TABLE OF CONTENTS

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Subtitle B--Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

42 USC 201 note.

[*511] SEC. 511. SHORT TITLE.

This subtitle may be cited as the "Paul **Wellstone** and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008".

[*512] SEC. 512. MENTAL HEALTH PARITY.

(a) AMENDMENTS TO ERISA.--Section 712 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185a) is amended--

(1) in subsection (a), by adding at the end the following:

"(3) FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS.--

"(A) IN GENERAL.--In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that--

"(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

"(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

"(B) DEFINITIONS.--In this paragraph:

"(i) FINANCIAL REQUIREMENT.--The term 'financial requirement' includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but excludes an aggregate lifetime limit and an annual limit subject to paragraphs (1) and (2),

"(ii) PREDOMINANT.--A financial requirement or treatment limit is considered to be predominant if it is the most common or frequent of such type of limit or requirement.

"(iii) TREATMENT LIMITATION.--The term 'treatment limitation' includes limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

"(4) AVAILABILITY OF PLAN INFORMATION.--The criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits (or the health insurance coverage offered in connection with the plan with respect to such benefits) shall be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. The reason for any denial under the plan (or coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or

beneficiary shall, on request or as otherwise required, be made available by the plan administrator (or the health insurance issuer offering such coverage) to the participant or beneficiary in accordance with regulations.

"(5) OUT-OF-NETWORK PROVIDERS.--In the case of a plan or coverage that provides both medical and surgical benefits and mental health or substance use disorder benefits, if the plan or coverage provides coverage for medical or surgical benefits provided by out-of-network providers, the plan or coverage shall provide coverage for mental health or substance use disorder benefits provided by out-of-network providers in a manner that is consistent with the requirements of this section.";

(2) in subsection (b), by amending paragraph (2) to read as follows:

"(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).";

(3) in subsection (c)--

(A) in paragraph (1)(B)--

(i) by inserting "(or 1 in the case of an employer residing in a State that permits small groups to include a single individual)" after "at least 2" the first place that such appears; and

(ii) by striking "and who employs at least 2 employees on the first day of the plan year"; and

(B) by striking paragraph (2) and inserting the following:

"(2) COST EXEMPTION.--

"(A) IN GENERAL.--With respect to a group health plan (or health insurance coverage offered in connection with such a plan), if the application of this section to such plan (or coverage) results in an increase for the plan year involved of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan (as determined and certified under subparagraph (C)) by an amount that exceeds the applicable percentage described in subparagraph (B) of the actual total plan costs, the provisions of this section shall not apply to such plan (or coverage) during the following plan year, and such exemption shall apply to the plan (or coverage) for 1 plan year. An employer may elect to continue to apply mental health and substance use disorder parity pursuant to this section with respect to the group health plan (or coverage) involved regardless of any increase in total costs.

"(B) APPLICABLE PERCENTAGE.--With respect to a plan (or coverage), the applicable percentage described in this subparagraph shall be--

"(i) 2 percent in the case of the first plan year in which this section is applied; and

"(ii) 1 percent in the case of each subsequent plan year.

"(C) DETERMINATIONS BY ACTUARIES.--Determinations as to increases in actual costs under a plan (or coverage) for purposes of this section shall be made and certified by a qualified and licensed actuary who is a member in good standing of the American Academy of Actuaries. All such determinations shall be in a written report prepared by the actuary. The report, and all underlying documentation relied upon by the actuary, shall be maintained by the group health plan or health insurance issuer for a period of 6 years following the notification made under subparagraph (E).

"(D) 6-MONTH DETERMINATIONS.--If a group health plan (or a health insurance issuer offering coverage in connection with a group health plan) seeks an exemption under this paragraph, determinations under subparagraph (A) shall be made after such plan (or coverage) has complied with this section for the first 6 months of the plan year involved.

"(E) NOTIFICATION.--

"(i) IN GENERAL.--A group health plan (or a health insurance issuer offering coverage in connection with a group health plan) that, based upon a certification described under subparagraph (C), qualifies for an exemption under this paragraph, and elects to implement the exemption, shall promptly notify the Secretary, the appropriate State agencies, and participants and beneficiaries in the plan of such election.

"(ii) REQUIREMENT.--A notification to the Secretary under clause (i) shall include--

"(I) a description of the number of covered lives under the plan (or coverage) involved at the time of the notification, and as applicable, at the time of any prior election of the cost-exemption under this paragraph by such plan (or coverage);

"(II) for both the plan year upon which a cost exemption is sought and the year prior, a description of the actual total costs of coverage with respect to medical and surgical benefits and mental health and substance use disorder benefits under the plan; and

"(III) for both the plan year upon which a cost exemption is sought and the year prior, the actual total costs of coverage with respect to mental health and substance use disorder benefits under the plan.

"(iii) CONFIDENTIALITY.--A notification to the Secretary under clause (i) shall be confidential. The Secretary shall make available, upon request and on not more than an annual basis, an anonymous itemization of such notifications, that includes--

"(I) a breakdown of States by the size and type of employers submitting such notification; and

"(II) a summary of the data received under clause (ii).

"(F) AUDITS BY APPROPRIATE AGENCIES.--To determine compliance with this paragraph, the Secretary may audit the books and records of a group health plan or health insurance issuer relating to an exemption, including any actuarial reports prepared pursuant to subparagraph (C), during the 6 year period following the notification of such exemption under subparagraph (E). A State agency receiving a notification under subparagraph (E) may also conduct such an audit with respect to an exemption covered by such notification.";

(4) in subsection (e), by striking paragraph (4) and inserting the following:

"(4) MENTAL HEALTH BENEFITS.--The term 'mental health benefits' means benefits with respect to services for mental health conditions, as defined under the terms of the plan and in accordance with applicable Federal and State law.

"(5) SUBSTANCE USE DISORDER BENEFITS.--The term 'substance use disorder benefits' means benefits with respect to services for substance use disorders, as defined under the terms of the plan and in accordance with applicable Federal and State law.";

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Part IV

Department of the Treasury

Internal Revenue Service
26 CFR Part 54

Department of Labor

Employee Benefits Security Administration
29 CFR Part 2590

Department of Health and Human Services

Centers for Medicare & Medicaid Services

45 CFR Part 146

Interim Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Final Rule

The language of the statute can be interpreted to support either alternative. The comments that supported allowing separately accumulating deductibles maintained that it is commonplace for plans to have such deductibles, and that the projected cost of converting systems to permit unified deductibles would be extremely high for the many plans that use a separate managed behavioral health organization (MBHO).[8] By contrast, comments that supported requiring combined deductibles argued that allowing separately accumulating deductibles undermines a central goal of parity legislation: To affirm that mental health and substance use disorder benefits are integral components of comprehensive health care and generally should not be distinguished from medical/surgical benefits. Distinguishing between the two requires individuals who need both kinds of care to satisfy a deductible that is greater than that required for individuals needing only medical/surgical care. Other comments that supported requiring combined deductibles noted that mental health and substance use disorder benefits typically comprise only 2 to 5 percent of a plan's costs, so that even using identical levels for separately accumulating deductibles imposes a greater barrier to mental health and substance use disorder benefits.

The Departments carefully considered the alternative of requiring separately accumulating or combined deductibles. Given that the statutory language does not preclude either interpretation, the Departments choose to require combined deductibles, because this position is more consistent with the policy goals that led to the enactment of MHPAEA.

2. Affected Entities and Other Assumptions

The Departments expect MHPAEA to benefit the approximately 111 million participants in 446,400 ERISA-covered employer group health plans, and an estimated 29 million participants in the approximately 20,300 public, non-Federal employer group health plans sponsored by state and local governments.[9] In addition, approximately 460 health insurance issuers providing mental health or substance use disorder benefits in the group health insurance market and at least 120 MBHOs providing mental health or substance use disorder benefits to group health plans are expected to be affected.[10]

3. Benefits

Congress first passed mental health parity legislation in 1996 with the enactment of MHPA 1996.[11] As discussed earlier in this preamble, this law requires health insurance issuers and group health plans that offer mental health benefits to have aggregate annual and lifetime dollar limits on mental health benefits that are no more restrictive than those for all medical/surgical benefits.

The impact of MHPA 1996 was limited, however, because it did not require parity with respect to day limits for inpatient or outpatient care, deductibles, co-payments or coinsurance, substance use disorder benefits, and prescription drug coverage.[12] While a large majority of plans complied with the MHPA 1996 parity requirement regarding annual and lifetime dollar limits, many employer-sponsored group health plans contained plan design features that were more restrictive for mental health benefits than for medical/surgical benefits. For example, data on private insurance arrangements from the pre-MHPAEA era show that after MHPA 1996, the most significant disparities in coverage for mental health substance use treatment involve limits on the number of covered days of inpatient care and the number of outpatient visits. Survey data from the Kaiser/HRET national employer survey shows that 64 percent of covered workers had more restrictive limits on the number of covered hospital days for mental health care and 74 percent had more restrictive limits on outpatient mental health visits. In addition, 22 percent of covered workers had higher cost-sharing imposed on mental health care benefits. Among those workers with more restrictive limits on inpatient days, 77 percent had limits of 30 days or less.[13] For these reasons, as discussed more fully below, the Departments expect that MHPAEA and these regulations will have their greatest impact on people needing the most intensive treatment and financial protection. The Departments do not have an estimate of the number of individuals who have exceeded the treatment limits. However, according to the FEHBP data used to analyze the FEHBP parity directive in the year before its implementation, the 90th percentile of the mental health spending distribution was corresponded to $2,134 in 1999 dollars. Among the people spending at the 90th percentile or higher, 12% had inpatient psychiatric stays and 20% of those above the 90th percentile had a diagnosis of schizophrenia or bipolar disorder, chronic conditions requiring prescription drugs and regular contact with mental health service providers. It is this group that experienced especially large declines in out of pocket payments after FEHBP implemented parity.

Treatment for alcohol abuse disorders showed a similar trend: Surveys indicate that 74 percent of private industry employees were covered by plans that imposed more restrictive limits for inpatient detoxification benefits than medical and surgical benefits, 88 imposed more restrictive limits for inpatient rehabilitation, and 89 percent imposed more restrictive limits for outpatient rehabilitation.[14]

After MHPA 1996, many states also passed mental health parity laws. Research focused on the impacts of parity laws found that similar to MHPA 1996, even the most comprehensive state laws resulted in little or no increase in access to and utilization of

[8] For a full discussion of the cost considerations involved with these alternatives, see section 4.b., below, Costs associated with cumulative financial requirements and quantitative treatment limitations, including deductibles.

[9] The Departments' estimates of the numbers of affected participants are based on DOL estimates using the 2008 CPS. ERISA plan counts are based on DOL estimates using the 2008 MEP–IC and Census Bureau statistics. The number of state and local government employer-sponsored plans was estimated using 2007 Census data and DOL estimates. Please note that the estimates are based on survey data that is not broken down by the employer size covered by MHPAEA making it difficult to exclude from estimates those participants employed by employers who employed an average of at least 2 but no more than 50 employees on the first day of the plan year.

[10] The Departments' estimate of the number of insurers is based on industry trade association membership. Please note that these estimates could undercount small state regulated insurers.

[11] Pub. L. 104–204, title VII, 110 Stat. 2874, 2944–50.

[12] GAO/HEHS–00–95, *Implementation of the Mental Health Parity Act*. In the report, GAO found that 87 percent of compliant plans contained at least one more restrictive provision for mental health benefits with the most prevalent being limits on the number of outpatient office visits and hospital day limits. *Id.* at 5.

[13] Barry, Colleen, *et al.* "Design of Mental Health Benefits: Still Unequal After All These Years," *Health Affairs* Vol. 22, Number 5, 2003. Please note that the baseline data from the Kaiser HRET survey cited in this article are weighted by region, firm size and industry to reflect the national composition of employers. So the data cited establishing the baseline reflects the impact of state parity laws. It is important to realize that state parity laws frequently focus on a subset of diagnoses, *e.g.,* biologically based disorders, and do not apply to self-funded insurance programs. Thus, in most states only a minority of insurance contracts is affected by state parity laws.

[14] Morton, John D. and Patricia Aleman. "Trends in Employer-provided Mental Health and Substance Abuse Benefits." *Monthly Labor Review,* April 2005.

mental health services for covered individuals.[15]

To address these issues, Congress amended MHPA 1996 by enacting MHPAEA. One of Congress' primary objectives in enacting MHPAEA was to improve access to mental health and substance use disorder benefits by eliminating discrimination that existed with respect to these benefits after MHPA 1996. Congress' intent in enacting MHPAEA was articulated in a floor statement from Representative Patrick Kennedy (D–RI), one of the chief sponsors of the legislation, who said "[a]ccess to mental health services is one of the most important and most neglected civil rights issues facing the Nation. For too long, persons living with mental disorders have suffered discriminatory treatment at all levels of society." [16] In a similar statement, Representative James Ramstad (R–MN) said, "[i]t's time to end the discrimination against people who need treatment for mental illness and addition. It's time to prohibit health insurers from placing discriminatory barriers on treatment." [17]

The Departments expect that the largest benefit associated with MHPAEA and these regulations will be derived from applying parity to cumulative quantitative treatment limitations such as annual or lifetime day or visit limits (visit limitations). As discussed above, a large percentage of plans imposed visit limitations pre-MHPAEA, and the GAO found that a major shortcoming of MHPA 1996 was its failure to apply parity to visit limitations. Applying parity to visit limitations will help ensure that vulnerable populations—those accessing substantial amounts of mental health and substance use disorder services—have better access to appropriate care. The Departments cannot estimate how large this benefit will be, because sufficient data is not available to estimate the number of covered individuals that had their benefits terminated because they reached their coverage limit. Though difficult to estimate, the number of beneficiaries who have a medical necessity for substantial amount of care are likely to be relatively small. Severe mental health disorders account for 2–3 percent of people in private health insurance plans and a substantially larger share of mental health spending. Evidenced-based treatments for severe and persistent mental illnesses like schizophrenia, bipolar disorder and chronic major depression requires prolonged (possibly lifetime) maintenance treatment that consists of pharmacotherapy, supportive counseling and often rehabilitation services.[18] The most common visit limits under current insurance arrangements are those for 20 visits per year. That means assuming a minimal approach to treatment of one visit per week, people with severe and persistent mental disorders will exhaust their coverage in about five months. This often results in people foregoing outpatient treatment and a higher likelihood of non-adherence to treatment regimes that produce poor outcomes and the potential for increased hospitalization costs.

Increased coverage also should provide enhanced financial protection for this group by reducing out-of-pocket expenses for services that previously were needed but uncovered. This should help prevent bankruptcy and financial distress for these individuals and families and reduce cost-shifting of care to the public sector, both of which occur when covered benefits are exhausted. In addition, increased coverage for those seeking substantial amounts of care potentially could reduce emergency room use by ensuring that benefits for individuals with serious conditions are not terminated. Finally, reduced entry into disability programs may result from having more complete insurance coverage for mental health and substance use disorder treatment.

Since the early 1990s, many health insurers and employers have made use of specialized vendors, known as behavioral health carve-outs to manage their mental health and substance abuse benefits. These vendors have specialized expertise in the treatment of mental and addictive disorders and organized specialty networks of providers. These vendors are known as behavioral health carve-outs. They use information technology, clinical algorithms and selective contracts to control spending on mental health and substance abuse treatment. There is an extensive literature that has examined the cost savings and impacts on quality of these organizations. Researchers [19] have reviewed this literature and estimated reductions in private insurance spending of 20 percent to 48 percent compared to fee-for-service indemnity arrangements. Also, it appears that the rate of utilization of mental health care rises under behavioral health carve out arrangements. The number of people receiving inpatient psychiatric care typically declines as does the average number of outpatient visits per episode.

The OPM encouraged its insurers to consider carve-out arrangements when implementing the parity directive in 2000 for the FEHBP. This is because of the ability of behavioral health carve-outs to use utilization management tools to control utilization and spending in the face of reductions in cost-sharing and elimination of limits. Thus, parity in a world dominated by behavioral carve-outs has meant increased utilization rates, reduced provider fees, reduced rates of hospitalization and fewer very long episodes of outpatient care. Intensive treatment was more closely aligned with higher levels of severity.

Another potential benefit associated with MHPAEA and these regulations is that use of mental health and substance use disorder benefits could improve.[20] Untreated or under treated mental health conditions and substance use disorders are detrimental to individuals and the entire economy. Day and visit limits can interfere with appropriate treatment thereby reducing the impact of care for workers seeking treatment. Many people with mental health conditions and substance use disorders are employed and these debilitating conditions have a devastating impact on employee attendance and productivity, which results in lost productivity for employers and lost earnings for employees. For example, studies have

[15] *Id.,* at 9. The state mental health parity laws varied significantly with most of differences related the following areas: the type of mental health mandate, definition of mental illness, the inclusion of substance abuse coverage, small employers' coverage, and cost increase exceptions. Few state laws provide as extensive coverage as MHPAEA, particularly with regard to its prohibition of visit limitations.

[16] 153 *Cong. Rec. S1864–5 (daily ed., February 12, 2007).*

[17] 154 *Cong. Rec. H8619 (daily ed., September 23, 2008).*

[18] See, Lehman AF "Quality of care in mental health: the case of schizophrenia" Health Affairs 18(5): 52–65.

[19] Sturm R, "Tracking changes in behavioral health services: How carve-outs changed care?" Journal of Behavioral Health Services and Research 26(4): 360–371, 1999. Frank RG and Garfield RL; "Managed Behavioral Health Carve-Outs: Past Performance and Future Prospects" *Annual Reviews of Public Health 2007,* 28:11; 1–18. Frank RG and Garfield RL; "Managed Behavioral Health Carve-Outs: Past Performance and Future Prospects" *Annual Reviews of Public Health 2007,* 28:11; 1–18.

[20] While studies have shown that state parity laws have increased access only marginally, most state laws still allowed disparate treatment limits for mental health conditions and substance use disorders, which limited access for those needing significant amounts of treatment. As discussed above, MHPAEA and these regulations prohibit the imposition of such disparate limits, which could increase access for those individuals. Nine states have treatment limit requirements similar to MHPAEA for mental health benefits, while 10 states have similar requirements for substance abuse disorder benefits.

shown that the high prevalence of depression and the low productivity it causes have cost employers $31 billion to $51 billion annually in lost productivity in the United States.[21] More days of work loss and work impairment are caused by mental illness than by various other chronic conditions, including diabetes and lower back pain.[22]

Moreover, studies have consistently found that workers who report symptoms of mental disorders have lower earnings than other similarly-situated coworkers. For example, a recent study funded by the National Institutes of Health's National Institute of Mental Health [23] found that mental disorders cost employees at least $193 billion annually in lost earnings alone, a staggering number that probably is a conservative estimate because it did not include the costs associated with people in hospitals and prisons, and included very few participants with autism, schizophrenia and other chronic illnesses that are known to greatly affect a person's ability to work. The study also noted that individuals suffering from depression earn 40 percent less than non-depressed individuals.

Although accurately determining cause and effect can be difficult, studies have attempted to estimate the beneficial impact of treating mental disorders. One study found that treating individuals suffering from mental disorders helped close the gap in productivity between those with mental disorders and those who did not have a mental disorder.[24] The finding that treatment can help increase the productivity of those suffering from mental illness suggests that increasing access to treatment of mental disorders could have a beneficial impact on lost productivity cost and lost earnings that stem from untreated and under treated mental health conditions and substance use disorders. The Departments, however, do not have sufficient data to determine whether this result will occur, and, if it does, the extent to which lost productivity cost and lost earnings could improve.

As noted above the combination of reduced cost sharing and the elimination of day and visit limits have the effect of making coverage more complete. The dominant role of managed behavioral health care in the market and the evidence about it success in controlling costs means that the moral hazard problem can be controlled (the evidence on this is discussed in more detail below). The implication is that more complete financial protection can be offered to people without a significant increase in social costs. This implies improved efficiency in the insurance market since more efficient risk spreading would occur without much welfare loss due to moral hazard.

In order to comply with MHPAEA and these regulations, cost-sharing requirements for mental health and substance use disorder benefits cannot be any more restrictive than the predominant cost-sharing requirement applied to substantially all medical/surgical benefits. Because expenditures on mental health and substance use disorder benefits only comprise 3–6 percent of the total benefits covered by a group health plan and 8 percent of overall healthcare costs,[25] the Departments expect that group health plans will lower cost-sharing on mental health and substance use disorder benefits instead of raising cost-sharing on medical/surgical benefits.

MHPAEA and these interim final regulations could have a positive impact on the delivery system of mental health services. Currently, approximately half of mental health care is delivered solely by primary care physicians.[26] This trend is likely due in part to the large discrepancies between insurance cost-sharing for services delivered by mental health professionals and primary care physicians. Historically, the cost-sharing associated with primary care physician visits is lower than cost-sharing for mental health professional visits. This difference in the relative price encouraged patients suffering from mental illness to visit primary care physicians for mental health-related conditions. If MHPAEA and these regulations result in lowering the relative price of mental health care, more individuals suffering from mental illness could visit and receive care from mental health professionals. One study [27] found that only 12.7 percent of individuals treated in the general medical sector received at least minimally adequate mental health care compared to 48.3 percent of patients treated in the specialty mental health sector.[28] A shift in source of treatment from primary care physicians to mental health professionals could lead to more appropriate care, and thus, better health outcomes.[29] The Departments, however, do not have sufficient data to estimate how large this shift in treatment could be or determine whether it will occur.

Mental health and physical health are interrelated, and individuals with poor mental health are more likely to have

[21] Stewart, W.F., Ricci, J.A., Chee, E., Hahn, S.R. & Morgenstein, D. (2003, June 18). "Cost of lost productive work time among US workers with depression." *JAMA: Journal of the American Medical Association. 289, 23,* 3135–3144.

Kessler, R.C., Akiskal, H.S., Ames, M., Birnbaum, H., Greenberg, P., Hirschfeld, H.M.A. et al. (2006). "Prevalence and effects of mood disorders on work performance in a nationally representative sample of U.S. workers." *American Journal of Psychiatry,* 163, 1561–1568.

[22] Stewart, W.F., Ricci, J.A., Chee, E., Hahn, S.R. & Morgenstein, D. (2003, June 18). "Cost of lost productive work time among US workers with depression." *JAMA: Journal of the American Medical Association. 289, 23,* 3135–3144.

[23] Kessler, Ronald C., Steven Heeringa, Matthew D. Lakoma, Maria Petukhova, Agnes E. Rupp, Michael Schoenbaum, Philip S. Wang, and Alan M. Zaslavsky. "Individual and Societal Effects of Mental Disorders on Earnings in the United States: Results From the National Comorbidity Survey Replication."

The American Journal of Psychiatry; June 2008; 165, 6; Research Library pg. 703.

[24] Hilton, Michael F., Paul A. Schuffham, Judith Sheridan, Catherine M. Clearly, Neria Vecchio, and Harvey A. Whiteford. "The Association Between Mental Disorders and Productivity in Treated and Untreated Employees." *Journal of Occupational and Environmental Medicine.* Volume 51, Number 9, September 2009.

[25] Finch R.A., Phillips K. Center for Prevention and Health Services. "An Employer's Guide to Behavioral Health Services: A Roadmap and Recommendations for Evaluating Designing, and Implementing Behavioral Health Services." National Business Group on Health 2005.

[26] Wang, P.S., Lane, M., Olfson, M., Pincus, H.A., Wells, K.B., and Kessler, R.C. (2005, June). "Twelve month use of mental health services in the United States." *Archives of General Psychiatry,* 62, 629–640. The study found that 40 percent of people reporting mental health and substance use disorders receive some treatment in a year.

[27] Wang, P.S., Lane, M., Olfson, M., Pincus, H.A., Wells, K.B., and Kessler, R.C. (2005, June). "Twelve month use of mental health services in the United states." *Archives of General Psychiatry,* 62, 629–640.

[28] Another analysis demonstrating poor adherence to evidence-based treatment for mental disorders is:

Wang PS, Berglund P, Kessler RC, *Journal of General Internal Medicine.* 2000; 15:284–292. Recent care of common mental disorders in the United States: Prevalence and conformance with evidence-based recommendations. This study finds that only 57.3 percent of people with major depression receive treatment during a year and less than one-third of those who receive treatment receive effective treatment.

Based on expert opinion, Normand et al. rated the likely effectiveness of combinations of general medical visits, specialty visits (with psychotherapy) and drug treatment to demonstrate the correlation between adequate treatment for depression and the probability of remission. For patients with no anti-depressant medication, the probability of remission increased as the number of specialty visits increased from one or less during a year to ten or more. The probability of remission was greater for patients with antidepressant medication and improved with more specialty visits during the year. Normand SLT, Frank RG, McGuire, TG. "Using elicitation techniques to estimate the value of ambulatory treatments for depression." Medical Decision Making, 2001; 22: 245–261.

[29] The Healthcare Effectiveness Data and Information Set report card for 2007 produced by National Center for Quality Assurance shows that for treatment of depression, only 20 percent of patients get appropriate levels of provider contacts; about 45 percent receive appropriate maintenance level medications and 62 percent obtain adequate medication doses and duration during the acute phase of illness.

physical health problems as well. Increased access and utilization of mental health and substance use disorder benefits could result in a reduction of medical/surgical costs for individuals afflicted with mental health conditions and substance use disorders. The decrease in medical/surgical costs could be significant; however, the Departments do not have sufficient data to estimate how large these health care spending offsets could be or determine whether they will occur.

There is disagreement among experts as to whether depression is an important antecedent risk factor for physical illness or whether the causal relationship acts in the opposite direction. Regardless, there is evidence that comorbid depression worsens the prognosis, prolongs recovery and may increase the risk of mortality associated with physical illness. In addition, comorbid depression has been shown to increase the costs of medical care, over and above the costs of treating the depression itself.[30]

The returns on investment from treatment of substance use disorders can be large.[31] Studies in Washington state clinics demonstrated that each dollar invested in inpatient and outpatient substance abuse treatment yielded returns of about 10 and 23 times their initial investments, respectively.[32] California and Oregon state treatment systems demonstrated a sevenfold return in their investments.[33] Other studies show effects ranging from a return of one and a half times the cost in a large study of a treatment clinic in Chicago to a return of 5 times the initial investment for a treatment for mentally ill chemical abusers,[34] resulting in a net benefit of about $85,000 per client for an investment of nearly $20,000.[35]

4. Costs

a. *Cost associated with increased utilization of mental health and substance use disorder benefits.* As discussed in the Benefits section earlier in this preamble, one of Congress' primary objectives in enacting MPHAEA was to eliminate barriers that impede access to and utilization of mental health and substance use disorder benefits. This has raised concerns among some that increased access and utilization of mental health and substance use disorder benefits will result in increases in associated payments and plan expenditures, which could lead to large premium increases that will make mental health and substance use disorder benefits unaffordable. The Departments are uncertain regarding the level of increased costs and premium increases that will result from MHPAEA and these regulations, but there is evidence that any increases will not be large.

One theory for increased costs resulting from parity is based on the fact that cost-sharing for mental health and substance use disorder benefits will decrease. A frequent justification for higher cost-sharing of mental health and substance use disorder benefits is the greater extent of moral hazard for these benefits; individuals will utilize more mental health and substance use disorder benefits at a higher rate when they are not personally required to pay the cost. To support this assumption, many have cited the RAND Health Insurance Experiment, conducted in 1977–1982, which demonstrated that individuals are more likely to increase their mental health care usage when their personal cost-sharing for mental health care services fall than they are to increase their physical health care usage when their personal cost-sharing for physical health care services decreases. Because this experiment was conducted nearly thirty years ago, researchers recently tested to determine whether this result held true.[36] Their results indicate that individuals' sensitivity to changes in cost-sharing may have changed significantly over time. These changes are explained at least in part due to the expansion of managed behavioral health care (described earlier). The authors found that individuals' price responsiveness of ambulatory mental health treatment is now slightly lower than physical health treatment. These results indicate that if plans lower the cost-sharing associated with mental health services, costs will not rise as much as would be expected using the results from the RAND Experiment.[37]

When the RAND Experiment was conducted, managed care was not nearly as prevalent as it is today. Health care economists have studied the impact of using cost control techniques associated with managed care to reduce the quantity of mental health and substance use disorder benefits utilized so that lowered cost sharing may result in only a small increase in spending.[38] This research concluded that "comprehensive parity implemented in the context of managed care would have little impact on total spending."[39]

These findings were similar to those of a recent study published in the New England Journal of Medicine examining the Federal Employees Health Benefits Program (FEHBP), which implemented parity for mental health and substance use disorder benefits in 2001.[40] The primary concern has been that the existence of parity in the FEHBP would result in large increases in the use of mental health and substance-abuse services and spending on these services. However, the study concluded that these fears were unfounded and "that parity of coverage of mental health and substance-abuse services, when coupled with management of care, is feasible and can accomplish its objectives of greater fairness and improved insurance protection without adverse consequences for health care costs."[41] The study found average per user declines in out patient cost sharing of between zero and $87 depending on the

[30] Conti R, Berndt ER, Frank RG. "Early retirement and DI/SSI applications: Exploring the impact of depression", in Culter DM, Wise DA. *Health in Older Ages: The causes and consequences of declining disability among the elderly,* (Chicago: National Bureau of Economic Research, 2008).

[31] The Office of National Drug Control Policy has information on effective treatment and cost savings at *http://www.whitehousedrugpolicy.gov.*

[32] French, M.T., H.J. Salome, A. Krupski, J.R. McKay, D.M. Donovan, A.T. McLellan, and J. Durrell. (2000). "Benefit-cost analysis of residential and outpatient addiction treatment in the State of Washington." *Evaluation Review, 24(6),* 609–634.

[33] Ettner, S.L., D. Huang, E. Evans, D.R. Ash, M. Hardy, M. Jourabchi, and Y. Hser. (2006). "Benefit-Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment 'Pay for Itself?'" *Health Services Research,* 41(1), 192–213.

[34] French, M.T., K.E. McCollister, S. Sacks, K. McKendrick, & G. De Leon. (2002). "Benefit cost analysis of a modified therapeutic community for mentally ill chemical abusers." *Evaluation and Program Planning, 25,* 137–148.

[35] The returns are the ratio of benefits to costs. Benefits include personal as well as societal benefits including increased employment and reduced crime.

[36] Meyerhoefer, Chad D. and Samuel Zuvekas, 2006. "New Estimates of the Demand for Physical and Mental Health Treatment." Agency for Healthcare Research and Quality Working Paper No. 06008.

[37] Another paper showing a similar result to the Myerhoefer paper cited above is: Lu CL, Frank, RG and McGuire TG. "Demand Response Under Managed Care." *Contemporary Economic Policy,* 27(1):1–15, 2009.

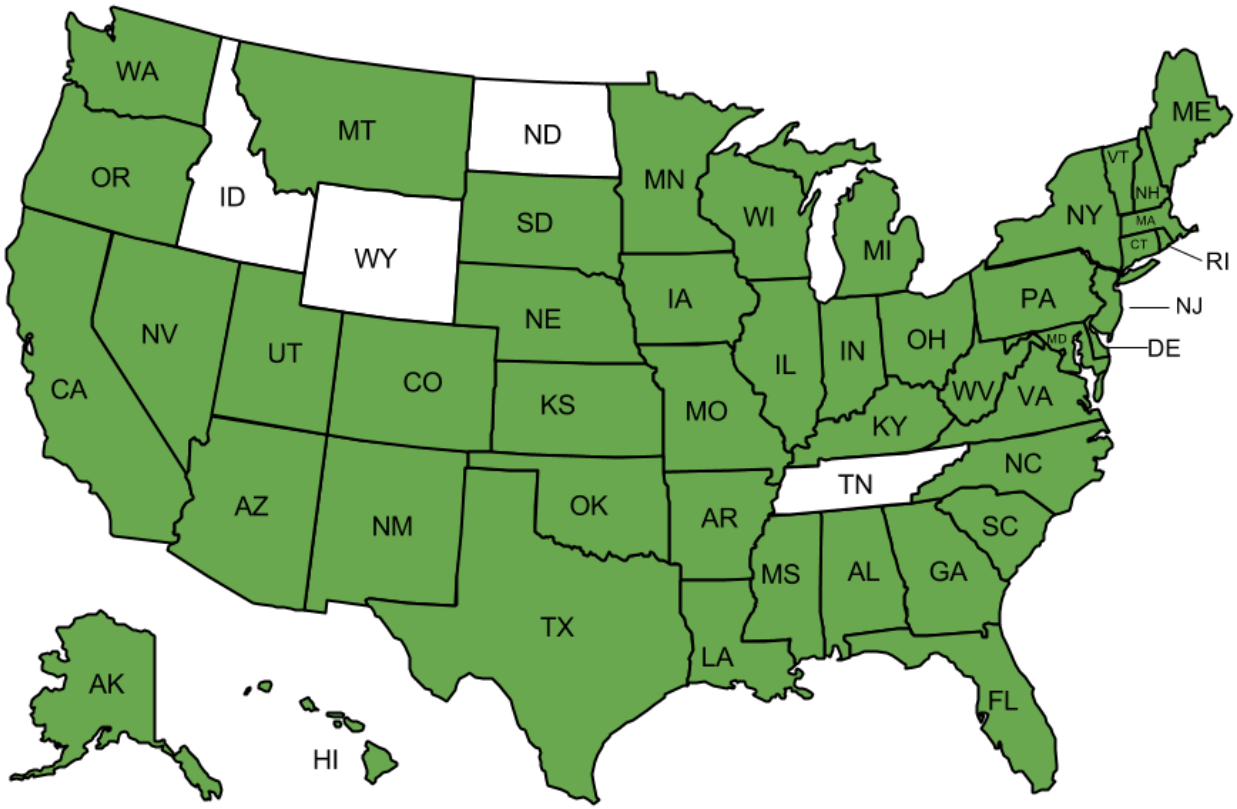
[38] Barry, Frank, and McGuire. "The Costs of Mental Health Parity: Still an Impediment?" *Health Affairs,* no. 3:623 (2006).

[39] *Id.*

[40] Goldman, *et al.,* "Behavioral Health Insurance Parity for Federal Employees," New England Journal of Medicine (March 30, 2006) Vol. 354, No. 13. In 1999, President Clinton directed the Office of Personnel Management (OPM) to equalize benefits coverage in the FEHBP, and parity was implemented in 2001. Parity under the FEHBP is very similar to MHPAEA. It requires benefits coverage for plan mental health, substance abuse, medical, surgical, and hospital providers to have the same limitations and cost-sharing such as deductibles, coinsurance, and co-pays. When patients use plan providers and follow a treatment regime approved by their plan, all diagnostic categories of mental health and substance abuse conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV) are covered.

[41] *Id.*

States with Autism Insurance Mandates



2001 - Indiana

2007 - South Carolina

2007 - Texas

2008 - Arizona

2008 - Florida

2008 - Louisiana

2008 - Pennsylvania

2008 - Illinois

2009 - Colorado

2009 - Nevada

2009 - Connecticut

2009 - Wisconsin

2009 - Montana

2009 - New Jersey

2009 - New Mexico

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2010 - Iowa

2010 - Vermont

2010 - Missouri

2010 - New Hampshire

2010 - Massachusetts

2011 - Arkansas

2011 - West Virginia

2011 - Virginia

2011 - Rhode Island

2011 - California

2011 - New York

2012 - Michigan

2012 - Alaska

2012 - Delaware

2013 - Minnesota

2013 - Oregon

2014 - Maryland

2014 - Nebraska

2014 - Utah

2014 - Washington

2015 - South Dakota

2015 - Mississippi

2015 - Georgia

2015 - Hawaii

2015 - North Carolina

2016 - Oklahoma

2017 - Ohio

2017 - Alabama

States that Have Passed an Autism Insurance Mandate But the Mandated Benefits are Not Available in Individual Plans

STATE	INDIVIDUAL - GRANDFATHERED	INDIVIDUAL - NONGRANDFATHERED
Alabama	Yes	No
Arizona	No	Yes
Arkansas	No	Yes
Colorado	No	Yes
Connecticut	No	Yes
Florida	No	No
Georgia	Yes	No
Iowa	No	No
Kansas	Yes	No
Louisiana	No	Yes
Minnesota	No	No
Mississippi	Yes	No
Nebraska	Yes	No
New Hampshire	No	Yes
North Carolina	Yes	No
Oklahoma	Yes	No
Pennsylvania	No	No
Rhode Island	No	No
South Carolina	No	No
South Dakota	Yes	No
Virginia	No	No
West Virginia	No	Yes

States that Have Passed an Autism Insurance Mandate But the Mandated Benefits are Not Available in Small Group Plans

STATE	SMALL GROUP - GRANDFATHERED	SMALL GROUP - NONGRANDFATHERED
Alabama	No	No
Arizona	No	Yes
Florida	No	No
Georgia	Yes	No
Idaho	No	No
Kansas	Yes	No
Minnesota	No	No
Mississippi	No	No
Nebraska	Yes	No
North Carolina	Yes	No
Oklahoma	Yes	No
Pennsylvania	No	No
Rhode Island	No	No
South Carolina	No	No
South Dakota	Yes	No
Utah	No	No
Virginia	No	No

JOHN R. KASICH
GOVERNOR
STATE OF OHIO

December 26, 2012

Director Gary Cohen
Centers for Medicare and Medicaid Services Center for Consumer Information and Insurance Oversight
200 Independence Avenue, SW, Suite 739H
Washington, D.C. 20201
Electronically submitted via www.regulations.gov

Dear Director Cohen,

This letter is to provide you with comments on the Proposed Rule 45 CFR Part 156 – Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges.

As a preliminary matter, please note that Appendix A of this rule incorrectly describes the proposed benchmark plan for the state of Ohio as providing habilitative services. A review of the plan contract documents for the benchmark plan you selected for Ohio indicates that the plan does not provide for habilitative services and, as such, the Appendix A should indicate "No" in the "Habilitative services" column. This information was previously communicated to your office on December 12, 2012.

Since the benchmark plan you selected for Ohio does not provide for habilitative services, the State of Ohio intends to exercise the authority provided by 45 CFR §156.110(f) to determine habilitative services as the following:

> "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
>
> (a) Speech and Language therapy and/or Occupational therapy, performed by a licensed therapists, 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."

Sincerely,

John Kasich
Governor

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STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of the Office of Financial and Insurance Regulation

In the matter of:

Essential Health Benefits: Habilitative Services **Order No. 13-003-M**

/

Issued and entered
this 17th day of January 2013
by R. Kevin Clinton
Commissioner

Order Requiring Coverage for Habilitative Services

The Patient Protection and Affordable Care Act (ACA) requires all non-grandfathered individual and small group health insurance plans, offered on and off the Exchange, to provide coverage in ten categories of essential health benefits (EHBs), including the category of "rehabilitative and habilitative services." Habilitative services are defined as "health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings."[1] Beginning January 1, 2014, any small group or individual plan must offer, at a minimum, the services covered in the state's EHB benchmark plan. Michigan's benchmark plan is the Priority Health HMO plan that was in effect as of March 31, 2012.

Like most health plans offered in Michigan, the Priority Health benchmark plan does not include coverage for habilitative services. In recently released proposed regulations, the Department of Health and Human Services (HHS) stated that if a state's chosen benchmark plan "does not include coverage of habilitative services the state may determine the services included in the habilitative services category." 77 Fed. Reg. 70650 (Nov. 26, 2012).

The Commissioner has determined that habilitative services encompasses many different types of services, including but not limited to applied behavioral analysis (ABA) for the treatment of autism spectrum disorder. ABA is defined by Michigan law as "the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation,

[1] This definition is taken from the uniform glossary that is required to be made available with every insurance plan offered on January 1, 2014, and it is substantively identical to the definition used in Medicaid laws. The Commissioner cites this definition because it is most likely to be referenced by health insurance carriers and insureds.

measurement, and functional analysis of the relationship between environment and behavior." See MCL 500.3406s(7)(a) and 550.1416e(6)(a).

Under existing state law, treatments for autism spectrum disorder are required to be offered in all health insurance policies and certificates. See MCL 500.3406s and MCL 550.1416e. However, state law does not specifically require that such treatments be offered in health insurance policies and certificates offered on the Exchange.

THEREFORE, IT IS ORDERED that ABA treatment for autism is included in Michigan's EHB "habilitative services" category. Any qualified health plan offered through an Exchange in Michigan is required, as a result of this Order, to include ABA treatment for autism. This will ensure that ABA treatment is available in all health insurance policies in Michigan, whether offered on or off the Exchange.

Furthermore, Michigan law allows insurers to impose annual dollar limits on coverage for autism spectrum disorder treatments. See MCL 500.3406s and MCL 550.1416e. However, these limits are not enforceable in any plan offered on or off the Exchange in Michigan because all listed treatments, including ABA, are now part of the EHB package and, according to federal guidance, cannot be subject to annual or lifetime dollar limits.

THEREFORE, IT IS ALSO ORDERED that insurance carriers must convert the applicable dollar limits to non-quantitative (e.g., scope and duration) limits for any small group or individual plan offered on or after January 1, 2014. The converted non-quantitative limits must be actuarially justified and must be included in the form and rate filings submitted through the SERFF system for Commissioner review and approval.

While the ACA does not require large group plans to offer EHBs, any EHBs that are offered by a large group plan must comply with the ACA's provisions on annual and lifetime dollar limits. Accordingly, large group plans providing coverage for ABA should also submit any converted non-quantitative limitations for plans offered on or after January 1, 2014 to the Commissioner for review and approval.

R. Kevin Clinton
Commissioner

Agency, Legislative and Carrier Action on Caps

State	Enacted	Annual Dollar Caps	Age Cap	Agency, Legislative and Carrier Action on Caps
Alabama	2017	40K: Age 0-9; 30K: Age 10-13; 20K: Age 14-18	18	BCBS not enforcing dollar caps
Alaska	2012	None	21	
Arizona	2008	50K: Age 0-9; 25K: Age 9-17	17	
Arkansas	2011	50K	18	
California	2011	None	None	
Colorado	2009	None	None	Specifically acknowleging MHP Law, the legislaure removed all dollar, age and visit limits in 2015. (Old caps: 34K: Age 0-9; 12K: Age 9-19.)
Connecticut	2009	None	None	Legislature removed all dollar and age caps in 2015. (Old caps: 50K: Age 0-9; 35K: Age 9-13; 25K: Age 13-15)
Delaware	2012	35K	21	
Florida	2008	36K (200K Lifetime)	18, or 21 if still in school	
Georgia	2015	30K	6	Legislation has passed on chamber that will raise the age caps from 6 to 12.
Hawaii	2015	25K	14	Hawaii Medical Service Association & Kaiser do not enforce caps.
Illinois	2008	36K	21	
Indiana	2001	None	None	
Iowa	2010	36K: Age 0-6; 25K: Age 7-13; 12.5K: Age 14-18	18	
Kansas	2010	1300 Hours/Yr for 4 years beginning on the later of the date of diagnosis or Jan 1, 2015 for an individual diagnosed before 5 years of age; then 520 Hours/Yr until age 12 SEHP 36K, 0-6; 27, 7-19	12, or 19 for SEHP	
Kentucky	2010	50K: Age 1-7; 12K: Age 7-21 (SG and indvidual cap is 12K age 1-21)	21	Pending legislation to remove age and dollar caps has passed one chamber.
Louisiana	2008	36K	21	Legislature raised age cap from 17 to 21 and removed lifetime max of 144K in 2014.

Agency, Legislative and Carrier Action on Caps

State	Enacted	Annual Dollar Caps	Age Cap	Agency, Legislative and Carrier Action on Caps
Maine	2010	36K	11	Legislature raised age cap raised from 5 to 11 in 2014.
Maryland	2014	25 Hours/Wk: Age 1.5-6; 10 Hours/Wk: Age 6-19	19	
Massachusetts	2010	None	None	
Michigan	2012	None	18	Legislature removed all dollar caps. (Old caps: 50K: Age 0-7; 40K: Age 7-13; 30K: Age 13-18)
Minnesota	2013	None	18	
Mississippi	2015	25 Hours/Wk	8	Age caps removed by agreement reached between State and BCBS, Magnolia Health and UHC. (See artilce, available at https://www.clarionledger.com/story/news/2018/01/16/services-folks-autism-spectrum-covered-after-8-years-old/1035097001/)
Missouri	2010	40K	19	
Montana	2009	50K: Age 0-9; 20K: Age 9-19	19	
Nebraska	2014	None	21	
Nevada	2009	72K	18, or 22 if in school	Legislature raised age cap raised from 36K to 72K in 2015.
New Hampshire	2010	36K: Age 0-12; 27K: Age 12-21	21	
New Jersey	2009	None	21	DOBI invalidated 36K dollar cap in 2010.
New Mexico	2009	36K	19, or 21 if in school	
New York	2011	None	None	
North Carolina	2015	40K	19	
Ohio	2017	20 Hours/Wk	14	
Oklahoma	2016	25K; (If diagnosed after age 3 coverage is provided for 6 years.)	9	
Oregon	2013	25 Hours/Wk	None	DOI issued bulletin stating that 25 hour limitation is a floor not a limit and if applied as a limit will violate MHP in 2014.

Agency, Legislative and Carrier Action on Caps

State	Enacted	Annual Dollar Caps	Age Cap	Agency, Legislative and Carrier Action on Caps
Pennsylvania	2008	36K	21	
Rhode Island	2011	32K	15	
South Carolina	2007	50K	16	BCBS does not enforce caps on the SEHP. Pending legislation to remove age and dollar caps has passed one chamber.
South Dakota	2015	36K: Age 0-7; 25K: Age 7-14; 12.5K: Age 14-19	19	
Texas	2007	No $ cap: Age 0-10; 36K after age 10	None	Legislature removed the treatment age cap in 2013.
Utah	2014	600 Hours/Yr	10	
Vermont	2010	None	21	Legislature raised age cap from 6 to 21 in 2012.
Virginia	2011	35K	10	Legislation is pending to raise the age cap for a 2nd time.
West Virginia	2011	30K: for a max of 3 years and then 2K per month	18	Legislature clarified that 30K cap applies to ABA only in 2012.
Wisconsin	2009	50K for 4 yrs (must occur age 2-9); 25K after first 4 years	None	

Warning Signs- Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by the Affordable Care Act, generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage[1] ensure that the financial requirements and treatment limitations on Mental Health or Substance Use Disorder (MH/SUD) benefits they provide are no more restrictive than those on medical or surgical (med/surg) benefits. This is commonly referred to as providing MH/SUD benefits in parity with med/surg benefits.

There are requirements for determining parity with respect to financial requirements (such as copays) and for treatment limitations, which limit the scope or duration of benefits for treatment. Treatment limitations may be quantitative treatment limitations (QTLs) which are numerical in nature (such as visit limits) or non-quantitative treatment limitations (NQTLs), which are non-numerical limits on the scope or duration of benefits for treatment (such as preauthorization requirements).[2] The rules for financial requirements and QTLs are different from the rules for NQTLs. This publication focuses on NQTLs and how to identify provisions that will require inquiry beyond the plan/policy terms in order to determine compliance with mental health parity requirements.

Under MHPAEA regulations, a plan or issuer may not impose an NQTL on MH/SUD benefits unless, under the terms of the plan or coverage as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification[3] are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to med/surg benefits in the same classification. Federal MHPAEA regulations contain an illustrative, non-exhaustive list of NQTLs,[4] which include:

- medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative (including standards for concurrent review);
- formulary design for prescription drugs;
- network tier design;
- standards for provider admission to participate in a network, including reimbursement rates;
- plan methods for determining usual, customary, and reasonable charges;
- fail-first policies or step therapy protocols;
- exclusions based on failure to complete a course of treatment; and
- restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

Stakeholders have asked for examples of plan provisions they might see on the MH/SUD side which should trigger careful analysis of the coverage on the med/surg side in order to ensure MHPAEA NQTL compliance.

---

1 MHPAEA contains an exemption for small employers (generally those with 50 or fewer employees), as well as plans that meet an increased cost exemption. The Affordable Care Act extended MHPAEA to individual coverage and HHS's essential health benefits regulations require non-grandfathered individual and small group coverage to ensure parity as an EHB requirement. Retiree health plans continue to be exempt.

2 See 29 CFR 2590.712(c)(2)-(3) for the test for financial requirements and QTLs and 29 CFR 2590.712(c)(4) for the requirements for NQTLs. 26 CFR 54.9812-1(c)(2)-(4); 29 CFR 2590.712(c)(2)-(4); 45 CFR 146.136(c)(2)-(4); and 147.160.

3 The classifications are inpatient in-network; inpatient out-of-network; outpatient in-network; outpatient out-of-network; prescription drugs and emergency care. Sub-classifications for outpatient office visits and network tiering are permissible. 26 CFR 54.9812-1(c)(2)(ii), (3)(iii); 29 CFR 2590.712(c)(2)(ii), (3)(iii); 45 CFR 146.136(c)(2)(ii), (3)(iii); and 147.160.

4 26 CFR 54.9812-1(c)(4)(ii); 29 CFR 2590.712(c)(4)(ii); 45 CFR 146.136(c)(4)(ii); and 147.160.

Language contained in the following provisions (absent similar restrictions on med/surg benefits) can serve as a red flag that a plan or issuer may be imposing an impermissible NQTL. Further review of the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to both MH/SUD and med/surg benefits will be required to determine parity compliance. Note that these plan/policy terms do not automatically violate the law, but the plan or issuer will need to provide evidence to substantiate compliance. The categories and examples below are not exhaustive and are not a substitute for any regulations or other interpretive guidance issued by the Departments.

EXAMPLE PROVISIONS: If you see these types of plan or policy provisions, investigate if these types of limits are also applied to med/surg benefits and if so, if they are being applied to MH/SUD and med/surg benefits in a manner that complies with MHPAEA.

I. Preauthorization & Pre-service Notification Requirements

- ***Blanket Preauthorization Requirement:*** Plan/insurer requires preauthorization for all mental health and substance use disorder services.

- ***Treatment Facility Admission Preauthorization:*** Plan/policy states that if the insured is admitted to a mental health or substance abuse facility for non-emergency treatment without prior authorization, insured will be responsible for the cost of services received.

  Plan states that for inpatient mental health precertification is required.

  Plan requires pre-notification or notification ASAP for non-scheduled MH/SUD admissions and reduces benefits 50% if pre-notification is not received.

  Plan requires preauthorization for all inpatient and outpatient treatment of chemical dependency and all inpatient and outpatient treatment of serious mental illness and mental health conditions.

  Plan requires preauthorization or concurrent care review every 10 days for MH/SUD services but not for med/surg services.

- ***Medical Necessity Review Authority:*** Plan's/insurer's medical management program (precertification and concurrent review) delegates its review authority to attending physicians for med/surg services but conducts its own reviews for MH/SUD services.

- ***Prescription Drug Preauthorization:*** Plan/insurer requires preauthorization every three months for pain medications prescribed in connection with MH/SUD conditions.

- ***Extensive Pre-notification Requirements:*** Plan/insurer requires pre-notification for all mental health and substance use disorder inpatient services, intensive outpatient program treatment, and extended outpatient treatment visits beyond 45-50 minutes.

II. Fail-first Protocols

- ***Progress Requirements:*** For coverage of intensive outpatient treatment for MH/SUD, the plan/insurer requires that a patient has not achieved progress with non-intensive outpatient treatment of a lesser frequency.

- ***Treatment Attempt Requirements:*** For inpatient SUD rehabilitation treatment plan/insurer requires a member to first attempt two forms of outpatient treatment, including the intensive outpatient, partial hospital, outpatient detoxification, ambulatory detoxification or inpatient detoxification levels of care.

  For any inpatient MH/SUD services, the plan/insurer requires that an individual first complete a partial hospitalization treatment program.

III. Probability of Improvement

- ***Likelihood of Improvement:*** For residential treatment of MH/SUD, the plan/insurer requires the likelihood that inpatient treatment will result in improvement.

  Plan/policy only covers services that result in measurable and substantial improvement in mental health status within 90 days.

IV. Written Treatment Plan Required

- ***Written Treatment Plan:*** For MH/SUD benefits, plan/insurer requires a written treatment plan prescribed and supervised by a behavioral health provider.

- ***Treatment Plan Required within a Certain Time Period:*** Plan/insurer requires that within seven days, an individualized problem-focused treatment plan be completed, including nutritional, psychological, social, medical and substance abuse needs to be developed based on a complex bio-psychosocial evaluation. Plan needs to be reviewed at least once a week for progress.

- ***Treatment Plan Submission on a Regular Basis:*** Plan/insurer requires that an individual-specific treatment plan will be updated and submitted, in general, every 6 months.

V. Other

- ***Patient Non-compliance:*** Plan/policy excludes services for chemical dependency in the event the covered person fails to comply with the plan of treatment, including excluding benefits for MH/SUD services if a covered individual ends treatment for chemical dependency against the medical advice of the provider.

- ***Residential Treatment Limits:*** Plan/policy excludes residential level of treatment for chemical dependency.

- ***Geographical Limitations:*** Plan/policy imposes a geographical limitation related to treatment for MH/SUD conditions but does not impose any geographical limits on med/surg benefits.

- ***Licensure Requirements:*** Plan/policy requires that MH/SUD facilities be licensed by a State but does not impose the same requirement on med/surg facilities.

The State of New Hampshire
Insurance Department

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Roger A. Sevigny
Commissioner

Alexander K. Feldvebel
Deputy Commissioner

BULLETIN
Docket No.: INS-15-046-AB

TO: All New Hampshire Licensed Health Carriers and Producers
FROM: Roger A. Sevigny
Insurance Commissioner
DATE: July 6, 2015
RE: Guidance on Administration of Autism Benefits

The purpose of this bulletin is to give carriers guidance on the administration of autism benefits, in particular on whether dollar or visit limits are permissible.

New Hampshire law requires coverage of certain treatments for persons with pervasive developmental disorder or autism. RSA 417-E:2. These treatments include "[p]rofessional services and treatment programs, including applied behavioral analysis, necessary to produce socially significant improvements in human behavior or to prevent loss of attained skill or function," specifically including prescribed pharmaceuticals and services provided by certain types of licensed professionals. RSA 417-E:2, I(a). On its face, the statute allows services to be capped at certain monetary levels depending on age. RSA 417-E:2, III. However, this provision may be preempted by the federal Affordable Care Act (ACA) if it prevents the application of federal law. ACA section 1321(d), 42 USC § 18041(d).

Under the ACA, mental health benefits are considered part of the Essential Health Benefits which must be covered under any individual or small group market health plan. ACA section 1302(b)(1)(E), 42 USC § 18021(b)(1)(E). In New Hampshire, "pervasive developmental disorder" and autism are specifically defined as biologically-based mental illnesses. RSA 417-E:1, III (h). Because state law defines these conditions as mental illnesses, they are subject not only to state law parity requirements, but also to the federal Mental Health Parity and Addiction Equity Act (MHPAEA), 42 USC § 300gg-26.

As a defined mental illness under RSA 417-E:1, autism is subject to the MHPAEA and must be treated in parity with any other illness covered under the plan. Coverage of the condition is also considered one of the Essential Health Benefits. The dollar limits set forth in RSA 417-E:2, if read as caps, would prevent the application of the ACA, and are therefore preempted. Any visit limitations established as equivalents to those dollar limits serve only as a minimum threshold for autism related services, not as a maximum cap.

Questions related to this bulletin should be directed to Jennifer Patterson, Health Policy Legal Counsel, at (603) 271-2261 ext. 215 or email at jennifer.patterson@ins.nh.gov; or Michael Wilkey, Director of Compliance and Consumer Services at the New Hampshire Insurance Department, at michael.wilkey@ins.nh.gov or by phone at (603) 271-2261 ext. 330.

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John G. Franchini (505) 827-4299

ACTING DEPUTY SUPERINTENDENT
Alan Seeley (505) 827-4307

BULLETIN NO. 2015-013

TO: EVERY INSURER, NONPROFIT HEALTH CARE PLAN, HEALTH MAINTENANCE ORGANIZATION, AND PREPAID DENTAL PLAN TRANSACTING BUSINESS IN NEW MEXICO

FROM: JOHN G. FRANCHINI, SUPERINTENDENT OF INSURANCE

DATE: MARCH 25, 2015

RE: AUTISM BENEFITS - INDIVIDUAL AND SMALL GROUP PLANS

This Bulletin is issued pursuant to Section 59A-2-8 NMSA 1978 of the New Mexico Insurance Code, 13.1.2 *et seq.* NMAC.

New Mexico's current mandate on autism coverage directs carriers to include autism spectrum benefits in their major medical health plans (Section 59A-22-49 NMSA 1978. COVERAGE FOR AUTISM SPECTRUM DISORDER DIAGNOSIS AND TREATMENT) and was created prior to the passage of the Affordable Care Act. The Affordable Care Act eliminated limits for commercial individual and small group plans. Therefore the limits outlined in the existing mandate are non-enforceable for commercial individual and small group major medical plans and will not be enforced by New Mexico Office of Superintendent of Insurance.

The Affordable Care Act makes an exception for large group plans, so the foregoing does not apply to large group plans. However, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008[1] does apply to large groups, and autism spectrum disorder as defined in 59A-22-49 and the Diagnostic and Statistical Manual of Mental Disorders IV and DSM V is a mental health condition covered by MHPAEA. Accordingly, pursuant to MHPAEA, 29 U.S.C. §1185a and its implementing regulations at 45 CFR §§146.136 and 147.160, quantitative limits on this coverage cannot be imposed or enforced unless the insurer imposes the same limits as the predominant treatment limitation on substantially all of its medical or surgical outpatient coverage.

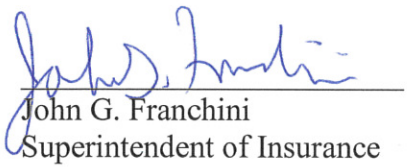
Additionally, the existing mandate specifies the autism definition found in DSM IV. The current manual used by the autism treatment providers is DSM V. New Mexico Office of Superintendent of Insurance

[1] The Final Rules implementing MHPAEA were published in the Federal Register on November 13, 2013. 78 FR 219.

will be seeking statutory change at the earliest opportunity to make the definition the one found in the current version of the manual.

ISSUED at Santa Fe, New Mexico on March 25, 2015.

OFFICE OF NEW MEXICO SUPERINTENDENT OF INSURANCE



John G. Franchini
Superintendent of Insurance

COLORADO
Department of Regulatory Agencies
Division of Insurance

Bulletin No. B-4.94

AGE DISCRIMINATION AND ESSENTIAL HEALTH BENEFITS

I. Background and Purpose

The purpose of this bulletin is to provide guidance to carriers offering health benefit plans and consumers regarding the prohibition on age discrimination for certain essential health benefits pursuant to both state and federal law for plans issued on or after January 1, 2017.

Bulletins are the Division of Insurance's (Division's) interpretations of existing insurance law or general statements of Division policy. Bulletins themselves neither establish binding norms nor finally determine issues or rights.

II. Applicability and Scope

This bulletin is intended for purchasers of, and carriers who offer individual, small group, and large group health benefit plans[1] in Colorado on or after January 1, 2017 that contain the essential health benefits required by Colorado Insurance Regulation 4-2-42.

III. Division Position

The final "HHS Notice of Benefits and Payment Parameters for 2017" issued by the U.S. Department of Health and Human Services (HHS) on March 8, 2016,[2] contains information concerning the federal civil rights laws which impose non-discrimination requirements on health benefit plan carriers. In that notice, HHS stated that benefits which impose age limits, whether due to state law or policy language, may be in violation of the Age Discrimination Act of 1975 ("Age Act").

This was followed by the issuance of further guidance in "Nondiscrimination in Health Programs and Activities (Final Rule)" issued by the U.S. Department of Health and Human Services (HHS) on May 18, 2016,[3] which contained information on Section 1557 of the Affordable Care Act, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities. In that final rule, HHS specified that consistent with exceptions found in the Age Act, "age distinctions contained in Federal, State, or local statutes or ordinances adopted by an elected, general purpose legislative body are not covered by the final rule."

[1] "Health benefit plan" is defined at § 10-16-102 (32), C.R.S.

[2] HHS Notice of Benefit and Payment Parameters for 2017, 81 FR 12204 (08 March 2016), page 12312

[3] Nondiscrimination in Health Programs and Activities; Final Rule, 81 FR 31375 (18 May 2016) , page 31375-31473

This means that the following Colorado mandates that currently have age limits will not be considered discriminatory under current state law and federal guidance:

- Early intervention services found at § 10-16-104(1.3), C.R.S.;
- Therapies for congenital defects found at § 10-16-104(1.7), C.R.S.;
- Hearing aids for children found at § 10-16-104(19), C.R.S.; and
- Phenylketonuria found at § 10-16-104(1)(c)(III)(B), C.R.S.

Under the Affordable Care Act, stand-alone pediatric dental coverage and stand-alone pediatric vision coverage are not subject to the prohibition on age discrimination as they are considered limited excepted benefits. Imposing age-related coverage limits on essential health benefits, other than pediatric dental coverage, pediatric vision coverage, and the mandated benefits listed above, will be considered discriminatory. This includes placing age-related coverage limits on the following:

- Medically necessary treatment for autism, including applied behavioral analysis, as parity must be provided; and
- Medically necessary habilitative and rehabilitative therapies.

IV. Additional Division Resources

Colorado Insurance Regulation 4-2-42

For More Information

Colorado Division of Insurance
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V. History

- Issued August XX, 2016

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Commissioner

BULLETIN NO: 10-02

TO: ALL HOSPITAL, MEDICAL AND HEALTH SERVICE CORPORATIONS, HEALTH INSURANCE COMPANIES AND HEALTH MAINTENANCE ORGANIZATIONS DELIVERING OR ISSUING FOR DELIVERY A HEALTH BENEFITS PLAN IN NEW JERSEY

FROM: NEIL N. JASEY, COMMISSIONER

RE: IMPLEMENTATION OF P.L. 2009, C. 115 WITH RESPECT TO CERTAIN BENEFITS FOR TREATMENT OF AUTISM AND OTHER DEVELOPMENTAL DISABILITIES

On August 13, 2009, P.L. 2009, c. 115 ("Chapter 115") was enacted. The new law is variously codified.[1] The law requires that carriers provide:

1. Coverage for expenses incurred in screening and diagnosing autism or another developmental disability;
2. Coverage for expenses incurred for medically necessary physical therapy, occupational therapy and speech therapy services for the treatment of autism or another developmental disability;
3. Coverage for expenses incurred for medically necessary behavioral interventions based on the principles of applied behavioral analysis (ABA) and related structured behavioral programs for treatment of autism in individuals under 21 years old; and
4. A benefit for the coverage of the "Family Cost Share" expense incurred for certain health care services obtained through the New Jersey Early Intervention System (NJEIS).

In addition, carriers must provide the required coverage without consideration of whether the services are restorative or have a restorative effect.

[1] Statutory codification of Chapter 115 is as follows: N.J.S.A. 17:48-6ii (applying to hospital service corporations); N.J.S.A. 17:48A-7ff (applying to medical service corporations); N.J.S.A. 17:48E-35.33 (applying to health service corporations); N.J.S.A. 17B:26-2.1cc (applying to insurers), N.J.S.A. 17B:27-46.1ii (applying to insurers), N.J.S.A. 17B:27A-7.16 (applying to all carriers offering individual health benefits plans); N.J.S.A. 17B:27A-19.20 (applying to all carriers offering small employer health benefits plans); N.J.S.A. 26:2J-4.34 (applying to HMOs and all HMO coverage); N.J.S.A. 52:14-17.29p (regarding the State Health Benefits Plan); and, N.J.S.A. 52:17.46.6b (regarding the School Employees' Health Benefits Plan).

Chapter 115 becomes effective on February 9, 2010. The Department of Banking and Insurance (DOBI) will not be able to adopt rules implementing and interpreting the provisions of Chapter 115 prior to February 9, 2010. Accordingly, the DOBI is issuing this bulletin to provide guidance for health service corporations, hospital service corporations, medical service corporations, health insurance companies, and health maintenance organizations (collectively, "carriers") in their efforts to comply with Chapter 115 in a timely manner.[2]

Scope of Chapter 115's Applicability

Chapter 115 applies to all health insurance policies issued or renewed on or after February 9, 2010 that provide hospital and medical expense benefits, including all health maintenance organization and all health service corporation contracts.

Definition of Developmental Disability

Chapter 115 does not define the term "developmental disability." However, the New Jersey Developmentally Disabled Rights Act at N.J.S.A. 30:6D-1 et seq. defines the term at N.J.S.A. 30:6D-3 to mean:

> …a severe, chronic disability of a person which:
>
> (1) is attributable to a mental or physical impairment or combination of mental or physical impairments;
>
> (2) is manifest before age 22;
>
> (3) is likely to continue indefinitely;
>
> (4) results in substantial functional limitations in three or more of the following areas of major life activity, that is, self-care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living or economic self-sufficiency; and
>
> (5) reflects the need for a combination and sequence of special inter-disciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated. Developmental disability includes but is not limited to severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met[.]

The DOBI believes this definition should be used in implementing Chapter 115.

Definition of Autism

The DOBI interprets "autism" as used in Chapter 115 to mean autism and related conditions often included under the phrase "Autism Spectrum Disorder." In current clinical terms, this would include several conditions classified under "Pervasive

[2] This bulletin should not be construed to provide any guidance with respect to the State Health Benefits Plan or the School Employee's Health Benefits Plan, to which Chapter 115 also applies, but which are outside the DOBI's regulatory authority.

Developmental Disorder." The DOBI considers diagnostic codes using 299, as set forth in the Diagnostic and Statistical Manual of Mental Health Disorders, Fourth Edition, Text Revised (DSM IV-TR) or International Classification of Disease (ICD), to be "autism" for purposes of complying with Chapter 115. However, because not all clinicians consider Childhood Disintegrative Disorder (CDD) and Rett's Disorder to be included under Autism Spectrum Disorder, it is acceptable for carriers to choose to exclude 299.1 and 299.8 when it is clear the diagnosis is for CDD or Rett's Disorder, respectively.[3,4]

Coverage of Applied Behavioral Analysis

Chapter 115 requires that carriers provide coverage for expenses incurred by an individual who is under 21 years of age and diagnosed with autism for medically necessary treatments of the autistic condition based on the principles of applied behavioral analysis (ABA) and related structured behavioral programs.

Behavioral Interventions based on ABA
and Related Structured Behavioral Programs

"Behavioral interventions based on ABA" are interventions or strategies based upon learning theory that are intended to improve socially important behavior of an individual using instructional and environmental modifications that have been evaluated through scientific research using reliable and objective measurements, including the empirical identification of functional relations between behavior and environmental factors. Behavioral intervention strategies based on ABA include, but are not limited to:

1. chaining;
2. functional analysis;
3. functional assessment;
4. functional communication training;
5. modeling, including video modeling (also known as imitation training);
6. procedures designed to reduce challenging and dangerous behaviors (e.g., differential reinforcement, extinction, time out, and response cost);
7. prompting; and
8. reinforcement systems, including differential reinforcement, shaping and strategies to promote generalization

"Related structured behavioral programs" are services delivered by a qualified practitioner that are comprised of multiple intervention strategies (that is, behavioral intervention packages) based upon the principles of ABA. These packages may include but are not limited to:

1. activity schedules;
2. discrete trial instruction;
3. incidental teaching;

[3] The DSM IV-TR and ICD-9's 299 code (Pervasive Developmental Disorder) includes: autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder and pervasive developmental disorder-not otherwise specified.

[4] Although a carrier may not consider a diagnosis of CDD or Rett's disorder to be "autism," carriers should still consider whether such diagnoses meet the criteria for developmental disability at N.J.S.A. 30:6D-3.

4. natural environment training;
5. picture exchange communication system;
6. pivotal response treatment;
7. script and script-fading procedures; and
8. self-management

Qualified Practitioners of ABA

The DOBI is aware that carriers define an eligible provider of health care services as a practitioner acting within the scope of his or her license in the state in which the license is issued. The DOBI is also aware that most states, including New Jersey, have no professional license for ABA practitioners. There are, however, voluntary credentials that practitioners of ABA may obtain through the national Behavior Analyst Certification Board upon satisfaction of one or more very robust sets of standards. The DOBI does not construe Chapter 115 as requiring carriers to pay for services for the treatment of autism without regard to practitioner qualifications. Consequently, the DOBI believes carriers should consider behavioral interventions based on ABA and related structured behavior program services eligible for benefits if administered directly by or under the direct supervision of an individual who is credentialed by the national Behavior Analyst Certification Board as either:

- a Board Certified Behavior Analyst - Doctoral (BCBA-D); or
- a Board Certified Behavior Analyst (BCBA)

Carriers will need to modify their forms and protocols to accommodate this exception for the delivery of behavioral interventions based on ABA and related structured behavior programs in those jurisdictions lacking a requisite license for practitioners. Carriers may amend the definition of practitioner as part of form filings, including rider filings, to add the coverage required by Chapter 115.

Calendar Year Benefit Maximum

Group health plans: Although DOBI recognizes that the Legislature intended to limit coverage of ABA services for persons under age 21 diagnosed with autism spectrum disorder to $36,000 per calendar year, carriers may not be able to limit the benefit as described. The federal Mental Health Parity and Addiction Equity Act of 2008, Pub. Law 110-343, sec. 512 (MHPAEA), generally prohibits group health plans, other than small employer group health plans, from having more restrictive benefits or services for treatment of mental illness than are applicable to treatment of physical conditions. MHPAEA states that the term mental illness is defined under the terms of the plan and in accordance with applicable Federal and State law. New Jersey law requires health coverage issued for delivery in this State to provide benefits or services for biologically-based mental illnesses, and specifically includes pervasive developmental disorders (autism) in this classification. Carriers providing biologically-based mental illness benefits in group health plans as required by New Jersey law must comply with both MHPAEA and Chapter 115[5]. The federal law preempts New Jersey state law when there

[5] MHPAEA (see 29 U.S.C. 1185a) does not require coverage for treatment of mental health conditions, but requires equitable benefits if coverage of mental health conditions is provided. However, MHPAEA also has exemption provisions that permit a plan's mental health coverage not to comply with parity

is a conflict between the two. Chapter 115's limit of $36,000 per calendar year for ABA-related treatment of a condition classified in New Jersey law as a mental illness conflicts with federal provisions prohibiting such limits on treatment of mental health conditions in group health plans. Thus, as the law is currently written, the ABA-related benefit limitation established in Chapter 115 in group health plans subject to MHPAEA may not be applied unless the employer obtains an exemption under MHPAEA for its group health plan based on the "1% cost increase." To resolve this conflict and preserve the original legislative intent of limiting these benefits to $36,000 per calendar year, the Legislature could enact necessary legislation to address this issue. Were such legislation to be enacted, the DOBI would provide additional guidance to carriers.

Federal mental health parity laws do not apply to group plans that are not "group health plans" as that term is defined in HIPAA.

Nongroup health plans: Federal mental health parity laws do not apply to coverage offered and renewed in the individual market. Accordingly, carriers may apply Chapter 115's per calendar year per person benefit limit for ABA-related treatment of autism when the coverage involved is under a nongroup policy.

Early Intervention Family Cost Share Expense Benefit

Carriers must provide benefits for the coverage of the "Family Cost Share" expense incurred by covered persons for the provision of certain health care services obtained in accordance with a treatment plan developed as a result of, or in conjunction with, an Individualized Family Service Plan (IFSP) for a child determined eligible for early intervention services through the New Jersey Early Intervention System (NJEIS).[6] Chapter 115 establishes limits for the Family Cost Share expense benefit, as follows:

- Carriers are only required to provide a benefit for the Family Cost Share expense associated with the provision of physical therapy, occupational therapy, speech therapy and behavioral interventions based on ABA or related structured behavior services.[7]
- Carriers are only required to provide a benefit for the Family Cost Share expense when the service in question is provided to a child diagnosed with autism or other developmental disability.
- Carriers cannot deny benefits for the Family Cost Share expense on the basis that treatment with any of the Chapter 115-identified therapies is not restorative.

Family Cost Share Participation Statement

Families that are responsible for the NJEIS Family Cost Share receive monthly invoices from NJEIS and submit payments to NJEIS. Families may then seek reimbursement for the expense from the carrier. Initially, Family Cost Share Participation (FCSP) statements detail health care services using Current Procedural

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requirements if it can be shown actuarially that compliance would result in an increase in actual total costs for the plan of 1% (2% initially).

[6] See http://www.state.nj.us/health/fhs/eis/index.shtml for more information regarding NJEIS. NJEIS' rules are at N.J.A.C. 8:17.

[7] There is no Family Cost Share expense for ABA at this time; however, DOBI has been advised that NJEIS will be making systemic improvements to ensure that families have access to related structured behavioral interventions.

Terminology – CPT – codes. After several months, the FCSP statement only provides a summary of the total cost share due. Because a family's Family Cost Share may be related to services other than those for which carriers are required to provide a benefit under Chapter 115, carriers may request that families submit the more detailed FCSP statement on a continuing basis, and documentation of payment of the Family Cost Share to NJEIS.

Diagnosis Codes

The FCSP statement may not identify the child as having a diagnosis of a developmental disability, and NJEIS does not limit eligibility for early intervention services to children diagnosed with a developmental disability. Given that Chapter 115 is specific to developmental disabilities, the DOBI recognizes that there may be instances in which a family may incur a covered Family Cost Share expense, but will receive no benefit because the child has not been diagnosed with a developmental disability. Nevertheless, carriers should request more information from the family regarding diagnosed developmental disabilities when the benefits for the Family Cost Share expense are in question to avoid inappropriate denials of benefits with respect to physical therapy, occupational therapy, speech therapy and ABA-related behavioral interventions.

NJEIS Providers and Practitioners

NJEIS clients generally do not choose the practitioners that will deliver services. The practitioners that deliver early intervention services to NJEIS clients through NJEIS-contracted provider agencies may or may not also contract with carriers through other means. The practitioners will, however, be in the NJEIS "network." Through a vendor, NJEIS verifies the credentials of practitioners before practitioners are eligible to deliver services to NJEIS clients. DOBI's position is that Chapter 115 requires that carriers cover the Family Cost Share expense benefit without regard to whether the delivery of the service is rendered by a practitioner in the carrier's network, so long as the service is provided through NJEIS.

Additional Family Cost Share Benefit Information

1. As explained in the Family Cost Participation Handbook issued by NJEIS, a Family Cost Statement (bill) is sent to families on a monthly basis and payment is required within 30 days of receipt of the Family Cost Statement. After families have made payment, families may seek reimbursement for the eligible portions of the Family Cost Share from their insurance carriers. In all instances, carriers should be reimbursing <u>families</u> for the Family Cost Share expense the families paid to the NJEIS. Families do not pay practitioners, and practitioners do not bill families for any portion of the cost associated with the health care services provided through the NJEIS. There is no assignment of benefits involved.
2. The FCSP statement will identify a family's cost share per service hour as well as the maximum monthly cost share the family could incur. Expenses are incurred on a 15 minute basis. Chapter 115 does not impose an obligation on carriers to provide a benefit that exceeds a family's maximum monthly Family Cost Share expense.

3. Family cost shares may change annually. The NJEIS posts the Family Cost Share formula and table on its web pages. However, it is reasonable for carriers to rely upon the Family Cost Share expense set forth in the FCSP statement.
4. Carriers may make the Family Cost Share expense benefit subject to a plan's deductible and coinsurance or copayment requirements. Eligible Family Cost Share expenses should be applied toward any out-of-pocket maximum limit established under the plan. The DOBI does not believe a carrier may establish a separate deductible, coinsurance, copayment or out-of-pocket maximum for the Family Cost Share expense benefit.

Limitations on Therapy Services

Chapter 115 states that coverage for physical therapy, occupational therapy, speech therapy and behavioral interventions based on ABA provided to treat a developmental disability should not limit benefits otherwise available to a covered person. Accordingly, carriers may not reduce the physical therapy, occupational therapy, speech therapy or behavioral therapy benefit(s) available under the contract for treatment of other illnesses, injuries and conditions based upon the provision of such services to treat autism or another developmental disability. Carriers may establish a separate set of benefits for these services for purposes of treating autism and other developmental disabilities, but the separate benefit must be subject to terms and conditions that are the same as or more favorable than the terms and conditions applicable to the benefits for treatment of other illnesses, injuries or conditions. The DOBI will not approve limits for physical therapy, occupational therapy or speech therapy for treatment of autism or other developmental disabilities that establish a maximum number of days of therapy measured from the date of diagnosis or inception of treatment, or benefit limits established on a per illness or injury basis.

Questions regarding this bulletin and implementation of Chapter 115 should be submitted by electronic mail to legsregs@dobi.state.nj.us. If warranted, the DOBI will issue additional guidance, and may post responses to frequently asked questions to the DOBI's website at http://www.state.nj.us/dobi/index.html.

January 14, 2010
Date

Neil N. Jasey, Commissioner

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Oregon
John A. Kitzhaber, MD, Governor

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OREGON INSURANCE DIVISION BULLETIN INS 2014-2

TO: All Health Insurers, Health Care Service Contractors and Other Interested Persons

DATE: November 14, 2014

SUBJECT: Autism Spectrum Disorder; Applied Behavior Analysis Therapy

I. Introduction

A. Purpose of Bulletin

Today, the Oregon Insurance Division (division) issued bulletin INS 2014-1 detailing the division's expectations of insurers issuing coverage subject to state and federal mental health mandates. This companion bulletin INS 2014-2 provides additional guidance to insurers about the expectations of the division regarding health benefit plan coverage for autism spectrum disorder (ASD) and other pervasive developmental disorders (PDDs), including the treatment known as applied behavior analysis (ABA).

In addition to the laws described in bulletin INS 2014-1, the specific statutes related to ASD, PDD, and ABA are:

1. ORS 743A.190 (Oregon PDD); and

2. Enrolled Senate Bill 365 (2013 Legislative Session), 2013 Oregon Laws Chapter 771 (SB 365). In addition to adding provisions to the Insurance Code, SB 365 enacted ORS 676.800, creating the Behavior Analysis Regulatory Board (BARB).

In this bulletin, ABA has the meaning defined in SB 365. References to "mandates" in this bulletin include the Oregon Mental Health Parity (MHP), Oregon PDD, and the federal Mental Health Parity and Addition Equity Act (MHPAEA) as implemented under the Affordable Care Act (ACA). If only one mandate is discussed, the bulletin specifies which mandate.

B. Background

In 2013, the division began developing guidance to clarify whether Oregon's Essential Health Benefit (EHB) Benchmark plan, the PacificSource Codeduct Value plan,[1] included coverage of

[1] OAR 836-053-0008(1)(a).

ABA. After considering the current status of pending lawsuits, work group discussions before and during the 2013 Legislative Session, and legislative history related to SB 365, the division decided to postpone issuing this guidance until the U.S. District Court for the District of Oregon adjudicated the legal arguments in the *A.F. v. Providence* lawsuit.
In August, 2014, the U.S. District Court for the District of Oregon issued its opinion on the legal arguments in *A.F. v. Providence*, a class action lawsuit challenging denial of coverage for ABA therapy in Oregon. A number of other developments also have occurred that are consistent with that opinion and that have assisted the division in developing this bulletin:

- Court decisions in Oregon and in other states with laws similar to ORS MHP and Oregon PDD;
- Independent Review Organization (IRO) decisions that have repeatedly overturned insurers' denials of coverage for ABA;
- Health Evidence Review Commission (HERC) review and recommendation to cover ABA therapy;
- Bulletins and rules adopted by insurance regulators in other states that address ABA issues and statutes similar to Oregon's statutes. These states include California, Indiana, Washington, and New York.

A list of and citations for many of these developments is attached in Appendix A to this bulletin.

C. Summary

The division expects insurers to comply with the following guidelines:

- An insurer must adjudicate ASD and PDD claims as mental health claims subject to state and federal mental health parity laws.

- An insurer may not categorically deny treatment for ABA therapy on the basis that the treatment is experimental or investigational. Coverage decisions must be made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. Such determinations must meet the requirements of federal and state law, including mental health parity standards as set forth in INS 2014-1 and OAR 836-053-1405.

- An insurer may not apply a categorical exclusion (such as exclusions for developmental, social or educational therapies) that results in a denial of all ABA or other medically necessary treatment or otherwise results in the mandates being effectively meaningless for ASD or PDDs.

- ABA therapy is a medical service for purposes of ORS 743A.190.

- Under SB 365, a provider actively practicing applied behavior analysis on August 14, 2013 (a "grandfathered provider") may claim reimbursement from a health benefit plan without being licensed until January 1, 2016. A grandfathered provider has that status for any insurer and for any patient. An insurer may impose credentialing requirement on ABA providers so long as the credentialing requirements do not prevent access to treatment required under the mandates. An insurer is not required to contract with any willing provider, but the insurer may not discriminate against any category of

legislatively authorized provider of ABA services and may not negate the mandate to cover medically necessary mental health services by refusing to credential legally qualified providers.

- The provisions of SB 365 that establish quantitative standards—the 25-hour per week coverage standard and the nine-year old age standard—are floors, not limitations on ABA coverage. As floors these provisions do not violate the MHPAEA. If applied as limits, these provisions would violate MHPAEA and its regulations, unless the insurer imposed the same limits as the predominant treatment limitation on substantially all of its medical or surgical outpatient coverage.

D. Related Bulletins

INS 2014-1 related to mental health parity provides general guidelines for all mental and nervous conditions. Because ASD and PDD are mental health conditions subject to all of the mental health laws described in bulletin INS 2014-1, all of the discussion in bulletin INS 2014-1 applies to ASD and PDD. This bulletin describes additional considerations specific to ASD, other PDDs, and ABA.

II. Discussion

A. Applicability

The Oregon PDD statute applies to health benefit plans issued or renewed on or after January 1, 2008. This statute was incorporated by law into the policy selected by Oregon as its benchmark plan establishing Oregon's essential health benefits (EHB) plan under OAR 836-053-0008. The benchmark plan, with limited exceptions, establishes the baseline requirements for all individual and small group health benefit plans to be considered ACA-compliant (i.e., comply with all 2014 reforms, including but not limited to essential health benefits, nondiscrimination and guaranteed issue).

SB 365 requires health benefit plans to cover screening, diagnosis, and medically necessary treatment for ASD, including ABA therapy. It applies to commercial health benefit plans that are issued or renewed on or after January 1, 2016. It also applies to the Public Employees' Benefit Board (PEBB) and the Oregon Educators Benefit Board (OEBB) for coverage beginning on or after January 1, 2015; both boards have decided to accelerate the effective date of ABA coverage (PEBB to August 1, 2015, OEBB to October 1, 2015).

B. Coverage Requirements

Under State Law:

The Oregon PDD statute requires a health benefit plan to cover, for a child enrolled in the plan who is under 18 years of age and who has been diagnosed with a pervasive developmental disorder, all medical services that are medically necessary and are otherwise covered under the plan. The statute includes, as medical services, rehabilitation services defined to include physical therapy, occupational therapy or speech therapy services. Therefore, the mandate for medical services requires at least some of both behavioral and physical services. ABA is a behavioral service and is included among "all medical services."

SB 365 defines ASD using the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). As bulletin INS 2014-1 mentions, the division is adopting a rule to update the references in OAR 836-053-1404(1)(a) to include the parallel references in DSM-5. ASD as defined in SB 365 is a PDD under ORS 743A.190 and a "mental or nervous disorder" under Oregon MHP.

The provisions of SB 365 that apply beginning January 1, 2016 (a year earlier for PEBB and OEBB) are those specifically concerning procedures for management of ABA therapy. The general requirement to cover medically necessary treatment for ASD already exists in the Oregon MHP and Oregon PDD. Insurers should provide access to ABA under existing law (Oregon MHP and PDD) as they would for any other treatment for a mental health condition.

Under Federal Law:

As bulletin 2014-1 summarizes, the regulations under MHPAEA prohibit quantitative treatment limits on mental health benefits in any classification (e.g. inpatient, outpatient) that are more restrictive than the predominant quantitative treatment limitation of that type applied to substantially all medical benefits in the same classification. Because of this requirement, the 25-hour per week floor for coverage of ABA therapy and the requirement to provide coverage if an individual begins treatment before nine years of age established in SB 365, if applied as limitations, could violate MHPAEA and therefore be prohibited. As stated in the preamble to the final MHPAEA rules, the parity requirements of MHPAEA may require an insurer to provide mental health benefits beyond the state minimum.[2]

C. Exclusions or Limitations

An insurer may apply age limits to coverage of ABA therapy only in a way consistent with the mandates. While medical necessity guidelines are helpful, the medical necessity and experimental character of the treatment must be considered on an individualized basis for a person of any age.

Insurers typically issue policies with broad-based treatment exclusions. Recent opinions by courts, however, have indicated that although insurers may limit their coverage by including broad exclusions, the scope of the exclusion must be restricted if the exclusion is inconsistent with a statutory mandate. An insurer may not profess to include ASD and PDD coverage required by these mandates while at the same time applying a broad exclusion that prevents the insured from receiving medically necessary treatments for these conditions.

D. Provider Qualifications

ORS 676.800 establishes the Behavior Analysis Regulatory Board (BARB) and sets out the requirements for licensing and registering professionals who provide treatment for ASD using ABA. Although SB 365 prohibits a provider who has not been licensed or registered by the BARB from seeking reimbursement from an insurer starting in 2016, the bill recognizes the need to allow continued services until the licensing and registration procedures are in place. As a result, SB 365 grandfathers certain providers who were actively practicing ABA therapy on the

[2] 78 Federal Register at 68252.

effective date of the Act (August 14, 2013) and allows these providers to continue to claim reimbursement without registration or licensing.

Grandfathering applies if the individual was actively practicing ABA on August 14, 2013, whether as a Board Certified Behavior Analyst (BCBA), Board Certified Assistant Behavior Analyst (BCABA), a licensed health care provider, or an interventionist (paraprofessional). For purposes of grandfathering, it is not required that the individual was being reimbursed by an insurer on August 14, 2013, so long as he or she was actively practicing ABA at that time. The division expects insurers to provide reimbursement to grandfathered ABA providers until expiration of the grandfathering period on January 1, 2016. This is consistent with the intent of SB 365 to make resources available for access to ABA that insureds might not have if limited to BARB-licensed or certified providers.

At this time, BARB expects the ABA licensing process to be available on December 1, 2014. After the licensing process is available, a new provider who was not actively practicing on the effective date of SB 365 must be licensed or registered in order to be reimbursed by an insurer.

Because the BARB is within the Oregon Health Authority's Health Licensing Office, providers who have been registered with or licensed by the BARB are considered to be "approved" by the Oregon Health Authority for the purposes of ORS 743A.168(5)(a) and thus eligible for reimbursement under Oregon MHP. Under the provider nondiscrimination provision in ACA Section 2706(a), 42 U.S.C. § 300gg–5, insurers may not discriminate in ACA compliant plans against ABA providers licensed by or registered with BARB. Because the grandfathering provision is an applicable state law in lieu of licensure or certification, Section 2706(a) also applies to grandfathered providers in ACA compliant plans.

An insurer may apply credentialing requirements to grandfathered providers so long as the credentialing requirements do not prevent access to medically necessary treatment as mandated by state and federal law. The division does not interpret SB 365 to require an actively practicing ABA provider to seek reimbursement from the same insurer or for the same patient in order to qualify under the grandfather provision.

E. Independent Review Organizations

The division has identified 22 instances since 2008 in which insurers' denials of ABA therapy were overturned by an IRO. The insurers' denials were based on determinations that the treatment was experimental or investigational. In these instances, the determinations were overturned by the IRO, which found that such treatment is the recognized standard of care for autism.

Insurers may not deny ABA claims as experimental or investigational unless there is a basis for determining that for a specific patient. The division will examine IRO decisions regarding ASD treatments including ABA therapy to determine if insurers are denying ABA claims on grounds not permitted by law.

III. Enforcement

An insurer's denial of coverage on a basis prohibited by this bulletin may subject the insurer to enforcement measures for violation of the Oregon Insurance Code.

This bulletin is dated the 14th of November, 2014, at Salem, Oregon.

Laura N. Cali, FCAS, MAAA
Insurance Commissioner

Appendix A

AUTHORITIES

A. Legislative and Regulatory Materials

1. Cal. Health and Safety Code, 1374.72
2. California Code of Regulations, Subchapter 3 of Chapter 5 of Title 10, Article 15.2: Mental Health Parity, Sections 2562.1 to 2562.4
3. California Department of Insurance, Notice "Enforcement of Independent Medical Review Statutes" (May 17, 2011).
4. CMCS Informational Bulletin, "Clarification of Medicaid Coverage of Services to Children with Autism" dated July 7, 2014.
5. DCBS 2009 Review of Coverage of Mental or Nervous Conditions and Chemical Dependency in Accordance with OAR 836-053-1405(8)
6. Health Evidence Review Commission (HERC) coverage determination for ABA for ASD (8/14/14)
7. HERC coverage determination for surgical sexual transition for gender dysphoria (8/14/14)
8. In Re United Health Care Insurance Company, Stipulation and Waiver (California Insurance Commissioner Order)
9. Indiana Bulletin 136 (March 30, 2006)
10. MHPAEA final rules, Federal Register Vol. 78, No. 219 p. 68240 (November 13, 2013); 45 CFR §§ 146.136 and 147.160
11. New York Articles on Requirements for MHP
12. Senate Bill 365 Legislative History
13. Washington Insurance Commission, Letter dated October 20, 2014

B. Court Cases

1. Arce v. Kaiser Foundation Health Plan, 181 Cal App 4th 471 (2010) Settlement Agreement and Order Approving Settlement
2. AF ex rel Legaard v. Providence Health Plan, 2014 WL 3893027 (2014)
3. AG et al. v. Premera Blue Cross and Lifewise, No. 11-2-30233-4SEA, J.P. v. Premera Blue Cross, No. 12-2-33676-8SEA, and R.H. v. Premera Blue Cross and Lifewise, No. 2:13-cv-00097-RAJ, Proposed Settlement Agreement (May 7, 2014).
4. Berge v. US, 879 F Supp 2d 98 (D.D.C., 2012) and 949 F Supp 2d 36 (D.D.C., 2013)
5. Boyle v. Blue Cross Blue Shield of N.C., 2011 WL 60000786 (E.D. Mich., 2011)
6. Chisholm ex rel CC, MC v. Kilebert, 2013 WL 3807990 (E.D.La., 2013)
7. Churchill v. Cigna Corp., 2012 WL 3590691 (E.D.Pa., 2012) and Stipulation of Settlement (January 2014)
8. DF et al v. Washington State Health Care Authority et al, Superior Court of Washington for King County, Case no. 10-2-29400-7 (June 8, 2011)
9. Hummel v. Ohio Dept. of Job and Family Services, 164 Ohio App 3d 776, 844 NE 2d 360 (2005)
10. Johns v. Blue Cross Blue Shield of Michigan, Case No. 2:08-cv-12272 (E.D. Mich) Proposed Settlement and Order Approving Proposed Settlement.
11. KG ex rel Garrido v. Dudek, 864 F Supp 2d 1314 (S.D.Fla., 2012) aff'd in part, 731 F3d 1152 (11th Cir., 2013)

12. KM v. Regence Blueshield, 2014 WL 801204 (W.D.Wa., 2014), and Settlement Agreement (October 2014)
13. Markiewicz v. State Health Benefits Commission, 390 N.J. Super 289, 915 A2d 553 (2007)
14. Mayfield v. ASC Inc. Health & Welfare Benefit Plan, 2007 WL 5272861 (E.D.Mich., 2007)
15. McHenry v. PacificSource, 679 F Supp 2d 1226 (D.Or., 2010)
16. Micheletti v. State Health Benefits Commission, 389 N. J. Super 510, 913 A2d 842 (2007)
17. O.S.T .v. Regence Blueshield, 88940-6, 2014 WL 5088260 (Wa. October 9, 2014)
18. Parents' League for Effective Autism Services v. Jones-Kelley, 339 F. Supp. 2d 542 (6th Cir., 2009)
19. Potter v. Blue Cross Blue Shield of Michigan, 2013 WL 4413310 (E.D. Mich).
20. Reid v. BCBSM, Inc., 984 F Supp 2d 949 (D., Minn., 2013)
21. SAH ex rel SJH v. State Dept. of Social and Health Services, 136 Wash App 342, 149 P3d 410 (2006)
22. ZD v. Group Health Cooperative, Case 2:11-cv-01119-RSL, Settlement Agreement filed 8/2/13 (United States District Court, Western District of Washington)

C. Arbitration Awards

1. Tappert v. Anthem Blue Cross Blue Shield, JAG Case No. 270779 (Nov. 20, 2007)

D. Articles

1. Daniela Caruso, Autism in the U.S.: Social Movement and Legal Change, 36 Am. J. L. & Med. 483 (2010)
2. Jeffrey A. Cohen, Thomas A. Dickerson, Joanne Matthews Forbes, A Legal Review of Autism, A Syndrome Rapidly Gaining Wide Attention in Our Society, 77 Alb. L. Rev. 389 (2014)
3. Kendra Hansel, Rethinking Insurance Coverage of "Experimental" Applied Behavioral Analysis Therapy and Its Usefulness in Combating Autism Spectrum Disorder, 34 J Legal Med 215 (2013)
4. Laura C. Hoffman, Ensuring Access to Health Care for the Autistic Child: More Is Needed Than Health Care Reform, 41 SW L. Rev. 435 (2012)
. Laura C. Hoffman, Health Care for the Autistic Child in the U.S.: The Case for Federal Legislative Reform for ABA Therapy, 46 J. Marshall L. Rev. 169 (2012)

Coverage for Autism Spectrum Disorders

The Alabama State Legislature recently passed a mandate requiring additional coverage for Autism Spectrum Disorders. Underwritten plans currently provide coverage for certain services including, but not limited to counseling, prescription drugs, occupational therapy and speech therapy.

Beginning with plan years on or after October 1, 2017, Applied Behavioral Analysis (ABA) therapy will be added as a benefit for covered members ages 0-18.

- ABA therapy is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.
- There are no visit or dollar limits on ABA therapy services.
- The mandate requires that ABA therapy services be provided by a Licensed Psychologist or a Board Certified Behavioral Analyst in the State of Alabama.

Since Autism is considered a mental health benefit and your plan is subject to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (mental health parity), coverage must be in compliance with mental health parity. This means that dollar limits and visit limits on these benefits are not permissible under mental health parity.

In addition, the following benefit changes will also apply to your health plan:

- Unlimited physical therapy visits will be added for children ages 0-18 with an autistic diagnosis.
- The age limit for unlimited occupational and speech therapy for children with an autistic diagnosis will change from ages 0-9 to ages 0-18.
- The diagnosis codes will be expanded to include all Autism Spectrum Disorder codes.

Your benefit booklet will be updated to reflect the changes listed above. You will receive a copy of your updated benefit booklet or Summary of Material Modifications (SMM) after your renewal date.

"[N]o disability claims more parental time and energy than autism."

New York Times, 12/20/04

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