

Questions to Consider for Marketplace Consumers – Rehabilitation/Habilitation

1. **Do you or one of the future beneficiaries of the insurance you are shopping for have special needs that have required, or may require in the future, therapy services such as occupational therapy, physical therapy, speech therapy, or other similar services?**
 - **Why does this matter?** – Different plans may cover a different number of therapy visits, as well as have different cost-sharing requirements.
 - **Example:** Plan 1¹ covers 40 annual visits for each covered therapy and has a 30% coinsurance requirement after a \$10,000 family deductible. Plan 2 covers only 20 annual visits for each covered therapy and has a 50% coinsurance requirement after an \$11,000 family deductible.

2. **If you answered yes to question #1, would you be willing to pay more each month for your premium in order to pay less in cost-sharing each time you or your family members access therapy services?**
 - **Why might this make sense?** – An individual or family that expects to need a significant quantity of therapy services may be better off paying a higher premium if doing so provides access to a plan that has substantially lower cost-sharing.
 - **Example:** Plan 1, with an unsubsidized premium of about \$270 a month, requires a family to spend \$10,000 out-of-pocket and then requires beneficiaries to pay 30% of the cost of each therapy visit. Plan 5, with an unsubsidized premium of about \$365 a month, only requires a \$30 copay for each therapy visit. With plan 5, therapy visits are not subject to the deductible. Plans 1 and 5 both cover the same number of therapy visits each year. However, for \$95 more per month, beneficiaries of plan 5 can access covered therapy services without meeting their deductible. For a family with significant needs (particularly if those needs are related to autism, which has no visit limits), plan 5 may leave a family financially better off than plan 1.

3. **Does the plan require a deductible be met before providing coverage of rehabilitative and habilitative services (i.e., therapy services)?**
 - **Why does this matter?** – If a deductible applies to rehabilitative and habilitative services, the beneficiaries of the plan will have to pay for those services in full until total out-of-pocket expenditures have reached the deductible.
 - **Example:** Plan 3 has a \$3,500 family deductible. After the beneficiaries of plan 3 spend \$3,500 on health care expenses, the plan pays 75% of the cost of outpatient therapy services up to the annual visit limits. Plan 5 does not apply its \$5,000 family deductible to therapy services, and only requires a \$30 copay for each therapy visit.

4. **What is the cost-sharing (i.e., copays, coinsurance, and/or deductibles) for rehabilitation and habilitation services?**

¹ Example plans are on page 3.

- **Why does this matter?** – Cost-sharing may include copays (i.e., a set amount the beneficiary pays at each visit), coinsurance (i.e., a percentage of the cost of the service the beneficiary pays at each visit), or deductibles (an amount the beneficiaries must pay out-of-pocket for all services subject to the deductible before the plan pays for any portion of those services). Significant cost-sharing (deductibles in particular) can be a barrier for beneficiaries to access services.
 - **Example:** Plan 4 requires a family to spend \$9,200 on health care services before covering 80% of the cost of therapy services up to the annual visit limits. If a family needs access to therapy services before meeting the deductible, the full cost of those services will be the responsibility of the beneficiaries.
- 5. Is there a difference between the information listed on the marketplace’s website interface and in the specific plans’ summaries of benefits?**

- **Why does this matter?** – The interface of some marketplace websites may be standardized or otherwise limited in such a way that plan benefits are confusingly displayed. Each plan is required to have a summary of benefits and coverage (SBC) that likely provides more detailed and accurate information than the marketplace interface. At the very least, it may be worth checking the SBC for the specific plan that seems most appealing to you to check for any important discrepancies, which can then be clarified by contacting the carrier selling the plan.
- **Example:** Plan 1’s rehabilitation benefit, as described on the marketplace website, appears to cover 40 visits per year of physical therapy and occupational therapy combined. However, in its SBC, it appears to cover 40 visits per year of each of those therapies. Similarly, plan 1’s habilitation benefit, as described on the marketplace website, appears to cover 40 visits per year without any specificity as to what that includes. In contrast, its SBC is more specific, indicating that the habilitation benefit is combined with the rehabilitation benefit.

Other Important Considerations

- Comparing health plan premiums, cost-sharing, and limitations on rehabilitative and habilitative services are not the only considerations that most consumers should evaluate when selecting a health plan. Factors like a health plan’s provider network and drug formulary may be of equal or more importance depending on one’s circumstances. Please seek assistance from navigators, assisters, application counselors, agents, or brokers should you have any questions or concerns.
- The specific dollar amounts cited in the examples above and below are based on real health plan offerings; however, they are specific to one state and are based on a hypothetical two-person household. More importantly, they do not take into account income-based subsidies that may lower both the premium and cost-sharing numbers for many individuals and families who are shopping for health plans on their state’s marketplaces. Please remember, the specific dollar amounts included here are only for illustrative purposes.
- In addition to the factors mentioned above, rehabilitation and habilitation services may be limited in other ways that are not easy for consumers to evaluate, such as by preauthorization requirements that are not described on marketplace websites or in SBCs. Often, one must look at the more detailed health plan contracts or contact the carrier to access this information.

Example Marketplace Health Plans – Rehabilitation/Habilitation Benefits

The following plan information is gathered from the SBCs available through Connect for Health Colorado (i.e., Colorado’s health insurance marketplace). It is based on the following hypothetical data – a 34 year old adult (non-smoker) and a 9 year old child living in the Denver area. These demographic characteristics were arbitrarily selected. Colorado’s marketplace was used only because the relevant information is easily accessible. These plans were selected only for illustrative purposes, but should accurately portray the sort of options marketplace consumers may have to decide between. The premiums specified below do not take into account any subsidies the hypothetical family described above may have qualified for based on its household income.

Plan 1 (bronze) - \$269.40/month

Visit limit for outpatient rehabilitation and habilitation services combined with 40 visits per therapy per year (autism spectrum disorders not subject to visit limit) – 30% coinsurance **AFTER** \$5,000 deductible for individual or \$10,000 for family

Plan 2 (bronze) - \$294.30/month

Combined limit of 20 therapy visits per year each for physical therapy, occupational therapy, and speech therapy; 20 visit limitation is a single combined limit for rehabilitation and habilitation services (no limit for children up to age 5 with congenital defects; no therapy limitation for autism) – 50% coinsurance **AFTER** \$5,500 deductible for individual or \$11,000 for family

Plan 3 (silver) - \$354.70/month

Visit limit for outpatient rehabilitation and habilitation services combined with 40 visits per therapy per year (autism spectrum disorders not subject to visit limit) – 25% coinsurance **AFTER** \$1,750 deductible for individual or \$3,500 for family

Plan 4 (silver) - \$362.22/month

Preauthorization required – 10 visits per year for spinal manipulations, adjustments, and modalities; 20 visits per year for all other therapies; limits for habilitation and rehabilitation services combined – 20% coinsurance **AFTER** \$4,600 deductible for individual and \$9,200 for family

Plan 5 (silver) - \$365.37/month

Visit limit for outpatient rehabilitation and habilitation services combined with 40 visits per therapy per year (autism spectrum disorders not subject to visit limit) - \$30 copay **NOT** subject to \$2,500 deductible for individual or \$5,000 for family