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Department of Developmental Services

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DEPARTMENT OF DEVELOPMENTAL SERVICES
TESTIMONY BEFORE THE
PUBLIC HEALTH COMMITTEE

March 2, 2011

House Bill 6392- An Act Concerning Birth to Three Services and Rehabilitation Services for Chronic Gamblers

Senator Gerratana, Representative Ritter, and members of the Public Health Committee, I am Peter O'Meara, Commissioner of the Department of Developmental Services (DDS). I'm here today to testify in support of House Bill 6392-An Act Concerning Birth to Three Services and Rehabilitation Services for Chronic Gamblers. I would specifically like to address the portion of the bill which implements Governor Malloy's recommended budget related to the Connecticut Birth to Three Program and respectfully request that the committee consider substitute language for Sections 1, 2, 4, and 5 (attached) to ensure that the intent of the legislation is fulfilled and the proposed savings can be achieved.

The intent of this bill is to implement provisions of the Governor's recommended budget which reflects a saving of $1.6 million in fiscal year (FY) 2012 and $3.2 million in FY13 as a result of the ability to capture additional health insurance revenue. The two specific changes that are intended by this legislation are to prohibit the charging of co-pays and deductibles against payments for Birth to Three services and raising the annual insurance cap for children with a diagnosis of autism spectrum disorder.

<u>The prohibition of charging co-pays and deductibles against payments for Birth to Three services</u>:

Currently, those co-pays and deductibles are absorbed by DDS in accordance with 17a-248(e) which says that public funds may be used to cover the cost of co-pays and deductibles. Parents with incomes of $45,000 or more are then charged monthly by the state on a sliding fee scale based on income and family size but they are not also charged the cost of those co-pays and deductibles. We recognize the fact that Health Savings Accounts (HSAs) must be exempt from

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this change since they are governed by Federal Internal Revenue Code and would be at risk of losing their tax-exempt status.

Raising the annual insurance cap for children with autism spectrum disorders from $6400 to $50,000 per year:

This increase is proposed in lieu of billing under Connecticut General Statute (CGS) Sections 38a-488b and 38a-514b which are the autism insurance coverage statutes. The Birth to Three Program has found that trying to make its insurance coverage statute work in concert with the autism insurance coverage statutes is extremely difficult and cumbersome. **This statutory change would streamline that process for our providers and would actually limit the insurance plans' liability to slightly less than their liability under CGS Sections 38a-488b 38a-514b.**

Suggested Substitute Language:

We have two concerns with the language as drafted and would propose the following changes:

As written, the bill says that the policy cannot impose MORE of a co-pay or deductible than they do for any other service: "No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such services that are more restrictive than that imposed on substantially all other benefits." We recommend deleting line 13 and line 14 up to and including the words "under such policy". We recommend the same changes Section 2 regarding group plans, deleting "that are more" on line 38 up to and including the words "under such policy" in line 40.

In addition, the new language in sections 4 (lines 76-77) and 5 (lines 90-91) proposes to amend CGS Sections 38a-488b and 38a-514b, to prohibit anyone from billing insurance for autism services for any child under the age of three. This would deny parents of children under the age of three the ability to purchase autism services outside of the Birth to Three System and that was certainly not the intent of this budget proposal. We propose the deletion of the words "child under the age of three" in lines 76-77 and lines 90-91 and instead substituting the words "medically necessary early intervention services provided as part of an individualized family service plan pursuant to section 17a-248e".

We have attached substitute language for your review that we believe would achieve Governor Malloy's proposed savings for Birth to Three in FY12 and FY13. This alternate language was drafted in an attempt to clear up any potential misinterpretations of the proposal. Thank you for the opportunity to testify in support of the intent of this proposal and for allowing us to share alternate language that we believe accomplishes savings for the state and streamlines the billing process for Birth to Three. We would be happy to answer any questions that you might have at this time and to work with you on any necessary additional revisions that might be needed.

DDS Proposed Substitute Language for Sections 1, 2, 4 and 5 of H.B. No. 6392 - An Act Concerning Birth to Three Services and Rehabilitation Services for Chronic Gamblers

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-490a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery or renewed in this state on or after July 1, 1996, shall provide coverage for medically necessary early intervention services provided as part of an individualized family service plan pursuant to section 17a-248e. Such policy shall provide **[**(1)**]** coverage for such services provided by qualified personnel, as defined in section 17a-248, for a child from birth until the child's third birthday. **[**, and (2)**]** No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such services, except that a high deductible plan, as that term is used in subsection (f) of section 38a-493, shall not be subject to the deductible limits set forth in this section. Such policy shall provide a maximum benefit of six thousand four hundred dollars per child per year and an aggregate benefit of nineteen thousand two hundred dollars per child over the total three-year period, except that for a child with autism spectrum disorders, as defined in section 38a-514b, as amended by this act, the maximum benefit shall be fifty thousand dollars per child per year and an aggregate benefit of one hundred fifty thousand dollars per child over the total three-year period. No payment made under this section shall be applied by the insurer, health care center or plan administrator against any maximum lifetime or annual limits specified in the policy or health benefits plan.

Sec. 2. Section 38a-516a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery or renewed in this state on or after July 1, 1996, shall provide coverage for medically necessary early intervention services provided as part of an individualized family service plan pursuant to section 17a-248e. Such policy shall provide **[**(1)**]** coverage for such services provided by qualified personnel, as defined in section 17a-248, for a child from birth until the child's third birthday. **[**, and (2)**]** No such policy shall impose a coinsurance, copayment, deductible or other out-of-pocket expense for such services, except that a high deductible plan, as that term is used in subsection (f) of section 38a-493, shall not be subject to the deductible limits set forth in this section. Such policy shall provide a maximum benefit of six thousand four hundred dollars per child per year and an aggregate benefit of nineteen thousand two hundred dollars per child over the total three-year period, except that for a child with autism spectrum disorders, as defined in section 38a-514b, as amended by this act, the maximum benefit shall be fifty thousand dollars per child per year and an aggregate benefit of one hundred fifty thousand dollars per child over the total three-year period. No payment made under this section shall be applied by the insurer, health care center or plan administrator against any maximum lifetime or annual limits specified in the policy or health benefits plan.

Sec. 4. Section 38a-488b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 that is delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2009, shall provide coverage for physical therapy, speech therapy and occupational therapy services for the treatment of autism spectrum disorders, as set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", to the extent such services are a covered benefit for other diseases and conditions under such policy. Coverage for medically necessary early intervention services provided as part of an individualized family service plan pursuant to section 17a-248e shall be in conformity with the provisions of this section and section 38a-490a, as amended by this act.

Sec. 5. Subsection (e) of section 38a-514b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2011*):

(e) Such policy shall not impose (1) any limits on the number of visits an insured may make to an autism services provider pursuant to a treatment plan on any basis other than a lack of medical necessity, or (2) a coinsurance, copayment, deductible or other out-of-pocket expense for such coverage that places a greater financial burden on an insured for access to the diagnosis and treatment of an autism spectrum disorder than for the diagnosis and treatment of any other medical, surgical or physical health condition under such policy. Notwithstanding the provisions of this subsection, coverage for medically necessary early intervention services provided as part of an individualized family service plan pursuant to section 17a-248e shall be in conformity with the provisions of section 38a-516a, as amended by this act.