MEASURE: SB 365
EXHIBIT: 10
S. HEALTHCARE & HUMAN SERVICES
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SUBMITTED BY: Brenna Legaard

April 15, 2013

To: Senate Committee On Health Care and Human Services

From: Brenna Legaard, SW Portland

Re: SB 365-3 (as amended) is significantly weaker than existing law

I am an attorney, licensed to practice in Oregon. I have a five year old son with autism. I have conducted an extensive analysis of current Oregon laws requiring insurance coverage for treatment of autism, and I have also extensively reviewed SB 365, both as originally filed and with the proposed -3 amendments.

Two existing Oregon laws require insurance coverage for ABA.

Senate Bill 365 is the Oregon Legislature's fifth attempt since 2005 to require insurance companies to cover treatment for autism such as Applied Behavior Analysis (ABA). Two existing Oregon laws already state that insurance policies must provide coverage for autism treatments.

ORS 743A.190 states that a health insurance plan "must cover" "all medical services... that are medically necessary" for children enrolled under the plan who have been diagnosed with autism. ORS 743A.190 is attached as Appendix A.

ORS 743A.168, The Oregon Mental Health Parity Act, also mandates insurance coverage for autism treatments by specifying that insurance policies "shall provide coverage for expenses arising from treatment for... mental or nervous conditions." ORS 743A.168 is attached as Appendix B.

Some insurers refuse to cover ABA despite existing mandates.

Despite ORS 743A.168 and 743A.190, a number of insurers such as Providence Health Plans and United Health Care refuse to cover ABA.

Providence bases its refusal on a provision in its policies which excludes coverage of "developmental disabilities, developmental delays, or learning disabilities." Providence asserts that:

> "Autism spectrum disorder is a 'developmental disability' and involves 'developmental delay.' Because ABA services are related to autism spectrum disorder, they are therefore not benefits covered under your child's plan."
>
> See redacted Providence correspondence attached as Appendix C.

United Health Care has contracts which explicitly exclude coverage of "Intensive behavioral therapies such as applied behavioral analysis [ABA] for Autism Spectrum Disorder" regardless of medical necessity.

Pacific Source has covered ABA since it was ordered to do so by a federal judge in 2010. However, it does not reimburse services provided by lower cost line therapists. SB 365's licensure provisions should solve this problem.

The Oregon Health Plan denies coverage of ABA on the grounds that it is experimental, despite the weight of evidence to the contrary.

Some children do receive coverage under the existing mandates.

Kaiser Permanente and Pacific Source have begun covering ABA therapy under the existing laws. Moreover, some families have fought for ABA coverage under the existing laws through IRO appeals and through the courts. Long, costly legal battles, including the one that resulted in coverage of ABA under Pacific Source plans, have resulted in coverage under existing law.

SB 356-3 is significantly weaker than current law.

SB 365-3 contains extensive amendments written by the insurance industry. These amendments create significant loopholes which will eviscerate the impact of the bill's ABA coverage mandate.

1. Page 3, lines 27-29: "This subsection does not require coverage of applied behavioral analysis that is being provided by the Oregon Health Authority, the Department of Human Services, a school district or an education service district."

Many autistic children do receive services through county early intervention programs and through school special education programs, although the amount of services is woefully inadequate. 20-40 hours of ABA a week are typically found to be medically necessary to change an outcome for an autistic child. Counties and school districts may provide two or three hours per week. Under the plain language of this amendment, an insurer could simply point to those services, call them ABA, and refuse to cover any further ABA.

2. Page 4, lines 15-17: "This section does not limit coverage for any services, other than applied behavior analysis, that are otherwise available to an individual under ORS 743A.168 and ORS 743A.190." This provision removes ABA therapy from the scope of the two existing coverage mandates. It means that ABA coverage is not subject to the parity requirements of the Oregon Mental Health Parity Act, and an insurer could cover ABA at an extremely low reimbursement rate. It also means that families which have fought for and obtained coverage under the existing two mandates will lose the benefit of those victories, and especially for these children, this new law will do far more harm than good.

It is difficult to see a legitimate purpose for this amendment. The insurance companies which continue to deny coverage for ABA do so because they insist that the existing laws do not require coverage. If the existing laws do not require coverage, and the new law will, than what purpose does this amendment serve?

The two amendments together would effectively eliminate any coverage of ABA for Oregon children. An insurer could refuse to cover ABA under the new law because a child was receiving an hour or two a

week of what an insurer could call "ABA" at school. A child would have lost the benefit of the previous mandates because ABA would have been removed from ORS 743A.168 and ORS 743A.190.

3. Page 11, lines 17-19: "(6) A health benefit plan that provides coverage of treatment for autism spectrum disorder in accordance with section 2 of this 2013 Act shall be deemed to be in compliance with this section notwithstanding any contrary decision of an independent review organization under ORS 743.857."

This provision is illegal in light of the Affordable Care Act's IRO requirements. The Affordable Care Act guarantees consumers independent review of the insurer's adverse denial. There is no good reason to deprive Oregonians with autism of these rights, and doing so will jeopardize Oregon's certification of compliance.

4. Page 15, lines 25-27 and page 16, lines 1-2: postpones implementation for six months, from January 2014 until June of 2014. Since most plans renew at the beginning of the year, the effect of this provision is to delay implementation until January 2015. My five year old son will not receive therapy until he is 7 ½, assuming that litigation will not be necessary to enforce a new mandate. From the perspective of a child with autism, this is a very significant delay.

Conclusion:

If this legislature is to succeed where two past legislatures have failed, its autism insurance mandate must close the loopholes in ORS 743A.168 and ORS 743A.190 and must not create any new loopholes. While SB 365 is stronger in some ways than the previous mandates, the proposed -3 amendments create very significant new loopholes and deprive consumers of a very important source of accountability. For that reason, amended SB 365-3 harms the autistic children of Oregon more than it helps them.

Brenna Legaard

743A.190 Children with pervasive developmental disorder. (1) A health benefit plan, as defined in ORS 743.730, must 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, including rehabilitation services, that are medically necessary and are otherwise covered under the plan.

(2) The coverage required under subsection (1) of this section, including rehabilitation services, may be made subject to other provisions of the health benefit plan that apply to covered services, including but not limited to:

(a) Deductibles, copayments or coinsurance;

(b) Prior authorization or utilization review requirements; or

(c) Treatment limitations regarding the number of visits or the duration of treatment.

(3) As used in this section:

(a) "Medically necessary" means in accordance with the definition of medical necessity that is specified in the policy, certificate or contract for the health benefit plan and that applies uniformly to all covered services under the health benefit plan.

(b) "Pervasive developmental disorder" means a neurological condition that includes Asperger's syndrome, autism, developmental delay, developmental disability or mental retardation.

(c) "Rehabilitation services" means physical therapy, occupational therapy or speech therapy services to restore or improve function.

(4) The provisions of ORS 743A.001 do not apply to this section.

(5) The definition of "pervasive developmental disorder" is not intended to apply to coverage required under ORS 743A.168. [2007 c.872 §2]

Note: 743A.190 was added to and made a part of the Insurance Code by legislative action but was not added to ORS chapter 743A or any series therein. See Preface to Oregon Revised Statutes for further explanation.

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743A.168 Treatment of chemical dependency, including alcoholism, and mental or nervous conditions; rules. A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment for chemical dependency, including alcoholism, and for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions. The following apply to coverage for chemical dependency and for mental or nervous conditions:

(1) As used in this section:

(a) "Chemical dependency" means the addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a recurring basis with the individual's social, psychological or physical adjustment to common problems. For purposes of this section, "chemical dependency" does not include addiction to, or dependency on, tobacco, tobacco products or foods.

(b) "Facility" means a corporate or governmental entity or other provider of services for the treatment of chemical dependency or for the treatment of mental or nervous conditions.

(c) "Group health insurer" means an insurer, a health maintenance organization or a health care service contractor.

(d) "Program" means a particular type or level of service that is organizationally distinct within a facility.

(e) "Provider" means a person that has met the credentialing requirement of a group health insurer, is otherwise eligible to receive reimbursement for coverage under the policy and is:

(A) A health care facility;

(B) A residential program or facility;

(C) A day or partial hospitalization program;

(D) An outpatient service; or

(E) An individual behavioral health or medical professional authorized for reimbursement under Oregon law.

(2) The coverage may be made subject to provisions of the policy that apply to other benefits under the policy, including but not limited to provisions relating to deductibles and coinsurance. Deductibles and coinsurance for treatment in health care facilities or residential programs or facilities may not be greater than those under the policy for expenses of hospitalization in the treatment of other medical conditions. Deductibles and coinsurance for outpatient treatment may not be greater than those under the policy for expenses of outpatient treatment of other medical conditions.

(3) The coverage may not be made subject to treatment limitations, limits on total payments for treatment, limits on duration of treatment or financial requirements unless similar limitations or requirements are imposed on coverage of other medical conditions. The coverage of eligible expenses may be limited to treatment that is medically necessary as determined under the policy for other medical conditions.

(4)(a) Nothing in this section requires coverage for:

(A) Educational or correctional services or sheltered living provided by a school or halfway house;

(B) A long-term residential mental health program that lasts longer than 45 days;

(C) Psychoanalysis or psychotherapy received as part of an educational or training program, regardless of diagnosis or symptoms that may be present;

(D) A court-ordered sex offender treatment program; or

(E) A screening interview or treatment program under ORS 813.021.

(b) Notwithstanding paragraph (a)(A) of this subsection, an insured may receive covered outpatient services under the terms of the insured's policy while the insured is living temporarily in a sheltered living situation.

(5) A provider is eligible for reimbursement under this section if:

(a) The provider is approved by the Department of Human Services;

(b) The provider is accredited for the particular level of care for which reimbursement is being requested by the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation of Rehabilitation Facilities;

(c) The patient is staying overnight at the facility and is involved in a structured program at least eight hours per day, five days per week; or

(d) The provider is providing a covered benefit under the policy.

(6) Payments may not be made under this section for support groups.

(7) If specified in the policy, outpatient coverage may include follow-up in-home service or outpatient services. The policy may limit coverage for in-home service to persons who are homebound under the care of a physician.

(8) Nothing in this section prohibits a group health insurer from managing the provision of benefits through common methods, including but not limited to selectively contracted panels, health plan benefit differential designs, preadmission screening, prior authorization of services, utilization review or other mechanisms designed to limit eligible expenses to those described in subsection (3) of this section.

(9) The Legislative Assembly has found that health care cost containment is necessary and intends to encourage insurance policies designed to achieve cost containment by ensuring that reimbursement is limited to appropriate utilization under criteria incorporated into such policies, either directly or by reference.

(10)(a) Subject to the patient or client confidentiality provisions of ORS 40.235 relating to physicians, ORS 40.240 relating to nurse practitioners, ORS 40.230 relating to psychologists, ORS 40.250 and 675.580 relating to licensed clinical social workers and ORS 40.262 relating to licensed professional counselors and licensed marriage and family therapists, a group health insurer may provide for review for level of treatment of admissions and continued stays for treatment in health care facilities, residential programs or facilities, day or partial hospitalization programs and outpatient services by either group health insurer staff or personnel under contract to the group health insurer, or by a utilization review contractor, who shall have the authority to certify for or deny level of payment.

(b) Review shall be made according to criteria made available to providers in advance upon request.

(c) Review shall be performed by or under the direction of a medical or osteopathic physician licensed by the Oregon Medical Board, a psychologist licensed by the State Board of Psychologist Examiners, a clinical social worker licensed by the State Board of Licensed Social Workers or a professional counselor or marriage and family therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists, in accordance with standards of the National Committee for Quality Assurance or Medicare review standards of the Centers for Medicare and Medicaid Services.

(d) Review may involve prior approval, concurrent review of the continuation of treatment, post-treatment review or any combination of these. However, if prior approval is required, provision shall be made to allow for payment of urgent or emergency admissions, subject to

subsequent review. If prior approval is not required, group health insurers shall permit providers, policyholders or persons acting on their behalf to make advance inquiries regarding the appropriateness of a particular admission to a treatment program. Group health insurers shall provide a timely response to such inquiries. Noncontracting providers must cooperate with these procedures to the same extent as contracting providers to be eligible for reimbursement.

(11) Health maintenance organizations may limit the receipt of covered services by enrollees to services provided by or upon referral by providers contracting with the health maintenance organization. Health maintenance organizations and health care service contractors may create substantive plan benefit and reimbursement differentials at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising out of other medical conditions and apply them to contracting and noncontracting providers.

(12) Nothing in this section prevents a group health insurer from contracting with providers of health care services to furnish services to policyholders or certificate holders according to ORS 743.531 or 750.005, subject to the following conditions:

(a) A group health insurer is not required to contract with all eligible providers.

(b) An insurer or health care service contractor shall, subject to subsections (2) and (3) of this section, pay benefits toward the covered charges of noncontracting providers of services for the treatment of chemical dependency or mental or nervous conditions. The insured shall, subject to subsections (2) and (3) of this section, have the right to use the services of a noncontracting provider of services for the treatment of chemical dependency or mental or nervous conditions, whether or not the services for chemical dependency or mental or nervous conditions are provided by contracting or noncontracting providers.

(13) The intent of the Legislative Assembly in adopting this section is to reserve benefits for different types of care to encourage cost effective care and to ensure continuing access to levels of care most appropriate for the insured's condition and progress.

(14) The Director of the Department of Consumer and Business Services, after notice and hearing, may adopt reasonable rules not inconsistent with this section that are considered necessary for the proper administration of these provisions. [Formerly 743.556; 2009 c.442 §47; 2009 c.549 §11]

Providence Health Plans
PO Box 4327
Portland, OR 97208-4327
www.providence.org/healthplans

January 16, 2013

PROVIDENCE
Health Plans

[redacted]
Portland, OR 97239

Re: [redacted] – Claim for Reimbursement of ABA Therapy
[redacted]

Dear Ms. [redacted]:

This letter responds to your Fist Level appeal dated December 18, 2012, in the matter referenced above. We have determined that we must uphold the denial on appeal, though not for the insufficient documentation reasons stated in the PBH explanation of benefits dated November 21, 2012, which you attached to your appeal. The reasons for the denial are explained below.

The Basis for the Denial Decision

Providence Health Plans sent you a letter on September 7, 2012, stating that your member reimbursement request lacked a diagnosis code, a procedure code, a provider tax identification number, and a copy of a paid receipt for the services for which you sought reimbursement. In an explanation of benefits document dated November 21, 2012, PBH stated that the claim was denied "due to both blank Billing and Rendering Provider NPI." Providence acknowledges your letter of October 19, 2012, providing further information. We have decided neither to overturn nor to affirm the decision on the basis stated by PBH.

Under the language of the Oregon Group Member Handbook for Open Option Plans, services "related to developmental disabilities, developmental delays or learning disabilities" are specifically excluded from coverage under this plan. (See Group Member Handbook, at 43). There is no question that autism spectrum disorder is a "developmental disability" or involves "developmental delay," and Providence as the plan administrator here has so interpreted it, in this case as it has in other cases seeking ABA services for autism spectrum disorder. Because ABA services are related to autism spectrum disorder, they are therefore not benefits covered under the plan. Providence is denying on this alternative basis because if it were to find in your favor on the issue of the adequacy of your prior documentation, your claim would nonetheless be denied on this coverage basis.

Further Questions/Appeal Rights

If you do not agree with this decision, you have the right to file a Second level appeal. Please see the enclosed Grievance and Appeal Rights for additional information.

If you have questions, please call your Customer Service Team at (503) 574-7500 or 1-800-878-4445, or the TDD/TTY number for the hearing impaired at (503) 574-8702 or 1-888-244-6642. Copies of medical policies are available upon request. Para obtener assistencia en Español, llame al (503) 574-7500.

Sincerely,

Dominic C.
Appeals and Grievances Department
Providence Health Plans

Enclosures