rehabilitative services and devices is an essential part of comprehensive health insurance. Rehabilitation and habilitation address function, communication, participation, mobility, and engagement limitations that result from illness, injury, disability, or other conditions. The key services covered under these categories in most US insurance products are **occupational therapy, physical therapy, and speech therapy services.**

Habilitation and rehabilitation benefits are cost effective. A study of "silver" marketplace plans found that these services represent only 2% of an average premium cost (or $96 annually) but provide return to function, productivity, and health. If financed separately, an average premium could increase to more than $2,200 annually for consumers.[i]

The American Physical Therapy Association (APTA), the American Occupational Therapy Association (AOTA), and the American Speech-Language-Hearing Association (ASHA) jointly developed this document as a resource for public and private insurers, employers, and consumers to evaluate the appropriateness of rehabilitation and habilitation benefit design. The following issues are of critical importance.

To ensure adequate scope of coverage and access, public and private insurers should:

- Conform coverage of habilitation and rehabilitation to the definition in the official Department of Health and Human Services (HHS) Uniform Glossary of Health Coverage and Medical Terms as defined by the National Association of Insurance Commissioners (NAIC) and adopted by the DHHS Center for Consumer Information and Insurance Oversight (CCIIO)[ii]:
  - **Habilitative services and devices** help a person keep, learn, or improve skills and functioning for daily living
  - **Rehabilitative services and devices** 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;
- Recognize occupational therapy, physical therapy, and speech therapy services as covered services;
- Include understandable benefit definitions and clear benefit implementation guidelines to facilitate choosing a plan that meets consumers' needs;
- Ensure that services will be covered for all individuals regardless of age, disability, health condition, or other factors, particularly for special populations such as children and individuals with chronic conditions and disabilities;
- Ensure adequate access to necessary services by requiring separate visit limits for occupational therapy, physical therapy, and speech therapy as each discipline provides distinct services focused on different functional goals. Patients should not have to choose between obtaining services for talking and walking or walking and thinking;

- Ensure that the policy permits individuals to access each therapy discipline without a referral from a physician or other practitioner when allowed by state law;
- Use AOTA, APTA, and ASHA practice guidelines, guidance documents, position statements, and other resources to assist in evidence-based utilization management/case management decision making; and
- Use only licensed therapists with the same credentials as the providing therapist to perform peer-to-peer reviews.

To ensure that providers of services will be qualified, public and private plans should:

- Only recognize qualified providers according to the following standards for providing skilled rehabilitation and habilitation for covered needs, including for special populations such as children and people with disabilities:
    - Occupational therapists (OT), occupational therapy assistants (OTA), physical therapists (PT), physical therapist assistants (PTA), and speech-language pathologists (SLP) deliver occupational therapy, physical therapy, and speech therapy, respectively, evaluating and treating individuals across the lifespan, consistent with rules, regulations, and provisions of each state.
    - OTs, PTs, and SLPs are health care professionals that graduate from nationally accredited programs, pass a national credentialing exam, and are licensed in all 50 states, Washington, DC (DC), Puerto Rico (PR) and the US Virgin Islands (VI).
    - The standard for educational preparation for PTs is the doctoral level. OTs and SLPs may enter practice at either the master's or doctoral level.
    - OTAs and PTAs enter practice at the 2-year associate degree level. OTAs are licensed in all 50 states, DC and PR. PTAs are licensed or certified in all 50 states, DC, PR, and VI.

To ensure that consumers can determine if a plan meets their needs, plans should provide the following information:

- Whether plan documents provided to consumers use Uniform Glossary[iii] definitions of habilitation, rehabilitation, and medically necessary and clearly identify separate visit limits for each of the therapy disciplines for both habilitation and rehabilitation as in the Summary of Benefits and Coverage that must be provided with each plan;
- Whether networks are of sufficient breadth to ensure consumer choice and availability of qualified providers with the skills to treat the full scope of conditions, illnesses, injuries, and other covered issues that can benefit from rehabilitation or habilitation;
- That network breadth, adequacy and availability, benefit structures, and service approval criteria center on the needs of the individual and are balanced with the needs of the purchaser, payer, and provider;
- Whether implementation of the plan is not delayed or impeded by utilization management and/or case management;
- Whether unique populations such as children and those with chronic conditions or disabilities receive special consideration regarding access and cost-sharing to ensure best outcomes;
- Whether payment to providers allows patients to receive OT, PT, and/or ST services on the same day of service without penalty to the provider; and
- Whether plans facilitate alternative treatment delivery mechanisms to include emerging methods such as telehealth and remote patient monitoring.

Consumers should review elements of affordability to affirm that:

- Copays and coinsurance do not reach or exceed the insurer-paid portion cost of the actual service; and

- Appropriate out-of-pocket mechanisms incentivize obtaining the right care for optimal outcomes:
    - Plans should make it as cost effective to seek pain management services via rehabilitation as through a medication or other treatment; and
    - Plans should consider copayment and deductible approaches that facilitate use of services, such as a single copay for an episode of care rather than per-visit copays.

APTA, AOTA, and ASHA are dedicated to advancing optimum value within the health care system; and we urge insurers, purchasers, and consumers to promote the same by:

- Developing collaborative partnerships with professional associations to identify proper quality measures and explore value-based pilots;
- Seeking and facilitating therapy participation in any alternative payment models used under the insurance plan;
- Evaluating providers and tier payments on outcomes and adherence to evidence and clinical practice guidelines instead of comparing costs in isolation;
- Using standardized outcomes to develop evidence-based benefit plan design implementation;
- Facilitating treatment for the right patient at the right time in the right setting including using telehealth;
- Recognizing the role of therapy providers in population health initiatives; and
- Recognizing and advancing the role of therapy providers in reducing further injury and downstream costs.

When developing a new or revised rehabilitation and habilitation benefit, APTA, AOTA, and ASHA urge plan developers and policy makers to:

- Avoid benefit design that results in barriers to appropriate services;
- Avoid limiting coverage of each discipline of therapy services to 1 condition, which may discriminate against individuals with other health conditions who would benefit from therapy to learn, maintain, or restore communication, mobility, and other functionality;
- Avoid limiting coverage of services, especially habilitative services that are clinically appropriate for all ages by labeling them "pediatric services," which may discriminate against adults who would benefit from services that help them attain or maintain skills and functioning or to accommodate changes that otherwise would not allow them to return to previous functioning;
- Use the official definition of medical necessity developed by NAIC and approved by CCIIO: "Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine";
- Avoid using restrictive phrases such as "recovery of *lost* function" or "restoration to a *previous level* of function";
- Affirm coverage for services for preventive or other purposes including acquiring an appropriate skill or function for the first time or in a different form; and
- Affirm that rehabilitative maintenance therapy and habilitative services are allowed for individuals with chronic, progressive conditions, such as multiple sclerosis or Parkinson disease, to prevent further deterioration of function.

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[i] https://www.rwjf.org/en/library/research/2017/07/the-implications-of-cutting-essential-health-benefits.html

[ii] https://www.healthcare.gov/sbc-glossary

[iii] IBID