INSURANCE
DEPARTMENT OF BANKING AND INSURANCE
DIVISION OF INSURANCE

Actuarial Services
Mandated Benefits for Biologically-Based Mental Illness

Adopted New Rules: N.J.A.C. 11:4-57

Proposed: November 15, 2004 at 36 N.J.R. 5080(a).

Adopted: April 7, 2005 by Donald Bryan, Acting Commissioner, Department of Banking and Insurance.

Filed: April 8, 2005 as R. 2005 d.141, **without change**.

Authority: N.J.S.A. 17:1-8.1, 15e and 26:2J-43h; P.L. 1999, c. 106.

Effective Date: May 2, 2005

Expiration Date: November 30, 2005.

Summary of Public Comment and Agency Response:

The Department received comments from the New Jersey Occupational Therapy Association, the New Jersey Association of Health Plans, Magellan Health Services, and Health Net of the Northeast, Inc.

1. COMMENT: One commenter renewed its objections to the Department's original proposal of these new rules (see 35 N.J.R. 2158(a)), stating that it still questions the Department's authority to enact regulations in relation to the biologically-based mental illness (BBMI) statute, and that the Department's response to the commenter's comments on the original proposal claimed authority under its statutory responsibility to review managed care policy forms. The commenter stated that the statute cited by the Department only

gives it the authority to promulgate regulations concerning "any actuarial or form requirements consistent with applicable statutory provisions."

1. RESPONSE: As the Department stated in its response to the commenter's original comment, the Department is responsible for reviewing health insurance policies issued by health insurance companies and health service corporations, as well as the contracts issued by health maintenance organizations (HMOs), to determine, among other things, whether benefits mandated by law are being provided (See N.J.S.A. 17B:30-18, 17B:26-45b, and 17B:27-49g). Moreover, the HMO Act, at N.J.S.A. 26:2J-43h, specifically authorizes the Commissioner of Banking and Insurance to promulgate regulations relating to the requirements for HMO contract forms. The Department disagrees with the commenter's limited interpretation of the Department's rulemaking authority. The Department's power to promulgate regulations dealing with the content of contract and policy forms clearly permits the Department to adopt rules dealing with policy exclusions and precertification requirements. This power is appropriately exercised when these exclusions and requirements operate to deny or limit statutorily mandated benefits such as coverage for the treatment of biologically based mental illness.

2. COMMENT: Three commenters objected to the Department's restriction on the use of preauthorization as a managed care tool. One of the commenters stated that it has supported parity in its management of biologically-based mental illness benefits since 1999 and that the application of parity is

clearly a way to enhance the care provided to its members and control costs. The commenter averred that the rules as proposed could, however, have a negative impact on the quality of care, the cost to members and employer groups and the financial reimbursement to providers. The commenter requested that the Department amend its proposed rules to clarify that pre-service case management activity is not prohibited in the delivery of BBMI services. The commenter stated that it believes that the Department's intent is to permit the type of pre-service case management review that the commenter conducts prior to a member receiving treatment. The commenter stated that a member does not need a referral from a PCP in order to access behavioral health care services, and that case management review assures that the proposed services are medically necessary and appropriate. The commenter stated that for care delivered by in-network providers, both inpatient and outpatient, it believes the Department intends to continue to permit carriers to manage the care as they currently do, utilizing a pre-service review as a case management activity. For out-of-network inpatient care, the commenter believes that the Department intends to permit carriers to conduct a pre-service case management review when the health plans have a similar case management requirement for medical benefits. For access to out-patient treatment by an out-of-network provider, the commenter believes the Department does not intend to permit carriers to require a pre-service case management review. Also, the commenter believes that the Department does not intend to prohibit carriers from offering a voluntary review

for this type of care, provided it is clearly communicated to the providers and members that this process is voluntary.

Two of the commenters stated that preauthorization requirements are a condition of payment for certain procedures because carriers wish to ensure that covered members receive high quality, medically necessary treatment. Further, not all benefits require preauthorization, but services that require long-term therapies, such as certain mental health services, generally do require preauthorization to determine that the patient is receiving the appropriate care. One commenter indicated that there are several types of mental illness care providers, including psychiatrists, psychologists, family therapists, LCSWs, ADAC counselors, psychiatric nurses and clinical nurse specialists, and that preauthorization is required to make sure that the member will see the right type of provider and receive the right level of care at the right time. The commenter stated that there are much clearer practice guidelines for medical illnesses than there are for mental illnesses and mental illness providers.

2. RESPONSE: The Department specifically stated in its reproposal that the rules would not prohibit carriers from imposing a requirement to have network care coordinated by a primary care physician or a care/case manager. In response to enactment of the mandate in 1999, the Department notes that some carriers tried to impose a blanket preauthorization requirement on all treatment for biologically based mental illness. Because such a requirement is not imposed on treatment for any other illness, including illnesses that require

long-term treatment such as asthma and diabetes, the Department concluded that imposition of a blanket preauthorization requirement was inconsistent with the mandate and an attempt to evade its terms. A preauthorization requirement applicable only to long-term therapies could be applied to certain mental health services so long as the same requirement was applicable to long-term therapies for physical conditions.

Regarding the commenter's concerns on out-of-network care and request that the Department clarify its intent concerning carriers' use of "pre-service case management review," the Department believes that its reproposal clearly and accurately sets forth its preauthorization requirements. It is not possible for the Department to determine from the limited information supplied by the commenter the nature and extent of its intended protocols. Therefore, the Department cannot comment on whether they are consistent with the preauthorization requirements contained in the reproposal.

3. COMMENT: Two commenters stated that the Department's characterization of preauthorization as a benefit limit contravenes the BBMI statute. The commenters indicated that the BBMI statute does not include a definition of benefit limit, but did state that BBMI services are to be provided under the same terms and conditions as medical services. The commenters understand this to mean that carriers should apply the same copayments, deductibles and health care service limits to BBMI as they do to benefits for physical illnesses. One commenter stated that the Legislature expressly

recognized that there may be different medical management tools employed for the administration of mental health care benefits. The commenters disagree with the Department's statement that it can construe preauthorization as a "health care service limit" since, if the provider or, in rarer instances, the member did not obtain the preauthorization for the service, reimbursement on the claim for the service may be reduced or denied. The commenters indicated that while it is true that carriers may establish preauthorization as a prerequisite for claim reimbursement, much as it does timely claim submission requirements, this in no way limits the health care service the member received. Preauthorization is established as a prerequisite for payment to encourage its use since managed care plans cannot manage the care if they do not know about it. It in no way limits the service that was provided, and often not the payment either. Providers and members can contest any denial of payment for failure to obtain prior authorization and more often than not, if the service was medically necessary and appropriate, there will be no reduction in reimbursement on the claim.

3. RESPONSE: The Department disagrees with the commenters, and reiterates its response included in its reproposal to the comments concerning preauthorization as a benefit limit. Preauthorization is a benefit limit because failure to obtain preauthorization of a medically necessary service that would otherwise be covered results in a benefit reduction of up to 50 percent of the benefit, which amount must be paid by the covered person (see N.J.A.C. 11:4-

42.8(a) and 11:22-6.4). In the Department's experience, the failure to obtain required certification in advance has, in all cases, resulted in a financial penalty, in most instances in the maximum amount of 50 percent of the fee that would be paid by the carrier for the service. Such increased financial responsibility is clearly a benefit limit since it reduces the benefit. Accordingly, the Department correctly characterizes preauthorization as a benefit limit.

4. COMMENT: Three commenters addressed the proposed rules' exclusions provision. Two commenters stated that the Department's list of prohibited exclusions that are applied to other sicknesses under a plan is completely contrary to the provisions of the BBMI statute, which requires carriers to apply the same terms and conditions to BBMI coverage as it does to coverage for physical illnesses. One commenter stated that health plans apply exclusions to various kinds of medical conditions, but the Department's proposal prohibits carriers from applying exclusions to BBMI services regardless of the availability of the benefit under the contract -- a restriction that is not placed on medical benefits. One commenter stated that it does not believe that the Department has the authority to mandate which treatments it thinks should be provided to persons with BBMI, contrary to the mandates of the statute. According to the commenter, if the State means to mandate the provision of certain services as medically necessary for the treatment of BBMI, it would have to do so through new legislation. The commenter added that bills concerning mandating specific treatment of BBMI beyond what is required in the BBMI parity statute are being

considered. In the previous legislative session (210th), two identical bills were introduced in the Assembly and the Senate (A-2578 and S-1693) that would have required carriers to provide certain therapies as medically necessary in the treatment of certain BBMI. Both bills died in their respective Houses, and were reintroduced in the current legislative session as A446 and S246. As recently as December 2004, the Senate Pension and Health Benefits Commission recommended not enacting S246, while A446 has not moved since its introduction in January 2004.

One commenter stated that the proposed rules would impact negatively on services provided to children with disabilities. The commenter stated that occupational therapy services are vital, particularly in the service of children with global developmental delays. When insurance covers therapy for skills that are lost through injury, but not developmental delays, this allows insurance companies to refuse to cover therapy services for children who are not typically developing. In the case of autism and PDD, skill development is addressed by the occupational, speech and physical therapists. The commenter stated that the chronic condition exclusion would cause children with diagnoses of autism and PDD to be denied the services of occupational therapy, speech therapy and physical therapy.

4. RESPONSE: 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 mandate to require carriers to cover the primary treatments for these disorders and to preclude them from relying on exclusions to deny such coverage.

The Department believes that the commenter who was concerned that the chronic condition exclusion would cause children with diagnoses of autism and PDD to be denied the services of occupational therapy, speech therapy and physical therapy, has misread the proposal. The Department's proposal would prohibit the application of such an exclusion.

Federal Standards Statement

A Federal standards analysis is not required because these adopted new rules are not subject to any Federal standards or requirements.

Full text of the adopted rules follows:

inoregs/bbmiadop