Bill #9 – Autism mandate bill

Sec. 1311 of PPACA requires that ... "a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 1302(b).....A State shall make payments to or on behalf of an individual eligible for the premium tax credit ... and any cost-sharing reduction under section 1402 to defray the cost to the individual of any additional benefits..." In essence, the state may have a financial liability if ABA therapy is not determined to be an "essential benefit".

Sec. 2711 states that an insurer may not establish any annual limits on essential benefits. If ABA is determined to be an "essential benefit", which is possible as it states that it includes "Mental health and substance use disorder services including behavioral health treatment".

Many who are performing ABA services are not "credentialed professionals" or require licensure within the state. Historically, we do not credential non-licensed individuals in the interest of quality care.

Scientific research has not proven definitive benefits to of ABA.

Section 1, the term defined as "Evidence-based research" does not exist other than in the definition.

Section 1, the definition of "Medically necessary "conflicts with accepted definitions already in statute. The statute defines it **(NDCC 26.1-04-03)** "As used in this subsection,"medically necessary care" means health care services, supplies, or treatments that a reasonably prudent physician or other health care provider would provide to a patient for the prevention, diagnosis, or treatment of illness, injury, disease, or its symptoms which are in accordance with generally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent, site, and duration, and not primarily for the convenience of the patient, physician, or other health care provider. This definition does not preclude an entity from establishing a definition of "medically necessary care" for determining which services are covered by the health plan."

Subsection 6 of Section 2 may conflict with PPACA.

Subsection 7 of Section 2 appears to preclude the insurer from denying any services that are not medically necessary for a period of 6 months after the last review. We are not exactly sure what this review means, since it is not defined in the bill.

Section 3 of the bill may be in conflict with new appeal processes established in PPACA.

Not sure what effect this bill would have on the "grandfathering" provision of PPACA.