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Frequently Asked Questions related to Mental Health Parity and Autism Spectrum Disorder Bulletins

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The Insurance Division has received a number of questions about bulletins INS 2014-1 and INS 2014-2. The answers below address those questions. Answers to questions of a legal nature are addressed in the Department of Justice public opinion released today along with the bulletins.

Reliance on Other States' Regulatory Provisions

1. Why does OID cite other states' statutes and court cases in these bulletins?

   The OID has requested and received advice from the Department of Justice related to the ability to rely on federal and other states' judicial decisions. In addition, the division has noted changes in regulatory approaches in other states and jurisdictions that have statutes similar to ORS 743A.168 and 743A.190 and that are also subject to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) provisions. Although the actions of other states' insurance regulatory bodies do not have any legal precedence or authority over Oregon, they do highlight how other regulators are interpreting similar laws. These actions by other state regulators are also indicative of policy trends, changes in opinions about certain treatments, observations about potentially discriminatory treatment, etc. Staying abreast of policy trends in other states is an important way to provide more uniformity in insurance regulation.

Independent Review Organizations

1. How does OID use IRO decisions in assessing whether an insurer is following the law?

   The Insurance Division examines IRO decisions to determine if a trend or pattern indicates that an insurer may be continuing to deny benefits on the same basis even though those denials are continually overturned by the IROs. It may indicate a need for the insurer to review its process or basis for denials to determine whether the denial of benefits continues to be valid. Insurers should also periodically review these records for the same reason.

2. Are insurers expected to be aware of IRO decisions other than their own?

   No, although the information is readily available from the Insurance Division. The OID can provide information about trends or patterns emanating from IRO decisions if that is useful to insurers.

3. How does the division monitor IRO decisions?

   Currently, the division reviews IRO decisions when received. If an apparent pattern of IRO decisions overturning a denial of benefit for the same treatment appears, the division will look more closely into the insurer's denials to determine whether there is a pattern of denials that conflicts with legal requirements.

4. Are IRO decisions precedents?

   No.

Information about Covered Services

1. Are insurer claims determination policies expected to be transparent and consistent? If so, how?

   Yes. Claims determination policies should be written, and a member or provider should be able to easily predict coverage in most cases without having to submit a claim.

2. May insurers provide oral information about covered services?

   Yes, but if the insurer is essentially denying a benefit, it needs to follow up with written information about the insurer's appeal process and the opportunity for additional review.

ABA Services

1. Does Oregon's Essential Health Benefit (EHB) benchmark plan, the PacificSource Codeduct Value plan (the "Benchmark Plan"), require coverage of ABA?

   Yes.

2. May age be a relevant clinical determinant when reviewing proposed ABA treatment?

   Yes. Proposed ABA treatment should always be reviewed and determined on the basis of medical necessity. If appropriate to that determination, age may be considered. However, an insurer may not categorically deny ABA treatment on the basis of age of the patient.

3. Must carriers pay for 25 hours per week even if fewer hours of service are provided?

   No, an insurer is only required to pay for services provided.

Cost Issues

1. Do the bulletins impose a new mandate under the ACA?

   No

2. May insurers adjust their filed rates to reflect these bulletins?

   No. The rate review process for 2015 plans is complete and open enrollment begins Nov. 15. It is not possible to adjust rates at this point in the process. Insurers will be able to consider any increased costs in developing 2016 rates.

ABA Providers

1. May an insurer restrict its in-network panel of ABA providers?

   Yes. An insurer may require credentialing of ABA providers. Insurers must accept grandfathered providers (under Senate Bill 365) if they meet credentialing requirements. Although an insurer may restrict its panel of ABA providers, the insurer must ensure that the in-network panel is adequate to meet the needs of its insureds.

2. Must an insurer have ABA providers on as part of its contracted network?

   Yes, but in light of passage of Senate Bill 365, the insurer may need to build ABA providers into the insurer's network.

3. May an insurer restrict covered ABA services to those provided by licensed or registered providers?

   Yes, depending on the credentialing requirements for the insurer. However, until Jan. 1, 2016, an insurer must treat a provider grandfathered under the terms of Senate Bill 365 as a licensed provider.

4. May an insurer restrict covered ABA services to those provided by providers it has credentialed?

   Yes, as long as the insurer's credentialing requirements do not result in having no providers. This would result in a negation of the mental health mandate and as such would not be allowed.

5. Does an insurer need to create credentialing standards for ABA providers?

   Yes. Credentialing standards for ABA providers should be developed in the same manner as other provider credentialing standards. The credentialing standards need to take into account the status of grandfathered providers under Senate Bill 365 and consider them the same as a licensed provider throughout the grandfather period.

Applicability

1. To what mental health conditions do these bulletins apply?

   These bulletins apply to all mental health and nervous conditions as defined in OAR 836-053-1404. This means that with very limited exceptions as set out in that rule, all conditions in the DSM-IV or DSM 5 must be covered.

2. What is the applicability date of the bulletins?

   The mandates discussed in these bulletins took effect on different dates. These bulletins set forth the division's interpretation of the mandates and the expectations for insurers in providing coverage as required by the mandates. To provide immediate clarification, these bulletins apply to claims related to a mental or nervous condition submitted to carriers on or after August 8, 2014.

3. Do the limitations on exclusions and conditions apply to all mental health conditions?

   Yes.

4. How will the division apply these bulletins to pending consumer complaints?

   The division will work with insurers to assess past denials and determine a plan to address past and pending benefit denials.

5. Do the restrictions/requirements of these bulletins apply to policy forms already filed with the division for 2015 plan years?

   Yes.

6. Does this bulletin mean that all medically necessary treatment for a mental health condition must be covered?

   No. An insurer must make a determination about whether a treatment is medically necessary. OAR 836-053-1405 requires the insurer to cover all medically necessary treatments. An insurer may find that a treatment is not medically necessary, and then the consumer could appeal to an IRO to reexamine medical necessity. ORS 743A.168 does include some limitations on the coverage required. However, even though these limitations or exclusions are allowed under state law, insurers must be mindful of the restrictions on these exclusions or limitations under the MHPAEA or other mandates.