

COMMONWEALTH OF VIRGINIA



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Administrative Letter 2020-03

TO: All Carriers Licensed to Write Accident and Sickness Insurance in Virginia, All Health Services Plans and Health Maintenance Organizations Licensed in Virginia, and Interested Parties

RE: Implementation and Enforcement of House Bill 1503/Senate Bill 1031 § 38.2-3418.17 of the Code of Virginia, as Amended

The purpose of this Administrative Letter is to provide guidance to health carriers regarding the implementation and enforcement of the above-referenced statute that was amended and reenacted by the 2020 Virginia General Assembly and that will take effect on **January 1, 2021**. The Bureau of Insurance (Bureau) is tasked with applying state law and will enforce all provisions of § 38.2-3418.17 of the Code of Virginia (Code). The explanation below provides guidance regarding such enforcement.

Section 38.2-3418.17 of the Code requires coverage for treatment of autism spectrum disorder (ASD), to include applied behavior analysis (ABA) services, in the large group market in Virginia. Identical bills HB 1503/SB 1031 will require such coverage to be extended to policies, contracts or plans issued, reissued or extended in the individual and small group markets on or after January 1, 2021, except as limited by certain subsections.

Virginia's essential health benefits (EHB) benchmark plan currently excludes ABA services.¹ Other treatment for ASD, to include medically necessary behavioral health treatment, pharmacy care, psychiatric care, psychological care, and therapeutic care, is covered under the EHB benchmark plan currently.

Subsection 38.2-3418.17 D of the Code requires that benefits provided pursuant to this section are not subject to any visit limits or separate cost sharing. Since this subsection may require an extension of existing benefits and not additional EHB, the Bureau has determined that ABA services are the only services required under Virginia Code § 38.2-3418.17 that exceed EHB.

¹ See <https://scc.virginia.gov/getattachment/0c71fa06-32c4-47cf-a4f9-313bf059230c/ehbfillin.pdf>

Pursuant to subsection 38.2-3418.17 L, qualified health plans (QHPs) offered through an exchange in the individual or small group markets are not required to provide the benefits stated in this section to the extent they exceed EHB. All on-exchange plans (QHPs) generally are required to be offered and made available off-exchange pursuant to § 38.2-3448 of the Code. Therefore, QHPs (with the same plan ID number) issued off-exchange also are not required to provide benefits that exceed EHB, i.e., ABA services.

The state, therefore, is not required to defray costs pursuant to 45 CFR 155.170 since no state mandate applies to QHPs for ABA services that would be in addition to EHB. Additionally, the state is not required to defray costs for any QHPs that provide benefits in accordance with § 38.2-3418.17 voluntarily, since no state mandate applies to QHPs (on or off the exchange) for this benefit. Should a QHP be required to provide ABA services under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the state is not required to defray those benefits pursuant to 45 CFR 155.170.

All non-QHPs providing individual or group health insurance coverage must provide benefits for treatment of ASD (including ABA) as stated in § 38.2-3418.17 of the Code. The state is not responsible to defray any costs related to these requirements for non-QHPs pursuant to 45 CFR 155.170.

The Bureau offers the following questions and answers to provide further clarification of its enforcement:

Treatment of Autism Spectrum Disorder FAQs

1. Q: What are the effects of amendments to § 38.2-3418.17 (HB 1503/SB 1031) in the 2020 General Assembly session?

A: For Applied Behavior Analysis (ABA) services: HB 1503/SB 1031 require coverage of ABA services for the treatment of autism spectrum disorder (ASD) for plans in the individual and small group markets. The essential health benefits (EHB) checklist indicates that ABA is excluded in Virginia's EHB benchmark plan. Therefore, the Bureau has determined that the new application of this section to individual and small employer group health insurance coverage would require benefits that exceed EHB.

For other services: HB 1503/SB 1031 require plans in the individual and small group markets to cover treatment of ASD, to include medically necessary behavioral health treatment, pharmacy care, psychiatric care, psychological care, and therapeutic care, with no visit limits. The EHB benchmark plan currently provides these benefits but allows certain services to be limited. For example, the benchmark plan provides a minimum for habilitative services of 30 visits per year.

Subsection 38.2-3418.17 L provides exemption to the benefits required in this section to the extent this section requires benefits that exceed essential health

benefits (EHB) for plans offered by a carrier through an exchange (qualified health plans or QHPs). Additionally, Subsection L requires that plans offered outside an exchange (non-QHPs) comply with the provisions of § 38.2-3418.17.

A QHP is a plan offered through an exchange but under guaranteed availability provisions that same plan also is required to be provided off-exchange. A QHP is the same plan whether offered on or off the exchange, therefore, the off-exchange version also is not required to provide ABA benefits required by this section. A non-QHP is a plan that is offered solely off the exchange.

Historically, the Bureau and Virginia have determined that benefits required that expand an existing EHB are not considered an “additional required benefit” but rather an extension of an existing required benefit. Therefore, the requirement in subsection 38.2-3418.17 D to remove visit limits from coverage provided under this section can be applied to all individual health insurance coverage and small employer group health insurance coverage since that does not require an additional EHB.

In Summary: Non-QHPs must cover all benefits required by this section. The requirements of this section to cover ABA services do not apply to QHPs (on and off the exchange) for individual and small employer group health insurance coverage. The requirement to cover other treatments listed in this section with no visit limits are required of all QHPs and non-QHPs. No mandate under this section applicable to QHPs is determined to be in addition to EHBs, therefore, the state is not required to defray costs.

2. Q: How is ASD defined?

A: According to MHPAEA and per 45 CFR § 146.136 (a), all conditions, including ASD, covered under a plan or coverage must be defined as either a mental health (MH) or medical/surgical (M/S) condition. Virginia Code defines ASD, but this definition does not clearly define ASD as either a MH or M/S condition. Therefore, plans or coverage must define ASD as either a MH or M/S condition.

3. Q: For large group plans, how are the requirements of § 38.2-3418.17 applied?

A: If the plan or coverage defines autism as a M/S condition, then all the requirements in § 38.2-3418.17 apply, including no visit limits, and minimum dollar caps may be applied to ABA services.

If the plan or coverage defines autism as a MH condition, the carrier shall not impose visit limits and may be able to apply the \$35,000 minimum dollar cap for ABA benefits per plan year if compliant with MHPAEA requirements.

4. Q: For individual and small group plans, what are the requirements for the treatment of ASD?

A: The treatment of ASD is required under EHBs. The plan must first define ASD as either a M/S condition or a MH condition and apply all covered treatment as either M/S benefits or MH benefits (but not both) in accordance with the applicable rules. The plan must provide benefits in accordance with Virginia Code § 38.2-3418.17, except a QHP is not required to provide benefits for ABA services under this section, unless required pursuant to MHPAEA.

5. Q: Are there circumstances under which QHPs in the individual and small group markets are required to cover ABA?

A: Yes. Coverage for ABA may be specifically excluded per the EHB benchmark plan, and as explained above, QHPs are not subject to the requirements of §38.2-3418.17 to cover ABA. However, if the carrier defines ASD as a MH condition, then the methodology for treatment limitations on ABA must be no more restrictive than treatment limitations on any M/S condition in any given classification under MHPAEA.

6. Q: Can QHPs voluntarily cover ABA?

A: Yes. ABA treatment consists of a number of therapy sessions. ABA therapy sessions may be considered habilitative services, mental health services, or ambulatory patient services, and may be covered under any of those. Costs associated with the voluntary coverage of ABA will not be defrayed by the State given that it is determined this mandate does not apply to QHPs.

7. Q: Can QHPs that voluntarily cover ABA therapy visits under habilitative services still impose the \$35,000 or 30-visit limit?

A: Possibly, since ABA benefits are not EHB and are not required to be offered by QHPs pursuant to Virginia Code § 38.2-3418.17, a carrier may place a dollar or visit limit on ABA services. However, if the carrier defines the condition for which the ABA therapy is being used to treat as a MH condition, then MHPAEA calculation requirements apply and it is possible this would require no dollar limit, a revised dollar limit, or visits limits to be increased or unlimited.

8. Q: If compliance with MHPAEA requires a carrier to exceed EHB benchmark limits, must the state defray the cost?

A: No. Compliance with MHPAEA does not require defrayal of cost.

This letter describes and summarizes the requirements of § 38.2-3418.17 of the Code. The provisions of which should be reviewed carefully for compliance.

Any questions concerning this Administrative Letter may be addressed to:

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Cordially,

A handwritten signature in black ink, appearing to read "Scott A. White". The signature is fluid and cursive, with a large loop at the end.

Scott A. White
Commissioner of Insurance