

DEPARTMENT OF INSURANCE

EXECUTIVE OFFICE
300 CAPITOL MALL, SUITE 1700
SACRAMENTO, CA 95814
(916) 492-3500
(916) 445-5280 (FAX)
www.insurance.ca.gov



**Senate Select Committee on Autism & Related Disorders
Informational Hearing on Health Insurance Coverage for Autism Spectrum
Disorders (ASD): Current Regulatory Oversight of Behavioral Intervention
Therapy**

(July 13, 2011; 10:00 AM-12:30 PM)

Department of Insurance responses to Panel Questions

Second Panel: Representatives from the Department of Managed Health Care and the Department of Insurance. This panel will be asked to focus on issues that are related to the determination of “coverage” and “medical necessity” for BIT. The following questions and issues will be discussed:

A. DMHC and DOI will be asked to provide a brief introductory statement as to the current status of providing behavioral health treatment for individuals with ASD and whether Behavioral Intervention Therapy (also frequently called ABA therapy) should be viewed as a component of therapy that is regulated under California’s Mental Health Parity Law.

Based on the numerous decisions of CDI’s independent medical reviewers concerning the medical necessity of behavioral health treatment, which includes Behavioral Intervention Therapies (BIT), such as Applied Behavioral Analysis therapy (ABA), CDI has concluded that ABA therapy is medically necessary treatment for individuals with autism. Those decisions are summarized in Section F below. The voluminous scientific literature cited and relied on by CDI’s independent medical reviewers demonstrates that this treatment is efficacious, well documented through five decades of research, widely accepted as an effective treatment modality for young autistic patients and consistent with the recommendations from the Office of the Surgeon General, the National Institute of Mental Health, and a number of other national governmental agencies, scientific institutions and professional organizations. A summary describing those entities and their recommendations is attached as Exhibit A.

CDI’s clinician reviewers consistently find that ABA therapy is neither experimental nor investigational; and leads to significant improvements in IQ, communication and language skills, and adaptive behaviors; as well as to reduction in self injurious behaviors. The reviewers further note that providing such essential health care treatment to children with autism results in enabling them to learn in school, succeed at work, and participate fully and productively in family and community activities, thereby providing a better quality of life for the patient and the family. The reviewers also cite the literature to show that early intervention with behavioral health treatment is of crucial importance and results in the young patient being better able to be mainstreamed into school and society, which lessens the burden on the taxpayer provided healthcare network and other support systems as the child matures.

CDI has further concluded as a matter of law that behavioral intervention therapies such as ABA should be viewed as treatment that is mandated under California's Mental Health Parity Act (MHPA). Specifically, California Insurance Code (CIC) Section 10144.5 (a) requires that "every policy of disability insurance that covers hospital, medical or surgical expenses in this state that is issued, amended or renewed on or after July 1, 2000, shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbance of a child...under the same terms and conditions applied to other medical conditions...". Pervasive development disorder or autism is included in the list of severe mental illnesses set forth in the Insurance Code for which parity is mandated. Moreover, ABA therapy is an outpatient service, which is listed in CIC Section 10144.5(b) as one of the benefits which is mandated.

A recent California appellate case concludes that the plain and unambiguous statutory language of the MHPA makes clear that parity is a mandate. *Yeager v. Blue Cross of California* (2009) 175 Cal.App.4th 1098. At issue was the interpretation of a provision of the California Health and Safety Code which provides a checklist of benefits that are legally required to be offered by a plan, and includes coverage for fertility treatment. In *Yeager* the plaintiff's insurance carrier offered infertility coverage that plaintiff challenged as inadequate. The plaintiff alleged that the applicable Health and Safety Code was a mandate on insurance carriers to offer full coverage for fertility treatment.

The court, construing the statutory language and reviewing the legislative intent, held that the statute's wording only required insurers to offer fertility coverage for purchase and not to actually provide full coverage for the treatment of infertility. The court reasoned that if the legislature had wanted to create a mandate that required insurers to provide full coverage for fertility treatment, they knew how to do so and would have enacted a statute similar to the MHPA. The court described the MHPA as a mandate which obligates "health plans to provide coverage (not merely offer it) for the diagnosis and treatment of mental illness equal to coverage that the plans applied to other medical conditions". *Id* at 1103. By contrast, the statute governing fertility treatment only requires that coverage be available.

The legislative history strongly supports the conclusion that the MHPA mandates diagnosis and treatment for severe mental illnesses. In enacting the MHPA, the authors specifically described the problem they were addressing and stated that "most private health insurance policies provide coverage for mental illness at levels far below other physical illnesses" and that "limitations in coverage for mental illness in private insurance policies have resulted in inadequate treatment for persons with these illnesses" (Stats. 1999, Ch.534(AB88), § (b)(2)-(3)).

The legislature's purpose was explicit. It recognized that autism is a severe mental illness, and that inadequate coverage for treatment of mental illnesses results in significant social harm. It further acknowledged that insurers' failure to cover and provide adequate treatment shifts the burden to state and local governments, by forcing policyholders to seek treatment from local regional centers and other public agencies. In the historical and statutory notes to the legislation the drafters state that inadequate treatment "causes relapses and untold suffering" as well as homelessness ... and other significant social problems experienced by individuals with mental illness and their families", and concluded that: "The failure to provide adequate coverage for mental illnesses in private health insurance policies has resulted in significant increased expenditures for state and local governments". *Id*

The purpose of the Act was to change insurers’ practices and mitigate social harm by providing for the adequate treatment of certain severe mental health conditions and putting the burden on the insurers, who are contractually and statutorily obligated to provide medically necessary treatment. Because autism is one of the specifically listed mental illnesses covered by the MHPA, and because ABA therapy has been recognized in the scientific literature as one of the most appropriate treatments for ameliorating the core deficits of autism, CDI has concluded that the MHPA requires insurers to provide coverage for BIT, including ABA.

B. How is “coverage” and “medical necessity” for BIT determined by each department? What has been the “process” for these making these determinations?

The Insurance Code has specific statutorily prescribed procedures which CDI’s compliance officers follow when CDI receives a consumer or provider complaint or a request for Independent Medical Review (IMR). Beginning in 2008, CDI considered all denials of requests for ABA therapy to be appropriate for independent medical review even if the insurer asserted coverage grounds for the denial of treatment in addition to claiming lack of medical necessity. This determination was based upon CIC Section 10169(b), which provides that a decision regarding a disputed health care service relates to the practice of medicine and is not a coverage decision. Since then, CDI’s IMR decisions almost invariably support the doctor’s prescription of ABA therapy for the autistic patient. Those decisions also address and refute the assertions made by insurers to deny ABA therapy, finding that it is neither experimental nor investigational and that it is medically necessary. These findings are not based on any specific facts involving an insured, but upon the scientific literature, so are generally applicable to the requests for ABA therapy by all insureds. Moreover, the finding that ABA therapy is medically necessary inescapably includes the determination that it is medical treatment rather than educational.

In light of this history of independent medical review decisions, and consistent with CDI’s duty to implement the MHPA, CDI exercises its authority under CIC Section 10169(d)(2) to determine whether an insured grievance is more properly resolved pursuant to IMR. Subsection (d)(3) makes CDI “the final arbiter when there is a question as to whether an insured grievance is a disputed health care service or a coverage decision. ” Those matters involving a disputed health care service concerning the medical necessity of treatment or continued treatment to individuals may be referred for independent medical review, and CDI will exercise its discretion to determine whether or not IMR is appropriate based on the facts of the specific case and the history of IMR decisions involving this type of therapy. If the Department determines that an insured grievance is not a disputed health care service relating to medical necessity and is solely a coverage dispute, it may treat the insured’s grievance as a request for the department to review it pursuant to CIC Section 10169(d)(1).

C. During the hearing in June, 2010 hearing on this issue, Sen. Steinberg recommended that regulations with regards to BIT therapy should be established by both departments; have these been implemented? (please discuss)

The statutory authority in the MHPA is clear and unambiguous, and is reinforced by the legislative history. Accordingly, CDI has not found it appropriate or necessary to promulgate regulations. Instead, CDI has applied the statutory mandate for diagnosis and medically necessary treatment to insureds with parity diagnoses codified in CIC Section

10144.5 to pursue enforcement of California’s mental health parity law for patients with autism.

D. Can health plans initially deny BIT based on “medical necessity” and subsequently (after exhausting the internal appeals process) deny the same case on the basis of the “coverage” issue?

No. Insurers may not subsequently assert two different bases to avoid their obligations to provide coverage for medically necessary BIT. While it is true that an insurer may assert any grounds for denial at any time, CIC 10123.13¹ requires an insurer to state the specific factual and legal reasons for denying any portion of a claim. The Fair Claims Settlement Practices Regulations, CCR Title 10, Section 2695.7(b)(1), provides:

“Where an insurer denies or rejects a first party claim, in whole or in part, it shall do so in writing and shall provide to the claimant a statement listing all bases for such rejection or denial and the factual and legal bases for each reason given for such rejection or denial which is then within the insurer's knowledge. Where an insurer's denial of a first party claim, in whole or in part, is based on a specific statute, applicable law or policy provision, condition or exclusion, the written denial shall include reference thereto and provide an explanation of the application of the statute, applicable law or provision, condition or exclusion to the claim....”.

Absent new or subsequent information coming into possession of the insurer, this regulation makes it a violation to come up with a subsequent basis for denial. Moreover, after an IMR decision, any insurer’s contention that it need not comply would be irrelevant. Not only is the Department the final arbiter of whether a grievance is a disputed health care service appropriate for IMR under CIC Section 10169(d)(3), but an IMR determination that the treatment is medically necessary, after it is adopted by the commissioner, is binding on the insurer pursuant to CIC Section 10169.3 (f). Therefore, in CDI’s opinion, if a health insurer initially denies BIT based on “medical necessity” and subsequently (after exhausting the internal appeals process) denies the same case or claim on the basis that the services is not covered, the insurer is in violation of these statutes.

E. How can consumers determine whether BIT is a covered benefit and should be provided by their health plan?

The CDI public website currently contains information that will be helpful in this regard. Consumers can review the Notice which CDI issued To All Admitted Health Insurers and Other Interested Persons on May 17, 2011 regarding Enforcement of Independent Medical Review Statutes. That Notice reminded insurers that the CDI is committed to enforcing the provisions of the Insurance Code governing IMR of disputed health care services to ensure the full protection under the law of insureds with policies of health care insurance

¹CIC 10123.13(a) in part...“The notice that a claim is being contested or denied shall identify the portion of the claim that is contested or denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for contesting or denying the claim. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or the legal basis for its reason for contesting or denying the claim. The insurer shall provide a copy of the notice to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue.

regulated by the CDI, and that the Insurance Commissioner's written decisions adopting the determinations of the IMR organization are binding on the insurer.

The Notice identified nine separate instances in 2010 in which insurers' denials of ABA were overturned in IMR, and specified that in two of those instances, the insurers' denials – based on a contention that the therapy was experimental or investigational – were overturned because such treatment is now recognized as the standard of care for autism. The Notice further stated that in another seven instances, the IMR reviewers overturned the insurer's denial, finding that the treatment was medically necessary for the insured. That Notice is attached as Exhibit B, and is posted on CDI's public website at <http://www.insurance.ca.gov/0250-insurers/0300-insurers/0200-bulletins/bulletin-notices-commiss-opinion/index.cfm>

Additional useful information will be posted on the CDI website in the near future. CDI's Information Technology Executive Council has approved putting up a new application on the website, which will allow consumers to search the data base of IMR decisions by diagnosis and other relevant information. This will help parents of children with autism because they will be able to locate all prior IMR decisions dealing with requests for treatment for autism. CDI also contemplates issuing a web notice of IMR rights and of the future availability of the search function and indicating the history of IMR decisions regarding autism treatment. In that context, CDI intends to specify, since January 1, 2009, the number of IMR decisions on the treatment of autism with BIT which were filed with CDI, and the number of insurer denials of treatment which were overturned by the IMR reviewers.

Additionally, consumers should work with their providers who have experience in filing ABA treatment claims. Consumers may also contact CDI's Consumer Services unit via our toll-free hotline (800-927-HELP) or our public website www.insurance.ca.gov. Those sources point out that if a health insurer denies authorization for or treatment of ABA therapy, the insurer is required to deny the claim in writing, provide all the bases for denial and include a notice that the insured may contact the CDI for its investigation of the insurer's denial. The notice must include a statement that, if the claimant believes all or part of the claim has been wrongfully denied, delayed or modified, he or she may have the matter reviewed by the California Department of Insurance, and shall include the address and telephone number of the unit of the Department which reviews claims practices. CDI will then investigate whether the claim was properly denied and whether the cases should be decided as coverage matters or placed into the IMR program. Insureds must also be notified of their right to seek an IMR with the Department on any Explanation of Benefits denying, in whole or in part, any claim.

Consumers might also consider contacting consumer groups that specialize in assisting parents to obtain insurance coverage for treatment for their children with autism and can provide additional assistance to them in appealing denials of ABA therapy. CDI is in the process of posting information about some of these autism advocacy groups on its public web site.

To date, CDI has added links on its Health Issues website page to two groups focused on assisting consumers with obtaining insurance coverage for treatment for autism. They are Insurance Help for Autism and Autism Health Insurance Project. Other groups may be added as we locate and screen additional advocacy groups that provide competent services at no or minimal cost. The links may be found at <http://www.insurance.ca.gov/0100-consumers/0070-health-issues/index.cfm>

F. What has been the number of cases related to BIT that have gone to IMR during the past 5 years? (Please review and discuss the implications of these findings).

CDI has tracked BIT (ABA) cases since 2009. Since 2009, CDI has received 32 cases related to BIT or ABA therapy that have gone to IMR. Of those 32 insurer denials, 28 were overturned by the reviewers, finding in favor of the insured receiving treatment. See Table A below.

Table A: Autism, ABA Therapy IMR Data 2009-2011 (YTD)

	2009	2010	2011 (thru 5/16/11)	Total
Number of Cases CDI received that involve BIT or ABA Therapy	10	18	4	32
Total sent to IMR Program	10	18	4	32
Total IMR decisions that Overturned the insurer denial.	7	17	4	28
Total IMR decisions that Upheld the insurer denial.	3	1	0	4

Summary and analysis of these findings: Since the great majority of these ABA IMR cases have overturned insurer denials of treatment and found in favor of the insured, and the clinical literature has established ABA therapy as the gold standard for young autistic patients, CDI concludes that ABA therapy is not an experimental or investigational treatment and, with few exceptions, is a medically necessary treatment for autism. As such, ABA must be covered under all health insurance policies regulated by CDI. CDI regulated health insurers may not legally continue to deny ABA claims unless there is a clear basis for determining that for that specific patient at that point in time, ABA therapy is not medically necessary.

Currently, despite the virtually unanimous findings in IMR, insurers continue to improperly deny insureds' claims for ABA therapy. Insurers have denied ABA therapy on the grounds that include (1) ABA treatment is not medically necessary, (2) ABA is not a covered benefit, (3) Autism is not a covered diagnosis (violation of parity laws), (4) ABA is experimental, (5) ABA is educational, and (6) the ABA provider is not licensed. Therefore, CDI is taking action to stop these practices, as is more fully described in the answer to question D relating to the third panel.

G. What happens if the health plans fail to implement the IMR findings and recommendations?

Section 10169.3(f) requires the Commissioner to immediately adopt the decision resulting from the independent medical review. This section also makes the written decision binding

on the insurer. If insurers fail to immediately implement the IMR findings adopted by the Commissioner, as Blue Shield has done recently, they are subject to an enforcement action under the Unfair Practices Act and the Fair Claims Settlement Regulations. See response to question D relating to the third panel.

H. How are the departments monitoring compliance by the health plans?

CDI is monitoring compliance with the IMR decisions, the mental health parity statutes, and the Fair Claims Settlement Practices regulations, through its consumer complaint investigation functions. When violations of law are identified, the insurer is cited and told to correct its actions to comply with the law. The goal is to get corrective action by the insurers so that all consumers, not only the ones that file complaints with CDI, receive the benefits they deserve and pay for. However, we recognize that several insurers continue to improperly deny ABA therapy, even in light of the law, IMR decisions, and previous cases that find ABA therapy is an appropriate, medical necessary treatment for autism and should be covered.

Accordingly, CDI expects shortly to commence enforcement actions, as described in response to question D relating to the third panel. In addition, CDI is in the process of developing a plan to perform targeted market conduct examinations of the major health insurers, beginning immediately and continuing over the next 12 months, to obtain evidence on the insurers' systems, procedures, practices, and policies related to behavioral intervention therapies and ABA.

CDI has also commenced a thorough analysis of existing health insurance policies to evaluate whether current policy forms are in compliance with the MHPA. If any policies are found out of compliance, CDI will require reformation of those contracts to meet the requirements of the MHPA.

In addition, CDI recently issued a data call to all insurers to identify all ABA providers in their networks and the location of those providers in relation to policyholders. Insurers are required to maintain this information pursuant to CDI regulation. A fuller explanation of that data call is contained in response to question C to the Third Panel.

I. Other questions?

CDI has reviewed the state of the law regarding autism and ABA across the country, and has identified 26 other states which have recently enacted laws specifically requiring that insurers in those states must provide ABA therapy for patients with autism. In so doing, the states acknowledge that ABA is a recognized medical treatment for this order and is neither experimental nor investigational. These 26 state statutes are similar to, but generally more narrow than, California's Mental Health Parity law, which mandates coverage for the diagnosis and medically necessary treatment of severe mental illnesses, and specifically lists autism or pervasive development disorder as a severe mental illness to which CID 10144.5 applies. Thus, a summary of those 26 state laws is included as Exhibit C.

CDI is also undertaking a review of the practices of the Regional Centers, the MIND Institute, and other providers of BIT for patients with autism to inform its decision making and the inquiry by this Select Committee. We intend at this point to provide the results of that review of policies and practices regarding licensure of personnel and the

distinction between health care treatment and educational services to the Senate Select Committee as soon as they are available.

At present, we are able to provide a letter from Dr. Daniel Shabani, who has a doctoral degree in Behavior Analysis and is a Board Certified Behavior Analyst, and President-Elect of the California Association for Behavior Analysis (CalABA), which is included as Exhibit D, and a letter and curriculum vitae from Peter Humber, M.D., Chief Medical Officer of the Orange County Regional Center, which are included in Exhibit D. Both describe how ABA treatment is provided in the regional centers, using individuals who do not hold state licenses, under the direction of certified or licensed individuals.

Third Panel will include representative from the Department of Managed Health Care and the Department of Insurance. This panel will be asked to focus on issues that are related to the delivery and implementation of BIT. The following questions and issues will be discussed:

A. What are the licensing/certification requirements that have been established by each department with regards to BIT?

The Insurance Code does not require state licensure of ABA therapists. It is silent on requirements pertaining to licensing/certification requirements for BIT. A related provision of the Government Code defines ABA therapy in section 95021 (d) and is similarly silent about any licensure requirement. Consequently, there is no legal requirement that insurers can impose to require licensing/certification of providers of BIT. Therefore, it is CDI's position that insurers are prohibited from denying payment for BIT claims for medically necessary services provided to insureds by BIT therapists on the grounds that they can impose a state-licensure requirement on BIT. Additionally, if an insurer applies a policy provision requiring non-existent state licenses for mental health services and does not apply the same requirements to the myriad of allied health professionals who participate in providing services for medical conditions, that insurer would be in violation of the Mental Health Parity Act. CDI is obtaining corrective actions from insurers who continue to improperly deny claims for services provided by BIT therapists on the grounds that these therapists must be state-licensed.

B. What is the regulatory basis for these requirements and what was the process by which these regulations were established?

CDI does not have regulations governing licensing/certification of BIT therapists. CDI relies on California's Insurance Code, and in particular, the Mental Health Parity statute which does not require state-licensure of BIT therapists but which does require coverage for diagnosis and medically necessary services for autistic patients. Because the statutory mandate for diagnosis and medically necessary treatment for autism is clear and unambiguous, regulations to interpret it are neither necessary nor appropriate.

C. How are health plans monitored to determine that they are providing an adequate network of providers?

CDI has regulations at Title 10, Chapter 5, Sections 2240-2240.5 which establish provider network access requirements for mental health care services required by Section 10144.5 in the definition of basic health services. Section 2240.1 (c)(4) requires insurers, in arranging for provider network services to ensure that " there are mental health professionals with skills appropriate to care for the mental health needs of covered persons and with sufficient

capacity to accept covered persons within 30 minutes or 15 miles of a covered person's residence or workplace.”

CDI has issued a Request for Geographical Access Report and Provider Network Listing of Behavioral Intervention Therapists to all 106 health insurers with covered lives in California. That data call was issued under the Provider Network Access Standards for Health Insurance Policies and Agreements, and is intended to evaluate adequacy and accessibility of behavioral intervention therapy, also referred to as ABA therapy, for the autistic insured population covered by each health issuer. It requires reports showing the geographic distribution of Behavioral Intervention Therapists in each insurer's network in relation to its members, listing all in-network providers, both individuals and organizations, by names, addresses including zip code, telephone numbers, and the number of individuals within an organizational provider who are available under the provider network contract. CDI is requiring insurers to submit separate reports for Individual, Small Group and Large Group policies, organized by county or geographic service areas. Network providers to be included in the reports are limited to network Behavioral Intervention Therapists, who may be mental health professionals who are trained to provide, directly or indirectly, behavioral intervention therapy, for whom the insurer documents that they are capable of providing medically necessary behavioral intervention therapy and have sufficient practice capacity to do so.

D. Please provide an overview and update with regards to any litigation that involve each department and involve ASD issues.

The Department is aware of private California litigation where access to BIT services is in dispute but we are not currently a party to any litigation involving BIT services. The Department anticipates filing shortly one or more enforcement actions against insurance companies that illegally denied coverage for BIT.

CDI is, however, aware of decisions from five federal and state courts in California and elsewhere in the country involving coverage for treatment for autism and related mental disorders. The most informative decision is McHenry, a 2009 federal district court case from Oregon. It contains a thorough discussion of the nature of autism and its behavioral manifestations. The decision also includes a description of ABA therapy, which is based on behavioral conditioning techniques and reinforcement of positive behaviors, to shape behaviors and teach new skills in an individual; and a review of the multiple studies over the past two decades which have confirmed Dr. Lovaas' findings that ABA is generally beneficial to children diagnosed with autism. The decision also analyzed two issues that are now being asserted by insurers and HMOs in California, and made two well researched and persuasive findings. First, the court found that the weight of the evidence demonstrates that ABA therapy is firmly supported by decades of research and application and is a well-established treatment modality of autism which is not an experimental or investigational procedure. Second, the court held that the insurer's contractual exclusions were inapplicable, concluding that ABA therapy is not primarily educational, academic or social skills training, but is behavioral training. Accordingly, ABA is not subject to the exclusions from coverage under the Plan for academic or social skills training.

Another matter, Tappert, a Colorado case decided by arbitration, involved other issues currently being raised by insurers and plans in California: whether ABA therapy is medically necessary or excluded as experimental or investigational and whether it is a covered benefit. On the first question, the arbitrator reviewed and rejected Anthem's claim that ABA is experimental and investigational. Instead, he concluded that ABA

therapy is the standard of care in treating autism, relying on expert testimony by Dr. Philip Strain that it is the standard of care when dealing with autistic children, reduces problem behaviors 80-90%, as found by many studies; and is endorsed by the National Academy of Sciences, the recognized authority in the United States for resolving scientific disputes, and by the National Institute of Mental Health. As to coverage, the arbitrator rejected Anthem's contention that covered services must be provided in a doctor's office, finding the exclusionary language conflicting and ambiguous and therefore construing the policy in favor of coverage. Finally, the arbitrator concluded that Anthem is required to cover the costs of ABA therapy for the four year old insured under the Other Outpatient Therapy Provisions of the contract, which covers treatment for congenital defects and/or birth abnormalities.

The most recent decision, on June 7, 2011 by a Superior Court Judge in Seattle, Washington, involves another issue that is similar to those now prevalent in California: whether refusal to provide treatment comports with state mental health parity law. In that matter, autistic children, identified as D.F. and S.F., among others, sought payment for treatment for autism under an insurance contract with the Washington State Health Care Authority. The Court concluded, as a matter of law, that plaintiffs were entitled to a declaration that specific exclusions in the health benefit plans for Applied Behavior Analysis therapy, even when medically necessary and performed by licensed health providers, do not comply with Washington's Mental Health Parity Act, RCW 41.05.600.

Two New Jersey cases, both decided in 2007, are also of interest because they construe the provisions of a New Jersey mental health parity statute which is closely analogous to California mental health parity law as codified in California Insurance Code section 10144.5. In Markowitz, the Superior Court, Appellate Division, characterized the issue to be decided as whether the Legislature intended, when it passed relevant parity statutes recognizing pervasive developmental disorder (PDD) as a "biologically-based mental illness," that the only effective treatments for PDD be barred from coverage by the State Health Benefits Commission under its NJ Plus plan as the result of a contractual exclusion contained in the Member Handbook provided to its subscribers. The Court found the Legislature's intent to have been otherwise, overturning the ruling of the administrative law judge, and holding that the parity statute applicable to health insurance benefits offered by the State Health Benefits Commission required coverage of medically-necessary occupational, speech, and physical therapy for children with biologically-based mental illness.

The governing statute, N.J.S.A. 52:14-17.29e, applicable to health insurance coverage offered by the State Health Benefits Commission, requires parity in coverage for treatments for biologically-based mental illness and for other sickness and provides in relevant part:

The State Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act that provides hospital or medical expense benefits shall provide coverage for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract.

A related statute, N.J.S.A. 52:14-17.29d defines "biologically-based mental illness" to be a "mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or [sic] psychological syndrome or pattern that

substantially limits the functioning of the person with the illness, including, but not limited to .. pervasive developmental disorder or autism.”

Similarly, in Micheletti, the Superior Court Appellate Division evaluated the propriety of a different argument by the State Health Benefits Commission for denying medically necessary treatment for a child with autism, relying on a purported contractual exclusion for speech and other therapy treatments for development of skills and functions not yet realized. In eloquent language, the Court found the decision of the Commission antithetical to the purpose and spirit of the State Health Benefits Program, the reasonable expectation of its participants, the legislative intention of equal treatment for biologically-based mental illnesses, and the public policy of the State for the nurturing of children. The court held the exclusions relied upon by the Commission to deny coverage for the treatment sought for autism are void because they would render the mental health parity statute a nullity by excluding medically necessary treatment for a parity diagnosis.

Finally in Arce, the only California case involving children with autism, the Court of Appeal concluded that there is a reasonable possibility that plaintiff can demonstrate a predominance of common issues to support a class action claim for violation of the Unfair Competition Law based on allegations that Kaiser has a uniform policy of categorically denying coverage for health care services to treat autism spectrum disorders based on arguments that such treatment is educational and not covered, without determining whether the services are medically necessary for the individual plan members.

CDI appreciates the opportunity to appear before the Committee, present information, and respond to questions.

Dated: July 1, 2011

Patricia Sturdevant
Deputy Insurance Commissioner

List of Exhibits

- Exhibit A: “ABA Therapy for Autism is Nationally Accepted and Approved”
List of Agencies
- Exhibit B: “Notice to All Admitted Health Insurers and Other Interested Persons”
Enforcement of Independent Medical Review Statues
- Exhibit C: Summary of Insurance Reform Laws Regarding Autism (Treatment) by State
- Exhibit D: Letters from the California Association of Behavior Analysis and Peter Himber,
M.D., Chief Medical Officer at the Regional Center of Orange County
- Exhibit E: Table of Cases

Exhibit A
**“ABA Therapy for Autism is Nationally Accepted and
Approved”**
List of Agencies

Exhibit A

ABA Therapy for Autism is Nationally Accepted and Approved

Many governmental agencies, scientific institutions and professional organizations have concluded, based on the empirical evidence, that behavioral intervention therapies, and specifically ABA-based procedures, are efficacious and represent best clinical practices for individuals with autism.

The Surgeon General of the United States

The Surgeon General serves as America's Doctor by providing Americans the best scientific information available on how to improve their health and reduce the risk of illness and injury. The Surgeon General has issued a Report on Mental Health, which is the product of collaboration between the Substance Abuse and Mental Health Services Administration (SAMHSA) and The National Institutes of Health (NIH), which supports and conducts research on mental illness and mental health through the National Institute of Mental Health (NIMH).

The Surgeon General Report recognizes autism as a severe, chronic developmental disorder, which results in significant lifelong disability. The goal of treatment is to promote the child's social and language development and minimize behaviors that are maladaptive and interfere with the child's functioning at home and at school. The Surgeon General's position on behavior therapy, based on thirty years of research is that sustained behavioral therapy and applied behavior analysis (ABA), early in life is effective in reducing inappropriate behavior and in acquiring language skills, increasing communication, ability to learn, and appropriate social behavior. See <http://www.surgeongeneral.gov/library/mentalhealth/chapter3/sec6.html#autism>

National Institute of Mental Health

The mission of the National Institute of Mental Health (NIMH) is to further the understanding and treatment of mental illness through clinical and basic research. Utilizing the evidence and results from their research, their goal is to create a path toward prevention, recovery, and cure for mental illness.

NIMH recognizes that applied behavior analysis (ABA) has become widely accepted as an effective treatment for individuals with autism. The goal of behavioral management is to reinforce desirable behaviors and reduce undesirable ones. Effective programs will teach early communication and social interaction skills. In children younger than 3 years, appropriate interventions usually take place in the home or a child care center. These interventions target specific deficits in learning, language, imitation, attention, motivation, compliance, and initiative of interaction. Included are behavioral methods, communication, occupational and physical therapy along with social play interventions. Often the day will begin with a physical activity to help develop coordination and body awareness; children string beads, piece puzzles together, paint, and participate in other motor skills activities. At snack time the teacher encourages social interaction and models how to use language to ask for more juice. The children learn by doing. Working with the children are students, behavioral therapists, and parents who have received extensive training. Positive reinforcement is used in teaching the children. See <http://www.nimh.nih.gov/health/publications/autism/treatment-options.shtml>

American Psychological Association

Based in Washington, D.C., the American Psychological Association (APA) is a scientific and professional organization that represents psychology in the United States. APA's mission is to advance the creation, communication and application of psychological knowledge to benefit

Exhibit A

society and improve people's lives. With more than 54,000 members, it is the largest association of psychologists worldwide.

The APA believes that medications on their own rarely improve behavior, so behavioral interventions are crucial. Many treatment programs emphasize "operant conditioning," which uses rewards to encourage good behavior and punishments to discourage bad behavior. APA's position is consistent with the Surgeon General's report on autism treatment. The APA also concurs with the findings of psychologist Ivar Lovaas, Ph.D. First developed in the 1960s by Dr. Lovaas, at the University of California, Los Angeles (UCLA), ABA therapy for autism makes use of the idea that when people--autistic or otherwise--are rewarded for a behavior, they are likely to repeat that behavior. In ABA treatment, the therapist gives the child a stimulus--like a question or a request to sit down--along with the correct response. The therapist uses attention, praise or a tangible incentive like toys or food to reward the child for repeating the right answer or completing the task; any other response is ignored. In a landmark 1987 study, Lovaas found that nearly half the children who received 40 hours per week of ABA therapy were eventually able to complete normal first-grade classes, while none of children who received the therapy only 10 hours per week were able to do the same. See <http://www.apa.org/monitor/dec04/autism.aspx>

American Speech-Language-Hearing Association

The American Speech-Language-Hearing Association (ASHA) is the nation's leading professional, credentialing, and scientific organization for speech-language pathologists, audiologists, and speech/language/hearing scientists. ASHA has been initiating the development of national standards for audiologists and for speech-language pathologists and certifying professionals for 55 years.

The American Speech-Language-Hearing Association's Speech-language pathologists prioritize assessment and intervention. They draw on empirically supported approaches to meet specific needs of children with autism. Speech-language pathologists assist communication partners in recognizing the potential communicative functions of challenging behavior and designing environments to support positive behavior. This treatment option comes from their article from the *American Speech-Language-Hearing Association*. (2004). Preferred practice patterns for the profession of speech-language pathology <http://www.asha.org/policy>.

Autism Society of America

The Autism Society, the nation's leading grassroots autism organization, exists to improve the lives of all affected by autism. They focus on increasing public awareness about the day-to-day issues faced by people on the autism spectrum, advocating for appropriate services for individuals across the lifespan, and providing the latest information regarding treatment, education, research and advocacy. The Autism Society is the leading source of trusted and reliable information about autism. Through its strong chapter network, the Autism Society has spearheaded numerous pieces of state and local legislation, including the 2006 Combating Autism Act, the first federal autism-specific law. The Autism Society's website is one of the most visited websites on autism in the world and its quarterly journal has a broad national readership.

The Autism Society of America believes that Applied Behavior Therapy (ABA) now is the most recognized and scientifically supported treatment for autism. By changing the antecedents and consequences of behaviors symptomatic of autism, ABA specialists teach children the skills in which they are delayed, thereby replacing challenging and aberrant behaviors with functional

Exhibit A

and adaptive skills. Research has shown that with early intensive ABA therapy, a large percent of children with autism fully recover and lead healthy lives. See <http://support.autism-society.org/site/Search?query=ABA+therapy&inc=10>

National Institute of Neurological Disorders and Stroke Center

The National Institute of Neurological Disorders and Stroke (NINDS) conducts and supports research on brain and nervous system disorders. Created by the United States Congress in 1950, NINDS is one of the more than two dozen research institutes and centers that comprise the National Institutes of Health (NIH). The NIH, located in Bethesda, Maryland, is an agency of the Public Health Service within the United States Department of Health and Human Services. NINDS has occupied a central position in the world of neuroscience for more than 50 years. NINDS also works with the National Institute of Mental Health to collaborate and share research findings and methods of treatment for serious mental illnesses.

NINDS' stance on the treatment of autism is one that is supportive of the findings of the Lovaas Institute. This stance is also consistent with the National Institute Mental Health. These finding include viewing applied behavior analysis (ABA) as widely accepted as an effective treatment for autism. See <http://www.ninds.nih.gov/disorders/autism/autism.htm>

National Institute of Child Health and Human Development

The NICHD was initially established to investigate the broad aspects of human development as a means of understanding developmental disabilities, including intellectual and developmental disabilities, and the events that occur during pregnancy. Today, the Institute conducts and supports research on all stages of human development, from preconception to adulthood, to better understand the health of children, adults, families, and communities. The NICHD has achieved an impressive array of scientific advances in its pursuit to enhance lives throughout all stages of human development, improving the health of children, adults, families, communities, and populations. Research supported and conducted by the NICHD has helped to explain the unique health needs of many, and has brought about novel and effective ways to fulfill them.

In general the National Institute of Child Health and Human Development concludes that behavior management therapy works to reinforce wanted behaviors and reduce unwanted behaviors. At the same time, these methods also suggest what caregivers should do before or between episodes of problem behaviors, and what to do during or after these episodes. Behavioral therapy is often based on Applied Behavior Analysis (ABA). NICHD believes that ABA therapy is a way to help minimize the symptoms of autism and to maximize learning. See http://www.nichd.nih.gov/search.cfm?search_string=ABA+therapy

Lovaas Institute

The Lovaas Institute has performed rigorous research at the University of California at Los Angeles (UCLA) under the direction of Dr. Ivar Lovaas, for decades, proving its effectiveness in treating children with autism. Treatment follows the procedures described by Dr. Lovaas, published along with long-term outcome data in peer-reviewed journals, and supported by additional long-term outcome research as recently as 2006. Dr. Lovaas and his staff have conducted countless studies and published more than 500 articles in the field of Applied Behavioral Analysis (ABA). The Lovaas Model of ABA is based on 40 years of research and is backed by published studies showing that half of children with autism who receive this intensive treatment become indistinguishable from other children on tests of cognitive and social skills by the time they complete first grade.

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The Lovaas Institute is a proponent of ABA because they have demonstrated that a sizable group of children diagnosed with autism, pervasive developmental disorders and related developmental disorders have been able to achieve normal educational and intellectual functioning by 7 years of age because of ABA therapy. The Lovaas Institute personnel help develop a child's language and social interactions with parents and peers while reducing interfering behaviors such as tantrums. Their research shows these children have been mainstreamed into regular classrooms and have advanced successfully through the school system without additional assistance. After ABA treatment, children show significant increases in intellectual functioning and perform within normal ranges on standardized tests of intelligence. They also appear indistinguishable from their peers in measures of social and emotional functioning. Even for children who do not reach the level of typically-developing peers, their quality of life is greatly improved from what they learn through ABA; sizable decreases in inappropriate behaviors and acquisition of basic language skills are most often achieved. These children become more active members of their family and are usually able to learn in less restrictive special education classrooms or supervised regular education classrooms. See <http://www.lovaas.com/approach-detailed.php>

The Kennedy Krieger Institute

The Kennedy Krieger Institute is an internationally recognized hospital, research, and teaching institution located in Baltimore, Maryland with outpatient clinics specializing in neurobehavioral health services. A renowned authority in research on behalf of children with brain, spinal cord and musculoskeletal related disorders, Kennedy Krieger also provides professional training by eminent experts. Faculty at Kennedy Krieger are among some of the world's leading experts in this field having made crucial medical discoveries leading to innovative treatments involving individuals with disabilities.

The treatment of autistic patients at Kennedy Krieger Institute emphasizes applied behavior analysis (ABA). The institute's official position is that ABA is a form of therapy that has been shown to reduce problem behavior and increase appropriate skills for individuals with intellectual disabilities. Their research, along with the large body of studies into ABA treatment, provides empirical evidence indicating that procedures developed using ABA-based principles are effective at assessing and treating a variety of maladaptive behaviors engaged in by individuals with a variety of diagnoses, including autism, and intellectual and developmental disabilities. See <http://www.kennedykrieger.org>

Center for Autism and Related Disorders

The Center's CARD I and CARD II programs include comprehensive and cutting-edge curricula that can be tailored to the specific needs of individuals from birth to 21 years of age. These programs help children learn to communicate, develop friendships, and lead happy, healthy lives. CARD Specialized Outpatient Services (SOS) provides assistance with specific areas of concern for a family and develops and implements strategies to diminish problem behaviors and teach necessary skills. Its Director, Dr. Doreen, studied autism treatment for 12 years under the direction of renowned autism treatment scientist Dr. Ivar Lovaas at the University of California, Los Angeles. Dr. Lovaas discovered that intensive early intervention using applied behavior analysis treatment yielded a 47 percent recovery rate among children with autism who participated in his study. Building off these findings, Dr. Doreen and her associates developed the CARD treatment curriculum for children diagnosed with autism. Their methodology and treatment forms are based on the Lovaas model of applied behavior analysis (ABA).

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CARD is committed to remaining at the forefront of research on ABA-based methods of autism assessment and treatment. In August 2009, CARD researchers published a study documenting recovery in a large group of children with autism. The primary focus of their research is ABA-based methods of assessment and treatment. They believe treatment approaches grounded in ABA are now considered to be at the forefront of therapeutic and educational interventions for children with autism. In general, this behavioral framework utilizes manipulation of antecedents and consequences of behavior to teach new skills and eliminate maladaptive and excessive behaviors. The Discrete Trial is a particular ABA teaching strategy which enables the learner to acquire complex skills and behaviors by first mastering the subcomponents of the targeted skill. See <http://www.centerforautism.com/card-approach.php>

Association for Science in Autism Treatment

ASAT is a not-for-profit organization of parents and professionals committed to improving the education, treatment, and care of people with autism. Its mission is to educate parents, professionals, and consumers by disseminating accurate, scientifically-sound information about autism and its treatment and by combating inaccurate or unsubstantiated information. In doing so, ASAT promotes the use of effective, science-based treatments for all people with autism, regardless of age, severity of condition, income or place of residence.

ASAT agrees with studies that show ABA is effective in increasing adaptive behaviors and teaching new skills. In addition, many studies demonstrate that ABA is effective in reducing problem behavior. A number of studies also indicate that, when implemented early in life, ABA may produce large gains in development and reductions in the need for special services. ASAT maintains ABA is an effective intervention for many individuals with autism spectrum disorders. ABA interventions should be supervised by behavior analysts. See <http://www.asatonline.org/intervention/treatments/applied.htm>

National Alliance of Autism Research

Autism Speaks was founded in February 2005 by Bob and Suzanne Wright, grandparents of a child with autism. Since then, Autism Speaks has grown into the nation's largest autism science and advocacy organization, dedicated to funding research into the causes, prevention, treatments and cure for autism; increasing awareness of autism spectrum disorders; and advocating for the needs of individuals with autism and their families.

Autism Speaks uses a network of treatment called the Interactive Autism Network (IAN) a project collecting information online from families of children with autism spectrum disorders (ASDs) from throughout the United States, containing reports on the use of speech and language therapy. Autism Speaks has ranked ABA therapy in the top three most used methods for effective treatment of autism. Moreover, their verbal behavior therapy is based on the applied behavior analysis (ABA), method of treatment. They therefore acknowledge the efficacy of ABA therapy and have adapted and modified its use to gain the desired results in improving verbal skills by intensive behavior treatment. See http://www.autismspeaks.org/search/apachesolr_search/what%20is%20ABA

Exhibit B
**“Notice to All Admitted Health Insurers and Other Interested
Persons”**
Enforcement of Independent Medical Review Statutes

DEPARTMENT OF INSURANCE

Executive Office
45 Fremont Street, Suite 2300
San Francisco, CA 94105

NOTICE**TO: All Admitted Health Insurers and Other Interested Persons****DATE: May 17, 2011****SUBJECT: Enforcement of Independent Medical Review Statutes**

This Notice reminds insurers that the California Department of Insurance (CDI) is committed to enforcing the provisions of the Insurance Code governing Independent Medical Review (IMR) of disputed health care services to ensure the full protection under the law of insureds with policies of health care insurance regulated by the CDI. The CDI requires that insurers fully comply with Insurance Code Section 10169 governing IMR as well as with Insurance Code Section 10169.3(f), which specifies that the Insurance Commissioner's written decisions adopting the determination of the independent medical review organization shall be binding on the insurer.

Please also take notice that CDI evaluates insurers' communications with insureds regarding coverage of health care services, and payment of claims for those services, for compliance with Insurance Code Section 790.03. This statute defines, and prohibits as unfair methods of competition and unfair and deceptive acts or practices, the following conduct, among other acts:

(a)
Making...or causing to be made...any...statement misrepresenting the terms of any policy issued, or the benefits or advantages promised thereby....

(h)
Knowingly committing or performing with such frequency as to indicate a general business practice any of the following unfair claims settlement practices:

(l)
Misrepresenting to claimants pertinent facts or insurance policy provisions relating to any coverages at issue;

(5)
Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

Additionally, please note that the CDI website at <http://www.insurance.ca.gov/0100-consumers/0020-health-related/imr2010stats.cfm>, identifies nine separate instances in 2010 in which insurers' denials of behavioral therapy such as Applied Behavioral Analysis have been overturned in IMR. In two of those instances, the insurers' denials - based on a contention that the therapy was experimental or investigational - were overturned because such treatment is now recognized as the standard of care for autism. In another seven instances, the IMR reviewers overturned the insurer's denial, finding that the treatment was medically necessary for the insured.

All health insurers should take steps to evaluate how they are processing, paying for, and denying health insurance claims to ensure that they are complying with the above statutes.

If you have any questions, please contact Patricia Sturdevant, Deputy Insurance Commissioner, at 916-492-3578 or via email at patricia.sturdevant@insurance.ca.gov.

Exhibit C

Summary of Insurance Reform Laws Regarding Autism (Treatment) By State

Exhibit C

States	Summary of Insurance Reform Laws Regarding Autism (Treatment)	Date Enacted	Citation
Arizona	<p>This law requires many private insurers to begin covering the costs of diagnostic assessments for autism and services for individuals with autism who are under the age of 16. Insurance providers can limit the coverage for behavioral therapy in the following manner: Benefits up to \$50,000 per year for a child under 9; Benefits up to \$25,000 per year for a child ages 9-15. Purchased individual health insurance plans are not subject to the requirements of this act. the law’s definition of “behavioral therapy” specifically includes ABA.</p>	March 21, 2008	HB 2847 (2008)
Arkansas	<p>Requires health insurance companies to provide coverage of : Diagnosis of an autism spectrum disorder - meaning medically necessary assessments, evaluations, or tests to diagnose whether an individual has an autism spectrum disorders; Applied behavior analysis (ABA); Pharmacy care; Psychiatric care; Psychological care; Therapeutic care - meaning services provided by licensed speech therapists, occupational therapists, or physical therapists; Any care for individuals with autism spectrum disorders that is determined by a licensed physician to be medically necessary and evidence-based treatment for autism spectrum disorder.</p>	March 4, 2011	House Bill 1315 (2011)
Colorado	<p>The law defines “treatment for autism spectrum disorders” as including: evaluation and assessment services; behavior training and behavior management, and applied behavior analysis, including consultations, direct care, supervision, or treatment; habilitative or rehabilitative care, including occupational therapy, physical therapy, or speech therapy; pharmacy care and medication (if covered by the insurance plan for other illness); psychiatric care; psychological care, including family counseling; and therapeutic care.</p>	June 2, 2009	SENATE BILL 244 (2009)

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States	Summary of Insurance Reform Laws Regarding Autism (Treatment)	Date Enacted	Citation
Connecticut	<p>The act requires coverage for the following types of services: Behavioral therapy, including ABA; Pharmacy care; Direct psychiatric or consultative services; Direct psychological or consultative services; Physical therapy; Speech and language pathology; Occupational therapy Under this law, a policy must cover these services if they are (1) medically necessary, (2) identified and ordered by a licensed physician, psychologist, or clinical social worker for an insured person who has been diagnosed with autism, and (3) based on a treatment plan.</p> <p>The act also requires coverage for evaluations and tests needed to diagnose your child's autism disorder.</p>	June 9, 2009	SB 301 (2009)
Florida	<p>The autism insurance reform law specifically covers treatment of autism through speech therapy, occupational therapy, physical therapy, and applied behavior analysis. Furthermore, coverage may not be denied on the basis that the services are habilitative in nature.</p>	May 2, 2008	SB 2654 (2008) http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?FileName=_s2654er.DOC&DocumentType=Bill&BillNumber=2654&Session=2008
Iowa	<p>The law includes coverage of the following treatments: Diagnosis, Habilitative or rehabilitative care, Pharmacy care, Psychiatric care, Psychological care, Therapeutic care, Applied Behavior Analysis (ABA)</p>	April 29, 2010	House File 2531 (2010) http://coolice.legis.state.ia.us/linc/HF2531_Enrolled.pdf (page 59)
Illinois	<p>The law requires coverage for diagnostic assessments, pharmacy care, psychiatric care, psychological care, and therapeutic care. These categories of mandated services are defined in the law. More specifically, the new act will cover evaluations and tests needed to diagnose your child's autism disorder, as well as the development of a plan to provide health care services for your child. This plan may include medically necessary prescribed treatments such as behavioral analysis and rehabilitative care, prescription drugs, psychiatric and psychological services, speech/language</p>		SB 934 (2008) http://www.autismvotes.org/atf/cf/%7B2A179B73-96E2-44C3-8816-1B1C0BE5334B%7D/IL%20PL%20095-1005.pdf

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States	Summary of Insurance Reform Laws Regarding Autism (Treatment)	Date Enacted	Citation
Illinois (cont'd)	therapy, occupational therapy and physical therapy. The law's definition of rehabilitative care specifically includes ABA.		SB 934 (2008) http://www.autismvotes.org/atf/cf/%7B2A179B73-96E2-44C3-8816-1B1C0BE5334B%7D/IL%20PL%20095-1005.pdf
Indiana	Broadly speaking, coverage is restricted to services prescribed by the individual's treating physician as laid out in a treatment plan. Generally, this coverage is limited to therapies that are commonly accepted by the medical community. These include types of behavior training, speech therapy, occupational therapy, physical therapy, and medications to address symptoms of ASD. ABA coverage is provided and cannot be limited to a certain number of calendar days per year and must be provided year-round.		Indiana Public Law 148 (2001) sec. 2, as amended by Indiana Public Law 173 (2007) sec. 32 http://www.autismvotes.org/atf/cf/%7B2A179B73-96E2-44C3-8816-1B1C0BE5334B%7D/Bulletin136_~1.pdf
Kansas	The bill includes coverage of the following treatments: Diagnosis, Habilitative or rehabilitative care, Pharmacy care, Psychiatric care, Psychological care, Therapeutic care, Applied Behavior Analysis (ABA)		Senate Substitute House Bill 2160 (2010)
Kentucky	Under this law, health insurance companies would be required to provide coverage of the following: Diagnosis of an autism spectrum disorder - meaning medically necessary assessments, evaluations, including neuropsychological evaluations, genetic testing, or other testing to determine whether an individual has one or more autism spectrum disorders; Habilitative or rehabilitative care - meaning professional counseling, guidance, services, and treatment programs, including applied behavior analysis (ABA) and other behavioral health treatments, that are necessary to develop, maintain, and restore to the maximum possible extent an individuals functioning; Pharmacy care; Psychiatric care; Psychological care; Therapeutic care - meaning services provided by licensed or certified speech language pathologists,	April 14, 2010	HB 159 (2010) http://www.lrc.ky.gov/record/10RS/HB159/bill.doc

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States	Summary of Insurance Reform Laws Regarding Autism (Treatment)	Date Enacted	Citation
Kentucky (cont'd)	occupational therapists, physical therapists, or social workers.	April 14, 2010	HB 159 (2010) http://www.lrc.ky.gov/record/10RS/HB159/bill.doc
Louisiana	The law requires that affected insurance companies cover treatment for autism spectrum disorders. It defines treatment for autism spectrum disorders as (1) habilitative or rehabilitative care, such as professional, counseling, and guidance services and treatment, including applied behavior analysis (“ABA”) ; (2) pharmacy care, defined as medications prescribed by a licensed physician; (3) psychiatric care, defined as direct or consultative services provided by a state-licensed psychiatrist; (4) psychological care, defined as direct or consultative services provided by a state-licensed psychologist; and (5) therapeutic care, defined as services provided by licensed or certified speech therapists, occupational therapists, or physical therapists.	July 2, 2008	HB 958 (2008) http://www.autismvotes.org/atf/cf/%7B2A179B73-96E2-44C3-8816-1B1C0BE5334B%7D/LA%20Act%20648.pdf
Maine	<p>§ 2766. Coverage for the diagnosis and treatment of autism spectrum disorders</p> <p>1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.</p> <p>A. "Applied behavior analysis" means 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 relations between environment and behavior.</p> <p>B. "Autism spectrum disorders" means any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.</p>	April 12, 2010	Chapter 635 S.P. 446 - L.D. 1198 http://www.mainelegislature.org/ros/LOM/LOM124th/124R2/PUBLIC635.asp

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States	Summary of Insurance Reform Laws Regarding Autism (Treatment)	Date Enacted	Citation
Maine (cont'd)	<p>C. "Treatment of autism spectrum disorders" includes the following types of care prescribed, provided or ordered for an individual diagnosed with an autism spectrum disorder:</p> <p>(1) Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;</p> <p>(2) Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and</p> <p>(3) Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist.</p> <p>2. Required coverage. All individual health insurance policies and contracts must provide coverage for autism spectrum disorders for an individual covered under a policy or contract who is 5 years of age or under in accordance with the following.</p>	April 12, 2010	<p>Chapter 635 S.P. 446 - L.D. 1198 http://www.mainelegislature.org/ros/LOM/LOM124th/124R2/PUBLIC635.asp</p>
Massachusetts	<p>Provides coverage for the diagnosis and treatment of Autism Spectrum Disorder, effective the first policy renewal after 01/01/2011.</p> <p>Private insurers, employees and retirees under the state plan, hospital service plans and HMOs would all be required to comply with law.</p> <p>Self-funded plans are regulated by ERISA – which is federal law - not subject to State laws and not required to provide coverage.</p> <p>No annual or lifetime limit which is less than coverage for physical conditions.</p> <p>The law covers the following care prescribed, provided, or ordered for an</p>	August 3, 2010	<p>House 4935 (2010, Chapter 207), http://www.malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter207</p>

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States	Summary of Insurance Reform Laws Regarding Autism (Treatment)	Date Enacted	Citation
Massachusetts (cont'd)	<p>individual diagnosed with one of the Autism Spectrum Disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary:</p> <p>Habilitative or Rehabilitative Care – this includes professional, counseling and guidance services and treatment programs, including but not limited to, applied behavior analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual.</p> <p>Pharmacy care -medications prescribed by a licensed physician and health-related services deemed medically necessary to determine the need or effectiveness of the medications, to the same extent that pharmacy care is provided by the insurance policy for other medical conditions.</p> <p>Psychiatric care - direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.</p> <p>Psychological care -direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.</p> <p>Therapeutic care - services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers.</p>	August 3, 2010	House 4935 (2010, Chapter 207), http://www.malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter207
Missouri	<p>This bill establishes provisions regarding health insurance coverage for individuals diagnosed with autism spectrum disorders (ASD).</p> <p>MANDATED INSURANCE COVERAGE Beginning January 1, 2011, all group health benefit plans delivered, issued, continued, or renewed that are written inside the state or written outside the state but insuring a Missouri resident must provide</p>	June 10, 2010	HB 1311 (2010) http://www.house.mo.gov/content.aspx?info=/bills101/bills/hb1311.htm

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States	Summary of Insurance Reform Laws Regarding Autism (Treatment)	Date Enacted	Citation
Missouri (cont'd)	<p>coverage for the diagnosis and treatment of ASD. A health carrier cannot deny or refuse to issue coverage on refuse to contract with, refuse to renew or reissue, or otherwise terminate or restrict coverage on an individual or his or her dependent because the individual is diagnosed with ASD.</p> <p>LIMITS ON COVERAGE A health carrier can limit coverage for ASD services to the medically necessary treatment ordered by the insured individual's licensed treating physician or psychologist in accordance with a treatment plan. An ASD treatment plan must include all elements necessary for a health benefit plan or carrier to pay the claim. Except for inpatient services, the carrier must have the right to review, at its expense, the treatment plan not more than once every six months unless the individual's treating physician or psychologist agrees that a more frequent review is necessary.</p> <p>BEHAVIOR ANALYST ADVISORY BOARD AND APPLIED BEHAVIOR ANALYSIS SERVICES</p> <p>The Behavior Analyst Advisory Board is established under the State Committee of Psychologists within the Department of Insurance, Financial Institutions and Professional Registration to establish licensure requirements for behavior analysts and assistant behavior analysts who provide applied behavior analysis (ABA) therapies to children with ASD. ABA services must be included in the coverage for ASD up to a maximum benefit of \$40,000 per year for an individual younger than 19 years of age. However, the maximum limit may be exceeded upon prior approval by the health benefit plan if additional services are medically necessary.</p>	June 10, 2010	HB 1311 (2010) http://www.house.mo.gov/content.aspx?info=/bills101/bills/hb1311.htm

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States	Summary of Insurance Reform Laws Regarding Autism (Treatment)	Date Enacted	Citation
Montana	<p>(3) (a) Coverage under this section must include:</p> <p>(i) habilitative or rehabilitative care that is prescribed, provided, or ordered by a licensed physician or licensed psychologist, including but not limited to professional, counseling, and guidance services and treatment programs that are medically necessary to develop and restore, to the maximum extent practicable, the functioning of the covered child;</p> <p>(ii) medications prescribed by a physician licensed under Title 37, chapter 3;</p> <p>(iii) psychiatric or psychological care; and</p> <p>(iv) therapeutic care that is provided by a speech-language pathologist, audiologist, occupational therapist, or physical therapist licensed in this state.</p> <p>(b) (i) Habilitative and rehabilitative care includes medically necessary interactive therapies derived from evidence-based research, including applied behavior analysis, which is also known as Lovaas therapy, discrete trial training, pivotal response training, intensive intervention programs, and early intensive behavioral intervention.</p> <p>(ii) Applied behavior analysis covered under this section must be provided by an individual who is licensed by the behavior analyst certification board or is certified by the department of public health and human services as a family support specialist with an autism endorsement.</p>	May 5, 2009	<p>SENATE BILL NO. 234 (2009)</p> <p>http://data.opi.mt.gov/bills/2009/billhtml/SB0234.htm</p>
Nevada	<p>AN ACT relating to insurance; requiring certain policies of health insurance and health care plans to provide an option of coverage for screening for and treatment of autism; authorizing the Board of Psychological Examiners to license behavior analysts and assistant behavior analysts and to certify autism behavior interventionists; increasing the size of the Board of psychological Examiners from</p>	May 29, 2009	<p>AB 169 (2009)</p> <p>http://www.leg.state.nv.us/Session/75th2009/Bills/AB/AB162_EN.pdf</p>

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States	Summary of Insurance Reform Laws Regarding Autism (Treatment)	Date Enacted	Citation
Nevada (cont'd)	five members to seven members; and providing other matters properly relating thereto.	May 29, 2009	AB 169 (2009) http://www.leg.state.nv.us/Session/75th2009/Bills/AB/AB162_EN.pdf
New Hampshire	(a) Professional 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. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by the national Behavior Analyst Certification Board or performed under the supervision of a person professionally certified by the national Behavior Analyst Certification Board.	July 23, 2010	House Bill 569 (2010) http://www.nhliberty.org/bills/view/2011/HB569
New Jersey	<p>The New Jersey Autism Coverage Act requires coverage for screening and diagnosing autism or another developmental disability, effective the first policy renewal after 02/09/2010. When the insured's primary diagnosis is autism or another developmental disability, the Act requires coverage for expenses incurred for medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan. When the insured is under 21 years of age and the insured's primary diagnosis is autism, the insurer shall provide coverage for expenses incurred for medically necessary behavioral programs, as prescribed through a treatment plan, subject to provisions of this subsection.</p> <p>ABA therapy is covered if the insured is under 21 years of age. In addition, according to Bulletin No: 10-02 provided by the New Jersey Department of Banking and Insurance, ABA must be 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 –</p>	August 13, 2009	New Jersey Public Law 2009, Chapter 115, http://www.njleg.state.nj.us/2008/Bills/PL09/115_PDF ; Implementation Letter - Bulletin 10-02, http://www.state.nj.us/dobi/bulletins/blt10_02.pdf

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States	Summary of Insurance Reform Laws Regarding Autism (Treatment)	Date Enacted	Citation
New Jersey (cont'd)	<p>Doctoral (BCBA-D) or a Board Certified Behavior Analyst (BCBA). The patient's physician determines whether treatment is medically necessary and prescribes the treatment plan. A treatment plan includes a diagnosis, treatment type, frequency and duration and the anticipated goals and outcomes. From the treatment plan, the health plan makes the determination of what services are medically necessary. Additionally, there is a utilization review process once every six months within the insurance company that may review the services ordered on the treatment plan.</p> <p>The law specifically requires that benefits will not be denied on the basis that the treatment is not restorative.</p> <p>Private insurers will use their own medical necessity criteria. The patient's physician or psychologist indicates on the treatment plan what services are medically necessary, however there is a utilization review process within the insurance company that may review the services ordered on the treatment plan.</p> <p>Families can appeal any denial or partial denial of an autism diagnostic or treatment service to your insurance company and obtain a decision on an expedited basis. If your appeal is denied by the insurance company, your family can appeal for an independent, external review. If the independent external review denies your appeal, you can further appeal to a court of competent jurisdiction.</p>	August 13, 2009	New Jersey Public Law 2009, Chapter 115, http://www.njleg.state.nj.us/2008/Bills/PL09/115_.PDF ; Implementation Letter - Bulletin 10-02, http://www.state.nj.us/dobi/bulletins/blt10_02.pdf
New Mexico	A. An individual or group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state shall provide coverage to an eligible individual who is nineteen years of age or younger, or an eligible individual who is twenty-two years of age or younger and is enrolled in high school, for: (1) well-baby and well-child screening for	April 2, 2009	SB 39 (2009) http://www.nmlegis.gov/lcs/session.aspx?chamber=S&legtype=B&legno=%20%2039&year=09

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States	Summary of Insurance Reform Laws Regarding Autism (Treatment)	Date Enacted	Citation
New Mexico (cont'd)	<p>diagnosing the presence of autism spectrum disorder; and</p> <p>(2) treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis.</p>	April 2, 2009	<p>SB 39 (2009) http://www.nmlegis.gov/lcs/session.aspx?chamber=S&legtype=B&legno=%20%2039&year=09</p>
Pennsylvania	<p>Coverage provided for: Children or young adults under age 21 with a diagnosis of an autism spectrum disorder who:</p> <ul style="list-style-type: none"> - Are covered under an employer group health insurance policy (including HMOs and PPOs) that has more than 50 employees and the policy is not a "self-insured" or "ERISA" policy; - Are on Medical Assistance; or - Are covered by Pennsylvania's Children's Health Insurance Program, CHIP, or adultBasic. <p>Coverage:</p> <ul style="list-style-type: none"> - Diagnostic assessment and treatment of autism spectrum disorders, which include: - Prescription drugs and blood level tests; - Services of a psychiatrist and/or psychologist (direct or consultation); - Applied behavioral analysis; and - Other rehabilitative care and therapies, such as speech and language pathologists, occupational and physical therapists. 	July 9, 2008	<p>House Bill 1150 (2007) http://www.legis.state.pa.us/CFDOCS/Legis/PN/Public/btCheck.cfm?txtType=HTM&sessYr=2007&sessInd=0&billBody=H&billType=B&billNumber=1150&pn=4133</p>
South Carolina	<p>"Section 38-71-280. (A) As used in this section:</p> <p>(1) 'Autism spectrum disorder' means one of the three following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:</p> <p>(a) Autistic Disorder; (b) Asperger's Syndrome; (c) Pervasive Developmental Disorder - Not Otherwise Specified.</p> <p>(B) A health insurance plan as defined in this section must provide coverage for the treatment of autism spectrum disorder. Coverage provided under this section is limited to treatment that is prescribed by the insured's treating</p>	June 7, 2007	<p>South Carolina Code of Laws: Title 38, Chapter 71, Section 280 http://www.scstatehouse.gov/sess117_2007-2008/prever/20_20070523.htm</p>

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States	Summary of Insurance Reform Laws Regarding Autism (Treatment)	Date Enacted	Citation
<p>South Carolina (cont'd)</p>	<p>medical doctor in accordance with a treatment plan. With regards to a health insurance plan as defined in this section an insurer may not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew or refuse to reissue or otherwise terminate or restrict coverage on an individual solely because the individual is diagnosed with autism spectrum disorder.</p> <p>(D) The treatment plan required pursuant to subsection (B) must include all elements necessary for the health insurance plan to appropriately pay claims. These elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency, and duration of treatment, the anticipated outcomes stated as goals, the frequency by which the treatment plan will be updated, and the treating medical doctor's signature. The health insurance plan may only request an updated treatment plan once every six months from the treating medical doctor to review medical necessity, unless the health insurance plan and the treating medical doctor agree that a more frequent review is necessary due to emerging clinical circumstances.</p> <p>(E) To be eligible for benefits and coverage under this section, an individual must be diagnosed with autistic spectrum disorder at age eight or younger. The benefits and coverage provided pursuant to this section must be provided to any eligible person under sixteen years of age. Coverage for behavioral therapy is subject to a fifty thousand dollar maximum benefit per year. Beginning one year after the effective date of this act, this maximum benefit shall be adjusted annually on January 1 of each calendar year to reflect any change from the previous year in the current Consumer Price Index, All Urban Consumers, as</p>	<p>June 7, 2007</p>	<p>South Carolina Code of Laws: Title 38, Chapter 71, Section 280 http://www.scstatehouse.gov/sess117_2007-2008/prever/20_20070523.htm</p>

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States	Summary of Insurance Reform Laws Regarding Autism (Treatment)	Date Enacted	Citation
South Carolina (cont'd)	published by the United States Department of Labor's Bureau of Labor Statistics."	June 7, 2007	South Carolina Code of Laws: Title 38, Chapter 71, Section 280 http://www.scstatehouse.gov/sess117_2007-2008/prever/20_20070523.htm
Texas	<p>HB 1919 adds new Insurance Code §1355.015, which requires in subsection (a) that group health benefit plans that provide benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness provide, at a minimum, coverage to enrollees older than two years of age and younger than six years of age who are diagnosed with autism spectrum disorder. Section 1355.015(b) requires the health benefit plan to provide coverage for all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in the treatment plan recommended by that physician. Under §1355.015(b), the prescribed treatment must be provided by an appropriately licensed, certified, or registered health care practitioner. Section 1355.015(c) states that generally recognized services may include: (1) evaluation and assessment services; (2) applied behavior analysis; (3) behavior training and behavior management; (4) speech therapy; (5) occupational therapy; (6) physical therapy; or (7) medications or nutritional supplements used to address symptoms of autism spectrum disorder. Under §1355.015(d), the mandated coverage may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan.</p>	June 15, 2007	HB 1919 http://www.tdi.state.tx.us/bulletins/2007/cc51.html
Vermont	<p>§ 4088i. COVERAGE FOR DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDERS (a) A health insurance plan shall provide</p>	May 27, 2010	S. 262 (2009-2010) http://www.leg.state.vt.us/docs/2010/Acts/ACT127.PDF

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States	Summary of Insurance Reform Laws Regarding Autism (Treatment)	Date Enacted	Citation
<p>Vermont (cont'd)</p>	<p>coverage for the diagnosis and treatment of autism spectrum disorders, including applied behavior analysis supervised by a nationally board-certified behavior analyst, for children, beginning at 18 months of age and continuing until the child reaches age six or enters the first grade, whichever occurs first.</p> <p>(d) As used in this section:</p> <p>(1) “Applied behavior analysis” means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior. The term includes the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.</p> <p>(2) “Autism services provider” means any licensed or certified person providing treatment of autism spectrum disorders.</p> <p>(3) “Autism spectrum disorders” means one or more pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder and Asperger’s disorder.</p> <p>(4) “Diagnosis of autism spectrum disorder” means medically necessary assessments; evaluations, including neuropsychological evaluations; genetic testing; or other testing to determine whether an individual has one or more autism spectrum disorders.</p> <p>(5) “Habilitative care” or “rehabilitative care” means professional counseling, guidance, services, and treatment programs, including applied behavior analysis and other behavioral health treatments, in which the covered individual makes clear, measurable progress, as determined by an autism services provider, toward attaining goals</p>	<p>May 27, 2010</p>	<p>S. 262 (2009-2010) http://www.leg.state.vt.us/docs/2010/Acts/ACT127.PDF</p>

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States	Summary of Insurance Reform Laws Regarding Autism (Treatment)	Date Enacted	Citation
<p>Vermont (cont'd)</p>	<p>the provider has identified.</p> <p>(6) “Health insurance plan” means Medicaid, the Vermont health access plan, and any other public health care assistance program, any individual or group health insurance policy, any hospital or medical service corporation or health maintenance organization subscriber contract, or any other health benefit plan offered, issued, or renewed for any person in this state by a health insurer, as defined in 18 V.S.A. § 9402. The term does not include benefit plans providing coverage for specific diseases or other limited benefit coverage.</p> <p>(7) “Medically necessary” means any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a physician licensed pursuant to chapter 23 of Title 26 or by a psychologist licensed pursuant to chapter 55 of Title 26 if such treatment is consistent with the most recent relevant report or recommendations of the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, or another professional group of similar standing.</p> <p>(8) “Therapeutic care” means services provided by licensed or certified speech language pathologists, occupational therapists, physical therapists, or social workers.</p> <p>(9) “Treatment of autism spectrum disorders” means the following care prescribed, provided, or ordered for an individual diagnosed with one or more autism spectrum disorders by a physician licensed pursuant to chapter 23 of Title 26 or a psychologist licensed pursuant to chapter 55 of Title 26 if such physician or psychologist determines the care to be medically necessary:</p> <p>(A) habilitative or rehabilitative care;</p> <p>(B) pharmacy care;</p> <p>(C) psychiatric care;</p>	<p>May 27, 2010</p>	<p>S. 262 (2009-2010) http://www.leg.state.vt.us/docs/2010/Acts/ACT127.PDF</p>

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States	Summary of Insurance Reform Laws Regarding Autism (Treatment)	Date Enacted	Citation
Vermont (cont'd)	(D) psychological care; and (E) therapeutic care. (e) Nothing in this section shall be construed to affect any obligation to provide services to an individual under an individualized family service plan, individualized education program, or individualized service plan.	May 27, 2010	S. 262 (2009-2010) http://www.leg.state.vt.us/docs/2010/Acts/ACT127.PDF
Virginia	Health insurance; mandated coverage for autism spectrum disorder. Requires health insurers, health care subscription plans, and health maintenance organizations to provide coverage for the diagnosis of autism spectrum disorder (ASD) and treatment for ASD in individuals from age two to six, subject to an annual maximum benefit of \$35,000 of coverage for applied behavior analysis. Treatment for ASD includes applied behavior analysis when provided or supervised by a board certified behavior analyst, who shall be licensed by the Board of Medicine, and the prescribing practitioner is independent of the provider of the applied behavior analysis. The mandate to provide coverage will not apply to individual or small group policies, contracts, or plans. The mandate will apply to the state employees' health insurance plan and to the local choice health program. This measure will not apply to an insurer, corporation, or health maintenance organization, or to government employee programs, if the costs associated with coverage exceed one percent of premiums charged over the experience period.	May 6, 2011	SB 1062 (2011) http://leg1.state.va.us/cgi-bin/legp504.exe?111+sum+SB1062
West Virginia	(8)(A) Any plan issued or renewed after January 1, 2012, shall include coverage for diagnosis and treatment of autism spectrum disorder in individuals ages eighteen months through eighteen years. To be eligible for coverage and benefits under this subdivision, the individual must be diagnosed with autism spectrum disorder at	April 1, 2011	House Bill 2693 (2011) http://www.legis.state.wv.us/bill_status/bills_history.cfm?year=2011&sessiontype=RS&i=2693

Exhibit C

States	Summary of Insurance Reform Laws Regarding Autism (Treatment)	Date Enacted	Citation
West Virginia (cont'd)	<p>age 8 or younger. Such policy shall provide coverage for treatments that are medically necessary and ordered or prescribed by a licensed physician or licensed psychologist for an individual diagnosed with autism spectrum disorder, in accordance with a treatment plan developed by a certified behavior analyst pursuant to a comprehensive evaluation or reevaluation of the individual, subject to review by the agency every six months. Progress reports are required to be filed with the agency semi-annually. In order for treatment to continue, the agency must receive objective evidence or a clinically supportable statement of expectation that:</p> <p>(1) The individual’s condition is improving in response to treatment, and</p> <p>(2) A maximum improvement is yet to be attained, and</p> <p>(3) There is an expectation that the anticipated improvement is attainable in a reasonable and generally predictable period of time.</p> <p>(B) Such coverage shall include, but not be limited to, applied behavioral analysis provided or supervised by a certified behavior analyst:</p> <p>(D) For purposes of this subdivision, the term:</p> <p>(i) “Applied Behavior Analysis” means 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.</p> <p>(ii) “Autism spectrum disorder” means any pervasive developmental disorder, including autistic disorder, Asperger’s</p>	April 1, 2011	House Bill 2693 (2011) http://www.legis.state.wv.us/bill_status/bills_history.cfm?year=2011&sessiontype=RS&i=2693

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States	Summary of Insurance Reform Laws Regarding Autism (Treatment)	Date Enacted	Citation
West Virginia (cont'd)	<p>Syndrome, Rett syndrome, childhood disintegrative disorder, or Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.</p> <p>(iii) “Certified behavior analyst” means an individual who is certified by the Behavior Analyst Certification Board or certified by a similar nationally recognized organization.</p> <p>(iv) “Objective evidence” means standardized patient assessment instruments, outcome measurements tools or measurable assessments of functional outcome. Use of objective measures at the beginning of treatment, during and/or after treatment is recommended to quantify progress and support justifications for continued treatment. Such tools are not required, but their use will enhance the justification for continued treatment.</p>	April 1, 2011	House Bill 2693 (2011) http://www.legis.state.wv.us/bill_status/bills_history.cfm?year=2011&sessiontype=RS&i=2693
Wisconsin	<p>632.895 (12m) TREATMENT FOR AUTISM SPECTRUM DISORDERS. (a) In this subsection:</p> <p>1. “Autism spectrum disorder” means any of the following:</p> <ul style="list-style-type: none"> a. Autism disorder. b. Asperger’s syndrome. c. Pervasive developmental disorder not otherwise specified. <p>2. “Insured” includes an enrollee and a dependent with coverage under the disability insurance policy or self-insured health plan.</p> <p>3. “Intensive-level services” means evidence-based behavioral therapy that is designed to help an individual with autism spectrum disorder overcome the cognitive, social, and behavioral deficits associated with that disorder.</p> <p>4. “Nonintensive-level services” means evidence-based therapy that occurs after</p>	October 19, 2009	2009 Wisconsin Act 28 Assembly Bill 75 http://legis.wisconsin.gov/2009/data/acts/09Act28.pdf

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States	Summary of Insurance Reform Laws Regarding Autism (Treatment)	Date Enacted	Citation
Wisconsin (cont'd)	<p>the completion of treatment with intensive-level services and that is designed to sustain and maximize gains made during treatment with intensive-level services or, for an individual who has not and will not receive intensive-level services, evidence-based therapy that will improve the individual's condition.</p> <p>5. "Physician" has the meaning given in s. 146.34 (1)(g).</p> <p>(b) Subject to pars. (c) and (d), and except as provided in par. (e), every disability insurance policy, and every self-insured health plan of the state or a county, city, town, village, or school district, shall provide coverage for an insured of treatment for the mental health condition of autism spectrum disorder if the treatment is prescribed by a physician and provided by any of the following who are qualified to provide intensive-level services or nonintensive-level services:</p> <ol style="list-style-type: none"> 1. A psychiatrist, as defined in s. 146.34 (1) (h). 2. A person who practices psychology, as described in s. 455.01 (5). 3. A social worker, as defined in s. 252.15 (1) (er), who is certified or licensed to practice psychotherapy, as defined in s. 457.01 (8m). 4. A paraprofessional working under the supervision of a provider listed under subds. 1. to 3. 5. A professional working under the supervision of an outpatient mental health clinic certified under s.51.038. 6. A speech-language pathologist, as defined in s.459.20 (4). 7. An occupational therapist, as defined in s. 448.96 (4). 	October 19, 2009	2009 Wisconsin Act 28 Assembly Bill 75 http://legis.wisconsin.gov/2009/data/acts/09Act28.pdf

Exhibit D:

**Letters from the California Association of Behavior Analysis
and Peter Himber, M.D., Chief Medical Officer at the Regional
Center of Orange County**



California Association for Behavior Analysis

630 Quintana Rd. #118 • Morro Bay, CA 93442 • Phone 877-843-0510 • Fax 888-518-7586 • calaba.org

July 1, 2011

Dear Senate Select Committee on Autism,

My name is Dr. Daniel Shabani and I hold a doctoral degree in Behavior Analysis and am a Board Certified Behavior Analyst, Doctoral Level (Certificate #1-01-0664). I completed my graduate training at the University of the Pacific and Western Michigan University and my internship at the Marcus Institute in Atlanta, Georgia.

Currently, I am the Executive Director of the Shabani Institute, Assistant Professor in the Department of Psychology at California State University, Los Angeles (CSULA), and President-Elect of the California Association for Behavior Analysis (CalABA).

The Shabani Institute is a provider of Applied Behavior Analytic assessment and treatment services. We are dedicated to providing effective, empirically validated educational and behavioral services to individuals diagnosed with autism and related developmental disabilities and their families. Although I am a provider of behavioral services, I am part of a larger professional community represented by my affiliation with CSULA, the BACB® (described below) and CalABA.

As Assistant Professor in the Department of Psychology at CSULA, I teach and conduct research in the area of Psychology and Behavior Analysis. Our graduate training program in Psychology, Applied Behavior Analysis (ABA) option, includes both basic and applied courses in Behavior Analysis and is approved by the Behavior Analyst Certification Board (BACB®). **The BACB® is the professional credentialing organization for Behavior Analysts and is recognized in more than 80% of the states that have insurance laws which mandate health coverage for autism.**

CalABA is the state association for professional Behavior Analysts in California. It is the largest state affiliate of the Association for Behavior Analysis International (ABAI). CalABA also works collaboratively with the Association of Professional Behavior Analysts (APBA) to provide support and resources for practitioners and credentialed behavior analysts. Its membership is comprised primarily of professionals; approximately 70% hold masters or doctoral degrees and are credentialed by the BACB®.

The mission of CalABA is to promote the science and theory of Behavior Analysis through the support of research, education, and practice. In order to fulfill this mission, CalABA commits to 1) supporting a certification process for Behavior Analysts and Assistant Behavior Analysts, 2) advocating for Behavior Analysis services and the profession, 3) promoting quality assurance in Behavior Analysis, 4) providing resources and information related to behavior analysis, and 5) advancing Behavior Analysis via professional development activities.

Applied Behavior Analysis is well documented in more than 500 studies¹ and multiple task force reports² as the most effective and well-established treatment and intervention for individuals with autism spectrum disorders and other developmental disabilities. Both national and state level task forces have focused specifically on ABA's effectiveness as a treatment for autism. Their findings reflect

¹ Cohen, H., Amerine-Dickens, M., & Smith, T. (2006); Howard, J. S., Sparkman, C. R., Cohen, H. G., Green, G., & Stanislaw, H. (2005); Sallows, G. & Graupner, T. D. (2005).

² U. S. Department of Health and Human Services (1999), Mental health: A report of the surgeon general; American Academy of Pediatrics (2007); National Autism Center (2009), National Standards Report; Centers for Medicare and Medicaid for the U.S. Dept. of Health and Human Services (2010)



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the peer-reviewed literature: *Intervention and treatments based on ABA have the strongest evidence of effectiveness and ability to consistently produce meaningful benefits to children diagnosed with autism spectrum disorders.*

Several studies have also demonstrated the cost saving³ effects of ABA. In a 2007 study by Chasson, Harris, and Neely, costs associated with intensive ABA were compared with special education costs in the state of Texas. Results indicated that Texas would save \$208,500 per child across eighteen years of intensive ABA. Based on approximately 10,000 children with autism in Texas, a total savings of \$2.09 billion was estimated.

In 1998, Jacobson, Mulick, and Green estimated that individuals diagnosed with autism or other pervasive developmental disorders require specialized services costing approximately \$4 million per person. With the implementation of intensive ABA, savings of between \$1 million to over \$2 million per individual were estimated across their life span.

In 2006, researchers in Ontario, Canada completed a study to determine the cost-effectiveness of expanding intensive ABA treatment to all children diagnosed with autism (Motiwala, Gupta, Lilly, Ungar, and Coyte, 2006). Results indicated “total savings from expansion of the current program were \$45,133,011 in 2003 Canadian dollars” (p. 136). In addition, the authors stated that “expansion of IBI (intensive behavioral intervention) to all eligible children represents a cost-savings policy whereby total costs for care of autistic individuals are lower and gains in dependency-free life years are higher” (p. 136).

The implementation of ABA therapy includes some general practices that are important to review.

First, ABA therapy is supervised by certified providers in addition to by licensed medical professionals who are board certified. Although some licensed medical professionals may have ABA in their scope of practice, this is not the focus of their training in medical school. To illustrate, most people *without* any medical training know how to treat common colds or headaches. This knowledge, however, does *not* make them a medical doctor. Similarly, some individuals understand and may have taken a course or two in Behavior Analysis or the principles of reinforcement. However, this does *not* give them the ability to develop and implement an ABA treatment plan for individuals with autism.

The qualifications of those designing the ABA therapy plan (e.g., conducting behavioral assessments, developing treatment plans, providing consultation, parent education/training, and/or ongoing monitoring and supervision) should be, [Preferred] Board Certified Behavior Analysts (BCBA) or be enrolled in formal academic and supervision program leading to BCBA. If not a BCBA, then 1) Master’s degree in a related field, 15 units of graduate level coursework in behavior analysis or 2) licensed or certified in related field with behavior analysis in its scope of practice. In addition, the individual should have 3–5 years of experience delivering and supervising treatment programs for children with autism.

The qualifications of those providing the direct services should include, [Preferred] Bachelor’s degree in psychology, Board Certified Assistant Behavior Analyst (BCaBA), or a related field with relevant experience. If no Bachelor’s degree, then the individual should have a high school diploma with competency-based training, and in all cases, regular on-site supervision and a background check. Second, the implementation of treatment by unlicensed professionals in the field of ABA is similar in practice to other fields. In the fields of occupational and physical therapy, certified paraprofessionals are

³ Chasson, G. S., Harris, G. E., & Neely, W. J. (2007); Jacobson J. W., Mulick J. A., Green G. (1998); Motiwala, S. S., Gupta, S., Lilly, M. B., Ungar, W. J., & Coyte, P. C. (2006).



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often the ones responsible for implementing treatment. In the field of ABA, effective implementation of ABA therapy by paraprofessionals⁴ has been demonstrated to be an effective model of intervention.

Therefore, in the area of ABA therapy for autism, appropriately certified or qualified professionals (as described above) oversee therapy provided by an unlicensed person (as described above). This is the model that ABA therapy for autism has been operating under for many years and has proven to be effective for improving the lives of individual's diagnosed with autism and their families.

One argument that has been made against the use of ABA therapy is that it is experimental or investigational. A common criticism has been that ABA has not been evaluated using between group designs. Given that between group designs are the “gold-standard” in the area of psychology, this criticism is not surprising. However, it is misleading.

First, as mentioned above, ABA therapy has been shown to be effective for individuals with autism in over 500 studies and has been documented as the treatment of choice for autism spectrum disorders by the U. S. Department of Health and Human Services (1999) and the American Academy of Pediatrics (2007).

Second, **there are currently seven controlled between group studies of the Lovaas/UCLA model of ABA therapy for autism and four controlled between-group studies of ABA therapy.** In most of these studies, treatment groups received ABA therapy under the supervision of qualified behavior analysts and the comparison groups received “eclectic” treatment. Results of these studies indicated that treatment models based on ABA therapy resulted in larger gains relative to the gains made by individuals receiving other treatments. In addition, **a recent meta-analysis⁵ reviewed 34 studies, 9 of which were controlled designs that had either a comparison or control group, evaluating the effectiveness of early intensive behavioral intervention. Results indicated that, “at present, and in the absence of other interventions with established efficacy, Early Intensive Behavioral Intervention should be an intervention of choice for children with autism” (p. 439).**

Third, although group designs are the “gold-standard” in terms of treatment evaluation, there is more than one way to determine the effectiveness of a therapy. Group designs have their own limitations and single-case designs (the methodology most commonly used in Behavior Analysis) offer a valuable alternative. Single-case designs are well suited to study treatment effectiveness and behavior change. In addition, single-case research designs have been identified to be an acceptable vehicle for identifying evidence based practice guidelines.

A second argument that has been made against the use of ABA therapy is that it is educational and not a medically necessary intervention. In the sense that ABA is used in schools, it is educational. In other words, many teachers commonly use reward systems to promote positive behaviors in the classroom. However, simply because ABA is used in schools does not make it educational. Other interventions commonly done in schools, such as speech, occupational, and physical therapy, are deemed medically necessary. Just because something is done in schools, does *not* mean it is *not* medically necessary. **ABA therapy has been proven effective for reducing the core symptoms of autism and reducing problems that directly jeopardize health and safety. This goes well beyond educational interventions. ABA therapy is medically necessary because it builds skills, improves overall health**

⁴ Sheinkopf & Siegel, 1998.

⁵ Eldevik, S., Hastings, R. P., Hughes, J. C., Jahr, E., Eikeseth, S. & Cross, S. (2009). Meta-Analysis of Early Intensive Behavioral Intervention for Children With Autism.



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and safety, and prevents deterioration. The educational system is not required by law to remediate the core symptoms of any condition. Their job is to address education and what is written in a student's individual education plan. The educational system does not have to address all the areas of functioning that are affected by autism. Schools do not provide the type of comprehensive, evidence-based treatment that is meaningful for individuals with autism and special education teachers often times do not have the specialized training to implement ABA therapy. Finally, schools are responsible for their students Monday to Friday from about 8am to 3pm. Autism does not end on Fridays, nor does it cease to exist after 3pm.

In conclusion, Autism is a pervasive developmental disorder that affects a variety of areas, including the development of language and communication, self-help, and social interaction skills. Therefore, **individuals diagnosed with autism have greater health care needs than people without autism.** However treatments are difficult to access, inadequate, or delayed. In some cases, parents have to pay out of pocket. Mandated insurance coverage will make treatment available to those who need it. In addition, as mentioned previously, the cost of covering ABA treatment is small and will result in greater savings over the long haul.

In addition, it is important to emphasize that **ABA is *not* long-term caretaking; it is, however, an effective approach to treatment that has been demonstrated to remediate the core symptoms of autism and related developmental disabilities to a greater extent than any other intervention.** Therefore, ABA therapy is a medically necessary treatment for autism and should be covered by health plans in the same way that other mental disorders are (mental health parity). Health plans should pay for evidence-based treatment and ABA therapy is clearly the treatment that has been shown to be effective in ameliorating the symptoms of autism.

Thank You,

A handwritten signature in black ink that reads "D. Shabani".

Daniel Shabani, Ph.D., BCBA-D
bshaban@calstatale.edu
310-467-8077

Exhibit D

July 1, 2011

Senator Darrell Steinberg
President Pro Tempore
Senate Select Committee on Autism
State Capitol, room 205
Sacramento, CA 95814

Dear Senator Steinberg:

I am a Board Certified Adult and Child Neurologist and the Chief Medical Officer at the Regional Center of Orange County (RCOC). Much of my professional career has focused on the evaluation and treatment of individuals with developmental disabilities including autism. Applied Behavioral Analysis (ABA) is considered the standard of care for treatment of children with autism and its use is well supported by the peer reviewed medical literature. Below I will detail my professional training and credentials, and the role of ABA in the treatment of autism.

I completed my medical training in pediatrics, neurology and pediatric neurology at the University of California, Irvine (UCI). Please see my attached curriculum vitae for additional details on my background and training. I went on to join the clinical faculty at UCI, then later the faculty of Penn State Hershey, Medical Center. Since 2000 I have worked at the Regional Center of Orange County first as a staff physician, then later as the Medical Director and most recently as the Chief Medical Officer. I am an assistant clinical professor at UCI. I have personally evaluated well over 1000 children with autism and reviewed the records of thousands more in my role at the Regional Center. I am an expert consultant for health plans, families and government agencies and serve as an independent reviewer for insurance plan denials, frequently for issues surrounding the treatment of autism.

To put my opinions into context, I will provide the following background information on autism and its effective treatment.

Understanding Autism Spectrum Disorder

Autism Spectrum Disorders (ASDs) are brain based, neurologic disorders which have a wide spectrum of symptoms and behaviors. There are three core deficits:

- Qualitative impairment in social interactions
- Qualitative impairment in verbal and nonverbal communication skills
- Restrictive, repetitive and stereotypic patterns of behavior, interests or activities
 - Abnormal response to sensations such as sound, smell, etc.
 - Difficulty processing sensation
 - Need for sameness

When I explain autism to parents of a child with newly diagnosed autism that are unfamiliar with the disorder, the best way I can summarize the child's challenges is that, "Your son doesn't understand the rules of life." I go on to share that, "Its not that your son is ignoring the rules and intentionally being disobedient, but rather he doesn't understand the rules." Parent's can appreciate this and are relieved that their child is not being "bad." Many, if not the large majority of parents I meet who have a child just diagnosed with autism believe that their child's autism is somehow their fault. They are relieved to learn this is not the case and that parenting a child with autism is not something they should automatically know how to do. All parents need

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guidance to help their child with autism. Often at the top of their list of concerns are behavioral issues.

The severity of ASDs vary along a continuum, with some individuals having more profound problems in one key diagnostic area than others, and is associated with the full range of cognitive abilities. There are children with autism who are intellectually disabled while others have IQs in the genius range. As is true of many other biomedical disorders, there is currently no cure for autism. Rather, autism care is focused on addressing the symptoms and associated impairments. In this way it does not differ from numerous other chronic medical disorders whose treatment is covered routinely by health insurance, including hypertension, diabetes, renal failure, and asthma. The appropriate interventions by qualified personnel can result in a dramatic improvement and sometimes resolution of the atypical behaviors.

There is evidence in the medical literature that a number of diverse treatments can lead to improved functioning in autism even though they do not lead to a “cure” per se. As is true of many other medical conditions, these treatments include non-pharmacologic approaches. For instance, exercise, general diet and avoidance of environmental factors such as salt and concentrated sugars are considered to be key elements of the management of hypertension and diabetes. Very often these treatments lead to markedly improved function, even though the core disorder remains.

Because ASDs are chronic, disabling disorders, by definition *all* children who meet the diagnostic criteria for ASDs have important health and related needs. Recent evidence from multiple epidemiologic studies points to a population prevalence of ASDs of about 1 per 150 children. In addition, some evidence suggests that the population prevalence has been rising in recent decades, but differences in study methods, diagnostic criteria for ASD, and increased attention to ASDs cannot be ruled out as accounting for some, if not most of the apparent increase.

Description of ABA Therapy

Applied behavior analysis (ABA) is a discipline concerned with the application of behavioral science in real-world settings such as clinics or schools with the aim of addressing socially important issues such as behavior problems and learning. Procedures derived from the discipline of ABA have been implemented to assess and treat a broad range of behaviors with individuals diagnosed with intellectual and developmental disabilities. The field of ABA is extremely broad and includes a range of techniques, methods, and procedures that have been shown to be effective for many different types of problems. Features common to all ABA-based approaches are the objective measurement of behavior, precise control of the environment, and use of procedures based on scientifically established principles of behavior. Any clinical procedure or research investigation adhering to these basic criteria can be considered to be an ABA-based procedure. This includes “functional behavioral assessment,” and approaches such as “Positive Behavioral Support,” and forms of “Behavior Therapy” that rely on direct observation of behavior and analysis of behavior-environment relations.

Programs using operant conditioning techniques to help autistic individuals develop skills with social value are referred to as ABA (Applied Behavior Analysis). Behavior analysis is a scientific approach to understanding behavior and how the environment affects it. The science of behavior analysis focuses on general principles (such as positive reinforcement) regarding the way that behavior works or learning takes place. ABA is the use of those techniques and principles intended to address socially important problems and bring about clinically significant behavior change.

Scientific evidence that ABA therapy is an effective treatment for autism

Over the past 40 years a large body of literature has shown the successful use of ABA-based procedures to reduce problem behavior and increase appropriate skills for individuals with intellectual disabilities (ID), autism, and related disorders. Several review articles and meta-analyses have been published summarizing this large body of literature. Six of these articles (DeMyer, Hingtgen, & Jackson, 1981; Herbert, Sharp, & Gaudiano, 2002; Hingtgen & Bryson, 1972; Kahng, Iwata, & Lewin, 2002; Matson, Benavidiz, Compton, Paclawskyj, & Baglio, 1996; Sturmey, 2002) collectively reviewed thousands of published studies spanning the years 1946 to 2001. Each of these reviews supported efficacy of ABA-based procedures in the assessment and treatment of problem behavior associated with autism, mental retardation, and related disorders. Similarly, three meta-analyses (Didden, Duker, & Korzilius, 1997; Lundervold & Bourland, 1988; Weisz, Weiss, Han, Granger, & Morton, 1995) that collectively analyzed hundreds of studies published between 1968 and 1994 concluded that treatments based on operant principles of learning were more effective for reducing problem behavior displayed by individuals with ID as well as typically-developing individuals than were alternative treatments.

The large body of literature reviewed in these studies provides empirical evidence indicating that procedures developed using ABA-based principles are effective at assessing and treating a variety of socially important behaviors engaged in by individuals with a variety of diagnoses. Furthermore, ABA-based approaches for educating children with autism and related disorders have been extensively researched and empirically supported (e.g., Howard, Sparkman, Choen, Green, & Stanislaw, 2005; Koegel, Koegel, & Harrower, 1999; Krantz & McClannahan, 1998; Lovaas, 1987; McGee, Morrier, & Daly, 1999; Strain & Kohler, 1998).

Based on the empirical evidence, many scientific, government, and professional agencies and organizations have concluded that ABA-based procedures represent best practices for individuals with autism and mental retardation. For example, the **American Association on Intellectual and Developmental Disabilities** (formerly the American Association on Mental Retardation), the oldest and largest interdisciplinary organization of professionals concerned with mental retardation and related disabilities, designated ABA-based procedures for the treatment of behavioral problems with individuals with mental retardation and related disorders as “highly recommended” (their highest rating). Based on the scientific evidence supporting the efficacy of ABA-based procedures for treating problems associated with mental retardation and autism, various scientific organizations have concluded that ABA-based procedures are highly effective, including:

- National Institute of Mental Health
- The National Academies Press
- Association for Science in Autism Treatment
- Autism Speaks
- Organization For Autism Research
- Surgeon General of the United States
- New York State Department of Health
- Maine Administrators of Services for Children with Disabilities

Several academic and trade journals that represent specific medical disciplines have published articles indicating that treatments for autism and mental retardation derived from ABA-based

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procedures are empirically supported treatments. For example, the goal of the journal **Current Opinion in Psychiatry**, is to assist clinicians and researchers in keeping up-to-date with the large amount of information published in psychiatry. An article reviewing literature on the assessment and treatment of individuals with mental retardations and psychiatric disorders concluded that: “Interventions based on applied behavior analysis have the strongest empirical basis, although there is some evidence that other therapies have promise.” (Sturmey, 2002). Also, in **Pediatrics**, the official journal of the

American Academy of Pediatrics, an article offering guidelines on scientifically supported treatments for childhood psychiatric disorders concluded: “The most efficacious psychosocial treatment for autism is applied behavior analysis...” (Lilienfeld, 2005). Discipline-specific journals that have published articles indicating that ABA-based procedures are empirically supported include:

Current Opinion in Psychiatry (Grey & Hastings, 2005; Sturmey, 2002)

Pediatrics (Lilienfeld, 2005)

Psychiatric Times (Erickson, Swiezy, Stigler, McDougle, & Posey, 2005)

Scientific Review of Mental Health Practice (Herbert, Sharp, & Gaudiano, 2002)

Furthermore, in 1993 Division 12 of the American Psychological Association developed guidelines for what defined an Empirically Supported Treatment (EST). Regarding ESTs based on single-case design research these guidelines state: “A large series of single-case design experiments must demonstrate efficacy with, (a) use of good experimental design and (b) comparison of intervention to another treatment.” (Chambless & Ollendick, 2001). Based on these criteria, ABA-based behavioral treatments have been defined as ESTs for individuals with developmental disabilities (Chambless, et al, 1996).

Additionally, substantial evidence in the scientific and medical literature documents that early detection and intervention are critical to the ultimate functioning level of people with ASDs, underscoring the importance of providing care for children under age 21. There is broad consensus across the medical and other fields that provide care to children with ASDs (e.g., pediatrics, psychiatry, neurology and the allied fields of psychology, speech therapy, occupational therapy and physical therapy) that the best and most efficacious treatment of autism requires early recognition, diagnosis and early intensive treatment while the brain has the maximum potential to recover and/or compensate for the underlying pathophysiologic processes. Intensive remediation through repeated appropriate behaviors in affected brain processes (communication, social responsiveness, sensory processing), which is analogous to physical therapy for victims of stroke or nerve damage, is very widely accepted as a critical element in the treatment of autism. The submitted evidence supporting this point is too numerous to list in their entirety but include the National Institute of Child Health and Human Development Autism Overview:

“Research shows that early diagnosis and interventions delivered early in life, such as in the preschool period, are more likely to result in major positive effects on later skills and symptoms. . . . Because a young child’s brain is still forming, early intervention gives children the best start possible and best chance of developing their full potential. Even so . . . it’s never too late to benefit from treatment. People of all ages with ASDs at all levels of ability generally respond positively to well designed interventions.”

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Evidence submitted by multiple insurers clarified that they routinely exclude coverage of some treatments for autism, particularly those that involve behavioral treatments such as speech therapy and Applied Behavioral Analysis (ABA). The reason for excluding speech therapy or limiting the number of sessions seems to be that they do not believe that such therapies have a “reasonable expectation of achieving sustainable, measurable improvement in a reasonable and predictable period of time.” The weight of the available evidence does not support this conclusion. The effectiveness of behavioral treatments for autism has been examined in hundreds of scientific studies, and is considered the most effective medical treatment for autism. Each one of the core symptoms of autism, those caused by the biology of autism, is effectively treated using ABA.

Regional Center’s Obligations/Duties Regarding Treatment for Children with Autism

The Regional Center of Orange County is one of 21 non-profit agencies contracted with the State of California for the provision of services to infants and children under three years of age with, or at high risk for, a developmental disability (“Early Start”) as well as children over the age of three and adults with substantially disabling developmental disabilities (“Lanterman services”). We serve children with autism in both programs. We have six Board Certified Behavior Analysts (BCBAs) on staff which attests to the importance of behavioral services to the consumers that we serve.

Regional Centers are required to be the “funder of last resort” meaning that all other potential funding sources, including health plans and insurance companies must be exhausted before RCOC can fund for a service. This requirement was strengthened in the Budget Trailer Bill of 2009 so that before a Regional Center can provide a service, a family must obtain a written denial from the health plan. The denial must then be appealed and the Regional Center must receive written documentation of the denial as well before the service can be provided by the Regional Center.

RCOC Experience with ABA

RCOC provides behavioral services (i.e., ABA) to children with autism as per our Purchase of Service Guideline, often with a significant improvement in the child’s developmental skills and a reduction in atypical behaviors, provided that the parents are actively involved in the their child’s behavioral therapy program. Over 1000 children per year receive ABA services funded by RCOC and those services are generally provided by individuals who do not hold licenses from the State of California.

Experience with Insurers

The Regional Center has received denials of ABA treatment for children with autism from the following **insurers**, on the bases described:

- **United HealthCare:** Intensive behavioral therapy/applied behavioral analysis is unproven for the treatment of autism spectrum disorders (i.e.; autistic disorder, Asperger's disorder, Rett syndrome, pervasive development disorder). There are limited studies to suggest that use of behavioral interventions, such as intensive behavioral therapy/applied behavioral analysis (Lovaas therapy), in very young children with autism may improve behavior, language skills, and cognitive function; however, the evidence is insufficient to establish a relationship between the intensity and duration of the intervention and degree of improvement in these areas, or to define specific criteria by which to select patients who might benefit from intensive intervention.

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- **Aetna:** There is insufficient evidence for the superiority of any particular intensive educational intervention strategy (such as applied behavioral analysis, structured teaching, or developmental models) over other intensive educational intervention strategies.
- **CIGNA:** CIGNA does not cover the following procedures/services for the assessment and/or treatment of ASD because they are considered experimental, investigational or unproven for this indication (these lists may not be all-inclusive):

Treatment:

- cognitive behavioral therapy
- cognitive rehabilitation
- facilitated communication
- intensive intervention programs for autism (e.g., early intensive behavior intervention [EIBI] intensive behavior intervention [IBI], Lovaas therapy, applied behavior analysis [ABA])

Conclusion

Autism is a complex brain based, neurologic disorder. Finding effective treatments has been difficult given the fact that the presentation and severity varies greatly and that there are multiple etiologies. Of all the treatments currently proposed or in use to treat autism, ABA has by far the most evidence in the peer reviewed medical literature to support its use. Behavioral services are medical in nature, rather than educational, and are neither experimental nor investigational. ABA should be covered by health plans.

If a reader of this letter has questions or has additional questions, they are welcome to contact me at:

Office: (714) 796-5271
Cell: (714) 321-7183
Email: phimber@aol.com

Note: Please see attached list of references below.

Respectfully,

Peter Himer MD
Board Certified Adult and Child Neurologist
Chief Medical Officer, Regional Center of Orange County
P.O. Box 22010
Santa Ana, CA. 92702-2010

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Curriculum Vitae

Name: Peter Hember, M.D.
Address: 10716 Equestrian Drive
Santa Ana, CA 92705-2943
Phone: (714) 508-7701
Email Address: phimber@aol.com
Fax: (714) 505-1971
Date of Birth: 6/9/61
Marital Status: Married

Education:

1978 – 1982 Cornell University, Bachelor of Science, Animal Science Member Ho-Nun-De-Kah (agricultural Honor Society)
1982 – 1986 University of California, Irvine, College of Medicine
Member A.O.A

Post Doctoral Training:

7/86 – 8/87 Intern, Department of Internal Medicine, Worcester Memorial Hospital, Worcester, MA.
12/90 – 6/92 Neurology Residency University of California, Irvine (50% time)
6/92 – 6/94 Neurology Residency University of California, Irvine (100% time)
7/94 – 6/95 Intern, Department of Pediatrics, University of California, Irvine
7/95 – 6/97 Fellow, Child Neurology, University of California, Irvine
7/96 – 6/98 Spinal Cord Injury and Neurorehabilitation Fellowship, Long Beach Veterans Hospital, Long Beach, CA

Hospital Appointments:

2005 – Present Assistant Clinical Professor, Department of Pediatrics
University of California, Irvine; Volunteer Faculty
2/99 – 3/00 Assistant Clinical Professor, Department of Pediatrics
Penn State-Hershey Medial Center, Hershey, PA
1/97 – 2/99 Assistant Clinical Professor, Department of Pediatrics
University of California, Irvine
1998 – 1989 Staff Physician Orange Coast College Health Services
Costa Mesa, CA
1988 – 1990 Staff Physician Rancho Santiago College, Student Health Services
Santa Ana, California

Positions Held:

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2000 - 2007 Staff Physician, Health Resources Group, Regional Center of Orange
County

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Positions Held (cont’):

- 2007 – 2010 Director, Health Resources Group, Regional Center of Orange County
2010- Present Chief Medical Officer, Regional Center of Orange County
Santa Ana, CA
1988 – 1990 Utilization Review Consultant, Researcher on Medical Policies and Guidelines, Cost Care
Huntington Beach, CA

Certifications and Licensure:

- 2008 Maintenance of Certification, American Board of Neurology with Special Qualification in Child Neurology
1999 Diplomate American Board of Neurology with Special Qualification in Child Neurology #1172
1999 Pennsylvania State Medical License MD067460
1991 Diplomate, American Board of Quality Assurance and Utilization Review Physicians
1988 California Board of Medical Quality Assurance #G64751
1987 National Board of Medical Examiners #322133
1988 DEA #BH17520280

Societies and Organizations:

- 1986 Alpha Omega Alpha
1994 American Academy of Pediatrics
1990 American Academy of Neurology
1997 Child Neurology Society

Grants:

- 6/90 – 12/90 The Use of Valproic Acid in the Control of Complex Partial Seizures; Linda Kaplan M.D. principle investigator, Funding: Abbott Laboratories
6/96 – 3/98 The Efficacy of Tigabine in the Control of Refractory Complex Partial Seizures; Tallie Z. Baram M.D., Ph.D., principle investigator, Funding: Abbott Laboratories
2/96 – 6/98 The use of 4-Aminopyridine in Spinal Cord Injury Patients; Jack Siegel M.D. Principle investigator, Funding: Paralyzed Veterans Association

Articles:

1. **Himber PL.** (1992) The Wrong Side of the Bed. Postgraduate Medicine 92 (6):37 – 39

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Articles (cont'd):

2. Segal JL, Hernandez JP, **Himber PL**, Brunnemann SR, Charter RS. Safety and Efficacy of 4-Aminopyridine in Humans with Spinal Cord Injury: A Long Term Controlled Trial. *Pharmacotherapy* 1999; 19(6):713:723 - 726

Chapters:

1. Filipek PA, Roth G, **Himber PL**, Dietrich RB. (1997). Neuroimaging Techniques. [In] R David (Ed.), *Child and Adolescent Neurology*. Philadelphia: Mosby
2. Himber PL, Barron TB. (2000). Increased Intracranial Pressure. [In] R Hoekelman RB, et al (Ed.), *Primary Pediatric Care*. Philadelphia: Mosby

Lectures:

- | | |
|----------|---|
| 7/3/95 | “The Pediatric Neurologic Exam.” Department of Pediatrics, U.C.I. Resident Lecture Series |
| 12/18/95 | “Pediatric Neurologic Emergencies.” Paramedic Continuing Education Program, Queen of the Valley Hospital, West Covina, California |
| 12/19/96 | “The Comatose Child.” Pediatric Lecture Series for U.C.I. Medical Students, Orange, California |
| 1/5/00 | “Everything You Wanted to Know About Autism But Were Afraid to Ask.” Pediatric Lecture Series for U.C.I. Medical Students, Orange, California |
| 2/1/96 | “Review of Pediatric Neurology.” U.C.I. Nurse Practitioner Program, Irvine, California |
| 7/8/96 | “A Practical Approach to the Diagnosis and Treatment of Seizures.” Department of Internal Medicine, Resident Lecture Series, Long Beach Veterans Hospital, Long Beach, California |
| 9/9/96 | “Febrile Seizures.” Pediatric Lecture Series for U.C.I. Medical Students, Orange, California |
| 12/2/96 | “When Can Anti-convulsants be Discontinued in Children With Epilepsy?” Pediatric Epilepsy Lecture Series, Department of Pediatrics, U.C.I. Medical Center, Orange, California |
| 12/3/96 | “The diagnosis and Treatment and Autism.” Pediatric Epilepsy Lecture Series, Department of Pediatrics, U.C.I. Medical Center
Orange, California |
| 3/9/99 | “A Practical Approach to the Diagnosis and Treatment of Childhood Seizures.” Department of Pediatrics, Resident Lecture Series, Hershey Medical Center, Hershey, PA |
| 7/8/99 | “A Practical Approach to the Diagnosis and Treatment of Headache.” Department of Pediatrics, Resident Lecture Series, Hershey Medical Center, Hershey, PA |

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Lectures (cont'd):

- 10/13/99 “The Use of Botox in the Treatment of Spasticity.” Pediatric Grand Rounds, Hershey Medical Center, Hershey, PA
- 11/14/99 “The Diagnosis and Treatment of Autism.” Pediatric Resident Rounds, Hershey Medical Center, Hershey, PA
- 11/16/99 “A Case of Pediatric Stroke.” Monthly Educational Conference Department of Neurology, Hershey Medical Center, Hershey, PA
- 12/20/99 “An Eight-Year-Old with Ataxia.” Monthly Educational Conference Department of Neurology, Hershey Medical Center, Hershey, PA
- 1/16/00 “The Diagnosis and Treatment of Cerebral Palsy.” The Pediatric Medical Student Lecture Series, Department of Neurology, Hershey, PA
- 2/17/00 “The Approach to Coma in the Pediatric Patient.” The Pediatric Resident Student Lecture Series, Department of Pediatrics, Hershey Medical Center, Hershey, PA
- 2/24/00 “Everything You Wanted to Know About Autism But Were Afraid to Ask.” Pediatric Resident Ward Rounds, Department of Neurology, Hershey Medical Center, Hershey, PA
- 2/22/00 “Head Trauma in the Pediatric Patient.” The Pediatric Student Lecture Series, Department of Pediatrics, Hershey Medical Center, Hershey, PA
- 10/21/00 “Is My Kid Normal?” Irvine Coast Mother of Twins Club, Child Development Seminar
- 5/07/01 “Normal Language Development.” Rehabilitation Institute of Orange, Staff Development Series, Orange, CA
- 7/09/01 “Understanding Autism.” Rehabilitation of Orange, Staff Development Series, Orange, CA
- 12/19/01 “Understanding Cerebral Palsy.” Rehabilitation Institute of Orange, Staff Development Series, Orange, CA
- 5/14/02 “Understanding Autism.” Western Medical Center, Grand Rounds, Santa Ana, CA
- 9/23/03 “Autism and the Regional Center of Orange County, What Practicing Doctors Need to Know.” West Anaheim Medical Center, Grand Rounds, Anaheim, CA
- 10/1/03 “Autism and the Regional Center of Orange County, What Practicing Doctors Need to Know.” Fountain Valley Regional Center, Grand Rounds, Fountain Valley, CA
- 2/17/04 “Autism and the Regional Center of Orange County, What Practicing Doctors Need to Know.” CHOC Mission Medical Center, Pediatric Grand Rounds, and Anaheim, CA
- 3/10/04 “Medications and Autism, What Parents Need to Know.” Orange County Asperger’s Support Group

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Lectures (cont'd)

- 6/2/06 "Communicable Diseases, Universal Precautions and Restricted Health Conditions." Regional Center of Orange County Vendor Training:
- 6/8/07 "An Overview of the Assessment and Treatment of People with Developmental Disabilities." Presented to Administrative Law Judges State of California.
- 9/22/08 "How Do I Access Services for My Pediatric Patients with Special Needs?" Presentation to CalOptima Staff
- 10/2/08 "Determining Regional Center Eligibility." Saddleback Valley School District Psychologists
- 12/5/08 "How Do I Access Services for My Special Needs Child?" Presentation to Orange County School Nurses

Lectures (cont'd)

- 7/29/10 "The California Early Start System and Regional Center Services" ARTA Healthcare Plan Personnel
- 9/20/10 "The California Early Start System and Regional Center Services" ARTA Healthcare Plan Personnel
- 3/23/11 "Roundtable for Children with Special Needs" CalOptima

Conference Presentations:

- 7/12/03 "Issues in Pediatric Epilepsy." Orange County Epilepsy Conference; Epilepsy Foundation of America, Orange County Chapter
- 9/24/08 "Regional Center of Orange County and CalOptima's Collaboration to Improve Services to People with Autism." California Department of Developmental Services Wellness Conference 2008, San Diego CA
- 9/25/08 "Using Multidisciplinary Team Practice to Reduce Rates of Consumer Hospitalization." Department of Developmental Services Wellness Conference 2008, San Diego CA
- 4/28/09 "Communicating With Doctors and Families About Medication Related Issues." Orange County/Los Angeles Transitions Conference. Los Angeles, CA

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Table of Cases

- 1) *Arce v. Kaiser Foundation Health Plan, Inc.* (2010) 181Cal.App.4th 471, 104 Cal.Rptr. 3d 545
- 2) *D.F. et. al. v. Washington State Health Care Authority*, Superior Court of Washington for King County No. 10-2-29400-7-SEA (2011)
- 3) *Markiewicz v. State Health Benefits Comm'n*, 390 NJ Super. 289, 915 A.2d 553 (App. Div. 2007)
- 4) *McHenry v. PacificSource Health Plans*, 643 F.Supp.2d 1236 (D.Or.2009).
- 5) *Micheletti v. State Health Benefits Comm'n*, 389 NJ Super. 510, 913 A.2d 842 (App. Div. 2007).
- 6) *Tappert v. Anthem Blue Cross Blue Shield*, Jag Case No.270779 (2007)

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Court of Appeal, Second District, Division 7, California.
Andrew ARCE, a Minor, etc. et al., Plaintiffs and Appellants,

v.

KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants and Respondents.

No. B215861.

Jan. 27, 2010.

Review Denied Apr. 28, 2010.

Background: Member brought putative class action against health care service plan under Unfair Competition Law (UCL), for alleged violations of health plan contract and Mental Health Parity Act. The Superior Court, Los Angeles County, No. BC388689, Emilie Elias, J., sustained demurrer without leave to amend. Member appealed.

Holdings: The Court of Appeal, Zelon, J., held that:

- (1) breach of contract claim would not require individualized determinations of medical necessity supporting dismissal of class allegations;
- (2) Mental Health Parity Act claim would not require individualized determinations of medical necessity supporting dismissal of class allegations; and
- (3) judicial abstention from adjudicating class allegations of UCL claim was abuse of discretion.

Reversed and remanded.

Attorneys and Law Firms

****552** Law Offices of Scott C. Glovsky and Scott C. Glovsky, Pasadena, for Plaintiffs and Appellants.

Epstein Becker & Green, William A. Helvestine, Andrew J. Hefty, Lisa Caccavo, San Francisco and Damian D. Capozzola, Los Angeles, for Defendants and Respondents.

Chavez & Gertler, Mark A. Chavez, Mill Valley and Nance F. Becker, San Francisco; Sid Wolinsky, Anna Levine and Katrina Kasey Corbit, Berkeley, for Disability Rights Advocates as Amicus Curiae on behalf of Plaintiffs and Appellants.

ZELON, J.

***477** The California Mental Health Parity Act (Health & Saf.Code,^{FNI} § 1374.72) mandates that every health care service plan provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses, including autism, under the same terms and conditions applied to other ***478** medical conditions. Appellant Andrew Arce ("Arce"), by and through his guardian ad litem Guillermo Arce, brought a class action suit under the Unfair Competition Law ("UCL") (Bus. & Prof.Code, § 17200 et seq.) against respondents Kaiser Foundation Health Plan, Inc., The Permanente Medical Group, Inc., and Southern California Permanente Medical Group, Inc. (collectively "Kaiser").

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In his second amended complaint, Arce alleges that Kaiser breached its health plan contract and violated the Mental Health Parity Act by categorically denying coverage for behavioral therapy and speech therapy to plan members with autism spectrum disorders.

FN1. Unless otherwise stated, all further statutory references are to the Health and Safety Code.

The trial court sustained Kaiser's demurrer to the UCL claim without leave to amend based on the doctrine of judicial abstention and the lack of commonality among class members. We conclude that the trial court erred in sustaining the demurrer because there is a reasonable possibility that Arce can establish the requisite community of interest for a class action suit under the UCL, and resolution of the UCL claim would not require the court to make individualized determinations of medical necessity or to decide complex issues of economic policy or other matters over which an administrative **553 agency has exclusive jurisdiction. We accordingly reverse.

FACTUAL BACKGROUND AND PROCEDURAL HISTORY

I. Kaiser's Denial of Coverage for Behavioral and Speech Therapy to Arce

Arce is a four-year-old boy with autism. According to a 2007 report of the California Legislative Blue Ribbon Commission on Autism,^{FN2} "[autism spectrum disorders are complex neurological disorders of development that onset in early childhood." (Cal. Legis. Blue Ribbon Commission on Autism, *An Opportunity to Achieve Real Change for Californians with Autism Spectrum Disorders* (Sept. 2007) p. 7.) These disorders, which include full spectrum autism, "affect the functioning of the brain to cause mild to severe difficulties, including language delays, communication problems, limited social skills, and repetitive and other unusual behaviors." (*Id.* at p. 8.) Nationally, autism spectrum disorders affect an estimated one in every 150 children across all racial, ethnic, and socioeconomic backgrounds. (*Ibid.*)

FN2. In 2005, the California Legislature, by a concurrent resolution, established the Legislative Blue Ribbon Commission on Autism to study and investigate issues relating to the early identification and intervention of autism spectrum disorders, and to identify gaps in programs and services in the education and treatment of persons with autism spectrum disorders. (Sen. Conc. Res. No. 51, Stats. 2005 (2005-2006 Reg. Sess.) res. ch. 124.)

Arce is, and has been, a member of a health care service plan provided by Kaiser. According to Kaiser's 2008 Evidence of Coverage for the Kaiser *479 Permanente Traditional Plan, Kaiser provides coverage for the "Services" described and defines the term "Services" as "Health care services or items." Among other exclusions, Kaiser's Evidence of Coverage contains an exclusion from coverage for "Custodial care," which is defined as "assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine), or care that can be performed safely and effectively by people, who in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse."

Before the age of two, Arce displayed certain symptoms associated with autism, including a lack of speech and lack of affection. In October 2007, Arce's pediatrician referred him to

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speech and occupational therapists for an assessment as to whether autism was the cause of his symptoms. Over the objections of Arce's father, Kaiser repeatedly cancelled and rescheduled the assessment appointment. In February 2008, after a delay of approximately four and one-half months, Kaiser's interdisciplinary team diagnosed Arce with autism and recommended two hours of occupational therapy per month to address his difficulty with swallowing food. Kaiser denied coverage for any other therapies to treat Arce's autism, including behavioral therapy and speech therapy requested by Arce's father. Kaiser informed Arce's father that it was denying coverage for these other therapies because they “were behavioral in nature, not medical, and could be provided by the Regional Center.” ^{FN3}

FN3. Pursuant to the Lanterman Developmental Disabilities Services Act (Welf. & Inst.Code, § 4500 et seq.), the California Department of Developmental Services contracts with private nonprofit corporations to establish and operate regional centers. (Welf. & Inst.Code, § 4621.) These regional centers are “responsible for determining eligibility, assessing needs and coordinating and delivering direct services to individuals with developmental disabilities and their families within a defined geographical area. [Citation.]” (*Capitol People First v. State Dept. of Developmental Services* (2007) 155 Cal.App.4th 676, 682-683, 66 Cal.Rptr.3d 300.)

****554** In a March 14, 2008 letter to Arce's father, Kaiser addressed its denial of coverage for a behavioral therapy known as Applied Behavior Analysis. Kaiser stated that, following a review by its Regional Appeals Committee, it was denying coverage for the requested therapy because “Applied Behavior Analysis has been identified as an educational intervention that can be performed by a nonlicensed person.” Kaiser explained that the “[p]hysician's review has identified Applied Behavioral Analysis as one form of intervention that can be used to improve the behavior of a patient who has been diagnosed with autism. However, because ABA can be performed by a non-licensed individual, health plan coverage of ABA is an exclusion of [Arce's] health plan benefits.” Kaiser specifically referred to the “Custodial care” exclusion set forth in its 2008 Evidence of Coverage.

***480** Arce's father filed an administrative grievance with the Department of Managed Health Care (“DMHC”) and requested an Independent Medical Review of Kaiser's denial of coverage. The physician reviewer responsible for conducting the Independent Medical Review overturned Kaiser's decision to deny coverage for the requested therapies. The reviewer determined that Kaiser was required to provide coverage for Applied Behavior Analysis therapy at 20 hours per week, occupational therapy at 10 hours per week, and speech therapy twice per week to treat Arce's autism. On April 21, 2008, the DMHC adopted the Independent Medical Review findings.

II. Arce's Civil Action against Kaiser

Acting through his father as his guardian ad litem, Arce filed a civil action against Kaiser in Los Angeles County Superior Court. In the operative second amended complaint, Arce alleged a cause of action for violation of the UCL on behalf of himself and a proposed class. ^{FN4} The proposed class consisted of all California residents who were Kaiser policyholders or health plan members and were “wrongfully” denied coverage for Applied Behavior Analysis therapy or speech therapy for an autism spectrum disorder on the grounds that the therapies are “non-health care services,” “academic or educational interventions,” or “custodial care.” Arce alleged that

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Kaiser has a pattern and practice of refusing to provide coverage for Applied Behavior Analysis therapy and speech therapy for autism spectrum disorders on these grounds, and that Kaiser's denial of coverage constitutes an unlawful, unfair and fraudulent business practice in violation of the UCL. Among other allegations, Arce asserted that Kaiser's conduct is unlawful under the Mental Health Parity Act because Kaiser has "refus[ed] to provide coverage for diagnosis and treatment of autism under the same terms and conditions applied to other medical conditions." Arce requested injunctive and declaratory relief on behalf of the alleged class.

FN4. The second amended complaint also included individual claims for breach of contract, breach of the implied covenant of good faith and fair dealing, and violation of the false advertising law (Bus. & Prof. Code, § 17500). The trial court overruled Kaiser's demurrers to the causes of action for breach of contract and breach of the implied covenant of good faith and fair dealing, and decided that the demurrer to the cause of action for violation of the false advertising law was moot. None of these individual claims are at issue in this appeal.

Kaiser demurred to the UCL cause of action, arguing that resolution of the UCL claim would require the trial court to make ****555** individualized determinations of medical necessity, which would defeat the commonality requirement for class claims under Code of Civil Procedure section 382. Kaiser also asserted that the trial court should equitably abstain from deciding which forms of therapy are properly subject to exclusion under Kaiser's health care plan and should instead leave such issues of economic policy to the ***481** Legislature or the DMHC to decide. On January 29, 2009, the trial court sustained Kaiser's demurrer to the UCL claim without leave to amend. In its written order, the trial court set forth its conclusions:

"The Court finds that the doctrine of abstention precludes the UCL cause of action. In addition to the reasons stated on the record during oral arguments, the Court sustains the demurrer to the UCL claim for the following reasons: [¶] The relief that the Plaintiffs seek is an injunction which would require the Court to take over the function of determining what treatments are 'medically necessary.' The Court declines to do this. [¶] Plaintiffs argue that they are not seeking such relief. However, if that is not the relief sought, then the only injunction that Plaintiffs seek is to force Kaiser to honor the contract. Thus, a breach of contract action stands. [¶] Plaintiffs have made no showing that the contract violates Health & Safety Code § 1374.72. The Code provides that treatment shall be provided if 'medically necessary.' Again, this Court cannot determine what is 'medically necessary.' [¶] Further, the determination of what is or is not 'medically necessary' would require an individual analysis of each putative class member's claim and thus the common questions do not predominate to warrant class action treatment of this issue."

Following the trial court's ruling on the demurrer, Arce filed a motion for reconsideration. In support of his motion, Arce submitted four letters from Kaiser to health plan members in 2007 and 2008 in which Kaiser allegedly denied coverage for Applied Behavior Analysis therapy and speech therapy for an autism spectrum disorder on the grounds that such therapies are "non-health services," "academic" or "educational" interventions, or "custodial care." Arce argued that the denial letters demonstrated that Kaiser categorically denied coverage for these therapies irrespective of any individual issues of medical necessity that might be involved for a particular plan member. On April 1, 2009, the trial court denied the motion for reconsideration. The court

stated on the record that "[t]here is nothing new for reconsideration. There is nothing here that would change my mind so there we are." On April 23, 2009, Arce filed a timely notice of appeal.

DISCUSSION

I. Standard of Review

In reviewing the sufficiency of a complaint against a demurrer, we "treat [] the demurrer as admitting all material facts properly pleaded," but we do not "assume the truth of contentions, deductions or conclusions of law." (*Aubrv v. Tri-City Hospital Dist.* (1992) 2 Cal.4th 962, 967, 9 Cal.Rptr.2d 92, 831 P.2d 317.) We liberally construe the pleading to achieve substantial justice between the parties, giving the complaint a reasonable interpretation and reading the allegations in context. (Code Civ. Proc., § 452; *482 *Schifando v. City of Los Angeles* (2003) 31 Cal.4th 1074, 1081, 6 Cal.Rptr.3d 457, 79 P.3d 569.) When a demurrer is sustained, we must determine de novo whether the complaint alleges facts sufficient to state a cause of action under any legal theory. **556 (*McCall v. PacifiCare of Cal. Inc.* (200 1) 25 Cal.4th 412, 415, 106 Cal.Rptr.2d 271, 21 P.3d 1189.) When a demurrer is sustained without leave to amend, we must also decide whether there is a reasonable possibility that the defect can be cured by amendment. (*Blank v. Kirwan* (1985) 39 Cal.3d 311, 318, 216 Cal.Rptr. 718, 703 P.2d 58.) If the complaint can be cured, the trial court has abused its discretion in sustaining without leave to amend. (*Ibid.*)

[1] [2] [3] In cases where the trial court dismisses a cause of action based on the doctrine of judicial abstention, the standard of review is abuse of discretion. (*Alvarado v. Selma Convalescent Hospital* (2007) 153 Cal.App.4th 1292,1297,64 Cal.Rptr.3d 250 (*Alvarado*); see also *Desert Healthcare Dist. v. PacifiCare. FHP. Inc.* (2001) 94 Cal.App.4th 781, 795, 114 Cal.Rptr.2d 623 (*Desert Healthcare*) ["because the remedies available under the UCL, namely injunctions and restitution, are equitable in nature, courts have the discretion to abstain from employing them".]) "The appropriate test for abuse of discretion is whether the trial court exceeded the bounds of reason. When two or more inferences can reasonably be deduced from the facts, the reviewing court has no authority to substitute its decision for that of the trial court. [Citations.]" (*Shamblin v. Brattain* (1988) 44 Cal.3d 474,478-479,243 Cal.Rptr. 902, 749 P.2d 339.)

II. Requests for Judicial Notice

[4] [5] [6] Because a demurrer challenges defects on the face of the complaint, it can only refer to matters outside the pleading that are subject to judicial notice. (*Blank v. Kirwan. supra.* 39 Cal.3d at p. 318, 216 Cal.Rptr. 718, 703 P.2d 58; *County of Fresno v. Shelton* (1998) 66 Cal.App.4th 996, 1008-1009, 78 Cal.Rptr.2d 272.) We must take judicial notice of matters properly noticed by the trial court, and may take notice of any matter specified in Evidence Code section 452. (Evid.Code, § 459, subd. (a).) While we may take judicial notice of court records and official acts of state agencies (Evid.Code, § 452, subds.(c), (d)), the truth of matters asserted in such documents is not subject to judicial notice. (*Sosinsky v. Grant* (1992) 6 Cal.App.4th 1548, 1564-1565,8 Cal.Rptr.2d 552.) We also may decline to take judicial notice of matters that are not relevant to dispositive issues on appeal. (*Doe v. City of Los Angeles* (2007) 42 Cal.4th 531, 544, fn. 4, 67 Cal.Rptr.3d 330, 169 P.3d 559;*Schifando v. City of Los Angeles, supra.* 31 Cal.4th at p. 1089, fn. 4, 6 Cal.Rptr.3d 457, 79 P.3d 569.) Here, the parties and amicus *483

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curiae have requested that this Court take judicial notice of numerous court records and other documents.^{FN5}

FN5. In addition to several requests for judicial notice, the parties have provided a rather voluminous record for an appeal from an order sustaining a demurrer. The parties and amicus curiae also cite to various journal articles and other publications about autism spectrum disorders which were not part of the record before the trial court, and are not subjects of requests for judicial notice to this Court. Because this is an appeal from a ruling on a demurrer, our review must be based on the properly pleaded factual allegations in the complaint and the facts that may be properly judicially noticed. It is through this limited lens that we consider the sufficiency of Arce's complaint against Kaiser's demurrer.

[7] Arce and Kaiser have requested judicial notice of the pleadings and related court records in another case pending before the Los Angeles County Superior Court, Consumer Watchdog et al. v. California Department of Managed Health Care et al., case No. BS121397, 2009 WL 1939942 ("Consumer Watchdog action"). In the Consumer Watchdog action, a non-profit consumer organization sued the DMHC, in part, for allegedly permitting **557 health care service plans to deny coverage for Applied Behavior Analysis therapy in violation of the Mental Health Parity Act. The documents at issue consist of (1) Consumer Watchdog's verified petition for writ of mandate and complaint, (2) the DMHC's demurrer to the complaint, (3) Consumer Watchdog's opposition to the demurrer, and (4) Consumer Watchdog's request for judicial notice in support of its opposition to the demurrer.^{FN6} Pursuant to Evidence Code section 452, subdivision (d), we take judicial notice of these documents as "[r]ecords of ... any court of this state." (Evid.Code, § 452, subd. (d)(1).) However, we do not take judicial notice of the truth of any factual assertions appearing in the documents. (Sosinsky v. Grant, supra, 6 Cal.App.4th at pp. 1564-1565, 8 Cal.Rptr.2d 552; see also Espinoza v. Calva (2008) 169 Cal.AppAth 1393, 1396, 87 Cal.Rptr.3d 492 ["We can take judicial notice of the fact the pleadings were filed, but not of the truth of the statements contained in them."].)

FN6. This Court previously granted Arce's request for judicial notice of the trial court's order in the Consumer Watchdog action overruling the DMHC's demurrer to the complaint. (Evid.Code, § 452, subd. (d)(1).) We also granted Arce's request for judicial notice of select portions of the legislative history of two bills related to the Mental Health Parity Act-Assembly Bill 88 and Senate Bill 468. (Evid.Code, § 452, subd. (c).) Assembly Bill 88 was approved by the Legislature in 1999 and enacted into law as Health and Safety Code section 1374.72. (Assem. Bill No. 88 (1999-2000 Reg. Sess.) § 2.) Senate Bill 468 was a competing bill considered by the Legislature, but not approved. (Sen. Bill No. 468 (1999-2000 Reg. Sess.) § 1.)

[8] [9] [10] In its amicus curiae brief, Disability Rights Advocates requests that we take judicial notice of the complaint filed in a case pending before the Alameda County Superior Court, *484Anderson et al. v. Kaiser Foundation Health Plan, Inc. et al., case No. RG09435560 ("Anderson action").^{FN7} Disability Rights Advocates in co-counsel for the plaintiffs in the Anderson action, which alleges that Kaiser violated the Unruh Civil Rights Act (Civ.Code, § 51 et seq.) and the Mental Health Parity Act by failing to provide coverage for the medically necessary treatment of autism under the same terms that it applies to other medical conditions. As with the court records in the Consumer Watchdog action, we take judicial notice of the

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complaint in the *Anderson* action, but not the truth of any allegations contained therein. (Evid.Code, § 452, subd. (d)(1); *Sosinsky v. Grant. supra*, 6 Cal.App.4th at pp. 1564-1565,8 Cal.Rptr.2d 552.) In support of its answer to the amicus curiae brief, Kaiser asks that we take judicial notice of an administrative decision of the DMHC partially overturning Kaiser's denial of coverage for one of the named plaintiffs in the *Anderson* action. Pursuant to Evidence Code section 452, subdivision (c), we take judicial notice of the DMHC's written decision as "[o]fficial acts of the legislative, executive, and judicial departments ... of any state." (Evid.Code, § 452, subd. (c).) We do not, however, take judicial notice of the truth of any factual findings made in the DMHC's decision or in the attached Independent Medical Review determination. (*Sosinsky v. Grant. supra*. at pp. 1564-1565,8 Cal.Rptr.2d 552; see also *Fowler v. Howell* (1996) 42 Cal.App.4th 1746, 1749, 50 Cal.Rptr.2d 484 ["a court may not take judicial notice of the truth of a factual finding made in another action"].)

FN7. We note that amicus curiae did not file a separate motion requesting judicial notice, as required by California Rules of Court, rule 8.252(a)(l). However, in the absence of any objection by the parties, we consider this request.

[11] [12] In ruling on Kaiser's demurrer to the second amended complaint, the trial **558 court also took judicial notice of numerous documents, as requested by the parties. On appeal, Arce argues that the trial court erred in overruling his objections to Kaiser's request for judicial notice of the 2007 report of the California Legislative Blue Ribbon Commission on Autism. Arce asserts that the report was prepared by a commission, not a legislative committee, and was not prepared in connection with a particular bill. However, " reports of legislative committees and commissions are part of a statute's legislative history," " and may properly be subject to judicial notice as official acts of the Legislature (Evid.Code, § 452, subd. (c)). (*Benson v. Workers' Comp. Appeals Bd* (2009) 170 Cal.App.4th 1535, 1554, fn. 16, 89 Cal.Rptr.3d 166; see also *Park V. Deftones* (1999) 71 Cal.App.4th 1465, 1472,84 Cal.Rptr.2d 616 [judicial notice taken of report of commission established by the Legislature and relied upon by the Legislature in enacting statute].) The commission that prepared the report at issue here was established by the Legislature pursuant to a concurrent resolution (Sen. Conc. Res. No. 51, Stats. 2005 (2005-2006 Reg. Sess.) res. ch. 124), and the recommendations of the commission were expressly referenced by the Legislature in approving *485 Senate Bill 1563 (2007-2008 Reg. Sess.).^{FN8} The trial court did not err in taking judicial notice of the commission report.

FN8. Senate Bill 1563, which was vetoed by the Governor, required the DMHC and the Department of Insurance to establish the Autism Workgroup for Equitable Health Insurance Coverage for purposes of examining issues related to health insurance coverage for autism. (Sen. Bill No. 1563 (2007-2008 Reg. Sess.) § 2.) In ruling on Kaiser's demurrer, the trial court took judicial notice of the bill and veto without any objection from Arce.

[13] [14] [15] Arce also contends that the trial court improperly refused to take judicial notice of a transcript and videotaped recording of an interview of Kaiser's Associate Executive Director with an ABC news affiliate. Arce claims that these materials were proper matters for judicial notice as party admissions that contradicted Kaiser's arguments in its demurrer to the second amended complaint. It is true that a court may take judicial notice of a party's admissions or concessions, but only in cases where the admission "can not reasonably be controverted," such

as in answers to interrogatories or requests for admission, or in affidavits and declarations filed on the party's behalf. (*Pang V. Beverly Hospital, Inc.* (2000) 79 Cal.App.4th 986, 989-990, 94 Cal.Rptr.2d 643; see also *Del E. Webb Corp. V. Structural Materials Co.* (1981) 123 Cal.App.3d 593, 604-605, 176 Cal. Rptr. 824 ["The court will take judicial notice of records such as admissions, answers to interrogatories, affidavits, and the like, when considering a demurrer, only where they contain statements of the plaintiff or his agent which are inconsistent with the allegations of the pleading before the court."].) On the other hand, a party's statements in a television news interview do not constitute judicially noticeable facts, and thus, the trial court properly declined to take judicial notice of these materials.

III. Demurrer to the Second Amended Complaint

[16] [17] [18] On appeal, Arce challenges the trial court's order sustaining Kaiser's demurrer to the cause of action for violation of the UCL.^{FN9} The UCL prohibits *486 "unfair **559 competition," which is defined by the Business and Professions Code to include "any unlawful, unfair or fraudulent business act or practice." (Bus. & Prof. Code, § 17200.) By its terms, the statute is broad in scope. "It governs 'anti-competitive business practices' as well as injuries to consumers, and has as a major purpose 'the preservation of fair business competition.' [Citations.]" (*Cel-Tech Communications, Inc. v. Los Angeles Cellular Telephone Co.* (1999) 20 Cal.4th 163, 180, 83 Cal.Rptr.2d 548, 973 P.2d 527.) "By defining unfair competition to include any 'unlawful ... business act or practice' [citation], the UCL permits violations of other laws to be treated as unfair competition that is independently actionable. [Citation.]" (*Kasky v. Nike, Inc.* (2002) 27 Cal.4th 939, 949, 119 Cal.Rptr.2d 296, 45 P.3d 243.) In addition, under the UCL, " 'a practice may be deemed unfair even if not specifically proscribed by some other law.' [Citation.]" (*Korea Supply Co. v. Lockheed Martin Corp.* (2003) 29 Cal.4th 1134, 1143, 131 Cal.Rptr.2d 29, 63 P.3d 937.) The remedies available under the UCL are "cumulative ... to the remedies or penalties available under all other laws of this state." (bus. & prof.code, § 17205.)

FN9. In the second amended complaint, Arce pleaded his cause of action for violation of the UCL both "individually and on behalf of other similarly situated people." Under the so-called "death knell" doctrine, an order sustaining a demurrer to class action allegations which has the effect of dismissing a class action suit is immediately appealable, even where the order preserves to the plaintiff any individual claims he or she might have. (*Daar v. Yellow Cab Co.* (1967) 67 Cal.2d 695, 698-699, 63 Cal.Rptr. 724, 433 P.2d 732; *Alch v. Superior Court* (2004) 122 Cal.App.4th 339, 359-360, 19 Cal.Rptr.3d 29.) Subject to this exception for class action claims, an order sustaining a demurrer without leave to amend is ordinarily not appealable since the order is not a final judgment. (*Daar v. Yellow Cab Co. supra*, at pp. 698-699, 63 Cal.Rptr. 724, 433 P.2d 732; *Alch v. Superior Court. supra*, at pp. 359-360, 19 Cal.Rptr.3d 29.) It is unclear from the record before us whether Kaiser intended to demur to Arce's individual claim for violation of the UCL, and if so, whether the trial court intended to dismiss both the individual and class claims in its order sustaining Kaiser's demurrer to the UCL cause of action. It also is unclear whether Arce is seeking appellate review of his individual UCL claim, in addition to his class claim. To the extent that Arce is challenging an order sustaining a demurrer to an individual claim, this Court does not have jurisdiction to entertain such an appeal. Our review of the trial court's ruling is therefore limited to the dismissal of the class action allegations in the third cause of action for violation of the UCL. To the extent that our opinion addresses legal issues that may

be equally applicable to Arce's individual claim for violation of the UCL, we anticipate that the trial court will apply the same analysis to the individual claim on remand.

The trial court sustained the demurrer to the UCL claim on two separate grounds. First, the trial court concluded that Arce could not establish the requisite community of interest for a class action suit under Code of Civil Procedure section 382. Second, the trial court declined to adjudicate the claim under the doctrine of judicial abstention. We consider each basis for the trial court's decision.

A. Community of Interest among Class Members

[19] [20] [21] [22] Section 382 of the Code of Civil Procedure authorizes class action suits "when the question is one of a common or general interest, of many persons, or when the parties are numerous, and it is impracticable to bring them all before the court " (Code Civ. Proc. § 382.) The party seeking certification of a class must establish the existence of both an ascertainable class and a well-defined community of interest among the class members. (Sav-On Drug Stores, Inc. v. Superior Court (2004) 34 Cal.4th 319,326, 17 Cal.Rptr.3d 906, 96 P.3d 194.) "The 'community of interest' requirement embodies three factors: (1) predominant common questions of law or fact; (2) class representatives with claims or defenses typical of the class; and (3) class representatives who can adequately represent the class. [Citation.]" *487 (Ibid.) "[T]his means "each *560 member must not be required to individually litigate numerous and substantial questions to determine his [or her] right to recover following the class judgment; and the issues which may be jointly tried, when compared with those requiring separate adjudication, must be sufficiently numerous and substantial to make the class action advantageous to the judicial process and to the litigants." [Citation.]" (Lockheed Martin Corp. v. Superior Court (2003) 29 Cal.4th 1096, 1108, 131 Cal.Rptr.2d 1, 63 P.3d 913.) "Other relevant considerations include the probability that each class member will come forward ultimately to prove his or her separate claim to a portion of the total recovery and whether the class approach would actually serve to deter and redress alleged wrongdoing. [Citation.]" (Linder v. Thrifty Oil Co. (2000) 23 Cal.4th 429,435,97 Cal.Rptr.2d 179,2 P.3d 27.)

[23] [24] [25] It is often premature for a trial court to make determinations pertaining to class suitability on demurrer. Rather, "all that is normally required for a complaint to survive demurrers to the propriety of class litigation is that the complaint allege facts that tend to show: (1) an ascertainable class of plaintiffs, and (2) questions of law and fact which are common to the class." (Beckstead v. Superior Court (1971) 21 Cal.App.3d 780, 784, 98 Cal.Rptr. 779.) As our Supreme Court has recognized, for purposes of determining whether a demurrer should have been overruled, "it is sufficient that there is a reasonable possibility plaintiffs can establish a prima facie community of interest among the class members " (Vasquez v. Superior Court (1971) 4 Cal.3d 800, 813,94 Cal.Rptr. 796,484 P.2d 964; see also Beckstead v. Superior Court, supra, at p. 783, 98 Cal.Rptr. 779 "[T]he California Supreme Court has mandated that a candidate complaint for class action consideration, if at all possible, be allowed to survive the pleading stages of litigation.") Accordingly, "[w]here there is a 'reasonable possibility' that the plaintiff in a class action can establish a community of interest among class members, 'the preferred course is to defer decision on the propriety of the class action until an evidentiary hearing has been held on the appropriateness of class litigation.' [Citation.]" (Canon U.S.A. v. Superior Court (1998) 68 Cal.App.4th 1, 5, 79 Cal.Rptr.2d 897; see also Prince v. CLS

Transportation, Inc. (2004) 118 Cal.App.4th 1320, 1329, 13 Cal.Rptr.3d 725 [demurrer to class action complaint improper where the plaintiff "alleges institutional practices ... that affected all of the members of the potential class in the same manner, and it appears from the complaint that all liability issues can be determined on a class-wide basis"].)

[26]  "The wisdom of allowing survival is elementary. Class action litigation is proper whenever it may be determined that it is more beneficial to the litigants and to the judicial process to try a suit in one action rather than in several actions It is clear that the more intimate the judge becomes with the character of the action, the more intelligently he [or she] may make the determination. If the judicial machinery encourages the decision to be made *488 at the pleading stages and the judge decides against class litigation, he [or she] divests the court of the power to later alter that decision Therefore, because the sustaining of demurrers without leave to amend represents the earliest possible determination of the propriety of class action litigation, it should be looked upon with disfavor." (*Beckstead v. Superior Court. supra.* 21 Cal.App.3d at p. 783, 98 Cal.Rptr. 7.79.)

In sustaining Kaiser's demurrer to the UCL claim, the trial court concluded that **561 Arce could not establish a predominance of common issues because resolution of the claim would require the court to make individualized determinations as to whether the therapies at issue were "medically necessary" for each member of the putative class. However, based on the allegations in the second amended complaint, the UCL claim presents two central legal issues that are common to all putative class members. First, does Kaiser's health plan contract exclude from coverage Applied Behavior Analysis therapy or speech therapy for autism spectrum disorders on the grounds that such therapies are "non-health care services," "academic or educational interventions," or "custodial care"? Second, assuming that the therapies are excluded from coverage by the health plan contract, does the Mental Health Parity Act allow Kaiser to categorically apply such exclusions on the basis that the therapies are not health care services, or are provided by persons not licensed or certified by the state? While these issues clearly raise questions of contractual and statutory interpretation, neither would require the court to make individualized determinations of medical necessity for class members.

1. Breach of the Health Plan Contract

[27]  The first issue is one of contractual interpretation. In his second amended complaint, Arce alleges that Kaiser's health plan contract covers Applied Behavior Analysis therapy and speech therapy to treat autism spectrum disorders, and that Kaiser has breached its contract by systematically denying coverage for these therapies to the putative class members. Resolution of this contractual issue would require the trial court to decide whether the therapies are "health care services," as that term is used in Kaiser's Evidence of Coverage, and if so, whether the therapies are subject to the contract's exclusion for "custodial care." It would not, however, require the trial court to evaluate whether the therapies are "medically necessary" for each member of the putative class. This is because the complaint does not allege that Kaiser's denial of coverage to the putative class was based on case-by- case determinations that the therapies were not medically necessary for the individual plan members. Instead, the complaint alleges that Kaiser's denial of coverage was based on an across-the-board determination that these categories of therapies are contractually excluded from coverage because they either are not "health care services" or are "custodial care," within the meaning of Kaiser's *489 Evidence of

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Coverage. Therefore, the common question of law posed by Arce's breach of contract allegations is whether the therapies at issue are covered services under the health plan contract; it is not whether the therapies, if covered services, are medically necessary for a particular plan member.

Kaiser argues that the trial court would not be able to adjudicate coverage issues without considering the individual medical needs of the class members. As an example, Kaiser points to a "speech therapy" exclusion in its Evidence of Coverage, which excludes coverage for speech therapy services "to treat social, behavioral, or cognitive delays in speech or language development unless Medically Necessary." According to Kaiser, the exclusion itself implicates issues of medical necessity because speech therapy would not be a covered service unless there was a showing that it was medically necessary for the individual plan member. However, in the second amended complaint, Arce does not allege that Kaiser improperly invoked this exclusion in denying coverage for speech therapy to the putative class. Instead, Arce alleges that the putative class members **562 were denied coverage for speech therapy on other distinct grounds.

Kaiser asserts that the application of the "custodial care" exclusion also would mandate consideration of each class member's medical needs. Unlike the "speech therapy" exclusion, Kaiser's exclusion for "custodial care" is among the disputed contract provisions at issue in this case. However, as used in Kaiser's Evidence of Coverage, the term "custodial care" is not defined by the medical necessity of the treatment in question, but rather is based on whether the treatment "can be performed safely and effectively by people who ... do not require medical licenses or certificates or the presence of a supervising licensed nurse." Indeed, in its letter denying coverage to Arce, Kaiser stated that Applied Behavior Analysis therapy was subject to the "custodial care" exclusion because it "can be performed by a non-licensed individual." Contrary to Kaiser's claim, there is nothing in the plain language of the "custodial care" provision that would suggest that its application depends on the particular medical needs of the plan member.

[28] [29] If the trial court were to find that Applied Behavior Analysis therapy and speech therapy for autism spectrum disorders are covered services under the term of the health care plan, then Kaiser's alleged practice of categorically denying coverage for such services to the putative class could constitute a breach of contract. A breach of contract in turn may form the predicate for a UCL claim, " *provided it also constitutes conduct that is "unlawful, or unfair, or fraudulent."* [Citations.]" (Puentes v. Wells Fargo Home Mortgage, Inc. (2008) 160 Cal.App4th 638,645, 72 Cal.Rptr.3d 903.) With respect to the unfairness prong of Business and Professions Code section 17200, *490 appellate courts have recognized that "a systematic breach of certain types of contracts (e.g., breaches of standard consumer or producer contracts involved in a class action) can constitute an unfair business practice under the UCL. [Citations.]" (Smith v. Wells Fargo Bank, NA. (2005) 135 Cal.App4th 1463, 1483,38 Cal.Rptr.3d 653; see also State Farm Fire & Casualty Co. v. Superior Court (1996) 45 Cal.App4th 1093, 1104, 53 Cal.Rptr.2d 229, disapproved on other grounds in CelTech Communications, Inc. v. Los Angeles Cellular Telephone Co. .. supra. 20 Cal.4th at pp. 184-185, 83 Cal.Rptr.2d 548, 973 P.2d 527; Allied Grape Growers v. Bronco Wine Co. (1988) 203 Cal.App.3d 432,451-453,249 Cal.Rptr. 872; Orkin Exterminating Co., Inc. v. FTC. (11th Cir.1988) 849 F.2d 1354, 1367-1368.) Consequently, Arce's allegations that Kaiser systematically breached its health plan contract by

refusing to provide all putative class members with contractually covered services is sufficient to state a class action claim under the UCL.

[30] Kaiser contends that Arce's breach of contract claim was pled solely as an individual claim, and not as a class action for violation of the UCL. Kaiser reasons that if Arce intended to pursue class relief for contractual issues, he should have pled such a theory in his second amended complaint. However, "the test of the adequacy of a complaint is whether it alleges sufficient/acts to support a particular cause of action and not whether it expressly alleges legal theories of liability underlying a cause of action. A complaint is adequate if its factual allegations are sufficient to support a cause of action on any available legal theory (whether specifically pleaded or not). [Citation.]" (*Smith v. Wells Fargo Bank, NA., supra*. 135 Cal.App4th at p. 1485, 38 Cal.Rptr.3d 653.) In pleading his class claim for violation of the UCL, Arce alleged ****563** that there were common questions as to whether Kaiser has "a pattern and practice of unlawfully, unfair, or fraudulently refusing to cover" Applied Behavior Analysis therapy and speech therapy for autism spectrum disorders "on the ground that there is no coverage for non-health care services[,] ... academic or educational interventions[,] ... [or] custodial care." Arce further alleged that there were common questions as to whether Kaiser's "contractual interpretations ... constitute a breach of contract." Given the requirement that we liberally construe the complaint, Arce's allegations are sufficient to state a class action claim for violation of the UCL based on Kaiser's purported systematic breach of its health care plan.

2. Violation of the Mental Health Parity Act

[31] Even assuming that Applied Behavior Analysis therapy and speech therapy for autismspectrum disorders are not covered services under Kaiser's health plan contract, Arce still could state a class action claim for violation of the UCL if Kaiser's alleged practice of categorically denying coverage for the therapies is unlawful under the Mental Health Parity Act (§ 1374.72). Under ***491** this theory of the case, the legal question common to the putative class is whether the Mental Health Parity Act permits Kaiser to exclude Applied Behavior Analysis therapy and speech therapy from coverage on the grounds that the therapies are "non-health care services," "academic or educational interventions," or "custodial care." This second issue is thus one of statutory interpretation.

[32] The Mental Health Parity Act, codified at section 1374.72 of the Health and Safety Code, was enacted by the California Legislature in 1999. (Stats. 1999, ch. 534, § 2.) It states, in pertinent part, that "[e]very health care service plan contract ... that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age ... under the same terms and conditions applied to other medical conditions " (§ 1374.72, subd. (a).) In essence, section 1374.72 is a mental health insurance mandate which "obligate[s] health plans to provide coverage (not merely offer it) for the diagnosis and treatment of mental illness equal to coverage that the plans appl[y] to other medical conditions." (*Yeager v. Blue Cross of California* (2009) 175 Cal.App.4th 1098, 1103, 96 Cal.Rptr.3d 723, fn. omitted.) The benefits mandated by the statute include outpatient services, inpatient and partial hospital services, and prescription drugs if the health plan contract includes prescription drug coverage. (§ 1374.72, subd. (b).) The terms and conditions that shall be applied equally to all such benefits include, but are not limited to, maximum lifetime benefits,

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copayments, and deductibles. (§ 1374.72, subd. (c).) The statute specifically defines "severe mental illnesses" to include autism. (§ 1374.72, subd. (d)(7).)

In enacting the Mental Health Parity Act, the Legislature expressly found that "[m]ost private health insurance policies provide coverage for mental illness at levels far below coverage for other physical illnesses," and that "[l]imitations in coverage for mental illness in private insurance policies have resulted in inadequate treatment for persons with these illnesses." (Stats. 1999, ch. 534, § 1.) The Legislature further found that "[t]he failure to provide adequate coverage for mental illnesses in private health insurance policies has resulted in significant increased expenditures for state and local governments." (Stats. 1999, ch. 534, § 1.) The stated purpose of the statute was to "prohibit ****564** discrimination against people with biologically-based mental illnesses, dispel artificial and scientifically unsound distinctions between mental and physical illnesses, and require equitable mental health coverage among all health plans and insurers to prevent adverse risk selection by health plans and insurers." (Assem. Com. on Health, Rep. on Assem. Bill No. 88 (1999-2000 Reg. Sess.) March 9, 1999, p. 2.)

The Mental Health Parity Act is a part of the Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene Act") (§ 1340 et seq.). The ***492** Knox-Keene Act sets forth a comprehensive system of licensing and regulation of the health care service plan industry. (*Bell v. Blue Cross of California* (2005) 131 Cal.App4th 211,215,31 Cal.Rptr.3d 688 (*Bell.*) Among other mandates, a health care service plan governed by the Knox-Keene Act generally must provide plan members with "basic health care services." (§ 1367, subd. (i).) The plan also must furnish the services "in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice." (§ 1367, subd. (d).) The Knox-Keene Act requires the DMHC to execute laws relating to the health care service plan industry and to ensure that health care service plans provide enrollees with access to quality health care services. (§ 1341, subd. (a).)

In accordance with its authority, the DMHC has adopted an administrative regulation regarding the Mental Health Parity Act. (Cal.Code Regs., tit. 28, § 1300.74.72.) It provides that "[t]he mental health services required for the diagnosis, and treatment of conditions set forth in Health and Safety Code section 1374.72 shall include, when medically necessary, all health care services required under the [Knox-Keene] Act including, but not limited to, basic health care services within the meaning of Health and Safety Code sections 1345(b) and 1367(i), and section 1300.67 of Title 28." (Cal.Code Regs., tit. 28, § 1300.74.72, subd. (a).) Section 1345, subdivision (b) defines "basic health care services" as including physician services, hospital inpatient services, ambulatory care services, and home health services. (§ 1345, subd. (b).) "Ambulatory care services" are defined by the regulations as "outpatient hospital services," and include "diagnostic and treatment services, physical therapy, speech therapy, [and] occupational therapy services as appropriate." (Cal.Code Regs., tit. 28, § 1300.67, subd. (c).)

The Mental Health Parity Act regulation also states that a health care plan "shall provide coverage for the diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 through health care providers within the meaning of Health and Safety Code section 1345(i) who are: [¶] (1) acting within the scope of their licensure, and [¶] (2) acting within their scope of competence, established by education, training and experience

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" (Cal.Code Regs., tit. 28, § 1300.74.72, subd. (b).) Section 1345, subdivision (i) defines a "provider" as "any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services." (§ 1345, subd. (i).) With respect to ambulatory or outpatient care services, the regulations state that "[s]uch services may be provided at a hospital, any other appropriate licensed facility, or any appropriate facility which is not required by law to be licensed, if the professionals delivering such services are licensed to practice, are certified, or practice under the authority of the plan, a ***493** medical group, or individual practice association or other authority authorized by applicable California law." (cal.code regs., tit. 28, § 1300.67, subd. (c).)

****565** In this case, Arce alleges that Kaiser has engaged in unlawful conduct under the UCL by denying coverage for the diagnosis and treatment of autism spectrum disorders under the same terms and conditions applied to other medical conditions in violation of the Mental Health Parity Act. In sustaining the demurrer to the UCL claim, the trial court noted that the Mental Health Parity Act only mandates coverage for health care services when such services are "medically necessary." The court reasoned that to determine whether there was an actual violation of the statute, it would need to evaluate whether the therapies at issue were medically necessary for each member of the putative class. In the trial court's view, because the determination of medical necessity would depend on the particular medical needs of each putative class member, Arce could not establish a predominance of common questions of law or fact. We conclude, however, that the trial court too narrowly read the nature of Arce's class allegations and the protections of the Mental Health Parity Act.

[33]  [34]  In sustaining the demurrer, it appears that the trial court assumed that Arce could only prove a violation of the Mental Health Parity Act if he could demonstrate that the therapies at issue were medically necessary for the putative class members and that Kaiser denied coverage based on a determination that they were not. While that is one means of establishing a violation the statute, it is not the exclusive means. It is possible that Arce also could prove a statutory violation by showing that Kaiser categorically denies coverage for mental health care services that may, in some circumstances, be medically necessary, and that Kaiser does so without considering whether such services are in fact medically necessary for its individual plan members. In that case, the violation would not be that Kaiser wrongfully determines that the services are not medically necessary-the violation would be that Kaiser refuses to make that determination at all. That is the nature of the statutory violation alleged here.

In his second amended complaint, Arce alleges that Kaiser has a statutory obligation under the Mental Health Parity Act to provide coverage for the medically necessary treatment of autism, and that Applied Behavior Analysis therapy and speech therapy are treatments for autism that can be medically necessary. Arce also alleges that Kaiser has a uniform practice of denying coverage for these therapies not on medical necessity grounds, but on the grounds that the therapies are "non-health care services," "academic or educational interventions," or "custodial care." Accordingly, the gravamen of Arce's complaint is that Kaiser categorically refuses to cover Applied Behavior Analysis therapy and speech therapy for autism spectrum disorders ***494** regardless of any individual issues of medical necessity that may be involved for a particular plan member. In other words, Kaiser never considers the issue of medical necessity because it has concluded that there is no coverage for these therapies in the first place. To adjudicate

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whether Kaiser has violated the Mental Health Parity Act by denying coverage for Applied Behavior Analysis therapy and speech therapy on these grounds, the trial court would not need to engage in individualized determinations of medical necessity for each putative class member. Instead, resolution of this issue would require the trial court to decide whether the therapies are health care services under the Mental Health Parity Act, and if so, whether the statute mandates that services only be provided by health care professionals licensed or certified by the state.

****566** As alleged in the second amended complaint, one of Kaiser's bases for denying coverage for Applied Behavior Analysis therapy and speech therapy to treat autism spectrum disorders is that the therapies are not "health care services" because they are either "academic" or "educational" interventions. In its respondent's brief, Kaiser asserts that both the Mental Health Parity Act and the Knox-Keene Act only require that a health care plan provide coverage for "health care services," and it is Kaiser's position that the therapies at issue are not "health care services." As discussed above, the Knox-Keene Act defines "basic health care services" as including ambulatory or outpatient care (§. 1345, subd. (b)), and "ambulatory care services" are defined as including "diagnostic and treatment services, physical therapy, speech therapy, [and] occupational therapy services as appropriate." (Ca1.Code Regs., tit. 28, § 1300.67, subd. (c)). Therefore, to determine whether Kaiser's classification of Applied Behavior Analysis therapy and speech therapy as "non-health care services" violates the Mental Health Parity Act, the trial court would need to decide whether the therapies constitute "health care services" within the meaning of the statute. If the trial court were to conclude that the therapies are "health care services" under the Mental Health Parity Act and the Knox-Keene Act, then Arce arguably could prove a violation of the statute by showing that Kaiser categorically has refused to cover such services for the treatment of autism irrespective of their medical necessity for the individual plan members.

[35] As alleged by Arce, Kaiser's other basis for denying coverage to the putative class members is that Applied Behavior Analysis therapy and speech therapy are subject to the "custodial care" exclusion because they can be provided by non-licensed persons. According to Kaiser, this exclusion is consistent with the Knox-Keene Act which requires that providers be licensed by the state to deliver or furnish health care services. Thus, to determine whether Kaiser's classification of Applied Behavior Analysis therapy and speech therapy as "custodial care" violates the Mental Health Parity Act, the trial court would need to decide whether the statute mandates that health care ***495** services be provided by persons who are licensed or certified by the state. If neither the Mental Health Parity Act nor the Knox-Keene Act requires that the providers of health care services have a state-issued license or certification, then Arce may be able to demonstrate that Kaiser has violated the statute by imposing such a condition on health care services for the treatment of autism. Resolving this aspect of Arce's UCL claim would require the trial court to interpret the relevant provisions of the Mental Health Parity Act and the Knox-Keene Act, as well as any applicable administrative regulations. It would not, however, require the trial court to consider the particular medical needs and health histories of the putative class members.

Kaiser argues that the injunctive relief requested by Arce would immerse the trial court in individual medical considerations that are inappropriate for class treatment. According to Kaiser, what Arce is actually seeking through his class claim is a court order that Applied Behavior

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Analysis therapy and speech therapy are always medically necessary services which must be covered for all autistic plan members. However, based on the allegations in the second amended complaint, Arce is not requesting an injunction requiring Kaiser to provide Applied Behavior Analysis therapy or speech therapy to all plan members with an autism spectrum disorder, nor is he seeking a judicial declaration that these therapies are medically necessary for each ****567** member of the putative class. Instead, as alleged by Arce, the UCL claim is limited to the questions of whether Kaiser is in breach of its health plan contract or in violation of the Mental Health Parity Act by categorically denying coverage for the therapies. While these questions raise issues of contractual and statutory interpretation, their resolution does not depend on a finding that Applied Behavior Analysis therapy and speech therapy are medically necessary for all class members.

[36] Kaiser further contends that its denials of coverage for Applied Behavior Analysis therapy and speech therapy are not based solely on the nature of the service, but also depend on the plan member's particular health history and medical needs. However, in reviewing the sufficiency of a complaint against a demurrer, we must assume the truth of all material facts properly pleaded, together with the facts that may be properly judicially noticed. (*Howard Jarvis Taxpayers Assn. v. City of La Habra* (2001) 25 Cal.4th 809,814,107 Cal.Rptr.2d 369, 23 P.3d 601; *Blank v. Kirwan, supra*, 39 Cal.3d at p. 318,216 Cal.Rptr. 718,703 P.2d 58.) Here, the complaint alleges that when Kaiser denies coverage for Applied Behavior Analysis therapy and speech therapy to treat autism spectrum disorders, it does so on the grounds that these categories of therapies are excluded from coverage as "non-health care services," "academic or educational interventions," or "custodial care." Kaiser's claim that its denials of coverage are actually based on individualized determinations of medical necessity is a factual issue that cannot be resolved on demurrer.

[37] [38] ***496** In sum, Arce's second amended complaint sufficiently alleges that Kaiser has a uniform policy of categorically denying coverage for health care services to treat autism spectrum disorders without determining whether the services are medically necessary for the individual plan members. We express no opinion about the truth of those allegations or the merits of Arce's UCL claim. Rather, we conclude that, for purposes of our review, there is a reasonable possibility that Arce can demonstrate a predominance of common issues to support a class action claim for violation of the UCL. The trial court accordingly erred in sustaining the demurrer to the UCL claim on the ground that Arce could not establish the requisite community of interest for a class action suit. ^{FNI0}

FNI0. We note that, in his second amended complaint, Arce defined the proposed class as Kaiser policyholders or health plan members for whom Applied Behavior Analysis therapy or speech therapy for an autism spectrum disorder "was wrongfully determined to be not covered" on the grounds that the therapies are non-health care services, academic or educational interventions, or custodial care. As this Court has explained, "a class is properly defined in terms of 'objective characteristics and common transactional facts,' not by identifying the ultimate facts that will establish liability. [Citation.]" (*Ghazaryan v. Diva Limousine. Ltd.* (2008) 169 Cal.App.4th 1524, 1531, 87 Cal.Rptr.3d 518.) However, given that the ascertainability of the putative class was not a basis for Kaiser's demurrer or the trial court's order, we leave it to the parties and the

trial court to address the proper definition of the proposed class in any later proceedings on class certification that may be held.

B. Doctrine of Judicial Abstention

The trial court sustained the demurrer to the UCL claim on the separate ground that the doctrine of judicial abstention precluded a cause of action for violation of the UCL. The court reasoned that the injunctive relief sought by Arce would require it "to take over the function of determining what treatments are 'medically necessary,' " which the court declined to do. **568 We conclude, however, that the trial court abused its discretion in applying the doctrine of judicial abstention to the UCL claim.

[39] [40] [41] As a general matter, a trial court may abstain from adjudicating a suit that seeks equitable remedies if "granting the requested relief would require a trial court to assume the functions of an administrative agency, or to interfere with the functions of an administrative agency." (*Alvarado. supra.* 153 Cal.App.4th at p. 1298,64 Cal.Rptr.3d 250.) A court also may abstain when "the lawsuit involves determining complex economic policy, which is best handled by the Legislature or an administrative agency." (*Ibid.*) In addition, judicial abstention may be appropriate in cases where "granting injunctive relief would be unnecessarily burdensome for the trial court to monitor and enforce given the availability of more effective means of redress." (*Ibid.*)

The courts have considered the authority of a trial court to adjudicate, or abstain from adjudicating, UCL claims that seek to enjoin alleged unlawful *497 conduct in the health care service industry. In *Samura v. Kaiser Foundation Health Plan, Inc.* (1993) 17 Cal.App.4th 1284,22 Cal.Rptr.2d 20 (*Samura*), a plan member sued Kaiser for injunctive relief under the UCL on the basis that Kaiser's third party liability provisions in its service agreements were unlawful under the Knox-Keene Act. Relying on certain regulatory provisions in the Knox-Keene Act, the trial court issued an injunction requiring Kaiser to re-write the service agreements to clarify its third party liability terms. (*Id.* at p. 1291, 22 Cal.Rptr.2d 20.) The Court of Appeal reversed on the ground that the trial court's order sought to enjoin acts that were not made unlawful by the Knox-Keene Act, but rather pertained to statutory provisions that were merely regulatory in nature. (*Id.* at pp. 1300-1302, 22 Cal.Rptr.2d 20.) The Court explained that it was "immaterial whether or not the challenged contract provisions and business practices comply with these portions of the Knox-Keene Act because the statutes do not define unlawful acts that may be enjoined under Business and Professions Code section 17200." (*Id.* at p. 1301, 22 Cal.Rptr.2d 20, fn. omitted.) Instead, the statutory provisions at issue related solely to the regulatory powers of the DMHC's predecessor, the Department of Corporations. (*Ibid.*) The Court in *Samura* made clear that a private party "may still sue to enjoin acts which are made unlawful by the Knox-Keene Act." (*Id.* at p. 1299,22 Cal.Rptr.2d 20.) However, to the extent that the injunction was "based on portions of the Knox-Keene Act having a purely regulatory import, it improperly invade [d] the powers that the Legislature entrusted to the Department of Corporations." (*Id.* at p. 1302, 22 Cal.Rptr.2d 20.)

In *Desert Healthcare, supra*, 94 Cal.App.4th 781, 114 Cal.Rptr.2d 623, a hospital brought a UCL action against a health care service plan to recover for medical services provided to plan members through an intermediary that had declared bankruptcy. The hospital alleged that the

plan violated the UCL by requiring waivers from its providers and by transferring its risk to intermediaries through capitation agreements. (*Id.* at p. 793, 114 Cal.Rptr.2d 623.) The Court of Appeal concluded that the hospital could not state an actionable UCL claim because the Knox-Keene Act expressly permitted the types of capitation agreements that the hospital alleged were unlawful, unfair, or fraudulent under the UCL. (*Ibid.*) The Court also expressed in dicta that even if the hospital could amend the complaint to plead a valid cause of action, it did "not believe that judicial intervention under the ****569** guise of the UCL would be proper in this case." (*Id.* at p. 794, 114 Cal.Rptr.2d 623.) The Court noted that the gravamen of the UCL action was that the plan had "abused the capitation system by transferring too much risk to its intermediary without adequate oversight." (*Id.* at pp. 795-796, 114 Cal.Rptr.2d 623.) The Court reasoned that to fashion an appropriate remedy for such a claim, "the trial court would have to determine the appropriate levels of capitation and oversight," and "[s]uch an inquiry would pull the court deep into the thicket of the health care finance industry, an economic arena that courts are ill-equipped to meddle in." (*Id.* at p. 796, 114 Cal.Rptr.2d 623.)

***498** In *Alvarado. supra.* 153 Cal.App.4th 1292, 64 Cal.Rptr.3d 250, a private party filed a class action suit for violation of the UCL, seeking restitution and injunctive relief to require the owners and operators of skilled nursing and intermediate care facilities to comply with certain statutory requirements for nursing hours. The statutory provision at issue required the Department of Health Care Services ("DHCS") to adopt regulations setting forth the minimum number of nursing hours per patient required in skilled nursing and intermediate care facilities. (*Id.* at p. 1303, 64 Cal.Rptr.3d 250.) In holding that the trial court did not abuse its discretion in applying the equitable abstention doctrine, the Court of Appeal first noted that the action was based on "a regulatory statute, which the Legislature intended the DHCS to enforce." (*Id.* at p. 1304, 64 Cal.Rptr.3d 250.) The Court then explained that there were numerous variables for determining whether a particular facility was providing the requisite number of nursing hours and that calculating whether each facility operating in California was in compliance was a "task better accomplished by an administrative agency than by trial courts." (*Id.* at p. 1306, 64 Cal.Rptr.3d 250.) The Court also reasoned that "[i]f the trial court were to adjudicate this case, it would have to decide whether to issue networks of injunctions across the State of California," and then "would have to monitor and enforce them." (*Ibid.*) Because "granting the requested injunctive relief would place a tremendous burden on the trial court to undertake a classwide regulatory function and manage the long-term monitoring process to ensure compliance," judicial abstention was appropriate. (*Ibid.*)

Other decisions, however, have recognized that trial courts can properly exercise jurisdiction over UCL claims that seek equitable relief for violations of the Knox-Keene Act. In *Bell. supra.* 131 Cal.App.4th 211, 31 Cal.Rptr.3d 688, for instance, emergency room physicians sued a health care service plan for injunctive relief under the UCL on the grounds that the plan violated section 1371.4 of the Knox-Keene Act by reimbursing non-contracting physicians at amounts below the cost and value of services. In holding that the physicians adequately pled a UCL cause of action, the Court of Appeal rejected the plan's argument that the DMHC had exclusive jurisdiction to enforce the provisions of the Knox-Keene Act. (*Id.* at pp. 214-215, 31 Cal.Rptr.3d 688.) Rather, as the Court explained, section 1371.4 of the Knox-Keene Act imposed a "mandatory duty upon health care plans to reimburse noncontracting providers for emergency medical services." (*Id.* at p. 216, 31 Cal.Rptr.3d 688.) "Although the Department of Managed

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Health Care has jurisdiction over the subject matter of section 1371.4 (as well as the rest of the Knox-Keene Act), its jurisdiction is not exclusive and there is nothing in section 1371.4 or in the Act generally to preclude a private action under the UCL [Citations.]" (*Id* at pp. 216-217, 31 Cal.Rptr.3d 688.) **570 The Court also noted that *Samura* was consistent with its holding because *Samura* did not purport to give the DMHC exclusive jurisdiction to enforce every section of statute, but "simply limits a ... suit for injunctive relief to 'acts which are *499 made unlawful by the Knox-Keene Act.' [Citation.]" (*Id* at p. 217, 31 Cal.Rptr.3d 688; see also *Ticconi v. Blue Shield of California Life & Health Ins. Co.* (2008) 160 Cal.App.4th 528,542, fn. 13, 72 Cal.Rptr.3d 888 [distinguishing *Samura* on similar grounds and "reject[ing] any suggestion that a private party cannot sue to enforce underlying laws when those laws provide for enforcement by a public officer"].)

In a recent decision, Division One of this district held that the doctrine of judicial abstention did not preclude a UCL action against a health care service plan alleging violations of the Knox-Keene Act. (*Blue Cross of California, Inc. v. Superior Court* (2009) 180 Cal.App.4th 1237, 102 Cal.Rptr.3d 615) (*Blue Cross*). In *Blue Cross*, the Los Angeles city attorney filed suit against Blue Cross under the UCL on the grounds that the plan's post-claims underwriting practices were unlawful under the Knox Keene Act. (*Id.* at pp. 1242-1243, 102 Cal.Rptr.3d 615.) Blue Cross argued that the trial court should abstain from adjudicating the action because the case would require the court to assume regulatory powers over the health care industry, which was a task better accomplished by the DMHC. (*Id* at p. 1246, 102 Cal.Rptr.3d 615.) The trial court declined to abstain and the Court of Appeal affirmed. (*Id.* at pp. 1257-1259, 102 Cal.Rptr.3d 615) In rejecting Blue Cross' abstention arguments, the Court noted that the city attorney was not asking the trial court to assume or interfere with the functions of the DMHC, but rather "to perform an ordinary judicial function, namely, to grant relief under the UCL ... for business practices that are made unlawful by statute." (*Id* at p. 1258, 102 Cal.Rptr.3d 615.) The Court further reasoned that the trial court would not be required to determine complex economic policy because the Legislature had "already made the relevant policy determinations" and the court was "merely being called upon to enforce those statutory prohibitions." (*Id.* at p. 1259, 102 Cal.Rptr.3d 615.) In addition, the city attorney was not seeking a form of equitable relief that "would be unnecessarily burdensome for the court to monitor or enforce." (*Ibid.*) Based on these factors, the UCL action was appropriate for adjudication by the trial court.

[42] [43] [44] In this case, the trial court decided to abstain from adjudicating Arce's UCL claim because it believed that the requested relief would require it to determine "what treatments were 'medically necessary.'" However, as discussed above, resolution of the UCL claim would not call upon the court to engage in individualized determinations of medical necessity for each putative class member, but rather to perform the basic judicial functions of contractual and statutory interpretation. To determine whether Kaiser systematically breached its health plan contract by denying coverage for Applied Behavior Analysis therapy and speech therapy for autism spectrum disorders, the trial court would need to interpret the relevant terms of the contract, and decide whether the therapies are or are not covered services. "While insurance contracts have special features, they are still contracts to which the ordinary rules of contractual interpretation apply." [Citation.]" *500 (*Palmer v. Truck Ins. Exchange* (1999) 21 Ca1.4th 1109, 1115,90 Cal.Rptr.2d 647, 988 P.2d 568.) Furthermore, "[t]he interpretation of an insurance contract, as with that of any written instrument, is primarily a judicial function.

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****571**[Citation.]" (*Cooper Companies v. Transcontinental Ins. Co.* (1995) 31 Cal.App.4th 1094, 1100, 37 Cal.Rptr.2d 508.)

[45]  Similarly, to determine whether Kaiser violated the Mental Health Parity Act by denying coverage for the therapies, the trial court would need to interpret the relevant provisions of the Mental Health Parity Act and the Knox-Keene Act, and decide whether the therapies are health care services under the statute and whether the statute requires that the services only be provided by state licensed or certified professionals. Issues of statutory interpretation clearly are questions of law for the courts. (*Reno v. Baird* (1998) 18 Cal.4th 640, 660, 76 Cal.Rptr.2d 499,957 P.2d 1333 ["ultimately statutory interpretation is a question of law the courts must resolve"].) Moreover, in resolving UCL claims, courts routinely are called upon to decide whether an alleged business practice is made unlawful by an underlying statute. This includes adjudicating UCL claims that are predicated on alleged violations of the Knox-Keene Act. (See, e.g., *Blue Cross. supra.* 180 Cal.App.4th at pp. 1257- 1259, 102 Cal.Rptr.3d 615 [UCL claim based on alleged violation of section 1389.3]; *Bell. supra.* 131 Cal.App.4th at pp. 216-217, 31 Cal.Rptr.3d 688 [DCL claim based on alleged violation of section 1371.4]; *Yeager v. Blue Cross of California. supra.* 175 Cal.App.4th at pp. 1100-1101, 96 Cal.Rptr.3d 723 [UCL claim based on alleged violation of section 1374.55].)

Although the trial court did not identify any other basis for abstaining apart from its concerns about medical necessity determinations, we conclude that none of the other traditional grounds for judicial abstention are applicable here. For instance, there is no indication that granting injunctive or declaratory relief in this action would be unnecessarily burdensome for the trial court. The relief sought by Arce in his UCL claim is limited to whether Kaiser has breached its health plan contract or violated the Mental Health Parity Act by categorically denying coverage for Applied Behavior Analysis Therapy and speech therapy. Arce is not seeking a declaratory judgment that Applied Behavior Analysis Therapy or speech therapy are medically necessary treatments for all putative class members. Nor is Arce asking the court to issue a network of injunctions across the state or to engage in a long-term monitoring process to ensure compliance with its order. As the Court of Appeal noted in *Blue Cross.* "[i]f the trial court issues an injunction, then defendants will be expected to comply with it, but that does not impose on the court any active role in monitoring compliance," such that abstention would be warranted. (*Blue Cross. supra.* 180 Cal.App.4th at p. 1259, 102 Cal.Rptr.3d 615.) Adjudication of Arce's DCL claim also would not call upon the court to determine complex issues of economic or health policy. We note that the ***501** parties and amicus curiae have provided rather detailed policy discussions about the social and economic benefits and costs associated with requiring health care service plans to provide coverage for the treatment of autism. Kaiser, in particular, argues that "whether and to what extent health insurance coverage is to be expanded to include new services not previously covered by health insurance involves complex health care and economic policy considerations" that are best left to the Legislature. However, the Legislature already has made the relevant policy determinations in mandating that health care plans provide coverage for the medically necessary treatment of autism under the same terms and conditions applied to other medical conditions. (§ 1374.72.) The legal question before the trial court is whether the therapies at issue ****572** are "health care services" within the meaning of the Mental Health Parity Act and the Knox-Keene Act, and if so, whether the statute requires that the services only be provided by

Exhibit E

persons licensed or certified by the state. These are issues of statutory interpretation that are well-suited for adjudication by the courts.

[46] [47] [48] Arce's request for injunctive relief also would not require the trial court to assume or interfere with the functions of an administrative agency. As the Courts in *Bell* and *Blue Cross* made clear, although the Knox-Keene Act expressly authorizes the DMHC to enforce the statute, its jurisdiction is not exclusive. (*Bell. supra.* 131 Cal.App.4th at pp. 216-217, 31 Cal.Rptr.3d 688; *Blue Cross. supra.* 180 Cal.App.4th at p. 1250, 102 Cal.Rptr.3d 615.) Private individuals are still entitled to bring suit under the UCL to enjoin acts made unlawful by the Knox-Keene Act. Here, Arce's UCL claim is predicated, in part, on an alleged violation of the Mental Health Parity Act. The Mental Health Parity Act, which is part of the Knox-Keene Act, is not a purely regulatory statute. Rather, it imposes mandatory obligations upon health care plans and makes it unlawful for a health care plan to deny coverage for the medically necessary treatment of autism. (§ 1374.72.) Because a denial of coverage for health care services to treat autism can constitute a violation of the Mental Health Parity Act, it may be enjoined as unlawful conduct under the UCL.

[49] While acknowledging that the jurisdiction of the DMHC is not exclusive, Kaiser asserts that the agency has established well-defined parallel procedures to address issues of coverage and medical necessity for the members of health care service plans. It is true that, pursuant to the Knox-Keene Act, the DMHC provides an administrative process by which a health care plan member may challenge a denial of coverage. In the DMHC's grievance system, the DMHC determines whether a disputed service is a covered benefit under the health plan contract, and if so, it orders the plan to promptly offer and provide the service to the member. (§ 1368, subd. (b).) If the DMHC determines that a health care plan has denied coverage for a service on the ground that the service is not medically necessary, then the grievance is eligible for review under the agency's Independent Medical Review system. *502 (§ 1374.30.) In the Independent Medical Review system, medical professional reviewers determine whether a disputed service is medically necessary based on such factors as the specific medical needs of the plan member and the medical evidence on the effectiveness of the service. (§ 1374.33.) However; the Knox-Keene Act makes clear that the DMHC grievance system and the Independent Medical Review system are neither required nor exclusive remedies. (See § 1368, subd. (d) [The DMHC's grievance system "shall be in addition to any other procedures that may be available to any person, and failure to pursue, exhaust, or engage in the procedures described in this section shall not preclude the use of any other remedy provided by law."]; § 1374.30, subd. (h) ["The independent medical review process authorized by this article is in addition to any other procedures or remedies that may be available."].) Thus, notwithstanding the availability of administrative remedies, a private party may still file suit under the UCL for violation of the Mental Health Parity Act.

Kaiser contends that the DMHC is better suited to decide when and under what circumstances a health care plan should provide coverage for services to treat autism. In particular, Kaiser points to a **573 March 2009 memorandum from the DMHC to health care service plans as evidence that "the regulatory process is working." In the memorandum, the DMHC stated that it is committed to ensuring that individuals with autism spectrum disorders receive the care to which they are entitled under the Knox-Keene Act. The DMHC also explained that it intends to "continue to enforce existing law regarding the grievance and

Exhibit E

[Independent Medical Review] process," and to "initiate the rulemaking process to formalize plan requirements and provide additional clarity through an open and public process." Kaiser reasons that abstention will allow the DMHC the time to perform its regulatory functions and to develop further regulations to address the specific issues raised by this suit. However, the fact that an administrative agency may, at some future time, adopt new regulations bearing on pending legal issues does not mean that a court should abstain from adjudicating a presently justiciable controversy. The putative class members in this case are children with autism spectrum disorders who allegedly have been denied coverage for mental health care services in breach of the health plan contract and in violation of the Mental Health Parity Act. These individuals are entitled to a timely determination of their rights. Because adjudication of Arce's suit would not require the trial court to make individualized determinations of medical necessity, to evaluate complex issues of economic policy, or to decide matters within the exclusive jurisdiction of the DMHC, the trial court abused its discretion in concluding that the doctrine of judicial abstention precluded the UCL claim. The trial court therefore erred in sustaining Kaiser's demurrer to the cause of action for violation of the UCL.

***503 DISPOSITION**

The trial court's order sustaining the demurrer to the class action allegations of the third cause of action for violation of the UCL is reversed. The matter is remanded to the trial court for further proceedings consistent with this opinion. Arce shall recover his costs on appeal.

HON. SUSAN J. CRAIGHEAD
Noted for Hearing: June 8, 2011
Without Oral Argument

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IN THE SUPERIOR COURT OF WASHINGTON
FOR KING COUNTY

D.F. and S.F., by and through their parents,
A.F. and R.F.; S.M.-O., by and through his
parents, S.M. and D.O.; on their own behalf
and on behalf of all similarly situated
individuals,

Plaintiffs,

v.

WASHINGTON STATE HEALTH CARE
AUTHORITY; PUBLIC EMPLOYEES
BENEFITS BOARD; DOUG PORTER,
Administrator of the Washington State
Health Care Authority and Chairman of the
Public Employees Benefits Board, in his
official capacity;

Defendants.

NO. 10-2-29400-7 SEA

~~[PROPOSED]~~ s c
ORDER:

- (1) GRANTING, IN PART,
PLAINTIFFS' MOTION FOR
PARTIAL SUMMARY
JUDGMENT AND
- (2) DENYING DEFENDANTS'
SUMMARY JUDGMENT MOTION

THIS MATTER came before the Court upon plaintiffs' Motion for Partial Summary Judgment and Permanent Injunction and defendants' Cross-Motion for Summary Judgment. The Court heard oral argument on February 4, 2011. Plaintiffs D.F., S.F. and S.M.-O., by and through their parents, were represented by Eleanor Hamburger and Richard E. Spoonemore, SIRIANNI YOUTZ SPOONEMORE. Defendants Washington State Health Care Authority, Public Employees Benefits Board and Doug Porter, in his official capacity as Administrator of the Washington State Health Care Authority and Chairman of the Public Employees Benefits Board (collectively

ORDER GRANTING, IN PART, PLAINTIFFS' MOTION
FOR SUMMARY JUDGMENT, AND DENYING
DEFENDANTS' SUMMARY JUDGMENT MOTION - 1

SIRIANNI YOUTZ SPOONEMORE
999 THIRD AVENUE, SUITE 3650
SEATTLE, WASHINGTON 98104
TEL. (206) 223-0303 FAX (206) 223-0246

Exhibit E

1 "defendants"), were represented by Melissa A. Burke-Cain and Kristen K. Culbert,
2 OFFICE OF THE ATTORNEY GENERAL.

3 In their motion, defendants seek an order declaring that the Washington
4 State Health Care Authority's health care coverage, which lists Applied Behavior
5 Analysis therapy as a specific exclusion, complies with Washington's Mental Health
6 Parity Act, RCW 41.05.600. Defendants also seek summary judgment on plaintiffs'
7 claims for the failure to exhaust their administrative remedies. Plaintiffs, in their
8 motion, seek partial summary judgment and an injunction declaring that defendants
9 are required to cover Applied Behavior Analysis when the service is medically
10 necessary, and that defendants' exclusion of Applied Behavior Analysis is illegal under
11 the Mental Health Parity Act.

12 Along with oral argument, the Court reviewed and considered the
13 pleadings and record herein, including:

- 14 • Plaintiffs' Motion for Partial Summary Judgment and Permanent
15 Injunction;
- 16 • the Declaration of Lynda Gable and any exhibits attached thereto;
- 17 • the Declaration of Jeffrey D. Mills and any exhibits attached thereto;
- 18 • the Declaration of Richard E. Spoonemore and any exhibits attached
19 thereto;
- 20 • the Declaration of A.F., mother of D.F. and S.F. and any exhibits attached
21 thereto;
- 22 • Defendants' Cross-Motion for Summary Judgment and any exhibits
23 attached thereto;
- 24 • the Declaration of Joleen McMahon and any exhibits attached thereto;
- 25 • the Declaration of Melissa Burke-Cain and any exhibits attached thereto;
- 26 • the Declaration of Nicole Oishi and any exhibits attached thereto;

ORDER GRANTING, IN PART, PLAINTIFFS' MOTION
FOR SUMMARY JUDGMENT, AND DENYING
DEFENDANTS' SUMMARY JUDGMENT MOTION - 2

SIRIANNI YOUTZ SPOONEMORE
999 THIRD AVENUE, SUITE 3650
SEATTLE, WASHINGTON 98104
TEL. (206) 223-0303 FAX (206) 223-0246

Exhibit E

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- Plaintiffs' Response to Defendants' Cross-Motion for Summary Judgment;
- the Second Declaration of Richard E. Spoonemore and any exhibits attached thereto;
- the Declaration of J.M. and any exhibits attached thereto;
- the Second Declaration of A.F. and any exhibits attached thereto;
- Defendants' Opposition to Plaintiffs' Motion for Partial Summary Judgment and Injunctive Relief re: Mental Health Parity Act;
- the Declaration of Melissa Burke-Cain in Support of Defendants' Opposition to Plaintiffs' Partial Summary Judgment Motion and any exhibits attached thereto;
- the Declaration and Amended Declaration of Eliana Gall and any exhibits attached thereto;
- Defendants' Reply Brief in Support of Defendants' Cross-Motion for Summary Judgment;
- Plaintiffs' Reply in Support of Their Motion for Partial Summary Judgment and Injunctive Relief re: Violation of the Mental Health Parity Act;
- the Third Declaration of A.F. and any exhibits attached thereto;
- the Declaration of Allison Lowy Apple and any exhibits attached thereto;
- the Third Declaration of Richard E. Spoonemore and any exhibits attached thereto;
- the Declaration of Michael A. Fabrizio, M.A. and any exhibits attached thereto; and
- the Declaration of Stacey Shook, Ph.D., B.C.B.A.-D., C.M.H.C. and any exhibits attached thereto.

Based upon the foregoing, the Court hereby GRANTS, in part, plaintiffs' Motion for Partial Summary Judgment and DENIES, in total, defendants' Motion for Summary Judgment.

ORDER GRANTING, IN PART, PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT, AND DENYING DEFENDANTS' SUMMARY JUDGMENT MOTION - 3

SIRIANNI YOUTZ SPOONEMORE
999 THIRD AVENUE, SUITE 3650
SEATTLE, WASHINGTON 98104
TEL. (206) 223-0303 FAX (206) 223-0246

Exhibit E

1 As set forth in a letter ruling dated May 23, 2011, which is incorporated
2 herein at *Exhibit A*, the Court concludes that, as a matter of law, plaintiffs are entitled
3 to a declaration that specific exclusions contained in health benefit plans administered
4 by the defendants that exclude coverage of Applied Behavior Analysis therapy, even
5 when medically necessary and performed by licensed health providers, do not comply
6 with Washington's Mental Health Parity Act, RCW 41.05.600. The Court further
7 declares that under the Mental Health Parity Act defendants are required to cover
8 medically necessary Applied Behavior Analysis therapy, as determined on an
9 individualized basis, when provided by licensed providers.

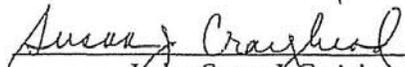
10 The Court reserves ruling, at this time, whether defendants are required
11 to cover Applied Behavior Analysis therapy when provided by certified or registered –
12 as opposed to licensed – health providers.

13 The Court denies, without prejudice, plaintiffs' request for injunctive
14 relief at this time. The Court anticipates that an evidentiary hearing may need to be
15 conducted after a ruling on class certification to determine whether an injunction
16 should issue against defendants as to the individual plaintiffs or a class of plaintiffs.

17 The Court denies defendants' motion for summary judgment because
18 (1) defendants have not complied with the Mental Health Parity Act (as set forth above
19 and in the Court's May 24, 2011 letter ruling), and (2) defendants' exhaustion defense
20 fails with respect to plaintiffs on summary judgment. The Court also concludes that
21 there is no need for other putative class members exhaust administrative remedies, ^{as}
_{set forth in the Court's May 24, 2011 letter ruling.}

22 IT IS SO ORDERED.

23 DATED this 7th day of June, 2011.

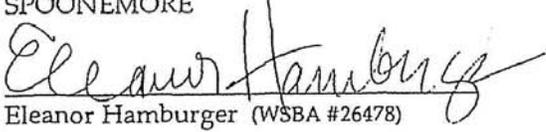
24
25 
26 Judge Susan J. Craighead
Superior Court Judge

ORDER GRANTING, IN PART, PLAINTIFFS' MOTION
FOR SUMMARY JUDGMENT, AND DENYING
DEFENDANTS' SUMMARY JUDGMENT MOTION - 4

SIRIANNI YOUTZ SPOONEMORE
999 THIRD AVENUE, SUITE 3650
SEATTLE, WASHINGTON 98104
TEL. (206) 223-0303 FAX (206) 223-0246

1 Presented by:

2 SIRIANNI YOUTZ
3 SPOONEMORE

4 

5 Eleanor Hamburger (WSBA #26478)

6 Richard E. Spoonemore (WSBA #21833)

7 Attorneys for Plaintiffs

8 Approved as to Form by:

9 ROBERT M. MCKENNA

10 Attorney General

11

12

13

Melissa A. Burke-Cain (WSBA #12895)

14 Kristen K. Culbert (WSBA #32930)

15 Attorneys for Defendants

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ORDER GRANTING, IN PART, PLAINTIFFS' MOTION
FOR SUMMARY JUDGMENT, AND DENYING
DEFENDANTS' SUMMARY JUDGMENT MOTION - 5

SIRIANNI YOUTZ SPOONEMORE
999 THIRD AVENUE, SUITE 3650
SEATTLE, WASHINGTON 98104
TEL. (206) 223-0303 FAX (206) 223-0246

Exhibit E

Superior Court for the State of Washington
in and for the County of King

SUSAN J. CRAIGHEAD
Judge

May 23, 2011

King County Courthouse
Seattle, Washington 98104-231
E-mail: Susan.Craighead@kingcounty.go

Mr. Richard E. Spoonemore
Ms. Eleanor Hamburger
Sirianni Youtz Meier & Spoonemore
999 3rd Ave. Ste 3650
Seattle, WA 98104-4038

Ms. Melissa A. Burke-Cain
Ms. Kristen K. Culbert
Office of the Attorney General
Agriculture & Health Division
7141 Cleanwater Drive SW
P.O. Box 40109
Olympia, WA 98504

S.F., et al v. Washington State Health Care Authority, No. 10-2-29400-7 SEA
Cross-Motions for Summary Judgment

Counsel,

Before the Court are cross-motions for summary judgment. The Washington Health Care Authority (HCA) seeks an order declaring that its coverage under its Uniform Medical Plan (UMP) complies with the mental health parity law, RCW 41.05.600; HCA also seeks summary judgment dismissing the action because plaintiffs failed to exhaust their administrative remedies. For the reasons set forth below, HCA's motion for summary judgment is denied.

Plaintiffs seek partial summary judgment in the form of an injunction requiring HCA to cover Applied Behavioral Analysis (ABA) for children with autism for whom the service is medically necessary. For the reasons set forth below, this motion is granted in part.

Plaintiffs are a putative class of children who have Autism Spectrum Disorder (ASD) whose families are insured through HCA; the named plaintiffs under UMP and Aetna. There is no dispute about the diagnosis. ABA therapy is an intensive, one-on-one intervention that has shown success with some children with ASD, assisting them changing behaviors that make it difficult for them to interact with others. Children spend between 25-40 hours per week undergoing therapy, at a cost of as much as \$50,000 per year. Plaintiffs contend that ABA therapy can enable children with ASD to attend school, even in mainstream classrooms, or avoid institutionalization. HCA contends that there is no scientific evidence establishing statistically significant improvement in children who have undergone ABA therapy. Both Aetna and UMP, in accordance with HCA's policy, flatly exclude ABA therapy from coverage.

S.F. and his family first enrolled in the Aetna Public Employees Plan in January 2009. His family had previously been insured through Premera Blue Cross. Premera provided limited coverage for ABA

Exhibit E

therapy. S.F. and his brother, D.F., received ABA therapy through a program prescribed and monitored by Dr. Stephen Glass, a well-known pediatric neurologist. The program was implemented by Allison Apple, Ph.D., who is a licensed mental health provider. The boys' parents were initially told that this therapy would be covered by Aetna under a "transition of Care" benefit, but later Aetna declined coverage for a consulting appointment with Dr. Glass and all other therapy related to ABA on the grounds that ABA is not covered under the plan. The parents appealed the denial; HCA denied the appeal on the grounds that the treatment was not "medically necessary." At that point, the parents requested an independent review of the dispute; this review found that ABA therapy is the standard medical care for children with autism and concluded that ABA therapy was medically necessary. After this review, Aetna paid for S.F.'s ABA therapy, which was provided by a master's level therapist who was a certified mental health counselor. However, as it had told S.F.'s parents it would, Aetna subsequently amended its certificate of coverage to specifically exclude ABA therapy, even if it was medically necessary.

HCA argues that it does not cover ABA therapy because it is provided by unlicensed practitioners. HCA contends that it only provides coverage for care performed by licensed health care providers, whether the care is for medical or mental health conditions. Plaintiffs acknowledge that many ABA therapists are not licensed by the State of Washington (although there is a voluntary national certification for ABA practitioners), but contend that HCA denied coverage in this case for care that would have been performed by licensed mental health providers. The crux of the plaintiffs' argument is that ABA is excluded from coverage by HCA regardless of who provides it and regardless of whether it is medically necessary for an individual child; in contrast, there is no similar blanket exclusion for any category of medical care. While HCA argues in this litigation that its concern is the licensure of the practitioners, it did not cite this basis as grounds for denying coverage to the named plaintiffs before the litigation began.

Both parties rely on language in the mental health parity law, RCW 41.05.600, to support their arguments. Plaintiffs cite RCW 41.05.600(1), which defines "mental health services" as "medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders..." and then lists certain categories of treatment that are expressly not included in the definition of "mental health services." Plaintiffs argue that this provision means that all other mental services are to be covered, without limitation. This, they argue, was the legislature's way of remedying past discrimination against mental health care.

HCA points to RCW 41.05.600(2)(c), which provides in part that "[t]reatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services." HCA argues that this provision allows it to restrict coverage to licensed mental health care providers, since only medical and surgical services performed by licensed providers are covered. HCA also notes RCW 41.05.600(4), which provides that a health plan may require that "mental health services be medically necessary...if a comparable requirement is applicable to medical and surgical services."

Exhibit E

The court is not persuaded that the statute's definition of mental health services evidences a legislative intent that all services that purport to remedy mental health problems must be covered by HCA, regardless of medical necessity. Similarly, the court is not persuaded that the legislature intended to require HCA to cover services no matter the qualifications of the provider. It appears from the language cited by HCA above, that the legislature anticipated that restrictions could be placed on coverage for mental health services as long as they were the same type of restrictions placed on coverage for medical and surgical services.

Although both parties attempt to persuade the court of their respective positions on the medical necessity of ABA therapy, or lack thereof, that is not an issue that needs to be resolved to rule on the plaintiffs' motion. From the evidence presented to the court, it is apparent that ABA therapy may provide benefit to some individuals. The plaintiffs are seeking the opportunity to establish medical necessity on a case by case basis.

The court concludes as a matter of law that HCA is not in compliance with the Mental Health Parity Act insofar as it imposes a blanket exclusion of ABA therapy, even when provided by licensed therapists. HCA is required by the Act to cover medically necessary ABA therapy (as determined on an individualized basis) that is provided by licensed therapists. The court cannot determine as a matter of law that HCA is required to cover ABA therapy provided by certified or registered providers because on this record it is not clear whether HCA covers mental health services provided by counselors or therapists who hold certifications or registrations, but not licenses. Neither is it clear whether a national certification as is held by some ABA providers is equivalent to any certification for providers of other mental health services currently covered by HCA.

Exhaustion: HCA contends that plaintiffs have failed to exhaust their administrative and/or contractual remedies and, therefore, their claims should be dismissed. It does not appear that the Administrative Procedure Act applies to this dispute; the relationship among the parties is contractual, governed by the Certificates of Coverage. S.F. has exhausted his contractual remedies under the Certificate of Coverage, inasmuch as he appealed the denial of coverage for ABA services, prevailed before the IRO, only to have Aetna change the Certificate of Coverage to thwart the result of his appeal. There is no need for other putative class members to go through a similar exercise when it is plain that the result will be the same. HCA's exhaustion defense fails on summary judgment.

Request for a Permanent Injunction: The court has struggled with the plaintiffs' request for a permanent or, in the alternative, preliminary, injunction. The extent to which the court may resort to injunctive relief in the context of summary judgment is unclear; under CR 56, the court is not supposed to weigh facts, but the court must make findings of fact and conclusions of law to support entry of injunctive relief. The plaintiffs seek an injunction that would apply not only to them, but to other children with autism, yet this court has not yet been asked to certify this action as a class action. The parties advised the court at oral argument that the question of whether ABA therapy qualified as a neurodevelopmental therapy has yet to be litigated. While HCA has not presented any information contradicting plaintiffs' assertions that ABA therapy is medically necessary for them, plaintiffs have not

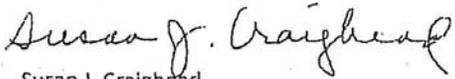
Exhibit E

presented declarations from experts establishing medical necessity or the likelihood of irreparable harm, other than the fact that the IRO concluded that ABA therapy was medically necessary for S.F. It is certainly the opinion of the plaintiffs' parents that the lack of ABA therapy has caused and will continue to cause irreparable injury to them, but the court is not certain that this opinion alone can justify findings to support entry of injunctive relief. For these reasons, the court denies the request for injunctive relief without prejudice. The court anticipates that some type of evidentiary hearing could be conducted following a ruling on class certification to determine whether a preliminary injunction should issue, either as to these plaintiffs or as to a class of plaintiffs. The court welcomes suggestions from counsel regarding this procedure.

Counsel for plaintiffs is directed to present proposed orders to the court that include a list of all of the documents this court reviewed in connection with these cross-motions.

The court apologizes for the length of time it took this matter under advisement. I hope the parties can see the degree of care the court devoted to this very important case.

Sincerely,



Susan J. Craighead
Judge

Exhibit E

Superior Court of New Jersey,
Appellate Division.
Walter MARKIEWICZ, Petitioner-Appellant,

v.

STATE HEALTH BENEFITS COMMISSION, Respondent-Respondent.

Submitted Oct. 24, 2006.

Decided Jan. 17, 2007.

Background: Insured, a public employee, sought review of decision of the State Health Benefits Commission (SHBC), denying coverage under health insurance policy treatment for son's biologically-based mental illness.

Holding: The Superior Court, Appellate Division, Payne, J.A.D., held that parity statute applicable to health insurance benefits offered by the SHBC required coverage of medically-necessary occupational, speech, and physical therapy for children with biologically-based mental illness.

Reversed and remanded.

****554** New Jersey Protection & Advocacy, Inc., for appellant (Susan W. Saidel, Camden, on the brief).

Stuart Rabner, Attorney General, for respondent (Michael J. Haas, Assistant Attorney General, of counsel; Jeff Ignatowitz, Deputy Attorney General, on the brief). .

Before Judges KESTIN, WEISSBARD and PAYNE.

The opinion of the court was delivered by

PAYNE, J.A.D.

291** N.J.S.A. 52: 14-17 .29e, applicable to health insurance coverage offered by the respondent State Health Benefits Commission (SHBC), requires parity in coverage for treatments for biologically-based mental *555** illness and for other sickness. It provides in relevant part:

The State Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act that provides hospital or medical expense benefits shall provide coverage for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract.

N.J.S.A. 52: 14-17 .29d defines "biologically-based mental illness" to be a "mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or [sic] psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including, but not limited to ... pervasive developmental disorder or autism."

Exhibit E

Petitioner Walter Markiewicz, a public employee, is insured by the SHBC under its NJ Plus ^{FN1} plan. His son, T., is a covered person under that insurance plan. T. suffers from "pervasive developmental disorder, not otherwise specified," (PDD-NOS or PDD), a severe condition, related to autism, that has caused gross delays in his development of motor skills and other neurological *292 and muscular problems. The recognized treatments for his condition consist of occupational, speech and physical therapy.

FN1. The name refers to the State's Point of Service plan.

The SHBC concedes that PDD is a biologically-based mental illness, that T. suffers from it, and that the therapeutic services provided to him are medically necessary. Nonetheless, after paying claims for such treatment for 22 months, commencing in June 2003 it has denied coverage for the treatment as the result of an exclusion in its health benefits contract as set forth in the NJ Plus Member Handbook for:

Educational or developmental services or supplies. This includes services or supplies that are rendered with the primary purpose being to provide the person with any of the following:

- a service or supply that is being provided to promote development beyond any level of function previously demonstrated.

In this appeal from a final determination of the SHBC enforcing the contractual exclusion in the circumstances presented, petitioner challenges the enforceability of the exclusion, arguing that it is contrary to the Legislature's intent when including PDD within the scope of its mental health parity legislation, that the exclusion is ambiguous, and that the recognition of the exclusion in this case results in a denial of equal protection. Because we find that the contractual exclusion as applied to covered persons with PDD is contrary to the Legislature's intent in enacting the parity statute applicable to the State Health Benefits Plan, we reverse.

I.

T. was born on February 4, 1997 with PDD, a neurologically-based developmental condition of unknown origin that is presently incurable, although its symptoms are, to an extent, treatable. T's condition is manifested in significantly low muscle tone and weakness, with hypermobile joints that render T. unable to do activities such as holding a pen or throwing a ball, because he cannot maintain a grasp. Unaware of where his tongue is in his mouth, T. has problems swallowing, and he has been known to choke as a result. He has visual and auditory processing problems. **556 T. has *293 severe problems with his balance, has little knowledge of where his body is in space, and must plan motions that, to others, would be automatic. Additionally, he is hypersensitive to touch, developing burn-like marks at pressure points as common as manufacturers' tags on clothes.

At a hearing conducted by an administrative law judge (ALJ) in the matter following the denial of benefits by the SHBC, Judy Richter, T.'s occupational therapist, testified without contradiction that physical and occupational therapy is the standard treatment for a child with PDD. T.'s treating pediatrician, Dr. Michael Schlitt, who also testified at the hearing, concurred.

Exhibit E

Richter described the occupational therapy and its goals in the following terms:

Because of the nature of his disorder, there are many things that occupational therapy does that are unique to any other therapies. What I primarily focus on is his ability to process information from the environment and also from his body to help him become more aware of where his body is in space. He's sort of like a lost soul. Means of doing this are through use of suspension, which is swings. I use balls, wedges, heavy equipment, all to help him organize himself better. Because by giving input, heavy input to his body, he has a better sense of where he is and he can complete tasks with success.

[T]he broad goal would be to help T. become as independent as possible. He's unable to function in the capacity that a child of his age should be. He's unable to do several tasks on his own without the implementation of O.T. But by asking him to put on his socks, an O.T. doesn't just look at that as, "Wow, you just put on your sock," what we look at is his ability to hold his body in flexion, to maintain both arms in front without having to keep [one] back here for support. We're looking at whether his eyes are capable of looking where his hands are, which is a huge problem with T.

So ... my goal would be something like working on visual motor tasks and using that to produce a functional outcome.

In contrast, T.'s physical therapist works on his stamina, with a goal of getting him to sit and walk for longer periods of time, climb stairs without falling, exit a car, and perform other similar functions. It was stated that speech therapy is frequently utilized as a treatment for persons such as T. who have swallowing difficulties.

***294** Richter testified that, if physical and occupational therapy services were not provided to T., he would regress, losing the skills that he had attained, a phenomenon that she had observed after an absence resulting from sickness or a vacation. Using tying shoes as an example, she testified:

It's so much work for his eyes to have to look and team together and look at the same place where his hands are. That it's such a struggle and such an effort to not hear the fan going and whatever else is going on in the room. To shut all that out and really concentrate on what he's doing and for his central nervous system to be able to hold that trunk up and keep those hands forward and lift that foot off the ground, it's so much effort for him. If we don't keep up with that stuff, he will regress. There's no doubt.

On cross-examination by the SHBC, however, Richter admitted that the occupational therapy that she had provided had increased T.'s development beyond what existed when he was first treated, although that development fell far short of the development ****557** appropriate to his age level of almost eight years. Indeed, she admitted that the goal of the therapy was to "get beyond what ... the child can currently perform" in order to increase the child's independence and to foster the development that in other children would happen naturally.

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When pediatrician Dr. Schlitt was asked on cross-examination where T. would stand without the therapy that he had prescribed to treat the effects of his condition, he responded that T. would be "[m]uch worse." In response to the ALJ's question, the doctor testified that the therapy provided a definite benefit that was related to the level of treatment. However, the doctor, too, conceded that the effect of the therapy had been to permit T. to do things now that he could not have done before, although he was of the opinion that, with additional therapy, T. should be able to develop further skills. According to the doctor, his immediate goal was to promote the child's development "to the point where he's safe." Later, the doctor stated, he would be "fighting" to make T. a well-functioning person in society. "Just to make him safe isn't good enough, but he's not even safe yet."

The hearing also included testimony from David Perry, who was employed by Horizon, the benefits administrator for the SHBC's *295 NJ Plus plan, as the Director of Account Management and Finance for the State Health Benefits Program. Perry testified that he believed that, prior to 2001, children with PDD were being provided with insurance coverage for occupational and physical therapy pursuant to the SHBC's presently existing contractual language. When Horizon's medical director determined from company data that the volume of therapy claims was "running at a certain level" and that therapy on behalf of children with PDD was being authorized, he contacted Perry to determine whether the SHBC wanted the developmental exclusion to be interpreted so as to bar such claims. It was then determined that such therapeutic claims had been "approved inappropriately." Thereafter, claims on behalf of children with PDD were flagged by Horizon to determine whether the claims fell within the developmental treatment exclusion. If so, they were denied.

Following the hearing, on July 7, 2005, the ALJ issued a written opinion in which he recommended that petitioner's claim for benefits be denied. The judge found, in relevant part, that occupational and physical therapy was being provided to train T. in "activities of daily living" in order to "promote development beyond any level of function previously demonstrated." The judge continued by finding:

That part of this therapy is aimed at developing the skills and abilities not yet demonstrated that will protect T. from harm does not lessen the fact that these are skills that he needs to develop, that some, if not all, of these involve "activities of daily living." The contract language does not differentiate between activities of daily living that have a safety element within them and those that do not, and the language does not differentiate between the promotion of development of functions not previously demonstrated that have safety elements and those that do not.

The judge additionally rejected arguments by petitioner similar to those offered on appeal that the contract was ambiguous, and that T., as a disabled child, had been denied equal protection of the law. The SHBC adopted the findings of fact and conclusions of law of the ALJ, along with his recommended disposition, and in a final decision dated August 16, 2005, denied petitioner's claim.

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The issue before us, in essence, is whether the Legislature intended, when it passed relevant parity statutes recognizing PDD as a "biologically-based mental illness," that the only effective treatments for PDD be barred from coverage by the SHBC under its NJ Plus plan as the result of a contractual exclusion contained in the Member Handbook provided to its subscribers. We find the Legislature's intent to have been otherwise.

[1] [2] The issue we confront is not a medical one, but rather, a matter of statutory interpretation. *Heaton v. State Health Benefits Comm'n*, 264 N.J.Super. 141, 147, 624 A. 2d 69 (App.Div.1993). Because of its nature, we are not bound by the interpretation of the parity statute offered by the ALJ and accepted by the SHBC, although we may accord that interpretation considerable weight. *Mayflower Sec. v. Bureau of Sec. .* 64 N.J. 85, 93, 312 A.2d 497 (1973) ("An appellate tribunal is, however, in no way bound by the agency's interpretation of a statute or its determination of a strictly legal issue."); *see also Peper v. Princeton Univ. Bd of Trs. .* 77 N.J. 55, 69- 70, 389 A.2d 465 (1978)(according deference to such agency interpretations). Nonetheless, in determining whether to intervene, we must restrict our inquiry to "(1) whether the agency's decision offends the State or Federal Constitution; (2) whether the agency's action violates express or implied legislative policies; (3) whether the record contains substantial evidence to support the findings on which the agency based its action; and (4) whether in applying the legislative policies to the facts, the agency clearly erred in reaching a conclusion that could not reasonably have been made on a showing of the relevant factors. *"George Harms Const. Co., Inc. v. N.J. Tpk. Auth.,* 137 N.J. 8, 27, 644A.2d 76 (1994) (citing *Campbell v. Dept. of Civil Serv. .* 39 N.J. 556, 562, 189 A.2d 712 (1963) and *In re Larsen*, 17 N.J. Super. 564, 570, 86A.2d 430 (App.Div.1952)).

We thus turn to the relevant legislation. In 1996, the federal government enacted a Federal Mental Health Parity Act, currently codified at 42 U.S. C.A. § 300gg-5. Following that enactment, *297 in 1999, New Jersey enacted its own mental health parity act, applicable to persons covered by individual health insurance policies. *See N.J.S.A. 17B:26-2.1s*, which provides:

Every individual health insurance policy that provides hospital or medical expense benefits and is delivered, issued, executed or renewed in this State ... shall provide coverage for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract. "Biologically-based mental illness" means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to ... pervasive developmental disorder or autism.

Later in that year, the substantially similar parity provisions that we quoted at the beginning of this opinion, applicable to insurance plans provided by the SHBC, were passed, effective January 18, 2000. *See N.J.S.A. 52:14-17.29d* and -17.29e. The primary legislative sponsors were identical for the two pieces of legislation, which were passed in the same legislative session within seven months of each other. The Senate and Assembly Statements accompanying the public employee version of the statute both note that the bill would require that the State Health Benefits Commission provide the same coverage for biologically-based mental ****559** illness to

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persons covered under the State Health Benefits Program as that required for other health insurers and health maintenance organizations under P.L. 1999, c. 106.^{FN2}

FN2. This is the underlying chapter law codified in part at N.J.S.A. 17B:26-2.1s.

[Statement to Assembly Bill No. 3588, December 12, 1999; Statement to Senate Bill No. 2277, December 13, 1999.]

Relevant evidence of the Legislature's intent in enacting the two parity statutes is not contained in their legislative histories. However, the State Department of Banking and Insurance, Division of Insurance, which administers the private insurer mental health parity law through promulgation of implementing regulations, has interpreted N.J.S.A. 17B:26-2.1s in a manner that is relevant to the present challenge. In May 2005, the Department adopted a proposed regulation, now codified at N.J.A.C. 11:4-57.1 to -57.4. Significantly, a portion of that regulation states that, "[n]otwithstanding the applicability of such exclusions to persons with *298 physical illness, carriers shall not apply any exclusion in a health insurance policy or health maintenance organization contract to deny benefits for services or supplies that are medically necessary for the treatment of covered persons with biologically-based mental illness," and it specifically lists as inapplicable "[e]xclusions for physical, speech and occupational therapy that is non-restorative (that is, that does not restore previously possessed function, skill or ability)". N.J.A.C. 11:4-57.3(a)2. The rule also forbids "[e]xclusions for the treatment of developmental disorders or developmental delay." N.J.A.C. 11:4-57.3(a)4.^{FN3}

FN3. The SHBC has not promulgated regulations that specifically address treatments for PDD and autism. The administrative code simply contains a regulation adopting by reference "all of the policy provisions contained in the contracts between the health and dental plans and the State Health Benefits Commission as well as any subsequent amendments thereto". N.J.A.C. § 17:9-2.14.

The Department's intent in promulgating this regulation appears from its history. The regulation, in a different form, was originally proposed in 2003. Because of various shortcomings, the proposed regulation was amended and re-published for comment in its present form in 2004. One commenter mistakenly envisioned that other provisions of the regulation would permit a denial of benefits for vital occupational therapy services to children with global developmental delays, including children with autism and PDD, whose skill development is addressed by occupational, speech and physical therapists. The Department, interpreting N.J.S.A. 17B:26-2.1s and its proposed regulation, responded:

The Department believes that to allow carriers to exclude the primary mode of treatment for autism and pervasive developmental disorder (speech, occupational and physical therapy) would render the statutory directive meaningless and, therefore, cannot be permitted. Interpretations that render a statute void are to be avoided. The Department, therefore, interpreted the BBMI [biologically-based mental illness] mandate to require carriers to cover the primary treatments for these disorders and to preclude them from relying on exclusions to deny such coverage.

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[37 N.J.R. 1523(a) (May 2, 2005).]

*299 The Department's interpretation of the parity statute applicable to individual insurance plans is not binding on the SHBC or us. Nonetheless, its construction of a substantially identical statutory provision that it is authorized to interpret **560 is " 'persuasive evidence of the Legislature's understanding of its enactment.' " St. Peter's Univ. Hosp. v. Lacy. 185 N.J. 1, 15, 878 A.2d 829 (2005)(quoting Cedar Cove, Inc. v. Stanzone. 122 N.J. 202, 212, 584A.2d 784 (1991)).

[3] We view the Department's regulations as reflecting a proper construction of the intent of the Legislature in passing the private insurance parity statute as it relates to the provision of benefits for developmentally disabled children who suffer from developmental conditions such as PDD and autism. As the Department has noted, an exclusion from coverage for claims based upon occupational, speech and physical therapy offered to developmentally disabled children would render meaningless the specific inclusion of PDD and autism within those biologically-based mental illnesses subject to the parity statute. The Legislature surely could not have intended that the principal treatments for developmental disabilities be excluded from coverage simply because those treatments differ in their essential nature from treatments applicable to other biologically-based mental illnesses, such as the use of psychiatric or psychological therapy and drugs. The fact that biologically-based mental illnesses affect development in some and other neurological functions in others should not be the determinant of coverage.

[4] As we have noted, the parity statute applicable to coverage offered through the SHBC is, in all relevant respects, identical to that applicable to private, individual insurance policies. Statutes that share a common purpose should be harmonized, not read in conflict, F & W Associates v. County of Somerset. 276 N.J. Super. 519, 525-26, 648 A.2d 482 (App.Div.1994)-a maxim that is particularly applicable when the statutes in question were passed in the same session, as these were. St. Peter's, supra. 185 N.J. at 15, 878 A.2d 829 (quoting *300 In re Adoption of a Child by WP. And M.P., 163 N.J.158, 182-83, 748A.2d 515 (2000) (Poritz, C.J., dissenting)).

[5] The SHBC, espousing a literal reading of the parity statute, contends that its contractual exclusion from coverage of educational or developmental services ^{FN4} that promote development beyond any level of function previously demonstrated comports with the parity statute because it applies equally to the treatment of physical illness and biologically-based mental conditions. However, the SHBC's interpretation of the statute renders null the inclusion of PDD and autism within its parity provisions. A statute should not be read so literally that the purpose of the legislation is circumvented and an anomalous result is achieved, as has occurred here. Reisman v. Great Am. Rec., Inc., 266N.J. Super. 87, 96, 628 A.2d 801 (App.Div.), certif. denied, 134 N.J. 560, 636 A.2d 519 (1993). In such a circumstance, literal interpretation must bow to a common-sense view of the law's intent. Wnuck v. N.J. DMV. 337 N.J. Super. 52, 57-58, 766 A.2d 312 (App.Div.2001). To read the governing statute as offering parity, but not affording coverage for medically necessary treatment of the very conditions that are the enumerated subjects of the parity provisions would be unreasonable.

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FN4. Neither term is defined by statute or regulation.

[6] The State Health Benefits Program Act, N.J.S.A. 52:14-17.25 to -17.45, created a state-funded, but privately-administered, health benefits program for public employees, established the SHBC, and authorized it to oversee the program. We have recognized that the "goal of the State Health Benefits Program Act is to provide comprehensive health benefits for ****561** eligible public employees and their families at tolerable cost." Heaton. supra. 264 N.J.Super. at 151, 624 A.2d 69. Horizon's witness, Perry, testifying at the administrative hearing in this matter, stated that the SHBC's decision to enforce the developmental exclusion to preclude coverage for occupational, speech and physical therapy administered to children with PDD and autism, occurred after a ***301** rise in such claims had been recognized by Horizon's medical director. That interpretive decision, while conserving the public fisc, served to undermine the purposes of the parity statute as we read it. It is well established that an administrative agency may not exercise its delegated authority to alter the terms of a statute or frustrate the policy underlying an enactment. N.J. State Chamber of Commerce v. N.J. Election Law Enforcement Comm'n.. 82 N.J. 57.82,411 A.2d 168 (1980).

Unfortunately, PDD and autism, with the mental distress and treatment expenses that accompany them, are appearing with alarmingly greater frequency among children in this country. To public employees, coverage by the SHBC may provide their "only source of protection from [such] catastrophic medical expenses." Heaton. Supra. 264 N.J.Super. at 150.624 A.2d 69. Yet, the SHBC would interpret the parity statute in a manner that would permit the exclusion of benefits for medically necessary treatment of children with PDD and autism, thereby limiting state-employee coverage to a level below the statutory minimum imposed on commercial carriers. We do not perceive either the nature of the State Health Benefits Program nor the cost concerns of the SHBC as providing a ground for this distinction in coverage under governing parity statutes, particularly in light of legislative sponsor statements expressing the equivalence of coverage that was envisioned.

We offer no opinion whether the exclusion at issue can be implemented legitimately in contexts other than those presented. However, for the reasons we have expressed, we find its use to preclude coverage of medically necessary occupational, speech and physical therapy provided to children with biologically-based mental illnesses manifesting as developmental disabilities to be contrary to the mental health parity statute as set forth in N.J.S.A. 52:14-17.29d and -17.2ge. An interpretation consistent with that of the Department of Banking and Insurance, as set forth in N.J.A.C. 11:4- 57.1 through -57.4, is required.

***302** In light of this resolution, we need not address petitioner's further arguments premised upon ambiguity and an equal protection violation.

Reversed and remanded to the State Health Benefits Commission for further action consistent with this opinion.

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United States District Court, D. Oregon.
Lisa A. McHENRY, Plaintiff,

v.

PACIFICSOURCE HEALTH PLANS and the Metro Area Collection Service, Inc. Group
Health/Dental Plan, Defendants.

No. CV-08-562-ST.

Jan. 5, 2010.

Background: Participant brought action against plan administrator under Employee Retirement Income Security Act (ERISA), seeking reimbursement under her group health plan for her son's applied behavioral analysis therapy to treat his autism. Parties cross-moved for summary judgment.

Holding: The District Court, Stewart, United States Magistrate Judge, held that participant was not entitled to coverage.

Ordered accordingly.

***1227** John C. Shaw, Megan E. Glor, Megan E. Glor Attorneys at Law, Nena Cook, Sussman Shank, LLP, Portland, OR, for Plaintiff.

***1228** Richard K. Hansen, Schwabe Williamson & Wyatt, PC, Portland, OR, for Defendants.

OPINION AND ORDER
STEWART, United States Magistrate Judge:

INTRODUCTION

Plaintiff, Lisa A. McHenry ("McHenry"), is a participant in the Metro Area Collection Service, Inc. Group Health/Dental Plan, which is insured by defendant, PacificSource Health Plans ("PacificSource"). McHenry's minor son, J.M., suffers from autism and receives Applied Behavioral Analysis ("ABA") therapy. This therapy has been effective in treating J.M.'s autism but at a substantial cost. Pacific Source is the claims administrator and has denied coverage for J.M.'s ABA therapy. McHenry brings this action under the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 USC §§ 1001-1461, to compel coverage.

On May 5, 2009, 643 F.Supp.2d 1236, this court ruled that because the Plan did not unambiguously grant PacificSource the power to determine eligibility, interpret Plan language, or making binding benefits determinations, the *de novo* standard of review applies to PacificSource's denial of benefits (docket # 27).

The parties have filed cross motions for summary judgment (dockets # 41 & # 47). All parties have consented to allow a Magistrate Judge to enter final orders and judgment in this case in accordance with FRCP 73 and 28 USC § 636(c). For the reasons set fourth below, McHenry's motion is denied and defendants' motion is granted.

UNDISPUTED FACTS

J.M. was diagnosed with autism in May 2006, at the age of one year and nine months. On or about November 20, 2006, J.M.'s pediatrician, Rupa K. Shah, M.D., submitted to PacificSource a request for coverage for ABA therapy. J.M. began receiving ABA therapy from Emily Hoyt, a Board Certified Behavior Analyst ("BCBA"), in January 2007. Hoyt submitted invoices to PacificSource for payment of services provided to J.M. from January through April 2007. SR 16_18.^{FN1}

FN1. "SR" refers to the stipulated record filed by the parties on May 22, 2009 (docket # 46).

In June 2007, PacificSource denied payment of these billings, explaining that the "[p]rovider is not eligible on this plan." SR 16. Later that same month, McHenry submitted to PacificSource an Initial Grievance of the denial. SR 20. In her grievance she inquired "what would make a therapist eligible to provide [ABA therapy] on our plan[?]" and whether PacificSource "offer[ed] a plan that include [d] ABA therapy?" *Id.* She requested that her claim receive a medical, not administrative, review.

Pacific Source submitted McHenry's grievance to its Medical Grievance Review Committee ("Grievance Committee"). SR 50-53. On August 2, 2007, the Grievance Committee notified McHenry that it had upheld PacificSource's denial of her claim on three bases: (1) the Plan "specifically exclude[d] coverage for experimental or investigational procedures, services and treatments;" (2) "the plan exclude[d] academic or social skills training;" and (3) BCBA's, "while professionally educated, are not medically trained clinicians and are not eligible providers for PacificSource." SR 54. It then explained:

This determination is based on the above exclusions and a lack of sufficient evidence-based peer-reviewed literature ***1229** and other supporting data to establish this as a standard of care of coverage. The committee determined that Applied Behavior Analysis meets the plan definition of an experimental or investigational procedure.

Id.

McHenry appealed this decision on August 6, 2007. SR 70-71. She disagreed with the conclusion that ABA therapy was experimental or investigational in nature and cited to an article listing the many medical professionals, medical organizations, and government agencies that had accepted it as a scientifically based treatment for children with autism. SR 70, 72-77 (Erick V. Larsson, Ph.D., *Intensive Early Intervention using Behavior Therapy is No Longer Experimental, available at* <http://rsaffran.tripod.com/ieibt.html>) (last accessed Jan. 5, 2010).^{FN2}

FN2. The stipulated record contains many articles from scientific and academic journals, government publications, websites, and other sources which McHenry submitted during the course of the administrative appeals process. These articles are cited by the page(s) on which they appear in the stipulated record and, if published, to the appropriate journal or publication. For government publications or other articles, a parallel citation to the website at which the article is available is given for the reader's convenience to the extent practicable.

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PacificSource submitted her appeal to its Policy and Procedures Review Committee ("Policy Committee"). SR 93. By letter dated August 28, 2007, the Policy Committee informed McHenry that it had upheld the denial, explaining that "[a]fter reviewing all of the available information in this case, the committee concluded that the services provided by ABA therapy are educationally based social/interactive skill training services" which were "specifically exclude [d]" by the Plan. *Id.* If McHenry believed any covered services were being provided "in adjunct to ABA therapy," she would need to submit those services for a payment decision, but to be covered, "eligible services would need to be provided by an eligible medical or mental health provider. ... " *Id.*

On September 24, 2007, McHenry submitted her written appeal of the Policy Committee's decision, disputing the conclusion that ABA therapy was primarily educational or social skills training. SR 108. She noted that while some of the results of the therapy included improvement in educational and social skills, "ABA therapy programs include speech and several hundreds of other therapeutic goals that are **essential activities of everyday life.**" *Id.* (emphasis in original). She compared the focus and improvement of everyday activities provided by ABA therapy to that provided by therapy for an orthopedic disability. *Id.* Additionally, she submitted letters in support of her claim from Dr. Shah and from Karen Grant, Psy.D., a psychologist with the Oregon Health Sciences University, Child Development and Rehabilitation Center Autism Clinic. SR 109-12.

PacificSource acknowledged McHenry's appeal by letter October 1, 2007, and informed her that the next and final level of PacificSource's internal review process was a hearing before the Membership Rights Panel ("MRP"). SR 196. McHenry appeared before the MRP on November 7, 2007. SR 219, 350. She presented testimony and documents which she believed refuted each of the three bases that had been cited for denying her claim at the three previous levels of review. SR 224- 347.

On November 21, 2007, PacificSource notified McHenry of the MRP's conclusion that ABA therapy was "behavioral-educational social skill training" specifically excluded by the Plan. SR 351. It also *1230 informed her that she could request an independent external review. *Id.*

McHenry requested that review, and PacificSource randomly selected Independent Medical Expert Consulting Services, Inc. ("IMEDICS") to conduct it. SR 368. On December 12, 2007, IMEDECS notified McHenry that because her dispute did not involve an adverse determination based on medical necessity, experimental or investigational treatment, or continuity of care, Oregon external review law did not apply, and it would conduct no review. SR 381.

Having exhausted her remedies with PacificSource, McHenry filed this lawsuit on May 5, 2009.

STANDARDS

The parties have filed motions for summary judgment pursuant to FRCP 56. However, it is clear from the parties' briefing that they desire the court to issue final judgment based upon the stipulated record and the additional evidence submitted with their supporting memoranda. In an

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ERISA case, under the *de novo* standard of review, "[t]he court simply proceeds to evaluate whether the plan administrator correctly or incorrectly denied benefits." Abatie v. Alta Health & Life Ins. Co., 458 F.3d 955, 963 (9th Cir.2006) (*en banc*.) In conducting this review the court "can evaluate the persuasiveness of conflicting testimony and decide which is more likely true." Kearney v. Standard Ins. Co., 175 F.3d 1084, 1095 (9th Cir.1999) (*en banc*), *cert. denied*, 528 U.S. 964, 120 S.Ct. 398, 145 L.Ed.2d 310 (1999). Moreover, given the nature of the issues in this case, to rule in favor of either party, this court must make factual findings by weighing the evidence in the record. Accordingly, FRCP 56, with its "genuine issue of material fact" standard, is inappropriate. See *id.* Instead, the proper procedural mechanism is a motion for judgment on the record pursuant to FRCP 52. See Thompson v. Ins. and Benefits Trust. 670 F.Supp.2d 1052, 1054-56 (E.D.Ca1.2009); Rodgers v. Metro. Life Ins. Co., 655 F.Supp.2d 1081, 1085-86 (N.D.Ca1.2009). The court construes the parties' motions as being brought pursuant to FRCP 52 and will decide this matter based upon the evidence contained in the stipulated record and such other evidence it finds is clearly "necessary to conduct an adequate *de novo* review." Mongeluzo v. Baxter Travenol Long Term Disability Benefit Plan. 46 F.3d 938, 944 (9th Cir.1995) (citation omitted).

DISCUSSION

I. Background

A. Nature of Autism

Autism is a neurobiological disorder that affects a child's development by severely limiting his or her ability to interact with others. See SR 267-68 (Dep't of Defense, *Report and Plan on Services to Military Dependent Children with Autism 5* (July 2007) ("DOD Report").) Federal regulations define autism as a "developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, that adversely affects a child's educational performance." 34 CFR § 300.8(c)(1)(i).

Autism is part of the larger class of Pervasive Developmental Disorders ("PDD") or Autistic Spectrum Disorders ("ASD"), synonymous terms which refer to a continuum of related cognitive and neurobehavioral disorders "characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities." Diagnostic and Statistical Manual of Mental Disorders 69 (4th ed. text revision 2000) ("DSM -IV -TR"); SR 931 (Pauline A. Filipek, *et al.*, *Intervention for Autistic Spectrum Disorders**1231, 3 NeuroRX 207, 207 (April 2006)). These conditions are present from birth or early in development and are typically diagnosed in early childhood. The cause of autism is unknown and may have "multiple etiologies that are currently grouped together under this diagnostic umbrella because of the similar core behavioral symptomatology." SR 931-32 (Filipek, *supra*, at 207- 08).

As its physiological etiology is unknown, autism is diagnosed by the behavioral symptoms it causes. Specifically, diagnostic criteria for autism require the presence of six symptoms from three categories of behavior: impaired reciprocal social interaction, impaired communication, and restricted, repetitive, or stereotyped behaviors. DSM-IV-TR at 75. Examples of these symptoms can include a lack interest in establishing relationships, obliviousness to others or their

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needs, lag in development of spoken language or language comprehension, and stereotyped body movements like clapping, finger flicking, rocking or swaying, or walking on tiptoes. *Id* at 70-71.

B. ABA Therapy

Autism has no known cure. Because its etiology is not fully understood, it is not surprising to find no etiology-based treatment methods. *See* SR 892 (Kostas Francis, *Autism Interventions: A Critical Update*, 47 *Developmental Med. & Child Neurology* 493 (2005)). Thus, many treatments focus primarily on addressing the developmental impairments caused by the disorder. *See* SR 903 (Patricia Howlin, *The Effectiveness of Interventions for Children with Autism*, *J. Neural Transmission*, Supplement 69, at 101 (2005)). ABA therapy is one such treatment.

"ABA describes a systematized process of collecting data on a child's behaviors and using a variety of behavioral conditioning techniques to teach and reinforce desired behaviors while extinguishing harmful or undesired behaviors Practically speaking, it is the application of behavioral principles to shape behaviors and teach new skills in an individual." SR 270 (*DOD Report* at 8). ABA is not unique to autism; its methods are derived from Skinnerian behavioral psychology and have been applied to community development, social work, nursing, industry, education, and medicine. *See* SR 1322 (Karola Dillenburger, *Parent Education and Home-Based Behavior Analytic Intervention: An Examination of Parents' Perceptions of Outcome*, 29 *J. Intellectual & Developmental Disability* (2004)). It was first studied and applied as a potential treatment methodology for autistic children by O. Ivar Lovaas at UCLA. *See* SR 991 (O. Ivar Lovaas, *Behavioral Treatment and Normal Educational and Intellectual Functioning in Young Autistic Children*, 55 *J. Consulting and Clinical Psychology* 3 (1987)).

ABA employs "operant conditioning" and "discrete trial training" among other behavioral psychology techniques to teach basic life skills one small step at a time. Throughout the treatment, "the focus is on the use of rewards or reenforcement to encourage desired behaviors and the elimination or reduction of unwanted behaviors by removing their positive consequences by means of 'time out,' 'extinction,' or punishment." SR 894 (Francis, *supra*, at 495). As new skills are acquired, they are "generalized" into other settings with the intent that the child learns to employ that skill in a new situation and without the encouragements or "prompts" initially relied upon. Following these methods over a period of several years, Lovaas's study found that it was possible for some autistic children to acquire the skills needed to enter into and successfully complete first grade in an "ordinary" classroom unassisted. Over 40% of the participants in *1232 his experimental group were reportedly indistinguishable from non-autistic children.

Although Lovaas's methods and results are not without their critics, multiple studies over the past two decades have confirmed his findings that ABA is generally beneficial to children diagnosed with PDDs. *See, e.g.*, SR 979 (Glen O. Sallows & Tamlynn D. Graupner, *Intensive Behavioral Treatment for Children with Autism: Four-Year Outcome and Predictors*, 110 *Am. J. on Mental Retardation* 417 (2005)); SR 1209 (Howard Cohen, *et al.*, *Early Intensive Behavioral Treatment: Replication of the UCLA Model In A Community Setting*, 271. *Developmental and Behavioral Pediatrics* 145 (2006)); SR 1335 (Tristram Smith, *et al.*, *Intensive Behavioral Treatment for Preschoolers with Severe Mental Retardation and Pervasive Developmental Disorder*, 102 *Am. J. on Mental Retardation* 238 (1997)); SR 1471 (Bob Remington, *et al.*, *Early Intensive Behavioral Intervention: Outcome for Children With Autism and Their Parents After*

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Two Years, 112 Am. 1. on Mental Retardation 418 (2007)). Since Lovaas's study, ABA has expanded and grown as research has continued to test its efficacy in different populations and in clinical or non-clinical settings and practitioners have attempted to standardize best practices. See SR 1228-30 (Robert Homer, *et al.*, *Problem Behavior Interventions for Young Children with Autism: A Research Synthesis*, 32 J. Autism & Developmental Disorders 423, 424-26 (2002)).

While the degree of ABA's efficacy is the subject of current research and debate, "[d]ecades worth of scientific research provide clear and convincing support" for its use as an "effective intervention." SR 926 (William J. Barbaresi, *et al.*, *Autism: A Review of the State of the Science for Pediatric Primary Health Care Clinicians*, 160 Archives of Pediatrics & Adolescent Medicine 1167, 1171 (AMA 2006)). These studies indicate that ABA should be initiated at an early age, for a minimum of 20 to 40 hours a week, and for two to four years. *Id.*; SR 996 (Lovass, *supra*); SR 1210 (Cohen, *supra*); SR 1252 (Svein Eikeseth, *et al.*, *Outcome for Children With Autism Who Began Intensive Behavioral Treatment Between Ages 4 and 7*, 31 Behavior Modification 264 (2007)).

ABA therapy is costly and demands a substantial investment of a family's time and money. Family involvement is a critical component, and it is common for parents to be trained in its methods to continue its application at home. See SR 1252 (Eikeseth, *supra.*) The financial cost of ABA therapy services in a clinical setting can easily reach as high as \$50,000 per year. SR 979 (Sallows, *supra*, at 418).

A defining feature of ABA intervention is treatment directed by a professional with advanced formal training in behavioral analysis. Oregon has no certification procedure for these professionals. Shaw Decl., ¶ 2 & Ex. A. The nationally accredited certification agency, the Behavior Analyst Certification Board ("BACB"), provides a standardized certification as a BCBA. See SR 1061-64 (BACB, *Standards for Board Certified Behavior Analyst® (BCBA®)*, available at http://www.bacb.com/becom_frame.html) (last accessed Jan. 5, 2010). A BACB certification as a BCBA requires, at a minimum, a masters degree and several hundred hours of graduate level instruction or mentored or supervised experience with another BCBA. Additionally, multiple universities throughout the United States provide advanced degree programs in ABA therapy which involve a combination of course work and practical experience.

C. ABA Therapy Provided to J.M.

J.M. began receiving ABA therapy from Hoyt in January 2007. Hoyt received her *1233 Masters Degree in Behavior Disorders/ABA from Columbia University in New York. SR 187. She is a certified BCBA and has worked with autistic children since 1998. *Id.*; SR 1188.

Hoyt provides ABA therapy through Building Bridges, a clinic in southeast Portland. SR 187. Its services include "comprehensive home programs for young children on the autism spectrum." SR 188. Each child is given an individual assessment and a plan specifically tailored to his or her needs. The ABA therapy is targeted at the child's communication, cognitive skills, academics, social skills, lay skills, and self-help and fine motor skills. Treatment is provided in home through two-hour, one-on-one sessions with a therapist, and multiple sessions a day are recommended. Parents are trained in the techniques used by the therapist in order to apply the elements of the treatment to daily interactions with their child. *Id.*

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According to McHenry, J.M. has benefitted greatly from the ABA therapy provided by Hoyt. SR 1159.

D. Coverage for Autism Under the Plan

At the time McHenry began seeking services for J.M., the Plan dated November 1, 2006 ("2006 Plan"), specifically excluded benefits for PDDs. SR 1732. It did, however, provide benefits for services related to conditions which may be symptoms of autism, such as speech, physical, and occupational therapy. SR 1717-18. PacificSource paid benefits for treatment J.M. received along these lines in early 2007, prior to the Plan's annual renewal date of November 1, 2007. SR 14-15. Pacific Source never cited the pervasive developmental disorder exclusion in its denials of reimbursement for J.M.'s ABA therapy.

The status of this exclusion was brought into question by legislation effective shortly after J.M.'s diagnosis. In August 2005, the State of Oregon enacted the Mental Health Parity Act ("Parity Act"), which went into effect on January 1, 2007. *See* Or. Laws 2005, c. 705, § 1, codified at ORS 743.556(renumbered ORS 743A.168).^{FN3} The Parity Act mandated that "[a] group health insurance policy providing coverage for hospital or medical expenses" must "provide coverage for expenses arising from treatment 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." *Id* This language required PacificSource to abandon its prior exclusion for PDDs in the 2006 Plan.

FN3. ORS 743.556 was renumbered as ORS 743A.168 in 2007. The newer citation is used for ease of reference.

After its passage, PacificSource announced on its website that:

[b]eginning January 1, 2007, PacificSource will be managing mental health and chemical dependency treatments consistent with the implementation of Oregon's new parity rules. We will apply utilization criteria and benefits for both mental health and chemical dependency in a manner similar to those applied to other medical benefits and treatment reviews.

SR 1745.

PacificSource also provided a table of covered and non-covered diagnoses under the Parity Act and listed autism (299.0) as a covered mental health diagnosis. SR 1746. Accordingly, PacificSource provided coverage in its 2007 Plan effective November *~~1234~~ 1, 2007, for "medically necessary services for the treatment of mental and nervous conditions" including autism. SR 1747, 1778. As amended, the 2007 Plan offered coverage for autism in compliance with the Parity Act. However, it retained several exclusions at issue here.

II. Preliminary Issues

As a threshold issue, PacificSource asserts that McHenry is not entitled to reimbursement for the ABA therapy provided to her son before November 1, 2007. McHenry admits that the 2007 Plan did not take effect until November 1, 2007, but argues that PacificSource was

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obligated to provide coverage when the Parity Act became law on January 1, 2007. Moreover, PacificSource expressed its intent to amend its policy language by stating on its website that it would be "managing mental health ... treatments" in compliance with the Parity Act "beginning January 1, 2007." PacificSource's actions throughout 2007 repeatedly affirmed that intent. First, Pacific Source explicitly relied on the 2007 Plan language in denying McHenry's claim at each level of review, though it was not technically operative until the time of her second appeal. SR 54-58, 93-97, 351. Second, throughout the course of processing McHenry's claim, PacificSource employees routinely referenced the 2007 Plan, both internally (SR 89-92, 103-05, 199, 348-49, 390-91) and in communications with the Oregon Insurance Division regarding her claim (SR 94-97, 124,394-95). Finally, McHenry argues that because PacificSource never relied on the 2006 Plan's exclusion for autism as a basis for denying her claims throughout her administrative appeals process, it is barred from doing so now.

[1] ERISA requires an employee benefits plan to set forth the specific reasons for an adverse benefits determination at the time of its decision. 29 USC § 1133; 29 CFR § 2560.503-1(g); see *Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463 (9th Cir.1997) ("If benefits are denied in whole or in part, the reason for the denial must be stated in reasonably clear language, with specific reference to the plan provisions that form the basis for the denial[.]"). In view of this requirement, a plan administrator is not permitted to assert rationales during litigation that it "adduces only after the suit has commenced." *Jebian v. Hewlett-Packard Co. Employee Benefits Organization Income Protection Plan*, 349 F.3d 1098, 1104 (9th Cir.2003), cert denied, 545 U.S. 1139, 125 S.Ct. 2956, 162 L.Ed.2d 887 (2005); see also *McCoy v. Fed. Ins. Co.*, 7 F.Supp.2d 1134, 1145 (E.D.Wash.1998) (defendant waived its right to raise an argument on *de novo* review where it had the opportunity to raise it during the ERISA review process but did not do so, and plaintiff did not acquiesce in defendant's raising of the issue)

PacificSource never cited the lack of autism coverage under the 2006 Plan as a reason for denying McHenry's claim during its administrative review. In fact, at every step of the review, it acted as if the 2006 Plan provided coverage and even cited language to McHenry from the 2007 Plan as the basis for its denial. This court declines to now entertain PacificSource's belated argument that autism was not a covered diagnosis prior to November 1, 2007.

III. Analysis

[2] To be entitled to reimbursement for J.M.'s treatment, the parties agree that ABA therapy must be medically necessary, a covered benefit under the Plan, and provided by an eligible provider. McHenry has the burden to prove that ABA therapy is a covered benefit under the Plan, and PacificSource has the burden to prove that *1235 it falls within an exclusion. See *Mario v. P & C Food Mkts., Inc.*, 313 F.3d 758, 765 (2nd Cir.2002).

A. Medically Necessary

J.M.'s pediatrician, Dr. Shah, has thrice written to PacificSource indicating that ABA treatment was medically necessary to treat J.M.'s autism. SR 1189-92. PacificSource has not challenged J.M.'s diagnosis or Dr. Shah's opinion that ABA is a medically necessary treatment. Therefore, she satisfies that requirement for coverage.

B. Covered Benefit

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Even if ABA therapy is medically necessary, PacificSource argues that it is not a covered benefit because it falls under the Plan's exclusions either for: (1) experimental or investigational procedures; (2) educational services; or (3) academic and social skills training.

1. *Experimental or Investigational Procedures*

The Plan excludes services for "[e]xperimental or investigational procedures," defined, in part, as:

Services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines or the use thereof that are; in PacificSource's judgment, experimental or investigational for the diagnosis and treatment of the patient. For purposes of this exclusion, experimental or investigational services and supplies include, but are not limited to, services, supplies, procedures " or the use thereof which at the time they are rendered and for the purpose and in the manner they are being used: ...

75 Are not of generally accepted medical practice in the state of Oregon or as determined by PacificSource in consultation with medical advisors, medical associations, and/or technology resources; [or]

75 Are not approved for reimbursement by the Centers for Medicare and Medicaid Services[.] SR 1789.

a. *Standard of Review*

Despite this court's earlier ruling on the standard of review, PacificSource argues that its decision with respect to this exclusion is still entitled to deference because the 2007 Plan commits the determination of which "services" are experimental and investigational to "PacificSource's judgment." *Id.* It points out that other courts have interpreted this language to confer discretionary authority. *See Chambers v. Family Health Plan Corp.*, 100 F.3d 818,825 (10th Cir.1996) (plan language stating "medical [or] surgical ... procedures ... which in the judgment of [the insurer] are experimental" expressly gave insurer discretion to determine whether to deny a claimant insurance benefits for an "experimental" *procedure*); *Loyola Univ. of Chicago v. Humana Ins. Co.*, No. 89 C 7855, 1992 WL 80522, at *2 (N.D.III. April 14, 1992), *aff'd*, 996 F.2d 895 (7th Cir.1993). PacificSource also interprets this court's prior ruling as recognizing that it retains discretion on this narrow issue. *See* Opinion and Order (docket # 27), p. 11.

[3]  Contrary to PacificSource's interpretation, this court's prior ruling did not find that Pacific Source retains the discretion to decide whether the exclusion for experimental and investigational procedures is satisfied. Rather, it unambiguously stated that this language was not sufficient to notify a claimant that the Plan granted discretionary authority to PacificSource to determine claims. Absent this broad grant of discretion, the standard of review in the Ninth Circuit is *de novo*, even where the Plan contains discretionary language as to one element of the Plan. "[A] plan will not sufficiently confer discretion *1236 sufficient to invoke review for abuse of discretion just because it includes a discretionary element. Rather, the power to apply that element must also be 'unambiguously retained' by the administrator." *Sandy v. Reliance Std. Life Ins. Co.*, 222 F.3d 1202, 1204 (9th Cir.2000) (citation omitted).

b. Generally Accepted Medical Practice

PacificSource first argues that ABA therapy is experimental or investigational, as those terms are defined by the Plan, because it is not the generally accepted standard of care for autism in Oregon or anywhere else. In making this determination, Pacific Source relied exclusively on the opinion of its Chief Medical Officer, Steven D. Marks, M.D., and offers his declaration explaining his rationale for finding that ABA therapy falls within this exclusion. McHenry objects to the admission of this declaration on the grounds that it is outside the administrative record.

[4] This court has discretion to allow additional evidence not before the plan administrator, but should exercise this discretion "only when circumstances clearly establish that additional evidence is necessary to conduct an adequate *de novo* review of the benefit decision." *Mongeluzo*. 46 F.3d at 944(citation omitted). One such circumstance is where a claim requires "consideration of complex medical questions or issues regarding the credibility of medical experts." *Opeta v. Nw. Airlines Pension Plan*. 484 F.3d 1211, 1217 (9th Cir.2007) (citation and internal quotation marks omitted).

Dr. Marks is the sole expert relied upon by PacificSource for arguing that ABA therapy falls within one of the Plan's exceptions. He formulated PacificSource's autism policy, including its rejection of ABA therapy as a covered benefit. His declaration is primarily a summary of his reasoning for choosing to reject ABA therapy based upon the Plan's exclusions. Considering the complexity of the medical issues in this case, McHenry's objection is overruled.

Dr. Marks states that in the course of developing the PacificSource policy to reject coverage for ABA therapy for autism (SR 25-29), he "read many articles and textbook chapters, along with doing some intensive internet searches to better understand the current state of treatment for autism." Marks Dec 1., (docket # 50), ¶ 4. After considering all of these materials, he concluded that the "consensus of all that I read was that there was and is no cure for autism." *Id.* Rather, "each treatment modality had its supporters and its detractors[,] ... there is no 'gold standard' for the treatment of autism, and there is much debate in the literature regarding the efficacy of anyone approach, including ABA." *Id.* From his review of the literature and his own experience as a practitioner, "it became clear that ABA was not a well-proven or evidence-based standard of medical care, nor was it a standard of coverage within the industry." *Id.*, ¶ 5.^{FN4}

FN4. A partial list of the sources Dr. Marks' relied upon in reaching his conclusion are appended to the PacificSource Health Service Procedure: Autism-Draft II, the development of which Dr. Marks' oversaw. Marks Aff., ¶ 8; SR 28-29. Dr. Marks represents that these sources included some articles that supported ABA therapy and some articles calling into question the validity of the studies used by supporters of ABA.

McHenry attacks Dr. Marks opinion on multiple fronts. First, she deems it irrelevant since he is not an expert in treating autism or other PDDs. Second, McHenry counters it with the opinion of Karen Grant, Psy.D. SR 110-12. Unlike Dr. Marks, Dr. Grant actively practices and does research in the field of autism treatment. *1237 She opines that based on "33 years of research[,] ... ABA therapy is not only an empirically supported and validated treatment, but ... is

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also a long standing treatment for individuals with autism," and cites to numerous articles to support her conclusion. SR 110-11. Third, McHenry cites a raft of scientific articles to contradict the notion that ABA therapy is experimental or investigational. Fourth, McHenry points to numerous government and state agencies which have concluded that "ABA-based procedures represent best practices for individuals with autism " SR 968.^{FN5} Fifth, McHenry notes that Dr. Marks has not been consistent in his position. Early on in the handling of J.M.'s claim, he indicated a favorable opinion of ABA therapy, stating "ideally I'd like to see these kids get into an ABA-type program that we could contract for on a case rate basis." SR 14. Finally, McHenry submits a recent external review obtained by the Oregon Insurance Division which concluded that ABA therapy was medically necessary for the treatment of autism and that denying ABA therapy was not consistent with national standards of care. SR 117-18.

FN5. An online article from the Kennedy Krieger Institute lists many of these entities including: National Institute of Mental Health, National Institute of Child Health and Human Development, The National Academies Press, American Association on Mental Retardation, American Psychological Association, Association for Science in the Treatment of Autism, the Surgeon General of the United States, New York State Department of Health, California State Department of Developmental Services, Florida State Department of Children and Families, and Maine Administrators of Services for Children with Disabilities. SR 968 (Louis P. Hagopian & Eric W. Boelter, *Applied Behavioral Analysis: Overview and Summary of Scientific Support*, available at http://www.kennedykrieger.org/kki_misc.jsp?pid=4761) (last accessed Jan. 5, 2010).

Based upon a thorough examination of the record, this court concludes that the weight of the evidence demonstrates that ABA therapy is firmly supported by decades of research and application and is a well-established treatment modality of autism and other PDDs. It is not an experimental or investigational procedure. Dr. Grant's opinion corresponds with this court's overall impression of the scientific consensus surrounding ABA therapy after reviewing each of the studies in the record. Moreover, because she is an expert in the field, Dr. Grant's opinion is much more persuasive than that of Dr. Marks. From a review of the numerous articles and other material in the record, this court finds no basis for Dr. Marks's opinion that "ABA was not a well-proven or evidence-based standard of medical care, nor was it a standard of coverage within the industry." Indeed, just the opposite is the case.

This court's view of the science is shared by multiple government agencies and professional organizations. For example, in 1999, the Department of Health and Human Services ("DHS") issued a report on the state of mental health and mental health treatment in the United States. One of its findings was that "[t]hirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior." SR 975 (DHS, *Mental Health: A Report of the Surgeon General*, c. 3., p. 163 (1999), available at http://www.surgeongeneral.gov/library/mental_health/pdfs/c3.pdf) (last accessed Jan. 5, 2010). The National Institute of Mental Health ("NIMH") has similarly concluded that "[a]mong the many methods available for treatment and education of people with autism, applied behavior analysis (ABA) has become widely accepted as an effective treatment." SR 1106 (NIMH, *Autism Spectrum Disorders: Pervasive Developmental Disorders* *1238, Doc. No. NIH 08-551 (2008), available

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at <http://www.nimh.nih.gov/health/publications/autism/nimhautismspectrum.pdf>) (last accessed Jan. 5, 2010). Professional organizations concluding that ABA therapy is an appropriate treatment for autism include the American Association on Mental Retardation, American Psychological Association, and the Association for Science in the Treatment of Autism. SR 968.

That a given mental disorder has no absolute cure is not a basis for rejecting treatments which purport to alleviate or ameliorate its symptoms. Many treatments purport only to alleviate symptoms or increase the quality or length of life of those suffering from a chronic, incurable disease. Furthermore, the fact that ABA therapy is not effective for every autistic child is not a reasonable basis for concluding that it is experimental or investigational. It is possible for a treatment to be both well-established and of limited efficacy in curing a neurological or mental disorder. Likewise, a scientific debate on the degree of improvement provided by a treatment or the instances in which it is the most effective does not show that the treatment is experimental or investigatory. The great majority of the studies in the record indicate that ABA therapy is not only supported by decades of research, but is one of the only autism treatments which has consistently shown measurable success in improving the lives of autistic children.^{FN6} These studies, and the other sources cited above, demonstrate that ABA therapy has become one of the standard treatment options for autistic children throughout the nation. Notably, other than Dr. Marks's summary opinion, PacificSource has pointed to no authority in the record that has labeled ABA therapy an experimental or investigational treatment for autistic children or that declare it to be not a standard of care in Oregon or anywhere else.

^{FN6}. See, e.g., SR 894 (Francis, *supra*, at 495 (finding "[t]he literature shows that intensive behavioral therapy clearly benefits children with autism and yields a high degree of parental satisfaction; however, the original effectiveness claim was overstated and its cost-effectiveness, in terms of time, effort, and money, has not been adequately assessed")); SR 900 (Scott O. Lilienfeld, *Scientifically Unsupported and Supported Interventions for Childhood Psychopathology: A summary*, 115 *Pediatrics* 761, 762 (2005) ("The most efficacious psychosocial treatment for autism is applied behavior analysis In controlled within-subject studies, applied behavior analysis has demonstrated positive effects on autistic children's social and intellectual behaviors, although almost all of these children are left with serious deficits in adaptive functioning."); SR 913-15 (Howlin, *supra*, pp. 111-13 (finding that of all the treatments for autism, early behavioral intervention enjoys the most scientific support although there remain unanswered questions about its total efficacy and proper methodology)); SR 926 (Barbaresi, *supra*, at 1171 ("Decades worth of scientific research provide clear and convincing support for the technique referred to as [ABA].")); SR 932 (Filipek, *supra*, at 208 ("Behavioral, as opposed to pharmacologic, treatment is the hallmark of effective intervention for everyone with autism.")); SR 1323-34 (Dillenburger, *supra*, at 120-21 (noting that "[e]xtensive research over 30 years shows that early intensive behavioral intervention can lead to significant gains in cognitive, social, emotional, and motor functioning that can be generaliz[ed] to other situations and maintained in the long term" and that "[a] review of over 500 studies shows that ABA consistently offers positive outcomes in terms of educating children with ASD and enhancing life skills")); SR 1471 (Remington, *supra*, at 418 (noting that an "increasing body of empirical research suggests that early, intensive, structured intervention, based on principles of applied behavioral analysis, is effective in remediating the intellectual, linguistic, and adaptive deficits

associated with autism" and reporting that a two-year study conducted by the authors further confirmed this research)).

Here PacificSource has submitted only one piece of evidence in support of its conclusion, namely the opinion of its own *1239 Chief Medical Officer. In light of the wealth of conflicting scientific research supporting ABA therapy, it was not reasonable for PacificSource to rely on Dr. Marks's opinion alone. As a result, this court concludes that ABA therapy is not experimental or investigational in nature and that PacificSource lacked a reasonable basis reaching the opposite conclusion.

c. *Approved by the Centers for Medicare and Medicaid Services*

Second, PacificSource argues that ABA therapy is not approved for reimbursement by the Centers for Medicare and Medicaid Services ("CMS"). It relies upon a letter sent from the Oregon Department of Human Services ("ODHS") to McHenry's attorney explaining that it "does not currently recognize BCBA as a specific provider type," but "therapists, with a *specialty of BCBA*, can be enrolled with the Department as an approved County Mental Health Program (CMHP) provider" and may "bill any appropriate covered procedure codes, including autism." Shaw Decl. (docket # 43), ¶ 2 & Ex. A, p. 1 (emphasis in original).^{FN7} The letter plainly does not state that ABA is not reimbursable, but states only that BCBAs as a provider type are not recognized by the ODHS or CMS. Notably, the letter provides a specific method by which ABA therapy could be successfully billed. Thus, it does not provide a reasonable basis for concluding that ABA therapy is not approved for billing by the CMS.^{FN8} Thus, PacificSource has failed to show that ABA therapy falls within the exclusion for experimental or investigative treatments.

FN7. Whether a treatment is approved for reimbursement by the CMS presumably is the basis for the ODHS approving it under the Oregon Health Plan. Neither party has addressed this issue.

FN8. *Cf. Parents League for Effective Autism Servs. v. Jones-Kelley*, 565 F.Supp.2d 905,915-16 (S.D.Ohio 2008) (granting TRO after finding that plaintiffs had a strong likelihood of success on their claim that ABA therapy was compensable under federal medicaid law), *aff'd in unpublished opinion*, 339 Fed.Appx. 542 (6th Cir.2009).

2. *Educational Services*

PacificSource argues that ABA therapy, even if not experimental or investigatory, is excluded as "educational or correctional services or sheltered living provided by a school or halfway house." SR 1790.

As support, PacificSource points to Dr. Grant's statement that "ABA intervention for children on the autism spectrum have been shown over time to be highly effective in *teaching and generalizing skills* for these children in all areas of difficulty." SR 11 0 (emphasis added). Additionally, some of the articles cited by McHenry use language seemingly indicative of educational or social training. *See, e.g.*, SR 967 ("ABA-based approaches for *educating* children with autism and related disorders have been extensively researched and empirically supported.") (emphasis added); SR 1106 ("Among the many methods available for treatment and *education* of people with autism, applied behavior analysis (ABA) has become widely accepted as an effective treatment.") (emphasis added). Even advocates of ABA therapy describe it in terms that suggest

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it is educationally based. For example, Hoyt's website states that ABA therapy "[i]nstruction focuses on *teaching* Core Learning Skills, Verbal Behavior, and social/play skills in natural and structured *learning* environments." SR 188 (emphasis added). Also, of the six categories of "treatment options" identified by the Autism Society for America ("ASA"), the ASA placed ABA therapy under the "Educational" category. SR 1089.

***1240** According to Dr. Marks, these sources agree with the literature he reviewed on ABA which "frequently referred to the persons receiving the therapy as 'learners'; the plans for working with the child as 'curricula'; referenced 'teacher/instructors,' and 'teacher/learner' ratios; and talked about teaching various skills in 'structured learning environments.'" Marks Decl., ¶ 6. He concludes that "applied behavioral analysis was more akin to remedial education and 'generalization' skill techniques, and not clinical treatment *per se*." *Id.*, ¶ 7. As a result, in his view, ABA therapy is properly classified along side special education classes or individualized education plans utilized to assist children with learning disabilities.

However, the full sentence of the exclusion reads as follows: "This plan does not cover educational or correctional services or sheltered living provided by a school or halfway house, except outpatient services received while temporarily living in a shelter[.]" PacificSource reads the clause "provided by a school or halfway house" as modifying only "sheltered living." However, there is no comma separating "educational or correctional services" and "or sheltered living." As a result, the clause "provided by a school or halfway house" may be read as not only modifying "sheltered living," but also as modifying "educational or correctional services." Given this ambiguity, the language must be construed against PacificSource and in favor of McHenry. *McClure v. Life Ins. Co. of N.Am.*, 84 F.3d 1129, 1134 (9th Cir.1996) ("ERISA insurance policies are governed by the rule that ambiguous language is construed against the insurer and in favor of the insured"). Construing the language most favorably to McHenry, even if ABA treatment were "educational," it is excluded only if it is "provided by a school or halfway house." J.M.'s services were not provided by a school or halfway house, but by

an employee of a private company that provides rehabilitative services for autistic children. Thus, this exclusion does not apply.

3. Academic and Social Skills Training

Finally, PacificSource relies on the Plan's exclusion for "academic skills training ... and social skills training." SR 1790. While acknowledging that ABA therapy may benefit an autistic child's academic and social skills, McHenry counters that its primary focus is on modifying behaviors pertinent to every area of that child's life.

As discussed above, autistic children may exhibit many types of problem behavior detrimental to social or academic progression. A list assembled by one article includes: aerophagy/swallowing, aggression, bruxism/teethgrinding, coprophagy/feces eating, dawdling, destruction, depression, disruption/tantrum, drooling, elective mutism, elopement (run), feces smearing, fears, food refusal, food theft, genital stimulation, hallucinating, hyperactive behavior, hyperventilation, inappropriate vocalizations, insomnia, noncompliance, obesity, obsessive compulsive disorder, pica, public disrobing, rapid eating, rectal digging, rumination, seizure behavior, self-injurious behavior, stereotypy, tongue protrusion, and vomiting. SR 1235 (Robert H. Homer, *et al.*, *Problem Behavior Interventions for Young Children with Autism: A Research Synthesis*, 32 J. Autism and Developmental Disorders 423, 431 (October 2002)).

It is reasonable to assume that a child exhibiting some of these behaviors would face serious obstacles to academic and social development. Autism's noted adverse impact on the ability of a child to form social connections or to express empathy or even awareness of another would have similar severe impacts in these areas. Indeed, the impairments caused by autism *1241 are acutely social in nature and the diagnostic criteria for autism require some "qualitative impairment in social interaction" in order to affirm a positive diagnosis. DSM-IV -TR at 70-71. Given the inherently social nature of the behavioral impairments caused by autism and the negative impacts of some of these behaviors on a child's academic development, it is no surprise that ABA therapy seeks to modify this behavior.

While ABA therapy may have beneficial effects on an autistic child's social and academic skills, its defining characteristic is application of techniques to modify behavior in every area of an autistic child's life. In this regard, a sports analogy is instructive. While participation in sports can benefit a student's academic and social skills, no one would classify sports as academic or social skills training. Similarly, the incidental benefits in these areas resulting from ABA therapy, while real, do not dictate that it be classified as either as academic or social skills training. Rather, it is more properly classified as behavioral modification.

PacificSource's contrary interpretation would sweep many other covered benefits into this exception to which it clearly does not apply. Nearly all types of psychological treatment (counseling, psychotherapy, etc.) could be classified as academic or social skills training. These types of treatments, like ABA therapy, undoubtedly have benefits on a person's ability to succeed in education and help to teach proper skills and behaviors for social interactions. However, they would presumably not fall within those exclusions.

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The focus of ABA therapy on discrete behaviors affecting all facets of living sets it apart. Researchers have found ABA to be effective in reducing problem behaviors, SR 1233 (Homer, *supra*, at 429), and in improving a child's ability to function in multiple areas including "intellectual, social, emotional, and adaptive functioning." SR 1252 (Svein Eikeseth, *et al.*, *Outcome for Children with Autism Who Began Intensive Behavioral Treatment Between Ages 4 and 7*, 31 Behavior Modification 264, 265 (2007). While aimed at improving social and academic functioning, it does this by specifically addressing behavioral deficits possessed by autistic children that interfere with every area of their life, not by educating kids on social norms or teaching study skills or other tools specific to academic success. To find for PacificSource on this issue would be to improperly stress the benefits of ABA therapy in only two out of many areas of functioning.

According to the weight of the evidence, ABA therapy is not primarily academic or social skills training, but is behavioral training. Accordingly, it is not subject to the exclusions under the Plan for academic or social skills training.

C. Eligible Provider

Although ABA therapy is medically necessary to treat J.M.'s autism, does not fall within any exclusion, and thus is a covered benefit under the 2007 Plan, McHenry is not entitled to reimbursement unless it is provided by an eligible provider. *See* SR 1772-74, 1778-79. The 2007 Plan defines eligible providers for mental health treatment as follows:

2. Provider Eligibility. A provider is eligible for reimbursement 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; or
- c. The patient is staying overnight at the facility and is involved in a structured program at least eight *1242 hours per day, five days per week; and
- d. The provider is providing a covered benefit under this policy; and
- e. The provider meets the credentialing requirements of PacificSource.

SR 1778.

The 2007 Plan further defines "provider" as "a person who meets the credentialing requirements of PacificSource, is otherwise eligible to receive reimbursement under the policy, and is ... ; v. An individual behavioral health or medical professional authorized for reimbursement under Oregon law." *Id.*

The Member Benefits Handbook (or Summary Plan Description ("SPD")) contains a slightly different description of eligible providers of mental health services as persons or

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facilities: that meet the credentialing requirements of PacificSource, if credentialing is required, are otherwise eligible to receive reimbursement for coverage under the policy and are either a health care facility, a residential program or facility, a day or partial hospitalization program, an outpatient service, or an individual behavioral health or medical professional authorized for reimbursement under Oregon law.

SR 1837.

Both the 2007 Plan ^{FN9} and SPD ^{FN10} provide a list of eligible providers. These lists are materially the same with BCBA's notably absent from both. That absence is immaterial because the SPD and Plan state only that "eligible providers *include*" and not "eligible providers *are limited to*" or similar exclusive language. See Ariz. State Bd. For Charter Sch. v. U.S.. Dep't of Educ. . 464 F.3d 1003, 1007 (9th Cir.2006) ("In both legal and common usage, the word 'including' is ordinarily defined as a term of illustration, signifying that what follows is an example of the preceding principle."), citing *Black's Law Dictionary*, 777-78 (8th ed.2004) ("[t]he participle *including* typically indicates a partial list"). By way of contrast, the 2006 Plan included *1243 a restrictive clause, stating that "[o]nly the following providers ... are eligible for reimbursement under this policy." SR 1722. PacificSource's decision to eliminate the restrictive clause in the 2006 Plan and replace it with a word commonly understood to proceed only a partial list is strong evidence that it did not intend the list of eligible providers in the 2007 Plan to be exhaustive.

FN9. The 2007 Plan provides that:

Eligible providers include:

- a. A program licensed, approved, established, maintained, contracted with, or operated by the Mental Health Division for Alcoholism;
- b. A program licensed, approved, established, maintained, contracted with, or operated by the Mental Health Division for Drug Addiction;
- c. A program licensed, approved, established, maintained, contracted with, or operated by the Mental Health Division for Mental or Emotional Disturbance;
- d. a. A medical or osteopathic physician licensed by the State Board of Medical Examiners;
- e. A psychologist (Ph.D.) licensed by the State Board of Psychologists' Examiners;
- f. A nurse practitioner registered by the State Board of Nursing;
- g. A clinical social worker (LCSW) licensed by the State Board of Clinical Social Workers;
- h. A Licensed Professional Counselor (LPC) licensed by the State Board of Licensed Professional Counselors and Therapists;
- i. A Licensed Marriage and Family Therapist (LMFT) licensed by the State Board of Licensed Professional Counselors and Therapists; and
- j. A hospital or other healthcare facility licensed for inpatient or residential care and treatment of mental health conditions and/or chemical dependency.

SR 1779.

FN10. Omitting the institutional providers, the SPD provides that:

"Eligible providers include: Licensed medical or osteopathic physicians (M. D. or D.O.), including psychiatrists, licensed psychologists (Ph. D.) and psychology associates, registered

nurse practitioners (N. P.), licensed clinical social workers (L. C. S. W.), licensed professional counselors (L. P. C.), and licensed marriage and family therapists (L. M. F. T.).

SR 1837.

Even so, PacificSource argues that Hoyt cannot be included with the other listed eligible provider types because she lacks the one attribute common to all others listed, namely, state licensing. While that may be true, the 2007 Plan nowhere explicitly requires state licensure as a precondition to provider eligibility. Thus, if Hoyt were to meet the explicit criteria set forth in the 2007 Plan, this nonexclusive list would not disqualify her even though she may not share one of the common features.

Turning to those explicit criteria, the court first recognizes not only significant overlap between the 2007 Plan's definitions of "provider" and "eligible provider" and the SPD's definition of "eligible provider," but also important distinctions. Combining the two terms used in the 2007 Plan to remove redundancies, Hoyt must: (1) be approved by ODHS; (2) meet PacificSource's credentialing requirements; (3) be authorized for reimbursement under Oregon law; and (4) provide a covered benefit or be "otherwise eligible" to receive reimbursement for coverage under the policy. The criteria in the SPD differ from these four elements in two important ways: first, the SPD only requires credentialing "if credentialing is required;" and second, there is no requirement that Hoyt be approved by ODHS. McHenry argues that the SPD controls.

To resolve a disagreement between plan documents, the court must adopt the language most favorable to the claimant. *See Bergt v. Retirement Plan for Pilots Employed by MarkAir, Inc.*, 293 F.3d 1139, 1145 (9th Cir.2002). Accordingly, the court finds that the more favorable elements in the SPD control. In view of the evidence, as discussed below, it seems likely that being approved by the ODHS is the method of being authorized for reimbursement under Oregon law. However, in the event of a distinction that neither party has pointed out, the court follows the terms of the SPD and removes approval by ODHS as one of the criteria.

Therefore, because Hoyt was providing a covered benefit under the Plan, as discussed above, to be eligible for reimbursement, McHenry must prove: (1) either that Hoyt met PacificSource's credentialing requirement or that PacificSource did not require her to be credentialed, and (2) that Hoyt was authorized for reimbursement under Oregon law.

1. Credentialing

It is undisputed that Hoyt has not been credentialed by PacificSource and does not meet its credentialing requirements. Instead, McHenry argues that no credentialing is required for Hoyt because she was a nonparticipating provider or a network not available provider. ^{FNI} Neither the 2007 Plan nor the SPD defines PacificSource's credentialing requirements or describes the process for becoming credentialed. These requirements are explained in two other documents, namely, the Physician and Provider Manual ("Provider Manual") (SR 735) and the Provider Network Management Credentialing Manual ("Credentialing Manual") (SR 870). As described *1244 by § 4.2 of the Provider Manual, the credentialing process "includes meticulous verification of the education, experience, judgment, competence, and licensure of all healthcare

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providers." SR 755. The process is described in outline form in the Provider Manual and in greater detail in the Credentialing Manual.

FN11. A network not available provider is a non-participating provider located in an area where the member does not have reasonable access to a participating provider. SR 1771, 1823. The designation affects only the reimbursement rate; there appears to be no distinction between the two in terms of credentialing requirements.

Significantly, the Provider Manual states that if, after the credentialing process is completed, "the Credentialing Committee does not approve the provider, the provider may be considered a 'nonparticipating provider' and claims may be processed at the nonparticipating benefit level." SR 756. Based on this language, McHenry argues that only those providers who wish to be participating providers must pass the certification process. For those who cannot, the Provider Manual expressly provides for the option of reimbursing them at the non-participating provider rate.

Nothing in the Credentialing Manual contradicts the Provider Manual. Indeed, the general statement of policy on the first page of the Credentialing Manual reads: "PacificSource makes every effort to contract with qualified participating practitioners by using appropriate credentialing standards." SR 870. This language confirms McHenry's argument that credentialing is related to issues of contracting with approved providers. The remainder of the Credentialing Manual describes in detail the requirements necessary to become and remain a participating provider through the credentialing process. It also requires that "[a]ll participating practitioners will be recredentialed at a minimum of every three years (36 months)." SR 876. The Credentialing Manual provides no similar recredentialed requirements for nonparticipating providers.

PacificSource argues against McHenry's interpretation by pointing to Section 4.2.4 of the Provider Manual which provides a limited exception from credentialing for "providers who practice exclusively within the inpatient setting and who provide care for the health plans' members only as a result of members being directed to the hospital or other inpatient setting." SR 757. According to PacificSource, this is the only class of providers who need not be credentialed.

The record reveals little else to resolve this issue. The 2007 Plan defines a nonparticipating provider as "a provider of covered medical services or supplies that does not directly or indirectly hold a provider contract or agreement with PacificSource." SR 1752. This merely returns the reader to the definition of "provider" in the 2007 Plan requiring the person to be "credentialed." On the other hand, the SPD indicates that credentialing may not always be required and the Provider Manual states that a non-credentialed person may be reimbursed at the nonparticipating provider rate. While the Provider Manual contains only one explicit exception to the credentialing requirement, it also explicitly contemplates reimbursing a person for services provided by a practitioner who fails to meet Pacific Source's credentialing requirements.

Given these conflicting provisions and the lack of a clear indication that all providers must be credentialed, the 2007 Plan is, at best, ambiguous on this issue. Given this ambiguity, the court must adopt the interpretation most favorable to McHenry. McClure, 84 F.3d at 1134.

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Consequently, the court finds that Hoyt need not be credentialed with Pacific Source to be considered an eligible provider.

2. Authorized for Reimbursement Under Oregon Law

Both the Plan and the SPD require an eligible provider to be authorized for reimbursement under Oregon law. The parties agree that ORS 743A.168(5) provides the applicable standards:

*1245 (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.

The four separate requirements are phrased in the disjunctive, meaning McHenry need satisfy only one to be "eligible for reimbursement." The final requirement renders a provider eligible for reimbursement simply by "providing a covered benefit under the policy." McHenry argues that because Hoyt was providing such a benefit (ABA therapy), she is eligible for reimbursement under Oregon law and thus satisfies the final requirement to be an eligible provider under the 2007 Plan.

But in order to be eligible for reimbursement, ORS 743A.168(5), like the 2007 Plan, requires that the person first be a "provider." In turn, a "provider" must have "met the credentialing requirements of a group health insurer," be "otherwise eligible to receive reimbursement for coverage under the policy" and be "[a]n individual behavioral health or medical professional authorized for reimbursement under Oregon law." ORS 743A.168(1)(e) These elements are identical to the 2007 Plan's definition of provider. The final element is the critical one here, namely that Hoyt has been, or could be, authorized for reimbursement.

Here McHenry'S evidence consists only of the ODHS letter responding to her attorney's inquiry as to whether "[BCBAs] who treat children with [ASDs] are approved as providers by the Department of Human Services." Shaw Decl., ¶ 2, & Ex. A, p. 1. ODHS responded that the department "does not currently recognize BCBA as a specific provider type" but that "therapists, with a *specialty of BCBA*, can be enrolled with the Department as an approved County Mental Health Program (CMHP) provider." *Id.* (emphasis in original). Once enrolled as a CMHP provider, the therapist would be "able to bill any appropriate covered procedure codes, including autism, which is a covered diagnosis for the Oregon Health Plan[.]" *Id.*

This letter fails to establish that Hoyt is "authorized for reimbursement." The letter merely poses a hypothetical situation in which a provider could bill the ODHS for ABA therapy. It does

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not establish that Hoyt fits within that hypothetical. Under its terms, to be authorized for reimbursement, a provider must be, at minimum, (1) a therapist with a specialty in BCBA and (2) enrolled with the ODHS as an approved CMHP provider. Even assuming that the ODHS would classify Hoyt as a therapist with a specialization in BCBA, there is no evidence that she has been, or could be, enrolled as an approved CMHP provider. ^{FN12}Nothing in the record defines *1246 this class of providers or describes the process to become one. There is no indication that Hoyt has ever attempted to become one, or that she is even capable of doing so. In short, the record fails to establish that Hoyt, a professional with a BCBA certification and nothing more, is authorized for reimbursement under Oregon law. Indeed, in the absence of any basis for authorization other than ODHS approval, the record affirmatively forecloses the possibility as ODHS "does not recognize BCBA as a specific provider type." *Id.*

FN12. ORS 430.610-695 provides for the creation and oversight of CMHPs, and OAR 309-14-0020 provides specific requirements for the establishment and management of CMHPs within communities. In particular, organizations seeking to be contractually affiliated with the local mental health authority for the purpose of enrolling with the CMHP must apply to the CMHP for a certificate of approval. OAR 309-12-0160(2). There is no evidence in the stipulated record that either Hoyt or her employer, Building Bridges, contracted with the relevant CMHP to provide services for autistic children or received the requisite certificate of approval. The stipulated record also fails to reveal that Hoyt or Building Bridges applied for a certificate of approval as a qualifying "non-inpatient provider" under OAR 309-12-0160(3) for services provided in accordance with ORS 743A.168 or sought a variance from the administrative requirements pursuant to OAR 309-39-0580.

Because nothing in the record demonstrates that Hoyt is authorized for reimbursement for Oregon law, McHenry has failed to prove that Hoyt satisfies the definition of eligible provider under the 2007 Plan.

D. Alternate Bases for Recovery

1. Limited Coverage for Ineligible Mental Health Providers

McHenry offers two additional arguments for finding in her favor. The first relies upon the PacificSource internal policy titled "Administrative Procedure: Request for Ineligible Mental Health Providers." SR 725. This internal policy permits PacificSource to extend coverage for six visits to an otherwise ineligible provider where there exists "[i]icense equivalency," "[n]etwork accessibility" issues, or other special circumstances. *Id.* The six visits are intended to provide for "transitional care to an eligible provider [,]" but "[i]f compelling reasons and special circumstances are demonstrated, the Medical Director may approve additional visits." *Id.* Any benefits approved for an ineligible provider "are subject to nonparticipating provider benefit rates for approved services." *Id.*

McHenry argues that in light of the overwhelming evidence in the record demonstrating the necessity and efficacy of ABA therapy in this case and the utter absence of any other participating providers available in Clackamas County to provide ABA therapy (*see* SR 253-55, 1158), this policy should provide benefits even if Hoyt is not an eligible provider.

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Even if she is correct, McHenry has not demonstrated the basis on which this court could enforce this policy. The policy appears to be a wholly discretionary internal procedure for handling claims which, in PacificSource's judgment, merit limited special consideration despite the lack of coverage under the terms of the 2007 Plan. It does not appear in the 2007 Plan or the SPD and is not otherwise incorporated into the Plan. In an action pursuant to 29 USC § 1132(a)(1), the plaintiff is only entitled to pursue or clarify benefits or rights due him "under the terms of the plan." There is no basis for this court to expand those terms to include discretionary internal policies adopted by PacificSource.

2. Illusory Contract

[5] [6] Finally, McHenry argues that if J.M. is not entitled to ABA therapy under the 2007 Plan, then its purported coverage for autism is illusory. In construing a contract, "an interpretation which gives a reasonable, lawful, and effective meaning to all the terms is preferred to an interpretation which leaves a part unreasonable, unlawful, or of no effect." RESTATEMENT (SECOND) OF CONTRACTS § 203(a) (1981), quoted in U.S. v. Franco-Lopez, 312 F.3d 984,991 (9th Cir.2002). *1247 Thus, "the provisions of an ERISA plan should be construed so as to render none nugatory and to avoid illusory promises." Carr v. First Nationwide Bank, 816 F.Supp. 1476, 1493 CN.D.Ca1.1993) (citations omitted).

According to McHenry, ABA therapy is the "gold standard" of autism treatment, such that to exclude ABA therapy is to not treat autism. Therefore, she argues, if the Plan does not cover ABA therapy, then its autism coverage is purely illusory. It is equally illusory, then, to find that the 2007 Plan covers ABA therapy, but to construe its provider eligibility requirements to eliminate the only providers of ABA therapy.

In support of her argument, McHenry cites K.F. ex rel. Fry v. Regence Blueshield, No. C08-0890RSL, 2008 WL 4330901, at *4 (W.D.Wash. Sept. 19, 2008), where the court confronted a similar situation. In *Fry*, an ERISA-governed medical benefits plan provided home health care for medically necessary inpatient care. The plaintiff sought payment for hourly nursing services to provide that care. However, the plan expressly excluded payment for hourly nursing services. The court concluded that interpreting the plan to exclude in-home nursing would render its promise of substituted services illusory in most circumstances because one of the primary reasons for inpatient care is round-the-clock nursing services. More importantly, the court found that the exclusion for hourly nursing services did not clearly apply to the substituted service provision. Under the doctrine of reasonable expectations,

[a]n insurer wishing to avoid liability on a policy purporting to give general or comprehensive coverage must make exclusionary clauses conspicuous, plain, and clear, placing them in such a fashion as to make obvious their relationship to other policy terms, and must bring such provisions to the attention of the insured.

Id at *4, quoting Saltarelli v. Bob Baker Group Med. Trust, 35 F.3d 382,386 (9th Cir.1994).

By violating this doctrine, the court held that the exclusion did not apply.

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Unlike the exclusion at issue in *Fry*, the eligible provider term in the 2007 Plan is a clear condition of coverage on which McHenry bears the burden of proof. To be an eligible provider, McHenry must prove that Hoyt was authorized for reimbursement under Oregon law. As discussed above, the evidence submitted by McHenry fails to meet that burden of proof. Therefore, the reasonable expectations doctrine is inapplicable to bar the exclusion that eliminates coverage here.

Moreover, there is insufficient evidence in the record to conclude that eliminating coverage for BCBA's would eliminate all coverage of ABA therapy under the 2007 Plan. The ODHS letter explicitly posits a scenario in which a practitioner providing ABA therapy would be authorized for reimbursement under Oregon law. Unfortunately, neither the letter nor anything else in the record establishes whether such a practitioner exists. In 2007, McHenry's husband contacted all of the participating mental health care providers in Clackamas County and found that none of them provides ABA therapy. SR 253-55, 1158. However, this evidence does not establish that no ABA therapy practitioners are available who would meet the eligibility requirements of the 2007 Plan.

To the extent that other providers of ABA therapy are available to McHenry, or that Hoyt could become authorized for reimbursement herself by following the procedure outlined in the ODHS letter but has failed to do so, the lack of coverage is due to McHenry choosing a provider who is not covered by the Plan. That Hoyt is *1248 not authorized for reimbursement under Oregon law is solely a product of Oregon law, not an illusory contract of insurance. In that case, McHenry's remedy is with the Oregon State Legislature or the ODHS.

If the record established that no other possible providers of ABA therapy can be found within a reasonable geographic area, then the potential of illusory coverage would be much stronger. However, the record does not affirmatively establish that fact. Absent such evidence, the court is reticent to override the eligible provider provisions in the 2007 Plan as creating illusory coverage for autism. The specific provisions at issue are adopted wholesale out of Oregon's insurance code and, thus, reflect not only the bargain struck between McHenry and PacificSource, but also Oregon's public policy.

The requirement that Hoyt be authorized for reimbursement under Oregon law is not an unreasonable condition in the 2007 Plan. The purpose of the requirement appears to be to ensure that providers are subject to a state-sanctioned governing body which is able to set standards and exercise control over its members. Lacking such oversight of providers of ABA therapy, PacificSource would have no way to assure that the services being provided to its members are legitimate or uniform.

The court recognizes the hardship that its ruling may impose on McHenry and her family. However, ERISA only authorizes this court to grant benefits as provided for in the plan. The services provided by Hoyt are not covered under the 2007 Plan. Therefore, the court must deny McHenry's motion and grant Pacific Source's cross-motion.

FINDINGS OF FACT

1. ABA therapy is medically necessary to treat J .M.'s autism.

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2. PacificSource has failed to establish that ABA therapy is an investigational or experimental treatment as those terms are defined by the 2007 Plan.
3. PacificSource has failed to establish that ABA therapy is educational as that term is defined by the 2007 Plan.
4. PacificSource has failed to establish that ABA therapy is academic or social skills training as those terms are defined by the 2007 Plan.
5. McHenry has failed to establish that Hoyt is authorized to receive reimbursement under Oregon law.

CONCLUSIONS OF LAW

1. ABA therapy does not fall within any exclusion under the 2007 Plan and is therefore a covered benefit.
2. Hoyt is not an eligible provider under the 2007 Plan.
3. Under the terms of the 2007 Plan, McHenry is not entitled to reimbursement for the services provided by Hoyt.

ORDER

McHenry's Motion for Summary Judgment (construed as a motion for judgment on the record) (docket # 41) is DENIED and defendants' Cross-motion for Summary Judgment (construed as a cross-motion for judgment on the record) (docket # 47) is GRANTED.

DATED this 5th day of January, 2010.

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Superior Court of New Jersey,
Appellate Division.
In the Matter of Jacob MICHELETTI (a minor) Dependent of the Adult Insured, Joseph
Micheletti,
Petitioner-Appellant,
v.
STATE HEALTH BENEFITS COMMISSION, Respondent-Respondent.

Submitted Sept. 13, 2006.
Decided Jan. 17, 2007.

Background: State employee appealed State Health Benefits Commission's decision to deny coverage for occupational and speech therapy to treat autistic child.

Holding: The Superior Court, Appellate Division, Collester, J.A.D., held that the exclusion of coverage was invalid.

Reversed.

****844** Joseph M. Micheletti, appellant pro se.

Anne Milgram, Acting Attorney General, for respondent (Michael I. Haas, Assistant Attorney General, of counsel; Jeff Ignatowitz, Deputy Attorney General, on the brief).

Before Judges STERN, COLLESTER and SABATINO.

The opinion of the court was delivered by

COLLESTER, J.A.D.

***513** The appeal by Joseph Micheletti (petitioner) on behalf of his son Jacob ("Jake") raises the issue as to whether coverage for medically necessary treatment may be declined to an autistic child as a dependent under the State Health Benefits Program (Program).

The Program was created by the State Health Benefits Program Act of 1961, N.J.S.A. 52:14-17.25 to .45 (Act), which also spawned the State Health Benefits Commission (SHBC). The SHBC was entrusted to establish the Program by negotiating and purchasing medical, surgical, hospital, and major medical benefits for participating public employees and their families, "in the best interests of the State and its employees" as well as exclusive jurisdiction to determine disputed matters under the plan. N.J.S.A. 52:14-17.27 to .28.

In addition to basic benefits and stated major medical expense benefits, the Act granted the SHBC sole authority to determine what other "eligible medical services" should be included within the Program as well as "those which shall be excluded from or limited under such coverage." N.J.S.A. 52:14-17.29(A)(2). This discretion to limit or exclude coverage is to be exercised by the ***514** SHBC as it deems "necessary or desirable to avoid inequity, unnecessary

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utilization ... or benefits otherwise available" under Medicare or other federal statutes, and "[n]o benefits shall be provided beyond those stipulated in the contracts held by the [SHBC]." N.J.S.A. 52:14-17.29(B).

The Act further gave the SHBC the authority to establish rules and regulations, and dependents enrolled in the program are "subject to such regulations and conditions as the [SHBC] and the carrier may prescribe." N.J.S.A. 52:14-17.30(B). The SHBC used its rule making power to **845 issue a regulation which provided dependents or those enrolled in the Program with benefits subject only to the terms specified in the relevant insurance contracts.

The [SHBC] adopts by reference all the policy provisions contained in the contracts between the health and dental plans and the [SHBC] as well as any subsequent amendments thereto, to the exclusion of all other possible coverages.

[*N.J.A.C 17:9-2.14.*]

Jake was three years old when he was diagnosed with autism by a neurologist and a neurodevelopmental pediatrician. As defined by the National Institute of Child Health and Human Development (NICHD), a division of the United States Department of Health and Human Services, autism is a neurobiological development disorder that usually begins at age three and lasts a lifetime. There is no known cause and no cure. The main symptoms involve communication, both verbal and non-verbal, difficulties with social interaction, and repetitive and obsessive behaviors toward objects and routines.

<http://www.nichd.nih.gov/publications/pubs/upload/autism-overview-2005.pdf>. See also *Autism Fact Sheet*, National Institute of Neurological Disorders and Stroke, http://www.ninds.nih.gov/disorders/autism/detail_autism.htm.

The severity of autism varies widely. Some autistic children have led functioning lives; some have obtained a college degree. But others never escaped total isolation of mind, body, and spirit. There is no definitive, separate treatment. Clinical study has demonstrated that speech therapy, physical therapy, and occupational therapy begun at an early age give the autistic child the *515 best chance of a functioning life by minimization of symptoms, acquisition of basic skills, and development to full potential. All authorities agree that treatment should commence as early as possible. *NICHD Report on Autism, supra*, p. 6-7.

The sooner a child begins to get help, the more opportunity for learning ... Early intervention programs typically include behavioral methods, early development education, communication skills, occupational and physical therapy, and structured social play.

[*Id.* at 7.]

Following his diagnosis, Jake was evaluated at the Hunterdon Medical Center. Speech therapy and occupational therapy were prescribed as "imperative and medically necessary to his treatment plan."

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Joseph Micheletti is employed by the State of New Jersey as a Deputy Attorney General and is a member the State Health Benefits Program, having selected family coverage under New Jersey Plus (NJPLUS), a point-of-service plan offered to eligible employees and retirees. He filed a NJPLUS claim seeking pre-authorization for the prescribed speech therapy and occupational therapy from Horizon Blue Cross Blue Shield (Horizon), the administrator of the Program charged with responsibility for evaluation and processing of claims. Horizon granted authorization for speech therapy, but declined occupational therapy on grounds that the NJPLUS policy set out in the NJPLUS Members Handbook excluded coverage. The Handbook provision stated:

The plan does not cover services or supplies that are rendered with the primary purpose being to provide the person with any of the following:

- Training in the activities of daily living. This does not include services directly related to treatment of an illness or injury that resulted in a loss of a previously demonstrated ****846** ability to perform those activities.

* * *

- To promote development beyond any level of function previously demonstrated.

Joseph Micheletti filed a petition from the denial of occupational therapy to the Horizon Appeals Subcommittee, which reaffirmed the denial on grounds that the occupational therapy was intended "to promote development beyond any level of function previously ***516** demonstrated by Jacob, and is therefore not covered under terms of your NJPLUS plan." A petition was then filed with the SHBC pursuant to its internal review procedure. The SHBC requested Horizon to review the entire file in the matter and report its decision.

Horizon reaffirmed its decision denying coverage for occupational therapy, and added that its prior authorization for speech therapy was erroneous, citing a provision in the NJPLUS Member Handbook stating that "speech therapy to correct pre-speech deficiencies or to improve speech skills that have not fully developed are not covered under NJPLUS." The SHBC concurred and issued its final administrative determination denying both the continuation of speech therapy and pre-authorization for occupational therapy on grounds that the therapies were sought to develop skills or improve skills that were not fully developed and were therefore excluded from coverage. This appeal followed.

In 1999, two years before Jake was born, the New Jersey Legislature enacted *L. 1999, c. 106*, the Mental Health Parity Law, which required health insurers and health maintenance organizations, denoted as carriers under supervision of the Department of Banking and Insurance (DOBI), to provide "coverage for biologically-based mental illness (BBMI) under the same terms and conditions as provided any other sickness under the contract." *N.J.S.A. 17:48-6v*. The same language is repeated in other sections of the Insurance Act Titles 17 and 17B, governing health insurance and benefits.^{FN1} By DOBI regulation, the term "carrier" applies to "any insurer authorized to sell health insurance pursuant to Title 17B of the New Jersey Statutes; a health, hospital or medical service corporation; or a health maintenance organization." *N.J.A.C 11:4-*

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57.2. The State Health Benefits Program is not a "carrier" and is not subject to the statutes and regulations of the DOBI.

FNI. N.J.S.A. 17:48-6v; 17:48A-7u; 17:48E-35.20; 17B:26-2.1s; 17B:27A-19.7; 26:2J-4.20; and 34:11A-15.

***517** Seven months after the Mental Health Parity Law governing health insurance carriers became law, a companion statute, *L. 1999, c. 441 § 2*, was enacted and codified as N.J.S.A. 52:14-17.29e, with the stated purpose of requiring that the SHBC provide the same coverage for BBMIs to persons covered under the State Health Benefits Program "as that required for other health insurers and health maintenance organizations under P.L. 1999 c. 106." (Statement to Sen. B. 2277, 208 Leg. (N.J. 1999); Statement to Assemb. B. 3588, 208 Leg. (N.J. 2000)). The statute as enacted reads as follows:

a. The State Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act that provides hospital or medical expense benefits shall provide coverage for biologically-based mental illness under the same terms and conditions as provided for any other sickness under the contract.

****847** b. Nothing in this section shall be construed to change the manner in which a carrier determines:

(1) whether a mental health care service meets the medical necessity standard as established by the carrier ...

[N.J.S.A. 52:14-17.29e.]

The two statutes used the same language respecting coverage of BBMIs, making clear the legislative intention to provide the same coverage to persons covered under the State Health Benefits Program as required for other health insurance carriers in this State by the companion statute. The two statutes also identically define BMI as:

[A] mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness including, but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder and pervasive developmental disorder or autism.

[N.J.S.A. 52:14-17.29d; N.J.S.A. 17:48-6v(a).]

Since the State Health Benefits Program is not a carrier, the SHBC, not the DOBI, has the responsibility to administer the Program. As the SHBC points out, its statutory mandate for maintenance of the largely publicly funded Program requires fiscal and administrative restraints in the allocation of limited resources, ***518** which may limit or exclude some benefits afforded

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under private medical health benefit plans. See Barone v. Dep't of Human Servs. .. 107 N.J. 355, 372-73, 526 A.2d 1055 (1987); State v. Senno. 79 N.J. 216, 229, 398 A.2d 873 (1979).

[1] The SHBC maintains that its denial of coverage of the prescribed therapy treatment for Jake under the "non-restorative" exclusion in the Handbook is properly grounded in its authorized discretion to limit or exclude coverage "in the best interests of the State and its employees." N.J.S.A. 52: 14-17.28. It asserts that the exclusion is in compliance with the clear and unambiguous statutory mandate of N.J.S.A. 52:14-17.29d and e because non-restorative treatment for conditions other than BBMIs are also excluded, and the statute requires no minimum level of care for BBMIs when not provided for any other sickness under the contract.

[2] In general, appellate review of a final agency determination is limited. Clowes v. Terminix Int'l. Inc. 109 N.J. 575,587,538 A.2d 794 (1988). We may not substitute our judgment if the agency's conclusion is supported by credible evidence, except when it is arbitrary, capricious, or unreasonable or violates legislative intent and public policy expressed or implicit in the enabling act. Campbell v. Dep't of Civil Serv. 39 N.J. 556,562, 189 A.2d 712 (1963).

[3] As succinctly stated by our Supreme Court:

The judicial role is restricted to four inquiries: (1) whether the agency's decision offends the State or Federal Constitution; (2) whether the agency's action violates express or implied legislative policies; (3) whether the record contains substantial evidence to support the findings on which the agency based its action; and (4) whether in applying the legislative policies to the facts, the agency clearly erred in reaching a conclusion that could not reasonably have been made on a showing of the relevant factors.

****848** [George Harms Constr. Co. v. N.J. Tpk. Auth.. 137 N.J. 8,27, 644A.2d 76 (1994).]

Here there is no dispute as to Jake's diagnosis, and the State does not contest that speech therapy and occupational therapy is medically necessary for treatment of Jake's autism. What we have is the atypical and unfortunate situation of two separate State agencies reaching contrary conclusions based on different ***519** interpretations of the same language in mirror statutes. Our inquiry, therefore, is the proper interpretation of the statutory mandate, and accordingly, we are not bound by the interpretation of either agency. Mayflower Sec. Co. .. Inc. v. Bureau of Sec. .. 64 NJ 85, 93, 312 A.2d 497 (1973); McKenzie v. Bd of Trs. of the Pub. Employees Ret. Sys. .. 389 N.J.Super. 456 at 461, 913 A.2d 810 at 813, 2006 WL 3771815, at *3, 2006 N.J.Super. Lexis 341, at *7 (App.Div.2006).

An interpretation of the same legislative language contrary to that given by the SHBC was incorporated by the DOBI in its rules and regulations adopted pursuant to the Administrative Procedure Act (APA), N.J.S.A. 52:14B-1 to -21. In May 2003, the DOBI proposed rules respecting benefits mandated for BBMIs under the Mental Health Parity Act, including a rule that carriers may not apply exclusions to deny or limit benefits and services, including speech and occupational therapy, that are non-restorative to persons with BBMIs. 35 NJ.R. 2158. The DOBI stated the following need for the clarification:

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Relying on the first type of exclusion, the chronic condition exclusion, carriers have refused to cover speech, physical and occupational therapy for children with autism and pervasive developmental disorder even though such therapy is a key component of the treatment of such conditions. Carriers have invoked the second type of exclusion, the non-restorative exclusion, to deny speech therapy to the same children, arguing that because these children did not previously possess the ability to speak such therapy is not required to be covered. The Department believes that the use of these exclusions to deny treatment for persons with biologically based mental disorders (BBMI) undermines the intent and purpose of the Act.

[Notice of Proposed Adoption of Regulation, 35 *N.J.R.* 2158.]

The proposed rules were amended for unrelated reasons and republished in May 2005. In response to an industry question as to whether carriers could refuse to cover therapy services for children who are not typically developing, the DOBI restated its position:

[T]o allow carriers to exclude the primary mode of treatment for autism and pervasive development disorder (speech, occupational and physical therapy) would render the statutory directive meaningless and, therefore, it cannot be permitted. Interpretations that render a statute void are to be avoided.

[37 *N.J.R.* 1524, response to comment 4.]

***520** The rules then adopted by the DOBI included a prohibition against carriers applying an exclusion to deny benefits and services medically necessary for the treatment of BBMI, specifically listing "exclusions for physical, speech and occupational therapy that is non-restorative (that is, does not restore previously possessed function, skill or ability)." *N.J.A.C. 11:4-57.3(a)(2)*. The rules also prohibit "exclusions for the treatment of developmental disorders or developmental delay." *N.J.A.C. 11:4.57.3(a)(4)*.

The SHBC underscores that the DOBI rules and regulations are applicable to commercial carriers and not to the State Health Benefits Program, for which the SHBC has exclusive authority under ****849** *N.J.S.A. 52: 14-17 .29(A)(2)* to set the terms of coverage for State employees except for treatments mandated by statute.^{FN2} Accordingly, it argues that it may impose exclusions and limitations on treatment for BBMIs as long as they apply equally to other sicknesses and physical limitations. Its rationale is based on its statutory authority and the fact that it has different fiscal and administrative constraints which may require limitation or exclusion of certain benefits afforded under private medical health benefit plans. Since the State is self-insured and cannot raise premiums, any change of coverage adds costs to the Program. Accordingly, the SHBC maintains that if the Legislature sought to bind itself to providing any additional coverage, it would have explicitly done so.

FN2. *N.J.S.A. 52:14-17.29b* (inpatient coverage for mastectomy); *N.J.S.A. 52: 14-17.29c* (treatment of inherited metabolic diseases); *N.J.S.A. 52:14-17.29f* (pap smear expenses); *N.J.S.A. 52:14- 17.29j* (female contraceptives).

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In interpreting whether N.J.S.A. 52:14-17.29e mandates the treatment sought for autism, we must consider that the Legislature included identical language in both of the parity statutes, including an identical definition of BBMI specifically identifying autism. Passed within seven months of each other in the same legislative session with the same Senate and Assembly sponsors, the parity statutes have a common purpose, and therefore, should *521 be read in harmony, not in conflict. F & W Assocs. v. County of Somerset Planning Bd., 276 N.J.Super. 519, 525-26, 648 A.2d 482 (App.Div.1994). Furthermore, the statements to the identical Senate and Assembly bills stated that the purpose of the legislation governing the State Health Benefits Program was "to require that the [SHBC] provide the same coverage for biologically-based mental illnesses to persons covered under [the Program] as required for other health insurers and health maintenance organizations" under the legislation applicable to carriers. S. 2277, 208 Leg. (N.J. 1999); Assemb. 3588, 208 Leg. (N.J. 1999).

[4] We agree with the interpretation of the statutory language by the DOBI, and find that it is equally applicable to N.J.S.A. 52:14-17.29e. The SHBC's restrictive literal reading conflicts with the legislative intent and purpose of the act. It is a cardinal rule of statutory construction that the act must be read "sensibly rather than literally, with the purpose and reason for the legislation controlling." Reisman v. Great Am. Recreation. Inc., 266 N.J.Super. 87,96,628 A.2d 801 (App.Div.) certif. denied, 134 N.J. 560,636 A.2d 519 (1993). The motivation and spirit of the parity statutes is to afford greater coverage to those afflicted with BBMIs. However, the SHBC's exclusion of treatment for autism eviscerates that purpose and renders the act a nullity.

[5] N.J.S.A. 52:14-17.29d specifically denotes autism as a BBMI, and the following subsection of 17 .29e seeks to remedy unfairness and inequality in its treatment when compared with coverage for physical conditions or sickness. Yet the SHBC excludes coverage for the only accepted treatment of autism, thereby excluding autism from coverage despite the legislative directive to the contrary in N.J.S.A. 52:14-17.29e. If the SHBC is correct in its reading, the statute would appear to promise much, but it really grants little or nothing for an autistic child. We cannot infer such a cruel intent by the Legislature.

[6] The wording of the statute cannot be considered apart from its purpose and spirit. When a literal reading leads to a *522 result contrary to the purpose and design of legislation, the spirit of the law controls the letter of the law. **850 N.J. Builders. Owners and Managers Ass'n v. Blair. 60 N.J. 330,338,288 A.2d 855 (1972); Jersey City Chapter of Prop. Owner's. etc. v. City Council. 55 N.J. 86, 100,259 A.2d 698 (1969); Wnuck v. N.J. Div. of Motor Vehicles. 337 N.J.Super. 52,57-8, 766 A.2d 312 (App.Div.2001). The spirit and stated intention of N.J.S.A. 52:14-17.29e cannot be read to exclude the medically necessary treatment for an autistic child.

By establishing the State Health Benefits Program, the State manifested its intention to put health benefits for State employees on a parity with those in the private sector who are afforded coverage through the commercial insurance market. Heaton v. State Health Benefits Comm'n. 264 N.J.Super. 141,151, 624A.2d 69 (App.Div.1993). But the SHBC's interpretation sub judice does the opposite and is contrary to the goals of the program. As we have previously stated,

The goal of the State Health Benefits Program Act is to provide comprehensive health benefits for eligible public employees and their families at tolerable costs. It establishes a plan for State funding and private administration of a health benefits program which will protect State

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employees from catastrophic health expenses, and which encourages public employees to rely on the Program instead of seeking protection in the commercial insurance market.

[*Id.* at 151, 624 A.2d 69]

[7] There can be little doubt that the Program is an inducement to public service. It is the sole source of medical benefits coverage for tens of thousands of State employees and their only protection from catastrophic medical expenses. While the SHBC has wide discretion to define benefit limits and exclusions from coverage, its statutory authority is circumscribed by the goals of the Program and the reasonable expectation of its participants.

In *G.B. v. State Health Benefits Comm'n.* 222 N.J.Super. 83,535 A.2d 1010 (App.Div.1988), decided prior to the mental health benefits parity laws, we held that the SHBC lacked statutory authority to exclude from coverage those totally disabled by *523 mental illness while allowing coverage for those suffering from mental retardation or physical disability. We stated that

N.J.S.A. 52: 14-17 .29(B), in our view, only gives the Commission the right to limit the extent of benefits payable to those persons provided with coverage and to circumscribe on a fair and rational basis those who are deemed eligible for extended coverage. *We cannot, however, reasonably conclude that the Legislature intended to invest the Commission with the authority to exclude certain categories of dependents who were totally disabled based solely on the cause of the disability.* When a dependent cannot provide for himself, the cause of the disability is irrelevant to and does not alter the burden upon the state employee.

[*Id.* at 90,535 A.2d 1010 (emphasis supplied).]

In this case the denial of coverage for Jake's prescribed treatment is couched in terms of the contractual exclusion of benefits for non-restorative speech, physical and occupational therapy, but the medical evaluations of Jake indicate that the therapy is the only treatment modality for an autistic child. Denial of the treatment amounts to exclusion from coverage of a class of dependents, notably afflicted children, based on the nature of their mental illness, which is beyond the limits of the statutory authority of the SHBC.

The exclusion as applied by SHBC is contrary to the goal of the State Health Benefits Program because it would lead to **851 the anomalous and unacceptable conclusion that while medically necessary treatment for autistic children is mandated for dependents of those insured by "carriers," an unfortunate State employee who has an autistic child must bear the entire cost of necessary treatment

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in addition to the emotional burden of having a child afflicted by this incurable and mysterious illness. This result runs contrary to the core of the State Health Benefits Act. As we stated in *Heaton, supra*,

By undertaking that very consequential role in the financial security of public employees and their families, the State also undertakes to play fair with them. Hidden or unfair reservation in insurance policies are ignored because they do not reflect the reasonable expectation of the parties [citations omitted] because of the significance of health insurance to public employees and their families, and the Legislature's undertaking to furnish insurance and determine its scope, one of the goals of the Legislature must have been to insure the fair and even-handed application of Program provisions, and the avoidance of crammed interpretations of ambiguous terms.

**524 [Heaton, supra. 264 N.J.Super. at 151-152, 624A.2d 69.]*

[8] Unlike the DOBI, the SHBC has not dealt with coverage for treatment of autism and other BBMIs through the regulatory process, although we have suggested that it do so due to the absence of any regulation delineating what benefits are covered and which are excluded beyond the minimum specified in *N.J.S.A. 52:14-29. Heaton, supra. 264 N.J.Super. at 152-53, 624 A.2d 69*. Instead, the SHBC continues its reliance on the catch-all language of *N.J.A.C. 17:9-2.14*, which adopts by reference all provisions in the contract with State employees and excludes any other benefits. Read literally, this regulation would grant the SHBC discretion to pick and choose coverage and exclude any sickness or treatment. There is no statutory basis for such unbridled discretion. An administrative agency may not exercise its delegated authority to alter the terms of a statute or frustrate its underlying policy. *N.J. State Chamber of Commerce v. N.J. Election Law Enforcement Comm'n*, 82 N.J. 57, 82, 411 A.2d 168 (1980); *Siri v. Bd of Trs. of Teachers' Pension & Annuity Fund* 262 N.J.Super. 147, 152, 620 A.2d 440 (App.Div. 1993).

[9] [10] The SHBC maintains that the medical benefits contract in the Member's Handbook clearly and unambiguously state that speech and other therapy treatments for development of skills and functions not yet realized are excluded, and, as a result, State employees are bound to its terms. The Program language is not to be read in the same light as a commercial insurance policy as a contract of adhesion, but is to be interpreted and applied with its legislative intent and purpose as well as the reasonable expectation of the State employees for whom it provides medical benefits. *Heaton, supra, 264 N.J.Super. at 151, 624 A. 2d 69*. In this regard, the insurance market is a guidepost for interpretation of benefits coverage since the Program was established with the intention of putting State employees on an equal footing with those covered by commercial medical benefits policies.

The reasonable expectations of both the State and the insured public employees are reached in large part after a consideration of the scope of the protections offered by the commercial insurance market. If Program provisions compatible with the **525* statute appear to furnish protection consistent with the offerings of the commercial insurance market, those provisions should be interpreted in a consistent manner. Thus, judicial interpretations ***852* of coverage provisions of commercial insurance contracts should guide, if not control, interpretation of Program provisions.

[Id at 152, 624A.2d 69.]

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[11] As with other insurance contracts, terms of the State benefits contracts excluding or limiting coverage are to be scrutinized with care. If the language supports two interpretations, the one favoring coverage is to be adopted. Charles Beseler Co. v. O'Gorman & Young, Inc., 188 N.J. 542, 911 A.2d 47 (2006); Lundy v. Aetna Cas. & Sur. Co., 92 N.J. 550, 559, 458 A.2d 106 (1983); Ryan v. State Health Benefits Comm'n. 260 N.J. Super. 359, 363, 616 A.2d 952 (App.Div.1992). As stated by us in Ryan,

Exclusionary language in an insurance contract is strictly interpreted. Butler v. Bonner & Barnewall, Inc., 56 N.J. 567, 576, 267 A.2d 527 (1970). The SHBP is no different. It deals with the same kinds of consumers of insurance protection, who accept what is available and try to find its meaning. An ambiguity exists where the policy language is so confusing that the average policy holder cannot make out the boundaries of coverage. Weedo v. Stone-E-Brick, Inc., 81 N.J. 233, 247, 405 A.2d 788 (1979).

[Ryan, *supra*. 260 N.J. Super. at 363, 616 A.2d 952.]

Far from accepting the SHBC contention that the exclusion of the prescribed therapy for Jake is clearly set forth in the NJPLUS contract, we find the exclusionary language to be ambiguous, as witnessed by the fact that Horizon initially approved speech therapy. Furthermore, the SHBC interpretation foreclosing non-restorative benefits is undercut by another Handbook provision indicating that speech therapy is covered after surgery "to correct a defect that existed at birth and impaired the ability to speak or would have impaired the ability to speak."

In addition, while the Handbook excludes treatment for development of a function or skill beyond that previously demonstrated, there is no definition of "development" or "developmental." Children are constantly developing. "Developmental" defines childhood. The words "restorative" and "non-restorative" when used in this context are also ambiguous and largely inapplicable to infants and young children. Every child is born with the potential to develop those skills necessary to life in society. Autistic *526 children and other children afflicted with BBMs are hindered from achieving that potential. The treatment for Jake can restore some of his potential. Even with the therapies described, Jake's prognosis is uncertain, but there is no claim that the treatment is futile. To the contrary, there is the expectation that, to some degree, he will share the skills and functions of more fortunate children, including his siblings.

The prescribed treatment for Jake is traditional, not exotic or wasteful of resources.^{FN3} Nor can we assume that inclusion of occupational or speech therapy for the small number of autistic children will significantly affect the fiscal burden of the State Health Benefits Program or hinder the mission of the SHBC to provide a comprehensive health program for State employees and their dependents at reasonable cost. We find no legislative goals to be advanced by the denial of the benefits sought and no statutory authority to do so. The decision of the SHBC is antithetical to the purpose and spirit of the State Health Benefits Program, the reasonable expectation of its participants, the legislative intention **853 of equal treatment for BBMs and the public policy of this State for the nurturing of children.

FN3. See general discussion, David Orenhicher, *Destructuring Disability: Rationing of Health Care and Unfair Discrimination Against the Sick*, 31 Harv. C.R.-C.L. L.Rev. 49 (1996).

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We hold the exclusions relied upon by the SHBC to deny coverage for the treatment sought for autism are void. We direct that speech and occupational therapy be instituted for Jake without delay, and that the date of coverage is retroactive to the date of the initial petition.

Reversed.

JUDICIAL ARBITER GROUP, INC.

JAG Case No. 270779

JILL and STEPHEN TAPPERT,

Claimants,

v.

ANTHEM BLUE CROSS BLUE SHIELD,

Respondent.

ARBITRATION AWARD

This matter is before the Arbitrator for issuance of the arbitration award. The Arbitrator has considered the evidence, counsel's arguments and submissions and the applicable law.

At issue, is whether Anthem is required to cover the costs of ABA autism treatment for Abby Tappert (age 4) and whether Anthem committed bad faith in adjudicating and denying Claimants' application for benefits. The Arbitrator answers the first question "yes" and second question, "no".

I. Is ABA treatment a benefit under the policy?

Respondent's justification for denial of ABA treatment as a benefit under the policy was based on two specific reasons:

1. The treatment was not medically necessary.
2. The services were not provided in a doctor's office and/or ABA therapy is not a covered benefit.

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The Arbitrator will consider each in turn.

1. Whether ABA treatment is medically necessary.

In general, Anthem's PPO policy provides:

Anthem's Process to Determine if Services are covered

To determine if a health care service is a covered benefit, Anthem considers whether the service is medically necessary and whether the service is experimental/investigational, cosmetic or otherwise excluded under this coverage. Anthem uses numerous resources, including current peer-reviewed medical literature, Anthem's adopted medical policies and practice guidelines, guidelines obtained from recognized national organizations and professional associations, and consultations with physician specialists when determining if a particular service is covered. Anthem will assist the member by determining what services are covered under the member's chosen coverage and what services are excluded from the health coverage.

Medically Necessary Health Care Services – Anthem determines if services, procedures, supplies or visits are medically necessary. Only medically necessary services (except as otherwise provided in this certificate), procedures, supplies or visits are covered services. Anthem uses medical policy, medical practice guidelines, professional standards and outside medical peer review to determine medical necessity. Anthem's medical policy reflects current standards of practice and evaluates medical equipment, treatment and interventions according to an evidence-based review of scientific literature. Medical technology is constantly changing, and Anthem reserves the right to periodically review and update medical policies. Providers and members may go to our website to view a list of services considered medically necessary. The benefits, exclusions and limitations of a member's coverage take precedence over medical policy. (Anthem PPO Policy; Exhibit 18, p.7-8.),

In the definitional section of the policy, Anthem more particularly describes what medically necessary means:

"Medically necessary - an intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and the Anthem solely determines to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury.
- Obtained from a physician and/or licensed, certified or registered provider.
- Provided in accordance with applicable with applicable medical and/or professional standards.

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- Known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- The most appropriate supply, setting or level of service that can safely be provided to the member and which cannot be omitted, and is consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained as an outpatient).
- Cost-effective compared to alternative interventions, including no intervention (cost-effective does not mean lowest cost).
 - Not experimental/investigational
 - Not primarily for the convenience of the member, the member's family or the provider.
 - Not otherwise subject to exclusion under this certificate.

The fact that a physician and/or provider may prescribe, order, recommend or approve care, treatment, services or supplies does not itself make such care, treatment, services or supplies medically necessary.”

(Anthem PPO Policy, Exhibit 18, p.71-72.)

Pursuant to this provision, Anthem promulgated a medical policy on autism. The policy was drafted by a non-physician, using medically accepted and scientifically reliable data bases. The policy was then reviewed by physicians before its adoption and utilization by Anthem. No evidence was presented that the physician reviewers had any experience in the diagnosis and treatment of autism. In fact, the doctors testifying for Anthem on the validity of the policy acknowledged that they had no experience treating autism. See for example, *Kunin v. Benefit Trust*, 910 F.3d 534 (9th Cir. 1990) (failure to consult with expert in autism was abuse of discretion when labeling autism a mental illness instead of an organic disorder).

Claimant presented the testimony of Drs. Strain and Huckabee – both of which are well versed and practiced in autism treatment. Dr. Strain is world recognized for his autism research and publication having authored over 170 articles, 44 book chapters and having received \$45 million in grants to study autism and its treatment. In his criticism of the Anthem policy, Dr. Strain points out that Anthem erroneously equates ABA

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therapy with Lovaas therapy – an approach which has received considerable justifiable scientific criticism. ABA therapy is based upon incidental teaching and pivotal response training, which Dr. Strain testified is the standard of care when dealing with autistic children. According to Dr. Strain, instead of being investigational and experimental, ABA therapy reduces problem behaviors 80 – 90% and studies have replicated these results repeatedly. Finally, Dr. Strain testified that the ABA therapy received by Abby was endorsed by the National Academy of Sciences – the recognized authority in the United States for resolving scientific disputes. Dr. Strain's opinions were echoed by Dr. Huckabee, Abby's treater for autism. Both Dr. Strain's and Huckabee's opinions are supported by the National Institute of Mental Health's publication on Autism Spectrum Disorders:

“Among the many methods available for treatment and education of people with autism, applied behavior analysis (ABA) has become widely accepted as an effective treatment. Mental Health: a Report of the Surgeon General states: “Thirty years of research demonstrated the efficiency of applied behavioral methods in reducing inappropriate behavior and in increasing social behavior.”

The Arbiter has reviewed the references submitted by Anthem. Most are critical of the Lovaas approach. ABA therapy is not Lovaas therapy. Many articles which do mention ABA therapy are positive. (For example, see meta-analysis, Exhibit O, p. 3) Anthem 00539: “Applied behavior analysis strategies have been demonstrated to be effective in young children with autism”) It appears both from the greater weight of the references and credible testimony that ABA therapy is the standard of care in treating autism.

While the scientific reliability of ABA therapy was contested, its ability to reduce harmful behaviors was not. Anthem's medical policy also provides:

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Behavioral modification for management of behavioral symptoms related to Autism . . . is considered medically necessary when required for the management of behaviors where the potential for patients to harm themselves or others is present . . .

(Anthem PPO Policy, Exhibit 15.)

Mr. London testified that this language does not apply to ABA therapy. The Arbitrator is unconvinced. ABA therapy uses behavior modification techniques to manage autistic behavioral symptoms such as self destructiveness and aggression. Abby's parents and Dr. Huckabee testified about Abby's self-destructive head banging and aggressiveness towards other children. It was uncontroverted that the ABA therapy has helped in the past and continues to help control Abby's self-destructive and outward aggressive behaviors. Similarly, it was undisputed that without such therapy, Abby would undoubtedly have suffered brain damage.

The Arbitrator concludes, at a minimum, that Abby's ABA therapy was medically necessary because it controls Abby's self-destructive behaviors and outward aggressions directed toward others.

2. Whether ABA therapy is a covered benefit under the policy.

The insured has the initial burden to demonstrate a loss, injury or benefit covered under the policy. The insurer then must establish an exclusion that applies which is not subject to any other reasonable interpretation. *Leprino Foods v. Factory Mutual Ins. Co.*, 453 F.3d 1281, 1287 (10th cir 2006); *American Family Mutual Insurance v. Bentley*, 953 P.2d 1297, 1301 (Colo. App. 1998). If the insurer shows that an exclusion applies, the burden then shifts back to the insured to establish an exception to the exclusion. *Pubic Service v. Wallis*, 955 P.2d 564, 568 (Colo. App. 1997), reversed other grounds, 986 P.2d 924 (Colo. 1999); *Rodriguez v. Safeco Ins. Co.*, 821 P.2d 849 (Colo. App. 1991).

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Claimants initially point to the policy's mental health provision to support their coverage position:

Biologically based mental illness conditions and autism are covered under the member's medical benefits and not subject to the limitations of the mental health benefit. They are covered the same as any other physical illness, and described in the appropriate section of the certificate depending upon the care type received. (Anthem's PPO Policy; Exhibit 18; p. 41)

Claimants cite two sections of medical benefits for coverage of the claimed treatment: Physician Office Services and Other Outpatient Therapy Services.

Physician Office Services includes benefits which are for medical care, consultation and second opinions for the examination, diagnosis and treatment of an illness or injury, when received in a physician's or other professional provider's office. (Anthem PPO Policy, Exhibit 18, page 27.) A physician is defined as a doctor of medicine or osteopathy who is licensed to practice medicine under the laws of the state or jurisdiction where the services are provided. (Anthem PPO Policy, Exhibit 18; p. 73.) A "professional provider" is defined as:

Professional provider – a physician or other professional provider who is licensed or otherwise authorized by the state or jurisdiction where services are provided to perform designated health care services. For benefits to be payable, services must be within the scope of the authority granted by the license and covered by this certificate. Such services are subject to review by a medical authority appointed by Anthem. Other professional providers include, among others, certified nurse midwives, dentists, optometrists and certified registered nurse anesthetists. Services of such a provider must be among those covered by this certificate and are subject to review by a medical authority appointed by Anthem.

(Anthem's PPO Policy, Exhibit 18; p. 73.)

Claimant is requesting reimbursement for services that were provided at multiple locations including, the child's home, Emerge, P.C., the Aspen Center, the child's school, in the community and staffing phone conferences. Dr. Helena Huckabee, a licensed

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clinical psychologist and pediatric neurophysiologist maintains offices at Emerge and at the Aspen Center. Services provided at both the Aspen Center and Emerge to Abby were within the scope and authority of Dr. Huckabee's license. The Aspen Center's executive director is a registered occupational therapist. The Aspen Center has apparently billed for Service for which Anthem has paid. (See Exhibit 34.)

The Respondent contends that the services must be provided in a physician's office. The Arbiter does not agree. While the first paragraph under Physician Office Services says that the services must be provided in a physician's office, the third paragraph clearly permits consultations to treat an illness or injury, when provided in a professional provider's office. (Anthem PPO Plan, Exhibit 18, p.27.)

At the very least, these two conflicting provisions create an ambiguity, or inconsistency in a policy of insurance and, therefore, the provision should be construed in favor of coverage. *Farmers Alliance Mutual Ins. v. Ho*, 68 P.3d 546 (Colo. App. 2002), *Tepe v. Rocky Mountain Hospital and Medical Services*, 893 P.2d 1323 (Colo. App. 1994).

The policy carries benefits for consultations and treatment when received in a professional provider's office. There does not appear to be any limitation on either the type or number of treatments as long as they are at the professional office within the scope and authority of the license. The services were provided by Dr. Huckabee and paraprofessionals which she trained and supervised. The Arbiter concludes that services provided at Emerge and the Aspen Center for Abby are a covered benefit.

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Claimant also asserts that there is coverage for ABA therapy under the Other Outpatient Therapy Provisions. The Arbiter agrees. The relevant section provides as an exclusion to coverage:

Therapies for learning disorders, behavioral or personality disorders, developmental delays, stuttering, voice disorders or rhythm disorders.

(Anthem PPO Plan, Exhibit 18, p. 33.)

However, an exception to that exclusion, provides that, up until the member's 5th birthday, the "exclusion shall not apply to therapies for the care and treatment of congenital defects or birth abnormalities." (Anthem PPO Policy, Exhibit 18, p. 33.)

Respondent contends that this exception to the exclusion only provides the 20 outpatient visits for physical, speech and occupational therapy. The Arbiter is not persuaded. The exception does not express any limitation and the Arbiter will not rewrite the contract to engraft such a limitation on the exception. *Farmers Alliance, supra*, at 550 (when the insurer seeks to restrict coverage, the limitation must be clearly expressed.)

Respondent also contends that the language in exclusion: "therapies for self help programs not specifically identified above" limits any benefits for ABA therapy. The Arbiter does not agree. The policy specifically delineates therapies for care and treatment of congenital defects, as an exception to the exclusion and thus, it is a therapy enumerated above.

Respondent finally asserts that there is a no coverage because autism is not a congenital defect or birth abnormality¹. Anthem has taken contradictory positions

¹ Claimant initially responds that Respondent's assertion is untimely because it was raised for the first time at the hearing. See *Public Service v. Wallis*, 955 P.2d 564, 571 (Colo. App. 1997), reversed other grounds

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regarding its interpretation of the cause of autism. In its medical policy, Anthem defines autism as a developmental disorder that affects parts of the brain that control social interaction and communication. Congenital defect is defined in the Anthem PPO Policy as a defect or anomaly existing before birth, such as cleft lip or club foot. (Anthem PPO Policy, Exhibit 18, p. 67.)

Anthem's interpretation of its own policy and conduct evinces its belief that autism is a congenital defect and/or a birth abnormality. In its coverage denial letter of May 30, 2006, Anthem acknowledged that Abby was entitled to outpatient therapy for congenital defects and birth abnormalities to wit—her autism. (See Exhibit AJ). Even before the issuance of the second level appeal, Dr. Jones, Anthem's Medical Director, expressed the opinion: "autism meets the requirements for therapies up until age 5 – the therapies need be PT, OT, and ST provided by a licensed provider..." (Anthem Appeal Review Request, 02/12/06, Exhibit 14.) For autism to meet the requirement of the PT, OT, and ST therapies, the benefits must be solely for the treatment of congenital defects and/or birth abnormalities. (Exhibit 18, p. 33)

The initial opinion of Dr. Jones, that autism is not a developmental disorder which Respondent now claims was an accommodation to the autism lobby, is well supported by Dr. Strain and Dr. Huckabee. Additionally, Dr. MacHaffie, the President of the Colorado Chapter of the American Academy of Pediatrics noted, citing five recent peer reviewed articles, that autism is a neurological disorder that is present in some children at birth. Jill Tappert testified about Abby's birth abnormalities which were consistent with autism as a congenital defect or birth anomaly.

986 P.2d 924 (Colo. 1999). The Arbiter finds it unnecessary to make this determination, because of Anthem's conduct in construing its own policy.

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Given Anthem's inconsistent interpretation of its own policy, the Arbiter must construe the policy to extend coverage. See *State Farm Mutual v. Nissen*, 851 P.2d 165 (Colo. 1993). The Arbiter concludes that autism is a congenital defect and/or birth abnormality. The Arbiter concludes that ABA treatment for autism is a covered benefit under the policy until Abby is five.

II. Did Anthem act in bad faith?

To prevail on their claim of bad faith the Claimant's must demonstrate that Anthem acted unreasonably with knowledge that its conduct was unreasonable or in reckless disregard that its conduct was unreasonable. *American Family v. Allen*, 102 P.3d 333, 342 (Colo. 2004). The *scienter* requirement for a bad faith action reflects the balance between the need for carriers to reject non-covered claims, yet, to investigate and pay covered claims. *Travelers Ins. Co. v. Savio*, 706 P.2d 1258, 1275 (Colo. 1985), Claimants assert Anthem acted in bad faith because:

1. In the first level appeal Dr. Jones did not consult a clinical peer nor did the denial letter accurately reflect Dr. Jones' decision.
2. The second level appeal two of the three members did not have appropriate expertise.
3. In the second level appeal, Dr. Pedowitz, the panel member with specialized autism knowledge abstained and Claimants were not so informed.
4. The second level appeal letter was not issued by the panel and failed to include the review panel's statement of their understanding of the covered person's request for review.

Exhibit E

5. Anthem delayed the proceedings by failing to seasonably select an arbiter and insisting Morgan Stine Fitzsimmons, that the Claimants should pursue a third level external review.
6. Anthem's reliance on Medical Policy BEH0004 is unreasonable because the policy out of date and not in accord with the current standard of care.

Although a close question, Claimant's contentions individually and cumulatively do not constitute bad faith. It is undeniable that Anthem did not adhere to each rule governing the appellate procedure. However, the Arbiter finds that the non-compliance was not done in bad faith.

In the first level appeal, Dr. Jones needed to be a clinical peer or consult a clinical peer. Dr. Jones is a board certified surgeon with substantial policy and administrative education and experience. He does not recall whether he consulted with a clinical peer. He testified that his decision to deny coverage in the first appeal was based upon coverage... i.e. the policy did not provide the benefit the Tapperts were seeking. Thus, a clinical peer's input was unnecessary because this was not a utilization review involving issues of medical necessity. Part of the first level review letter was authored by Mr. Espo, the Anthem assigned Member Appeals Advocate. The Espo language somewhat tracks Dr. Jones' determination. (Compare Exhibit 12 and 14)

In the second level appeal, the panel members must consider all issues, regardless of whether they were raised in the first appeal. Amended Reg. 4-2-17 § 11(G) (4). The appeal panel must be comprised of health care professional with appropriate expertise to the case presented by the covered person. Amended Regulation 4-2-17 § 11(F). On the other hand, a third level review contemplates that the reviewers have expertise in the

Exhibit E

treatment of the medical condition of the covered individual. § 10-16-113.5, C.R.S. (2007). The statute has no mandate for such specialized expertise for second level reviewers. The statute simply requires that the review be conducted by a health care professional who has appropriate expertise, who was not previously involved in the appeal and who does not have a financial or other interest in the case outcome. Appropriate expertise should not be equated with the more rigorous level of expertise directed towards the specific medical condition required for the covered individual. If the legislature had wanted such expertise, they could have used the same language. The neutral must construe statutes together to give meaning to all the terms, *People v. Lowe*, 967 P.2d 177 (Colo. App. 1998).

Drs. Burgess and Sbarbaro had appropriate expertise to review issues of medical necessity and coverage. Dr. Pedowitz abstained in the decision because the other two reviewers had voted to deny coverage on the basis of contract interpretation. The fact that the decision was written by Anthem, while technically not in compliance with the regulations, is of no moment because the un-rebutted testimony was that the decision accurately reflected the view of the majority of the panel. The non-disclosure of Dr. Pedowitz abstention and the failure of the panel to delineate their understanding of Claimant's position does not constitute bad faith.

Exhibits 20-27 reflect Claimants efforts to move the case into arbitration. Mr. Fitzsimmons insistence that Claimants pursue a third level appeal was undoubtedly frustrating. However, Anthem's PPO Plan gave Claimants the absolute right to pursue arbitration at any time after the first appeal. Any delay would have been truncated by the

Exhibit E

Claimants through filing with Anthem a demand for arbitration and later selecting an arbiter.

Claimant finally contends that:

“Most importantly, Anthem’s reliance upon Medical Policy BEH00004 is done in bad faith, Anthem’s Medical Policy BEH00004 is fundamentally flawed and not representative of the current standard of care for autism therapy. Anthem has an ethical and contractual obligation to institute medical policies that are accurate, fair and based upon appropriate scientific standards.”

The Arbiter has reviewed the articles and research supporting Anthem’s medical policy.

Several of the articles seem dated, having been authorized in 1993 (Exhibit S); 1999 (Exhibit T & U) and 2000 (Exhibit N); others are quite current, authored in 2004 (Exhibit M) and 2005 (Exhibits L & R).

The definitions of autism range from a “developmental abnormality”, to an “endpoint of several organic etiologies”, to a “neurobehavioral disorder”, to a “disorder of brain development with a strong genetic base”. The Anthem policy impugns the efficacy of ABA treatment because of its association with Lovaas therapy. While it appears that ABA therapy grew out of the research that Lovaas did, they appear to be significantly different approaches with widely disparate results. The Arbiter based his decision on medical necessity on a very narrow ground – self harm and harm to others. The Arbiter will not dictate to Anthem what its medical policy should be and, thus, its contractual obligations on ABA and treatment for autism. Multiple other carriers do not cover ABA therapy. (Exhibits G-K). Anthem’s policy on medical necessity does not constitute bad faith.

III Conclusions

During the hearing, Claimants submitted bills for \$110,490.02 that should be

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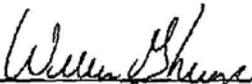
reimbursed and/or paid. (Exhibit 35) Anthem's counsel properly raised the issues of out-of-pocket annual maximum payments and annual deductibles. The parties have not had the opportunity to fully address these issues. In addition, the provider at issue here are apparently out-of-network and, thus, Anthem asserts certain caps may apply. The Claimants argue that pursuant to § 10-6-704 (2) (a), that in cases where the benefit is not available in-network, Anthem must provide the benefits to the member at the same cost as if there was an in-network provider. The record has not been fully developed on this issue.

IV Award

The Arbitrator issues the following awards:

1. For the Claimants Jill and Stephen Tappert, as parents of Abigail Roberta Tappert on their claim that ABA therapy is a covered benefit under the Anthem PPO Policy.
2. For Respondent Anthem Blue Cross and Blue Shield on Claimant's bad faith claim.
3. For Claimants for their reasonable costs in pursuing and prosecuting the arbitration.
4. Counsel shall meet within 20 day to determine if they can resolve the remaining issues. If the parties cannot agree on a resolution of the remaining issues, they will submit to the Arbitrator a joint statement of remaining issues by 12/28/07. The matter shall be set for a continued arbitration hearing to resolve the outstanding issues before January 31, 2008. The Arbitrator will issue a ruling at the conclusion of the hearing.

Issued this 20th day of November, 2007, in Denver, Colorado.


WILLIAM G. MEYER, Arbitrator
JUDICIAL ARBITER GROUP, INC.

CERTIFICATE OF MAILING AND FACSIMILE

I hereby certify that on this 20th day of November, 2007, I faxed by facsimile transmission and deposited in the United States mail, postage prepaid, a true and correct copy of the foregoing Arbitration Award to the following:

R. Craig Ewing, Esq.
Ewing & Ewing, P.C.
3601 South Pennsylvania
Englewood, Colorado 80113
FAX: 303-761-8100

Steve Fitzsimmons, Esq.
Anthem Blue Cross Blue Shield
700 Broadway
Denver, Colorado 80273
FAX: 303-831-2278

Dean A. McConnell, Esq.
Kennedy Childs & Fogg, PC
1050 17th Street, #2500
Denver, CO 80265
FAX: 303-825-0434

Lisa DeLeon
Judicial Arbitrator Group, Inc.