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June 4, 2010

Via U.S. First Class Mail and Electronic Mail

Dayle Axman
Supervisor, Life & Health Consumer Affairs Section
Division of Insurance
Colorado Department of Regulatory Agencies
1560 Broadway, Suite 850
Denver, CO 80202

Re: Health Insurance Mandated Autism Treatment

Dear Ms. Axman,

Thank you for inviting the Autism Society of Colorado (“ASC”) to submit written questions regarding “HIMAT” (Health Insurance Mandated Autism Treatment, C.R.S. §10-16-104(1.4)). As you know, ASC is committed to serving the autism community by aiding in the implementation of this new law by spreading awareness and accurate information and by advocating for fair and legal compliance with the law’s requirements. To that end, we have the following questions at this time and would greatly appreciate your guidance on these matters.

For purposes of this letter, all questions are regarding insureds, private group health insurance policies and health benefit plans that are subject to HIMAT. In addition, all terms that are not defined herein shall have the meaning set forth in HIMAT.

1. The statute sets forth five categories of professionals who qualify as an “Autism Services Provider.” It has come to our attention that certain health benefit plans (“Plans”) refuse to certify as in-network providers those professionals who meet the criteria set forth in certain of the five categories. We further understand that some Plans do not intend to cover claims as out-of-network (presuming the Plan has out-of-network benefits) if otherwise qualifying services are performed by certain Autism Service Providers.
 - a. Presuming that a Plan is a “Managed Care Plan” as defined in C.R.S. §10-16-102(26.5), will the network adequacy requirements of C.R.S. §10-16-704 apply?
 - b. Can a Plan refuse to cover claims for services (either as in-network or as out-of-network) if the services are provided by an Autism Services Provider and otherwise meet all requirements of the law (for the sake of clarity, for example, if qualifying “ABA”

treatment is provided by a provider who meets the criteria set forth in C.R.S. § 10-16-104(1.4)(a)(II)(C) but does not meet the criteria set forth in any other category of Autism Services Provider; in this example, the provider “has a master’s degree or higher in behavioral sciences and is nationally certified as a “board certified behavior analyst” or certified by a similar nationally recognized organization”)?

2. The statute uses the terms “consultation” and “supervision” in § 10-16-104(1.4)(a)(XII)(B).
 - a. Is coordination, case management, preparation of reports, conferences among service providers, supervision and training of therapists and professionals, etc. a covered benefit under HIMAT?
3. A number of children with ASD are receiving treatment prior to the date on which a child’s policy issues or renews after July 1, 2010, and are paying for that treatment without the benefit of insurance coverage. Continuity of treatment is often critically important. Under Section 6 of Amended Regulation 4-2-17, Prompt Investigation of Health Plan Claims Involving Utilization Review and Denial of Benefits (“Utilization Review Regulation”), which address standard utilization review, it is possible for a review to take over two months.
 - a. For a child who is receiving treatment prior to the date on which his or her policy issues or renews after July 1, 2010, will a pre-authorization request be considered “concurrent” under Section 7 of the Utilization Review Regulation and, therefore, be subject to the benefits and requirements of the expedited review process?
 - b. For a child who is receiving treatment prior to the date on which his or her policy issues or renews after July 1, 2010, will a pre-authorization request be subject to the protection of Section 6(B)(3), such that ongoing treatments that are reasonably believed by the insured to be covered by HIMAT will be deemed to be covered under HIMAT until the insured has been notified of a denial?
4. Many providers and insureds in the autism community are attempting to obtain information regarding (1) the substantive policies of the Plans that relate directly or indirectly to ASD and/or HIMAT, (2) the procedural policies of the Plans that relate directly or indirectly to ASD and/or HIMAT, and (3) the actual contract (i.e., policy or Certificate of Coverage) that will be effective on an insured’s issuance or renewal date.

Although some of this information may be available on a Plan’s website, such information is often very difficult to find and its identification is simply confusing. In addition, requiring an insured, the party to the contract who has less power and is often less sophisticated, to locate the information online places an unfair risk on the insured that he or she will not be able to locate the correct document or that he or she will rely on a document that the Plan can later state was not the correct document. The exact language used in a contract or substantive or procedural policy is critical to an insured knowing his or her rights under the contract and the laws and regulations. The Plan, as the party with more power and as the drafter of the contract and substantive or procedural policies, should have an obligation to provide those documents to an insured.

June 4, 2010

DOI, Dayle Axman, from ASC, Jill Tappert, regarding HIMAT

- a. Does an insured have a right to request and be provided the written substantive and procedural policies of a Plan, particularly prior to receiving a denial or request for additional information under the Utilization Review Regulation? If so, within how many days is a Plan required to provide that information?
 - b. Does a treatment professional have a right to request and be provided the written substantive and procedural policies of a Plan, particularly prior to his or her patient receiving a denial or request for additional information under the Utilization Review Regulation? If so, within how many days is a Plan required to provide that information?
 - c. Does an insured have a right to request and be provided the actual contract (i.e., policy or Certificate of Coverage) that is effective or will be effective on an insured's issuance or renewal date? If so, within how many days is a Plan required to provide that information?
 - d. Does a treatment professional have a right to request and be provided the actual contract (i.e., policy or Certificate of Coverage) that is effective or will be effective on his or her patient's issuance or renewal date? If so, within how many days is a Plan required to provide that information?
5. The term "Treatment Plan" is defined in HIMAT but the law does not require the submission of such a plan. It is anticipated that some Plans will require documentation (whether a Treatment Plan or other documentation) to support pre-authorization and the ongoing need for medical treatment under HIMAT. The development of such documentation will require office, home or community visits and often a significant number of hours of work.
- a. Is the development of a Treatment Plan or other documentation in support of pre-authorization and ongoing treatment a covered benefit under HIMAT if treatment is approved?
 - b. Is the development of a Treatment Plan or other documentation in support of pre-authorization and ongoing treatment a covered benefit under HIMAT if treatment is denied?

Thank you in advance for your consideration of the matters we have raised in this letter. If you would like further clarification of a question or require additional information, please let us know so that we can resubmit this letter accordingly.

Best Regards,

Jill Tappert