The Affordable Care Act and Coverage for Exercise Rehabilitation Services

David R. Nerenz, PhD[1]

ABSTRACT

The Affordable Care Act (ACA) provides for expanded coverage of rehabilitation and therapy services under the broad concept of "essential health services," but that coverage generally involves out-of-pocket expense for those receiving it. The ACA does not include exercise rehabilitation services in the list of preventive services that must be covered with no out-of-pocket expense. *Journal of Clinical Exercise Physiology*. 2016;5(3):49–52.

Keywords: insurance coverage, prevention, health care

The Patient Protection and Affordable Care Act (otherwise known as the "Affordable Care Act," or "ACA," or "Obamacare"), passed by Congress in 2010, is a landmark piece of legislation that had as its main goal the expansion of insurance coverage for millions of Americans who did not have health insurance. The two main pathways to expanded coverage are the expansion of Medicaid eligibility to include low-income adults who were not previously covered and the establishment of state insurance exchanges to allow individuals and small groups access to private insurance options offered through those exchanges. A combination of individual and employer mandates, along with subsidies for insurance for individuals with relatively low incomes, provide the motivation for individuals to actually take up one of the coverage options made available through the ACA.

The ACA also includes a number of features that regulate the benefit offerings of private insurance plans, including those offered through employers and outside the context of the new state exchanges. These include features like no lifetime coverage limits, no exclusion of preexisting conditions, coverage of dependent children through age 26 years on parents' policies, and coverage of specific preventive services without any beneficiary cost sharing (e.g., no copays or deductibles applied to the preventive services) (1).

Four specific classes of preventive services are identified in the text of the ACA. These include evidence-based screening and counseling, immunizations, preventive services for children and youth, and preventive services for women. As of the summer of 2016, a total of 63 specific services had been identified as covered without any cost-sharing requirements (2). The four classes of covered preventive services come from those recommended by four national advisory groups: the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices, the Health Resources and Services Administration's (HRSA) Bright Futures Project, and the HRSA and Institute of Medicine committee on women's clinical preventive services (3).

Many of the covered services are in the domain of "primary prevention," that is, services in which the goal is to prevent disease from occurring in the first place. Education and counseling services and immunizations are examples of this type of service. Many are in the domain of "secondary prevention," that is, services in which the goal is to catch disease at an early stage and prevent subsequent adverse health consequences. Cancer screenings, blood pressure monitoring, and autism screening for children would be examples of this type of service.

Outside the context of the ACA, the broad domain of prevention also includes "tertiary prevention," that is,

[1]Henry Ford Health System, Detroit, Michigan

Address for correspondence: David R. Nerenz, PhD, Director, Center for Health Policy and Health Services Research. Henry Ford Health System, 1 Ford Place (3A), Detroit, MI 48202; (313) 874 5454; dnerenz1@hfhs.org.

Conflicts of Interest and Source of Funding; The author reports no conflicts of interest and no external funding.

services in which the goal is to prevent or delay morbidity or mortality related to an existing disease. This type of prevention is often difficult to distinguish from treatment or management of a disease, and perhaps for that reason, tertiary prevention services are not included in the list of preventive services that must be offered without cost sharing, nor are they regularly addressed by the recommendations of the USPSTF or other groups.

The exclusion of tertiary prevention services from the list of those covered without cost sharing means that most rehabilitation services, exercise programs, and similar programs for patients with known disease are not covered with a requirement for no cost sharing. Private plans may indeed cover these services (see the later discussion of essential health services), but their coverage without cost sharing is not mandated by the ACA nor is there any limit on cost sharing imposed by the ACA, other than limits defined by the insurance plan in general.

WHY ARE EXERCISE REHABILITATION SERVICES NOT CONSIDERED PREVENTIVE SERVICES AND NOT INCLUDED IN THIS PART OF THE ACA?

An argument could certainly be made that a variety of exercise programs have the planned and actual effects of preventing disease progression (secondary prevention) or preventing or delaying mortality and morbidity related to the disease in question (tertiary prevention). Why then are these services not included in the list of those that must be covered without beneficiary cost sharing under the ACA?

One specific reason is that the language of the ACA requires coverage with no cost sharing for any preventive services that have a recommendation grade of A or B from the USPSTF. The recommendation grades represent a judgment on the part of the USPSTF about the scientific evidence base for a particular preventive service. A service with an A grade is definitely recommended, and the scale moves down to include some services that are definitely not recommended. One answer to the ACA question for exercise-based services is that no exercise-based services currently have an A or B grade from the USPSTF. That begs the question, though, of why that is the case, given that there is a reasonably strong evidence base for many specific exercise-based services.

One possible answer might be that no exercise-based or similar therapy services have been reviewed by the USPSTF and received an A or B rating. However, exercise and other therapy services are not within the scope of the USPSTF and therefore have not been formally reviewed. The scope of the USPSTF is clinical preventive services provided in the primary care setting, or referred from the primary care setting. According to the USPSTF, the scope defined more specifically includes the following: screening texts, counseling, preventive medications.

Furthermore, recommendations only address services offered in the primary care setting or services referred by a primary care clinician and apply to adults and children with no signs or symptoms (or unrecognized signs and symptoms) (4).

One possible exception to the general scope of review by USPSTF might be the recommendation on screening and management of obesity (5). Given that the recommendation is about both screening and management, it would seem to at least open the door to possible expansion of USPSTF review to the domain of exercise-based services designed to prevent progression or recurrence of disease. Although the issue is not explicitly addressed in the USPSTF materials, the recommendation seems to conceive of obesity as a risk factor for disease, not a disease itself. The recommendation then fits into the normal scope of USPSTF review of services in the domain of screening and risk factor management.

The other three classes of preventive services identified in the ACA as being pathways to having preventive services covered under a no-cost-sharing arrangement have similar defined scopes (e.g., immunizations for children), so there simply is no mechanism under the current legislative language and regulations to have exercise or therapy services considered as preventive services and covered without cost sharing under the ACA.

The question then has to be "Why is this the case?" and perhaps, "Is there some chance that Congress will act to amend the ACA and expand the definition and scope of preventive services?" There may be no single, clear answer to these questions. At the time of debate on what became the ACA, there was a clear distinction in the minds of many of the major sponsors of the legislation between wellness services (i.e., prevention/screening) and sick care. Since exercise and therapy services follow the diagnosis and perhaps acute treatment of an illness, those services almost certainly fell into sick care in the minds of the ACA sponsors. Here are a few examples from Senator Tom Harkin of Iowa, on the Senate floor on October 14, 2009 (6):

> There is one huge part of the health reform bill that is not being discussed very much that I believe will have a transformative effect on the system we have in America today, which I have often referred to as not a health care system but a sick care system. When we think about it, that is what we have in America: a sick care system. If you get sick, you get care one way or the other, but we do precious little to keep you healthy in the first place… . The bill we reported out of our HELP [Health, Education, Labor & Pensions] Committee creates a sharp new emphasis on fitness, physical activity, good nutrition, disease prevention; in short, keeping people out of the hospital in the first place. This will give Americans access to a 21st century true health care system focused on preventing disease and helping us live healthy, active, productive lives, and it will reduce wasteful, avoidable costs that are built into our current system. Again, this sort of disease management approach we have in our country now is about patching things up after people develop a serious illness or a chronic condition. It is a system that overspends, which we know, and

> underperforms. It has been a colossally expensive failure…. 77 percent of Americans support a new emphasis on prevention in a health care reform bill because they know it is the right thing to do. It is common sense. If we can use cost-effective screenings and other upfront intervention programs to prevent tens of millions of occurrences of chronic diseases such as cancer, diabetes, and cardiovascular disease, it is self-evident that we are going to slash health care costs very significantly.

I find no specific reference to the intentional exclusion of exercise and therapy services from the scope of preventive services in the ACA, but the focus in the minds of those who were instrumental in the creation and passage of the ACA is clearly on services that precede the onset of illness and prevent that onset, rather than on services that prevent downstream consequences of illnesses that have already occurred. Similarly, I find no specific mention of a detailed rationale for exclusion of tertiary prevention services in the description and list of activities of the USPSTF. However, the exclusion is very clearly stated in the USPSTF Procedure Manual (7, p. 2): "Preventive measures that are part of the treatment and management of persons with clinical disease are usually considered tertiary prevention and are outside the scope of the USPSTF."

Given the USPSTF's extensive analysis work in arriving at its recommendations, it seems unlikely that it would seek to expand its scope of work to include tertiary prevention, since that domain includes a wide variety of clinical treatments for patients with one or more of a very long list of clinical conditions. Addressing the domain of tertiary prevention would be a massive expansion of scope for the USPSTF, certainly far beyond what its current staffing and budget could possibly support.

Inclusion of exercise-based services in the list of evidence-based preventive services mandated by the ACA for coverage without beneficiary cost sharing would then require legislative action to amend the language restricting that list to those services recommended by the USPSTF. There are three other classes of preventive services in the ACA (immunizations, preventive services for children and youth; and preventive services for women) that must also be offered without cost sharing but do not require a recommendation from the USPSTF. The three other classes of services are defined by recommendations of other named groups; to the extent that these other classes might serve as a template for future expansion of coverage for exercise-based services, some respected guideline development or advisory group would presumably have to be identified to provide a basis for identifying the appropriate list of covered exercise services.

DOES THIS MEAN EXERCISE AND THERAPY SERVICES ARE NOT COVERED AT ALL UNDER THE ACA?

The ACA does indeed speak to coverage for exercise and therapy services under the broader label of essential health benefits. All health plans that are not grandfathered (i.e., those coming into existence after the spring of 2010 or those that made significant changes since that time, even if they existed before that time) have to meet a set of standards about coverage for essential health benefits, and rehabilitative and habilitative services are identified as a class of essential health benefits. There has not been a single standard definition of rehabilitative or habilitative services, but many states have adopted a definition provided by the National Association of Insurance Commissioners (8). The ACA does require coverage for these services in plans that fall under ACA-related regulation.

The difference between the two issues is between coverage without any cost sharing as a preventive service on the one hand, and coverage with cost sharing as an essential health benefit on the other hand. The former does not apply to exercise and therapy services; the latter does.

CONCLUSION

The ACA provides for expanded coverage of exercise and therapy services under the broad concept of essential health services, but that coverage generally involves out-of-pocket expense for those receiving it. The ACA does not consider exercise and other therapy services to be preventive services and therefore available to individuals without any cost sharing.

The exclusion of exercise-based services from the list of preventive services that must be offered without cost sharing is related first to the language of the ACA that limits the list to those services receiving an A or B recommendation from the USPSTF and second to the USPSTF's long-standing focus on preventive services in the primary care setting, not tertiary preventive services for patients with diagnosed disease.

REFERENCES

1. Blumenthal D, Collins SR. Health care coverage under the Affordable Care Act—a progress report. New England Journal of Medicine. 2014:371(3):275–81.
2. Department of Health and Human Services [Internet]. Preventive Services Covered Under the Affordable Care Act; [cited 2016 Aug 10]. Available from: http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/preventive-services-covered-under-aca/
3. Kaiser Family Foundation [Internet]. Preventive Services Covered by Private Health Plans under the Affordable Care Act; [cited 2016 Aug 12]. Available from: http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/
4. United States Preventive Services Task Force [Internet]. Understanding How the US Preventive Services Task Force Works; [cited 2016 Aug 15]. Available from: http://www.

uspreventiveservicestaskforce.org/Page/Name/understanding-how-the-uspstf-works
5. United States Preventive Services Task Force [Internet]. Recommendation Statement: Obesity in Adults-Screening and Management; [cited 2016 Aug 15]. Available from: https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/obesity-in-adults-screening-and-management
6. Congressional Record [Internet]. Health Care Reform Senate-October 14, 2009; [cited 2016 Aug 14]. Available from: https://www.congress.gov/congressional-record/2009/10/14/senate-section/article/s10389-1
7. Procedure manual – US Preventive Services Task Force. AHRQ Publication No. 08-05118-EF. Newton, MA: Agency for Healthcare Research and Quality; 2008
8. American Occupational Therapy Association [Internet]. [cited 2016 Sept 27]. Available from: https://www.aota.org/~/media/Corporate/Files/Advocacy/Health-Care-Reform/Essential-Benefits/Analysis-of-Rehabilitation-and-Habilitation-Benefits-in-Qualified-Health-Plans.pdf