The Affordable Care Act also known as health reform or “Obamacare” – was signed into law on March 23, 2010. The health reform law is expected to affect millions of Americans, including the autism community. Autism Speaks knows that health insurance is complicated but we want to help you make sense of these changes so you can make the best choice for your family. We have developed this series of fact sheets to provide factual information about some of the law’s most significant reforms and how they might affect you.

Essential Health Benefits, Including Applied Behavior Analysis

One of the most significant changes under the Affordable Care Act is that – beginning on January 1, 2014 – insurers will have to cover at least 10 categories of defined medical benefits, known as “essential health benefits.” What do you need to know about this new requirement? Here are a few questions that Autism Speaks has identified.

What types of benefits are included as “essential health benefits”?

“Essential health benefits” include—at a minimum—the following 10 categories of benefits:

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care
- mental health and substance use disorder services, including behavioral health treatment
- prescription drugs
- rehabilitative and habilitative services and devices
- laboratory services
- preventive and wellness services and chronic disease management pediatric services, including oral and vision care.

This means that insurance companies that offer new coverage to individuals and small businesses must cover all 10 categories of benefits beginning on January 1, 2014. In addition, insurance companies cannot place lifetime or annual dollar caps on essential health benefits.
What benefits must be covered in my state?

Although insurers will have to cover each of the 10 specified categories, benefits will continue to vary by state. This is because – instead of defining a national benefit standard – each state was asked to identify an existing health insurance plan to serve as a reference point. This reference plan is referred to as the “benchmark plan.”

Insurers must cover benefits that are substantially equal to those in the benchmark plan. This means that insurers must cover similar services, limits on coverage (such as the number of visits with a certain specialist), and prescription drug benefits. Insurers can offer benefits that are different from those in the benchmark so long as the new benefits provide the same value as the benefit that is being replaced. This process is known as “benefit substitution.” States have the option to prohibit benefit substitution so it is important to understand whether your state allows it or not.

To learn more about the specific benefits that must be covered in your state, you can contact your state’s insurance department.

Does my state’s benchmark plan include applied behavior analysis?

To date, Autism Speaks has identified 25 states and the District of Columbia that include applied behavior analysis in their benchmark plan. This means that insurers that offer new coverage to individuals and small businesses are expected to cover applied behavior analysis beginning in 2014. In addition to the District of Columbia, these states are Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Illinois, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, Ohio, Texas, Vermont, West Virginia, and Wisconsin. (see map below)

Many of these states impose a dollar cap on the amount of applied behavior analysis that must be provided each year. Because the Affordable Care Act prohibits annual dollar limits on essential health benefits, insurers in these states can convert these limits into non-dollar limits (such as a cap on the number of sessions of applied behavior analysis each year).

Autism Speaks will continue to monitor implementation of this requirement to help ensure that families affected by autism are being served by this important new provision.

Does my coverage have to include the essential health benefits?

It depends on what type of coverage you have. Under the Affordable Care Act, this rule applies to “fully insured” insurance companies that offer “new” health insurance plans to individuals and small businesses. (In some circumstances, large employers must cover a certain level of medical spending under a particular benchmark plan.)
There are plans that do not have to comply with the essential health benefits requirements. These include plans that are "self-insured" and "grandfathered health plans" that you buy yourself or from your employer. Grandfathered plans are those that were purchased on or before March 23, 2010. Your plan materials will say whether you are enrolled in a grandfathered health plan or not. If you have one of these plans but would like to explore your options, you can switch to a plan through the new Health Insurance Marketplace in your state.

In addition, nearly all insurers are prohibited from imposing lifetime and annual limits on the dollar value of essential health benefits. This includes fully insured and self-insured plans, with the exception of grandfathered plans that you buy yourself.