2014

Analysis of Rehabilitation and Habilitation Benefits in Qualified Health Plans

Prepared by the American Occupational Therapy Association (AOTA)

About

Founded in 1917, the American Occupational Therapy Association (AOTA) represents the professional interests and concerns of more than 185,000 occupational therapists, occupational therapy assistants, and occupational therapy students nationwide. The Association educates the public and advances the profession of occupational therapy by providing resources, setting standards including accreditations, and serving as an advocate to improve health care. Based in Bethesda, MD, AOTA's major programs and activities are directed toward promoting the professional development of its members and ensuring consumer access to quality services so patients can maximize their individual potential. For more information, go to www.aota.org.

Disclaimer

AOTA prepared this report largely based on information acquired from a national sample of 266 qualified health plans' summaries of benefits acquired in the summer of 2014. Although attempts were made to ensure this sample was random and representative, the difficulty of accessing some of the referenced documents made it impossible to fully standardize the data collection. Please see the appropriate sections for additional information about methodology and source material.

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Introduction

The Patient Protection and Affordable Care Act (ACA) requires 10 categories of health care services to be covered by certain health insurance plans, including ***qualified health plans*** (QHPs).[1] The services QHPs must cover are collectively referred to as ***essential health benefits*** (EHBs). One category of EHBs is ***rehabilitative and habilitative services and devices***. The ACA provided little additional detail in terms of the specific services that must be covered within each EHB category. As a result, the U.S. Department of Health & Human Services (HHS) adopted regulations specifying a process to establish a ***benchmark plan*** to serve as each state's model of how EHBs must be covered by QHPs in that state. Although many categories of EHBs vary little between state's benchmark plans, others lack such relative uniformity.

Among those categories of EHBs for which the coverage varies considerably between state's benchmark plans is the rehabilitative and habilitative services category.[2] In terms of rehabilitation and habilitation, the benchmark plans typically establish the types of therapies covered and the number of annual visits permitted. It should be noted that QHPs must emulate coverage in benchmark plans, but in most cases they are given flexibility to substitute benefits within the same EHB category, so long as actuarial equivalence is maintained.[3] In the case of habilitative services, there is the potential for additional variation. Habilitative services, a benefit often excluded from private insurance coverage in the past (and therefore absent from many benchmark plans),[4] were treated differently from other benefits. States were permitted to define habilitative services, and some states did so. In the states that did not, health insurance carriers were authorized to decide how to cover habilitative services.[5]

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[1] A QHP has been certified as having met certain requirements of the ACA, including coverage of the essential health benefits (EHBs). For the purposes of this analysis, the scope is limited to coverage of EHBs by QHPs. The ACA also required the EHBs to be covered by ***alternative benefit plans***, which are the benefit packages designed for new beneficiaries of Medicaid in states that elected to expand eligibility pursuant to the ACA. See the following link for the statutory definition of QHP (accessed 9/11/14): http://www.law.cornell.edu/uscode/text/42/18021

[2] AOTA performed an analysis of rehabilitation and habilitation coverage in EHB benchmark plans in 2013. A summary chart of those findings is available at the following link: (accessed 9/11/14) http://otconnections.aota.org/cfs-filesystemfile.ashx/__key/telligent-evolution-components-attachments/01-8597-00-00-00-12-24-51/AOTA-chart-of-EHB-coverage-of-rehab-and-hab-_2800_updated-9_2D00_12_2D00_13_2900_.pdf

[3] Several states prohibited benefit substitution (at least temporarily) pursuant to authority granted by federal regulations (e.g., MD, WA, CA). See,for example, (accessed 9/11/14) http://www.mdinsurance.state.md.us/sa/docs/documents/insurer/bulletins/bulletin13-02_substitutionrules_010713.pdf%20

[4] Benchmark plans were developed using, as a baseline, one of 10 specified plans from each state that existed in 2012.

[5] For additional background information on these issues, please consult the following resources: (accessed 9/11/14) http://ajot.aota.org/article.aspx?articleid=1864917 and http://www.aota.org/-/media/Corporate/Files/Advocacy/Health-Care-Reform/Essential-Benefits/Habilitative%20Services%20Fact%20Sheet.pdf

AOTA has closely monitored the implementation of the ACA's EHB requirements, with particular interest in the rehabilitative and habilitative services category. After discovering a number of QHPs that seemed to fail to comply with the standards established by one state's benchmark plan, as well as not providing adequate and accurate information about coverage of rehabilitative and habilitative services, AOTA conducted more comprehensive research. By collecting and analyzing a national sample of QHPs' summaries of benefits and coverage (SBCs), AOTA was able to evaluate the manner by which QHPs were meeting the EHB requirements (or seemingly failing to do so), as well as determine what information would be readily available to consumers attempting to compare marketplace plans.

Methodology Overview

The basic methodology of this research contained two stages. The first involved a more comprehensive collection of data to ensure a representative sample of information was collected. The second stage narrowed the data collection, relying on the determination made during the first stage that the narrower sample would remain representative.

In the first stage, four to six SBCs were collected for each insurance carrier selling marketplace coverage in five states. The SBC sample included bronze, silver, gold, and multi-state plans. Four data points were identified as the core information sought by the project,[6] and each carrier's SBCs were evaluated to determine whether there was any variation between the different plans offered by each carrier for each of the four core data points. There was a single variation identified for one carrier in one state.[7] All other carriers' plans in all five states were consistent on the core data points across all plans. Therefore, in the second stage, only one SBC was collected for each insurance carrier selling marketplace coverage in each state. As a result, the total data set that forms the basis for the research findings highlighted below is based on having collected data from one SBC at the silver metal level for each carrier selling marketplace coverage in each state. It is assumed that for the core data points at issue in this research the sample is representative. For a more detailed methodological discussion, please refer to Appendix 1.

Summary

The research and findings summarized in this report lead to two overarching conclusions. First, consumers in many cases do not have access to adequate information about rehabilitation and habilitation benefits in QHPs to make informed choices when shopping for coverage on the marketplaces. Second, insurance carriers in many cases seem not to be complying with the EHB benchmark standards for coverage of rehabilitative and habilitative services that exist in each

[6] The four core data points were therapies covered for rehabilitation, therapies covered for habilitation, visit limits for rehabilitation, and visit limits for habilitation.

[7] The only variation identified was where one carrier in one state offered multiple plans, some of which established annual visit limits and others of which established "per condition" visit limits.

state. Although the focus of this research was on rehabilitation and habilitation benefits, the problems identified likely apply more broadly.

Key Findings

- **Inadequate information is available about rehabilitation and habilitation services for consumers to make informed choices about which plan to select.**

As the research project got underway, it became apparent the information included in SBCs varied substantially across insurance carriers. Most SBCs (≈71%) included information about the number of visits a QHP included under the rehabilitation and habilitation benefits. Far fewer (≈33%) made it clear whether a plan beneficiary would need to meet the deductible before rehabilitation and/or habilitation coverage would take effect. A similar number (≈31%) indicated the core therapies identified in the National Association of Insurance Commissioners' (NAIC) definitions of rehabilitation and habilitation were covered.[8] Very few (≈9%) contained all these characteristics (see Figure 1 below).

[8] The therapies listed in the NAIC's definitions, which were created for a consumer glossary of insurance terms, include the following: rehabilitation—physical therapy, occupational therapy, speech-language pathology, and psychiatric rehabilitation; habilitation—physical therapy, occupational therapy, and speech-language pathology. For purposes of this analysis, we did not consider psychiatric rehabilitation as a core rehabilitation therapy, because if we had, instead of about 31% of the SBCs listing the core therapies, almost none would have. Psychiatric rehabilitation services may well be covered by many QHPs, but is likely categorized in most plans' SBCs under the mental/behavioral health benefits.

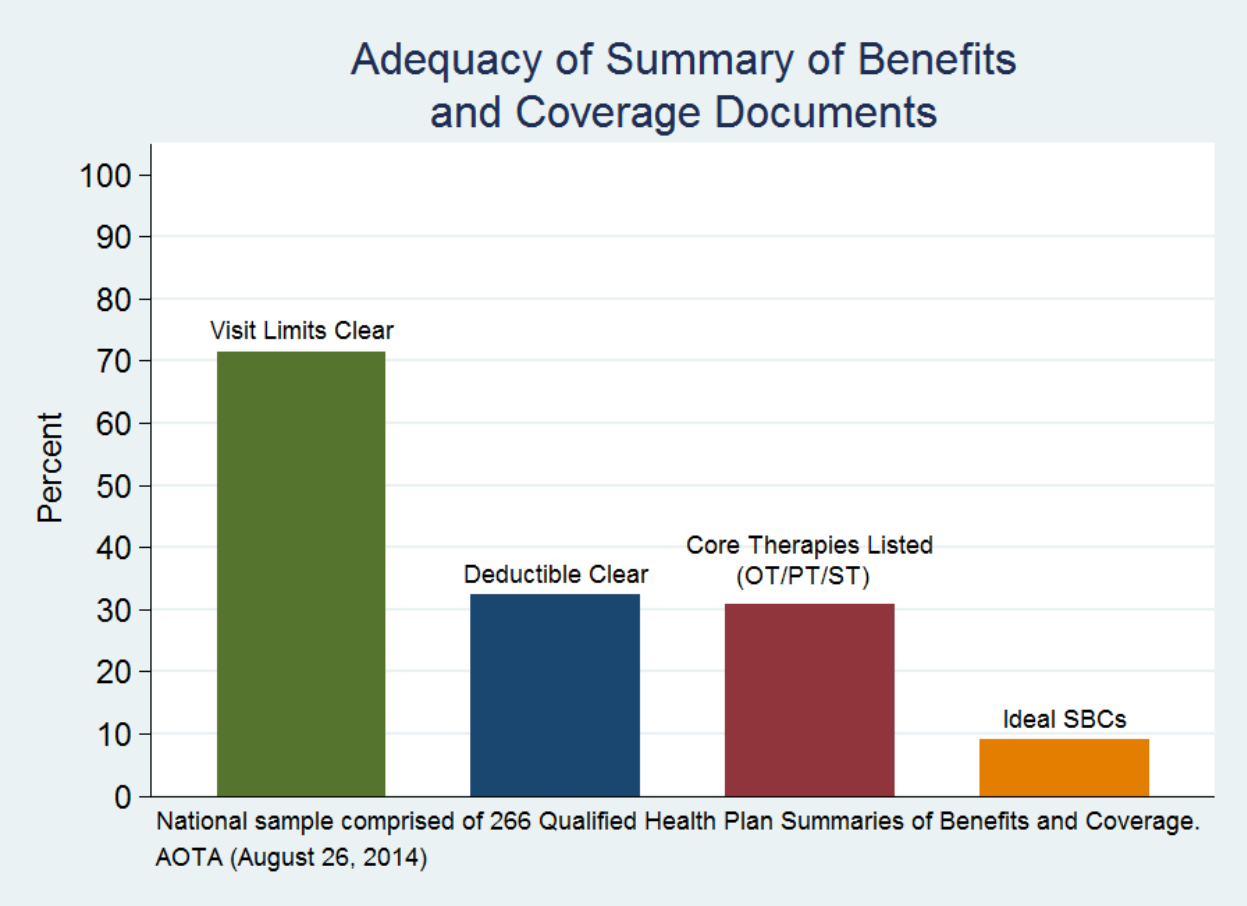

Figure 1

The purpose of the SBCs was to enable consumers to evaluate, understand, and compare the covered services and cost sharing of health insurance plans.[9] By enabling consumers to make informed choices, the SBCs have the potential to increase the likelihood that consumers' expectations and needs are met. They also may promote competition among carriers to develop plan designs that appeal to consumers. Although having partially standardized documents that all insurance carriers must create for each of the plans they sell (i.e., SBCs) is a significant improvement over the varied and often lacking information available in the past, it is clear that consumers would benefit from enhanced attention to how the SBCs are populated with information. For example, focusing on the data illustrated in Figure 1 above, the following improvements could be made:

[9] Center for Consumer Information & Insurance Oversight Description of SBCs (accessed 9/11/14): http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/Summary-of-Benefits-and-Coverage-and-Uniform-Glossary.html

1. For any covered services, if there is a quantitative limit (e.g., number of days, hours, visits covered) applicable to that service, the SBC should clearly specify that limit in the "Limitations & Exceptions" column.
2. With deductibles for silver plans (the most commonly purchased metal level) sometimes reaching $6,000 for individuals, the clarity of the applicability of deductibles to every service listed on the SBCs should be improved.
3. The core therapies listed in the NAIC consumer glossary's definitions of rehabilitation and habilitation should always be listed in the SBC if they are in fact covered, so that in the instances when any of those therapies are not covered, that is clear to consumers.

The fact that some QHPs' SBCs included all the aforementioned information in clearly understandable terms—albeit too few, at less than 10%—suggests that all carriers *could* include this information without modifying the SBC format or requiring new regulations.[10]

In addition, two other characteristics were commonly present that no carriers have seemed to address. First, it was common to encounter the use of abbreviations, including those that seem too esoteric to assume consumers would know their meaning. In fact, sometimes the abbreviations could reasonably be interpreted to mean two or more different things. The use of abbreviations for any terms should be avoided unless a key to facilitate accurate interpretation of those terms is made available. Second, SBCs will often reference other nonspecific plan documents with no guidance to assist a consumer in obtaining them. Any references to other plan documents should not be made without indicating a method to obtain such documents.

- **Applicability of the deductible to rehabilitation and habilitation services seems likely for most silver plans; however, it is frequently ambiguous.**

Reports have indicated the most frequently selected metal level among consumers of marketplace plans is the silver level.[11] With deductibles for silver plans reaching as much as $6,000 for individuals,[12] the applicability of the deductible to QHP services is likely the most important financial characteristic about plans for consumers to evaluate while shopping, besides the monthly premium. Although consumers' understanding of the meaning of "deductible" is itself a problem,[13] if the applicability of the deductible is also obscure, many consumers are likely to encounter unexpected costs. This dynamic could have a host of

[10] Although a new format and/or regulations do not seem necessary to accomplish these goals, it is possible they will only be achieved if those steps are taken.
[11] "Silver Plans By Far the Most Popular Insurance Option," *USA Today*, 5/1/14 (accessed 9/12/14), http://www.usatoday.com/story/news/nation/2014/05/01/almost-13-million-insured-under-aca-admin-says/7735239/
[12] Silver plans' deductibles vary considerably, and some consumers may qualify for income-based cost-sharing subsidies that would lower or eliminate the deductible.
[13] Although an understanding of the meaning of deductible is not universal, the SBCs contain standardized language designed to explain the concept. There is no similar standardized mechanism to explain the applicability of the deductible. "A Perilous Gap in Health Insurance Literacy," *Wall Street Journal*, 9/4/14 (accessed 9/12/14), http://blogs.wsj.com/washwire/2014/09/04/a-perilous-gap-in-health-insurance-literacy/

undesirable effects. For example, consumers may fail to access medically necessary services, drop coverage that to them seems to not cover anything, and choose plans for which the deductible applies to necessary services when alternatives were available. As Figure 2 below indicates, approximately two-thirds of QHPs obscure the applicability of the deductible.

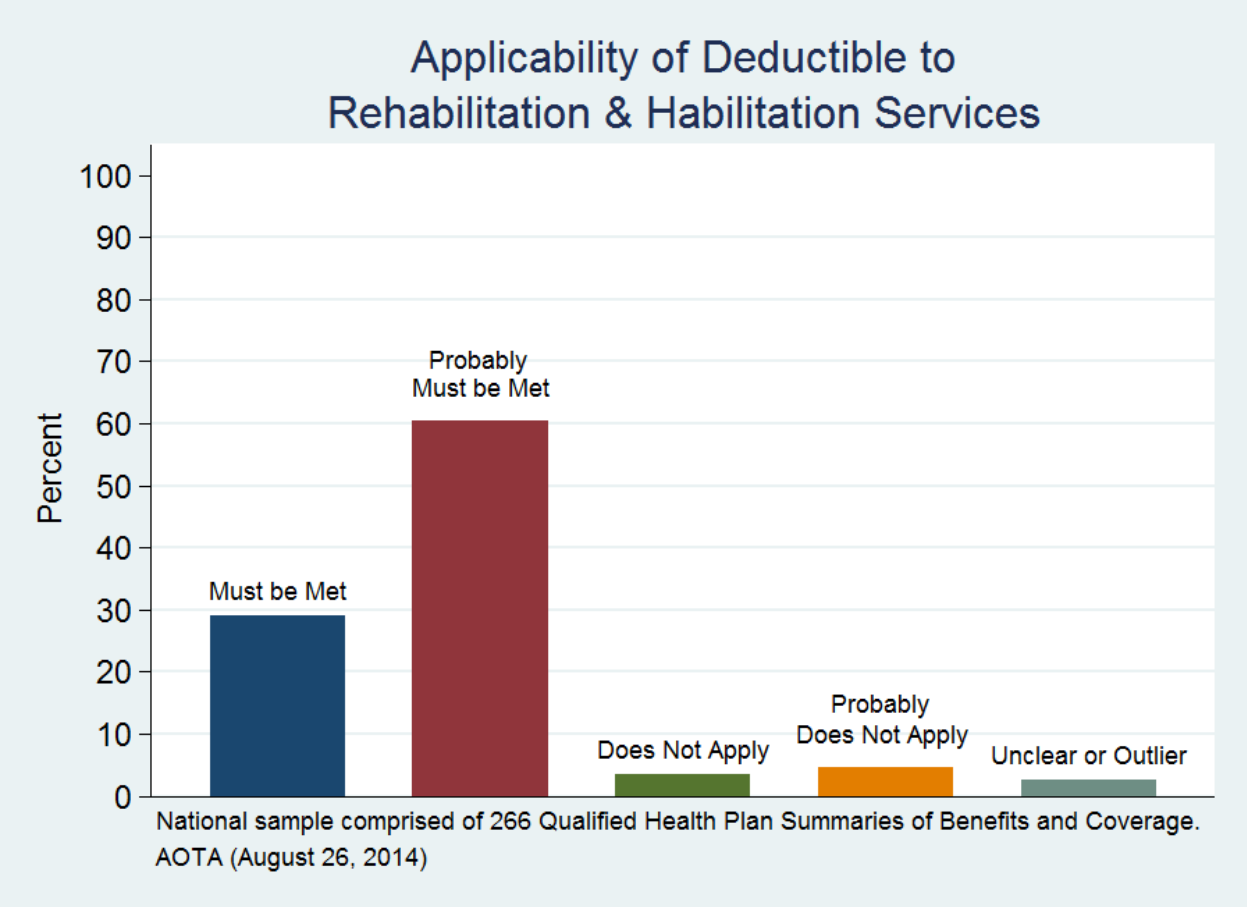

Figure 2

To be clear, in most cases, the deductible does (or seems likely to) apply to rehabilitative and habilitative services covered by silver plans. However, there are instances when it clearly does not. For consumers who expect they or their dependents will need rehabilitation and/or habilitation, they are likely better off selecting a plan in which the deductible does not apply to that category of services, or perhaps a plan with a lower deductible. Without clear information, consumers cannot make that choice. As was previously mentioned, this is a point of information that many insurance carriers (about one-third—see Figure 2 above) managed to convey clearly in their SBCs; this issue could be resolved if all carriers emulated the minority that are already doing it well.

- **The most basic information about the rehabilitation and habilitation benefits (e.g., what services are covered and to what extent covered services are limited) is often unclear or absent.**

Although there are similarities between many QHPs' coverage of rehabilitative and habilitative services, differences are frequent and often quite significant, especially for consumers who rely on those services to remain mobile, functional, and independent. Of greatest concern is that more than half of QHPs do not list *any* of the therapies they cover under their rehabilitation and habilitation benefits (see Figure 3 below).

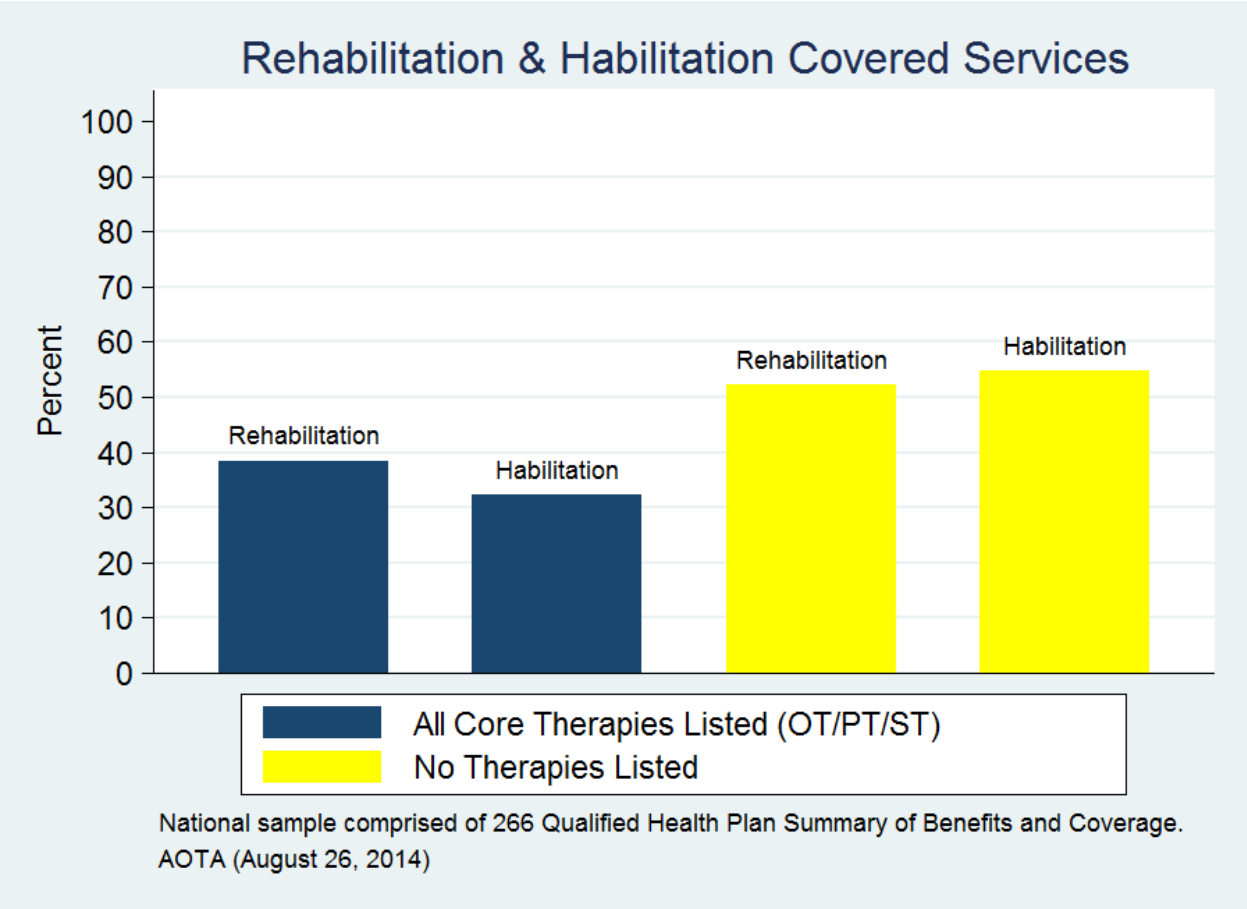

Figure 3

QHPs do significantly better in terms of specifying visit limits (see Figure 4 below), although that information is far from universally available as well. Some plans may have broad rehabilitation and habilitation benefits (e.g., no visit limits or specifically excluded therapies), and instead limit utilization by means of a preauthorization process. It seems as likely (or perhaps more likely, in light of the available information) that some insurance carriers are simply not

volunteering this information, even though it is critically important for some consumers. Besides making it difficult for consumers to make informed choices about which QHP best meets their needs, this lack of information may lead to adverse selection for carriers that do include complete and accurate information. As a result, if this issue remains unresolved, an incentive exists for carriers to *reduce* the amount of information they include in their QHPs' SBCs, making the situation worse. Once again, enough carriers are providing this information to suggest that all could be doing it.

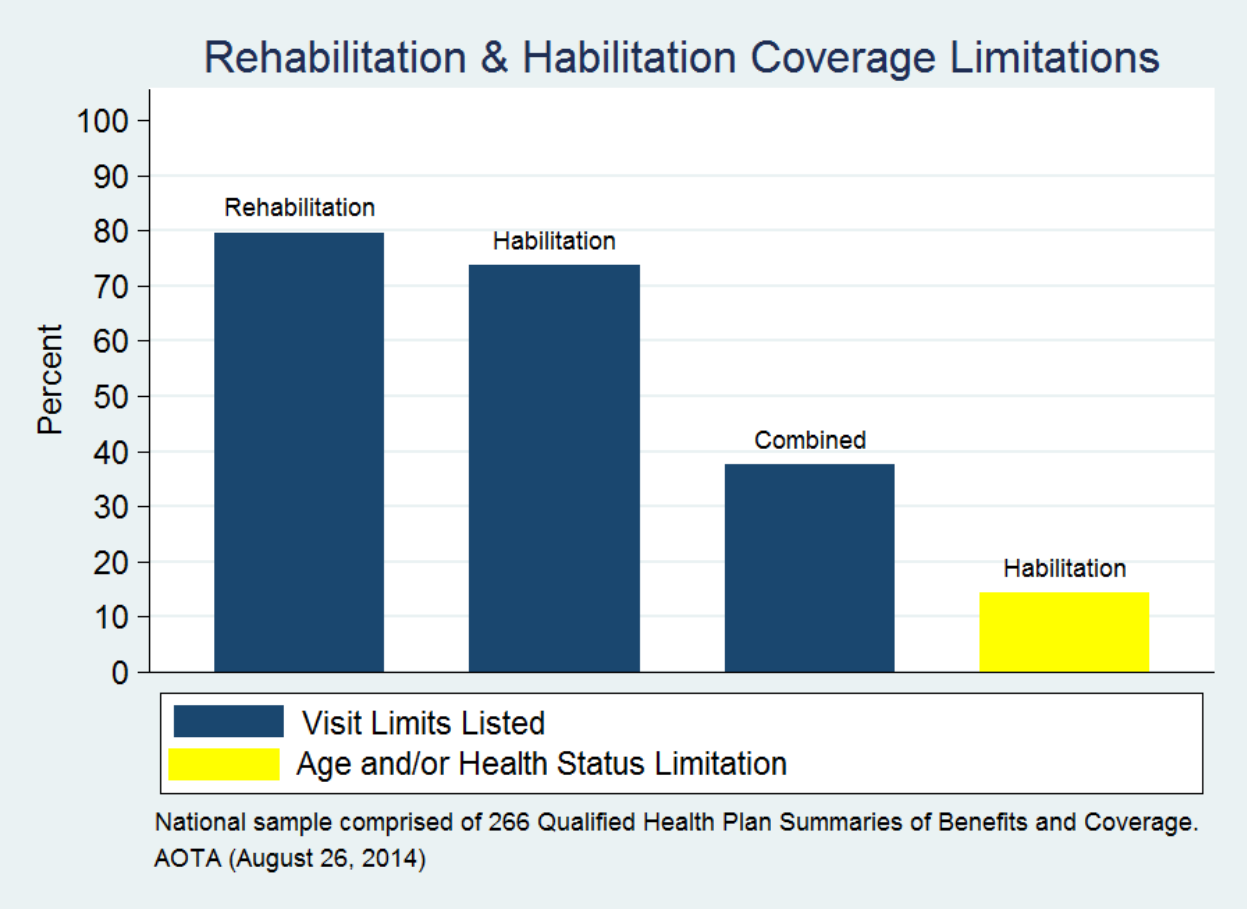

Figure 4

- **Some insurance carriers' habilitation benefit designs appear discriminatory by placing age- or health status–based limitations on covered services.**

Approximately 14% of QHPs' SBCs include a description of coverage of habilitative services containing references to age limits and/or health condition limits (see Figure 4 above). These seem to be in conflict with the non-discrimination provisions of the ACA and federal

regulations, in terms of their prohibition on discriminatory design of any EHBs.[14] Although federal regulations do not provide a specific test to determine what constitutes discriminatory benefit design, presumably limiting coverage of an EHB based on age when there is no clinical rationale for doing so, or limiting coverage of a service to beneficiaries with a specific diagnosis when those services are clinically appropriate for beneficiaries with other diagnoses, would constitute discriminatory design of EHBs.

In almost all cases, the potentially discriminatory references are related to coverage of services for children and adolescents on the autism spectrum, and they are likely carryovers due to state insurance benefit mandates included in base benchmark plans. Although the annual dollar limits that often accompanied these benefit mandates appear to have been jettisoned to comply with the ACA's prohibition on annual dollar limits for EHBs, the age- and health status–based limits have sometimes not similarly been discarded. In some cases, as a result, a QHPs' entire habilitation benefit may be available only to children with an autism diagnosis (see, e.g., Figure 12 below). It is likely that greater than 14% of QHPs have these problematic limitations, because so many SBCs (over 50% in our sample—see Figure 3 above) have no information about covered services for habilitation to determine whether their benefit designs are discriminatory. All such discriminatory limits should be eliminated, so the full range of consumers with disabilities and other conditions that may benefit from habilitative services have access to them as the ACA intended.

- **Some QHPs' coverage of rehabilitative and/or habilitative services is likely not meeting the standards established by the respective state's benchmark plan, nor are those QHPs likely using an actuarially equivalent benefit substitution.**

Federal and state regulations allow for some flexibility in terms of how QHPs must emulate the benchmark plan benefits established in each state. For example, as previously mentioned, QHPs may vary the benefits within an EHB category if the actuarial value of the category in the benchmark plan is maintained in the QHP (unless the state has placed restrictions on benefit substitution, as some have). In addition, in states with base benchmark plans that did not include coverage of habilitative services, and when the state also did not define coverage requirements for habilitative services, QHPs may establish their own criteria for how those services are covered. A further difficulty in determining whether QHPs are complying with benchmark plan coverage requirements for rehabilitation and habilitation is that information about how benchmark plans covered those services is not uniformly accessible and understandable.[15] Nonetheless, many benchmark plans have understandable parameters for

[14] "In defining the essential health benefits…the Secretary shall…ensure that health benefits established as essential not be subject to denial to individuals…on the basis of…age or…disability…." 42 USC § 18022(b)(4)(D); "An issuer does not provide EHB if its benefit design…discriminates based on an individual's age…disability…or other health conditions." 45 CFR § 156.125(a)

[15] The Center for Consumer Information & Insurance Oversight (CCIIO) has included EHB benchmark plan descriptions on its website (see: http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html). However,

rehabilitation and habilitation in terms of covered services and visit limits that can be compared to QHPs, and those comparisons can lead to reasonable inferences about whether any particular QHP is in compliance with the EHB regulations. Below are some comparisons of benchmark plan requirements to QHP benefits, many of which appear to be representative of plans not in compliance with the regulations.

Example 1—Colorado

Colorado's EHB benchmark plan requires 20 annual visits for *each* of occupational therapy (OT), physical therapy (PT), and speech therapy (ST) for rehabilitative purposes. The benchmark plan also requires coverage of unspecified services for those with an autism diagnosis without limits, and OT, PT, and ST with no limits for children with congenital defects up to age 5 years.[16] In addition, Colorado defined coverage requirements for habilitative services as follows:

> 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.[17]

Therefore, Colorado's EHB coverage requirements for rehabilitative and habilitative services may be summarized as follows (numbers below represent annual visits):

Colorado Benchmark Requirements

Rehabilitation	Habilitation
20 OT, 20 PT, 20 ST	20 OT, 20 PT, 20 ST, OT/PT/ST without limits for children with congenital defects up to age 5 years; unspecified services for autism without limits

Whereas a number of QHPs in Colorado appear to meet the benchmark standards, others clearly do not.[18] An example of an apparently compliant Colorado QHP appears in Figure 5

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those descriptions are not always clear, and they sometimes do not include information about standards that states have established through authority granted to them by federal regulations.

[16] Colorado EHB Benchmark Plan (CCIIO summary; accessed 9/12/14): http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/colorado-ehb-benchmark-plan.pdf

[17] Although Colorado's definition appears in the CCIIO summary referenced above, it was originally established by a letter from the Colorado Department of Regulatory Agencies Division of Insurance to CCIIO dated 12/26/12.

[18] It should be noted that AOTA has partnered with the Occupational Therapy Association of Colorado to advocate for a resolution to the apparently noncompliant plans identified in Colorado. Those efforts resulted in communications from state officials that expressed a commitment to ensure all Colorado QHPs will provide the

below. Although the QHP below does not list the covered therapies, it does suggest it covers more than one type of therapy at the rate of 40 visits per year. Assuming the core therapies (i.e., OT/PT/ST) are covered, then its total coverage of outpatient therapy for rehabilitation and habilitation would equal the 120 annual visit requirement imposed by Colorado's benchmark plan. It also references the fact that services to treat autism are not subject to visit limits, which is consistent with the benchmark plan.

Colorado QHP 1[19]

Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions*
Rehabilitation services	Inpatient:30% Coinsurance Outpatient:$30 Copay	Not Covered	Inpatient: Multi-disciplinary facility limited to 60 days per condition per year. Outpatient:Combined outpatient visit limit between rehabilitation and habilitation services of 40 visits per therapy per year, autism spectrum disorders are not subject to visit limits.
Habilitation services	$30 Copay	Not Covered	Combined visit limit between rehab/habilitation of 40 visits per therapy per year, autism spectrum disorders are not subject to visit limits. Copay not subject to deductible.

Figure 5

In contrast, as can be seen in Figure 6 below, this QHP covers a total of 30 annual visits for *all* therapies for both rehabilitation and habilitation, with no mention of an exemption for autism or children with congenital defects up to age 5 years. By referencing what appears to be a benefit less than 25% as comprehensive as the benchmark plan, it is difficult to conceive how the rehabilitation and habilitation benefit category in Colorado QHP 2 is actuarially equivalent to the benchmark plan.

required level of access to services. However, some Colorado QHPs' SBCs for the 2014 plan year are not representative of compliance with the EHB requirements.

[19] Kaiser Permanente: CO Silver 2500/30/Dental (accessed 9/12/14): http://www.ehealthinsurance.com/ehealthinsurance/benefits/ifp/CO/silver-2500-30-dental.pdf

Colorado QHP 2[20]

Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions*
Rehabilitation services	20% coinsurance	Not Covered	Preauthorization required, penalty may apply. 10 visits per calendar year for spinal manipulations, adjustments and modalities 20 visits per calendar year for all other therapies Any limits for Habilitation services and Rehabilitation services are combined.
Habilitation services	20% coinsurance	Not Covered	Preauthorization required, penalty may apply. 10 visits per calendar year for spinal manipulations, adjustments and modalities 20 visits per calendar year for all other therapies Any limits for Habilitation services and Rehabilitation services are combined.

Figure 6

Another plan that appears out of sync with the benchmark, albeit less egregiously so, appears in Figure 7 below. By combining the rehabilitation and habilitation visit limits, and covering a total of 60 visits for the core therapies, Colorado QHP 3's benefit appears to be roughly 50% of the actuarial value of the benchmark plan. With the exception of the visit limits falling short, the plan indicates coverage of all the services contained in the benchmark plan, with the appropriate services exempt from limitations.

[20] Humana Connect Silver 4600/6300 (a URL is not available for this plan, but AOTA has the SBC on file)

Colorado QHP 3[21]

Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions*
Rehabilitation services	**Tier 1** **40%** coinsurance/visit **Tier 2** **40%** coinsurance/visit	**Tier 1** **$60** copay/visit **Tier 2** **$60** copay/visit	**50%** coinsurance/visit	Combined Network/Non-Network limit of 20 therapy visits per year each for physical therapy, occupational therapy, and speech therapy. The 20 visit limitation is a single combined limit for rehabilitation and habilitation services. Not limited for children up to age 5 with congenital defects; No therapy limitation for autism.
Habilitation services	**Tier 1** **40%** coinsurance/visit **Tier 2** **40%** coinsurance/visit	**Tier 1** **$60** copay/visit **Tier 2** **$60** copay/visit	**50%** coinsurance/visit	Combined Network/Non-Network limit of 20 therapy visits per year each for physical therapy, occupational therapy, and speech therapy. The 20 visit limitation is a single combined limit for rehabilitation and habilitation services. Not limited for children up to age 5 with congenital defects; No therapy limitation for autism.

Figure 7

As noted in a footnote 18 above, AOTA has partnered with the Occupational Therapy Association of Colorado to advocate for a resolution to the apparently noncompliant plans identified in Colorado. Those efforts resulted in communications from state officials that expressed a commitment to ensure that all Colorado QHPs will provide the required level of access to services. However, as the examples

[21] Colorado HealthOP Bison PPO-4 (accessed 9/12/14): https://s3-us-west-2.amazonaws.com/cohealthop/public/plans/grids/individual/SBC_ENG_COHealthOP_20472CO0010006-01_20131106+Bison+PPO-4.pdf

above illustrate, some Colorado QHPs' SBCs for the 2014 plan year are not representative of compliance with the EHB requirements.

Example 2—Arkansas

Arkansas's EHB benchmark plan requires 30 combined annual visits of OT, PT, ST, and chiropractic for rehabilitation.[22] In addition, the state defined habilitative services as follows:

> DEFINITION OF HABILITATIVE SERVICES
> Habilitative services are 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.
> COVERAGE OF HABILITATIVE SERVICES
> 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.[23]

Therefore, state and federal regulations require Arkansas QHPs to cover rehabilitative and habilitative services in the following manner (numbers below represent annual visits):

Arkansas Benchmark Requirements

Rehabilitation	Habilitation
30 OT/PT/ST/chiropractic (combined)	OT, PT, ST, and developmental services

However, as the examples below demonstrate, coverage differs from the benchmark in various ways. The first Arkansas QHP (Figure 8 below) may or may not cover OT, PT, and ST for rehabilitation. In addition, there is no indication that it covers OT, PT, and ST for habilitation.

[22] Arkansas EHB Benchmark Plan (CCIIO summary; accessed 9/9/14): http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/arkansas-ehb-benchmark-plan.pdf
[23] Arkansas Insurance Department Requirements for 2014 QHP Certification (Appendix B; Bulletin No. 3B-2013; accessed 9/9/14): www.insurance.arkansas.gov/Legal/Bulletins/3B-2013.docx

Arkansas QHP 1[24]

Services You May Need	Your Cost If You Use an In-network Provider	Out-of-network Provider	Limitations & Exceptions*
Rehabilitation services	$25 copay	Not Covered	Coverage is limited to 30 visits per person per calendar year. Not subject to deductible.
Habilitation services	$25 copay	Not Covered	Coverage for developmental services is limited to 180 visits per person per calendar year. Not subject to deductible.
Other practitioner office visit	$25 copay/visit	Not Covered	Not subject to deductible. Coverage for chiropractic care subject to 30 visit Rehabilitation limit.

Figure 8

The second Arkansas QHP (Figure 9 below) may or may not cover chiropractic, but it otherwise seems to meet the requirements for coverage of rehabilitative and habilitative services (although its SBC does not specify what its outpatient habilitative services consist of to confirm that OT/PT/ST are all covered).

Arkansas QHP 2[25]

Services You May Need	Your Cost If You Use an In-network Provider	Out-of-network Provider	Limitations & Exceptions*
Rehabilitation services	$50 Copay/visit	50% Coinsurance	Prior approval required after limits have been met. 30 Visit(s) per Year. Combined with PT, OT, and ST
Habilitation services	$50 Copay/visit	50% Coinsurance	Prior approval required after limits have been met. Your benefits/ services may be denied. 30 visits per year for outpatient habilitative services, 180 hours per year for developmental services

Figure 9

The third Arkansas QHP (Figure 10 below) seems to meet all the coverage requirements except there is no reference to developmental habilitative services.

[24] Arkansas Blue Cross Blue Shield: Silver 2500 PPO (accessed 9/9/14): https://secure.arkansasbluecross.com/members/ViewSbc.aspx?id=32001

[25] Ambetter of Arkansas: Ambetter Silver 1 (accessed 9/9/14): https://api.centene.com/SBC/62141AR0080003-01.pdf

Arkansas QHP 3[26]

Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions*
Rehabilitation services	$150 Co-payment	50% Coinsurance	PT/OT/ST combined with Chiro 30 visit CY limit
Habilitation services	$150 Co-payment	50% Coinsurance	PT/OT/ST 30 visit CY limit; requires Pre-auth
Other practitioner office visit	$150 Co-payment	50% Coinsurance	Chiro combined with PT/OT/ST 30 visit CY limit

Figure 10

Although the QHPs from Arkansas listed above may or may not meet the benchmark requirements, none of them provide adequate information in their SBCs to confirm that they do. It should be noted that Arkansas's Insurance Department clarified habilitation coverage requirements in its 2015 plan year certification requirements. Those requirements establish a minimum standard of 180 hours for developmental services, and confirm that at least 30 visits of OT/PT/ST must be covered for habilitation *in addition* to 30 visits for rehabilitation.[27] With these clarifications, it seems even less likely that the aforementioned Arkansas QHPs meet the benchmark standards.

Example 3 – Ohio

Ohio's EHB benchmark plan requires 20 annual visits for *each* of the following therapies: OT, PT, ST, and pulmonary therapy. In addition, it requires 36 annual visits for cardiac rehabilitation.[28] As with Colorado and Arkansas, Ohio provided a definition of coverage requirements for habilitation. Its definition is as follows:

> Habilitative services benefits shall be determined by the individual plans and must include, but shall not be limited to, Habilitative Services to children (0 to 21) with a medical diagnosis of Autism Spectrum disorder which at a minimum shall include:
> (1) Out-Patient Physical Rehabilitation Services including

[26] Silver Basic Plus: QCA Health Plan, Inc. (accessed 9/9/14): https://www.qualchoice.com/%21userfiles/pdfs/Products%20and%20Services/ES0150I-QCRX902M.pdf

[27] Arkansas Insurance Department Requirements for 2015 QHP Certification (Appendix F; Bulletin No. 9-2014; accessed 9/9/14): http://www.insurance.arkansas.gov/Legal/Bulletins/9-2014.pdf

[28] Ohio EHB Benchmark Plan (CCIIO summary; accessed 9/9/14): http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/ohio-ehb-benchmark-plan.pdf

(a) Speech and Language therapy and/or Occupational therapy, performed by a licensed therapists [*sic*], 20 visits per year of each service; and
(b) Clinical therapeutic intervention defined as therapies supported by empirical evidence, which include but are not limited to applied behavioral analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the services in accordance with a treatment plan, 20 hours per week;
(2) Mental/Behavioral Health Outpatient Services performed by a licensed psychologist, psychiatrist, or physician to provide consultation, assessment, development, and oversight of treatment plans, 30 visits per year total.[29]

Therefore, state and federal regulations require Ohio QHPs to cover rehabilitation and habilitation with at least the following covered services and limits (numbers below represent annual visits unless otherwise indicated):

Ohio Benchmark Requirements

Rehabilitation	Habilitation
20 OT, 20 PT, 20 ST, 20 pulmonary therapy, 36 cardiac rehabilitation	"…must include, but shall not be limited to…Services [for] children (0-21) with a…diagnosis of Autism Spectrum disorder…" 20 ST, 20 OT, 20 hours per week of clinical therapeutic interventions (including, but not limited to Applied Behavioral Analysis or ABA), 30 mental/behavioral health

Putting aside the fact that Ohio's definition of habilitation includes age- and health status–based references that could lead to QHP limitations contrary to the ACA's prohibition on

[29] Letter to CCIIO from Ohio Governor John Kasich, 12/26/12 (accessed 9/9/14): https://www.insurance.ohio.gov/Company/Documents/Habilitative%20Services%20Letter.pdf

discriminatory EHB designs,[30] many Ohio QHPs seem out of compliance with these benchmark standards (as evidenced below).

The first Ohio QHP (Figure 11 below) covers unspecified services at a rate of 20 visits per year for rehabilitation, and provides no information about what habilitative services are covered, so it is not possible to confirm that it's meeting the benchmark standards.

Ohio QHP 1[31]

Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions*
Rehabilitation services	30% Coinsurance after deductible	Not covered	Prior approval required after limits have been met. 20 Visit(s) per Year
Habilitation services	30% Coinsurance after deductible	Not covered	Prior approval required after limits have been met. Your benefits/ services may be denied. Exclusions or limitations may apply

Figure 11

The second Ohio QHP (Figure 12 below) provides much more information about its coverage, and in many respects mirrors the benchmark. However, its habilitation coverage combines the visits for ST and OT, and it limits habilitative services based on age and diagnosis, both of which are contrary to Ohio's chosen standards. Although Ohio's definition of coverage requirements for habilitative services is somewhat long and complicated, it is clear on several points, including the following (emphasis added): covered services "***must include, but shall not be limited to***, habilitative services to children (0-21) with a medical diagnosis of autism spectrum disorder, which ***at a minimum shall include***…speech and language therapy and/or occupational therapy, performed by a licensed therapists [*sic*], ***20 visits per year of each service***…."Although Ohio did reference age and diagnosis in its coverage requirements, it clearly states that coverage must go beyond the minimum it requires for the demographic it specifies. In addition, although some confusion could be expected due to the use of "and/or" in reference to ST and OT, the next clause is less ambiguous in stating that *each* service must have a minimum limit of 20 visits per year.

[30] The Ohio requirements actually *prohibit* habilitation coverage that only provides habilitative services for children with an autism diagnosis (i.e., by stating "must include, but shall not be limited to"), but including an age limit still seems contrary to the ACA's requirements.

[31] Buckeye Community Health Plan Ambetter Silver 1 (accessed 9/9/14): https://api.centene.com/SBC/41047OH0010005-03.pdf

Ohio QHP 2[32]

Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions*
Rehabilitation services	40% coinsurance	60% coinsurance	Must be illness/injury related. Coverage for outpatient cardiac rehabilitation is limited to 36 visits per calendar year. Outpatient speech, occupational and physical therapy is limited to 20 visits each per calendar year.
Habilitation services	40% coinsurance	60% coinsurance	Coverage for Autism Spectrum Disorder (must be under 21 years of age) is limited to the following:; Speech/Language/Occupational Therapy -20 visits per calendar year; Mental/Behavioral Health Outpatient Services-30 visits per calendar year; and, therapies for Applied Behavioral Analysis-20 hours per week.

Figure 12

The third Ohio QHP (Figure 13 below) has a description of covered services for rehabilitation that is of little value, specifying a vague visit limit range and no specific therapies. Its habilitation coverage description is little better by using Ohio's awkward use of "and/or" in reference to ST and OT, a consumer would not know which therapies are covered and to what extent. Therefore, it is impossible to determine whether it meets the benchmark standard, although it seems unlikely, with no reference to the required clinical therapeutic interventions for habilitation required by the benchmark plan.

[32] Aultcare Silver 5000 Select (accessed 9/9/14): http://www.aultcas.com/Application/na/getForm.aspx?sbc=sbc626.pdf

Ohio QHP 3[33]

Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions*
Rehabilitation services	Benefits reflect those stated for each covered service category.	Not covered.	Depending on the type of therapy, there is a limit of 12-36 visits per calendar year.
Habilitation services	Benefits reflect those stated for each covered service category.	Not covered.	Speech and language therapy and/or occupational therapy, 20 visits per benefit year. Mental/behavioral health outpatient services, 30 visits per benefit year.

Figure 13

The fourth Ohio QHP (Figure 14 below) also unfortunately carries over the use of "and/or" in reference to coverage of habilitative services, unnecessarily causing confusion for consumers. However, the plan otherwise indicates that it meets most (but not all) of the state's coverage requirements.

Ohio QHP 4[34]

Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions*
Rehabilitation services	**$50 Copay**	**Not Covered**	20 visits each for Physical, Speech and Occupational therapy; 36 visits for Cardiac therapy.
Habilitation services	**$50 Copay**	**Not Covered**	20 visits each / year for Speech and/or Occupational therapy; Clinical Therapeutic Intervention 20 hours per week.

Figure 14

[33] Just4Me Individual Silver: CareSource (accessed on 9/9/14): https://www.caresource.com/documents/just4me-individual-silver-summary-of-benefits-2/

[34] HealthSpanOne 3000-80 (accessed on 9/9/14): http://static.squarespace.com/static/520e7861e4b086f44d23f509/t/52531403e4b0e4152af3710f/1381176323033/HealthSpanOne3000-80SBC.pdf

The fifth Ohio QHP (Figure 15 below) leaves out important information about coverage of rehabilitative services, but of even greater concern is the inclusion of the phrase "Habilitative services benefits shall be determined by the individual plans" to describe this plan's coverage of habilitative services. Of course, a plan's SBC is supposed to be representative of an "individual plan," so the inclusion of that phrase is of no use to a consumer evaluating that plan. It appears this is another unfortunate carryover from Ohio's coverage standards, as that same phrase appears in the document that created Ohio's requirements.

Ohio QHP 5[35]

Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions*
Rehabilitation services	40% Coinsurance after deductible	Not covered	Inpatient limited to 60 days per year. Outpatient therapy services limited to 20 visits per therapy type.
Habilitation services	40% Coinsurance after deductible	Not covered	Habilitative services benefits shall be determined by the individual plans.

Figure 15

As is hopefully evident from all these examples, many QHPs in Ohio seem to fail to comply with the state's coverage requirements and/or provide inadequate information in their SBCs to determine their compliance. Of course, the exclusion of that information from the SBCs also prevents consumers from being fully informed and well positioned to make educated decisions when evaluating which plan to purchase. It seems clear that a comprehensive review of QHPs' compliance with the EHB coverage requirements for rehabilitative and habilitative services is warranted.

Other Findings

This research was designed primarily to ascertain whether consumers have access to adequate and accurate information about QHPs' rehabilitation and habilitation benefits, and to determine whether QHPs' rehabilitation and habilitation benefits conform to the standards established by each state's benchmark plan. The conclusions drawn about those issues are summarized above in the Key Findings section. However, a number of other observations were made as this research was conducted. This section will summarize those additional observations.

- **A number of QHPs that provide coverage for out-of-network services (e.g., PPOs) restrict rehabilitation and habilitation coverage to in-network providers only.**

[35] Paramount Insurance Company: Paramount HMO Silver (accessed 9/9/14): http://www.paramounthealthcare.com/documents/marketplace/Paramount-HMO-Silver-01.pdf

Although this research did not systematically collect QHPs with a particular type of provider network design (e.g., PPO, EPO, HMO), the process by which QHPs were selected was sufficiently random that a variety of plan designs fell within the data collected. As a result, it was observed that some plans that provided out-of-network coverage (e.g., PPOs) restricted rehabilitation and habilitation coverage to in-network providers. This has ramifications for consumers who may select a certain plan design (e.g., a PPO) with the expectation that it provides some level of reimbursement for out-of-network providers for *all* services that it covers in-network. This is also of importance to any discussions about network adequacy in general, because the existence of more comprehensive plan designs (like PPOs) in any given market does not inherently ensure that consumers will have access to out-of-network providers for all services any particular PPO covers. It may be appropriate for any QHPs providing only *some* coverage out-of-network to indicate that more explicitly. This is even more important for any covered services not described in the SBC.

- **Some QHPs' rehabilitation and habilitation benefits have cost-sharing that is so significant that the plans are in effect not offering an actual benefit at all.**

In some instances, a QHP's cost-sharing for in-network outpatient rehabilitative and habilitative services is likely more than or equal to the reimbursement rate the Insurance carrier has negotiated with the provider. For example, Arkansas QHP 3 (see Figure 10 above) imposes a $150 copayment for these types of services. In many cases (likely most), a therapist will not receive more than $150 as an in-network provider for an outpatient therapy visit. Therefore, to impose that level of cost-sharing is to effectively have no in-network therapy benefit at all.[36] It seems appropriate to classify plans with benefit designs like this as not covering the EHBs as required.

- **Regulatory requirements may need to be enhanced to ensure consumers have adequate information about QHPs in general.**

In the Key Findings section, many examples were provided of QHP SBCs that provided inadequate information about coverage of rehabilitative and habilitative services. However, there are other related issues that were not highlighted. For example, in Louisiana, there are five insurance carriers offering marketplace coverage, and not one included any information about covered therapies or visit limits for their rehabilitation and habilitation benefits in their SBCs. What is a consumer for whom that information is relevant to his or her decision making process to do? All the SBCs for QHPs in Louisiana did include a telephone number for inquiries unanswered by the SBC, but why should a consumer in Louisiana have to call five different

[36] There could still be certain benefits derived from having in-network coverage, such as a contractual prohibition on balance billing. However, the conventional understanding of any health insurance benefit is that the plan covers some of the costs for any covered services. In the case of the plan identified here, that conventional understanding would not apply.

telephone numbers to acquire information that dozens of other insurance carriers included in plain terms in the same SBC that the Louisiana insurance carriers had to fill out for their QHPs? Similarly, many carriers refer consumers to "other plan documents" at various points within their SBCs, and they often provide URLs for their websites, with the implication being that those documents are accessible on those websites. However, this research revealed that more often than not, no additional plan documents could be found on the carriers' websites. These types of informational barriers likely apply to consumers whose primary interest is in services other than rehabilitation and habilitation as well.

One potential (and partial) solution to these problems may be to require states to publish the benchmark coverage requirements in the form of an SBC, and stipulate to consumers that if a QHP's SBC does not provide information about covered services within a particular field of the SBC, it can be assumed that the QHP covers services at the benchmark level. Another possible solution would be to require insurance carriers to prominently provide public access on their websites to all QHP documents, including SBCs and more detailed subscriber terms (e.g., "evidence of coverage" documents). Regardless of the specific means by which consumers are provided more information, it seems necessary to ensure that access to additional details about QHP terms of coverage is provided.

Conclusion

Although a variety of challenges have been identified by this research, most of them could likely be resolved through the issuance of additional guidance, enhanced oversight and enforcement, and increased diligence by insurance carriers. AOTA is committed to working with all stakeholders to address these issues in the most efficient and equitable manner possible.

Appendix 1: Detailed Methodology

Overview

For a summary of the research methodology, please see the overview at the beginning of this report. It has already been stated that the methodology consisted of two stages to ensure the representative nature of the data collected. In addition, the earlier overview indicated that the findings were based on a data set that included an SBC for a silver plan for each insurance carrier selling marketplace coverage in each state. In sum, there were 270 carriers identified for the 50 states plus the District of Columbia. Four of those carriers' SBCs were not found, so the aggregate analysis is of 266 SBCs that should be representative of the range of carrier offerings throughout the country on the core data points of therapies covered and visit limits for rehabilitation and habilitation. Other information was collected about cost sharing and plan design that would not be representative of all carrier offerings.

How were the SBCs acquired?

The SBCs were acquired in one of three places, and in the following order:

1. The federal database housed at the following link (accessed 9/14/14): https://data.healthcare.gov/dataset/QHP-Landscape-Individual-Market-Medical/b8in-sz6k
2. Through state-run marketplace websites
3. From insurance carriers' websites

Is it possible some carriers selling marketplace plans are absent from the data collected?

Yes, the federal database includes information only for states that are not operating their own marketplaces. There was no single resource to access information about all carrier offerings for those states not in the database. As a result, there are likely some carriers' offerings not represented, particularly from states that are operating their own marketplaces that are geographically large. (In geographically large states, some carriers operate regionally and therefore cannot be counted on to appear while "window-shopping" on that state's marketplace, because to window shop one typically needs to enter a zip code.) As mentioned above, there are also four carriers identified as selling marketplace coverage for which the SBCs were not obtainable (at least not by the means through which the other 266 were obtained).

Where is the data underlying the report's findings kept?

AOTA has entered the data into a spreadsheet. A subset of that data is available in Appendix 2.

Is there a way to access the SBCs to verify the data or better understand the findings?

Yes, in most cases. Appendix 3 includes URLs for most of the SBCs. In some cases, it was difficult or impossible to obtain a URL, so the SBC was downloaded and is housed on AOTA's servers (when the URL contains "G:" instead of "http" or "www," then the SBC is on AOTA's servers and

will not be accessible directly for those not logged into AOTA's network). It should also be noted that the URLs may be disabled as carriers begin posting 2015 plan year documents. AOTA has downloaded copies of all SBCs to its network to ensure ongoing access if necessary.

What do the abbreviations in the summary chart refer to, and what are the other conventions that may require interpretation?

There is an abbreviations' key in Appendix 4. However, there are a number of other conventions for how the data was entered that must be known to understand it, including the following:

1. If slashes are used between the abbreviations for the therapies (e.g., OT/PT/ST), then any numerical limit associated with those therapies (e.g., an annual visit limit represented by the number 30) applies to all of those therapies combined. Therefore, if a plan beneficiary were to visit an occupational therapist three times, a physical therapist five times, and a speech therapist 10 times, and the plan covers 30 OT/PT/ST, then the beneficiary has only 12 visits left for all those therapies. In other words, using three OT visits does not mean the beneficiary has 27 visits for OT left, because the visit limit applies to all the therapies together and 15 visits were used to access the other therapies.
2. In contrast to the example above, if commas are used to separate the abbreviations for the therapies (e.g., OT, PT, ST), then any numerical limit associated with those therapies (e.g., 30 annual visits) applies to each of those therapies. Therefore, there are 90 total therapy visits covered when 30 OT, 30 PT, 30 ST is how the benefits are represented.
3. In most cases, the data collected refer to outpatient services. Unless otherwise indicated, that should always be assumed.
4. Numerical limits can be assumed to represent "visits" unless otherwise described (e.g., by "hours" or "days").
5. Semicolons are sometimes used to separate data representative of significantly different things such as outpatient versus inpatient (abbreviations should help clarify such separations).
6. "Combined with rehab," or something similar, will frequently appear in the habilitation column. That is intended to describe the fact that a visit limit is shared for rehabilitative and habilitative services. In other words, if rehabilitation coverage consists of 30 OT/PT/ST and habilitation coverage is combined with rehabilitation coverage, then a beneficiary has reduced his or her rehabilitation coverage limit by one when he or she accesses habilitative services for one visit (and vice versa). This data point is likely to be error prone, because there are instances when it's open to interpretation.
7. Question marks sometimes appear after various data entries to indicate there was some level of uncertainty about that entry.
8. "Yes" and "no" appear in the deductible column to indicate that "yes," the deductible must be met before the rehabilitation and habilitation coverage takes effect, or "no" the deductible does not apply. Often, a question mark accompanies the "yes" or "no" to indicate (as mentioned above) some level of uncertainty (and generally, unless it was

completely clear, it was treated as uncertain). It should be noted that looking at any particular plan may lead one to believe there is no uncertainty about the applicability of the deductible, but based on significant variation encountered when looking at the data in aggregate, it was determined that such assumptions may not be as reliable as they seem in isolation. A slash appearing in the deductible column means there are differences for in-network and out-of-network coverage (unless otherwise specified).

Appendix 2: QHP Raw Data Summary Chart

State	Issuer	Deductible	Rehabilitation	Habilitation	Limitations
AK	ModaHealth	No?/Yes?	45 OP, 30 IP	Combined with rehab	
AK	Premera BCBS	Yes?	45 OP, 30 IP	Combined with rehab?	
AL	BCBS	Yes	30 OT/PT/ST	Combined with rehab?	
AL	Humana	Yes?	30 PT/OT/ST	Combined with rehab	Preauthorization may be required, penalty will be $500.
AR	Ambetter	Unclear	30 PT/OT/ST	30 visits/180 hours of developmental services	Prior approval required after limits have been met for rehab and hab.
AR	BCBS	No	30 Chiro+?	180 visits of developmental services	
AR	QualChoice	Yes?	30 PT/OT/ST/chiro	30 PT/OT/ST	Hab requires preauthorization
AZ	Aetna	Yes?	60 PT/OT/ST	Combined with rehab	

AZ	BCBS	Yes?	60 PT/OT/ST/C&PR, 90 days EAR/SNF	Combined with rehab	Precertification required for facility admission. $500 charge if not obtained for out-of-network admission. No coverage for group PT or OT....Skilled nursing care covered only through home health and SNF benefits.
AZ	Cigna	Yes	60 PT/OT/ST/C&PR	Combined with rehab?	
AZ	HealthChoice				
AZ	HealthNetLife	Yes?	60	Combined with rehab?	If precertification is not obtained, benefit reimbursement is reduced by 50%. All rehab therapy services combined.
AZ	HealthNetOfArizona	Yes?	60	Combined with rehab?	Requires prior authorization. All rehab therapy services combined.
AZ	Humana	Yes?	60 PT/OT/CogT/audiology/C&RT	Combined with rehab?	
AZ	MeritusHealth	Yes?	60	Nothing specified	
AZ	Meritus Mutual	Yes	60	Nothing specified	

AZ	UniversityofAZ	Yes?	60	ABA	Rehab: Prior authorization is required for certain services. Hab: Prior authorization is required. ABA therapy for autism excludes sensory integration, LOVASS therapy, and music therapy.
CA	LA Care	Yes?	Nothing specified	Nothing specified	Prior authorization is Required.
CA	Chinese Community	Yes?	Nothing specified	Nothing specified	
CA	Sharp Health Plan	Yes?	Nothing specified	Nothing specified	Prior authorization is Required.
CA	Kaiser	No?/Yes	Nothing specified	Nothing specified	
CA	Valley Health Plan	Yes?	Nothing specified	Nothing specified	Charges may incur with no prior authorization.
CA	Western Health Advantage	Yes	Nothing specified	Nothing specified	
CA	Anthem BCBS	Yes	Nothing specified	Nothing specified	

CA	Blue Shield of CA	Yes	Nothing specified	Nothing specified	
CA	Molina	Yes?	Nothing specified	Nothing specified	Prior authorization is required, or services are not covered.
CA	Health Net	Yes?	Nothing specified	Nothing specified	Requires prior authorization.
CO	Anthem BCBS	Yes	20 PT, 20 OT, 20 ST	20 PT, 20 OT, 20 ST	
CO	Kaiser	Rehab yes?/hab No	40 per therapy; 60 IP per condition	Combined with rehab; unlimited autism	IP rehab specified ”multi-disciplinary facility.”
CO	Colorado Healthop	Yes?	20 PT, 20 OT, 20 ST	Combined with rehab; unlimited autism	Not limited for children up to age 5 with congenital defects
CO	Cigna	Yes?	20 per therapy	20 per therapy	
CO	Humana	Yes?	10 Chiro; 20 “for all other therapies”	10 chiro; 20 ”for all other therapies”	Preauthorization required; penalty may apply.
CO	Rocky Mountain Health Plans	Yes	40; unlimited CP	Combined with rehab	
CO	Denver Health	Yes?	20 PT, 20 OT, 20 ST	20 PT, 20 OT, 20 ST	
CO	United Healthcare				
CO	Colorado Choice				

CO	Access Health	Yes?	CR/OT/PT/PY&RY/ST	40	Rehab: Check with plan for limitations that may apply based on type of therapy. Precertification required. If not obtained, payment may be reduced or the service may not be covered. Hab: Precertification required. Payment for the service may not be covered if precertification not obtained.
CT	Connecticare	Yes	40	Combined with rehab	
CT	Anthem BCBS	Yes?	40 PT/OT/ST	Habilitation and rehabilitation visits count toward your rehabilitation limit.	
CT	Healthy Partner	No?/Yes	40	Combined with rehab	
D.C.	Aetna DC	Yes?	Nothing specified	Nothing specified	
D.C.	CareFirst Blue Choice	Yes	Nothing specified	30 per condition, if 21 years or older	Hab requires preauthorization.

D.C.	Kaiser	Yes?/Yes	90 CR consecutive days, 1 PR program per lifetime	Nothing specified	No IP rehab
DE	Coventry	Yes?	Nothing specified	30	Not covered without prior authorization
DE	Highmark BCBS	No	30 PT/OT, 30 ST	30 PT/OT, 30 ST, $36,000 ABA	Precertification may be required.
FL	Aetna	Yes?	35 PT/OT/ST/chiro	Combined with Rehab	Spinal manipulation not to exceed 26 visits.
FL	Ambetter from Sunshine	Yes	35	Nothing specified	Rehab: Prior approval required after limits have been met. Hab: Prior approval required after limits have been met. Your benefits/ services may be denied.
FL	Cigna	Yes?	35	35?	Coverage is limited to 35 visits annual max for all rehabilitative therapies combined.
FL	Coventry	Yes?	Nothing specified	Nothing specified	Consequence for no preauthorization if required.
FL	BCBS	Unclear/Yes	35	Combined with rehab	Implies no IP rehab. Services performed in hospitals may have a higher cost-share.
FL	FloridaHealthCare	Yes?	35 PT/ST/OT	Combined with rehab	

FL	Health First	Yes	35	20 hours per condition	Authorization required (for hab). See plan provisions for details.
FL	Humana	Yes?	35 PT/OT/ST/RT/cardiac	Combined with rehab	Preauthorization may be required; penalty will be $500.
FL	Molina	No?	35	Combined with rehab?	Rehab includes 26 visit limit for spinal manipulation. Prior authorization is required, or services not covered.
FL	Preferred Medical	No	35 (includes chiro)	Combined with rehab?	Preauthorization required
GA	Alliant	Yes	See certificate of coverage	See certificate of coverage	
GA	Ambetter	Yes	20	20	Rehab: Prior approval required after limits have been met. Hab: Prior approval required after limits have been met. Your benefits/ services may be denied.
GA	BCBS	Yes?	20 PR, 20 ST, 20 OT, 20 PT	Combined with rehab	
GA	Humana	Yes?	20 PT/OT, 20 ST	Combined with rehab	Preauthorization may be required, penalty will be 50% or $500, whichever is less.

GA	Kaiser	No?/Yes	20 PT/OT, 20 ST, unlimited CR	Combined with rehab?	Cardiac rehab: 30% coinsurance after deductible. Inpatient: Prior authorization required.
HI	HMSA	Yes?	Nothing specified	DME, PT/OT, ST	Excludes cardiac rehabilitation. Services may require precertification.
HI	Kaiser	No?/Yes	Nothing specified	Nothing specified	
IA	Avera	Yes?	30 PT, 30 OT, 30 ST, 36 CR (Phase II)	Combined with rehab	Precertification required after 30 visits per plan year for each therapy: physical, occupational and speech.
IA	CoOpportunity	Yes?	Nothing specified	Nothing specified	
IA	Coventry	Yes?	Nothing specified	Combined with rehab?	No inpatient coverage without preauth. Hab ”same as rehab”
IA	Gundersen	Yes?	20 PT, 20 ST, 20 OT	20 PT, 20 ST, 20 OT	Prior authorization required after 20 visits per therapy discipline (physical, speech, occupational)
ID	BC of Idaho	Yes?	20	20	
ID	SelectHealth	Yes?	20 PT, 20 ST, 20 OT	Subject to outpatient rehabilitation limits	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.

ID	Pacific Source	Yes?	20 OP	20 OP	Inpatient: Preauthorization required. No coverage for recreation therapy.
ID	BridgeSpan	Yes?	20 OP	Combined with rehab	
IL	Aetna	Yes?	Nothing specified	Nothing specified	
IL	BCBS	Yes?	Nothing specified	Nothing specified	
IL	Coventry	Yes?	60	60	Preauthorization for OON required; penalty will be lesser of $1000 or 50%.
IL	Health Alliance	Yes?	60 per year	Combined with rehab	
IL	Humana Health Plan Inc.	Yes?	72 CT	Combined with rehab	Preauthorization may be required; penalty will be 50% or $500, whichever is less.
IL	Humana Insurance Company	Yes?	72 CT	Combined with rehab	Preauthorization may be required; penalty will be 50% or $1000, whichever is less.
IL	Land of Lincoln	Yes?	Nothing specified	Nothing specified	
IN	Ambetter	Yes	20 OT, 20 PT, 20 ST	20 OT, 20 PT, 20 ST	Rehab: Prior approval required after limits have been met. Hab: Prior approval required after limits have been met. Your benefits/ services may be

					denied.
IN	Anthem BCBS	Yes	20 PR, 20 ST, 20 OT, 20 PT	Combined with rehab	
IN	MDWise	Yes?	20 PT, 20 OT, 20 ST, 36 CR	20 PT, 20 OT, 20 ST	Combines Tier 1 and Tier 2.
IN	PHP	Yes?	20 PT/OT/ST/PR, 12 MT, 36 CR; 60 IP	Combined with rehab	Inpatient: Prior authorization required to prevent claim denial.
KS	BCBS of Kansas City	Yes?	90 ST/HT; unlimited PT (including skeletal manipulations)/OT	”Same limitations as rehabilitation services“ Combined with rehab?	
KS	BlueCare	Yes	Nothing specified	Nothing specified	
KS	BCBS of Kansas	Yes	Nothing specified	Nothing specified	
KS	Coventry Health and Life	Yes?	20 per therapy	20 per therapy	Prior authorization required. Failure to obtain prior authorization may result in noncovered services.
KS	Coventry Health of Kansas	Yes?	20 per therapy	20 per therapy	Prior authorization required. Failure to obtain prior authorization may result in noncovered

					services.
KY	Anthem BCBS	Yes	20 PT, 20 OT, 20 ST, 20 PR, 36 CR	Habilitation visits count towards your rehabilitation limits.	For network physical therapy and occupational therapy in the office, the primary care physician office cost shares apply. There may be other levels of cost share that are contingent on how services are provided. Please see your formal contract of coverage for a complete explanation.
KY	Humana	Yes?	20 PT, 20 OT, 20 ST, 20 RT, 36 CT	Combined with rehab	Preauthorization may be required; penalty will be $500.
KY	Kentucky Health Coop	Yes?	20 on certain services (speech therapy, physical therapy, etc.)	20 on certain services (speech therapy, physical therapy, etc.)	Preauthorization/Pre-certification may be required.
LA	BCBS	Yes	Nothing specified	Nothing specified	Rehab: Must obtain authorization.

LA	HMO Louisiana	Yes (for rehab IN and OON and hab OON), No (for hab IN)	Nothing specified	Nothing specified	Rehab: Must obtain authorization. Hab IN service doesn't seem to require deductible. (Deductible clearly stated for Hab OON and for all Rehab.)
LA	Humana	Yes?	Nothing specified	Nothing specified	Preauthorization may be required; penalty will be $500.
LA	Louisiana Health Coop	Yes?	Nothing specified	Nothing specified	Prior authorization is required. Failure to obtain prior authorization may result in an additional penalty or nonpayment.
LA	Vantage	Yes?	Nothing specified	Nothing specified	Pre-authorization required.
MA	BMC HealthNet	Yes	60 PT/OT, CR, EI	Nothing specified	Authorization is required. PT/OT limits do not apply to members with autism spectrum disorders or for children under age 3 years who are receiving early intervention services. Early intervention services are covered in full. Cardiac rehab services are covered after deductible is met.

MA	Network Health	Yes?	90 PT and 90 OT per condition, ST	Not covered	Prior authorization required for speech, physical, and occupational therapy. Prior authorization not required for initial evaluation.
MA	Neighborhood Health	No?/Yes	60 PT/OT OP; 60 days IP	Rehabilitation therapy coverage limits apply.	Rehab IP: Prior authorizaiton required. Your cost and coverage limits waived for early intervention services for eligible children.
MA	Ambetter	Yes	60	60	Hab: Prior authorization required after limits have been met. No limit applies to autism, home health care, and speech/hearing disorders.
MA	Minuteman Health	Yes	60	Combined with rehab	
MA	Fallon Community	Yes	60 PT/OT	Nothing specified	Referral and preauthorization required for certain covered services.
MA	Tufts Health	Yes	30 PT, 30 OT	30 PT, 30 OT	Prior authorization may be required.
MA	Harvard Pilgrim	Yes	60 days IP	60 PT/OT	

MA	MA BCBS	Yes	60 (other than for autism, home health care, and speech therapy)	Rehab therapy coverage limits apply.	Cost share and coverage hab limits waived for early intervention services for eligible children.
MD	CareFirst	Yes	30 per condition	30 per condition if 19 years and older.	Hab: Requires prior authorization Benefits available for members age 19 and older are limited to 30 visits/condition/benefit period.
MD	Evergreen Health Coop	Yes?	30 PT, 30 ST, 30 OT, 90 CR	30 PT, 30 ST, 30 OT	Preauthorization is required. Hab is limited to adults 19 years and over.
MD	Kaiser	Yes?/Yes	30 PT, 30 OT, 30 ST, 36 CR sessions or 12 weeks per episode, one PR program per lifetime	30 visits if adult; no limit if under 19 years.	
MD	United Healthcare	Yes?	100 days IP	Adults: 100 days IP (i.e., "...equal to those for rehabilitation and skilled nursing care services"). Children: Benefits for services for children are available for treatment of a congenital or genetic birth	

				defect.	
ME	Anthem BCBS	Yes	60 PT/OT/ST	Nothing specified	
ME	Maine Community	No?/Yes	Nothing specified	Nothing specified	
MI	BlueCare	Yes	30 PT/OT, 30 ST visits; 25 ABA hours of LT per week	Combined with rehab?	ABA through age 18. Rehab may require authorization; Hab requires authorization. PT/OT/ST for autism-unlimited visit limit.
MI	Consumers	Yes?	30 OT/chiro/?	Combined with rehab?	
MI	HAP	Unclear/Yes	30 PT/OT, 30 ST	30 PT/OT, 30 ST	Services may be rendered in the home.
MI	Humana	Yes?	30 PT/OT/Chiro, 30 ST, 30 AT(?)/CT(?), 30 RT(?)/cardiac	Combined with rehab	Preauthorization may be required, penalty will be $500.
MI	McLaren	Yes	OT/PT/ST	Home health and autism?	
MI	Meridian	Yes?	30 PT/OT, 30 ST, 30 CT/PT	Nothing Specified	Pre-certification required or not covered.

MI	Molina	Yes?	30 PT/OT, 30 ST, 30 C&PR	30 PT/OT, 30 ST, 30 C&PR	Prior authorization is required, or services not covered.
MI	Priority Health	Yes?	30 PT/OT/chiro/OMT, 30 ST, 30 CR/PR	135 days PT/OT/ST/ABA (ASD only); 30 PT/OT, 30 ST (non-ASD)	Prior approval required for ABA. Treatment of ASD is available for children and adolescents through the age of 18 years only.
MI	Total Health	Yes	30 days	Nothing specified	
MN	Ucare	Yes	Nothing usual specified	Nothing usual specified	Authorization required
MN	Preferred One	Yes	Nothing specified	Nothing specified	
MN	Medica	Yes?	15 OON	15 OON	
MN	Health Partners	Yes?	Nothing specified	Nothing specified	
MN	BCBC of MN	Yes?	Nothing specified	Nothing specified	First two office visits are combined for all in-network providers for illness/injury related services.

MO	Anthem BCBS	Yes	20 PR, 20 OT, 20 PT	Combined with rehab	For covered services you receive in the office from a physical therapist, you will not have to pay an office visit copayment or coinsurance that is higher than what you would pay for a primary care physician.
MO	BCBS of Kansas City	Yes	20 PT, 20 OT, Unlimited ST/HT, 20 PY, 36 CT	”Same limitations as Rehabilitation services“ Combined with rehab?	
MO	Coventry Health and Life	Yes?	20 per therapy	20 per therapy	Prior authorization required Failure to prior authorization may result in noncovered services.
MO	Coventry Health Care	Yes?	Nothing specified	20 PT, 20 OT, 20 PY, 36 CT	
MS	Ambetter	Yes	20	20	Rehab: Prior approval required after limits have been met. Hab: Prior approval required after limits have been met. Your benefits/ services may be denied.
MS	Humana	Yes?	20 PT/OT, 20 ST, 36 CT	Combined with rehab	Preauthorization may be required; penalty will be $500.

MT	BCBS	Yes?	Nothing specified	ABA+?	No ABA benefits for ASD available for members 19 years of age or older.
MT	Montana Health Coop	Yes?	Nothing specified	Nothing specified	
MT	Pacific Source	Yes	Nothing specified	Nothing specified	IP: Preauthorization required. OP: No coverage for recreation therapy.
NC	BCBS	Yes?	30 OT/PT/Chiro, 30 ST	Combined with rehab	
NC	Coventry	Yes?	30 PT/OT/Chiro, 30 ST	Nothing specified	Inpatient not covered without preauthorization.
ND	BCBS	No/Yes?	30 PT/OT/ST?	Combined with rehab	Deductible is waived IN.
ND	Medica	Yes?	30 per therapy	30 per therapy? Combined with rehab?	
ND	Sanford	Yes?	30 per therapy	30 per therapy? Combined with rehab?	Includes practitioner consult. Includes but is not limited to x-rays, labs, ultrasounds, and rehabilitative therapy.

NE	BCBS	Yes?	45 PT/OT/ST, 20 MT, 18 CR per event, 18 PR	See the ”rehabilitation services“ and ”If you have a hospital stay” sections. Combined with rehab?	OP CR pertains only to ”certain cardiac diagnoses.” OP PR pertains only to ”certain diagnoses and criteria,” and prior certification required. IP must follow withint 90 days of discharge from acute hospitalization; prior certification required. Hab only: educational services not covered; additional limitations and exclusions may apply; prior certification required (from ”If you have a hospital stay” section).
NE	CoOpportunity	Yes?	Nothing specified	Nothing specified	
NE	Coventry	Yes?	45 PT/ST/OT, 36 PY/CT	”Same as rehab.” Combined with rehab?	No inpatient coverage without preauthorization
NE	Health Alliance	Yes?	60 per condition	”See rehabilitation visit maximum” Combined with rehab?	
NH	Anthem BCBS	Yes	20 ST, 20 OT, 20 PT	Combined with Rehab.	

NJ	AmeriHealth	No	30 PT, 30 OT, 30 ST, 30 CogT	30 PT, 30 OT, 30 ST, 30 CogT	
NJ	Health Republic	No?	30	30	Hab: Pre-certification Required
NJ	Horizon BCBS	Yes?/Yes IP	30 Chiro, 30 PT/OT/CogT* (see notes—not listed under rehab on SBC)	IP	IP service requires pre-approval.
NM	BCBS of NM	Yes	PT/OT/ST	Combined with rehab?	
NM	New Mexico Health Connections	No?	Nothing specified	Nothing specified	Failure to obtain prior authorization may result in a denial of coverage.
NM	Presbyterian Health Plan	Yes?	Nothing specified	Nothing specified	Prior authorization may be required.
NM	Molina of NM	Yes?	Nothing specified	Nothing specified	Prior authorization is required, or services not covered.
NV	Saint Mary's	Yes?	60 PT, 60 OT, 60 ST	200 autism	Rehab is combined with acute rehabilitation visits.
NV	Anthem BCBS	Yes?	60 PT/OT/ST	Habilitation and rehabilitation visits count toward your rehabilitation limits.	
NV	Nevada Health Coop	No/Yes?/Yes?	60	60	Inpatient rehabilitation services require prior authorization; otherwise, benefits

					may be reduced.
NV	Health Plan of Nevada	Yes?/Yes	Nothing specified	Nothing specified in hab section; ABA is 250 visits with maximum of 750 hours.	
NY	Affinity	Yes	60 per condition, per lifetime combined therapies	60 per condition, per lifetime combined therapies.	Preauthorization required. Rehab: Speech and physical therapy are only covered following a hospital stay or surgery.
NY	Today's Options of NY	Yes	PT/OT/ST	PT/OT/ST	
NY	CDPHP	Yes	60 per condition, per lifetime combined therapies	60 PT/OT/ST per condition, per lifetime combined therapies; 680 hours ABA	Rehab: If you do not secure authorization before receiving care, you can be held responsible for an additional payment of 50% of the allowed amount, up to $500 per service, in addition to your usual cost-share. Hab: ABA services [are] at PCP copay (which happens also to be $0). ABA seems to have no

					lifetime limit, unlike other rehab/hab benefits.
NY	Emblem Health	Yes?	90 OT/PT/ST per condition, per lifetime, Unlimited C&R; 60 IP consecutive days, per condition, per lifetime	90 OT/ST/PT per condition, per lifetime	
NY	Empire BCBS	Yes?	60 PT/OT/ST per condition per lifetime	Habilitation visits counts toward your rehabilitation limit.	Failure to obtain preauthorization may result in noncoverage or reduced coverage.
NY	Univera Healthcare	Yes	60 per condition per lifetime; 1 IP consecutive 60-day stay per condition per lifetime	60 per condition per lifetime	
NY	Fidelis	Yes?	60 per condition, per lifetime	60 per condition, per lifetime	
NY	Health Republic	Yes?	60 per condition per lifetime	60 per condition per lifetime	

NY	Healthfirst NY	Yes	60 per condition, per lifetime combined therapies.	Nothing specified	Preauthorization required
NY	BlueShield of NENY	Yes?	60 per condition, per lifetime	60 per condition, per lifetime	
NY	Metro Plus (Market Plus)	Yes?	60 per condition per lifetime; 1 IP consecutive 60 day period per condition per lifetime, IP short-term PT/ST/OT.	60 per condition per lifetime.	
NY	MVP Healthcare	Yes	54 per condition/lifetime	54 per condition/lifetime	Rehab: ”imitations apply”
NY	North Shore LIJ CareConnect	Yes?	60 per condition per lifetime for combined therapies	60 per condition per lifetime for combined therapies	
NY	Oscar	Yes?	Nothing specified	Nothing specified	
NY	United Healthcare	Yes	60 per lifetime	Combined with rehab	Referral is required. Any combination of outpatient rehabilitation services is limited to 60 visits per lifetime.
OH	Ambetter from Buckeye	Yes	20	Nothing specified	Prior approval required after limits have been met for rehab and hab.
OH	Anthem BCBS	Yes?	20 ST, 20 PR, 20 OT, 20 PT	20 ST, 20 OT (visits), 20 ABA (hours per week)	Habilitation and rehabilitation visits count toward your Rehabilitation limit.

OH	Aultcare	Yes?	36 CR, 20 ST, 20 OT, 20 PT	20 ST/OT, 30 MBH (visits), 20 ABA (hours per week)	Rehab must be illness/injury related. Coverage for ASD (must be under 21 years).
OH	Caresource	Yes?	12 to 36 ”depending on type“	20 ST and/or OT, 30 MBH	
OH	Coventry	Yes?	60 days?	20 OT, 20 ST	Rehab not covered without prior authorization.
OH	HealthSpan	No?	20 ST, 20 OT, 20 PT, 36 CT	20 ST and/or OT visits? 20 CTI hours per week	
OH	Humana	Yes?	20 PT, 20 OT, 20 ST, 20 or 36 CT?, 20 RT	Combined with rehab	Preauthorization may be required; penalty will be $500.
OH	Kaiser	Unclear	20 per type	20 PT, 20 OT, 20 ST visits; 20 TI hours per week	Prior authorization required for IP. TI is for children birth to 21 years.
OH	MedMutual	Yes?	40 PT/OT?	40 OT/PT? 20 ST, 20 OT autism?, 20 ST autism?	
OH	Molina	Yes?	20 PT/ST/OT, 36 CR, 12 chiro	30 Autism	Prior authorization is required, or services not covered.
OH	Paramount	Yes	20 per therapy type, 60 IP	Habilitative services benefits shall be determined by the individual plans.	

OH	SummaCare	Yes?	20 OT, 20 PT, 20 ST, 36 CR, 20 PR, 90 days SNF	30	
OK	Aetna	Yes?	25 PT/OT/ST/chiro	Autism; non-autism combined with Rehab.	
OK	BCBS	Yes	25 PT/ST/OT; 30-day IP	Combined with Rehab.	Preauthorization required
OK	CommunityCare	Yes?	60 PT/OT/ST per disability (is this only describing the IP benefit? It's described in terms of days….)	60 PT/OT/ST per disability (Combined with rehab?)	Requires preauthorization. Failure to receive preauthorization will result in non-payment of benefits.
OK	Coventry Health and Life	Yes?	20 per therapy	20 per therapy	Prior authorization required. Failure to prior authorization may result in non-covered services.
OK	Coventry Health Care of KS	Yes?	20 per therapy	20 per therapy	Prior authorization required. Failure to prior authorization may result in noncovered services.
OK	GlobalHealth	Yes?	30 per injury or illness	30 per injury or illness	Referral and preauthorization required.
OR	ModaHealth	Yes?	30; 30 days IP	Combined with rehab	
OR	HealthNet (HNOR)	Yes?	30; 30 days IP	Combined with rehab?	May require prior authorization. IP is "Level 1/2 combined."

OR	Providence	Yes?	30, and ”up to 30 additional visits per specified condition“; ”30 days/60 days head/spinal” IP.	Combined with rehab	
OR	Pacific Source	No/Yes?	30 per condition; 30 days IP per condition	30 per condition; 30 days IP per condition	No coverage for recreational therapy. IP preauthorization required. OP is up to 30 additional visits if neurological condition. IP is 60 days if head or spinal cord injury.
OR	LifeWise	No?/Yes?	30; 30 IP days	Combined with rehab	
OR	Health Republic	Yes	30 days	30 days	Additional 30 days for head/spinal cord injury.
OR	Kaiser	No?/Yes	30; 30 IP days	30 IP days	Additional 30 IP days for head or spinal cord injury [for Rehab and Hab separately]. Additional 30 [OP Rehab] visits for neurological condition.
OR	Oregon Health Co-op	Yes?/Yes	30	30	Preauthorization required
OR	BridgeSpan	No/Yes	30; 30 IP days	30; 30 IP days	Coverage for neurodevelopmental therapy is limited to services for insureds through age 17.

OR	Atrio	Yes?	30; 30 days IP	30; 30 days IP	OP: Prior authorization required. Up to 30 additional visits if neurological condition [each, for OP and IP Rehab, and for OP Hab]. IP Hab: 60 days if head or spinal cord injury.
OR	Trillium	Yes?	30 days/visits IP/OP	30 days/visits IP/OP	An additional 30 days/visits per condition for neurological conditions.
PA	Aetna	Yes?	30 PT/OT, 30 ST	Combined with rehab	
PA	Blue Cross of NEPA	Yes	30 PT/OT, 30 ST	30 PT/OT, 30 ST	
PA	Capital BlueCross	Yes	60 PT/OT, 60 ST, 20 RY	Combined with rehab	
PA	Geisinger Choice	No?/Yes	30 PT/ST/OT?	30 combined (Combined with what, rehab?)	
PA	Geisinger Health	Yes	30 combined	30 combined	
PA	HealthAmerica	Yes?	Nothing specified	30	Rehab: Not covered without Prior Authorization. Hab: Covered only as required by state and federal mandates.

PA	Highmark Health	Yes?	30 PM, 30 ST/OT	Combined with rehab	
PA	Highmark Inc.	Yes	30 PM, 30 ST/OT	Combined with rehab	
PA	Independence BC	No/Yes	30 ST, 30 PT/OT	30 ST, 30 PT/OT	
PA	Keystone (Capital Blue)	N/A	60 PT/OT, 60 ST, 20 RY	Combined with rehab	
PA	UPMC	Yes?	30 PT/OT, 30 ST	30 PT/OT, 30 ST	
RI	Neighborhood Health	Yes?	Nothing specified.	Nothing specified	
RI	BCBS of RI	Yes	Unlimited ST, 10 PT, 10 OT	Unlimited ST, 10 PT, 10 OT	Preauthorization is recommended for Speech Therapy. Additional visits [for PT/OT?] may be covered but are subject to preauthorization.
SC	BlueChoice	Yes	30 OT/PT/ST	Combined with rehab	
SC	BCBS	Yes?	30 PT/OT/ST	Combined with rehab	No inpatient benefits if not preapproved.
SC	Consumers Choice	Yes?	20 OT, 20 ST, 20 PT	Combined with rehab	Prior authorization is required for Occupational, Speech and Physical therapy after the 10th visit.
SC	Coventry	Yes?	30 PT/OT/Chiro, 30 ST	Nothing specified	Inpatient not covered without

					preauthorization.
SD	Avera	Yes?	30 PT, 30 OT, 30 ST, 36 CR	Combined with rehab	Precertification required after 30 visits per plan year for each therapy: physical, occupational and speech.
SD	DakotaCare	Yes?	No numbers specified. Conscribed OT/ST mentioned.	Combined with rehab	50% Penalty for NPP Rehab. (See Cost Share column.) Inpatient services require preauthorization and are only available at designated facilities. Occupational therapy is limited to upper extremities only. Speech therapy is limited to the restoration of speech and swallowing abilities lost due to an illness or injury. Outpatient services provided by non-participating providers are not covered.
SD	Sanford	Yes?	30 per therapy	Combined with rehab?	Includes practitioner consult. Includes but is not limited to x-rays, labs, ultrasounds and

					rehabilitative therapy.
TN	BCBS	Yes	20 visits per therapy, 36 C&PR	Combined with rehab	
TN	Cigna	Yes/Yes?	20 per therapy	20 per therapy	
TN	Community Health Alliance	Yes?	20 OT, 20 ST, 20 PT	Combined with rehab	Prior authorization is required for Occupational, Speech and physical therapy after the 10th visit annually.
TN	Humana	Yes?	20 PT/OT, 36 CT/RT (36 CT, 36 RT?)	Combined with rehab	Preauthorization may be required, penalty will be $500.
TX	Aetna	Yes?	35 PT/OT/ST/chiro	Non-autism hab services are combined with rehab; autism.	
TX	Ambetter	Yes	35	35	Rehab: Prior approval required after limits have been met. Hab: Prior approval required after limits have been met. Your benefits/ services may be denied.
TX	BCBS	Yes	35 including chiro	Combined with rehab	$250 IP

TX	Cigna	Yes?	35	35	
TX	Community Health Choice	Yes	35 OP	Combined with tehab	Benefit visit limitation is combined with habilitation services, chiropractic care, rehabilitative speech therapy, and rehabilitative occupational, & speech therapy.
TX	Community First	Yes?	35	35	
TX	First Care	Yes?	35	35	Services that are not preauthorized will be denied.
TX	Humana Health Plan	Yes?	35 PT/OT/ST/CT/AT/RT/Cardiac/Chiro	Combined with rehab	Preauthorization may be required, penalty will be 50% or $500 whichever is less.
TX	Humana Insurance	Yes?	35 PT/OT/ST/CT/AT/RT/Cardiac/Chiro	Combined with rehab	Preauthorization may be required, penalty will be 50% or $500 whichever is less.
TX	Molina	Yes	35	35	Prior authorization is required, or services not covered.
TX	Scott and White	Yes?	Nothing specified	Nothing specified	

TX	Sendero	Yes?	35 PT/OT/ST/chiro	Non-autism hab services are combined with rehab; autism.	Preauthorization may apply. [35 Visit] limit does not apply to Autism Spectrum Disorder treatment through 9 years of age.
UT	Altius	Yes	30	20	Prior authorization required.
UT	Arches	Yes	20	Combined with rehab	
UT	BridgeSpan	Yes?	20; 30 IP	Combined with rehab OP	The 30 IP days are combined with skilled nursing care.
UT	Humana	Yes?	20 PT/OT/ST	Combined with rehab	Preauthorization may be required;, penalty will be $500.
UT	Molina	Yes?	20	Combined with rehab	Prior authorization is required, or services not covered.
UT	Select Health	Yes?	20 PT, 20 ST, 20 OT; 40 PT/ST/OT IP	Subject to outpatient rehabilitation limits.	Benefits may be denied or reduced by 50% for failure to obtain preauthorization for certain services.
VA	Aetna	Yes?	30 PT/OT, 30 ST	Combined with Rehab; Early Intervention	Early intervention unlimited up to age 3.
VA	CareFirst	Yes	30	30	
VA	Coventry	Yes?	30 PT/OT, 30 ST (all OP)	30 PT/OT, 30 ST (all OP)	IP not covered without preauthorization

VA	Group Hospitalization (BCBS)	Yes	30	30	
VA	Health Keepers (Anthem)	Yes	30 PT/OT, 30 ST	Combined with Rehab.	Apply to in-network providers. Habilitation and rehabilitation visits count toward your rehabilitation limit.
VA	Innovation	Yes?	30 PT/OT, 30 ST	Combined with rehab; Early intervention	Early intervention unlimited up to age 3.
VA	Kaiser	Yes	30 PT/OT, 30 ST (all OP)	Combined with rehab	
VA	Optima	Yes?	30 PT/OT, 30 ST	Combined with rehab	Preauthorization required.
VT	BCBS of VT	Yes	Nothing specified other than IP and CP	IP	Inpatient rehabilitation services require prior approval. Frequency limits apply. Hab: Requires prior approval.
VT	MVP Healthcare	Yes?/No	30 PT/OT/ST	30 PT/OT/ST	
WA	LifeWise of WA	Yes?	25; 30 IP days	25; 30 IP days	
WA	Premera BCBS	Yes?	25; 30 IP days	25; 30 IP days	
WA	Group Health Coop	Yes?	25; 30 IP days	25; 30 IP days	Requires preauthorization.

WA	BridgeSpan	Yes?	25; 30 IP days	25 OP; 30 IP days; 25 OP NDT	Coverage for neurodevelopmental therapy is limited to services for members through age 6.
WA	Molina of WA	Yes?	25 ST/PT/OT, 20 Chiro, 12 Acu	Nothing specified	Prior authorization is required, or services not covered.
WI	Anthem BCBS	Yes	20 PR, 20 ST, 20 OT, 20 PT	Combined with rehab	Apply to in-network providers. Habilitation and rehabilitation visits count toward your rehabilitation limit.
WI	Arise	Yes?	20 PT, 20 OT, 20 ST, 20 RT; 60 IP	20 PT, 20 OT, 20 ST, 20 RT	
WI	Common Ground	Yes	36 CR	20 PT, 20 OT, 20 ST	Services for custodial care are a policy exclusion.
WI	Dean	Yes	90 days; 60 PT/OT/ST visits	Habilitative means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based	Services for custodial care are a policy exclusion.

				settings.	
WI	Group Health Coop	Yes	40 OT/PT/VT, 20 ST, 36 CPRT	Combined with rehab?	Written prior authorization is required.
WI	Gundersen	Yes?	20 PT, 20 ST, 20 OT, 20 Hab Services	20 PT, 20 ST, 20 OT	
WI	Health Tradition	Yes?	60	Nothing specified	Hab: Prior authorization is required.
WI	Medica	Yes?	20 per therapy	20 per therapy	
WI	MercyCare	Yes (Coinsurance)/Yes? (Copay)	OT/ST	Austism	
WI	Molina	Yes?	20 PT/ST/OT/PY, 36 CR, 30 PCIAT	Nothing specified	Prior authorization is required, or services not covered.
WI	Physicians Plus	Yes	50	Combined with rehab	
WI	Security Health				

WI	Unity	Yes	20 PT, 20 ST, 20 OT, 20 PR, 30 CR, 30 PCIAT; 60 IP days	20 PT, 20 ST, 20 OT
WV	Highmark BCBS	Yes?	30 PM/OT	Combined with rehab
WY	BCBS	Yes?	40 PT, 20 OT/ST; 45 IP days	Combined with rehab
WY	WINhealth	Yes?	40 PT, 40 OT, 20 ST, 1 CR course of treatment	80

Appendix 3: SBC URLs

State	Issuer (Click Link to Read SBC)
AK	ModaHealth
AK	Premera BCBS
AL	BCBS
AL	Humana
AR	Ambetter
AR	BCBS
AR	QualChoice
AZ	Aetna
AZ	BCBS
AZ	Cigna
AZ	HealthChoice - No SBC Link Available
AZ	HealthNetLife
AZ	HealthNetOfArizona

AZ	Humana
AZ	MeritusHealth
AZ	Meritus Mutual
AZ	UniversityofAZ
CA	LA Care
CA	Chinese Community
CA	Sharp Health Plan
CA	Kaiser
CA	Valley Health Plan
CA	Western Health Advantage
CA	Anthem BCBS
CA	Blue Shield of CA
CA	Molina
CA	Health Net
CO	Anthem BCBS

CO	Kaiser
CO	Colorado Healthop
CO	Cigna
CO	Humana
CO	Rocky Mountain Health Plans
CO	Denver Health
CO	United Healthcare - No SBC Link Available
CO	Colorado Choice - No SBC Link Available
CO	Access Health
CT	Connecticare
CT	Anthem BCBS
CT	Healthy Partner
D.C.	Aetna DC

D.C.	CareFirst Blue Choice
D.C.	Kaiser
DE	Coventry
DE	Highmark BCBS
FL	Aetna
FL	Ambetter from Sunshine
FL	Cigna
FL	Coventry
FL	BCBS
FL	FloridaHealthCare
FL	Health First
FL	Humana
FL	Molina
FL	Preferred Medical
GA	Alliant

GA	Ambetter
GA	BCBS
GA	Humana
GA	Kaiser
HI	HMSA
HI	Kaiser
IA	Avera
IA	CoOpportunity
IA	Coventry
IA	Gundersen
ID	BC of Idaho
ID	SelectHealth
ID	Pacific Source

ID	BridgeSpan
IL	Aetna
IL	BCBS
IL	Coventry
IL	Health Alliance
IL	Humana Health Plan Inc.
IL	Humana Insurance Company
IL	Land of Lincoln
IN	Ambetter
IN	Anthem BCBS
IN	MDWise
IN	PHP
KS	BCBS of Kansas City
KS	BlueCare

KS	BCBS of Kansas
KS	Coventry Health and Life
KS	Coventry Health of Kansas
KY	Anthem BCBS
KY	Humana
KY	Kentucky Health Coop
LA	BCBS
LA	HMO Louisiana
LA	Humana
LA	Louisiana Health Coop
LA	Vantage
MA	BMC HealthNet
MA	Network Health
MA	Neighborhood Health

MA	Ambetter
MA	Minuteman Health
MA	Fallon Community
MA	Tufts Health
MA	Harvard Pilgrim
MA	MA BCBS
MD	CareFirst
MD	Evergreen Health Coop
MD	Kaiser
MD	United Healthcare
ME	Anthem BCBS
ME	Maine Community
MI	BlueCare
MI	Consumers

MI	HAP
MI	Humana
MI	McLaren
MI	Meridian
MI	Molina
MI	Priority Health
MI	Total Health
MN	Ucare
MN	Preferred One
MN	Medica
MN	Health Partners
MN	BCBC of MN
MO	Anthem BCBS
MO	BCBS of Kansas City

MO	Coventry Health and Life
MO	Coventry Health Care
MS	Ambetter
MS	Humana
MT	BCBS
MT	Montana Health Coop
MT	Pacific Source
NC	BCBS
NC	Coventry
ND	BCBS
ND	Medica
ND	Sanford
NE	BCBS

NE	CoOpportunity
NE	Coventry
NE	Health Alliance
NH	Anthem BCBS
NJ	AmeriHealth
NJ	Health Republic
NJ	Horizon BCBS
NM	BCBS of NM
NM	New Mexico Health Connections
NM	Presbyterian Health Plan
NM	Molina of NM
NV	Saint Mary's
NV	Anthem BCBS

NV	Nevada Health Coop
NV	Health Plan of Nevada
NY	Affinity
NY	Today's Options of NY
NY	CDPHP
NY	Emblem Health
NY	Empire BCBS
NY	Univera Healthcare
NY	Fidelis
NY	Health Republic
NY	Healthfirst NY
NY	BlueShield of NENY
NY	Metro Plus (Market Plus)

NY	MVP Healthcare
NY	North Shore LIJ CareConnect
NY	Oscar
NY	United Healthcare
OH	Ambetter from Buckeye
OH	Anthem BCBS
OH	Aultcare
OH	Caresource
OH	Coventry
OH	HealthSpan
OH	Humana
OH	Kaiser
OH	MedMutual
OH	Molina

OH	Paramount
OH	SummaCare
OK	Aetna
OK	BCBS
OK	CommunityCare
OK	Coventry Health and Life
OK	Coventry Health Care of KS
OK	GlobalHealth
OR	ModaHealth
OR	HealthNet (HNOR)
OR	Providence
OR	Pacific Source
OR	LifeWise
OR	Health Republic

OR	Kaiser
OR	Oregon Health Co-op
OR	BridgeSpan
OR	Atrio
OR	Trillium
PA	Aetna
PA	Blue Cross of NEPA
PA	Capital BlueCross
PA	Geisinger Choice
PA	Geisinger Health
PA	HealthAmerica
PA	Highmark Health
PA	Highmark Inc.
PA	Independence BC

PA	Keystone (Capital Blue)
PA	UPMC
RI	Neighborhood Health
RI	BCBS of RI
SC	BlueChoice
SC	BCBS
SC	Consumers Choice
SC	Coventry
SD	Avera
SD	DakotaCare
SD	Sanford
TN	BCBS
TN	Cigna
TN	Community Health Alliance

TN	Humana
TX	Aetna
TX	Ambetter
TX	BCBS
TX	Cigna
TX	Community Health Choice
TX	Community First
TX	First Care
TX	Humana Health Plan
TX	Humana Insurance
TX	Molina
TX	Scott and White
TX	Sendero
UT	Altius

UT	Arches
UT	BridgeSpan
UT	Humana
UT	Molina
UT	Select Health
VA	Aetna
VA	CareFirst
VA	Coventry
VA	Group Hospitalization (BCBS)
VA	Health Keepers (Anthem)
VA	Innovation
VA	Kaiser
VA	Optima

VT	BCBS of VT
VT	MVP Healthcare
WA	LifeWise of WA
WA	Premera BCBS
WA	Group Health Coop
WA	BridgeSpan
WA	Molina of WA
WI	Anthem BCBS
WI	Arise
WI	Common Ground
WI	Dean
WI	Group Health Coop
WI	Gundersen
WI	Health Tradition
WI	Medica

WI	MercyCare
WI	Molina
WI	Physicians Plus
WI	Security Health - No SBC Link Available
WI	Unity
WV	Highmark BCBS
WY	BCBS
WY	WINhealth

Appendix 4: Abbreviations' Key

ABA: Applied Behavior Analysis
Acu: Acupuncture
AR: Acute Rehab
C&PR: Cardiac and Pulmonary Rehabilitation
C&R: Cardiac & Respiratory
CogT: Cognitive Therapy
CP: Cardiac/Pulmonary
CPRT: Cardiopulmonary Rehabilitation Therapy.
CR: Cardiac Rehab
CT: Cardiac Therapy
CTI: Clinical Therapeutic Intervention
EAR: Extended Active Rehabilitation Facility
EI: Early Intervention
HS: Habilitation Services
HT: Hearing Therapy
IN: In-Network
IP: In-Patient
LT: Line Therapy (applies to ABA)
MBH: Mental/Behavioral Health
MT: Manipulation Therapy
NA: Not Applicable
NDT: Neurodevelopmental therapy
NPP: Non-Participating Provider
NPref: Not Preferred
NPart: Not Participating
OMT: Osteopathic Manipulative Therapy
OON: Out-of-Network
OP: Out-Patient
PC: Primary Care
PCIAT: Post-Cochlear Implant Aural Therapy.
PhysioT: Physiotherapy
PhysR: Physical Rehab
PM: Physical Medicine
PR: Pulmonary Rehab
PS: Physical Speech
PY: Pulmonary
RSF: Unclear, but seems to mean a more preferred IN provider.
RY: Respiratory
SC: Specialty Care
SNF: Skilled Nursing Facility
ST: Speech Therapy
TI: Therapeutic Intervention
VT: Vision Therapy