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No. 68726-3-I

DIVISION I, COURT OF APPEALS
OF THE STATE OF WASHINGTON

A.G., by and through his parents, J.G. and K.G.,

Plaintiff-Respondent,

v.

PREMERA BLUE CROSS and LIFEWISE OF WASHINGTON,
Washington corporations,

Defendants-Appellants.

ON NOTICE OF DISCRETIONARY REVIEW FROM
KING COUNTY SUPERIOR COURT
(Hon. Michael Trickey)

**PREMERA BLUE CROSS AND LIFEWISE OF WASHINGTON'S
APPENDIX TO MOTION FOR DISCRETIONARY REVIEW**

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AND LIFEWISE OF WASHINGTON'S
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CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury under the laws of the State of Washington that on May 29, 2012, I caused to be served a copy of the foregoing **Appendix to Motion for Discretionary Review** on the following person(s) in the manner indicated at the following addresses:

Richard E. Spoonemore
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- by CM/ECF
- by Electronic Mail
- by Facsimile Transmission
- by First Class Mail
- by Hand Delivery
- by Overnight Delivery

DATED this 29th day of May, 2012 at Seattle, Washington

/s/ Janet Wiley
Janet Wiley

EXHIBIT 1

FILED

11 SEP 01 PM 4:27

KING COUNTY
SUPERIOR COURT CLERK
E-FILED

CASE NUMBER: 11-2-30233-4 SEA

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IN THE SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and
K.G., on his own behalf and on behalf of all
similarly situated individuals,

Plaintiffs,

v.

PREMERA BLUE CROSS and LIFEWISE OF
WASHINGTON, Washington corporations,

Defendants.

NO.

COMPLAINT (CLASS ACTION)

I. PARTIES

1. **A.G.** Plaintiff A.G., a thirteen year-old son and dependent of J.G. and K.G., is a resident of King County Washington. Plaintiff is insured under a health insurance plan issued, delivered, administered and insured by Lifewise of Washington ("Lifewise"). Plaintiff's coverage was through an individual policy purchased by his parents. Plaintiff is diagnosed with autism.

2. **Lifewise of Washington.** Defendant Lifewise is a Washington Corporation that does business in the State of Washington, including King County. Lifewise is an authorized health carrier and is engaged in the business of insurance in the State of Washington, including King County.

3. **Premera Blue Cross.** Defendant Premera Blue Cross ("Premera") is a Washington Corporation is a Washington Corporation that does business in the State of Washington, including King County. Premera is an authorized health carrier

1 Final Substitute House Bill 1154 (2005 Leg.). A study by the Washington Department
2 of Health had concluded that insurers' false distinction between physical and mental
3 health had caused thousands of Washington residents to go untreated. See Mental
4 Health Parity Mandated Benefits Sunrise Review, Washington Department of Health,
5 November 1998. The study concluded that untreated mental disorders ultimately cost
6 our state far more than the relatively minimal cost for providing timely and medically
7 necessary treatment.

8 8. The Act generally requires Washington health plans to cover all
9 outpatient and inpatient services to treat mental disorders covered by the diagnostic
10 categories listed in the most current version of the diagnostic and statistical manual of
11 mental disorders, so long as the services are medically necessary. For all health plans
12 delivered, issued for delivery or renewed on or after July 1, 2010, the Act also requires
13 those health plans to ensure that treatment limitations on services to treat mental
14 disorders are the same as any such limitations imposed on other medical and surgical
15 services.

16 9. The legislature's chosen language is purposefully broad, so as to
17 encompass virtually all mental disorders. The legislature rejected the option to provide
18 only partial parity, which would have singled out certain mental disorders for parity
19 while leaving others still subject to discriminatory exclusions and limitations. Instead,
20 the legislature designed the Act to apply equally and evenhandedly to all mental
21 disorders.

22 10. The Diagnostic and Statistical Manual of Mental Disorders, 4th Ed.
23 Text Revision (DSM-IV-TR) is the version of the DSM that was in effect when the
24 legislation was passed. This version includes diagnostic categories for certain
25 conditions – such as mental retardation, pervasive developmental disorder, and
26 autism (Plaintiff's diagnosis). Thus, Plaintiff and other individuals diagnosed with

1 conditions recognized in the DSM-IV-TR, are entitled to all medically necessary
2 outpatient and inpatient services to treat their mental disorders, as required by the
3 Mental Health Parity Act.

4 11. Defendant Premera does not apply the Mental Health Parity Act
5 requirements to all services that are necessary to treat conditions listed in the DSM-IV-
6 TR as required by the Mental Health Parity Act. For example, Premera denied
7 coverage of Plaintiff's neurodevelopmental therapies to treat his autism, solely because
8 Plaintiff was over the age of seven (7). Premera also denies coverage of behavioral
9 therapies necessary to treat conditions listed in the DSM-IV-TR. Premera's uniform
10 policies and practices violate the requirements of RCW 48.44.341.

11 12. This lawsuit seeks to recover the benefits that have been
12 wrongfully denied to plaintiff and the class he seeks to represent. It also seeks a court
13 order declaring Premera's policies and practices illegal and void. The lawsuit further
14 seeks an injunction to prevent any future or ongoing efforts by Premera to use and
15 enforce any policies or practices that impermissibly deny, exclude or limit its insureds'
16 access to medically necessary services to treat conditions recognized in the DSM-IV-TR.

17 IV. CLASS ALLEGATIONS

18 13. *Size and Definition of Class.* The class consists of all individuals
19 who:

- 20 (1) have been, are, or will be insured under a non-ERISA governed "health
21 plan," as that term is defined by RCW 48.43.005(19), that has been or will
22 be delivered, issued for delivery, or renewed on or after January 1, 2006
23 by: (a) defendant Premera; (b) any affiliate of defendant; (c) predecessors
24 or successors in interest of any of the foregoing; and (d) all subsidiaries or
25 parent entities of any of the foregoing; and
26

1 (2) have received, require, or are expected to require behavioral and/or
2 neurodevelopmental therapy for the treatment of a condition listed in the
3 DSM-IV-TR other than (a) substance related disorders and (b) life
4 transition problems, currently referred to as "V" codes, and diagnostic
5 codes 302 through 302.9 as found in the diagnostic and statistical manual
6 of mental disorders, 4th edition, published by the American psychiatric
7 association, where the service received, required, or expected to be
8 required is not properly classified as skilled nursing facility services,
9 home health care, residential treatment, custodial care or non-medically
10 necessary court ordered treatment.

11 14. *Class Representative A.G.* Plaintiff is insured under a health plan
12 issued by Lifewise/Premera to Washington state residents who purchase their own
13 health insurance. Plaintiff is diagnosed with autism, a diagnostic category in the DSM-
14 IV-TR. Plaintiff receives speech and occupational therapy to treat his autism. Premera
15 denied coverage of Plaintiff's speech and occupational therapy, asserting that the
16 therapy was excluded under his health insurance contract.

17 15. Plaintiff's claims are typical of the claims of the other members of
18 the class, and, through his parents, he will fairly and adequately represent the interests
19 of the class.

20 16. *Size of Class.* The class of persons who have received, require, or
21 are expected to require neurodevelopmental and/or behavioral therapy for the
22 treatment of a condition listed in the DSM-IV-TR, and who have been insured, are
23 insured, or will be insured under health plans (as that term is defined in RCW
24 48.43.005(19)) issued by Premera and not subject to ERISA, is expected to number in
25 the thousands and is so large that joinder of all members is impracticable.
26

1 17. *Common Questions of Law and Fact.* This action requires a
2 determination of whether Premera's application of policies and practices that deny,
3 exclude and/or limit coverage of services to treat conditions identified in the DSM-IV-
4 TR in health plans issued, delivered, or renewed by Premera, violates the requirements
5 of RCW 48.44.341. The law requires health plans to cover "mental health services"
6 which is defined as any medically necessary outpatient and inpatient service provided
7 to treat a mental disorder covered by the diagnostic categories in the DSM-IV-TR. *See*
8 RCW 48.44.341 (1); (2). The law renders void and unenforceable all policies or practices
9 that wholly exclude or establish treatment limitations greater than that for medical and
10 surgical services for services to treat developmental disabilities listed in the DSM-IV-
11 TR. A determination of this issue will in turn determine whether plaintiff and the class
12 are entitled to a declaratory judgment pursuant to RCW 7.24 *et seq.*, an injunction
13 pursuant to RCW 19.86.090, an injunction under common law, damages for breach of
14 contract and damages and treble damages due to violations of the Washington
15 Consumer Protection Act, RCW 19.86 *et. seq.*

16 18. *Premera Has Acted On Grounds Generally Applicable to the*
17 *Class.* Premera, by applying policies and practices that result in the exclusion and
18 improper limitation of certain services to treat certain conditions listed in the DSM-IV-
19 TR, has acted on grounds generally applicable to the class. Certification is therefore
20 proper under CR 23(b)(2).

21 19. *Questions of Law and Fact Common to the Class Predominate*
22 *Over Individual Issues.* The claims of the individual class members are too small to
23 justify filing and prosecuting the claims separately. Thus, any interest that individual
24 members of the class may have in individually controlling the prosecution of separate
25 actions is outweighed by the efficiency of the class action mechanism. Upon
26 information and belief, there has been no class action suit filed against this defendant

1 the class are entitled to a declaration that Premera may not exclude coverage for
2 neurodevelopmental and/or behavioral therapies or otherwise apply policies or
3 procedures that result in the denial, exclusion or limitation to a greater extent than
4 other medical or surgical services of services to treat conditions listed in the DSM-IV-
5 TR, so long as the treatment sought is medically necessary.

6 **C. THIRD CLAIM: VIOLATION OF THE WASHINGTON CONSUMER**
7 **PROTECTION ACT, RCW 19.86 ET SEQ.**

8 30. Plaintiff re-alleges paragraphs 1 through 29, above.

9 31. Premera's repeated breaches of its insurance contracts with
10 plaintiff and the class, and its failure to comply with RCW 48.44.341 violates the
11 Washington Consumer Protection Act, RCW 19.86 *et seq.* Specifically, Premera has
12 engaged in, and continues to engage in, unfair or deceptive acts or practices in trade or
13 commerce in violation of the Washington State Consumer Protection Act. Such
14 conduct affects the public interest, and has caused injury to the named plaintiff and the
15 plaintiff class.

16 32. Plaintiff and the proposed class are entitled to an injunction under
17 RCW 19.86.090 to enjoin further violations of RCW 48.44.341.

18 33. Plaintiff and plaintiff's class are entitled to compensatory damages,
19 and treble damages under RCW 19.86.090, along with costs of suit and attorney fees
20 due to Premera's violations of RCW 48.44.341.

21 **D. FOURTH CLAIM: INJUNCTIVE RELIEF**

22 34. Plaintiff re-alleges paragraphs 1 through 33, above.

23 35. Plaintiff and plaintiff's class are entitled to an injunction under
24 RCW 19.86.090, under the common law, and under any other applicable laws, to enjoin
25 further violations of RCW 48.44.341 and enjoin Premera's further breaches of its health
26 insurance contracts and/or its unfair or deceptive acts and practices.

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8. Award such other relief as is just and proper.

DATED: September 1, 2011.

SIRIANNI YOUTZ
MEIER & SPOONEMORE

/s/ Richard E. Spoonemore
Eleanor Hamburger (WSBA # 26478)
Richard E. Spoonemore (WSBA #21833)
Attorneys for Plaintiff

EXHIBIT 2

THE HONORABLE MICHAEL HEAVEY
Motion Date: March 2, 2012
Hearing time: 10:00 a.m.
WITH ORAL ARGUMENT

SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and
K.G., on his own behalf and on behalf of all
similarly situated individuals,

Plaintiffs,

v.

PREMERA BLUE CROSS and LIFEWISE
OF WASHINGTON, Washington
corporations,

Defendants.

No. 11-2-30233-4 SEA

DEFENDANTS' MOTION TO DISMISS

I. INTRODUCTION AND RELIEF REQUESTED

Defendants Premera Blue Cross and Lifewise of Washington ("Defendants") move to dismiss Plaintiffs' class action complaint pursuant to CR 12(b)(6). Plaintiff A.G. alleges that Defendants violated the Mental Health Parity Act (the "Parity Act") when they denied A.G. insurance coverage for neurodevelopmental therapy that A.G. claims is necessary to treat his autism. A.G.'s complaint must be dismissed because Defendants' denial of coverage was entirely consistent with the terms of A.G.'s individual health insurance plan and Washington law. A.G.'s plan contains an express exclusion for neurodevelopmental therapy. That exclusion does not violate the Parity Act because it is not subject to the Parity Act.

Neurodevelopmental therapy is subject to an earlier and separate Washington statute that requires only *group health plans* to cover neurodevelopmental therapy for children under

1 the age seven (the “Neurodevelopmental Therapy Mandate”). The Mandate does not apply to
2 *individual health plans* and, thus, Defendants are entitled to exclude neurodevelopmental
3 therapy from A.G.’s plan. The Parity Act did not trump the Neurodevelopmental Therapy
4 Mandate. On the contrary, after passage of the Parity Act, there have been repeated efforts to
5 enact new mandates that would require insurers to cover neurodevelopmental therapy for
6 individuals with autism—something that would not be required if, as A.G. claims, the Parity
7 Act already compelled insurers to cover such therapy. All of those efforts have failed.

8 This Court must reject A.G.’s attempt to use class action litigation to create a new
9 mandate that the legislature has refused to enact. Until the legislature does so, individual
10 health plans can continue to exclude coverage for neurodevelopmental therapy. A.G.’s plan
11 has always excluded coverage for neurodevelopmental therapy, and A.G.’s parents have never
12 paid for that coverage. Because A.G. fails to allege any conduct that constitutes a breach of
13 contract or violation of law, all of A.G.’s claims must be dismissed.

14 II. STATEMENT OF FACTS

15 The complaint contains many class action allegations and legal conclusions, but very
16 few factual allegations related to A.G.¹ A.G.’s parents purchased or renewed an individual
17 health insurance plan issued by Lifewise of Washington. Complaint, ¶¶ 1, 4 & 24. A.G. is
18 covered by that individual health plan (the “Plan”). *Id.*, ¶¶ 1 & 14. A.G. has autism, a mental
19 health disorder recognized in the fourth edition of the Diagnostic and Statistical Manual of
20 Mental Disorders (referred to as “DSM-IV”). *Id.*, ¶¶ 10, 14 & 22. A.G. has received certain
21 neurodevelopmental therapy—specifically, speech and occupational therapy—to treat his
22 autism. *Id.*, ¶¶ 14 & 23. Defendants have denied coverage and/or refused to reimburse

23
24 ¹ A.G.’s factual allegations are accepted as true for purposes of this motion to dismiss
25 only. *See Reid v. Pierce County*, 136 Wn.2d 195, 201, 961 P.2d 333 (1998). Moreover,
26 Defendants’ motion focuses only on factual allegations pertaining to A.G. The Complaint’s
class allegations have no relevance to the legal sufficiency of A.G.’s individual claim. *See Parrish v. National Football League’s Players Ass’n*, 534 F. Supp. 2d 1081, 1094 (N.D.Cal. 2007) (“Plaintiffs cannot defeat this motion to dismiss by relying on class allegations.”).

1 A.G.'s parents for A.G.'s speech and occupational therapy because benefits for
2 neurodevelopmental therapy are excluded by the Plan. *Id.*, ¶¶ 11 & 14. Because it is not a
3 covered benefit, A.G.'s parents have paid, or will pay, for A.G.'s speech and occupational
4 therapy out of their own pocket. *Id.*, ¶ 24.²

5 A.G.'s complaint asserts claims for breach of contract, declaratory relief, violation of
6 the Consumer Protection Act and an injunction. All of the claims are premised on the theory
7 that Defendants' denial of coverage for neurodevelopmental therapy violates the Parity Act.
8 *Id.*, ¶¶ 27, 29, 31 & 35. A.G.'s attorneys also seek certification for a class that would include
9 all persons insured under a non-ERISA health plan issued by Defendants or their affiliates
10 who "have received, require, or are expected to require behavioral and/or neurodevelopmental
11 therapy for a condition listed in DSM-IV-TR ...[.]" *Id.*, ¶ 13. The proposed class, therefore,
12 would include individuals who are diagnosed with different disorders than A.G., who require
13 different treatment than A.G., who are subject to different health plans than A.G., and whose
14 claims for benefits have been denied for different reasons than those applicable to A.G. The
15 same lawyers have filed similar class action lawsuits in state and federal court.³

16 III. STATEMENT OF ISSUES

17 1. Does the Neurodevelopmental Therapy Mandate permit an individual health
18 insurance plan to exclude coverage for neurodevelopmental therapy? **Yes.**

19 ² A.G. did not challenge Defendants' denial of coverage through the Plan's internal
20 complaint or appeal process, and alleges that pursuit of administrative remedies would be
21 futile. Complaint, ¶ 25. Defendants reserve the right to challenge A.G.'s failure to exhaust
22 the Plan's appeal process. Failure to exhaust contractual remedies can be the basis for
23 dismissal. See *Spokoiny v. Wash. St. Youth Soccer Assoc.*, 128 Wn. App. 794, 117 P.3d 1141
24 (2005); *Anderson v. Enterprise Lodge No. 2*, 80 Wn. App. 41, 906 P.2d 962 (1996).

25 ³ The cases include *S.F. v. Washington State Health Care Authority, et al.*, No. 10-2-
26 29400-7 SEA (King Co. Sup. Ct.); *D.M. v. Group Health Coop.*, No. 10-2-28618-7-SEA
(King Co. Sup. Ct.); *Z.D. v. Group Health Coop.*, No. 2:11-cv-01119-RSL (W.D.Wash. Dist.
Ct.); and *J.E. v. Washington State Health Care Authority, et al.*, No. (King Co. Sup. Ct.). Of
particular note, like this case, the plaintiff in the *Z.D.* case has alleged that a policy exclusion
for neurodevelopmental therapy violates the Parity Act. The defendant has moved to dismiss
the complaint on grounds similar to those Defendants raise here: the Neurodevelopmental
Therapy Mandate permits such an exclusion. The motion to dismiss is pending.

1 **A. Neurodevelopmental Therapy Is Specifically Excluded By The Plan.**

2 A.G.'s claims all rest on the theory that Defendants improperly denied A.G. insurance
3 coverage for neurodevelopmental therapy. Complaint, ¶¶ 11 & 14. The complaint does not,
4 however, describe the basis for the denial. The basis was straightforward. The Plan expressly
5 excludes coverage for neurodevelopmental therapy. The Plan states in relevant part:

6 **EXCLUSIONS**

7 This section of the contract lists those services, supplies or drugs [that]
8 are not covered under this plan.

9 * * *

10 **Learning Disorders and Neurodevelopmental Therapy**

11 Services, therapy and supplies related to the treatment of learning
12 disorders, cognitive handicaps, dyslexia, developmental delays or
13 neurodevelopmental disabilities.

14 Duffy Decl., Exh. A, pp. 30-31 (the "Neurodevelopmental Therapy Exclusion"). Although
15 the Plan was amended in 2008 and 2010 to provide certain coverage for "Mental Health Care"
16 to comply with the Parity Act, the Neurodevelopmental Therapy Exclusion was not deleted or
17 revised. *Id.*, Exh. B (January 1, 2008 endorsement); Exh. C (January 1, 2010 endorsement).
18 Indeed, the Neurodevelopmental Therapy Exclusion has been part of A.G.'s Plan from the
19 time his parents purchased it. Given this plain and unambiguous Plan language, A.G. cannot
20 state a valid claim for breach of contract or any other theory.

21 **B. The Neurodevelopmental Therapy Mandate Allows Individual Health Plans To
22 Exclude Neurodevelopmental Therapy.**

23 Defendants' Neurodevelopmental Therapy Exclusion is entirely consistent with the
24 Neurodevelopmental Therapy Mandate. In 1989, the Washington legislature enacted an
25 insurance mandate requiring certain health plans to cover "neurodevelopmental therapies."
26 1989 Laws, ch. 345. This Neurodevelopmental Therapy Mandate has two important aspects:
(1) the Mandate applies only to certain group health plans and to the public employee health
plan; and (2) the Mandate applies to "occupational therapy, speech therapy, and physical

1 therapy.” RCW 41.05.170; RCW 48.21.310; RCW 48.44.450; RCW 48.46.520. There is no
2 Neurodevelopmental Therapy Mandate for individual health plans. By limiting the Mandate
3 in this way, the legislature specifically elected to allow individual health plans, like the Plan at
4 issue here, to exclude neurodevelopmental therapies.

5 The Neurodevelopmental Therapy Mandate requires dismissal of A.G.’s claims. A.G.
6 seeks coverage only for “neurodevelopmental therapies” and, specifically, for “speech and
7 occupational therapy” to treat his autism. Complaint, ¶¶ 11, 14 & 23. Those precise benefits
8 are expressly addressed by the Mandate. The legislature determined that group health plans
9 must cover those therapies for children under the age of seven, but it refused to require
10 individual health plans to do so.⁴ While Defendants can provide coverage greater than what is
11 required by the Mandate, they are not required to do so. *Liljestrand v. State Farm Mut. Auto*
12 *Ins. Co.*, 47 Wn. App. 283, 290 (1987). Like any other non-mandated benefit, Defendants
13 were free to exclude or provide coverage for neurodevelopmental therapy, and A.G.’s parents
14 were free to choose a different plan if they wanted different coverage. In short, the
15 Neurodevelopmental Therapy Exclusion does not violate Washington law because it is
16 expressly permitted by the Neurodevelopmental Therapy Mandate.

17 **C. The Parity Act Did Not Trump The Neurodevelopmental Therapy Mandate.**

18 The Complaint does not mention the Neurodevelopmental Therapy Mandate, even
19 though it addresses the precise benefits A.G. seeks. Instead, A.G. alleges that Defendants’
20 Neurodevelopmental Therapy Exclusion violates a different insurance mandate—the Parity
21 Act. The Parity Act was first enacted in 2005, but did not include individual health plans until
22 2007. 2007 Laws, ch. 8. The Act requires plans that cover medical and surgical services to

23 ⁴ Where it applies, the Neurodevelopmental Therapy Mandate mandates coverage only
24 for children six and under. *See, e.g.*, RCW 48.44.450(1). A.G.’s complaint implies that
25 Defendants’ Neurodevelopmental Therapy Exclusion applies only to individuals over the age
26 of six. Complaint, ¶ 11. That is incorrect. Because the Mandate only applies to group health
plans, but not individual health plans, Defendants are entitled to, and do, exclude coverage for
neurodevelopmental therapy regardless of age. *See* Duffy Decl., Exh. A, pg. 31.

1 also provide coverage for “mental health services” to individuals diagnosed with a condition
2 listed in DSM-IV. RCW 48.44.341(1). The Parity Act mandates this coverage in phases. For
3 plans issued or renewed after January 1, 2008, the Act generally requires only that the co-pay
4 for mental health services be no more than the co-pay for medical and surgical services.
5 RCW 48.44.341(2)(b)(ii). For plans issued or renewed after July 1, 2010, the Act also
6 requires that treatment limitations on coverage for mental health services be the same as those
7 imposed on coverage for medical and surgical services. RCW 48.44.341(2)(c)(i).

8 A.G.’s theory must be rejected because Defendants could not both lawfully *follow* the
9 Neurodevelopmental Therapy Mandate and unlawfully *violate* the Parity Act at the same time.
10 In effect, A.G. asks this Court to conclude that the legislature intended the Parity Act to
11 abrogate the Neurodevelopmental Therapy Mandate where, as here, the covered individual is
12 diagnosed with a DSM-IV condition. But nothing in the text of the Parity Act text nor its
13 history shows a legislative intent to do so; indeed, there is no reference to the Mandate in
14 either. RCW 48.44.341; Duffy Decl., Exh. D.⁵ Nor can this Court conclude that the Parity
15 Act repeals the Neurodevelopmental Therapy Mandate by implication. “Authority is legion
16 that implied repeals of statutes are disfavored and courts have a duty to interpret statutes so as
17 to give them effect.” *Bellevue Sch. Dist. No. 405 v. Brazier Constr. Co.*, 103 Wn.2d 111, 122,
18 691 P.2d 178 (1984). Thus, repeal by implication occurs only where:

19 (1) the later act covers the entire subject matter of the earlier
20 legislation, is complete in itself, and is evidently intended to supersede
21 prior legislation on the subject; or (2) the two acts are so clearly
22 inconsistent with, and repugnant to, each other that they cannot be
23 reconciled and both given effect by a fair and reasonable construction.

24 ⁵ As noted, the Parity Act was originally enacted in 2005, but was limited to large
25 group health plans. It was amended in 2007 to expand the Act to small group and individual
26 health plans. For sake of completeness, Defendants submit the bill reports for the original
enactment (SHB 1154) and the 2007 amendment (EHB 1460). Courts may look at legislative
history to determine whether there has been a repeal by implication. *See ATU Legislative
Council of Washington State v. State*, 145 Wn.2d 544, 553, 40 P.3d 656 (2002).

1 *Id.* Repeal by implication “will not be found to exist where earlier and later statutes may
2 logically stand side by side and be held valid.” *Id.* at 23. That is plainly the case here.

3 The Parity Act does not cover the entire subject matter of the Neurodevelopmental
4 Therapy Mandate. In some ways it is broader, and in other ways it is narrower. The Parity
5 Act covers unspecified “mental health services,” but only for plan enrollees with a DSM-IV
6 diagnosis. RCW 48.44.341. The Mandate covers specific services (occupational, speech and
7 physical therapy), but has no DSM-IV limitation. RCW 48.44.450. The Mandate, therefore,
8 may cover types of therapy and individuals not covered by the Parity Act. Moreover, the two
9 statutes can be read to logically stand “side by side.” The Mandate applies when
10 “neurodevelopmental therapies” are at issue; that is, occupational, speech or physical therapy
11 prescribed to treat a neurodevelopmental disorder. The Parity Act, on the other hand, applies
12 to “mental health services” other than neurodevelopmental therapies. In other words,
13 neurodevelopmental therapy is a medical benefit, and not a “mental health service” within the
14 meaning of the Parity Act. This construction gives effect to both statutes, and aligns perfectly
15 with another established rule of statutory construction. It gives preference to the specific
16 provisions of the Mandate over the general ones of the Parity Act. *See ETCO, Inc. v. Dep’t of*
17 *Labor & Indus.*, 66 Wn. App. 302, 305-06, 831 P.2d 1133 (1992) (apparent conflict between
18 statutes may be resolved by favoring specific statutory language over general language).

19 Subsequent legislative history supports this construction. *See Spokane County Health*
20 *Dist. v. Brockett*, 120 Wn.2d 140, 153, 839 P.2d 324 (1992) (subsequent proposed legislation
21 may be relevant to legislative intent). If the legislature intended the Parity Act to supersede
22 the Neurodevelopmental Therapy Mandate, there would be no need to enact new measures to
23 address neurodevelopmental therapy. Yet, since the passage of the Parity Act in 2005, there
24 have been repeated efforts to do just that. Some bills proposed to amended the existing
25 Mandate to require group plans to cover neurodevelopmental therapy for plan enrollees up to
26 age eighteen. *See Duffy Decl.*, Exh. E (SB 5750 (2007)); Exh. F (SB 5756 (2011)). Another

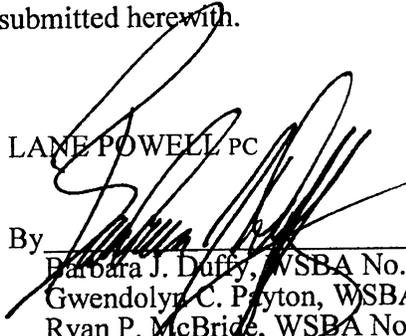
1 bill proposed a new mandate that would have required group plans to provide
2 neurodevelopmental therapy to enrollees up to age eighteen, and expressly required those
3 plans to cover that therapy when prescribed to treat autism. *Id.*, Exh. G (HB 1412 (2009)).
4 Even other bills would have required group plans to specifically cover treatments for autism,
5 including “services provided by a speech therapist, occupational therapist, or physical
6 therapist”—the same therapy addressed Neurodevelopmental Therapy Mandate. *Id.*, Exh. H
7 (SB 5203 (2009)); Exh. I (SB 5059 (2011)). Not one of these bills passed the legislature.

8 In sum, when the legislature enacted the Neurodevelopmental Therapy Mandate, it
9 carefully limited that mandate to group plans and exempted individual plans. When the
10 legislature enacted the Parity Act some fifteen years later, it did not expressly or implicitly
11 repeal the Mandate so as to require individual plans to cover neurodevelopmental therapy that
12 they otherwise were permitted to exclude. Subsequent *failed* efforts to change the law
13 confirm that neither the Mandate nor the Parity Act require individual plans to cover benefits
14 for neurodevelopmental therapy where, as here, they are sought as a treatment for autism.
15 This Court should reject A.G.’s claim because this Court cannot require insurance coverage
16 that the parties did not contract for and the legislature has refused to mandate.

17 **VI. CONCLUSION**

18 For all the reasons stated above, Defendants ask this Court to dismiss A.G.’s claims
19 with prejudice. A proposed Order has been submitted herewith.

20 DATED: October 5th, 2011

21 LANE POWELL PC
22 
23 By _____
24 Barbara J. Duffy, WSBA No. 18885
25 Gwendolyn C. Peyton, WSBA No. 26752
26 Ryan P. McBride, WSBA No. 33280
*Attorneys for Defendants Premera Blue Cross
and Lifewise of Washington*

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CERTIFICATE OF SERVICE

I hereby certify that on October 11, 2011, I caused to be served a copy of the foregoing **Motion to Dismiss** on the following person(s) in the manner indicated at the following addresses:

Richard E. Spoonemore
Eleanor Hamburger
Sirianni Youtz Meier & Spoonemore
999 Third Ave., Suite 3650
Seattle, WA 98104

- by **CM/ECF**
- by **Electronic Mail**
- by **Facsimile Transmission**
- by **First Class Mail**
- by **Hand Delivery**
- by **Overnight Delivery**

/s/ Janet Wiley
Janet Wiley

EXHIBIT 3

THE HONORABLE MICHAEL HEAVEY

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SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and K.G., on his own behalf and on behalf of all similarly situated individuals,

Plaintiffs,

v.

PREMERA BLUE CROSS and LIFEWISE OF WASHINGTON, Washington corporations,

Defendants.

No. 11-2-30233-4 SEA

DECLARATION OF BARBARA J. DUFFY IN SUPPORT OF DEFENDANTS' MOTION TO DISMISS

I, Barbara J. Duffy declare as follows:

1. I am a shareholder at Lane Powell PC, attorneys of record for Premera Blue Cross and Lifewise of Washington, Defendants in the above-captioned matter, am of legal age, competent to testify and have personal knowledge of the matters herein.

2. Attached hereto as Exhibit A is a true and correct copy of the individual health insurance plan that has covered Plaintiff A.G. since January 1, 2007 (the "Plan").

3. Attached hereto as Exhibit B is a true and correct copy of an endorsement to the Plan, effective January 1, 2008.

4. Attached hereto as Exhibit C is a true and correct copy of an endorsement to the Plan, effective July 1, 2010.

DECLARATION OF BARBARA J. DUFFY - 1

LANE POWELL PC
1420 FIFTH AVENUE, SUITE 4100
SEATTLE, WASHINGTON 98101-2338
206.223.7000 FAX: 206.223.7107

100407.0381/5186725.1

1 5. Attached hereto as Exhibit D are true and correct copies of the legislative bill
2 reports for the 2005 Mental Health Parity Act (SHB 1154) and the 2007 amendment to the
3 Mental Health Parity Act (EHB 1460).

4 6. Attached hereto as Exhibit E is a true and correct copy of SB 5760, the bill
5 digest for SB 5760, and the bill report for SB 5760.
6

7 7. Attached hereto as Exhibit F are true and correct copy of SB 5756 and the bill
8 digest for SB 5756.

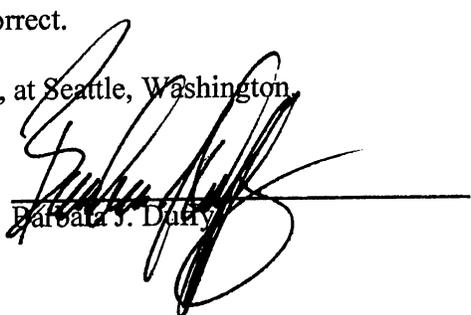
9 8. Attached hereto as Exhibit G is a true and correct copy of HB 1412, the bill
10 digest for HB 1412, and the bill report for HB 1412.

11 9. Attached hereto as Exhibit H is a true and correct copy of SB 5203, the bill
12 digest for SB 5203, and the bill report for SB 5203.

13 10. Attached hereto as Exhibit I is a true and correct copy of SB 5059, the bill
14 digest for SB 5059, and the bill report for SB 5059.
15

16 I declare under penalty of perjury under the laws of the United States and the State of
17 Washington that the foregoing is true and correct.

18 Dated this 5th day of October, 2011, at Seattle, Washington.

19
20 
21 _____
22 Barbara J. Duffy
23
24
25
26

DECLARATION OF BARBARA J. DUFFY - 2

100407.0381/5186725.1

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CERTIFICATE OF SERVICE

I hereby certify that on October 11, 2011, I caused to be served a copy of the foregoing **Declaration of Barbara J. Duffy** on the following person(s) in the manner indicated at the following addresses:

Richard E. Spoonemore
Eleanor Hamburger
Sirianni Youtz Meier & Spoonemore
999 Third Ave., Suite 3650
Seattle, WA 98104

- by **CM/ECF**
- by **Electronic Mail**
- by **Facsimile Transmission**
- by **First Class Mail**
- by **Hand Delivery**
- by **Overnight Delivery**

/s/ Janet Wiley
Janet Wiley

See Appendix Exhibit #9

The exhibits attached to Duffy Declaration in Support of Defendants' Motion to Dismiss (AE 3) are identical to exhibits attached to Duffy Declaration in Opposition to Plaintiff's Motion for Partial Summary Judgment (AE 9)

EXHIBIT 4

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HON. MICHAEL J. TRICKEY
Noted for Hearing: March 2, 2012, at 10:00 a.m.
With oral argument

IN THE SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and
K.G., on his own behalf and on behalf of all
similarly situated individuals,

Plaintiff,

v.

PREMERA BLUE CROSS and LEFWISE OF
WASHINGTON, Washington corporations,

Defendants.

NO. 11-2-30233-4 SEA

PLAINTIFF'S RESPONSE TO
DEFENDANTS' MOTION TO DISMISS

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I. INTRODUCTION

Premera moves to dismiss, arguing—just like Group Health recently argued in *Z.D. v. Group Health*—that it cannot “lawfully *follow* the Neurodevelopmental Therapy Mandate and unlawfully *violate* the [Mental Health] Parity Act at the same time.” Premera Mot., p. 7 (emphasis in original); *Z.D., ex rel. J.D. v. Group Health Coop.*, ___ F. Supp. 2d ___, 2011 WL 5299592, *3 (W.D. Wash. Nov. 4, 2011) (attached as *Appendix A*) (“[Defendants] contend that RCW 48.44.450 limits the benefits available to individuals in need of neurodevelopmental therapies, and that this limit controls over the more general mandate of RCW 48.46.291 [Mental Health Parity Act for HMOs]”).

Judge Lasnik had no difficulty rejecting this argument, concluding that “the mere fact that the statutes overlap does not mean that both cannot apply.” *Id.*, *4. Instead, the two Acts are easily harmonized:

By its plain terms, RCW 48.44.450 evidences legislative intent to establish a minimum mandatory level of “coverage for neurodevelopmental therapies for covered individuals age six and under.” Equally plain, however, is that RCW 48.44.450 does not preclude providers from extending that same coverage to individuals older than six. *The statute establishes a floor, not a ceiling.*

When it enacted [the Mental Health Parity Act], Washington raised the minimum standard by *further* requiring that mental health coverage “be delivered under the same terms and conditions as medical and surgical services.” *This new burden does not conflict with RCW 48.44.450.*

Id. (internal citations omitted, emphasis added).

This is not a close call. Denying Group Health’s request for certification of this very issue to the Washington Supreme Court, Judge Lasnik held:

... [T]he Court sees no justification for certifying. As the Court concluded in its previous Order, *this is not a close question*. Applying common and well-accepted principles of statutory construction, the Court readily concluded that

1 no conflict exists between the Neurodevelopmental Therapy
2 Mandate, RCW 48.44.450, and the Mental Health Parity Act,
3 RCW 48.46.291.

4 *Z.D. v. Group Health*, Dkt. No. 36, (attached as *Appendix B*) (emphasis added).

5 This Court should similarly conclude Premera violated the Mental Health
6 Parity Act by denying coverage of medically necessary neurodevelopmental therapies.
7 Premera's Motion to Dismiss should be denied, and Plaintiff's Motion for Partial
8 Summary Judgment and Preliminary Injunction, filed on January 13, 2012, should be
9 granted.

10 II. RE-STATEMENT OF THE ISSUES

11 **Question:** Must Premera's coverage of neurodevelopmental therapies
12 comply with *both* the Neurodevelopmental Therapy Act and the Mental Health Parity
13 Act?

14 **Answer:** Yes. Premera must comply with the plain language of both
15 statutes. There is no conflict between the two statutes and they are easily harmonized.

16 III. LAW AND ARGUMENT

17 A. CR 12(b)(6) Legal Standard.

18 Under CR 12(b)(6), dismissal is appropriate only if it is "beyond doubt that
19 the plaintiff can prove no set of facts, consistent with the complaint, which would
20 entitle the plaintiff to relief." *Bravo v. Dolsen Companies*, 125 Wn.2d 745, 750, 888 P.2d
21 147 (1995). If a court can identify any "hypothetical situation conceivably raised by the
22 complaint" in which standing could be found, it must deny the motion. *Id.* What is at
23 issue is the "legal sufficiency of the claim" to be considered, rather than the specific
24 facts alleged in the complaint. *Id.* As such, CR 12 (b)(6) motions should be granted
25 only sparingly and with care. *Id.* at 750.

1 **B. The Mental Health Parity Act Requires Coverage of Medically**
2 **Necessary Neurodevelopmental Mental Health Services for**
3 **Covered DSM-IV Conditions.**

4 Under the Parity Act, *all* health benefit plans issued by health carriers must
5 provide coverage of all mental health services:

6 *All health service contracts providing health benefit plans*
7 *that provide coverage for medical and surgical services shall*
8 *provide:*

9 (a) ... *coverage for:*

10 (i) *Mental Health Services*

11 RCW 48.44.341(2) (emphasis added). The term “mental health services” is broadly
12 defined as treatment necessary to treat mental disorders identified in the DSM-IV-TR
13 (with four exceptions, which do not apply here):

14 “[M]ental health services” means *medically necessary*
15 *outpatient and inpatient services provided to treat mental*
16 *disorders covered by the diagnostic categories listed in the*
17 *most current version of the diagnostic and statistical*
18 *manual of mental disorders, published by the American*
19 *psychiatric association, on July 24, 2005, or such subsequent*
20 *date as may be provided by the insurance commissioner by*
21 *rule, consistent with the purposes of chapter 6, Laws of*
22 *2005....*

23 RCW 48.44.341(1) (emphasis added).¹ Mental health services may only be denied for
24 lack of medical necessity. RCW 48.44.341(4) (coverage required for all “medically
25 necessary” services). That is the sole basis for excluding a particular form of mental
26 health treatment.

 As described more extensively in Plaintiff’s Motion for Summary Judgment
and Injunctive Relief, Premera’s exclusion of neurodevelopmental therapies in A.G.’s

¹ The version of the DSM published on July 24, 2005 is the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Ed. Text Revision (DSM-IV-TR). There has been no update, and the Insurance Commissioner has not, by rule, adopted a different version of the DSM.

1 plan (and others) violates the Parity Act. Neurodevelopmental therapies are medically
2 necessary services to treat covered DSM-IV-TR conditions such as autism. As a result,
3 Premera cannot exclude the therapy in its contracts. It must undertake an
4 individualized medical necessity review of each request for neurodevelopmental
5 therapy when sought to treat a DSM-IV condition. See Plaintiff's Mot. for Partial
6 Summ. J. (01/13/12), pp. 8-12; RCW 48.44.341(4).

7 **C. Premera's Obligations Under the Mental Health Parity Act Are**
8 **Not "Superseded" by the Neurodevelopmental Therapy Act.**

9 Premera claims that it may wholly exclude all neurodevelopmental therapies
10 in its individual market plans, like A.G.'s, and exclude coverage for all persons over
11 the age of six in its group plans, because the therapies are not covered by the Mental
12 Health Parity Act. Premera's assertion is based upon three arguments: (1) Premera
13 alleges that there is an irreconcilable conflict between the Parity Act and the
14 Neurodevelopmental Therapy Act, such that only the Neurodevelopmental Therapy
15 Act applies; (2) Premera claims that the definition of "mental health services" under the
16 Parity Act does not include neurodevelopmental therapies to treat mental health
17 conditions; and (3) Premera claims that the legislature did not intend to cover
18 neurodevelopmental therapies under the Parity Act. *Id.*, pp. 8-9.

19 Premera's analysis is flawed on all counts. The simple conclusion based
20 upon the plain language the two statutes is that both Acts apply to ensure broad
21 coverage of neurodevelopmental therapies to persons with developmental disabilities.

22 **1. There Is No "Irreconcilable Conflict" Between the**
23 **Parity Act and the Neurodevelopmental Mandate.**

24 "The primary objective of statutory construction is to carry out the intent of
25 the Legislature, which must be determined primarily from the language of the statute
26 itself." *Roberts v. Johnson*, 137 Wn.2d 84, 91, 969 P.2d 446, 449 (1999). "Where the

1 language of the statute is plain and unambiguous, the meaning should be discovered
2 from the wording of the statute itself." *Id.*

3 When two statutes govern the same subject matter, effect will be given to
4 both to the extent possible. *Walker v. Wenatchee Valley Truck & Auto Outlet, Inc.*, 155
5 Wn. App. 199, 208, 229 P.3d 871 (2010). Courts must attempt to harmonize the two
6 statutes. *Id.* Only where two statutes conflict to the extent that they cannot be
7 harmonized will a more specific statute supersede a general one.² *Id.*

8 When simultaneous compliance is possible, there simply is no statutory
9 conflict—both statutes will be enforced as written:

10 Where two legislative enactments relate to the same subject
11 matter and are not actually in conflict, they should be
12 interpreted to give meaning and effect to both. Such
13 construction gives significance to both acts of the legislature.

14 *Davis v. King County*, 77 Wn.2d 930, 933, 468 P.2d 679 (1970). See also *Z.D.*, 2011 WL
15 5299592, *4 (Judge Lasnik citing to same cases); *Mortell v. State*, 118 Wn. App. 846, 849,
16 78 P.3d 197, 198 (2003) ("Statutes relating to the same subject matter will be read as
17 complimentary").

18 The plain language of both Acts shows that they work hand-in-hand. The
19 Neurodevelopmental Therapy Act mandates coverage of the therapies for *all children*
20 under the age of seven in group coverage (whether or not they are diagnosed with

21
22
23 ² Premera argues that the Court should "give preference to the specific provisions of the
24 [Neurodevelopmental Therapy] Mandate over the general ones of the Parity Act." Premera Mot., p. 8.
25 Premera misconstrues the rule of statutory construction. A more specific statute may only supersede a
26 general one when there is an irreconcilable conflict. *Walker*, 155 Wn. App. at 208; *ETCO, Inc. v. Dep't of
Labor & Indus.*, 66 Wn. App. 302, 306, 831 P.2d 1133 (1992) ("Where two statutes dealing with the same
subject matter are *in apparent conflict*, established rules of statutory construction require giving
preference to the more specific statute") (cited by Premera). Where, as here, there is no conflict and both
can be given full meaning, the general-specific rule of statutory construction simply does not apply. *Id.*

1 DSM-IV conditions), while the Mental Health Parity Act expands that coverage to *all*
2 *insureds with DSM-IV conditions*, regardless of age. As Judge Lasnik held:

3 Defendant can readily comply with both statutes simply by
4 comports with the parity requirements of RCW 48.46.291
5 for all covered individuals, keeping in mind that RCW
6 48.44.450 confers a more specific and more onerous
7 requirement upon Defendants to provide “neurodevelop-
8 mental therapies for covered individuals age six and under”
9 without regard for parity. This “construction gives
10 significance to both acts of the legislature.”

11 Z.D., 2011 WL 5299592, *4.

12 Premera fundamentally misunderstands insurance mandates by arguing that
13 the neurodevelopmental mandate “conflicts” with the Parity Act. A mandate, such as
14 the neurodevelopmental mandate, sets forth legislative intent with respect to the
15 *minimum amount* of coverage a carrier must offer:

16 Each employer-sponsored group contract for comprehensive
17 health care service which is entered into, or renewed, on or
18 after twelve months after July 23, 1989, *shall include coverage*
19 for neurodevelopmental therapies for covered individuals
20 age six and under.

21 RCW 48.44.450(1) (emphasis added). This mandate is not, as Premera suggests, an
22 expression of legislative intent with respect to coverage of neurodevelopmental
23 therapy services above the established minimum. Premera Mot., p. 6 (erroneously
24 asserting that Premera’s exclusion is “expressly permitted by the Neurodevelopmental
25 Therapy Mandate”). As Judge Lasnik concluded:

26 By its plain terms, RCW 48.44.450 evidences legislative
intent to establish a minimum mandatory level of coverage
for neurodevelopmental therapies for covered individuals
age six and under. Equally plain, however, is that RCW
48.44.450 does not preclude providers from extending that
same coverage to individuals older than six.

1 Z.D., 2011 WL 5299592, *4. The mandate established a “floor, not a ceiling.” *Id.* After
2 the mandate was passed, an insurer was free to offer neurodevelopmental benefits to
3 insureds in the individual market or children over the age of six without running afoul
4 of any legislative directive. And simply because an insurer was, in 1985, impliedly
5 “permitted” to deny neurodevelopmental mental health services to children over the
6 age of six did not foreclose the operation of another statutory mandate, such as the
7 2006 Parity Act, from later requiring such coverage.

8 Premera does not get to choose which state mandate it wants to follow,
9 ignoring the other. It is required to follow both. Here, providing mental health
10 services required by the Parity Act does not in any way jeopardize Premera’s
11 compliance with the neurodevelopmental mandate. Nor does complying with the
12 neurodevelopmental mandate jeopardize compliance with the Parity Act. The statutes
13 are complementary, and both can—and should—be enforced as written.

14 **2. Neurodevelopmental Therapies are “Mental Health**
15 **Services” as Defined by the Parity Act.**

16 Premera’s second argument, that neurodevelopmental therapies are
17 excluded from the definition of “mental health services” under the Parity Act, ignores
18 the Parity Act’s plain language. *See* Premera Mot., p. 8. “When interpreting a statute,
19 we first look to its plain language.” *HomeStreet Inc. v. State*, 166 Wn.2d 444, 451, 210
20 P.3d 297, 300 (2009). “If the plain language is subject to only one interpretation, our
21 inquiry ends because plain language does not require construction.” *Id.*

22 The Parity Act specifically and unambiguously defines “mental health
23 services” to include all services that are “medically necessary ... to treat mental
24 disorders covered by” the DSM-IV-TR. RCW 48.44.341(1). The legislature carefully
25 crafted the definition broadly to include within its scope neurodevelopmental mental
26 health services. *Id.* It knew how to exclude specific services from its mandate and did

1 so. *Id.* (“substance related disorders” and “life transition problems” specifically
2 excluded from definition). Neurodevelopmental therapies were not excluded from the
3 broad definition of “mental health services.”

4 **3. The Legislature Intended to Cover Neurodevelopmental**
5 **Therapies as Part of the Mental Health Parity Act.**

6 Premera argues that failed legislative efforts in 2007 and 2011 to expand the
7 Neurodevelopmental Therapy Act are somehow evidence that the Legislature intended
8 to exclude neurodevelopmental therapies under the Parity Act. There are at least four
9 fundamental problems with this argument.

10 *First*, the intent of the legislature is derived from the language of a statute
11 under Washington’s “plain meaning” rule. *State Dept. of Ecology v. Campbell & Gwinn,*
12 *LLC*, 146 Wn.2d 1, 9-10, 43 P.3d 4, 9 (2002) (“[I]f the statute’s meaning is plain on its
13 face, then the court must give effect to that plain meaning as an expression of
14 legislative intent”). Under this rule, legislative history is irrelevant if the language of
15 the statute is unambiguous:

16 If the plain language is subject to only one interpretation,
17 our inquiry ends because plain language does not require
18 construction. “Where statutory language is plain and
19 unambiguous, a statute’s meaning must be derived from the
20 wording of the statute itself.”

21 *HomeStreet, Inc. v. State*, 166 Wn.2d 444, 451, 210 P.3d 297, 300 (2009) (citations omitted).
22 Different interpretations of a statute do not render it ambiguous under the plain
23 meaning rule. Rather, the court must conclude that the language used by the
24 legislature is inherently ambiguous. *Id.* at 452 (“[A] statute is not ambiguous merely
25 because different interpretations are conceivable”).

26 Premera does not even attempt to make a threshold showing of statutory
ambiguity before launching into its prolonged discussion of legislative history. *State v.*
Hahn, 83 Wn. App. 825, 831-32, 924 P.2d 392 (1996) (“[Defendants] fail to show why the

1 language of [the statute] is ambiguous. Without a threshold showing of ambiguity, the
2 court derives a statute's meaning from its language alone"). Here, the Parity Act is
3 unambiguous: it requires coverage for services designed to treat mental health
4 conditions.

5 *Second*, even when resort to legislative history is appropriate, failed
6 legislation is irrelevant. See *State v. Conte*, 159 Wn.2d 797, 813, 154 P.3d 194 (2007) (the
7 failure of the Legislature to take action on a proposed bill is not evidence of any
8 legislative intent). Even the case cited by Premera recognizes that any "intent" that can
9 be gleaned from failed legislation is, at best, highly speculative. *Spokane County Health*
10 *Dist. v. Brockett*, 120 Wn.2d at 140, 153, 839 P.2d 324 (1992) ("[W]hen the Legislature
11 rejects a proposed amendment, as they did here, we will not speculate as to the reason
12 for the rejection"). If anything, the failed efforts to expand the Neurodevelopmental
13 Therapy Act (and the autism mandate) show that the legislature recognized that the
14 services sought in the bills were already mandated by the Parity Act, rendering the
15 proposed legislation unnecessary.

16 *Third*, while there is some overlap in the statutes, the Neurodevelopmental
17 Mandate is not restricted to children with DSM-IV-TR mental health diagnosis. Under
18 the Neurodevelopmental Mandate, a child in need of physical therapy without a DSM-
19 IV-TR diagnoses would not be covered under the Parity Act. Given the different
20 scopes of the two statutes—and despite some overlap—the failure to expand coverage
21 under the Neurodevelopmental Mandate is irrelevant to legislature intent regarding
22 treatment of individuals with DSM-IV-TR mental health conditions. As Judge Lasnik
23 concluded, "The fact that the Washington legislature is apparently considering
24 expanding the Neurodevelopmental Therapy Mandate to require coverage up to the
25 age of 18 has no bearing on whether the legislature intended to require parity coverage
26

1 under RCW 48.46.291—the statute in question.” *Z.D. v. Group Health Cooperative*,
2 *Appendix B*, p. 3.

3 *Fourth*, all of the legislative history indicates that the legislature knew full
4 well that it was passing an extraordinarily broad mandate in the Parity Act, limited
5 only by a few explicit exceptions:

6 The legislature finds that the costs of leaving mental
7 disorders untreated or undertreated are significant, and
8 often include: ... deteriorating school performance,
9 increased use of other health services, treatment delays
10 leading to more costly treatments, suicide, family
breakdown and impoverishment, and institutionalization

11 ... [T]he legislature declares that it is not cost-effective to
12 treat persons with mental disorders differently than persons
with medical and surgical disorders.

13 *Therefore the legislature intends to require that insurance*
14 *coverage be at parity for mental health services, which*
15 *means this coverage be delivered under the same terms and*
16 *conditions as medical and surgical services.*

17 Hamburger Decl. (01/13/12), *Exh. G*, p. 1-2 (emphasis added); *Spokane County Health*
18 *Dist.*, 120 Wn. 2d at 151 (“[T]he preamble or statement of intent can be crucial to
19 interpretation of a statute”). The breadth of the mandate is also reflected in the
20 Legislative Sunrise Review:

21 The requirement for mental health coverage is broad—“all
22 mental disorders included in the diagnostic and statistical
23 manual of mental disorders”—but the insurance policy may
24 make mental health coverage subject to prior authorization
and medical necessity requirements the same as other
services. The requirement for parity in coverage is also
broadly worded, so that it applies to both treatment
limitations and various forms of financial participation.

25 Hamburger Decl. (01/13/12), *Exh. H*, p. 1. *See also id.* (Parity Act “would require group
26 health plans and the public employees benefit board health plan to (a) provide mental

1 health coverage if they currently do not, and (b) cover mental health at the same level
2 that physical health is covered"). In contrast, there is absolutely *nothing* in the
3 legislative history of the Parity Act which suggests that the legislature wanted to
4 exclude neurodevelopmental conditions or therapies from this broad mandate, as it
5 expressly did for "substance related disorders" and "life transition problems."
6 RCW 48.44.341(1).

7 **D. Premera's Position Undermines the Mental Health Parity Act.**

8 Even if both statutes could not be simultaneously followed – and they can –
9 the Parity Act more accurately reflects present legislative intent with respect to
10 insurance coverage for mental health services. Society has made progress towards
11 understanding and addressing the inherent discrimination in a health care system
12 which treats mental illness differently than physical illness since the 1989
13 neurodevelopmental mandate. The Parity Act, in fact, was widely recognized as the
14 major accomplishment of the 2005 legislative session.³

15 This societal change, reflected in the plain language and legislative intent of
16 the Parity Act itself, cannot be ignored:

17 Since legislative policy changes as economic and sociological
18 conditions change, the relevant legislative acts which are
19 nearer in time to the enactment in question are more
20 indicative of legislative intent than those which are more
remote.

21 *Connick v. City of Chehalis*, 53 Wn. 2d 288, 291, 333 P.2d 647, 649 (1958). See also *State v.*
22 *Wright*, 84 Wn. 2d 645, 650, 529 P.2d 453, 457 (1974) ("Also, the entire sequence of

23
24 ³ See, e.g., http://seattletimes.nwsourc.com/html/opinion/2002175525_revelle10.html (last visited
25 2/10/12) (article by Randy Revelle, Pat Thibaudeau and Shay Schaul-Berke noting that before the law,
26 Washington insureds with mental conditions "face[d] an unjust societal stigma, while battling health-
insurance discrimination that severely limits access and treatment for their mental illnesses," and
recognizing the eight-year effort to pass the groundbreaking Parity Act in Washington State).

1 statutes relating to a given subject matter should be considered, since legislative policy
2 changes as economic and sociological conditions change”).

3 The Parity Act should be seen for what it is: an expression of contemporary
4 public policy condemning discriminatory disparate insurance coverage practices which
5 have historically infected health plans issued by major Washington health carriers,
6 such as Premera. Premera’s coverage approach—a construction which would results
7 in the exclusion of *every* neurodevelopmental mental health service for insureds in the
8 individual market and all insureds over six in the group market—would gut the Parity
9 Act.

10 IV. CONCLUSION

11 The Court should apply common and well-accepted principles of statutory
12 construction to conclude that the Neurodevelopmental Therapy Act and the Mental
13 Health Parity Act do not conflict and are easily harmonized. Premera must obey both
14 Acts when providing coverage of neurodevelopmental therapies to its insureds.
15 Whether Premera’s motion should be denied, and Plaintiff’s motion granted, is simply
16 “not a close question.” *Z.D.*, No. 2:11-cv-01119-RSL, *Appendix B*.

17 DATED: February 10, 2012.

18 SIRIANNI YOUTZ SPOONEMORE

19 /s/ Eleanor Hamburger

20 Eleanor Hamburger (WSBA #26478)

21 Richard E. Spoonemore (WSBA #21833)

22 Attorneys for Plaintiff

EXHIBIT 5

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THE HONORABLE MICHAEL J. TRICKEY
Motion Date: March 2, 2012
Hearing time: 10:00 a.m.
WITH ORAL ARGUMENT

SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and
K.G., on his own behalf and on behalf of all
similarly situated individuals,

Plaintiffs,

v.

PREMERA BLUE CROSS and LIFEWISE
OF WASHINGTON, Washington
corporations,

Defendants.

No. 11-2-30233-4 SEA

**DEFENDANTS' REPLY IN SUPPORT
OF MOTION TO DISMISS**

1 Plaintiff A.G. does not dispute that the Neurodevelopmental Therapy Mandate allows
2 Defendants Premera Blue Cross and Lifewise of Washington to offer individual health plans
3 that do not cover neurodevelopmental therapy benefits. Nor does A.G. dispute that his plan
4 excludes the neurodevelopmental therapy benefits he seeks. A.G. therefore argues, as he
5 must, that the Mental Health Parity Act trumps the Neurodevelopmental Therapy Mandate
6 and, by extension, the unambiguous terms of his health plan. For the reasons explained in
7 Defendants' Motion and below, A.G.'s theory of statutory construction must be rejected. At
8 bottom, A.G. asks the Court to create insurance coverage that A.G.'s parents did not purchase
9 and the legislature refused to statutorily mandate. Defendants' motion should be granted.

10 **I. Neurodevelopmental Therapy Is Considered A Medically Necessary "Mental**
11 **Health Service" Under The Parity Act For Purposes Of This Motion Only.**

12 A.G. recognizes that the Parity Act requires health plans to cover only those "mental
13 health services" that are "medically necessary ... to treat" a DSM-IV condition. RCW
14 48.44.341(1). The Parity Act does not define "mental health services" and, as discussed
15 below, the Act's history does not show a legislative intent to include neurodevelopmental
16 therapy within its scope. Nevertheless, A.G.'s entire argument is premised on the assumption
17 that "neurodevelopmental therapies are medically necessary services to treat covered DSM-
18 IV-TR conditions such as autism." Opp. at 4. That assumption is hotly disputed and not
19 supported on this record.¹ For purposes of this motion only, however, this Court can assume
20 that neurodevelopmental therapy *could be* medically necessary to treat a DSM-IV condition.
21 That fact only highlights the conflict between the Neurodevelopmental Therapy Mandate and
22 the Parity Act and reveals why the Parity Act does not cover neurodevelopmental therapy.

23 _____
24 ¹ As Defendants explain in their opposition to A.G.'s motion for partial summary judgment, even if the
25 Parity Act applies, A.G. is entitled to relief only if he proves that neurodevelopmental therapy is medically
26 necessary to treat autism. A.G. failed to bring forward any admissible evidence to show medical necessity and,
indeed, Defendants submitted evidence to refute such a showing. *See Defendants' Opp. to Plaintiff's Mot. for
Partial Summary Judgment; Declaration of Nancy Moore; Declaration of Dr. Chellie Moat.* Thus, even if this
Court denies Defendants' motion to dismiss as a matter of statutory construction, it cannot grant A.G.'s motion.

1 **II. The Neurodevelopmental Therapy Mandate Conflicts With The Parity Act.**

2 Under A.G.'s construction, there is an impermissible conflict between the two statutes.
3 On one hand, the Neurodevelopmental Therapy Mandate allows individual plans *to exclude*
4 neurodevelopmental therapy for members with a DSM-IV condition. On the other, the Parity
5 Act, if it applied, would require individual plans *to cover* neurodevelopmental therapy for
6 members with a DSM-IV condition. The Mandate permits what the Parity Act forbids. A.G.
7 tries to harmonize this conflict by suggesting that the Parity Act merely "extends" a "floor"
8 established by the Mandate. Not so. If the Parity Act requires an individual plan to provide
9 neurodevelopmental therapy benefits (or a group plan to provide benefits to individuals over
10 the age of six), then the limited scope of the Mandate becomes meaningless—contrary to a
11 settled rule of statutory construction. *Cockle v. Dep't of Labor & Indus.*, 142 Wn.2d 801,
12 809, 16 P.3d 583 (2001) ("statutes must not be construed in a manner that renders any portion
13 thereof meaningless or superfluous"). A.G. chides Defendants for "trying to choose which
14 state mandate it wants to follow" (Opp. at 7), but that is exactly what A.G. wants as well.

15 A.G. similarly argues there is no conflict because the Mandate "sets forth legislative
16 intent with respect to the *minimum amount* of coverage," but not "coverage of ... services
17 above the established minimum." Opp. at 6. But the Mandate does both. An insurer is
18 "permitted to limit its liability unless inconsistent with ... some statutory provision." *Mutual*
19 *of Enumclaw Ins. Co. v. Wiscomb*, 97 Wn.2d 203, 210, 643 P.2d 441 (1982). In defining what
20 coverage an insurer must afford, a mandate defines what coverage it may exclude. *See Hodge*
21 *v. Raab*, 151 Wn.2d 351, 356-58, 88 P.3d 959 (2004). To suggest that the Mandate does not
22 show a legislative intent to permit exclusion of neurodevelopmental therapy ignores its text
23 and history—which, as discussed below, shows that the legislature understands that insurers
24 have uniformly viewed the Mandate as a legislative imprimatur to exclude coverage for most
25 neurodevelopmental therapy benefits. In sum, if neurodevelopmental therapy is medically
26 necessary to treat autism, then the Mandate conflicts with the Parity Act.

1 **III. The Neurodevelopmental Therapy Mandate Controls Over The Parity Act.**

2 Because the two statutes cannot be harmonized, this Court must therefore decide that
3 either (1) the Parity Act implicitly repealed the Mandate, or (2) the specific provisions of the
4 Mandate control over the general ones of the Parity Act. A.G. ignores the issue of implicit
5 repeal entirely—conceding that this disfavored doctrine has no application here. *Bellevue*
6 *Sch. Dist. No. 405 v. Brazier Constr. Co.*, 103 Wn.2d 111, 122, 691 P.2d 178 (1984) (implicit
7 repeal applies if “later act covers the entire subject matter of the earlier legislation, ... and is
8 evidently intended to supersede prior legislation on the subject”). As Defendants have shown,
9 and A.G. does not refute, there is not a single reference to neurodevelopmental therapy in the
10 Parity Act’s legislative history, much less any suggestion that the legislature intended the Act
11 to supersede the Mandate. *See* Duffy Decl., Exh. D. The legislature is “presumed to have full
12 knowledge of existing statutes affecting the matter upon which they are legislating.” *State v.*
13 *Conte*, 159 Wn.2d 797, 808 154 P.3d 194 (2007) (citation and internal quotes omitted). It is
14 simply implausible that the legislature intended to override a long-standing mandate without
15 specifically saying so in the Act’s findings, the statute’s text or the bill’s legislative history.²

16 As to the specific/general rule, A.G. agrees that in cases of apparent conflict, a more
17 specific statute supersedes a general one. *Opp.* at 7. This is true even if the general statute is
18 passed after the specific statute. *Wark v. Wash. Nat’l Guard*, 87 Wn.2d 864, 867, 557 P.2d
19 844 (1976) (if “passed before the general statute, the special statute will be construed as ... an
20 exception to its terms”). A.G. does not dispute which statute is more specific here. The
21 Neurodevelopmental Therapy Mandate is specific in scope, and mandates insurance coverage
22 for neurodevelopmental therapy, which it defines as “occupational therapy, speech therapy,
23

24 ² A.G. suggests that the Parity Act includes neurodevelopmental therapy by negative implication
25 because it is not specifically excluded from the Act. *Opp.* at 7-8. But the Parity Act does not exclude any
26 specific service or therapy. It only excludes certain disorders (e.g., substance abuse), long-term care (e.g.,
nursing facility services) and court-ordered treatment. RCW 48.44.341(1). Whether a particular treatment is a
“mental health service” is a determination left to the carrier’s medical director or designee. RCW 48.44.341(4).

1 and physical therapy”—the very same kind of therapy A.G. receives. Compl., ¶¶ 14 & 23.
2 The Parity Act is general in scope, and mandates coverage for unspecified “mental health
3 services” which, unlike the Mandate, it does not define. This Court must resolve the inherent
4 conflict between the Mandate and the Parity Act by construing the Neurodevelopmental
5 Therapy Mandate as an exception to the Parity Act or, to put it differently, by concluding that
6 neurodevelopmental therapy is not a covered “mental health service” under the Parity Act.

7 **IV. Legislative History And Agency Analysis Support Defendants’ Construction.**

8 Legislative history confirms this construction. A.G. argues that resorting to legislative
9 history is unnecessary but, as shown, the “plain language” of the Mandate and Parity Act only
10 highlights—not harmonizes—the conflict. “[I]n interpreting conflicting statutory language, a
11 court may ascertain legislative intent by examining the legislative history of particular
12 enactments.” *Gorman v. Garlock, Inc.*, 155 Wn.2d 198, 211, 118 P.3d 311 (2005). Further,
13 contrary to A.G.’s suggestion, courts can and do consider subsequent amendments and bills,
14 even those that fail, as a legitimate tool to ascertain legislative intent. *Costanich v. Dep’t of*
15 *Soc. and Health Servs.*, 164 Wn.2d 925, 932, 194 P.3d 988 (2008); *Impecoven v. Dep’t of*
16 *Revenue*, 120 Wn.2d 357, 362, 841 P.2d 752 (1992). As Defendants explained in the Motion,
17 after enactment of the Parity Act, the legislature has been asked repeatedly to amend the
18 Mandate or pass new bills that would require insurers to cover neurodevelopmental therapy
19 benefits for children with autism. Duffy Decl., Exhs. G, H & I. Of course, there would be no
20 need for this legislation if the Parity Act actually mandated such coverage.

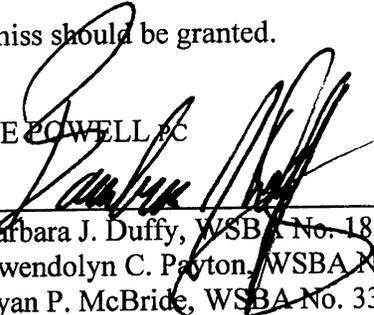
21 A.G.’s suggestion that the legislature rejected these proposals because it considered
22 neurodevelopmental therapy already covered by the Parity Act is implausible, and contrary to
23 the Department of Health’s interpretation of the Act. See *Anfinson v. FedEx Ground Package*
24 *System, Inc.*, 159 Wn. App. 35, 41, 244 P.3d 32 (2010) (“We give great weight to an agency’s
25 interpretation of a statute absent a compelling indication that its interpretation conflicts with
26 the legislative intent.”). In its 2009 Sunrise Review regarding the “Treatment of Autism

1 Spectrum Disorders [ASD],” the DOH reported: “It is unclear at this time how much (if any)
2 ASD treatment should be covered under this mandate.” *Declaration of Barbara J. Duffy in*
3 *Supp. of Def.’s Opp. to Pltf.’s Mtn. for Partial Summary Judgment*, Exh. L (pp. 8-9).³ The
4 DOH recommended the legislature “[e]xpand the neurodevelopmental therapy mandate to,”
5 among other things, raise the age limits, and “[e]xpand and/or clarify the mental health parity
6 mandate to include treatment for ASD.” *Id.* (pp. 16-17). Thus, the DOH understood that,
7 without amendment, the Parity Act did not require insurers to cover neurodevelopmental
8 therapy benefits as a treatment for autism. The legislature rejected those amendments.

9 The Office of Insurance Commissioner (“OIC”) apparently agrees that the Parity Act
10 does not require insurers to cover neurodevelopmental therapy benefits. As noted in
11 Defendant’s opposition to A.G.’s motion for summary judgment, Defendants submit their
12 contract forms to the OIC, which has authority to review and reject any contract that “contains
13 unreasonable restrictions on the treatment of patients” or “violates any provision of this
14 chapter”—including the Parity Act. RCW 48.44.020. The OIC did not disapprove A.G.’s
15 plan or its Neurodevelopmental Therapy Exclusion. This Court should reject A.G.’s request
16 for a judicial construction of the Parity Act that conflicts with both legislative intent and
17 agency interpretation. Defendants’ motion to dismiss should be granted.

18 DATED: February 24th, 2012

19 LANE POWELL PC

20 By 

21 Barbara J. Duffy, WSBA No. 18885

22 Gwendolyn C. Payton, WSBA No. 26752

23 Ryan P. McBride, WSBA No. 33280

24 *Attorneys for Defendants Premera Blue Cross*
25 *and Lifewise of Washington*

26 ³ A.G. cites to a 1998 Sunrise Review to support his view of the expansive breadth of the Parity Act.
Opp. at 10 (*citing* Hamburger Decl. (01/13/12), Exh. H). This review pre-dated the actual Parity Act by seven
years, related to proposed mental health parity legislation that was not enacted, and says nothing about whether
neurodevelopmental therapy is a medically necessary treatment for autism or any DSM-IV condition. Only the
2009 Sunrise Review reflects the DOH’s interpretation of the Parity Act as it is written.

1 **CERTIFICATE OF SERVICE**

2 I hereby certify under penalty of perjury under the laws of the State of Washington
3 that on February 24, 2011, I caused to be served a copy of the foregoing **Reply in Support of**
4 **Motion to Dismiss** on the following person(s) in the manner indicated at the following
5 addresses:

6 Richard E. Spoonemore
Eleanor Hamburger
7 Sirianni Youtz Spoonemore
999 Third Ave., Suite 3650
8 Seattle, WA 98104

- by **CM/ECF**
- by **Electronic Mail**
- by **Facsimile Transmission**
- by **First Class Mail**
- by **Hand Delivery**
- by **Overnight Delivery**

9 DATED February 24, 2012, at Seattle, Washington

10
11 
12 Janet Wiley

EXHIBIT 6

HON. MICHAEL J. TRICKEY
Noted for Hearing: March 2, 2012 @ 10:00 a.m.
With Oral Argument

IN THE SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and
K.G., on his own behalf and on behalf of all
similarly situated individuals,

Plaintiff,

v.

PREMERA BLUE CROSS and LIFEWISE OF
WASHINGTON, Washington corporations,
Defendants.

NO. 11-2-30233-4 SEA

PLAINTIFF'S MOTION FOR PARTIAL
SUMMARY JUDGMENT AND
PRELIMINARY INJUNCTION

I. INTRODUCTION

A.G.'s health benefit plan, like others issued by defendants Premera Blue Cross and its wholly-owned subsidiary Lifewise Health Plan of Washington (collectively "Premera"), excludes coverage of neurodevelopmental therapies even when medically necessary to treat DSM-IV mental conditions like A.G.'s autism.¹ This exclusion violates Washington's Mental Health Parity Act, RCW 48.44.341.² As a

¹ Premera's individual policies wholly exclude neurodevelopmental therapies. *See e.g.*, Duffy Decl. Exh. A, pp. 30-31. Premera's non-ERISA group policies exclude coverage of neurodevelopmental therapies to persons over the age of six. *See e.g.*, Hamburger Decl., Exh. A, Premera's WEA Select Plan 1, p. 18.

² The Mental Health Parity Act is actually four separate statutes. *See* RCW 48.44.341 (covering health care service contractors like Premera and Lifewise); RCW 48.46.241 (covering HMOs like Group Health Cooperative); RCW 41.05.600 (covering public employees' health benefit plans); and RCW 70.47.200 (covering the Basic Health Plan).

1 matter of law, neurodevelopmental therapies to treat covered DSM-IV conditions are
2 “mental health services” under the Parity Act and cannot be excluded.

3 This exact issue was recently adjudicated by Judge Robert Lasnik in
4 similar litigation against Group Health Cooperative.³ See *Z.D., ex rel. J.D. v. Group*
5 *Health Coop.*, __ F. Supp. 2d __, 2011 WL 5299592 (W.D. Wash. Nov. 4, 2011) (Appendix
6 A). Judge Lasnik determined that the Mental Health Parity Act requires coverage of
7 medically necessary neurodevelopmental therapies *even when the explicit terms of the*
8 *health benefit plan exclude that coverage*. That is because the Mental Health Parity Act
9 is incorporated into the terms and conditions of the contract:

10 It is true that the literal terms of the Plan, as written, do not
11 require coverage for the mental health treatment of
12 individuals over the age of six. *The problem for Defendants*
13 *lies in the fact that Washington law governs the Plan*. And,
14 as alleged by Plaintiffs, Washington law, specifically RCW
15 48.46.291(2)[the Mental Health Parity Act as applied to
16 HMOs], requires Defendants to provide coverage for the
17 mental health services at issue in this case.

18 *Id.* p. *3 (internal citations omitted, emphasis added). Judge Lasnik concluded that the
19 Parity Act expanded coverage of neurodevelopmental therapies beyond what was
20 required under the Neurodevelopmental Therapy Act, RCW 48.44.450. *Id.* p.*4.

21 By its plain terms, RCW 48.44.450 evidences legislative intent
22 to establish a minimum mandatory level of “coverage for
23 neurodevelopmental therapies for covered individuals age
24 six and under.” Equally plain, however, is that RCW
25 48.44.450 does not preclude providers from extending that
26 same coverage to individuals older than six. *The statute*
establishes a floor, not a ceiling.

3 All major health carriers in Washington use the same or similar exclusions in their health benefit plans. See *e.g.*, *Z.D. v. Group Health Cooperative*, No. 2:11-cv-01119 (W.D. Wash. J. Lasnik); *O.S.T. v. Regence BlueShield*, No. 11-2-34187-9 SEA (King Cty. Sup. Ct., J. Erlick).

1 When it enacted [the Mental Health Parity Act], Washington
2 raised the minimum standard by *further* requiring that
3 mental health coverage “be delivered under the same terms
and conditions as medical and surgical services.”

4 *Id.* (emphasis added).

5 This Court should similarly conclude that Premera’s exclusion of
6 medically necessary neurodevelopmental therapies violates the Mental Health Parity
7 Act, and order the preliminary injunctive relief sought by the named plaintiff.
8 Premera’s exclusionary clause is exactly the kind of discrimination in health insurance
9 that the Parity Act was designed to end.

10 II. RELIEF REQUESTED

11 Plaintiff seeks a declaration that Premera’s exclusion of
12 neurodevelopmental therapies in its non-ERISA contracts is void and unenforceable
13 because the exclusion violates the requirements of the Parity Act. This Motion also
14 seeks entry of a preliminary injunction prohibiting Premera from applying the illegal
15 exclusion to Plaintiff A.G.’s ongoing requests for coverage of neurodevelopmental
16 therapies.

17 III. EVIDENCE RELIED UPON

18 Plaintiffs rely upon the Declaration of Eleanor Hamburger with attached
19 exhibits, the declaration of J.G. and attached exhibits and the records, pleadings and
20 files in this case.

21 IV. FACTS

22 A. Identity of Plaintiff

23 A.G. is the 13 year old son of J.G. and K.G. who live in Renton,
24 Washington. J.G. Decl., ¶2. In 2006, A.G. was diagnosed with autism by a licensed
25 psychologist and speech language pathologist, both at Seattle Children’s Hospital. *Id.*

26 ¶3. In 2007, A.G.’s pediatrician, Dr. MacPherson, referred A.G. to Valley Medical

1 Center's Children's Therapy Program ("Valley") for neurodevelopmental evaluation
2 and therapy. *Id.* ¶4. The evaluations by Valley's therapists recommended that A.G.
3 receive weekly occupational therapy and speech therapy. *Id.* ¶5.

4 **B. Identity of Defendants**

5 Premera Blue Cross is the nonprofit owner of Lifewise Health Plan of
6 Washington. Hamburger Decl., *Exh. B*. Both Premera Blue Cross and Lifewise Health
7 Plan of Washington are licensed health care service contractors in Washington state,
8 also known as "health carriers." *Id.*; see RCW 48.43.005 (23). A.G. is and has been
9 insured under an individual policy issued by Lifewise Health Plan of Washington since
10 at least January 1, 2006. J.G. Decl., ¶2; see Duffy Decl., (10/12/11) ¶2, *Exh. A*. Premera
11 and Lifewise are "alter egos." See *McKinnon v. Blue Cross-Blue Shield of Alabama*, 691 F.
12 Supp. 1314, 1319 (1988), *aff'd*, 874 F.2d 820 (1989). For the purpose of this Motion, both
13 are referred to as a single defendant, "Premera."

14 **C. A.G.'s Medical Condition Requires Treatment With**
15 **Neurodevelopmental Therapies**

16 The Washington Department of Health describes Autism and Autism
17 Spectrum Disorders (ASDs) as follows:

18 Autism spectrum disorders (ASD) are pervasive
19 developmental disorders characterized by impairments or
20 delays in social interaction, communication and language, as
21 well as by repetitive routines and behaviors. They are called
22 spectrum disorders because of the wide range and severity of
23 symptoms. Children diagnosed with ASD suffer from
24 problems with sensory integration, speech, and basic
25 functions like toilet training, getting dressed, eating meals,
26 brushing teeth, or sitting still during classes. Many medical
conditions can accompany autism spectrum disorders. These
include digestive problems, severe allergies, inability to
detoxify, very high rate of infection, and vision problems.
Some children with ASD display violent or self-harmful

1 behaviors. IQs in children with this disorder range from
2 superior to severely mentally retarded.

3 Hamburger Decl., *Exh. C*, p. 5. Treatment of individuals, particularly children, is
4 critical. As the United States Surgeon General notes:

5 Because autism is a severe, chronic developmental disorder,
6 which result in significant lifelong disability, the goal of
7 treatment is to promote the child's social and language
8 development and minimize behaviors that interfere with the
9 child's functioning and learning.

10 *Id. Exh. D* (excerpt from DHS, *Mental Health: A Report of the Surgeon General*, p. 163
11 (1999)).

12 ASD has no known cure. However, it can effectively be treated. In
13 particular, speech therapy and occupational therapy are often essential therapies to
14 improve functioning in children with autism. These therapies are so critical that
15 coverage of speech, occupational and physical therapies were among the top priorities
16 for the Department of Health's Autism Task Force. *Id., Exh. E*, p. 9.

17 **D. Premera Retroactively Denies Nearly \$24,000 In
18 Neurodevelopmental Therapy Bills**

19 A.G. received speech and occupational therapy from Valley Medical
20 Center's Children's Therapy Clinic since 2007. J.G. Decl., ¶¶4-5. Valley routinely
21 submitted the bills for A.G.'s speech and occupational therapy services to Premera,
22 which paid for the services, at least for the first twenty visits. *Id.*, ¶9. Premera always
23 paid for the services and never questioned their medical necessity. *Id.*

24 In late July, 2011, A.G.'s parents received an envelope with forms called
25 "Explanations of Benefits" (EOBs) from Premera. *Id.* ¶10, *Exh. A*. These documents
26 revealed that Premera had conducted a retrospective review of the
neurodevelopmental therapy provided to A.G. since January 1, 2010, and determined
that *all* of the therapy was incorrectly covered. *Id.* The EOBs stated "our medical staff

1 reviewed this claim and determined this service is not covered by your plan." *Id.* In
2 sum, Premera determined that nearly \$24,000 in neurodevelopmental therapies had
3 been improperly paid, and that A.G.'s parents -- not the insurance company -- were
4 financially responsible for all of the treatment. *Id.*

5 A.G.'s father called Premera to object to the determination and to request
6 an explanation. *Id.*, ¶¶12-14. On August 12, 2011, Premera sent J.G. a letter confirming
7 the decision. Premera maintained that there was no coverage for neurodevelopmental
8 therapies:

9 This letter is being issued to provide confirmation the
10 following listed of claims (*sic*) were processed incorrectly and
11 will be adjusted as Neurodevelopment[al] therapy is not a
12 covered benefit under the above listed policy.

13 *Id.*, ¶13, *Exh. B.* Premera included a copy of the relevant section of A.G.'s contract
14 which contained the exclusion:

15 **EXCLUSIONS**

16 This section of the contract lists those services, supplies or
17 drugs [that] are *not covered* under this plan.

18 ...

19 **Learning Disorders and Neurodevelopmental Therapy**

20 Services, therapy and supplies related to the treatment of
21 learning disorders, cognitive handicaps, dyslexia,
22 *developmental delay or neurodevelopmental disabilities.*

23 *Id.*, *Exh. B.*, Contract pp. 30-31 (emphasis added); *see also*, Duffy Decl., *Exh. A.*, pp. 30-31.
24 The August 12, 2011 letter did not provide any information about A.G.'s right to appeal
25 Premera's retroactive decision. *Id.* ¶14. The sections of the contract provided by
26 Premera did not include the sections related to A.G.'s appeal rights. *Id.*, *Exh. B.*
Premera's representative did not explain to J.G. that he could appeal Premera's
decision. *Id.*, ¶14.

1 **E. A.G. Needs Immediate Injunctive Relief So He Can Continue To**
2 **Receive Medically Necessary Neurodevelopmental Therapy**
3 **Services**

4 Since Premera retroactively denied coverage of A.G.'s therapy services,
5 A.G.'s parents have been forced to eliminate his speech therapy. *Id.*, ¶15. His parents
6 may be forced to reduce or eliminate his occupational therapy. *Id.*, ¶17. Valley
7 Medical Center has begun to bill A.G.'s parents for the amount retroactively denied by
8 Premera. *Id.*, ¶¶18; 20. Valley has sent collections notices and calls to A.G.'s parents. *Id.*
9 When A.G. received the therapy, his parents assumed it was covered by Premera. As a
10 result, they have not budgeted either for A.G.'s ongoing therapy nor any method of
11 paying for the unexpected \$24,000 therapy bill. *Id.*, ¶ 11, 21.

12 A.G. has suffered actual and substantial harm from the loss of his speech
13 therapy. *Id.*, ¶¶7, 15-16. He will suffer more if he also loses his occupational therapy.
14 *Id.*, ¶17. A.G. continues to have frequent choking and gagging episodes due to
15 difficulty he has manipulating food in his mouth. *Id.*, ¶7. He struggles with visual and
16 auditory comprehension, failing to comprehend basic, common visual cues necessary
17 to live safely in his home and community, such as street signs and written instructions.
18 *Id.*, ¶¶ 15-16. If A.G. loses his occupational therapy as well, he will likely further
19 regress, losing skills to support his fine motor control, necessary to write, tie his shoes
20 and button his pants, count money, prepare food, use tools and many other daily living
21 skills. *Id.* ¶17. The loss of these services will not only affect A.G.'s immediate health,
22 but could jeopardize his ability to live and work as independently as possible. *Id.*

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V. LAW AND ARGUMENT

A. **The Parity Act Requires Coverage of Medically Necessary Neurodevelopmental Therapies To Treat Covered DSM-IV Conditions**

The Parity Act requires that *all* health benefit plans issued by health carriers shall comply with its mandate:

All health service contracts providing health benefit plans that provide coverage for medical and surgical services shall provide:

(a) *...coverage for:*

(i) *Mental Health Services*

RCW 48.44.341 (2) (emphasis added). The term “mental health services” is defined as treatment necessary to treat mental disorders identified in the DSM-IV-TR (with four exceptions, which do not apply here):

“[M]ental health services” means 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*, published by the American psychiatric association, on July 24, 2005, or such subsequent date as may be provided by the insurance commissioner by rule, consistent with the purposes of chapter 6, Laws of 2005....

RCW 48.44.341(1) (emphasis added).⁴ The Parity Act allows health plans to determine whether particular mental health services are “medically necessary” so long as a “comparable requirement is applicable to medical and surgical services.” RCW 48.44.341(4).

⁴ The version of the DSM published on July 24, 2005 is the Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. Text Revision (DSM-IV-TR). There has been no update, and the Insurance Commissioner has not, by rule, adopted a different version of the DSM.

1 The Parity Act's two requirements - coverage and comparable treatment
2 limitations - are designed to end the historic discrimination by health insurers
3 experienced by persons with mental disorders. As the U.S. Surgeon General noted,

4 Stigmatization of people with mental disorders has persisted
5 through history....It deters the public from seeking, and
6 wanting to pay for care. In its most overt and egregious
7 form, stigma results in outright discrimination.

8 Hamburger Decl., *Exh. F*, Preface p. 6. Passage of the Parity Act was intended to wipe
9 out such discrimination. The Legislature intended that the Parity Act would require
10 insurance coverage to be provided to treat mental disorders in just the same way that
11 other physical conditions are covered:

12 The legislature finds that the potential benefits of improved
13 access to mental health services are significant. Additionally,
14 the legislature declares that it is not cost-effective to treat
15 persons with mental disorders differently than persons with
16 medical and surgical disorders.

17 *Therefore, the legislature intends to require that insurance
18 coverage be at parity for mental health services, which
19 means this coverage be delivered under the same terms and
20 conditions as medical and surgical services.*

21 *Id.*, *Exh. G*, pp. 1-2 (emphasis added). See also *id.*, *Exh. H*, p. 7 ("[T]hat physical and
22 mental illnesses should be treated the same in insurance coverage, as a matter of
23 fairness, has ethical appeal that goes beyond the sunset criteria.").

24 The Parity Act renders Premera's contractual exclusion of
25 neurodevelopmental therapies void. As plaintiff shows below, (1) both defendants,
26 Premera and Lifewise, are health care service contractors that issue health benefit plans
for the benefit of insured enrollees such as the plaintiff; (2) A.G.'s autism is a DSM-IV
mental condition, also covered by the Act; and (3) Neurodevelopmental therapies, such
as speech and occupational therapy provided to A.G., can be medically necessary

1 therapies to treat autism and other DSM-IV conditions. Indeed, Premera covered
2 A.G.'s therapies as medically necessary for many years. Under the Parity Act, Premera
3 cannot exclude coverage of medically necessary neurodevelopmental therapies.

4 **1. Premera and Lifewise are "Health Carriers" that issue**
5 **"Health Benefit Plans"**

6 Both Premera and Lifewise are licensed health care service contractors.
7 *Id.*, *Exh. B*; RCW 48.44.010(9). Health care service contractors are "health carriers."
8 RCW 48.43.005(23). As "health carriers," Premera and Lifewise issue "health plans" or
9 "health benefit plans." RCW 48.43.005(24) ("Health plan" or "health benefit plan"
10 means any policy, contract, or agreement offered by a health carrier to provide,
11 arrange, reimburse or pay for health care services ..."). Policies issued by Premera
12 and Lifewise must comply with the Parity Act.

13 **2. Autism and ASD are DSM-IV Conditions**

14 A.G. is diagnosed with Autism, a specific mental condition in the DSM-
15 IV. *Id.*, *Exh. I*, p. 1. See also *id.*, *Exh. C*, p. 9 ("Autism spectrum disorder is a disorder
16 included in the DSM."). As such, under the Parity Act, D.M. is entitled to coverage for
17 medically necessary treatment to address his mental disorder of autism.
18 RCW 48.44.341(2).

19 **3. Neurodevelopmental Therapies Can Be Medically**
20 **Necessary to Treat Autism**

21 Speech and occupational therapy are key forms of intervention when
22 treating autism. Indeed, the Department of Health's Caring for Washington
23 Individuals with Autism Task Force listed the need to improve insurance coverage of
24 neurodevelopmental therapies such as speech, occupational and physical therapies in
25 its top objective. *Hamburger Decl., Exh. E*, pp. 7-10.
26

1 Premera has already determined that A.G.'s neurodevelopmental
2 therapies are medically necessary. Premera covered A.G.'s therapies for years, finding
3 that the therapies met Premera's medical necessity standards. See J.G. Decl., ¶9.
4 Indeed, the only basis for Premera's retroactive determination that the services were
5 wrongly paid, was Premera's contract exclusion. *Id.*, *Exh. A, B.*

6 **B. Premera's Exclusion Of Neurodevelopmental Therapies Is Void And**
7 **Unenforceable**

8 **1. The Terms of a Health Plan Include State Mandates**

9 Premera is correct that the literal written terms of A.G.'s policy exclude
10 neurodevelopmental therapy services. See Premera Mot. to Dismiss, pp. 5-6; Duffy
11 Decl., *Exh. A*, pp. 30-31. Premera, however, ignores that the "terms of" a health plan
12 must include all statutorily mandated benefits, whether or not the health carrier
13 properly codifies those terms in the plan.

14 It is fundamental insurance law that the "terms of" insurance policies
15 include requirements or restrictions imposed by state law. Russ, Lee R., Segalla,
16 Thomas F., COUCH ON INSURANCE 3D, *Statutory law as part of contract*, § 19:1 (2011). In
17 the event of a conflict between the written words of a policy and the requirements of
18 state law, state law will supersede the literal written terms of the contract:

19 As a general rule, stipulations in a contract of insurance in
20 conflict with, or repugnant to, statutory provisions which are
21 applicable to the contract are invalid since contracts cannot
22 change existing statutory laws. *If the terms of an insurance*
23 *policy do not comport with the statutory requirements, the*
statutory requirements supersede the conflicting policy
provisions and become part of the insurance policy itself.

24 *Id.*, § 19:3 (footnotes omitted) (emphasis added). See also *Brown v. Snohomish County*
25 *Physicians Corp.*, 120 Wn.2d 747, 753, 845 P.2d 334 (1993). In *Brown*, the Washington
26 Supreme Court considered whether certain contract limitations in health insurance

1 contracts were enforceable, or void. The court concluded that "limitations in insurance
2 contracts which are contrary to public policy and statute will not be enforced." *Id.* In
3 that case, the health plans at issue were reformed, eliminating the contract limitation
4 that prevented full coverage to the insured. *Id.* at 759.

5 Courts in other jurisdictions, when faced with insurance policies that
6 violate mandatory coverage requirements, have read those requirements into the
7 policy. *Aetna Cas. & Sur. Co. v. McMichael*, 906 P.2d 92, 101 (Colo. 1995); *Wetzel v. Lou*
8 *Ehlers Cadillac Group Long Term Disability Ins. Program*, 222 F.3d 643, 648 n. 4 (9th Cir.
9 2000); *Plumb v. Fluid Pump Service, Inc.*, 124 F.3d 849, 861 (7th Cir. 1997) ("[E]xisting and
10 valid statutory provisions enter into and form a part of all contracts of insurance to
11 which they are applicable, and, together with settled judicial construction thereof,
12 become part of the contract as much as if they were actually incorporated therein").

13 Not only is the Parity Act incorporated as "terms of" the plan as a matter
14 of state law, it is expressly incorporated into A.G.'s policy as a matter of contract law.
15 Premera's contract with A.G. expressly incorporates state law:

16 PLEASE READ THIS CONTRACT CAREFULLY. *This* is a
17 *contract* between the subscriber and Lifewise Health Plan of
18 Washington and *shall be construed in accordance with the*
19 *laws of the State of Washington.*

20 Duffy Decl., *Exh. A*, Face Page (emphasis added). Here, as in the Group Health case,
21 "[t]he problem for Defendants lies in the fact that Washington law governs the Plan. ...
22 Washington law, specifically [the Mental Health Parity Act, RCW 48.44.341(2)],
23 requires Defendants to provide coverage for the mental health services at issue in this
24 case." *Z.D.*, 2011 WL 5299592, *3 (internal citations omitted).

1 **C. The Mental Health Parity Act Is In Complete Harmony With The**
2 **Neurodevelopmental Mandate**

3 The Parity Act is not limited by the separate Neurodevelopmental
4 Therapy Act, RCW 48.44.450. Indeed, the two Acts work hand-in-hand. Where
5 statutes overlap, “effect will be given to both to the extent possible” and “efforts will be
6 made to harmonize statutes.” *Walker v. Wenatchee Valley Truck and Auto Outlet, Inc.*, 155
7 Wn. App. 199, 208, 229 P.3d 871 (2010). When simultaneous compliance is possible
8 there simply is no statutory conflict—both statutes will be enforced as written:

9 Where two legislative enactments relate to the same subject
10 matter and are not actually in conflict, they should be
11 interpreted to give meaning and effect to both. Such
12 construction gives significance to both acts of the legislature.

13 *Davis v. King County*, 77 Wn.2d 930, 933, 468 P.2d 679 (1970); *see Z.D.*, *4, *citing to same*
14 *cases; Mortell v. State*, 118 Wn. App. 846, 849, 78 P.3d 197, 198 (2003) (“Statutes relating
15 to the same subject matter will be read as complimentary”).

16 In 1985, Washington passed a Neurodevelopmental Therapy Act which
17 required employer-sponsored group plans in Washington to provide some minimal
18 coverage of neurodevelopmental therapies to children under the age of seven. RCW
19 48.44.450. The statute did not address whether or how neurodevelopmental therapies
20 would be covered in individual policies, such as A.G.’s. *Id.* Premera (and the other
21 major health carriers) chose to provide the barest minimum, excluding
22 neurodevelopmental therapy coverage entirely in its individual market plans, and for
23 persons over the age of six in its group plans. *See e.g.* Duffy Decl., *Exh. A*, p. 31;
24 Hamburger Decl., *Exh. A*, p. 18.

25 After the Mental Health Parity Act took effect, health carriers were
26 required to re-consider their provision of neurodevelopmental therapies, in light of the
 minimum requirements mandated by the Parity Act. Thus, health carriers could no
 longer exclude medically necessary neurodevelopmental therapies for individuals with

1 DSM-IV conditions. In essence, the Parity Act raised the “floor” to expand coverage.

2 As Judge Lasnik explained:

3 Defendant can readily comply with both statutes simply by
4 comporting with the parity requirements of [RCW 48.44.341]
5 for all covered individuals, keeping in mind that RCW
6 48.44.450 confers a more specific and more onerous
7 requirement upon Defendants to provide
8 neurodevelopmental therapies for covered individuals age
9 six and under, without regard for parity.

10 *Z.D.*, 2011 WL 5299592, p. *4. This is not a close question. Denying Group Health’s
11 request that this issue be certified to the Washington Supreme Court, Judge Lasnik
12 determined:

13 ...[T]he Court sees no justification for certifying. As the
14 Court concluded in its previous Order, this is not a close
15 question. *Applying common and well-accepted principles of
16 statutory construction, the Court readily concluded that no
17 conflict exists between the Neurodevelopmental Therapy
18 Mandate, RCW 48.44.450, and the Mental Health Parity Act,
19 RCW 48.46.291.*

20 *Z.D. v. Group Health Cooperative*, No. 2:11-cv-01119-RSL, Dkt. No. 36, Order dated
21 12/20/11, Appendix B (emphasis added).

22 Premera does not get to choose which state mandate it wants to follow
23 while ignoring the other. It is required to follow both. Here, providing mental health
24 services required by the Parity Act does not in any way jeopardize Premera’s
25 compliance with the neurodevelopmental mandate. Nor does complying with the
26 neurodevelopmental mandate jeopardize compliance with the Parity Act. The statutes
are complimentary, and both can—and should—be enforced as written. *Z.D.*, 2011 WL
5299592, p. *4.

1 **D. A Preliminary Injunction Should Be Entered On behalf Of Plaintiff**
2 **A.G.**

3 An injunction is appropriate where a plaintiff does not have a plain,
4 complete, speedy and adequate remedy at law. *Kucera v. State, Dept. of Transp.*, 140 Wn.
5 2d 200, 209, 995 P.2d 63 (2000). If that is the case, the plaintiff must “demonstrate that
6 (1) he has a clear legal or equitable right, (2) he has a well-grounded fear of immediate
7 invasion of that right, and (3) that the acts he is complaining of have or will result in
8 actual and substantial injury.” *DeLong v. Parmelee*, 157 Wn. App. 119, 150-51, 236 P.3d
9 936, 951-52 (2010). Additionally, courts must consider a “balancing of the relative
10 interests of the parties, and if appropriate, the interests of the public.” *Kucera*, 140 Wn.
11 2d at 209. Here, all of the factors are met.

12 **1. A.G. Has No Speedy Adequate Remedy at Law**

13 Plaintiff has claims for legal relief arising out of Premera’s wrongful
14 denial of coverage. Those claims include reimbursement for treatment that Plaintiff
15 and proposed class members have paid out-of-pocket. Legal relief, however, is far
16 from adequate. Plaintiff A.G. requires immediate access to treatment because his
17 family cannot front the cost of treatment and wait for monetary relief, especially while
18 paying off the nearly \$24,000 in payments that Premera wrongfully claims A.G.’s
19 parents owe for his past therapies. Without injunctive relief, A.G. will be forced to
20 forgo necessary treatment. A.G.’s threatened loss of health care during the pendency
21 of this litigation is not surprising. This precise problem was identified by the
22 Department of Health:

23 Many children with ASD go without necessary treatments
24 and services because the costs are so high and insurance
25 coverage is not generally available. Many families simply
26 cannot afford to pay for the necessary early, intensive
treatments.

1 Hamburger Decl., *Exh. C*, p. 10. Here, A.G.'s parents simply cannot afford to continue
2 to pay for neurodevelopmental therapies *and* pay off the unexpected \$24,000 in past
3 therapy that Premera claims they owe. J.G. Decl., ¶¶15; 17; 21. They cannot wait until
4 the conclusion of this litigation for Premera to reimburse them for the cost of A.G.'s
5 medically necessary therapy.

6 **2. Clear Legal Right**

7 As demonstrated above, Plaintiff A.G. (as well as the proposed class) has
8 a clear legal right to medically necessary neurodevelopmental therapies to treat their
9 DSM-IV conditions. *See* Sections V. A, B, C *above*.

10 **3. Premera's Actions Invade Plaintiff A.G.'s Legal rights**

11 Premera's retroactive and ongoing denial of A.G.'s medically necessary
12 neurodevelopmental therapies based upon Premera's void and unenforceable contract
13 exclusion is an invasion of A.G.'s legal rights.

14 **4. Actual and Substantial Injury/Irreparable Harm**

15 The loss of coverage for medically necessary medical benefits is actual
16 and substantial injury. The Washington Supreme Court recognizes that evidence that
17 plaintiffs' health insurance coverage may be "depleted or cancelled" is evidence of
18 "actual or substantial injury" necessary for a preliminary injunction. *Washington Fed'n*
19 *of State Employees (WSFE), Council 28, AFL-CIO v. State*, 99 Wn. 2d 878, 891, 665 P.2d
20 1337 (1983) (It is "well nigh irrefutable" that a cancellation of health insurance is an
21 injury that has no remedy at law). That is because the loss of health coverage directly
22 impacts an individual's health, causing "(1) substantial risk to plaintiffs' health;
23 (2) severe financial hardship; (3) the inability to purchase life's necessities; and
24 (4) anxiety associated with uncertainty." *LaForest v. Former Clean Air Holding Co., Inc.*,

1 376 F.3d 48, 55 (2d Cir. 2004) (affirming the issuance of a preliminary injunction
2 regarding medical benefits).

3 Premera's retroactive decision to deny nearly \$24,000 of A.G.'s
4 neurodevelopmental therapy provided during the past two years and to deny all
5 ongoing therapy has caused A.G. actual and substantial harm. A.G. has halted his
6 ongoing speech therapy because of the financial burden imposed by Premera's sudden
7 denials. As a result, A.G. continues to struggle with frequent gagging and choking
8 episodes, as well as visual and auditory comprehension problems, including problems
9 with understanding street signs and written instructions. J.G. Decl., ¶¶15-16.

10 Without injunctive relief, A.G.'s parents may also be forced to stop
11 providing him with occupational therapy. The loss of occupational therapy would
12 significantly impact A.G.'s development, his ability to live independently and to
13 become employed. He would likely regress losing the progress he has made with fine
14 motor control, impacting his ability to write, tie his shoes, button his pants, count
15 money, prepare food, use tools and other daily living skills. *Id.*, ¶¶17; 21.

16 Given that Premera has already determined that A.G.'s speech and
17 occupational therapies are medically necessary for A.G. (by paying for it since 2007,
18 *id.*, ¶9), the sudden loss of the therapies is irreparable harm.

19 **5. Balancing of the Hardships and the Interests of Third**
20 **Persons and the Public**

21 Balancing of the hardships tips decidedly in A.G.'s favor. The loss of
22 medically necessary therapies needed to maintain and improve a disabled child's
23 functioning at a critical time in his development causes a tremendous hardship. A.G.
24 has suffered regression and will continue to experience actual and substantial injury
25 without injunctive relief.

1 In contrast, Premera suffers no hardship. This lawsuit seeks to enforce
2 statutory policy against a non-compliant regulated health carrier. Premera should not
3 be heard to complain when it is simply required to follow statutory directives.
4 Moreover, covering medically necessary neurodevelopmental therapies now will likely
5 result in substantial savings to Premera and the general public in the long-term.
6 Hamburger Decl., *Exh. G*, pp. 1-2 (“[T]he legislature declares that it is not cost-effective
7 to treat persons with mental disorders differently than persons with medical and
8 surgical disorders.”). The legislature has already made the common sense policy
9 decision that insurance parity brings long-term savings, and is worth any short-term
10 costs.

11 The public benefits from the treatment of children with
12 medical conditions. Although the cost of providing care to
13 autistic children appears daunting, the potential that such
14 care will have to be continued throughout adulthood poses a
potentially larger economic burden.

15 *Parents League for Effective Autism Services v. Jones-Kelley*, 565 F. Supp. 2d 905, 918 (S.D.
16 Ohio 2008) *aff’d sub nom.*, 339 F. App’x. 542 (6th Cir. 2009). The balancing of the
17 hardships also justifies immediate injunctive relief.

18 **E. No Bond Is Required**

19 As Plaintiff’s health is at stake, no bond should be required. RCW
20 7.40.080 (“The court in its sound discretion may waive the required bond in situations
21 in which a person’s health or life would be jeopardized”).

22 **VI. CONCLUSION**

23 The “terms of” Premera’s non-ERISA health benefit plans include the
24 requirements of the Parity Act. Premera, however, systematically excludes medically
25 necessary neurodevelopmental mental health services for its insureds who have DSM-
26 IV-TR diagnoses covered by the Parity Act. Just as Judge Lasnik ruled in the case

1 adjudicated against Group Health, Premera's neurodevelopmental therapy exclusions
2 are void and unenforceable.

3 Plaintiff A.G. will suffer actual and substantial harm if he is required to
4 wait until the conclusion of this litigation to obtain relief from Premera's contractual
5 exclusion of neurodevelopmental therapies. A.G. has already lost access to his
6 medically necessary speech therapy and is at risk of losing access to his ongoing
7 occupational therapy. The Court should enjoin Premera from applying its
8 neurodevelopmental exclusion to Plaintiff A.G.'s claims for coverage.

9 DATED: January 13, 2012.

10 SIRIANNI YOUTZ SPOONEMORE

11 /s/ Eleanor Hamburger

12 Eleanor Hamburger (WSBA #26478)

13 Richard E. Spoonemore (WSBA #21833)

14 Attorneys for Plaintiff

Appendix A

2011 WL 5299592
Only the Westlaw citation is currently available.
United States District Court, W.D. Washington,
at Seattle.

Z.D., by and through her parents and guardians, J.D. and T.D., individually, on behalf of the Technology Access Foundation Health Benefit Plan, and on behalf of similarly situated individuals, Plaintiffs,

v.

GROUP HEALTH COOPERATIVE; Group Health Options, Inc.; and the Technology Access Foundation Health Benefit Plan, Defendants.

No. C11-1119RSL. | Nov. 4, 2011.

Synopsis

Background: Beneficiary of Employee Retirement Income Security Act (ERISA) plan brought class action against plan defendants, challenging their denial of coverage for mental health services. Defendants filed motion to dismiss.

Holdings: The District Court, Robert S. Lasnik, J., held that:

1 no irreconcilable conflict existed between Washington's minimum mandatory level of coverage for neurodevelopmental therapies for covered individuals age six and under and provision of Washington's Mental Health Parity Act raising the minimum standard by further requiring that mental health coverage "be delivered under the same terms and conditions as medical and surgical services," and

2 provision requiring that mental health coverage "be delivered under the same terms and conditions as medical and surgical services" was not preempted by ERISA.

Motion denied.

Attorneys and Law Firms

Richard E. Spoonemore, Eleanor Hamburger, Sirianni Youtz Spoonemore, Seattle, WA, for Plaintiffs.

Charles S. Wright, Nigel P. Avilez, Davis Wright Tremaine (SEA), Seattle, WA, for Defendants.

Opinion

ORDER DENYING DEFENDANTS' 12(b)(6) MOTION TO DISMISS

ROBERT S. LASNIK, District Judge.

*1 This matter comes before the Court on "Defendants' Motion to Dismiss" (Dkt.# 7). Defendants contend that dismissal with prejudice is warranted because (1) Plaintiffs failed to exhaust their internal appeal rights; (2) Group Health's denial of benefits was consistent with the language of the Plan; (3) Plaintiffs do not allege and cannot establish that Group Health acted in a fiduciary capacity or that the Plan was harmed; (4) Plaintiffs are not entitled to equitable relief; and (5) ERISA preempts any claim based on the Washington Mental Health Parity Act. For the reasons set forth below, the Court DENIES Defendants' motion.

BACKGROUND

In the context of a motion to dismiss, the Court's review is generally limited to the contents of the complaint. *Campanelli v. Bockrath*, 100 F.3d 1476, 1479 (9th Cir.1996). It may also extend, however, to include evidence on which the "complaint 'necessarily relies,' if: (1) the complaint refers to the document; (2) the document is central to the plaintiff's claim; and (3) no party questions the authenticity of the copy attached to the 12(b) (6) motion." *Daniels-Hall v. Nat' Educ. Ass'n*, 629 F.3d 992, 998 (9th Cir.2010) (citations and internal quotation marks omitted).

Thus, for purposes of this motion, the Court considers only the allegations contained within the "Amended Complaint" (Dkt.# 3), which the Court accepts as true and construes in the light most favorable to Plaintiffs. *Daniels-Hall*, 629 F.3d at 998. The Court also relies on the Plan Agreement itself, which Defendants attach to their Motion, Carroll Declaration (Dkt.# 8) at 5-55 (Exhibit A, Group Health Medical Coverage Agreement). The Court does not consider those factual allegations asserted only in the parties' memoranda.

THE ALLEGATIONS

Plaintiffs filed suit against Defendants in federal court on July 6, 2011. Complaint (Dkt.# 1). On July 12, prior to the filing of any responsive documents, Plaintiffs filed their "Amended Complaint" (Dkt.# 3). As is relevant to the disposition of this Motion, Plaintiffs allege the following:

Plaintiff Z.D. is the ten-year old daughter and dependant of J.D. and T.D. She is a beneficiary of "The Technology Access Foundation Health Benefit Plan," an ERISA "employee welfare benefit plan," 29 U.S.C. § 1002(1), underwritten and administered by Group Health Options, Inc.—a wholly owned subsidiary of Group Health Cooperative. Amended Complaint (Dkt.# 3) at ¶¶ 1-5. Z.D. and the proposed class of Plaintiffs are beneficiaries of health plans "delivered, issued for delivery, or renewed on or after January 1, 2006." *Id.* at ¶ 15.

Z.D. has been diagnosed with one or more of the conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, 4th Ed. Text Revision ("DSMIV-TR"). *Id.* at ¶¶ 11, 17. On or after January 1, 2006, she sought coverage from Defendants for the treatment of her mental disorders, but Defendants denied her requests and refused to reimburse her for or authorize treatment. *Id.* at ¶¶ 17, 23, 25. Z.D. unsuccessfully attempted to appeal these denials through the internal administrative processes set forth in the Plan. *Id.* at ¶ 27.

*2 Notably, the Plan *does not* explicitly require Defendant to cover the treatment for which Z.D. has submitted her requests. Rather, the Plan states only:

2. Neurodevelopmental Therapies for Children Age Six (6) and Under. Physical therapy, occupational therapy and speech therapy services for the restoration and improvement of function for neurodevelopmentally disabled children age six (6) and under shall be covered. Coverage includes maintenance of a covered Member in cases where significant deterioration in the Member's condition would result without the services.

Carroll Declaration (Dkt.# 8) at 37 (Exhibit A, Group Health Medical Coverage Agreement). Nevertheless, Plaintiffs contend that Washington's Mental Health Parity Act, specifically those provisions codified at RCW 48.46.291, supplements the literal terms of the Plan and precludes Defendants from denying Z.D.'s claims for coverage. Amended Complaint (Dkt.# 3) at ¶¶ 8-14, 18.

Accordingly, Plaintiffs allege that Defendants have applied "policies and practices that result in the exclusion and improper limitation of certain services to treat conditions listed in the DSM-IV-TR" and "have acted on grounds generally applicable to a broad group of individuals" situated similarly to Z.D. *Id.* at ¶ 20. They seek to recover the "benefits due them due to [Defendants'] improper exclusion and/or limitations of behavioral and neurodevelopmental therapy." *Id.* at 36-38 (relying on 29 U.S.C. § 1132(a)(1)(B)). They seek the recovery of all losses to the Plan for Defendants' alleged failure "to act in accordance with the documents and instruments governing the Plan." *Id.* at ¶¶ 28-35 (relying on 29 U.S.C. § 1132(a)(2) ("breach of fiduciary duty")). And they ask the Court to enjoin Defendants from continuing to process and pay claims in a manner inconsistent with RCW 48.46.291 and grant any other equitable relief the Court deems appropriate. Amended Complaint (Dkt.# 3) at 39-41 (relying on 29 U.S.C. § 1132(a)(3)).

DISCUSSION

To reiterate, Defendants contend that dismissal with prejudice is warranted because (1) Plaintiffs failed to exhaust their internal appeal rights; (2) Group Health's denial of benefits was consistent with the language of the Plan; (3) Plaintiffs do not allege and cannot establish that Group Health acted in a fiduciary capacity or that the Plan was harmed; (4) Plaintiffs are not entitled to equitable relief; and (5) ERISA preempts any claim based on the Washington Mental Health Parity Act. The Court considers each of these contentions in turn.

A. Exhaustion of Administrative Remedies

Defendants first assert that dismissal is warranted because Plaintiffs failed to exhaust their internal appeal rights. The Court agrees that controlling case law requires that a plaintiff first "avail himself or herself of a plan's own internal review procedure before bringing suit in federal court." *Vaught v. Scottsdale Healthcare Corp. Health Plan*, 546 F.3d 620, 626 (9th Cir.2008). That said, "the usual practice under the Federal Rules is to regard exhaustion as an affirmative defense," not a pleading requirement. *Jones v. Bock*, 549 U.S. 199, 211, 127 S.Ct. 910, 166 L.Ed.2d 798 (2007). The Court therefore finds no basis for Defendants' first contention.¹

B. Denial of Benefits & ERISA Preemption

Defendants next contend that they acted in conformity with the terms of the Plan when they denied Plaintiffs' claims for mental health treatment. Alternatively, Defendants assert that even if RCW 48.46.291 might otherwise require coverage, ERISA preempts the statute's application.

It is true that the literal terms of the Plan, as written, do not require coverage for the mental health treatment of individuals over the age of six. Carroll Declaration (Dkt.# 8) at 37 (Exhibit A, Group Health Medical Coverage Agreement). The problem for Defendants lies in the fact that Washington law governs the Plan. *Id.* at 8, ¶ 8 ("The Group and the GHO shall comply with all applicable state and federal laws and regulations in performance of this Agreement. This Agreement is entered into and governed by the laws of the state of Washington, except as otherwise pre-empted by ERISA and other federal laws."). And, as alleged by Plaintiffs, Washington law, specifically RCW 48.46.291(2),² requires Defendants to provide coverage for the mental health services at issue in this case. See *FMC Corp. v. Holliday*, 498 U.S. 52, 61, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990) ("The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer."). That section provides:

(2) All health benefit plans offered by health maintenance organizations

(a) that provide coverage for medical and surgical services shall provide: (a) For all group health benefit plans for groups other than small groups, as defined in RCW 48.43.005 delivered, issued for delivery, or renewed on or after January 1, 2006, coverage for:

(i) Mental health services. The copayment or coinsurance for mental health services may be no more than the copayment or coinsurance for medical and surgical services otherwise provided under the health benefit plan. Wellness and preventive services that are provided or reimbursed at a lesser copayment, coinsurance, or other cost sharing than other medical and surgical services are excluded from this comparison; and

(ii) Prescription drugs intended to treat any of the disorders covered in subsection (1) of this section to the same extent, and under the same terms and conditions, as other prescription drugs covered by the health benefit plan.

RCW 48.46.291(2) (emphasis added).

To avoid the implications of RCW 48.46.291's mandate, Defendants argue that its provisions conflict with Washington's previously enacted Neurodevelopmental Therapy Mandate, which provides in part:

Each employer-sponsored group contract for comprehensive health care service which is entered into, or renewed, on or after twelve months after July 23, 1989, shall include coverage for neurodevelopmental therapies for covered individuals age six and under.

RCW 48.44.450(1). They contend that RCW 48.44.450 limits the benefits available to individuals in need of neurodevelopmental therapies, and that this limit controls over the more general mandate of RCW 48.46.291. The Court disagrees.

*4 2 3 “The purpose of statutory construction is to give effect to the meaning of legislation.” *Walker v. Wenatchee Valley Truck & Auto Outlet, Inc.*, 155 Wash.App. 199, 208, 229 P.3d 871 (2010). And the mere fact that the statutes overlap does not mean that both cannot apply. *Id.* Rather, “[i]n the case of multiple statutes or provisions governing the same subject matter, effect will be given to both to the extent possible.” *Id.* Efforts must be made to harmonize overlapping statutes. *Id.*; *accord Davis v. King County*, 77 Wash.2d 930, 933, 468 P.2d 679 (1970) (“Where two legislative enactments relate to the same subject matter and are not actually in conflict, they should be interpreted to give meaning and effect to both. Such construction gives significance to both acts of the legislature.”). “Only when two statutes dealing with the same subject matter “conflict to the extent that they cannot be harmonized” will a more specific statute supersede a general statute. *Walker*, 155 Wash. at 208, 283 P. 709.

4 The Court finds no irreconcilable conflict between RCW 48.44.450 and RCW 48.46.291. By its plain terms, RCW 48.44.450 evidences legislative intent to establish a minimum mandatory level of “coverage for neurodevelopmental therapies for covered individuals age six and under.” Equally plain, however, is that RCW 48.44.450 does not preclude providers from extending that same coverage to individuals older than six. The statute establishes a floor, not a ceiling.

When it enacted RCW 48.46.291, Washington raised the minimum standard by further requiring that mental health coverage “be delivered under the same terms and conditions as medical and surgical services.” H.B. 1154, 59th Leg., Reg. Sess., ¶ 1 (Wash.2005). This new burden does not conflict with RCW 48.44.450. Cf. *UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358, 377, 119 S.Ct. 1380, 143 L.Ed.2d 462 (1999) (“By allowing a longer period to file than the minimum filing terms mandated by federal law, the [state law] notice-prejudice rule complements rather than contradicts ERISA and the regulations.”). Defendant can readily comply with both statutes simply by comports with the parity requirements of RCW 48.46.291 for all covered individuals, keeping in mind that RCW 48.44.450 confers a more specific and more onerous requirement upon Defendants to provide “neurodevelopmental therapies for covered individuals age six and under” without regard for parity. This “construction gives significance to both acts of the legislature.” *Davis*, 77 Wash.2d at 933, 468 P.2d 679.

5 Having determined that RCW 48.44.450 does not negate the mandate of RCW 48.46.291, the Court next considers Defendants’ contention that ERISA preempts RCW 48.46.291’s effect. Defendant has not convinced the Court that it does. Normally, “ERISA preempts ‘any and all state laws insofar as they relate to any [covered] employee benefit plan.’” *Standard Ins. Co. v. Morrison*, 584 F.3d 837, 841 (9th Cir.2009) (alteration in original) (quoting 29 U.S.C. § 1144(a)). However, “the so-called savings clause saves from preemption ‘any law of any state which regulates insurance, banking, or securities.’” *Id.* (emphasis added) (quoting 29 U.S.C. § 1144(b)(2)(A)).

*5 6 To fall within this savings clause, the state law must satisfy the two-part test set out by the Supreme Court in *Kentucky Ass’n of Health Plans, Inc. v. Miller*, 538 U.S. 329, 342, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003). *Standard Ins.*, 584 F.3d at 842. “First, the state law must be specifically directed toward entities engaged in insurance.” *Ky. Ass’n*, 538 U.S. at 342. Second, “the state law must substantially affect the risk pooling arrangement between the insurer and the insured.” *Id.* RCW 48.46.291 readily satisfies both elements. Cf. *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 758, 105 S.Ct. 2380, 85 L.Ed.2d 728 (“We hold that Massachusetts’ mandated-benefit law is a ‘law which regulates insurance’ and so is not pre-empted by ERISA as it applies to insurance contracts purchased for plans subject to ERISA.”).

As Plaintiffs argue, the statute is directed at “health benefit plans,” which are, by definition, underwritten by an “insurer.” RCW 48.43.005(23), (24). In addition, the statute acts to “control the actual terms of insurance policies.” *Ky. Ass’n*, 538 U.S. at 337. Thus, the statute is clearly directed toward entities engaged in insurance. *Standard Ins.*, 584 F.3d at 842 (“It is well-established that a law which regulates what terms insurance companies can place in their policies regulates insurance companies.”).

The Court is also presently convinced that RCW 48.46.291 affects the risk pooling arrangement between the insurer and the insured. As discussed at length in *Standard Ins.*, this second requirement was intended predominately to ensure that only those state regulations “targeted at insurance practices, not merely at insurance companies” escaped preemption. *Id.* at 844;

see *id.* at 844–45. And, as *Metropolitan Life* makes clear, a state law mandating mental health care services “obviously regulates the spreading of risk”; it reflects “legislative judgment that the risk of mental-health care should be shared.” 471 U.S. at 758.

In sum, the Court concludes that RCW 48.46.291 controls. It is neither negated by RCW 48.44.450 nor preempted by ERISA. Moreover, the Court finds that Plaintiffs have plead adequate facts to set forth the required “short and plain statement.” They allege sufficient facts to establish for present purposes that they fall within the statutory definition of those entitled to coverage. Compare RCW 48.46.291(1) (defining “mental health services”), with Amended Complaint at ¶ 23–24 (alleging that Plaintiffs have been diagnosed with mental conditions covered under the statutory definition). And Plaintiffs further allege that they have been denied benefits by Defendants despite that statutory entitlement. *E.g.*, Amended Complaint at ¶ 25–27. These factual allegations are sufficient. *Ashcroft v. Iqbal*, 556 U.S. 662, 129 S.Ct. 1937, 1949, 173 L.Ed.2d 868 (2009) (“A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged.”). The Court concludes that Defendants’ second and fifth contentions are without merit.

C. Fiduciary Capacity

*6 The Court next considers Defendants’ claim that Plaintiffs have not stated a claim for breach of fiduciary duty. Defendants argue two points. First, relying on their previously discussed contention that RCW 48.46.291 does not affect the terms of the plan, Defendants assert that they exercised no fiduciary discretion in denying Plaintiffs’ benefits. Motion (Dkt.# 7) at 21. Second, Defendants argue that Plaintiffs allege only harm to the beneficiaries and not harm to the Plan. They contend that this failure precludes Plaintiffs from obtaining relief under any ERISA provision other than § 1132(a)(1)(B).

7 The Court readily dispatches with Defendants’ first assertion. As discussed, the terms of the Plan require that Defendants “comply” with Washington law in *the performance of the parties’ Plan Agreement*. Carroll Declaration (Dkt.# 8) at 8, ¶ 8 (Exhibit A, Group Health Medical Coverage Agreement). Accordingly, Defendants were required to comply with RCW 48.46.291 “in the performance” of fulfilling their fiduciary function of making benefit determinations. Compare *id.*, with *Aetna Health Inc. v. Davila*, 542 U.S. 200, 218–19, 124 S.Ct. 2488, 159 L.Ed.2d 312 (2004) (“A benefit determination under ERISA ... is generally a fiduciary act.” It “is part and parcel of the ordinary fiduciary responsibilities connected to the administration of a plan.”); see also 29 U.S.C. § 1104(a) (1)(D) (conferring a fiduciary duty on plan administrators to discharge his duties “in accordance with the documents and instruments governing the plan” (emphasis added)); 29 C.F.R. § 2509.75–8 (1995) (“[A] plan employee who has the final authority to authorize or disallow benefit payments in cases where a dispute exists as to the interpretation of plan provisions ... would be a fiduciary within the meaning of section 3(21)(A) of the Act.”).

8 Defendants’ second contention is equally unconvincing. Even assuming that it would be appropriate to dismiss a redundant § 1132(a)(3) claim at this stage in the litigation,³ Plaintiffs allege a claim broader than that which could be remedied under § 1132(a)(1)(B). As stated in paragraph 13 of the Amended Complaint, Plaintiffs allege that “GHC is systematically and uniformly failing to properly process claims and administer the Plans it insures.” Plaintiffs seek relief compelling Defendants to restore *to the Plan* all losses arising from its breach. Amended Complaint (Dkt.# 3) at ¶ 40–41. And Plaintiffs seek both injunctive relief enjoining Defendants from continuing to manage its insured Plans in contravention of RCW 48.46.291 as well as appropriate equitable relief. Amended Complaint at ¶ 40–41. These allegations and claims satisfy the threshold plain-statement pleading requirement necessary to bring a cause of action under § 1132(a)(2) and (a)(3). *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985) (noting that a § 1132(a)(2) claim can be brought only “to make good to [a] plan any losses to the plan ... and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan....”); *Hill v. Blue Cross & Blue Shield of Mich.*, 409 F.3d 710, 711 (6th Cir.2005) (noting that a “fiduciary-duty claim based on allegations of systemic, plan-wide claims-administration problems” is distinct from a personal claim for the reimbursement of benefits under § 1132(a)(1)(B) because “[o]nly injunctive relief of the type available under § 1132(a)(3) will provide the complete relief sought by Plaintiffs by requiring [Defendant] to alter the manner in which it administers all the Program’s claims”).

D. Equitable Relief

*7 Finally, the Court considers Defendant’s claim that equitable and injunctive relief are unavailable to Plaintiff because (1)

Defendants were not acting in a fiduciary capacity, (2) § 1132(a)(1)(B) is adequate to remedy any injuries Plaintiffs suffered, and (3) money damages “are not an available remedy under ERISA’s equitable safety net,” § 1132(a)(3). Motion (Dkt.# 7) at 23–24. The Court’s prior discussion resolves Defendants’ first two contentions.

9 The third contention is directly disposed of by *CIGNA Corp. v. Amara*, — U.S. —, —, 131 S.Ct. 1866, 1880, 179 L.Ed.2d 843 (2011), controlling authority that Defendants apparently failed to take note of prior to Plaintiffs’ Response (Dkt.# 13). In *CIGNA*, the Supreme Court concluded that courts may award “monetary ‘compensation’ [pursuant to § 1132(a)(3)] for a loss resulting from a trustee’s breach of duty, or to prevent the trustee’s unjust enrichment.” *Id.* To the extent Defendants attempt to re-characterize their argument in their Reply as stating that monetary relief under § 1132(a)(3) is unavailable because § 1132(a)(1)(B) provides an adequate remedy, that argument is redundant and, as previously explained, unpersuasive.

CONCLUSION

Pursuant to the terms of the Plan itself, Defendants were obligated to comply with RCW 48.46.291 in their performance of the Agreement. Accordingly, Plaintiffs have sufficiently plead a short and plain statement that, if proven, would demonstrate Defendants’ liability to Z.D. under § 1132(a)(1)(B) and Defendants’ liability to the Plan under § 1132(a)(2). Moreover, because Plaintiffs allege that Defendants’ failure is systemic, equitable relief may be available under § 1132(a)(3).

For all of the foregoing reasons, Defendants’ Motion is DENIED.

- 1 The Court also notes that Plaintiffs allege at paragraph 27 of the Amended Complaint that “Z.D. has tried to pursue her internal administrative remedies at GHC, to no avail.”
- 2 The Court turns to RCW 48.46.291(2) given Plaintiffs’ definition of the purported class in paragraph 15 of the Amended Complaint.
- 3 *Contra In re Farmers Ins. Exch. Claims Representatives’ Overtime Pay Litig.*, 2005 WL 1972565, at * 3 (D.Or. Aug.15, 2005) (“Defendants respond that plaintiffs are not entitled to relief under § 1132(a)(3) because alternative remedies exist. According to defendants, these remedies include ... recovery of allegedly lost plan benefits (§ 1132(a)(1)(B)). While other remedies ultimately may exist and be appropriate, the pleading stage is not the proper stage at which to make that determination.”).

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Appendix B

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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

Z.D., by and through her parents and guardians, J.D. and T.D., individually, on behalf of THE TECHNOLOGY ACCESS FOUNDATION HEALTH BENEFIT PLAN, and on behalf of similarly situated individuals,

Plaintiffs,

v.

GROUP HEALTH COOPERATIVE, *et al.*,

Defendants.

No. C11-1119RSL

ORDER DENYING
DEFENDANTS'
MOTION TO CERTIFY

This matter comes before the Court on Defendants' "Motion to Certify Washington State Law Question to the Supreme Court of Washington" (Dkt. # 31).

Defendants disagree with the Court's conclusion that RCW 48.46.291 does not conflict with Washington's previously enacted Neurodevelopmental Therapy Mandate, RCW 48.44.450. They would like the Washington Supreme Court to rule on whether Defendant can "readily comply with both statutes simply by comports with the parity requirements of RCW 48.46.291 for all covered individuals, keeping in mind that RCW 48.44.450 confers a more specific and more onerous requirement upon Defendants to provide 'neurodevelopmental therapies for covered individuals age six and under' without regard for parity." Order (Dkt. # 30) at 8-9. The Court DENIES the motion.

ORDER DENYING DEFENDANTS' MOTION TO CERTIFY - 1

1 The Court described the background facts underlying this matter in the Court's
2 prior Order (Dkt. # 30). It will not repeat those facts here.

3 As Defendants contend, the Court has discretion to certify controlling issues of
4 state law that are either novel or unsettled to the Washington Supreme Court. RCW
5 2.60.020; Parents Involved in Cmty. Sch. v. Seattle Sch. Dist. No. 1, 294 F.3d 1085,
6 1086–87 (9th Cir. 2002). Certification is particularly appropriate when the question
7 may have far-reaching effect or carries important public policy ramifications. Kremen
8 v. Cohen, 325 F.3d 1035, 1037 (9th Cir. 2003) (“The certification procedure is reserved
9 for state law questions that present significant issues, including those with important
10 public policy ramifications, and that have not yet been resolved by the state courts.”).

11 Notably, however, courts look with disfavor upon requests that come only after a
12 federal court has ruled against the movant. “There is a presumption against certifying a
13 question to a state supreme court after the federal district court has issued a decision.”
14 Thompson v. Paul, 547 F.3d 1055, 1065 (9th Cir. 2008). “A party should not be
15 allowed ‘a second chance at victory’ through certification . . . after an adverse district
16 court ruling.” Id.; accord In re Complaint of McLinn, 744 F.2d 677, 681 (9th Cir. 1984)
17 (“Ordinarily such a movant should not be allowed a second chance at victory when, as
18 here, the district court employed a reasonable interpretation of state law.”); Cantwell v.
19 Univ. of Mass., 551 F.2d 879, 880 (1st Cir. 1977) (“We do not look favorably, either on
20 trying to take two bites at the cherry by applying to the state court after failing to
21 persuade the federal court, or on duplicating judicial effort.”); In re Mortg. Elec.
22 Registration Sys. (MERS) Litig., No. 09–2119–JAT, 2011 WL 4571663, *1 (D. Ariz.
23 October 3, 2011) (“[F]ederal courts disapprove of a party’s request to certify an issue
24 that has already been adversely decided against it . . .”).

25 Arguably, the Court could hang its hat on this presumption alone. Thompson,
26 547 F.3d at 1065. The Court notes though that, even ignoring this “strong
presumption,” the Court sees no justification for certifying. As the Court concluded in

1 its previous Order (Dkt. # 30), this is not a close question. Applying common and well-
2 accepted principles of statutory construction, the Court readily concluded that no
3 conflict exists between the Neurodevelopmental Therapy Mandate, RCW 48.44.450,
4 and the Mental Health Parity Act, RCW 48.46.291. Id. at 8–9. The fact that the
5 Washington legislature is apparently considering expanding the Neurodevelopmental
6 Therapy Mandate to require coverage up to the age of 18, Mot. (Dkt. # 31) at 8, has no
7 bearing on whether the legislature intended to require parity coverage under RCW
8 48.46.291—the statute in question. To the contrary, it merely suggests that Washington
9 is considering raising the floor of required coverage even higher.

10 Accordingly, Defendants’ Motion is DENIED.

11 DATED this 19th day of December, 2011.

12
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14 Robert S. Lasnik
15 Robert S. Lasnik
16 United States District Judge
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26 ORDER DENYING DEFENDANTS’ MOTION TO CERTIFY - 3

EXHIBIT 7

HON. MICHAEL J. TRICKEY
Noted for Hearing: March 2, 2012 at 10:00 a.m.
With Oral Argument

IN THE SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and
K.G., on his own behalf and on behalf of all
similarly situated individuals,

Plaintiff,

v.

PREMERA BLUE CROSS and LIFEWISE OF
WASHINGTON, Washington corporations,

Defendants.

NO. 11-2-30233-4 SEA

DECLARATION OF J G

REDACTED

I, J G , declare under penalty of perjury and in accordance with
the laws of the State of Washington that:

1. I am the father of A G the named plaintiff in this
litigation.

2. A is thirteen years old. He lives with my wife, K and
me, as well as my other son J My family, including A , are all covered
under an individual policy that my wife and I purchased in 2004 from Lifewise Health
Plan of Washington ("Lifewise").

3. In October 2006, A received a joint evaluation by licensed
clinical psychologist, Corola F. Meyer, PhD and speech language pathologist, Shanna
Alvarez-Francois at Children's Hospital, Seattle, WA. At that time, he was diagnosed
with autism and mixed expressive-receptive language disorder.

DECLARATION OF J G - 1

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

1 4. In 2007, Dr. MacPherson, A s pediatrician, recommended that
2 A be assessed at the Valley Medical Center Children's Therapy Clinic to determine
3 if he would benefit from neurodevelopmental therapies.

4 5. A was then evaluated by speech therapist, Laura Keever and
5 occupational therapist, Erin Jackowski. It was recommended that A receive
6 weekly speech therapy and occupational therapy.

7 6. The therapy was designed to assist A 's behavioral and
8 adaptive functioning at home, in the community and in social settings, and to alleviate
9 the stress A was experiencing related to his autism. Prior to therapy A was
10 prone to frequent emotional outbursts in public due to noisy or emotionally intense
11 situations (including school fire drills and witnessing other students being disciplined),
12 consistent trouble with balance or even stepping off of a curb (which he could not do
13 without assistance), and difficulty manipulating food in his mouth, resulting in both
14 choking and gagging episodes at most meal times.

15 7. A also needs feeding therapy, in addition to speech and
16 occupational therapy, due to his frequent choking episodes. However, we were told
17 that Lifewise would never cover it.

18 8. A 's speech and occupational therapy was highly successful.
19 We saw steady progress on both speech and occupational therapy goals. Today,
20 A 's gross motor function has greatly developed. For example, he has learned how
21 to ride a bicycle which he had been unable to learn to do without skilled support. His
22 speech has also significantly improved as well as his ability to manage his emotional
23 responses to social situations. Things like fire drills are now manageable for him,
24 largely because his therapists at Valley have taught him how to appropriately respond
25 to situations where he experiences sensory overload.
26

1 9. When A first started speech and occupational therapy, Valley
2 Medical Center sent the health care claims to Lifewise and Lifewise paid the claims up
3 to twenty total visits per calendar year. As a result, my wife and I both understood that
4 A 's therapy was covered, at least for twenty visits per year.

5 10. In late July 2011, we received an envelope containing a set of 13
6 revised "Explanation of Benefits" ("EOBs") indicating that all of A s speech and
7 occupational therapy since January 1, 2010 was retroactively denied. A true and
8 correct copy of those EOBs is attached as *Exh. A*.

9 11. We were astounded that Lifewise could retroactively deny
10 coverage of 20 months worth of therapy visits, which they had already covered,
11 totaling nearly \$24,000. We had no idea how we could come up with the money to pay
12 for the therapies.

13 12. In late July/early August 2011, I called Lifewise to find out what
14 was going on. I hoped that some sort of mistake had been made. Instead, the Lifewise
15 customer service agent told me that A s speech and occupational therapy services
16 were completely excluded from our policy.

17 13. I requested that the Lifewise representative provide me with a
18 written explanation of Lifewise's decision. Attached as *Exh. B* is a true and correct
19 copy of the letter dated August 12, 2011 and the excerpts from my Lifewise Policy that
20 Lifewise provided in response to my request.

21 14. The Lifewise representative did not inform me that I could appeal
22 Lifewise's retroactive denial of coverage. Nor did the letter he sent me contain any
23 information about how to appeal the Lifewise decision.

24 15. Once we realized that Lifewise would no longer cover A 's
25 speech and occupational therapies, we decided to stop his speech therapy, but continue
26 with his bi-monthly occupational therapy. Unfortunately, this was the only affordable

1 option for us. This was a difficult decision because A continues to need speech
2 therapy. He still has physical trouble with enunciation and, as mentioned above, is
3 struggling with the manipulation of food in his mouth. He also needs help with
4 cognitive flexibility and adapting his speech based on social context changes. Progress
5 on these goals stopped abruptly when we were forced to discontinue his speech
6 therapy.

7 16. Since A stopped receiving speech therapy, A continues to
8 struggle with visual and auditory comprehension. This includes basic understanding
9 of things like street signs, written instructions and abstract or non-literal subject matter
10 when conversing with others, watching movies and reading books. This impacts his
11 ability to relate to his peers in social settings where the use of metaphors, slang and
12 other non-literal language is often lost on him, leading to him being increasingly
13 isolated from typically developing friends with whom he already has difficulty
14 relating.

15 17. We may not be able to afford to continue his occupational therapy
16 if we have no insurance coverage for it. In that case, A would likely regress, losing
17 the skills he is developing to improve fine motor control which impacts his ability to do
18 things like write, tie his shoes and button his pants. It also affects grip strength, ability
19 to count money, prepare food, use tools and many other daily living skills. The loss of
20 ongoing occupational therapy could significantly impact A's ability to care for
21 himself independently and severely jeopardize his ability to find and maintain
22 employment in adulthood.

23 18. Since August, 2011, Valley Medical Center has billed my wife and
24 me for both the treatment that Lifewise retroactively denied, as well as A's
25 ongoing therapy. We are now faced with more than \$24,000 in unexpected medical
26 expenses for which we have not budgeted.

1 19. Valley charges us the full, unnegotiated rate for speech and
2 occupational therapy. For occupational therapy that is typically between \$480- \$572
3 per hour or approximately \$1100 per month. A s speech therapy was typically
4 \$360 per week. If we pay promptly, Valley extends a 45% discount, lowering the rate
5 but that amount is still too expensive for us to provide out-of-pocket in addition to our
6 existing health insurance premiums.

7 20. Valley has started to pursue collections against my family for the
8 \$24,000 in past therapy bills. We have received collections notices from Valley and
9 started receiving calls from a collections agency on the day after Christmas. Recently,
10 Valley agreed to temporarily put the account on hold, but, at this time, we do not know
11 how long that will last.

12 21. We would like A 's occupational and speech therapy to
13 continue but we cannot continue to pay for both his speech and occupational therapies
14 *and* pay for the \$24,000 that Lifewise claims we owe to Valley.

15
16 DATED: January 13, 2012, at Renton, Washington.

17
18 /s/

19 _____
20 J G

Exhibit A

DECLARATION OF J.G.-7
REDACTED



P.O. Box 91059
Seattle, WA 98111

DATE: Jul 23, 2011

A G

RENTON WA 98059

This is an Explanation of Benefits statement (EOB), which we send to you whenever you use your health plan for services or products from a healthcare provider. **The EOB is not a bill.**

You will find the following information on your EOB:

- **Charges billed by provider** - Amount billed to you and your healthcare plan(s).
- **Provider's fee adjustment** - Difference between "charges billed by provider" and the amount providers have agreed to accept as full payment. See message codes for details.
- **Your copay, deductible or amount not covered** - "Copay" is a set fee you pay a provider at each visit; "deductible" is how much you pay each year before your benefits start; "amount not covered" applies to services/products not covered by your plan. See message codes for details.
- **Total amount eligible for benefits** - Charges billed by provider minus provider fee adjustment minus your copay, deductible or amount not covered. See message codes for details.
- **%** - The percentage your plan pays for covered services/products.
- **Your co-insurance amount** - What you must pay the provider after we pay the covered percentage.
- **Adjustment** - See message codes for details.
- **Total benefits from your plan** - Total amount eligible for benefits "minus" your coinsurance/adjustment amounts.
- **Amount you're responsible for** - What you must pay of the billed charges after plan benefits are paid. If you receive payment intended for a provider, it is your responsibility to pay the provider.
- **Benefit booklet information** - A description of your plan's benefits as it pertains to the service/product listed on the EOB. Your benefit booklet may be available by logging into www.lifewisewa.com.

If you have any questions about your EOB or if English is not your primary language

Call Customer Service at 800-592-6804, Monday through Friday, between 8:00 a.m. and 5:00 p.m. Pacific Time. Our TDD/TTY number for the hearing impaired is 800-842-5357.



If you have questions about your claim and want to request a review

You can call Customer Service. If you still have concerns after speaking with Customer Service, you--or someone you appoint in writing to represent you--may file an appeal. To file an appeal, you may write a letter or submit a member appeal form. Include a copy of this EOB and any other information that might help clarify your statement. You may also request to receive records we relied upon to make our decision. We must receive your statement within 180 days after you received this EOB. If you have group coverage through your employer, and your employer is subject to the Employee Retirement Income Security Act (ERISA), you may have the right to file a civil action at the end of the appeals process.

You can also seek assistance from the Washington Consumer Assistance Program:
5000 Capitol Blvd., Tumwater, WA 98501 800-562-6900 www.insurance.wa.gov

If you suspect any fraud in your claim or payments were made for services you didn't receive
Call Premera's fraud hotline 800-360-9535 .

1-800-592-6804

www.lifewisewa.com

DECLARATION OF J.G.-8
REDACTED

EXPLANATION OF BENEFITS

JUL 23, 2011

Group Number: 1000000
 Member: A G
 Member's ID: 816369120701
 Claim Number: VALLEY MEDICAL CENTER
 Provider: 2011072314301146
 Payment Reference ID: 2011072314301146

(This is NOT a bill)

Service/ product description	Date(s) you received service/product (include time if any)	Charges billed by provider	Provider's fee (deductible/coinsurance)	Your copay (C) deductible (D) or amount not covered	Total amount eligible for benefits	%	Your coinsurance amount	Adjustment	Total benefits from your plan	Amount you're responsible for
MEDICAL CARE	01/07/10 01/07/10	417.32		417.32 583	0.00	0%	0.00	0.00	0.00	417.32
MEDICAL CARE	01/14/10 01/14/10	208.66		208.66 583	0.00	0%	0.00	0.00	0.00	208.66
MEDICAL CARE	01/14/10 01/14/10	88.43		88.43 583	0.00	0%	0.00	0.00	0.00	88.43
MEDICAL CARE	01/21/10 01/21/10	417.32		417.32 583	0.00	0%	0.00	0.00	0.00	417.32
MEDICAL CARE	01/28/10 01/28/10	312.99		312.99 583	0.00	0%	0.00	0.00	0.00	312.99
MEDICAL CARE	01/28/10 01/28/10	88.43		88.43 583	0.00	0%	0.00	0.00	0.00	88.43
MEDICAL SERVICE	01/07/10 01/07/10	281.19		281.19 583	0.00	0%	0.00	0.00	0.00	281.19
MEDICAL SERVICE	01/07/10 01/07/10	143.08		143.08 583	0.00	0%	0.00	0.00	0.00	143.08
MEDICAL SERVICE	01/14/10 01/14/10	281.19		281.19 583	0.00	0%	0.00	0.00	0.00	281.19
MEDICAL SERVICE	01/14/10 01/14/10	143.08		143.08 583	0.00	0%	0.00	0.00	0.00	143.08
MEDICAL SERVICE	01/21/10 01/21/10	281.19		281.19 583	0.00	0%	0.00	0.00	0.00	281.19
MEDICAL SERVICE	01/28/10 01/28/10	281.19		281.19 583	0.00	0%	0.00	0.00	0.00	281.19
Totals		\$2944.07	\$0.00	\$2944.07	\$0.00		\$0.00	\$0.00	\$0.00	\$2944.07

Amount you're responsible for: **\$2,944.07**

We have recovered the following amount from the provider due to an overpayment: **(\$817.28)**

Less Amount Previously Paid **(\$817.28)**

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DECLARATION OF J.G.-9 REDACTED

EXPLANATION OF BENEFITS

JUL 23, 2011

Group Number: 1000000
 Member: A G
 Member's ID: 819210419201
 Claim Number: 819210419201
 Provider: VALLEY MEDICAL CENTER
 Payment Reference ID: 2011072314301146

(This is NOT a bill)

Product description	Date you received services/product (m/d/y to m/d/y)	Charges billed by provider	Provider's fee adjustments (?)	Your copay (C) deductible (D) or amount not covered (?)	Total amount eligible for benefits	%	Your coinsurance amount	Adjustment	Total benefits from your plan	Amount you're responsible for
MEDICAL CARE	01/06/11 01/06/11	480.00		480.00 583	0.00	0%	0.00	0.00	0.00	480.00
MEDICAL CARE	01/20/11 01/20/11	480.00		480.00 583	0.00	0%	0.00	0.00	0.00	480.00
MEDICAL SERVICE	01/06/11 01/06/11	337.00		337.00 583	0.00	0%	0.00	0.00	0.00	337.00
MEDICAL SERVICE	01/20/11 01/20/11	337.00		337.00 583	0.00	0%	0.00	0.00	0.00	337.00
Totals		\$1634.00	\$0.00	\$1634.00	\$0.00		\$0.00	\$0.00	\$0.00	\$1634.00

Amount you're responsible for: **\$1,634.00**

We have recovered the following amount from the provider due to an overpayment: **(\$390.10)**

Message Codes: 583 OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THIS SERVICE IS NOT COVERED BY YOUR PLAN.

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DECLARATION OF J.G.-10 REDACTED

1-800-592-6804

www.lifewise.com

EXPLANATION OF BENEFITS

JUL 23, 2011

Group Number : 1000000
 Member : A G
 Member's ID : 111740003400
 Claim Number : 111740003400
 Provider : VALLEY MEDICAL CENTER
 Payment Reference ID : 2011072314301146

(This is NOT a bill)

Product/Service Description	Dates you received service/product (refer to study)	Charges billed by provider	Provider's fee adjustments (*)	Your copay (G) deductible (D) or amount not covered (C)	Total amount eligible for benefits	%	Your coinsurance amount	Adjustment	Total benefits from your plan	Amount you're responsible for
MEDICAL CARE	02/03/11 02/03/11	480.00		480.00 583	0.00	0%	0.00	0.00	0.00	480.00
MEDICAL CARE	02/17/11 02/17/11	480.00		480.00 583	0.00	0%	0.00	0.00	0.00	480.00
MEDICAL SERVICE	02/03/11 02/03/11	337.00		337.00 583	0.00	0%	0.00	0.00	0.00	337.00
MEDICAL SERVICE	02/17/11 02/17/11	337.00		337.00 583	0.00	0%	0.00	0.00	0.00	337.00
MEDICAL CARE	02/17/11 02/17/11	102.00		102.00 583	0.00	0%	0.00	0.00	0.00	102.00

Totals \$1736.00 \$0.00 \$1736.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$1736.00
 Amount you're responsible for: \$1,736.00

Message Codes:
 583 OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THIS SERVICE IS NOT COVERED BY YOUR PLAN.

GO PAPERLESS! Register at lifewisewa.com to sign up and see your EOB statements, anytime - online!



DECLARATION OF J.G.-11 REDACTED

EXPLANATION OF BENEFITS

JUL 23, 2011

Group Number: 1000000
 Member: A G
 Member's ID: 816793011701
 Claim Number: VALLEY MEDICAL CENTER
 Provider: 2011072314301146
 Payment Reference ID: 2011072314301146

(This is NOT a bill)

Service/ product description	Dates you received services/product (daily to monthly)	Charges billed by provider	Provider's fee adjustments (*)	Your copy (C) deductible (D) or amount not covered (*)	Total amount eligible for benefits	Your coinsurance or amount	Adjustment	Total benefits from your plan	Amount you're responsible for
MEDICAL CARE	09/18/10 09/18/10	417.32		417.32 583	0.00	0.00	0.00	0.00	417.32
MEDICAL SERVICE	09/18/10 09/18/10	281.19		281.19 583	0.00	0.00	0.00	0.00	281.19
Totals		\$698.51	\$0.00	\$698.51	\$0.00	\$0.00	\$0.00	\$0.00	\$698.51

Amount you're responsible for:

We have recovered the following amount from the provider due to an overpayment: **\$698.51**
 (\$195.28)

Message Codes:
 583 OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THIS SERVICE IS NOT COVERED BY YOUR PLAN.

GO PAPERLESS! Register at lifewisewa.com to sign up and see your EOB statements, anytime - online!



DECLARATION OF J.G.-12 REDACTED

EXPLANATION OF BENEFITS

JUL 23, 2011

Group Number: 1000000
 Member: A G
 Member's ID: 819703243501
 Claim Number: VALLEY MEDICAL CENTER
 Provider: VALLEY MEDICAL CENTER
 Payment Reference ID: 2011072314301146

(This is NOT a bill)

Service/ product description	Date you received service/product (M/D/Y to M/D/Y)	Charges billed by provider	Provider's fee adjustments (1)	Your copy (C) deductible (D) or out-of-pocket covered (1)	Total amount eligible for benefits	Your insurance amount	Your adjustment	Total benefits from your plan	Amount you're responsible for
MEDICAL CARE	09/09/11 09/09/11	480.00		480.00 583	0.00	0.00	0.00	0.00	480.00
MEDICAL CARE	09/17/11 09/17/11	480.00		480.00 583	0.00	0.00	0.00	0.00	480.00
MEDICAL SERVICE	09/09/11 09/09/11	337.00		337.00 583	0.00	0.00	0.00	0.00	337.00
MEDICAL SERVICE	09/17/11 09/17/11	337.00		337.00 583	0.00	0.00	0.00	0.00	337.00
Totals		\$1634.00	\$0.00	\$1634.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1634.00

Amount you're responsible for: **\$1,634.00**

We have recovered the following amount from the provider due to an overpayment: **(\$390.10)**

Message Codes: 583 OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THIS SERVICE IS NOT COVERED BY YOUR PLAN.

GO PAPERLESS! Register at lifelivesawa.com to sign up and see your EOB statements, anytime - online!



DECLARATION OF J.G.-13 REDACTED

1-800-692-6804

www.lifelivesawa.com

EOB W0 - RECLAIMER1 LAST CHANGED 06/19/2010

EXPLANATION OF BENEFITS

JUL 23, 2011

Group Number : 1000000
 Member : A G
 Member's ID : 817049333401
 Claim Number : VALLEY MEDICAL CENTER
 Provider : VALLEY MEDICAL CENTER
 Payment Reference ID : 2011072314301146

(This is NOT a bill)

Service/ product description	Dates you received service/product (MM/DD/YYYY to MM/DD/YYYY)	Charges billed by provider	Provider's fee adjustments (A)	Your copy (C) deductible (D) or amount not covered (E)	Total amount eligible for benefits	%	Your coinsurance amount	Adjustment	Total benefits from your plan	Amount you're responsible for
MEDICAL CARE	04/01/10 04/01/10	417.32		417.32 583	0.00	0%	0.00	0.00	0.00	417.32
MEDICAL CARE	04/22/10 04/22/10	417.32		417.32 583	0.00	0%	0.00	0.00	0.00	417.32
MEDICAL SERVICE	04/01/10 04/01/10	281.19		281.19 583	0.00	0%	0.00	0.00	0.00	281.19
MEDICAL SERVICE	04/22/10 04/22/10	281.19		281.19 583	0.00	0%	0.00	0.00	0.00	281.19
Totals		\$1397.02	\$0.00	\$1397.02	\$0.00		\$0.00	\$0.00	\$0.00	\$1397.02

Amount you're responsible for: **\$1,397.02**
 We have recovered the following amount from the provider due to an overpayment: **(\$390.56)**

Message Codes:
 583 OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THIS SERVICE IS NOT COVERED BY YOUR PLAN.

GO PAPERLESS! Register at lifewisewa.com to sign up and see your EOB statements, anytime - online!



DECLARATION OF J.G.-14 REDACTED

1-800-592-6804

www.lifewisewa.com

EXPLANATION OF BENEFITS

JUL 23, 2011

Group Number: 1000000
 Member: A G
 Member's ID: 819962401901
 Claim Number: VALLEY MEDICAL CENTER
 Provider: VALLEY MEDICAL CENTER
 Payment Reference ID: 2011072314301146

(This is NOT a bill)

Service/ product description	Date you received service/product (m/d/y to m/d/y)	Charges billed by provider	Provider's fee adjustments (*)	Your copay (C) deductible (D) or amount not covered (N)	Total amount eligible for benefits	%	Your coinsurance amount	Adjustment	Total benefits from your plan	Amount you're responsible for
MEDICAL CARE	04/07/11 04/07/11	480.00		480.00 583	0.00	0%	0.00	0.00	0.00	480.00
MEDICAL CARE	04/21/11 04/21/11	480.00		480.00 583	0.00	0%	0.00	0.00	0.00	480.00
MEDICAL SERVICE	04/07/11 04/07/11	337.00		337.00 583	0.00	0%	0.00	0.00	0.00	337.00
MEDICAL SERVICE	04/21/11 04/21/11	337.00		337.00 583	0.00	0%	0.00	0.00	0.00	337.00
Totals		\$1634.00	\$0.00	\$1634.00	\$0.00		\$0.00	\$0.00	\$0.00	\$1634.00

Amount you're responsible for:

We have recovered the following amount from the provider due to an overpayment: **(\$390.10)**
\$1,634.00

Message Codes:
 583 OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THIS SERVICE IS NOT COVERED BY YOUR PLAN.

GO PAPERLESS! Register at lifewisewa.com to sign up and see your EOB statements, anytime - online!



DECLARATION OF J.G.-15
 REDACTED

EXPLANATION OF BENEFITS

JUL 23, 2011

Group Number : 1000000
 Member : A G
 Member's ID : 817854827002
 Claim Number : VALLEY MEDICAL CENTER
 Provider : VALLEY MEDICAL CENTER
 Payment Reference ID: 2011072314301146

(This is NOT a bill)

Service/ product description	Dates you received services/product (only to verify)	Charges billed by provider	Provider's fee adjustment(s)	Your copay (C) or amount not covered (N)	Total amount eligible for benefits	%	Your insurance amount	Adjustment	Total benefits from your plan	Amount you're responsible for
MEDICAL CARE	05/08/10 05/08/10	480.00		480.00 583	0.00	0%	0.00	0.00	0.00	480.00
MEDICAL CARE	05/13/10 05/13/10	480.00		480.00 583	0.00	0%	0.00	0.00	0.00	480.00
MEDICAL CARE	05/20/10 05/20/10	480.00		480.00 583	0.00	0%	0.00	0.00	0.00	480.00
MEDICAL CARE	05/27/10 05/27/10	480.00		480.00 583	0.00	0%	0.00	0.00	0.00	480.00
MEDICAL SERVICE	05/06/10 05/06/10	337.00		337.00 583	0.00	0%	0.00	0.00	0.00	337.00
MEDICAL SERVICE	05/13/10 05/13/10	337.00		337.00 583	0.00	0%	0.00	0.00	0.00	337.00
MEDICAL SERVICE	05/20/10 05/20/10	337.00		337.00 583	0.00	0%	0.00	0.00	0.00	337.00
MEDICAL SERVICE	05/27/10 05/27/10	337.00		337.00 583	0.00	0%	0.00	0.00	0.00	337.00
Totals		\$3268.00	\$0.00	\$3268.00	\$0.00		\$0.00	\$0.00	\$0.00	\$3268.00

Amount you're responsible for: **\$3,268.00**

We have recovered the following amount from the provider due to an overpayment: **(\$781.12)**

Message Codes: 583 OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THIS SERVICE IS NOT COVERED BY YOUR PLAN.

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DECLARATION OF J.G.-16 REDACTED

1-800-592-6804

www.lifewisewa.com

EXPLANATION OF BENEFITS

JUL 23, 2011

Group Number : 1000000
 Member : A G
 Member's ID : 820281200701
 Claim Number : VALLEY MEDICAL CENTER
 Provider : 2011072314301146
 Payment Reference ID: 2011072314301146

(This is NOT a bill)

Product description	Service	Dates you received services/product (m/d/y to m/d/y)	Charges billed by provider	Provider's fee adjustments (*)	Your copy (C) deductible (D) or amount not covered (*)	Total amount eligible for benefits	%	Your coinsurance amount	Adjustment	Total benefits from your plan	Amount you're responsible for
MEDICAL CARE		05/19/11 05/19/11	572.00		572.00 583	0.00	0%	0.00	0.00	0.00	572.00
MEDICAL SERVICE		05/05/11 05/05/11	373.00		373.00 583	0.00	0%	0.00	0.00	0.00	373.00
MEDICAL SERVICE		05/19/11 05/19/11	360.00		360.00 583	0.00	0%	0.00	0.00	0.00	360.00
Totals			\$1305.00	\$0.00	\$1305.00	\$0.00		\$0.00	\$0.00	\$0.00	\$1305.00

Amount you're responsible for:

\$1,305.00

We have recovered the following amount from the provider due to an overpayment:

(\$230.67)

Message Codes: 583 OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THIS SERVICE IS NOT COVERED BY YOUR PLAN.

GO PAPERLESS! Register at lifelwise.com to sign up and see your EOB statements, anytime - online!



DECLARATION OF J.G.-17 REDACTED

1-800-592-6804

www.lifelwise.com

EXPLANATION OF BENEFITS

JUL 23, 2011

Group Number: 1000000
 Member: A G
 Member's ID: 817534620201
 Claim Number: 817534620201
 Provider: VALLEY MEDICAL CENTER
 Payment Reference ID: 2011072314301146

(This is NOT a bill)

Service/Procedure Description	Dates you received services (include frequency)	Charges billed by provider	Provider's fee adjustments (C)	Your copy (C) deductible (D) or amount not covered (C)	Total amount eligible for benefits	Your coinsurance amount	Adjustment	Total benefits from your plan	Amount you're responsible for
MEDICAL CARE	06/03/10 06/03/10	480.00		480.00 583	0.00	0.00	0.00	0.00	480.00
MEDICAL CARE	06/24/10 06/24/10	480.00		480.00 583	0.00	0.00	0.00	0.00	480.00
MEDICAL SERVICE	06/03/10 06/03/10	337.00		337.00 583	0.00	0.00	0.00	0.00	337.00
MEDICAL SERVICE	06/10/10 06/10/10	337.00		337.00 583	0.00	0.00	0.00	0.00	337.00
Totals		\$1634.00	\$0.00	\$1634.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1634.00

Amount you're responsible for: **\$1,634.00**

We have recovered the following amount from the provider due to an overpayment: **(\$390.56)**

Message Codes: 583 OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THIS SERVICE IS NOT COVERED BY YOUR PLAN.

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DECLARATION OF J.G.-18 REDACTED

1-800-592-6804

www.lifewise.com

EXPLANATION OF BENEFITS

JUL 23, 2011

Group Number: 1000000
 Member: A G
 Member's ID: 820479436301
 Claim Number: VALLEY MEDICAL CENTER
 Provider: VALLEY MEDICAL CENTER
 Payment Reference ID: 2011072314301146

(This is NOT a bill)

Service/ product description	Dates you received service/product (first, last, day)	Charges billed by provider	Provider's fee adjustments (1)	Your copy (G) deductible (D) not covered (1)	Total amount eligible for benefits	%	Your coinsurance amount	Adjustment	Total benefits from your plan	Amount you're responsible for
MEDICAL SERVICE	06/02/11 06/02/11	360.00		360.00 583	0.00	0%	0.00	0.00	0.00	360.00
MEDICAL SERVICE	06/16/11 06/16/11	360.00		360.00 583	0.00	0%	0.00	0.00	0.00	360.00
Totals		\$720.00	\$0.00	\$720.00	\$0.00		\$0.00	\$0.00	\$0.00	\$720.00

Amount you're responsible for: **\$720.00**

We have recovered the following amount from the provider due to an overpayment: **(\$71.24)**

Message Codes: 583 OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THIS SERVICE IS NOT COVERED BY YOUR PLAN.

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DECLARATION OF J.G.-19 REDACTED

1-800-592-8804

www.lifewisewa.com

EXPLANATION OF BENEFITS

JUL 23, 2011

Group Number: 1000000
 Member: A G
 Member's ID: 817754710601
 Claim Number: VALLEY MEDICAL CENTER
 Provider: VALLEY MEDICAL CENTER
 Payment Reference ID: 2011072314301146

(This is NOT a bill)

Service/ product description	Dates you received service/product (m/d/y to m/d/y)	Charges billed by provider	Provider's fee adjustment(s)	Your copay (C) deductible (D) or amount not covered (N)	Total amount eligible for benefits	%	Your insurance amount	Adjustment	Total benefits from your plan	Amount you're responsible for
MEDICAL CARE	07/15/10 07/15/10	120.00		583	0.00	0%	0.00	0.00	0.00	480.00
MEDICAL CARE	07/22/10 07/22/10	480.00		583	0.00	0%	0.00	0.00	0.00	480.00
MEDICAL CARE	07/29/10 07/29/10	480.00		583	0.00	0%	0.00	0.00	0.00	397.00
MEDICAL SERVICE	07/15/10 07/15/10	397.00		583	0.00	0%	0.00	0.00	0.00	397.00
MEDICAL SERVICE	07/22/10 07/22/10	397.00		583	0.00	0%	0.00	0.00	0.00	397.00
MEDICAL SERVICE	07/29/10 07/29/10	397.00		583	0.00	0%	0.00	0.00	0.00	397.00
Totals		\$2091.00	\$0.00	\$2091.00	\$0.00		\$0.00	\$0.00	(\$467.14)	\$2091.00

Amount you're responsible for:

We have recovered the following amount from the provider due to an overpayment:
\$2,091.00

Message Codes:
 583 OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THIS SERVICE IS NOT COVERED BY YOUR PLAN.

GO PAPERLESS! Register at lifewisewa.com to sign up and see your EOB statements, anytime - online!



DECLARATION OF J.G.-20 REDACTED

EXPLANATION OF BENEFITS

Jul 23, 2011

Group Number: 1000000
 Member: A G
 Member's ID: 818123726701
 Claim Number: VALLEY MEDICAL CENTER
 Provider: VALLEY MEDICAL CENTER
 Payment Reference ID: 2011072314301146

(This is NOT a bill)

Service/ product description	Dates you received service/product (MM/DD/YYYY to MM/DD/YYYY)	Charges billed by provider	Provider's fee adjustments (%)	Your copay (C) or deductible (D) (not provided)	Total amount eligible for benefits	%	Your coinsurance amount	Adjustment	Total benefits from your plan	Amount you're responsible for
MEDICAL CARE	08/05/10 08/05/10	480.00		480.00 583	0.00	0%	0.00	0.00	0.00	480.00
MEDICAL CARE	08/12/10 08/12/10	480.00		480.00 583	0.00	0%	0.00	0.00	0.00	480.00
MEDICAL CARE	08/19/10 08/19/10	480.00		480.00 583	0.00	0%	0.00	0.00	0.00	480.00
MEDICAL CARE	08/26/10 08/26/10	480.00		480.00 583	0.00	0%	0.00	0.00	0.00	480.00
MEDICAL CARE	08/05/10 08/05/10	337.00		337.00 583	0.00	0%	0.00	0.00	0.00	337.00
MEDICAL SERVICE	08/12/10 08/12/10	337.00		337.00 583	0.00	0%	0.00	0.00	0.00	337.00
MEDICAL SERVICE	08/19/10 08/19/10	337.00		337.00 583	0.00	0%	0.00	0.00	0.00	337.00
MEDICAL SERVICE	08/26/10 08/26/10	337.00		337.00 583	0.00	0%	0.00	0.00	0.00	337.00
Totals		\$3268.00	\$0.00	\$3268.00	\$0.00		\$0.00	\$0.00	\$0.00	\$3268.00

Amount you're responsible for: **\$3,268.00**

We have recovered the following amount from the provider due to an overpayment: **(\$390.56)**

Message Codes: 583 OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THIS SERVICE IS NOT COVERED BY YOUR PLAN.

GO PAPERLESS! Register at lifewise-wa.com to sign up and see your EOB statements, anytime - online!



DECLARATION OF J.G.-21 REDACTED

EXPLANATION OF BENEFITS



JUL 23, 2011

Group Number : 10000000
 Member : A G
 Member's ID : 816369120701
 Claim Number : VALLEY MEDICAL CENTER
 Provider : VALLEY MEDICAL CENTER
 Payment Reference ID : 2011072314301146

(This is NOT a bill)

Service/ product description	Dates you received service/product (refer to ruler)	Charges billed by provider	Provider's fee adjustments (*)	Your copay (C) deductible (D) or amount not covered (N)	Total amount eligible for benefits	Your coinsurance amount	Adjustment	Total benefits from your plan	Amount you're responsible for

Message Codes: 583 OUR MEDICAL STAFF REVIEWED THIS CLAIM AND DETERMINED THIS SERVICE IS NOT COVERED BY YOUR PLAN.

GO PAPERLESS! Register at lifewise.com to sign up and see your EOB statements, anytime - online!



DECLARATION OF J.G.-22 REDACTED

1-800-582-6804

www.lifewise.com

Exhibit B

DECLARATION OF J.G.-23
REDACTED



HEALTH PLAN OF WASHINGTON

P.O. Box 91059
Seattle, WA 98111

August 12, 2011

J G

RENTON WA 98059

Subscriber: J G
Subscriber ID:
Group #: 1000000
Group Name: Lifewise Health Plan of Washington
Member ID:
Member Name: A

Dear A G :

Thank you for recently contacting our Customer Service Department regarding the above listed policy.

This letter is being issued to provide confirmation the following listed of claims were processed incorrectly and will be adjusted as Neurodevelopment Therapy is not a covered benefit under the above listed policy.

Date of Service:	Total Charge:	Claim Number:
January 7, 2010	\$2,944.07	816369120700
March 18, 2010	\$698.51	816793011700
April 1, 2010	\$1,397.02	817049333400
May 6, 2010	\$3,268.00	817854827000
June 3, 2010	\$1,634.00	817534620200
July 15, 2010	\$2,091.00	817754710600
August 5, 2010	\$3,268.00	818123726700
January 6, 2011	\$1,634.00	819210419200
March 3, 2011	\$1,634.00	819703243500
April 7, 2011	\$1,634.00	819962401900
May 5, 2011	\$1,305.00	820281200700
June 2, 2011	\$720.00	820479436300

For your convenience we have also enclosed the applicable contract page regarding this service.

If you have any questions, please call Customer Service at 1-800-592-6804.

Sincerely,

Correspondence Team
Customer Service Department
(tjw)

**your
benefit
booklet**

2007

**WiseChoices 20
\$1,000 Deductible**

Benefit Booklet
for Individuals and Families
Residing in Washington



LIFEWISE | 
HEALTH PLAN OF WASHINGTON

DECLARATION OF J.G.-25
REDACTED

provided only for covered services received after the waiting period is met.

Organ and Bone Marrow Transplant Exclusion Period

Benefits for organ and bone marrow transplants are not available during the first 12 consecutive months after your effective date. The only exceptions are in the following situations:

- The transplant is necessary due to an accidental injury that occurs on or after your effective date of coverage under this plan
- The transplant is necessary due to a congenital anomaly of a child who has been covered through us since birth
- The transplant is necessary due to a congenital anomaly of a child who has been covered through us since placement for adoption with the subscriber

Please see the Transplants benefit for more information on the transplant benefit.

EXCLUSIONS

This section of the contract lists those services, supplies or drugs are not covered under this plan.

Amounts That Exceed The Allowable Charge

All benefits of this plan are based on the allowable charge (see Definitions). Benefits are not provided for amounts in excess of the allowable charge.

Benefits From Other Sources

Benefits aren't available under this plan when coverage is available through:

- Motor vehicle medical or motor vehicle no-fault
- Personal injury protection (PIP) coverage
- Commercial liability coverage
- Homeowner policy
- Other type of liability or insurance coverage
- Worker's Compensation or similar coverage

Benefits That Have Been Exhausted

Services, supplies, drugs, and medications furnished in connection with or directly related to a benefit that has been exhausted, or in excess of stated benefit maximums.

Biofeedback

Benefits are not provided for biofeedback, regardless of diagnosis.

Chemical Dependency

Services and supplies for the treatment of chemical dependency, whether or not received as part of a

court-ordered admission. Also excluded is the diagnosis and treatment of caffeine dependency. Emergency medical detoxification treatment is covered under this plan's medical benefits.

Conditions From Professional Sports

Any condition related to semiprofessional or professional athletics, including practice. Semiprofessional athletics are athletics requiring a high level of skill, for which you are paid, even if the activity is not your full-time occupation.

Counseling and Assessments

- Services and supplies related to marital, family, or sexual counseling; vocational counseling; outreach; job training; health education and wellness classes, materials and services; and other counseling or training services, except as specifically stated under the Diabetes Health Education benefit.
- Psychological and neuropsychological assessments or testing. The exception is for a single assessment visit per calendar year related to neurodevelopmental therapy to establish a diagnosis.

Cosmetic and Reconstructive Services

- Services, supplies or drugs provided for cosmetic purposes whether cosmetic or reconstructive in nature, regardless of whether rendered to restore, improve, correct or alter the appearance, shape or function of a body structure, including any direct or indirect complications and aftereffects thereof.

The only exceptions to this exclusion are:

- Repair of a defect that's the direct result of an injury, providing such repair is started within 12 months of the date of the injury
- Repair of a dependent child's congenital anomaly
- Reconstructive breast surgery in connection with a mastectomy. See the Mastectomy and Breast Reconstruction Services benefit.

Custodial Care

Custodial, Domiciliary, or rest care, except as specifically stated under the hospice benefit.

Dental Care

Benefits are not provided for dental services or orthodontia, regardless of origin or cause, except as provided under the Dental Accident benefit.

Benefits for hospital services for dental treatment are only provided when medically necessary due to a member's serious medical condition such as hemophilia or heart disease.

Environmental Therapy

Milieu therapy (treatment designed primarily to provide a change in environment or a controlled environment).

Experimental and Investigative Services

Services or supplies we determine are experimental or investigative on the date furnished. Our determination is based on the criteria stated in the definition of "Experimental/Investigative." (See Definitions.)

If we determine that a service is experimental or investigative, and therefore not covered, you may appeal our decision. We will respond in writing within 20 working days after receipt of a claim or other fully documented request for benefits, or a fully documented appeal. The 20-day period may be extended only with your informed written consent.

This exclusion does not apply to certain services provided as part of oncology clinical trials. Benefit determination is based on the criteria specified in the definition of "Oncology Clinical Trials" in the Definitions section in this contract.

Human Growth Hormone Benefit Limitations

Benefits for human growth hormone are only provided under the Prescription Drugs benefit.

Hearing Examinations and Hearing Aids

Hearing examinations; hearing aids and their fitting and maintenance.

Hospital Admission Limitations

Hospital admissions solely for diagnostic studies, physical examinations, checkups, medical evaluations, or observations, unless:

- The services cannot be provided without the use of a hospital
- There is a medical condition that makes hospital care medically necessary

Infertility or Fertility Enhancement

Services, supplies, and drugs furnished in connection with infertility or fertility enhancement, and any direct or indirect complications of such procedures. This exclusion applies whether or not the condition is a consequence of illness, disease, or injury. This plan does not cover services for diagnosis of fertility problems, fertility-related drugs, donor sperm, artificial insemination, In-vitro fertilization, and gamete intra-fallopian transplant (GIFT).

Also not covered is reversal of prior sterilization, and the direct or indirect complications of such

services.

Learning Disorders and Neurodevelopmental Therapy

Services, therapy and supplies related to the treatment of learning disorders, cognitive handicaps, dyslexia, developmental delay or neurodevelopmental disabilities.

Mental or Psychiatric Conditions

Services and supplies, including inpatient and outpatient care, and drugs, for the treatment of a mental or psychiatric condition, including eating disorders.

Military-Related Disabilities

Services to which you are legally entitled for a military service-connected disability and for which Facilities are reasonably available.

Military Service And War-Related Conditions

Conditions caused by or arising from military, war-related conditions and illegal acts, including :

- Acts of war, declared or undeclared, including acts of armed invasion
- Service in the armed forces of any country, including the air force, army, coast guard, marines, national guard, navy, or civilian forces or units auxiliary thereto
- A member's commission of an act of riot or insurrection
- A member's commission of a felony or act of terrorism

Nicotine Dependency

Smoking cessation services, nicotine dependency cessation treatment, drugs or devices.

Non-Covered Services

Services, supplies, drugs, and medications furnished in connection with or directly related to any condition, service, or supply that is not covered under this contract

Obesity and Weight Management

Services, supplies, drugs, procedures, or any treatment, including surgical treatment, furnished in connection with obesity, morbid obesity or weight management, and any direct or indirect complications from such treatment. This exclusion applies even if you have a condition which would be helped by weight loss.

On-Line or Telephone Consultations

Benefits are not provided for electronic, telephone, on-line or Internet medical consultations or

EXHIBIT 8

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HON. MICHAEL J. TRICKEY
Noted for Hearing: March 2, 2012 @ 10:00 a.m.
With Oral Argument

IN THE SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and
K.G., on his own behalf and on behalf of all
similarly situated individuals,

Plaintiff,

v.
PREMERA BLUE CROSS and LIFEWISE OF
WASHINGTON, Washington corporations,

Defendants.

NO. 11-2-30233-4 SEA

DECLARATION OF
ELEANOR HAMBURGER

I, Eleanor Hamburger, declare under penalty of perjury and in
accordance with the laws of the State of Washington that:

1. I am a partner at Sirianni Youtz Spoonemore and am one of the
attorneys for Plaintiffs in this action.

2. Attached are true and correct copies of the following documents,
with underlining where appropriate for the Court's convenience:

Exhibit	Description
A	Excerpts from Premera Blue Cross WEA Select Plan 1 effective October 1, 2011, from https://www.premera.com/stellent/groups/public/documents/xccproject/wea-medical.asp (as of 01/13/2012).

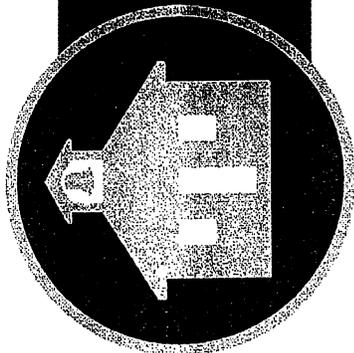
Exhibit	Description
B	Washington Office of the Insurance Commissioner Summary of Premera Blue Cross and Lifewise Health Plan of Washington, from http://www.insurance.wa.gov/consumertoolkit/start.aspx (as of 01/10/12).
C	Excerpts from the Washington State Department of Health's <i>Information Summary and Recommendations concerning Treatment of Autism Spectrum Disorders Mandated Benefits Sunrise Review</i> dated January 2009.
D	Pages 163 and 164 from <i>Mental Health: A Report of the Surgeon General</i> (1999). See www.surgeongeneral.gov/library/mentalhealth/pdfs/c3.pdf (as of 12/02/10)).
E	Excerpts from Washington Department of Health, "Caring for Washington Individuals with Autism Task Force," December 2007. See http://www.doh.wa.gov/cfh/autism/ATF/default.htm (as of 01/13/12).
F	<i>Mental Health: A Report of the Surgeon General, Children and Mental Health</i> (selected pages)
G	Substitute House Bill 1154, as passed, effective 7/24/05.
H	The Washington State Department of Health's <i>Information Summary and Recommendations concerning Mental Health Party Mandated Benefits Sunrise Review</i> dated November 1998.
I	A web page from the United States Centers for Disease Control and Prevention (CDC) concerning the DSM-IV-TR code for autism disorders.

I declare under penalty of perjury of the laws of the State of Washington and the United States of America that the foregoing is true and correct.

DATED: January 13, 2012, at Seattle, Washington.

/s/ Eleanor Hamburger
Eleanor Hamburger

Exhibit A



WEA Select Plan 1

Plan effective October 1, 2011

INTRODUCTION

Your WEA Select Medical Plan was designed specifically for school employees in Washington by the Washington Education Association (WEA) in cooperation with Aon Hewitt (Employee Benefits Consultant), Premera Blue Cross (Medical Plan Underwriter) and UnumProvident Life and Accident Insurance Company (Life Insurance Underwriter).

The WEA is the policyholder for this medical benefits plan. The WEA retains full and exclusive authority, at its discretion, to determine its availability. The plan is not guaranteed to continue indefinitely, and it may be altered or terminated at any time.

The WEA Benefits Services Advisory Board (BSAB) reviews all plan benefits and limitations, and they are approved by the WEA Board of Directors. Your suggestions for plan improvements are always welcome and may be forwarded to the WEA or Aon Hewitt.

WEA CLAIM REVIEW

The WEA Board of Directors or its appointed Benefit Services Advisory Board (BSAB) has the authority under this contract to reconsider claims for benefits which have been denied in whole or in part by Premera Blue Cross and to determine if additional benefits should be provided. This provision will provide a means whereby a claim for benefits can be reconsidered and additional benefits provided to the extent herein specified and to the extent there are WEA funds available to cover such additional benefits. The circumstances under which the appointed BSAB may approve additional benefits when a claim for benefits is denied are outlined in the WEA "Procedure for Benefit Services Claim Review."

If you do not agree with a claim denial made by Premera Blue Cross, you may submit a request for review. BSAB shall conduct a hearing at which the participant shall be entitled to present his or her opinion and any evidence in support thereof. Thereafter, BSAB shall issue a written decision affirming, modifying or setting aside the former action. For more information on the WEA claim review, you may contact Aon Hewitt at 206-467-4646.

Costs incurred by a claimant in preparing or presenting an appeal to the BSAB, such as attorney's fees, copying or postage charges or travel expenses, must be born by the claimant, and the claimant will be asked to sign a written consent to have the pertinent medical information provided to the BSAB.

To understand how your benefits are paid, please review this booklet when you enroll. As you incur medical expenses, you may wish to review the section which applies to them.

Premera Blue Cross has a WEA Select Customer Service Team which serves WEA Medical Plan enrollees. Please call one of the following numbers if you have questions on coverage or claims:

Toll-Free: 1-800-932-9221
Hearing-impaired TDD: 1-800-842-5357

The WEA Select Medical Plans are administered to comply with the requirements of the Patient Protection and Affordable Care Act (PPACA), also known as federal health care reform. Federal and state authorities continue to issue new and revised guidance, including laws regulations, regarding administration of health plans. If additional laws or regulations are issued, this plan will be administered in accordance with the applicable requirements.

Group Name:..... Washington Education Association
Plan Year:..... October 1, 2011 – September 30, 2012
Group Number: WEA Select Medical Plan 1 (Heritage)
Contract Form Number: 1223W1

The benefit does not include:

- Weight loss drugs
- Food supplements or replacements
- Weight loss programs not supervised by a physician, even when the enrollee's participation is prescribed or recommended by a physician

Please call the WEA Select Customer Service Team at 1-800-932-9221 for details.

Naturopathic Services (See Office Visits)

Neurodevelopmental Therapy, Outpatient

Benefits are provided when the enrollee is **not** confined in a hospital.

Benefits are provided **up to 45 visits** per calendar year for enrollees age 6 and under for all forms of therapy combined. A "visit" is a session of treatment for each type of therapy. Each type of therapy accrues toward the visit maximum. Multiple therapy sessions on the same day will be counted as one visit, unless provided by different providers. Benefits are provided as follows:

- **Heritage Providers:**\$20 copay
- **Non-Heritage Providers:**\$25 copay

Outpatient neurodevelopmental therapy services are not subject to your calendar year deductible.

Benefits may include speech and hearing therapy, physical therapy, massage therapy, rehabilitative counseling and functional occupational therapy when it meets all of the following criteria:

- The care restores or improves lost body functions, or maintains function, related to neurodevelopmental delay or deficiencies (neurological and body functions that fail to develop normally after birth) where significant deterioration would occur without the services.
- Treatment is appropriate to the condition being treated.
- Services must be furnished and billed by a legally operated hospital, by a physician (M.D. or D.O.), or by a massage practitioner, physical, occupational or speech therapist.

When the covered child reaches age seven, outpatient neurodevelopmental therapy services may be continued as outpatient rehabilitative care if discontinuation of therapy would result in a loss or deterioration in function.

Benefits are not provided for:

- Neurodevelopmental therapy and related evaluations for enrollees age seven and older
- Social, cultural, and vocational therapy
- Acupressure
- Services provided by employees of a home health agency or hospice

Please see "What's Not Covered?" for additional limitations and exclusions.

Nicotine Dependency/Tobacco Cessation

Benefits are provided for classes, programs and other services customarily used in a formal treatment program to help the enrollee quit using tobacco. Treatment must be performed by a recognized organization, group or individual known to normally and routinely provide treatment as follows:

- **Heritage Providers:** The plan pays 100% of allowable charges; deductible waived.
- **Non-Heritage Providers:** After meeting the calendar year deductible, you pay 30% of allowable charges; plan pays 70% of allowable charges.

Excluded are expenses for over-the-counter drugs and supplies, travel, meals, lodging, books, tapes and other personal expenses or charges considered to be incidental, unreasonable or inconsistent with the intent of this benefit.

Exhibit B

Search > **PREMERA BLUE CROSS**

PREMERA BLUE CROSS

[General](#) | [Contact](#) | [Licensing](#) | [Appointments](#) | [Complaints](#) | [Orders](#) | [National Info](#) | [Ratings](#)

[Back to Search](#)

General information

Name: PREMERA BLUE CROSS
Corporate family group: PREMERA BLUE CROSS GRP [What is this?](#)
Organization type: HEALTH CARE SERVICE CONTRACTOR

WAOIC: 204
NAIC: 47570

Status: ACTIVE
Admitted date: 07/08/1948
Ownership type: NON-PROFIT

[↑ back to top](#)

Contact information

Registered address
 7001 - 220TH ST SW
 MTLAKE TERRACE, WA
 98043

Mailing address
 P O BOX 327
 SEATTLE, WA 98111

Telephone
 425-670-4000

Telephone
 425-670-4000

Types of coverage authorized to sell [What is this?](#)

Insurance types
Health Care

[↑ back to top](#)

Agents and agencies that represent this company (Appointments) [What is this?](#)

[View agents](#)

[View agencies](#)

[↑ back to top](#)

Company complaint history [What is this?](#)

[View complaints](#)

[↑ back to top](#)

Disciplinary orders 2008-2012 [What is this?](#)

Year	Order Number
2009	09-0015

Looking for other orders? Our online orders search allows you to search a ten year history of all orders, including enforcement orders, administrative orders, and general orders.

[↑ back to top](#)

National information on insurance companies

Want more information about this company? The NAIC's Consumer Information (CIS) page allows you to retrieve national financial and complaint information on insurance companies, plus has information and tips to help you understand current insurance issues.

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Ratings by financial organizations

The following organizations rate insurance companies on their financial strength and stability. Some of these companies charge for their services.

A.M. Best
Weiss Group Ratings

DECLARATION OF ELEANOR HAMBURGER - 9

Search > LIFEWISE HEALTH PLAN OF WASHINGTON

LIFEWISE HEALTH PLAN OF WASHINGTON

[General](#) | [Contact](#) | [Licensing](#) | [Appointments](#) | [Complaints](#) | [Orders](#) | [National Info](#) | [Ratings](#)

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General information

Name: LIFEWISE HEALTH PLAN OF WASHINGTON
Corporate family group: [PREMERA BLUE CROSS GRP](#) What is this?
Organization type: HEALTH CARE SERVICE CONTRACTOR

WAOIC: 170257
NAIC: 52633

Status: ACTIVE
Admitted date: 08/31/2000
Ownership type: NON-PROFIT

[↑ back to top](#)

Contact information

Registered address
 7001 - 220TH SW
 MNTLAKE TERRACE, WA
 98043

Telephone
 425-670-4000

Mailing address
 PO BOX 91120
 SEATTLE, WA 98111-9220

Telephone
 425-670-4000

Types of coverage authorized to sell What is this?

Insurance types

Health Care

[↑ back to top](#)

Agents and agencies that represent this company (Appointments) What is this?

[View agents](#)

[View agencies](#)

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Company complaint history What is this?

[View complaints](#)

[↑ back to top](#)

Disciplinary orders 2008-2012 What is this?

Year	Order Number
2009	09-0128
2011	11-0149

Looking for other orders? Our online orders search allows you to search a ten year history of all orders, including enforcement orders, administrative orders, and general orders.

[↑ back to top](#)

National information on insurance companies

Want more Information about this company? The NAIC's Consumer Information (CIS) page allows you to retrieve national financial and complaint information on insurance companies, plus has information and tips to help you understand current insurance issues.

[↑ back to top](#)

Ratings by financial organizations

The following organizations rate Insurance companies on their financial strength and stability. Some of these companies charge for their services.

A.M. Best

DECLARATION OF ELEANOR HAMBURGER - 10

Weiss Group Ratings
Standard and Poor's Corp
Moody's Investors Service
Fitch IBCA, Duff and Phelps Ratings

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Exhibit C

Information Summary and Recommendations

Treatment of Autism Spectrum Disorders Mandated Benefit Sunrise Review

January 2009



SUMMARY OF INFORMATION

Overview of Proceedings

Department of Health informed interested parties of the mandated benefit review. Interested parties included parents of children with autism spectrum disorders, insurance carriers, and health care providers. The proponent, Arzu Forough, submitted a proposal to assess the bill based on the statutory criteria (See Appendix A). The department shared the proposal with interested parties and invited them to comment. Agency staff did research when needed and reviewed all information submitted.

We conducted a public hearing on Sept. 5, 2008. Interested parties, including parents of children with autism spectrum disorders, health care providers, a representative from the insurance industry, and a representative from the state Health Care Authority (HCA), presented testimony. A review panel assisted with the hearing by asking clarifying questions of the hearing participants. We sought further comments from interested parties after the hearing.

We sent a draft report to participants and interested parties for review. There was a 10-day rebuttal period to comment on the draft report. Once the final comment period ended, staff finalized the recommendations. The final draft was reviewed and approved by the Assistant Secretary for Health Systems Quality Assurance and the Secretary of the Department of Health. The final report was sent to the legislature via the Office of Financial Management.

Background

In 2007 the Caring for Washington Individuals with Autism Task Force issued a report on autism spectrum disorders. Their report listed an insurance mandate for evidence-based autism spectrum disorders services as its highest and most urgent priority. The proposal under review was not submitted by the task force. However, the task force's 2007 report included a recommendation for an analysis to assess the sunrise criteria.

Autism spectrum disorders (ASD) are pervasive developmental disorders characterized by impairments or delays in social interaction, communication and language, as well as by repetitive routines and behaviors. They are called spectrum disorders because of the wide range and severity of symptoms. Children diagnosed with ASD suffer from problems with sensory integration, speech, and basic functions like toilet training, getting dressed, eating meals, brushing teeth, or sitting still during classes. Many medical conditions can accompany autism spectrum disorders. These include digestive problems, severe allergies, inability to detoxify, very high rate of infection, and vision problems. Some children with ASD display violent or self-harmful behaviors. IQs in children with this disorder range from superior to severely mentally retarded.^{1,2}

¹ "Caring for Washington Individuals with Autism Task Force: Report to the Governor and Legislature," Caring for Washington Individuals with Autism Task Force, 2006, Executive Summary.

² *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., American Psychiatric Association, Washington DC, 1994, pp. 65-66.

- Some insurance carriers only cover a small portion of the therapies necessary to treat ASD. They often limit treatment to \$1,000 to \$2,000 per year and/or limit the number of visits. Effective treatment for children with autism spectrum disorder can far surpass these limits.
- Low income children in Washington eligible for Medicaid have no age limits or therapy limits for neurodevelopmental therapy services.

Mental health parity

There is also a mental health parity mandate. It is unclear at this time how much (if any) ASD treatment should be covered under this mandate. The statute 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 (DSM)..." Autism spectrum disorder is a disorder included in the DSM.

State and federal programs

There are some programs that provide limited treatment for autism spectrum disorder. These include the Infant and Toddler Early Intervention Program's (ITEIP) Birth to Three Program, some programs through the Department of Social and Health Services, Department of Health's Children with Special Health Care Needs Program, neurodevelopmental therapy services under Medicaid, and some other ASD coverage under Medicaid.

A number of states have insurance mandates for autism. The Council for Affordable Health Insurance reports 11 states as having mandates. However, the proponent counts eight states as having autism parity mandates. The proponent reports as many as 21 states that have either introduced legislation or are working on legislation for autism parity mandates.

Private insurance

Many parents described the Premera Blue Cross Health Insurance plan offered by Microsoft as being a model for other plans to follow. This plan covers applied behavior analysis (ABA) therapy for children with ASD. Providers must meet strict qualifications including a master's or doctoral degree in education, psychology, speech/language pathology, behavior analysis or occupational therapy (or have national ABA certification), and 1,500 supervised hours working with children with autism spectrum disorder.

Education or health care?

Anecdotal evidence given during the review indicates that autism spectrum disorder (ASD) treatment is sometimes considered the responsibility of schools. Representatives from the insurance industry and the Health Care Authority questioned whether this is an educational issue, rather than a health care issue.

Limited treatment may be available in schools. However, it is designed, as required by law, to be educationally-relevant. It is designed to allow the child to participate in the educational program. The therapy does not include skills the child may need in other environments such as home, work place, and the community.

ASSESSMENT OF THE SUNRISE CRITERIA

Social impact

To what extent is the benefit generally utilized by a significant portion of the population?

It is estimated that one in 150 children has autism spectrum disorder. All of these children have need of some level of autism treatment.^{10,11}

To what extent is the benefit already generally available?

Intensive early intervention for autism, such as applied behavior analysis (ABA), is not generally available, nor is it covered through most health insurance plans.

There are a few programs that provide limited treatment to a small number of children with autism. These programs include:

- Infant and Toddler Early Intervention Program's (ITEIP) Birth to Three Program
- Programs through the Department of Social and Health Services
- Department of Health's Children with Special Health Care Needs Program
- Microsoft's private health plan
- Neurodevelopmental therapy services under Medicaid
- Other coverage under Medicaid

These programs are not generally available to a large portion of the population of children with ASD.

According to the 2007 "Washington State Autism Task Force Report", medically necessary treatment for people with autism spectrum disorder (ASD) is not widely available. It is routinely denied by insurance plans based on certain misconceptions. These include:

- ASD is widely seen as a mental illness, leading to referrals to ineffective treatments such as counseling or psychotherapy
- Treatment is considered habilitative, rather than rehabilitative
- Treatments are incorrectly thought of as being available in schools

If the benefit is not generally available, to what extent has its unavailability resulted in persons not receiving needed services?

Many children with ASD go without necessary treatments and services because the costs are so high and insurance coverage is not generally available. Many families simply cannot afford to pay for the necessary early, intensive treatments.

¹⁰ "Surveillance Summaries. Prevalence of Autism Spectrum Disorders--Autism and Developmental Disabilities Monitoring Network, 14 Sites, United States, 2002," *MMWR Morbidity Mortality Weekly Report*, Centers for Disease Control and Prevention, February 9, 2007, <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5601a1.htm>, accessed on October 1, 2008, cited by proponent's proposal, Appendix A.

¹¹ Eric Fombonne, "Epidemiology of Autistic Disorder and Other Pervasive Developmental Disorders," *Journal of Clinical Psychiatry*, 66 (suppl 10), 2005, pp. 3-8, cited by proponent's proposal, Appendix A.

Several parents stated that they chose less expensive, less effective therapies or unqualified providers because that is all they could afford. Many families said they were forced to end effective treatments because they could no longer afford to pay for them.

If the benefit is not generally available, to what extent has its unavailability resulted in unreasonable financial hardship?

"In the absence of coverage, out-of-pocket expenses for services can cost upwards of \$50,000 per year. In the process of trying to attain medical treatments and therapies, many risk their homes and the educations of their unaffected children — essentially mortgaging their entire futures."¹²

Many families wrote letters and testified at the hearing about the severe financial hardships caused by the high cost of treatment for autism spectrum disorder. The costs of treatments for children more severely impacted ranged from \$40,000 to \$100,000 per year. However, the proponent also notes that the cost for older children and those less severely impacted are often much lower, with average costs of \$9,000 to \$15,000 per year. Without adequate insurance coverage, parents were forced to cash in retirement accounts and college funds, charge up the maximum on multiple credit cards, borrow from extended families, take out second mortgages or sell their homes, or hold fundraisers in their communities.

We received testimony about families being in dire financial positions in order to pay for necessary treatments for their children with ASD. Many were forced to file bankruptcy or lost their homes to foreclosure. Many have spent their life savings on treatments. Some have been forced to quit their jobs because their children with ASD need full-time care. Parents also shared stories about siblings of children with this disorder being forced to sacrifice dental or vision care, sports, and other opportunities so their family could pay for treatment.

In addition, parents of children with autism spectrum disorder reported a higher than average divorce rate, which often results in increased financial hardship for the family. They believe effective ASD treatment provides a benefit to the entire family, not just the child.

What is the level of public demand for the benefit?

The demand for autism treatments is high. During the review, over 80 families stated there is a great need for an autism benefits mandate. No member of the public testified that ASD treatment is unnecessary. However, several parties commented that singling out ASD for a mandate unfairly excludes children with other developmental disabilities, such as Down syndrome.

What is the level of interest of collective bargaining agents in negotiating privately for inclusion of this benefit in group contracts?

The proponent did not have sufficient information to address this question.

¹² See proponent's response included in proposal.

Exhibit D

Recent research suggests that some children with OCD develop the condition after experiencing one type of streptococcal infection (Swedo et al., 1995). This condition is referred to by the acronym PANDAS, which stands for Pediatric Autoimmune Neuro-psychiatric Disorders Associated with Streptococcal infections. Its hallmark is a sudden and abrupt exacerbation of OCD symptoms after a strep infection. This form of OCD occurs when the immune system generates antibodies to the streptococcal bacteria, and the antibodies cross-react with the basal ganglia¹³ of a susceptible child, provoking OCD (Garvey et al., 1998). In other words, the cause of this form of OCD appears to be antibodies directed against the infection mistakenly attacking a region of the brain and setting off an inflammatory reaction.

The selective serotonin reuptake inhibitors appear effective in ameliorating the symptoms of OCD in children, although more clinical trials have been done with adults than with children. Several randomized, controlled trials revealed SSRIs to be effective in treating children and adolescents with OCD (Flament et al., 1985; DeVeaugh-Geiss et al., 1992; Riddle et al., 1992, 1998). The appropriate duration of treatment is still being studied. Side effects are not inconsequential: dry mouth, somnolence, dizziness, fatigue, tremors, and constipation occur at fairly high rates. Cognitive-behavioral treatments also have been used to treat OCD (March et al., 1997), but the evidence is not yet conclusive.

Autism

Autism, the most common of the pervasive developmental disorders (with a prevalence of 10 to 12 children per 10,000 [Bryson & Smith, 1998]), is characterized by severely compromised ability to engage in, and by a lack of interest in, social interactions. It has roots in both structural brain abnormalities and genetic predispositions, according to family studies and studies of brain anatomy. The search for genes that predispose to autism is considered an

extremely high research priority for the National Institute of Mental Health (NIMH, 1998). Although the reported association between autism and obstetrical hazard may be due to genetic factors (Bailey et al., 1995), there is evidence that several different causes of toxic or infectious damage to the central nervous system during early development also may contribute to autism. Autism has been reported in children with fetal alcohol syndrome (Aronson et al., 1997), in children who were infected with rubella during pregnancy (Chess et al., 1978), and in children whose mothers took a variety of medications that are known to damage the fetus (Williams & Hersh, 1997).

Cognitive deficits in social perception likely result from abnormalities in neural circuitry. Children with autism have been studied with several imaging techniques, but no strongly consistent findings have emerged, although abnormalities in the cerebellum and limbic system (Rapin & Katzman, 1998) and larger brains (Fiven, 1997) have been reported. In one small study (Zilbovicius et al., 1995), evidence of delayed maturation of the frontal cortex was found. The evidence for genetic influences include a much greater concordance in identical than in fraternal twins (Cook, 1998).

Treatment

Because autism is 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 interfere with the child's functioning and learning. Intensive, sustained special education programs and behavior therapy early in life can increase the ability of the child with autism to acquire language and ability to learn. Special education programs in highly structured environments appear to help the child acquire self-care, social, and job skills. Only in the past decade have studies shown positive outcomes for very young children with autism. Given the severity of the impairment, high intensity of service needs, and costs (both human and financial), there has been an ongoing search for effective treatment.

¹³ Basal ganglia are groups of neurons responsible for motor and impulse control, attention, and regulation of mood and behavior.

Mental Health: A Report of the Surgeon General

Thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior. A well-designed study of a psychosocial intervention was carried out by Lovaas and colleagues (Lovaas, 1987; McEachin et al., 1993). Nineteen children with autism were treated intensively with behavior therapy for 2 years and compared with two control groups. Followup of the experimental group in first grade, in late childhood, and in adolescence found that nearly half the experimental group but almost none of the children in the matched control group were able to participate in regular schooling. Up to this point, a number of other research groups have provided at least a partial replication of the Lovaas model (see Rogers, 1998).

Several uncontrolled studies of comprehensive center-based programs have been conducted, focusing on language development and other developmental skills. A comprehensive model, Treatment and Education of Autistic and Related Communication Handicapped Children (TEACCH), demonstrated short-term gains for preschoolers with autism who received daily TEACCH home-teaching sessions, compared with a matched control group (Ozonoff & Cathcart, 1998). A review of other comprehensive, center-based programs has been conducted, focusing on elements considered critical to school-based programs, including minimum hours of service and necessary curricular components (Dawson & Osterling, 1997).

The antipsychotic drug, haloperidol, has been shown to be superior to placebo in the treatment of autism (Perry et al., 1989; Locascio et al., 1991), although a significant number of children develop dyskinesias¹⁴ as a side effect (Campbell et al., 1997). Two of the SSRIs, clomipramine (Gordon et al., 1993) and fluoxetine (McDougle et al., 1996), have been tested, with positive results, except in young autistic children, in whom clomipramine was not found to be therapeutic, and who experienced untoward side effects (Sanchez et al., 1996). Of note, preliminary studies of

¹⁴ Dyskinesia is an impairment of voluntary movement, such that it becomes fragmentary or incomplete.

some of the newer antipsychotic drugs suggest that they may have fewer side effects than conventional antipsychotics such as haloperidol, but controlled studies are needed before firm conclusions can be drawn about any possible advantages in safety and efficacy over traditional agents.

Disruptive Disorders

Disruptive disorders, such as oppositional defiant disorder and conduct disorder, are characterized by antisocial behavior and, as such, seem to be a collection of behaviors rather than a coherent pattern of mental dysfunction. These behaviors are also frequently found in children who suffer from attention-deficit/hyperactivity disorder, another disruptive disorder, which is discussed separately in this chapter. Children who develop the more serious conduct disorders often show signs of these disorders at an earlier age. Although it is common for a very young children to snatch something they want from another child, this kind of behavior may herald a more generally aggressive behavior and be the first sign of an emerging oppositional defiant or conduct disorder if it occurs by the ages of 4 or 5 and later. However, not every oppositional defiant child develops conduct disorder, and the difficult behaviors associated with these conditions often remit.

Oppositional defiant disorder (ODD) is diagnosed when a child displays a persistent or consistent pattern of defiance, disobedience, and hostility toward various authority figures including parents, teachers, and other adults. ODD is characterized by such problem behaviors as persistent fighting and arguing, being touchy or easily annoyed, and deliberately annoying or being spiteful or vindictive to other people. Children with ODD may repeatedly lose their temper, argue with adults, deliberately refuse to comply with requests or rules of adults, blame others for their own mistakes, and be repeatedly angry and resentful. Stubbornness and testing of limits are common. These behaviors cause significant difficulties with family and friends and at school or work (DSM-IV; Weiner, 1997). Oppositional defiant disorder is sometimes a precursor of conduct disorder (DSM-IV).

Exhibit E

Caring for Washington Individuals with Autism Task Force

Report to Governor and Legislature
Priority Recommendations and Implementation Plans

December 2007

Chapter 4

Priority Recommendation 1

Ensure all individuals with ASD receive comprehensive health services and coverage within a Medical Home.

Cost Estimates

Estimating costs for mandated insurance benefits would require a Sunrise Review by the Department of Health (48.47.030 RCW).¹⁷ The Caring for Washington Individuals with Autism Task Force will continue to explore the activities described in Objective 2 to increase access to medical homes for individuals with ASD and identify any related costs in the future.

Justification

The ATF chose to make mandating insurance benefits its first priority recommendation. Transforming the way insurance carriers include autism and related conditions within health insurance policy will significantly affect access for the majority of individuals with an autism spectrum or related disorder in our state.

Children with autism commonly have a range of medical conditions for which they need treatment.¹⁸ Nationally, 22 states have successfully mandated insurance coverage for evidence based intervention services that benefit children with autism.¹⁹ There is no mandate for insurance coverage within Washington State. Only four major private insurers in Washington offer any coverage for comprehensive services for children with autism. Only Microsoft, one of the four, is broad in benefit coverage. This could be a model for the state and industry. Many families have no coverage for needed services. This places families under tremendous financial burdens and strain to provide adequate care for their children. The Council for Affordable Health Insurance, in a 2007 report reviewing 10 states mandating insurance coverage, find the incremental cost of mandated benefits for autism at less than one percent.²⁰

¹⁷ Sunrise Review Process. Mandated Health Insurance Benefits. Washington State Department of Health. Accessed November 9, 2007 <http://www.doh.wa.gov/hsqa/sunrise/mandated.htm>

¹⁸ Gurney, J. G., McPheeters, M. L., Davis, M. M. *Parental Report of Health Conditions and Health Care Use Among Children With and Without Autism*. National Survey of Children's Health. *Archives of Pediatrics & Adolescent Medicine*. 2006; Vol. 160: pp. 825-830. Accessed November 21, 2007 from <http://archpedi.ama-assn.org/cgi/content/full/160/8/825>

¹⁹ Steering Committee Legislative Information, Appendix 4f)

²⁰ Bunce, V. C., Wieske, J. P., Prikazsky, V. *Health Insurance Mandates in the States, 2007*. Council for Affordable Health Insurance. Accessed November 21, 2007 from www.cahi.org

Appropriate, financially feasible services are not accessible for many individuals and families within their communities. Barriers to health care access include specific exclusions for autism diagnosis by many private health insurance plans,²¹ no coverage for Applied Behavioral Analysis (ABA) and other autism—related services,²² or denial of coverage for behavioral interventions by licensed PhD clinical psychologists or Board Certified Behavior Analysts (BCBA). All of these barriers contribute to access of care.

Wait-lists in the greater Seattle area typically exceed 6 months. Many families in our state have no access to services. To ensure that all individuals with autism and related conditions receive appropriate, accessible, and affordable services within their communities, insurance coverage for evidenced-based practices, including but not limited to, early intensive behavioral intervention is critical.

The task force believes that everyone deserves to have access to health care that follows sound evidence-based practices, and that the struggle for equality and recognition of autism and appropriate treatment will take both time and effort. Establishing good health policy takes thoughtful and considerate action to accomplish. As such, the task force recognizes that other priority recommendations such as training providers on new screening tools regarding autism may be more immediately attainable. These other steps are important for raising awareness and will help in the developing comprehensive health policy.

Implementation Plan

Objective 1: Improve Insurance Coverage for Individuals with ASD

1. Extend insurance benefits to cover interventions for individuals with ASD.
 - a. Consult with individuals from states such as South Carolina and Pennsylvania where successful legislation mandating state insurance coverage for ASD intervention was passed.
 - b. Mandate coverage of behavioral interventions provided by licensed PhD level clinical psychologists and Board Certified Behavior Analysts (BCBA).
2. Expand Medicaid benefits to promote equity in health care access and encourage providers to serve clients who are enrolled in Medicaid.

²¹ Peele, P. B., Lave, J. R., Kelleher, K. J. *Exclusions and Limitations in Children's Behavioral Health Care Coverage. Psychiatric Services.* 2002. Vol. 53, pp. 591-594. Accessed November 21, 2007 from <http://www.ps.psychiatryonline.org/cgi/content/full/53/5/591>

²² Peele, P. B., Lave, J. R., Kelleher, K. J. *Exclusions and Limitations in Children's Behavioral Health Care Coverage. Psychiatric Services.* 2002. Vol. 53, pp. 591-594. Accessed November 21, 2007 from <http://www.ps.psychiatryonline.org/cgi/content/full/53/5/591>

- a. Increase the number of psychological assessments allowed (currently one per lifetime).
 - b. Increase rate of reimbursement and streamline paperwork and service approval process to encourage more providers to accept Medicaid patients.
 - c. Provide benefits comparable to private insurance, including reimbursement for costs of behavioral intervention.
 - d. Allow coverage of behavioral interventions provided by licensed PhD level clinical psychologists and board certified behavior analysts for individuals with an autism spectrum disorder.
3. Support policies that ensure neurodevelopmental therapy insurance benefits.
- a. Extend neurodevelopmental therapy benefit including speech-language services, occupational and physical therapy to individuals aged 18 years.
 - b. Include certified behavioral analysts (BCBA) in neurodevelopmental therapy benefits.

Objective 2: Train and provide support to health care providers caring for individuals with ASD and increase access to medical homes.

The ATF recognizes that a medical home supports knowledge of and access to comprehensive services within the community. Providing increased support to health care providers is essential so that they have easily accessible, scientifically sound, reliable information about autism and related disorders. Health care providers need to be able to easily direct patients to the services they need. See Chapter 6 for additional activities to promote medical homes and increase provider knowledge of ASD and related disorders.

1. Improve advanced registered nurse practitioners, physician assistants, and medical school residency training on ASD and related conditions.
 - a. Assess and provide training standards for Washington State programs.
 - b. Collaborate with training programs to increase awareness and surveillance of autism and related conditions.
2. Identify an on-line medical consultation service to provide a quality consultation resource for primary care providers. Service could expand consultative service to primary care providers who serve individuals with autism. Promote use of the service across the state.²³
3. Improve access to high-quality medical homes for individuals with ASD and related disorders.
 - a. Explore successful programs nationally:
 - i. Obtain consultation from the Waisman Center or similar organization.²⁴

²³ Appendix 4c), Identification/Tracking Mid-Term Report

²⁴ Waisman Center. National Medical Home Autism Initiative. Framework, Partnerships, Resources, Publications, What's New. 2007. Accessed October 30, 2007 website <http://www.waisman.wisc.edu/nmhai/index.html>

- ii. Obtain assistance from the National Center on Medical Home Initiatives for Children with Special Needs at the American Academy of Pediatrics.²⁵
- b. Explore regional successful medical home programs such as those available to the armed forces.
- c. Make use of the Medical Home Leadership Network in Washington to pilot successful strategies to increase high quality medical homes throughout the state.²⁶
- d. Use Child Health Notes²⁷ as another possible model to provide more information about autism to primary care providers in Washington.

²⁵ National Center of Medical Home Initiatives for Children with Special Needs. What is a Medical Home. May 24, 2006. American Academy of Pediatrics. Accessed November 1, 2007 from website <http://www.medicalhomeinfo.org/lion.html>

²⁶ Washington State Medical Home. The Medical Home Leadership Network. Washington State Department of Health. 2007. Accessed October 30, 2007 from website http://www.medicalhome.org/leadership/the_mhln.cfm

²⁷ Washington State Medical Home. Child Health Notes. University of Washington & DOH. 2007. Accessed November 9, 2007 from <http://www.medicalhome.org/leadership/chn.cfm>

Exhibit F

Mental Health

A Report of the Surgeon General Executive Summary

DEPARTMENT OF HEALTH AND HUMAN SERVICES
U.S. Public Health Service



The Center for Mental Health Services
*Substance Abuse and Mental Health
Services Administration*

NIMH

National Institute
of Mental Health
National Institutes of Health

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Message from Donna E. Shalala *Secretary of Health and Human Services*

The United States leads the world in understanding the importance of overall health and well-being to the strength of a Nation and its people. What we are coming to realize is that mental health is absolutely essential to achieving prosperity. According to the landmark "Global Burden of Disease" study, commissioned by the World Health Organization and the World Bank, 4 of the 10 leading causes of disability for persons age 5 and older are mental disorders. Among developed nations, including the United States, major depression is the leading cause of disability. Also near the top of these rankings are manic-depressive illness, schizophrenia, and obsessive-compulsive disorder. Mental disorders also are tragic contributors to mortality, with suicide perennially representing one of the leading preventable causes of death in the United States and worldwide.

The U.S. Congress declared the 1990s the Decade of the Brain. In this decade we have learned much through research—in basic neuroscience, behavioral science, and genetics—about the complex workings of the brain. Research can help us gain a further understanding of the fundamental mechanisms underlying thought, emotion, and behavior—and an understanding of what goes wrong in the brain in mental illness. It can also lead to better treatments and improved services for our diverse population.

Now, with the publication of this first Surgeon General's Report on Mental Health, we are poised to take what we know and to advance the state of mental health in the Nation. We can with great confidence encourage individuals to seek treatment when they find themselves experiencing the signs and symptoms of mental distress. Research has given us effective treatments and service delivery strategies for many mental disorders. An array of safe and potent medications and psychosocial interventions, typically used in combination, allow us to effectively treat most mental disorders.

This seminal report provides us with an opportunity to dispel the myths and stigma surrounding mental illness. For too long the fear of mental illness has been profoundly destructive to people's lives. In fact mental illnesses are just as real as other illnesses, and they are like other illnesses in most ways. Yet fear and stigma persist, resulting in lost opportunities for individuals to seek treatment and improve or recover.

In this Administration, a persistent, courageous advocate of affordable, quality mental health services for all Americans is Mrs. Tipper Gore, wife of the Vice President. We salute her for her historic leadership and for her enthusiastic support of the initiative by the Surgeon General, Dr. David Satcher, to issue this groundbreaking Report on Mental Health.

The 1999 White House Conference on Mental Health called for a national antistigma campaign. The Surgeon General issued a Call to Action on Suicide Prevention in 1999 as well. This Surgeon General's Report on Mental Health takes the next step in advancing the important notion that mental health is fundamental health.

Foreword

Since the turn of this century, thanks in large measure to research-based public health innovations, the lifespan of the average American has nearly doubled. Today, our Nation's physical health—as a whole—has never been better. Moreover, illnesses of the body, once shrouded in fear—such as cancer, epilepsy, and HIV/AIDS to name just a few—increasingly are seen as treatable, survivable, even curable ailments. Yet, despite unprecedented knowledge gained in just the past three decades about the brain and human behavior, mental health is often an afterthought and illnesses of the mind remain shrouded in fear and misunderstanding.

This Report of the Surgeon General on Mental Health is the product of an invigorating collaboration between two Federal agencies. The Substance Abuse and Mental Health Services Administration (SAMHSA), which provides national leadership and funding to the states and many professional and citizen organizations that are striving to improve the availability, accessibility, and quality of mental health services, was assigned lead responsibility for coordinating the development of the report. The National Institutes of Health (NIH), which supports and conducts research on mental illness and mental health through its National Institute of Mental Health (NIMH), was pleased to be a partner in this effort. The agencies we respectively head were able to rely on the enthusiastic participation of hundreds of people who played a role in researching, writing, reviewing, and disseminating this report. We wish to express our appreciation and that of a mental health constituency, millions of Americans strong, to Surgeon General David Satcher, M.D., Ph.D., for inviting us to participate in this landmark report.

The year 1999 witnessed the first White House Conference on Mental Health and the first Secretarial Initiative on Mental Health prepared under the aegis of the Department of Health and Human Services. These activities set an optimistic tone for progress that will be realized in the years ahead. Looking ahead, we take special pride in the remarkable record of accomplishment, in the spheres of both science and services, to which our agencies have contributed over past decades. With the impetus that the Surgeon General's report provides, we intend to expand that record of accomplishment. This report recognizes the inextricably intertwined relationship between our mental health and our physical health and well-being. The report emphasizes that mental health and mental illnesses are important concerns at all ages. Accordingly, we will continue to attend to needs that occur across the lifespan, from the youngest child to the oldest among us.

The report lays down a challenge to the Nation—to our communities, our health and social service agencies, our policymakers, employers, and citizens—to take action. SAMHSA and NIH look forward to continuing our collaboration to generate needed knowledge about the brain and behavior and to translate that knowledge to the service systems, providers, and citizens.

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Administrator
Substance Abuse and Mental Health
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Steven E. Hyman, M.D.
Director
National Institute of Mental Health
for The National Institutes of Health

Bernard S. Arons, M.D.
Director
Center for Mental Health Services

Preface
from the Surgeon General
U.S. Public Health Service

The past century has witnessed extraordinary progress in our improvement of the public health through medical science and ambitious, often innovative, approaches to health care services. Previous Surgeons General reports have saluted our gains while continuing to set ever higher benchmarks for the public health. Through much of this era of great challenge and greater achievement, however, concerns regarding mental illness and mental health too often were relegated to the rear of our national consciousness. Tragic and devastating disorders such as schizophrenia, depression and bipolar disorder, Alzheimer's disease, the mental and behavioral disorders suffered by children, and a range of other mental disorders affect nearly one in five Americans in any year, yet continue too frequently to be spoken of in whispers and shame. Fortunately, leaders in the mental health field—fiercely dedicated advocates, scientists, government officials, and consumers—have been insistent that mental health flow in the mainstream of health. I agree and issue this report in that spirit.

This report makes evident that the neuroscience of mental health—a term that encompasses studies extending from molecular events to psychological, behavioral, and societal phenomena—has emerged as one of the most exciting arenas of scientific activity and human inquiry. We recognize that the brain is the integrator of thought, emotion, behavior, and health. Indeed, one of the foremost contributions of contemporary mental health research is the extent to which it has mended the destructive split between “mental” and “physical” health.

We know more today about how to treat mental illness effectively and appropriately than we know with certainty about how to prevent mental illness and promote mental health. Common sense and respect for our fellow humans tells us that a focus on the positive aspects of mental health demands our immediate attention.

Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender. A key disparity often hinges on a person's financial status; formidable financial barriers block off needed mental health care from too many people regardless of whether one has health insurance with inadequate mental health benefits, or is one of the 44 million Americans who lack any insurance. We have allowed stigma and a now unwarranted sense of hopelessness about the opportunities for recovery from mental illness to erect these barriers. It is time to take them down.

Promoting mental health for all Americans will require scientific know-how but, even more importantly, a societal resolve that we will make the needed investment. The investment does not call for massive budgets; rather, it calls for the willingness of each of us to educate ourselves and others about mental health and mental illness, and thus to confront the attitudes, fear, and misunderstanding that remain as barriers before us. It is my intent that this report will usher in a healthy era of mind and body for the Nation.

David Satcher, M.D., Ph.D.
Surgeon General

CHAPTER 1

INTRODUCTION AND THEMES

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CHAPTER 1

INTRODUCTION AND THEMES

This first Surgeon General's Report on Mental Health is issued at the culmination of a half-century that has witnessed remarkable advances in the understanding of mental disorders and the brain and in our appreciation of the centrality of mental health to overall health and well-being. The report was prepared against a backdrop of growing awareness in the United States and throughout the world of the immense burden of disability associated with mental illnesses. In the United States, mental disorders collectively account for more than 15 percent of the overall burden of disease from *all* causes and slightly more than the burden associated with all forms of cancer (Murray & Lopez, 1996). These data underscore the importance and urgency of treating and preventing mental disorders and of promoting mental health in our society.

The report in its entirety provides an up-to-date review of scientific advances in the study of mental health and of mental illnesses that affect at least one in five Americans. Several important conclusions may be drawn from the extensive scientific literature summarized in the report. One is that a variety of treatments of well-documented efficacy exist for the array of clearly defined mental and behavioral disorders that occur across the life span. Every person should be encouraged to seek help when questions arise about mental health, just as each person is encouraged to seek help when questions arise about health. Research highlighted in the report demonstrates that mental health is a facet of health that evolves throughout the lifetime. Just as each person can do much to promote and maintain overall health regardless of age, each also can do much to promote and strengthen mental health at every stage of life.

Much remains to be learned about the causes, treatment, and prevention of mental and behavioral

disorders. Obstacles that may limit the availability or accessibility of mental health services for some Americans are being dismantled, but disparities persist. Still, thanks to research and the experiences of millions of individuals who have a mental disorder, their family members, and other advocates, the Nation has the power today to tear down the most formidable obstacle to future progress in the arena of mental illness and health. That obstacle is stigma. Stigmatization of mental illness is an excuse for inaction and discrimination that is inexcusably outmoded in 1999. As evident in the chapters that follow, we have acquired an immense amount of knowledge that permits us, as a Nation, to respond to the needs of persons with mental illness in a manner that is both effective and respectful.

Overarching Themes

Mental Health and Mental Illness: A Public Health Approach

The Nation's contemporary mental health enterprise, like the broader field of health, is rooted in a population-based public health model. The public health model is characterized by concern for the health of a population in its entirety and by awareness of the linkage between health and the physical and psychosocial environment. Public health focuses not only on traditional areas of diagnosis, treatment, and etiology, but also on epidemiologic surveillance of the health of the population at large, health promotion, disease prevention, and access to and evaluation of services (Last & Wallace, 1992).

Just as the mainstream of public health takes a broad view of health and illness, this Surgeon General's Report on Mental Health takes a wide-angle lens to *both* mental health and mental illness. In years

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past, the mental health field often focused principally on mental illness in order to serve individuals who were most severely affected. Only as the field has matured has it begun to respond to intensifying interest and concerns about disease prevention and health promotion. Because of the more recent consideration of these topic areas, the body of accumulated knowledge regarding them is not as expansive as that for mental illness.

Mental Disorders are Disabling

The burden of mental illness on health and productivity in the United States and throughout the world has long been profoundly underestimated. Data developed by the massive Global Burden of Disease study,¹ conducted by the World Health Organization, the World Bank, and Harvard University, reveal that mental illness, including suicide,² ranks second in the burden of disease in established market economies, such as the United States (Table 1-1).

Mental illness emerged from the Global Burden of Disease study as a surprisingly significant contributor to the burden of disease. The measure of calculating disease burden in this study, called Disability Adjusted Life Years (DALYs), allows comparison of the burden

Table 1-1. Disease burden by selected illness categories in established market economies, 1990

	Percent of Total DALYs*
All cardiovascular conditions	18.6
All mental illness**	15.4
All malignant diseases (cancer)	6.0
All respiratory conditions	4.8
All alcohol use	4.7
All infectious and parasitic diseases	2.8
All drug use	1.5

*Disability-adjusted life year (DALY) is a measure that expresses years of life lost to premature death and years lived with a disability of specified severity and duration (Murray & Lopez, 1996).

**Disease burden associated with "mental illness" includes suicide.

¹ Murray & Lopez, 1996.

² The Surgeon General issued a Call to Action on Suicide in 1999, reflecting the public health magnitude of this consequence of mental illness. The Call to Action is summarized in Figure 4-1.

of disease across many different disease conditions. DALYs account for lost years of healthy life regardless of whether the years were lost to premature death or disability. The disability component of this measure is weighted for severity of the disability. For example, major depression is equivalent in burden to blindness or paraplegia, whereas active psychosis seen in schizophrenia is equal in disability burden to quadriplegia.

By this measure, major depression alone ranked second only to ischemic heart disease in magnitude of disease burden (see Table 1-2). Schizophrenia, bipolar disorder, obsessive-compulsive disorder, panic disorder, and post-traumatic stress disorder also contributed significantly to the burden represented by mental illness.

Table 1-2. Leading sources of disease burden in established market economies, 1990

	Total DALYs (millions)	Percent of Total
All causes	98.7	
1 Ischemic heart disease	8.9	9.0
2 Unipolar major depression	6.7	6.8
3 Cardiovascular disease	5.0	5.0
4 Alcohol use	4.7	4.7
5 Road traffic accidents	4.3	4.4

Source: Murray & Lopez, 1996.

Mental Health and Mental Illness: Points on a Continuum

As will be evident in the pages that follow, "mental health" and "mental illness" are not polar opposites but may be thought of as points on a continuum. *Mental health* is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. Mental health is indispensable to personal well-being, family and interpersonal relationships, and contribution to community or society. It is easy to overlook the value of mental health until problems surface. Yet from early childhood until death, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem. These

are the ingredients of each individual's successful contribution to community and society. Americans are inundated with messages about *success*—in school, in a profession, in parenting, in relationships—without appreciating that successful performance rests on a foundation of mental health.

Many ingredients of mental health may be identifiable, but mental health is not easy to define. In the words of a distinguished leader in the field of mental health prevention, “. . . built into any definition of wellness . . . are overt and covert expressions of values. Because values differ across cultures as well as among subgroups (and indeed individuals) within a culture, the ideal of a uniformly acceptable definition of the constructs is illusory” (Cowen, 1994). In other words, what it means to be mentally healthy is subject to many different interpretations that are rooted in value judgments that may vary across cultures. The challenge of defining mental health has stalled the development of programs to foster mental health (Secker, 1998), although strides have been made with wellness programs for older people (Chapter 5).

Mental illness is the term that refers collectively to all diagnosable mental disorders. Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Alzheimer's disease exemplifies a mental disorder largely marked by alterations in thinking (especially forgetting). Depression exemplifies a mental disorder largely marked by alterations in mood. Attention-deficit/hyperactivity disorder exemplifies a mental disorder largely marked by alterations in behavior (overactivity) and/or thinking (inability to concentrate). Alterations in thinking, mood, or behavior contribute to a host of problems—patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom (American Psychiatric Association, 1994).

This report uses the term “mental health problems” for signs and symptoms of insufficient intensity or duration to meet the criteria for any mental disorder. Almost everyone has experienced mental health problems in which the distress one feels matches some

of the signs and symptoms of mental disorders. Mental health problems may warrant active efforts in health promotion, prevention, and treatment. Bereavement symptoms in older adults offer a case in point. Bereavement symptoms of less than 2 months' duration do not qualify as a mental disorder, according to professional manuals for diagnosis (American Psychiatric Association, 1994). Nevertheless, bereavement symptoms can be debilitating if they are left unattended. They place older people at risk for depression, which, in turn, is linked to death from suicide, heart attack, or other causes (Zisook & Shuchter, 1991, 1993; Frasure-Smith et al., 1993, 1995; Conwell, 1996). Much can be done—through formal treatment or through support group participation—to ameliorate the symptoms and to avert the consequences of bereavement. In this case, early intervention is needed to address a mental health problem before it becomes a potentially life-threatening disorder.

Mind and Body are Inseparable

Considering health and illness as points along a continuum helps one appreciate that neither state exists in pure isolation from the other. In another but related context, everyday language tends to encourage a misperception that “mental health” or “mental illness” is unrelated to “physical health” or “physical illness.” In fact, the two are inseparable.

Seventeenth-century philosopher Rene Descartes conceptualized the distinction between the mind and the body. He viewed the “mind” as completely separable from the “body” (or “matter” in general). The mind (and spirit) was seen as the concern of organized religion, whereas the body was seen as the concern of physicians (Eisendrath & Feder, in press). This partitioning ushered in a separation between so-called “mental” and “physical” health, despite advances in the 20th century that proved the interrelationships between mental and physical health (Cohen & Herbert, 1996; Baum & Posluszny, 1999).

Although “mind” is a broad term that has had many different meanings over the centuries, today it refers to the totality of mental functions related to thinking, mood, and purposive behavior. The mind is generally

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seen as deriving from activities within the brain but displaying emergent properties, such as consciousness (Fischbach, 1992; Gazzaniga et al., 1998).

One reason the public continues to this day to emphasize the difference between mental and physical health is embedded in language. Common parlance continues to use the term "physical" to distinguish some forms of health and illness from "mental" health and illness. People continue to see mental and physical as separate functions when, in fact, mental functions (e.g., memory) are physical as well (American Psychiatric Association, 1994). Mental functions are carried out by the brain. Likewise, mental disorders are reflected in physical changes in the brain (Kandel, 1998). Physical changes in the brain often trigger physical changes in other parts of the body too. The racing heart, dry mouth, and sweaty palms that accompany a terrifying nightmare are orchestrated by the brain. A nightmare is a mental state associated with alterations of brain chemistry that, in turn, provoke unmistakable changes elsewhere in the body.

Instead of dividing physical from mental health, the more appropriate and neutral distinction is between "mental" and "somatic" health. Somatic is a medical term that derives from the Greek word *soma* for the body. Mental health refers to the successful performance of mental functions in terms of thought, mood, and behavior. Mental disorders are those health conditions in which alterations in mental functions are paramount. Somatic conditions are those in which alterations in nonmental functions predominate. While the brain carries out all mental functions, it also carries out some somatic functions, such as movement, touch, and balance. That is why not all brain diseases are mental disorders. For example, a stroke causes a lesion in the brain that may produce disturbances of movement, such as paralysis of limbs. When such symptoms predominate in a patient, the stroke is considered a somatic condition. But when a stroke mainly produces alterations of thought, mood, or behavior, it is considered a mental condition (e.g., dementia). The point is that a brain disease can be seen as a mental disorder or a somatic disorder depending on the functions it perturbs.

The Roots of Stigma

Stigmatization of people with mental disorders has persisted throughout history. It is manifested by bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance. Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders, especially severe disorders such as schizophrenia (Penn & Martin, 1998; Corrigan & Penn, 1999). It reduces patients' access to resources and opportunities (e.g., housing, jobs) and leads to low self-esteem, isolation, and hopelessness. It deters the public from seeking, and wanting to pay for, care. In its most overt and egregious form, stigma results in outright discrimination and abuse. More tragically, it deprives people of their dignity and interferes with their full participation in society.

Explanations for stigma stem, in part, from the misguided split between mind and body first proposed by Descartes. Another source of stigma lies in the 19th-century separation of the mental health treatment system in the United States from the mainstream of health. These historical influences exert an often immediate influence on perceptions and behaviors in the modern world.

Separation of Treatment Systems

In colonial times in the United States, people with mental illness were described as "lunatics" and were largely cared for by families. There was no concerted effort to treat mental illness until urbanization in the early 19th century created a societal problem that previously had been relegated to families scattered among small rural communities. Social policy assumed the form of isolated asylums where persons with mental illness were administered the reigning treatments of the era. By the late 19th century, mental illness was thought to grow "out of a violation of those physical, mental and moral laws which, properly understood and obeyed, result not only in the highest development of the race, but the highest type of civilization" (cited in Grob, 1983). Throughout the history of institutionalization in asylums (later renamed mental hospitals), reformers strove to improve treatment and curtail abuse. Several waves of reform culminated in

the deinstitutionalization movement that began in the 1950s with the goal of shifting patients and care to the community.

Public Attitudes About Mental Illness: 1950s to 1990s

Nationally representative surveys have tracked public attitudes about mental illness since the 1950s (Star, 1952, 1955; Gurin et al., 1960; Veroff et al., 1981). To permit comparisons over time, several surveys of the 1970s and the 1990s phrased questions exactly as they had been asked in the 1950s (Swindle et al., 1997).

In the 1950s, the public viewed mental illness as a stigmatized condition and displayed an unscientific understanding of mental illness. Survey respondents typically were not able to identify individuals as "mentally ill" when presented with vignettes of individuals who would have been said to be mentally ill according to the professional standards of the day. The public was not particularly skilled at distinguishing mental illness from ordinary unhappiness and worry and tended to see only extreme forms of behavior—namely psychosis—as mental illness. Mental illness carried great social stigma, especially linked with fear of unpredictable and violent behavior (Star, 1952, 1955; Gurin et al., 1960; Veroff et al., 1981).

By 1996, a modern survey revealed that Americans had achieved greater scientific understanding of mental illness. But the increases in knowledge did not defuse social stigma (Phelan et al., 1997). The public learned to define mental illness and to distinguish it from ordinary worry and unhappiness. It expanded its definition of mental illness to encompass anxiety, depression, and other mental disorders. The public attributed mental illness to a mix of biological abnormalities and vulnerabilities to social and psychological stress (Link et al., in press). Yet, in comparison with the 1950s, the public's perception of mental illness more frequently incorporated violent behavior (Phelan et al., 1997). This was primarily true among those who defined mental illness to include psychosis (a view held by about one-third of the entire sample). Thirty-one percent of this group mentioned violence in its descriptions of mental illness, in

comparison with 13 percent in the 1950s. In other words, the perception of people with psychosis as being dangerous is stronger today than in the past (Phelan et al., 1997).

The 1996 survey also probed how perceptions of those with mental illness varied by diagnosis. The public was more likely to consider an individual with schizophrenia as having mental illness than an individual with depression. All of them were distinguished reasonably well from a worried and unhappy individual who did not meet professional criteria for a mental disorder. The desire for social distance was consistent with this hierarchy (Link et al., in press).

Why is stigma so strong despite better public understanding of mental illness? The answer appears to be fear of violence: people with mental illness, especially those with psychosis, are perceived to be more violent than in the past (Phelan et al., 1997).

This finding begs yet another question: Are people with mental disorders truly more violent? Research supports some public concerns, but the overall likelihood of violence is low. The greatest risk of violence is from those who have dual diagnoses, i.e., individuals who have a mental disorder as well as a substance abuse disorder (Swanson, 1994; Eronen et al., 1998; Steadman et al., 1998). There is a small elevation in risk of violence from individuals with severe mental disorders (e.g., psychosis), especially if they are noncompliant with their medication (Eronen et al., 1998; Swartz et al., 1998). Yet the risk of violence is much less for a stranger than for a family member or person who is known to the person with mental illness (Eronen et al., 1998). *In fact, there is very little risk of violence or harm to a stranger from casual contact with an individual who has a mental disorder.* Because the average person is ill-equipped to judge whether someone who is behaving erratically has any of these disorders, alone or in combination, the natural tendency is to be wary. Yet, to put this all in perspective, the overall contribution of mental disorders to the total level of violence in society is exceptionally small (Swanson, 1994).

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Because most people should have little reason to fear violence from those with mental illness, even in its most severe forms, *why* is fear of violence so entrenched? Most speculations focus on media coverage and deinstitutionalization (Phelan et al., 1997; Heginbotham, 1998). One series of surveys found that selective media reporting reinforced the public's stereotypes linking violence and mental illness and encouraged people to distance themselves from those with mental disorders (Angermeyer & Matschinger, 1996). And yet, deinstitutionalization made this distancing impossible over the 40 years as the population of state and county mental hospitals was reduced from a high of about 560,000 in 1955 to well below 100,000 by the 1990s (Bachrach, 1996). Some advocates of deinstitutionalization expected stigma to be reduced with community care and commonplace exposure. Stigma might have been greater today had not public education resulted in a more scientific understanding of mental illness.

Stigma and Seeking Help for Mental Disorders

Nearly two-thirds of all people with diagnosable mental disorders do not seek treatment (Regier et al., 1993; Kessler et al., 1996). Stigma surrounding the receipt of mental health treatment is among the many barriers that discourage people from seeking treatment (Sussman et al., 1987; Cooper-Patrick et al., 1997). Concern about stigma appears to be heightened in rural areas in relation to larger towns or cities (Hoyt et al., 1997). Stigma also disproportionately affects certain age groups, as explained in the chapters on children and older people.

The surveys cited above concerning evolving public attitudes about mental illness also monitored how people would cope with, and seek treatment for, mental illness if they became symptomatic. (The term "nervous breakdown" was used in lieu of the term "mental illness" in the 1996 survey to allow for comparisons with the surveys in the 1950s and 1970s.) The 1996 survey found that people were likelier than in the past to approach mental illness by coping with, rather than by avoiding, the problem. They also were more likely now to want *informal* social supports (e.g.,

self-help groups). Those who now sought *formal* support increasingly preferred counselors, psychologists, and social workers (Swindle et al., 1997).

Stigma and Paying for Mental Disorder Treatment Another manifestation of stigma is reflected in the public's reluctance to pay for mental health services.

Public willingness to pay for mental health treatment, particularly through insurance premiums or taxes, has been assessed largely through public opinion polls. Members of the public report a greater willingness to pay for insurance coverage for individuals with severe mental disorders, such as schizophrenia and depression, rather than for less severe conditions such as worry and unhappiness (Hanson, 1998). While the public generally appears to support paying for treatment, its support diminishes upon the realization that higher taxes or premiums would be necessary (Hanson, 1998). In the lexicon of survey research, the willingness to pay for mental illness treatment services is considered to be "soft." The public generally ranks insurance coverage for mental disorders below that for somatic disorders (Hanson, 1998).

Reducing Stigma

There is likely no simple or single panacea to eliminate the stigma associated with mental illness. Stigma was expected to abate with increased knowledge of mental illness, but just the opposite occurred: stigma in some ways intensified over the past 40 years even though understanding improved. Knowledge of mental illness appears by itself insufficient to dispel stigma (Phelan et al., 1997). Broader knowledge may be warranted, especially to redress public fears (Penn & Martin, 1998). Research is beginning to demonstrate that negative perceptions about severe mental illness can be lowered by furnishing empirically based information on the association between violence and severe mental illness (Penn & Martin, 1998). Overall approaches to stigma reduction involve programs of advocacy, public education, and contact with persons with mental illness through schools and other societal institutions (Corrigan & Penn, 1999).

Another way to eliminate stigma is to find causes and effective treatments for mental disorders (Jones, 1998). History suggests this to be true. Neurosyphilis and pellagra are illustrative of mental disorders for which stigma has receded. In the early part of this century, about 20 percent of those admitted to mental hospitals had "general paresis," later identified as tertiary syphilis (Grob, 1994). This advanced stage of syphilis occurs when the bacterium invades the brain and causes neurological deterioration (including psychosis), paralysis, and death. The discoveries of an infectious etiology and of penicillin led to the virtual elimination of neurosyphilis. Similarly, when pellagra was traced to a nutrient deficiency, and nutritional supplementation with niacin was introduced, the condition was eventually eradicated in the developed world. Pellagra's victims with delirium had been placed in mental hospitals early in the 20th century before its etiology was clarified. Although no one has documented directly the reduction of public stigma toward these conditions over the early and later parts of this century, disease eradication through widespread acceptance of treatment (and its cost) offers indirect proof.

Ironically, these examples also illustrate a more unsettling consequence: that the mental health field was adversely affected when causes and treatments were identified. As advances were achieved, each condition was transferred from the mental health field to another medical specialty (Grob, 1991). For instance, dominion over syphilis was moved to dermatology, internal medicine, and neurology upon advances in etiology and treatment. Dominion over hormone-related mental disorders was moved to endocrinology under similar circumstances. The consequence of this transformation, according to historian Gerald Grob, is that the mental health field became over the years the repository for mental disorders whose etiology was unknown. This left the mental health field "vulnerable to accusations by their medical brethren that psychiatry was not part of medicine, and that psychiatric practice rested on superstition and myth" (Grob, 1991).

These historical examples signify that stigma dissipates for individual disorders once advances

render them less disabling, infectious, or disfiguring. Yet the stigma surrounding *other* mental disorders not only persists but may be inadvertently reinforced by leaving to mental health care only those behavioral conditions without known causes or cures. To point this out is not intended to imply that advances in mental health should be halted; rather, advances should be nurtured and heralded. The purpose here is to explain some of the historical origins of the chasm between the health and mental health fields.

Stigma must be overcome. Research that will continue to yield increasingly effective treatments for mental disorders promises to be an effective antidote. When people understand that mental disorders are not the result of moral failings or limited will power, but are legitimate illnesses that are responsive to specific treatments, much of the negative stereotyping may dissipate. Still, fresh approaches to disseminate research information and, thus, to counter stigma need to be developed and evaluated. Social science research has much to contribute to the development and evaluation of anti-stigma programs (Corrigan & Penn, 1999). As stigma abates, a transformation in public attitudes should occur. People should become eager to seek care. They should become more willing to absorb its cost. And, most importantly, they should become far more receptive to the messages that are the subtext of this report: mental health and mental illness are part of the mainstream of health, and they are a concern for all people.

The Science Base of the Report

Reliance on Scientific Evidence

The statements and conclusions throughout this report are documented by reference to studies published in the scientific literature. For the most part, this report cites studies of empirical—rather than theoretical—research, peer-reviewed journal articles including reviews that integrate findings from numerous studies, and books by recognized experts. When a study has been accepted for publication but the publication has not yet appeared, owing to the delay between acceptance and final publication, the study is referred to as "in press." The

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report refers, on occasion, to unpublished research by means of reference to a presentation at a professional meeting or to a "personal communication" from the researcher, a practice that also is used sparingly in professional journals. These personal references are to acknowledged experts whose research is in progress.

Research Methods

Quality research rests on accepted methods of testing hypotheses. Two of the more common research methods used in the mental health field are experimental research and correlational research. Experimental research is the preferred method for assessing causation but may be too difficult or too expensive to conduct. Experimental research strives to discover cause and effect relationships, such as whether a new drug is effective for treating a mental disorder. In an experimental study, the investigator deliberately introduces an intervention to determine its consequences (i.e., the drug's efficacy). The investigator sets up an experiment comparing the effects of giving the new drug to one group of people, the experimental group, while giving a placebo (an inert pill) to another group, the so-called control group. The incorporation of a control group rules out the possibility that something other than the experimental treatment (i.e., the new drug) produces the results. The difference in outcome between the experimental and control group—which, in this case, may be the reduction or elimination of the symptoms of the disorder—then can be causally attributed to the drug. Similarly, in an experimental study of a psychological treatment, the experimental group is given a new type of psychotherapy, while the control or comparison group receives either no psychotherapy or a different form of psychotherapy. With both pharmacological and psychological studies, the best way to assign study participants, called subjects, either to the treatment or the control (or comparison) group is by assigning them randomly to different treatment groups. Randomization reduces bias in the results. An experimental study in humans with randomization is called a randomized controlled trial.

Correlational research is employed when experimental research is logistically, ethically, or

financially impossible. Instead of deliberately introducing an intervention, researchers observe relationships to uncover whether two factors are associated, or correlated. Studying the relationship between stress and depression is illustrative. It would be unthinkable to introduce seriously stressful events to see if they cause depression. A correlational study in this case would compare a group of people already experiencing high levels of stress with another group experiencing low levels of stress to determine whether the high-stress group is more likely to develop depression. If this happens, then the results would indicate that high levels of stress are associated with depression. The limitation of this type of study is that it only can be used to establish associations, not cause and effect relationships. (The positive relationship between stress and depression is discussed most thoroughly in Chapter 4.)

Controlled studies—that is, studies with control or comparison groups—are considered superior to uncontrolled studies. But not every question in mental health can be studied with a control or comparison group. Findings from an uncontrolled study may be better than no information at all. An uncontrolled study also may be beneficial in generating hypotheses or in testing the feasibility of an intervention. The results presumably would lead to a controlled study. In short, uncontrolled studies offer a good starting point but are never conclusive by themselves.

Levels of Evidence

In science, no single study by itself, however well designed, is generally considered sufficient to establish causation. The findings need to be replicated by other investigators to gain widespread acceptance by the scientific community.

The strength of the evidence amassed for any scientific fact or conclusion is referred to as "the level of evidence." The level of evidence, for example, to justify the entry of a new drug into the marketplace has to be substantial enough to meet with approval by the U.S. Food and Drug Administration (FDA). According to U.S. drug law, a new drug's safety and efficacy must be established through controlled clinical trials

conducted by the drug's manufacturer or sponsor (FDA, 1998). The FDA's decision to approve a drug represents the culmination of a lengthy, research-intensive process of drug development, which often consumes years of animal testing followed by human clinical trials (DiMasi & Lasagna, 1995). The FDA requires three phases of clinical trials³ before a new drug can be approved for marketing (FDA, 1998).

With psychotherapy, the level of evidence similarly must be high. Although there are no formal Federal laws governing which psychotherapies can be introduced into practice, professional groups and experts in the field strive to assess the level of evidence in a given area through task forces, review articles, and other methods for evaluating the body of published studies on a topic. This Surgeon General's report is replete with references to such evaluations. One of the most prominent series of evaluations was set in motion by a group within the American Psychological Association (APA), one of the main professional organizations of psychologists. Beginning in the mid-1990s, the APA's Division of Clinical Psychology convened task forces with the objective of establishing which psychotherapies were of proven efficacy. To guide their evaluation, the first task force created a set of criteria that also was used or adapted by subsequent task forces. The first task force actually developed two sets of criteria: the first, and more rigorous, set of criteria was for *Well-Established Treatments*, while the other set was for *Probably Efficacious Treatments* (Chambless et al., 1996). For a psychotherapy to be well established, at least two experiments with group designs or similar types of studies must have been published to demonstrate efficacy. Chapters 3 through 5 of this report describe the findings of the task forces in relation to psychotherapies for children, adults, and older adults. Some types of psychotherapies that do not meet the criteria might be effective but may not have been studied sufficiently.

³ The first phase is to establish safety (Phase I), while the latter two phases establish efficacy through small and then large-scale randomized controlled clinical trials (Phases II and III) (FDA, 1998).

Another way of evaluating a collection of studies is through a formal statistical technique called a meta-analysis. A meta-analysis is a way of combining results from multiple studies. Its goal is to determine the size and consistency of the "effect" of a particular treatment or other intervention observed across the studies. The statistical technique makes the results of different studies comparable so that an overall "effect size" for the treatment can be identified. A meta-analysis determines if there is consistent evidence of a statistically significant effect of a specified treatment and estimates the size of the effect, according to widely accepted standards for a small, medium, or large effect.

Overview of the Report's Chapters

The preceding sections have addressed overarching themes in the body of the report. This section provides a brief overview of the entire report, including a description of its general orientation and a summary of key conclusions drawn from each chapter.

Chapter 2 begins with an overview of research under way today that is focused on the brain and behavior in mental health and mental illness. It explains how newer approaches to neuroscience are mending the mind-body split, which for so long has been a stumbling block to understanding the relationship of the brain to behavior, thought, and emotion. Modern integrative neuroscience offers a means of linking research on broad "systems-level" aspects of brain function with the remarkably detailed tools and findings of molecular genetics. There follows an overview of mental illness that highlights topics including symptoms, diagnosis, epidemiology (i.e., research having to do with the distribution and determinants of mental disorders in population groups), and cost, all of which are discussed in the context of specific disorders throughout the report. The section on etiology reviews research that is seeking to define, with ever greater precision, the causes of mental illnesses. As will be seen, etiology research must examine fundamental biological and behavioral processes, as well as a necessarily broad array of life events. No less than research on normal healthy development, etiological research underscores the inextricability of

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nature and nurture, or biological and psychosocial influences, in mental illness. The section on development of temperament reveals how mental health research has attempted over much of the past century to understand how biological, psychological, and sociocultural factors meld in health as well as illness. The chapter then reviews research approaches to the prevention and treatment of mental disorders and provides an overview of mental health services and their delivery. Final sections cover the growing influence on the mental health field of cultural diversity, the importance of consumerism, and new optimism about recovery from mental illness.

Chapters 3, 4, and 5 capture the breadth, depth, and vibrancy of the mental health field. The chapters probe mental health and mental illness in children and adolescents, in adulthood (i.e., in persons up to ages 55 to 65), and in older adults, respectively. This life span approach reflects awareness that mental health, and the brain and behavioral disorders that impinge upon it, are dynamic, ever-changing phenomena that, at any given moment, reflect the sum total of every person's genetic inheritance and life experiences. The brain is extraordinarily "plastic," or malleable. It interacts with and responds—both in its function and in its very structure—to multiple influences continuously, across every stage of life. Variability in expression of mental health and mental illness over the life span can be very subtle or very pronounced. As an example, the symptoms of separation anxiety are normal in early childhood but are signs of distress in later childhood and beyond. It is all too common for people to appreciate the impact of developmental processes in children yet not to extend that conceptual understanding to older people. In fact, older people continue to develop and change. Different stages of life are associated with distinct forms of mental and behavioral disorders and with distinctive capacities for mental health.

With rare exceptions, few persons are destined to a life marked by unremitting, acute mental illness. The most severe, persistent forms of mental illness tend to be amenable to treatment, even when recurrent and episodic. As conditions wax and wane, opportunities

exist for interventions. The goal of an intervention at any given time may vary. The focus may be on recovery, prevention of recurrence, or the acquisition of knowledge or skills that permit more effective management of an illness. Chapters 3 through 5 cover a uniform list of topics most relevant to each age cluster. Topics include mental health; prevention, diagnosis, and treatment of mental illness; service delivery; and other services and supports.

It would be impractical for a report of this type to attempt to address every domain of mental health and mental illness; therefore, this report casts a spotlight on selected topics in each of Chapters 3 through 5. The various disorders featured in depth in a given chapter were selected on the basis of their prevalence and the clinical, societal, and economic burden associated with each. To the extent that data permit, the report takes note of how gender and culture, in addition to age, influence the diagnosis, course, and treatment of mental illness. The chapters also note the changing role of consumers and families, with attention to informal support services (i.e., unpaid services) with which patients are so comfortable (Phelan et al., 1997) and upon which they depend for information. Patients and families welcome a proliferating array of support services—such as self-help programs, family self-help, crisis services, and advocacy—that help them cope with the isolation, family disruption, and possible loss of employment and housing that may accompany mental disorders. Support services can help dissipate stigma and guide patients into formal care as well.

Although the chapters that address stages of development afford a sense of the breadth of issues pertinent to mental health and illness, the report is not exhaustive. The neglect of any given disorder, population, or topic should not be construed as signifying a lack of importance.

Chapter 6 discusses the organization and financing of mental health services. The first section provides an overview of the current system of mental health services, describing where people get care and how they use services. The chapter then presents information on the costs of care and trends in spending. Only within recent decades have the dynamics of

insurance financing become a significant issue in the mental health field; these are discussed, as is the advent of managed care. The chapter addresses both positive and adverse effects of managed care on access and quality and describes efforts to guard against untoward consequences of aggressive cost-containment policies. The final section documents some of the inequities between general health care and mental health care and describes efforts to correct them through legislative regulation and financing changes.

The confidentiality of all health care information has emerged as a core issue in recent years, as concerns regarding the accessibility of health care information and its uses have risen. As Chapter 7 illustrates, privacy concerns are particularly keenly felt in the mental health field, beginning with the importance of an assurance of confidentiality in individual decisions to seek mental health treatment. The chapter reviews the legal framework governing confidentiality and potential problems with that framework, and policy issues that must be addressed by those concerned with the confidentiality of mental health and substance abuse information.

Chapter 8 concludes, on the basis of the extensive literature that the Surgeon General's report reviews and summarizes, that *the efficacy of mental health treatment is well-documented*. Moreover, there exists a range of treatments from which people may choose a particular approach to suit their needs and preferences. Based on this finding, the report's principal recommendation to the American people is to *seek help if you have a mental health problem or think you have symptoms of mental illness*. The chapter explores opportunities to overcome barriers to implementing the recommendation and to have seeking help lead to effective treatment.

Chapter Conclusions

Chapter 2: The Fundamentals of Mental Health and Mental Illness

The past 25 years have been marked by several discrete, defining trends in the mental health field. These have included:

1. The extraordinary pace and productivity of scientific research on the brain and behavior;
2. The introduction of a range of effective treatments for most mental disorders;
3. A dramatic transformation of our society's approaches to the organization and financing of mental health care; and
4. The emergence of powerful consumer and family movements.

Scientific Research. The brain has emerged as the central focus for studies of mental health and mental illness. New scientific disciplines, technologies, and insights have begun to weave a seamless picture of the way in which the brain mediates the influence of biological, psychological, and social factors on human thought, behavior, and emotion in health and in illness. Molecular and cellular biology and molecular genetics, which are complemented by sophisticated cognitive and behavioral sciences, are preeminent research disciplines in the contemporary neuroscience of mental health. These disciplines are affording unprecedented opportunities for "bottom-up" studies of the brain. This term refers to research that is examining the workings of the brain at the most fundamental levels. Studies focus, for example, on the complex neurochemical activity that occurs within individual nerve cells, or neurons, to process information; on the properties and roles of proteins that are expressed, or produced, by a person's genes; and on the interaction of genes with diverse environmental influences. All of these activities now are understood, with increasing clarity, to underlie learning, memory, the experience of emotion, and, when these processes go awry, the occurrence of mental illness or a mental health problem.

Equally important to the mental health field is "top-down" research; here, as the term suggests, the aim is to understand the broader behavioral context of the brain's cellular and molecular activity and to learn how individual neurons work together in well-delineated neural circuits to perform mental functions.

Effective Treatments. As information accumulates about the basic workings of the brain, it is the task of translational research to transfer new knowledge into clinically relevant questions and targets of research

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opportunity—to discover, for example, what specific properties of a neural circuit might make it receptive to safer, more effective medications. To elaborate on this example, theories derived from knowledge about basic brain mechanisms are being wedded more closely to brain imaging tools such as functional Magnetic Resonance Imaging (MRI) that can observe actual brain activity. Such a collaboration would permit investigators to monitor the specific protein molecules intended as the “targets” of a new medication to treat a mental illness or, indeed, to determine how to optimize the effect on the brain of the learning achieved through psychotherapy.

In its entirety, the new “integrative neuroscience” of mental health offers a way to circumvent the antiquated split between the mind and the body that historically has hampered mental health research. It also makes it possible to examine scientifically many of the important psychological and behavioral theories regarding normal development and mental illness that have been developed in years past. The unswerving goal of mental health research is to develop and refine clinical treatments as well as preventive interventions that are based on an understanding of specific mechanisms that can contribute to or lead to illness but also can protect and enhance mental health.

Mental health clinical research encompasses studies that involve human participants, conducted, for example, to test the efficacy of a new treatment. A noteworthy feature of contemporary clinical research is the new emphasis being placed on studying the effectiveness of interventions in actual practice settings. Information obtained from such studies increasingly provides the foundation for services research concerned with the cost, cost-effectiveness, and “deliverability” of interventions and the design—including economic considerations—of service delivery systems.

Organization and Financing of Mental Health Care. Another of the defining trends has been the transformation of the mental illness treatment and mental health services landscapes, including increased reliance on primary health care and other human service providers. Today, the U.S. mental health system

is multifaceted and complex, comprising the public and private sectors, general health and specialty mental health providers, and social services, housing, criminal justice, and educational agencies. These agencies do not always function in a coordinated manner. Its configuration reflects necessary responses to a broad array of factors including reform movements, financial incentives based on who pays for what kind of services, and advances in care and treatment technology. Although the hybrid system that exists today serves diverse functions well for many people, individuals with the most complex needs and the fewest financial resources often find the system fragmented and difficult to use. A challenge for the Nation in the near-term future is to speed the transfer of new evidence-based treatments and prevention interventions into diverse service delivery settings and systems, while ensuring greater coordination among these settings and systems.

Consumer and Family Movements. The emergence of vital consumer and family movements promises to shape the direction and complexion of mental health programs for many years to come. Although divergent in their historical origins and philosophy, organizations representing consumers and family members have promoted important, often overlapping goals and have invigorated the fields of research as well as treatment and service delivery design. Among the principal goals shared by much of the consumer movement are to overcome stigma and prevent discrimination in policies affecting persons with mental illness; to encourage self-help and a focus on recovery from mental illness; and to draw attention to the special needs associated with a particular disorder or disability, as well as by age or gender or by the racial and cultural identity of those who have mental illness.

Chapter 2 of the report was written to provide background information that would help persons from outside the mental health field better understand topics addressed in subsequent chapters of the report. Although the chapter is meant to serve as a mental health primer, its depth of discussion supports a range of conclusions:

1. The multifaceted complexity of the brain is fully consistent with the fact that it supports all behavior and mental life. Proceeding from an acknowledgment that all psychological experiences are recorded ultimately in the brain and that all psychological phenomena reflect biological processes, the modern neuroscience of mental health offers an enriched understanding of the inseparability of human experience, brain, and mind.
2. Mental functions, which are disturbed in mental disorders, are mediated by the brain. In the process of transforming human experience into physical events, the brain undergoes changes in its cellular structure and function.
3. Few lesions or physiologic abnormalities define the mental disorders, and for the most part their causes remain unknown. Mental disorders, instead, are defined by signs, symptoms, and functional impairments.
4. Diagnoses of mental disorders made using specific criteria are as reliable as those for general medical disorders.
5. About one in five Americans experiences a mental disorder in the course of a year. Approximately 15 percent of all adults who have a mental disorder in one year also experience a co-occurring substance (alcohol or other drug) use disorder, which complicates treatment.
6. A range of treatments of well-documented efficacy exists for most mental disorders. Two broad types of intervention include psychosocial treatments—for example, psychotherapy or counseling—and psychopharmacologic treatments; these often are most effective when combined.
7. In the mental health field, progress in developing preventive interventions has been slow because, for most major mental disorders, there is insufficient understanding about etiology (or causes of illness) and/or there is an inability to alter the *known* etiology of a particular disorder. Still, some successful strategies have emerged in the absence of a full understanding of etiology.
8. About 10 percent of the U.S. adult population use mental health services in the health sector in any year, with another 5 percent seeking such services from social service agencies, schools, or religious or self-help groups. Yet critical gaps exist between those who need service and those who receive service.
9. Gaps also exist between optimally effective treatment and what many individuals receive in actual practice settings.
10. Mental illness and less severe mental health problems must be understood in a social and cultural context, and mental health services must be designed and delivered in a manner that is sensitive to the perspectives and needs of racial and ethnic minorities.
11. The consumer movement has increased the involvement of individuals with mental disorders and their families in mutual support services, consumer-run services, and advocacy. They are powerful agents for changes in service programs and policy.
12. The notion of recovery reflects renewed optimism about the outcomes of mental illness, including that achieved through an individual's own self-care efforts, and the opportunities open to persons with mental illness to participate to the full extent of their interests in the community of their choice.

Mental Health and Mental Illness Across the Lifespan

The Surgeon General's report takes a lifespan approach to its consideration of mental health and mental illness. Three chapters that address, respectively, the periods of childhood and adolescence, adulthood, and later adult life beginning somewhere between ages 55 and 65, capture the contributions of research to the breadth, depth, and vibrancy that characterize all facets of the contemporary mental health field.

The disorders featured in depth in Chapters 3, 4, and 5 were selected on the basis of the frequency with which they occur in our society, and the clinical, societal, and economic burden associated with each. To the extent that data permit, the report takes note of how

Exhibit G

CERTIFICATION OF ENROLLMENT
SUBSTITUTE HOUSE BILL 1154

Chapter 6, Laws of 2005

59th Legislature
2005 Regular Session

MENTAL HEALTH

EFFECTIVE DATE: 7/24/05

Passed by the House January 28, 2005
Yeas 67 Nays 25

FRANK CHOPP
Speaker of the House of Representatives

Passed by the Senate March 3, 2005
Yeas 40 Nays 9

BRAD OWEN
President of the Senate
Approved March 9, 2005.

CHRISTINE GREGOIRE
Governor of the State of Washington

CERTIFICATE

I, Richard Nafziger, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is SUBSTITUTE HOUSE BILL 1154 as passed by the House of Representatives and the Senate on the dates hereon set forth.

RICHARD NAFZIGER
Chief Clerk

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Secretary of State
State of Washington

1 significant. Additionally, the legislature declares that it is not
2 cost-effective to treat persons with mental disorders differently than
3 persons with medical and surgical disorders.

4 Therefore, the legislature intends to require that insurance
5 coverage be at parity for mental health services, which means this
6 coverage be delivered under the same terms and conditions as medical
7 and surgical services.

8 NEW SECTION. Sec. 2. A new section is added to chapter 41.05 RCW
9 to read as follows:

10 (1) For the purposes of this section, "mental health services"
11 means medically necessary outpatient and inpatient services provided to
12 treat mental disorders covered by the diagnostic categories listed in
13 the most current version of the diagnostic and statistical manual of
14 mental disorders, published by the American psychiatric association, on
15 the effective date of this section, or such subsequent date as may be
16 provided by the administrator by rule, consistent with the purposes of
17 this act, with the exception of the following categories, codes, and
18 services: (a) Substance related disorders; (b) life transition
19 problems, currently referred to as "V" codes, and diagnostic codes 302
20 through 302.9 as found in the diagnostic and statistical manual of
21 mental disorders, 4th edition, published by the American psychiatric
22 association; (c) skilled nursing facility services, home health care,
23 residential treatment, and custodial care; and (d) court ordered
24 treatment unless the authority's or contracted insuring entity's
25 medical director determines the treatment to be medically necessary.

26 (2) All health benefit plans offered to public employees and their
27 covered dependents under this chapter that provide coverage for medical
28 and surgical services shall provide:

29 (a) For all health benefit plans established or renewed on or after
30 January 1, 2006, coverage for:

31 (i) Mental health services. The copayment or coinsurance for
32 mental health services may be no more than the copayment or coinsurance
33 for medical and surgical services otherwise provided under the health
34 benefit plan. Wellness and preventive services that are provided or
35 reimbursed at a lesser copayment, coinsurance, or other cost sharing
36 than other medical and surgical services are excluded from this
37 comparison; and

1 (ii) Prescription drugs intended to treat any of the disorders
2 covered in subsection (1) of this section to the same extent, and under
3 the same terms and conditions, as other prescription drugs covered by
4 the health benefit plan.

5 (b) For all health benefit plans established or renewed on or after
6 January 1, 2008, coverage for:

7 (i) Mental health services. The copayment or coinsurance for
8 mental health services may be no more than the copayment or coinsurance
9 for medical and surgical services otherwise provided under the health
10 benefit plan. Wellness and preventive services that are provided or
11 reimbursed at a lesser copayment, coinsurance, or other cost sharing
12 than other medical and surgical services are excluded from this
13 comparison. If the health benefit plan imposes a maximum out-of-pocket
14 limit or stop loss, it shall be a single limit or stop loss for
15 medical, surgical, and mental health services; and

16 (ii) Prescription drugs intended to treat any of the disorders
17 covered in subsection (1) of this section to the same extent, and under
18 the same terms and conditions, as other prescription drugs covered by
19 the health benefit plan.

20 (c) For all health benefit plans established or renewed on or after
21 July 1, 2010, coverage for:

22 (i) Mental health services. The copayment or coinsurance for
23 mental health services may be no more than the copayment or coinsurance
24 for medical and surgical services otherwise provided under the health
25 benefit plan. Wellness and preventive services that are provided or
26 reimbursed at a lesser copayment, coinsurance, or other cost sharing
27 than other medical and surgical services are excluded from this
28 comparison. If the health benefit plan imposes a maximum out-of-pocket
29 limit or stop loss, it shall be a single limit or stop loss for
30 medical, surgical, and mental health services. If the health benefit
31 plan imposes any deductible, mental health services shall be included
32 with medical and surgical services for the purpose of meeting the
33 deductible requirement. Treatment limitations or any other financial
34 requirements on coverage for mental health services are only allowed if
35 the same limitations or requirements are imposed on coverage for
36 medical and surgical services; and

37 (ii) Prescription drugs intended to treat any of the disorders

1 covered in subsection (1) of this section to the same extent, and under
2 the same terms and conditions, as other prescription drugs covered by
3 the health benefit plan.

4 (3) In meeting the requirements of subsection (2)(a) and (b) of
5 this section, health benefit plans may not reduce the number of mental
6 health outpatient visits or mental health inpatient days below the
7 level in effect on July 1, 2002.

8 (4) This section does not prohibit a requirement that mental health
9 services be medically necessary as determined by the medical director
10 or designee, if a comparable requirement is applicable to medical and
11 surgical services.

12 (5) Nothing in this section shall be construed to prevent the
13 management of mental health services.

14 (6) The administrator will consider care management techniques for
15 mental health services, including but not limited to: (a) Authorized
16 treatment plans; (b) preauthorization requirements based on the type of
17 service; (c) concurrent and retrospective utilization review; (d)
18 utilization management practices; (e) discharge coordination and
19 planning; and (f) contracting with and using a network of participating
20 providers.

21 NEW SECTION. Sec. 3. A new section is added to chapter 48.21 RCW
22 to read as follows:

23 (1) For the purposes of this section, "mental health services"
24 means medically necessary outpatient and inpatient services provided to
25 treat mental disorders covered by the diagnostic categories listed in
26 the most current version of the diagnostic and statistical manual of
27 mental disorders, published by the American psychiatric association, on
28 the effective date of this section, or such subsequent date as may be
29 provided by the insurance commissioner by rule, consistent with the
30 purposes of this act, with the exception of the following categories,
31 codes, and services: (a) Substance related disorders; (b) life
32 transition problems, currently referred to as "V" codes, and diagnostic
33 codes 302 through 302.9 as found in the diagnostic and statistical
34 manual of mental disorders, 4th edition, published by the American
35 psychiatric association; (c) skilled nursing facility services, home
36 health care, residential treatment, and custodial care; and (d) court

1 ordered treatment unless the insurer's medical director or designee
2 determines the treatment to be medically necessary.

3 (2) All group disability insurance contracts and blanket disability
4 insurance contracts providing health benefit plans that provide
5 coverage for medical and surgical services shall provide:

6 (a) For all health benefit plans established or renewed on or after
7 January 1, 2006, for groups of more than fifty employees coverage for:

8 (i) Mental health services. The copayment or coinsurance for
9 mental health services may be no more than the copayment or coinsurance
10 for medical and surgical services otherwise provided under the health
11 benefit plan. Wellness and preventive services that are provided or
12 reimbursed at a lesser copayment, coinsurance, or other cost sharing
13 than other medical and surgical services are excluded from this
14 comparison; and

15 (ii) Prescription drugs intended to treat any of the disorders
16 covered in subsection (1) of this section to the same extent, and under
17 the same terms and conditions, as other prescription drugs covered by
18 the health benefit plan.

19 (b) For all health benefit plans established or renewed on or after
20 January 1, 2008, for groups of more than fifty employees coverage for:

21 (i) Mental health services. The copayment or coinsurance for
22 mental health services may be no more than the copayment or coinsurance
23 for medical and surgical services otherwise provided under the health
24 benefit plan. Wellness and preventive services that are provided or
25 reimbursed at a lesser copayment, coinsurance, or other cost sharing
26 than other medical and surgical services are excluded from this
27 comparison. If the health benefit plan imposes a maximum out-of-pocket
28 limit or stop loss, it shall be a single limit or stop loss for
29 medical, surgical, and mental health services; and

30 (ii) Prescription drugs intended to treat any of the disorders
31 covered in subsection (1) of this section to the same extent, and under
32 the same terms and conditions, as other prescription drugs covered by
33 the health benefit plan.

34 (c) For all health benefit plans established or renewed on or after
35 July 1, 2010, for groups of more than fifty employees coverage for:

36 (i) Mental health services. The copayment or coinsurance for
37 mental health services may be no more than the copayment or coinsurance
38 for medical and surgical services otherwise provided under the health

1 benefit plan. Wellness and preventive services that are provided or
2 reimbursed at a lesser copayment, coinsurance, or other cost sharing
3 than other medical and surgical services are excluded from this
4 comparison. If the health benefit plan imposes a maximum out-of-pocket
5 limit or stop loss, it shall be a single limit or stop loss for
6 medical, surgical, and mental health services. If the health benefit
7 plan imposes any deductible, mental health services shall be included
8 with medical and surgical services for the purpose of meeting the
9 deductible requirement. Treatment limitations or any other financial
10 requirements on coverage for mental health services are only allowed if
11 the same limitations or requirements are imposed on coverage for
12 medical and surgical services; and

13 (ii) Prescription drugs intended to treat any of the disorders
14 covered in subsection (1) of this section to the same extent, and under
15 the same terms and conditions, as other prescription drugs covered by
16 the health benefit plan.

17 (3) In meeting the requirements of subsection (2)(a) and (b) of
18 this section, health benefit plans may not reduce the number of mental
19 health outpatient visits or mental health inpatient days below the
20 level in effect on July 1, 2002.

21 (4) This section does not prohibit a requirement that mental health
22 services be medically necessary as determined by the medical director
23 or designee, if a comparable requirement is applicable to medical and
24 surgical services.

25 (5) Nothing in this section shall be construed to prevent the
26 management of mental health services.

27 NEW SECTION. Sec. 4. A new section is added to chapter 48.44 RCW
28 to read as follows:

29 (1) For the purposes of this section, "mental health services"
30 means medically necessary outpatient and inpatient services provided to
31 treat mental disorders covered by the diagnostic categories listed in
32 the most current version of the diagnostic and statistical manual of
33 mental disorders, published by the American psychiatric association, on
34 the effective date of this section, or such subsequent date as may be
35 provided by the insurance commissioner by rule, consistent with the
36 purposes of this act, with the exception of the following categories,
37 codes, and services: (a) Substance related disorders; (b) life

1 transition problems, currently referred to as "V" codes, and diagnostic
2 codes 302 through 302.9 as found in the diagnostic and statistical
3 manual of mental disorders, 4th edition, published by the American
4 psychiatric association; (c) skilled nursing facility services, home
5 health care, residential treatment, and custodial care; and (d) court
6 ordered treatment unless the health care service contractor's medical
7 director or designee determines the treatment to be medically
8 necessary.

9 (2) All health service contracts providing health benefit plans
10 that provide coverage for medical and surgical services shall provide:

11 (a) For all health benefit plans established or renewed on or after
12 January 1, 2006, for groups of more than fifty employees coverage for:

13 (i) Mental health services. The copayment or coinsurance for
14 mental health services may be no more than the copayment or coinsurance
15 for medical and surgical services otherwise provided under the health
16 benefit plan. Wellness and preventive services that are provided or
17 reimbursed at a lesser copayment, coinsurance, or other cost sharing
18 than other medical and surgical services are excluded from this
19 comparison; and

20 (ii) Prescription drugs intended to treat any of the disorders
21 covered in subsection (1) of this section to the same extent, and under
22 the same terms and conditions, as other prescription drugs covered by
23 the health benefit plan.

24 (b) For all health benefit plans established or renewed on or after
25 January 1, 2008, for groups of more than fifty employees coverage for:

26 (i) Mental health services. The copayment or coinsurance for
27 mental health services may be no more than the copayment or coinsurance
28 for medical and surgical services otherwise provided under the health
29 benefit plan. Wellness and preventive services that are provided or
30 reimbursed at a lesser copayment, coinsurance, or other cost sharing
31 than other medical and surgical services are excluded from this
32 comparison. If the health benefit plan imposes a maximum out-of-pocket
33 limit or stop loss, it shall be a single limit or stop loss for
34 medical, surgical, and mental health services; and

35 (ii) Prescription drugs intended to treat any of the disorders
36 covered in subsection (1) of this section to the same extent, and under
37 the same terms and conditions, as other prescription drugs covered by
38 the health benefit plan.

1 (c) For all health benefit plans established or renewed on or after
2 July 1, 2010, for groups of more than fifty employees coverage for:

3 (i) Mental health services. The copayment or coinsurance for
4 mental health services may be no more than the copayment or coinsurance
5 for medical and surgical services otherwise provided under the health
6 benefit plan. Wellness and preventive services that are provided or
7 reimbursed at a lesser copayment, coinsurance, or other cost sharing
8 than other medical and surgical services are excluded from this
9 comparison. If the health benefit plan imposes a maximum out-of-pocket
10 limit or stop loss, it shall be a single limit or stop loss for
11 medical, surgical, and mental health services. If the health benefit
12 plan imposes any deductible, mental health services shall be included
13 with medical and surgical services for the purpose of meeting the
14 deductible requirement. Treatment limitations or any other financial
15 requirements on coverage for mental health services are only allowed if
16 the same limitations or requirements are imposed on coverage for
17 medical and surgical services; and

18 (ii) Prescription drugs intended to treat any of the disorders
19 covered in subsection (1) of this section to the same extent, and under
20 the same terms and conditions, as other prescription drugs covered by
21 the health benefit plan.

22 (3) In meeting the requirements of subsection (2)(a) and (b) of
23 this section, health benefit plans may not reduce the number of mental
24 health outpatient visits or mental health inpatient days below the
25 level in effect on July 1, 2002.

26 (4) This section does not prohibit a requirement that mental health
27 services be medically necessary as determined by the medical director
28 or designee, if a comparable requirement is applicable to medical and
29 surgical services.

30 (5) Nothing in this section shall be construed to prevent the
31 management of mental health services.

32 NEW SECTION. Sec. 5. A new section is added to chapter 48.46 RCW
33 to read as follows:

34 (1) For the purposes of this section, "mental health services"
35 means medically necessary outpatient and inpatient services provided to
36 treat mental disorders covered by the diagnostic categories listed in
37 the most current version of the diagnostic and statistical manual of

1 mental disorders, published by the American psychiatric association, on
2 the effective date of this section, or such subsequent date as may be
3 provided by the insurance commissioner by rule, consistent with the
4 purposes of this act, with the exception of the following categories,
5 codes, and services: (a) Substance related disorders; (b) life
6 transition problems, currently referred to as "V" codes, and diagnostic
7 codes 302 through 302.9 as found in the diagnostic and statistical
8 manual of mental disorders, 4th edition, published by the American
9 psychiatric association; (c) skilled nursing facility services, home
10 health care, residential treatment, and custodial care; and (d) court
11 ordered treatment unless the health maintenance organization's medical
12 director or designee determines the treatment to be medically
13 necessary.

14 (2) All health benefit plans offered by health maintenance
15 organizations that provide coverage for medical and surgical services
16 shall provide:

17 (a) For all health benefit plans established or renewed on or after
18 January 1, 2006, for groups of more than fifty employees coverage for:

19 (i) Mental health services. The copayment or coinsurance for
20 mental health services may be no more than the copayment or coinsurance
21 for medical and surgical services otherwise provided under the health
22 benefit plan. Wellness and preventive services that are provided or
23 reimbursed at a lesser copayment, coinsurance, or other cost sharing
24 than other medical and surgical services are excluded from this
25 comparison; and

26 (ii) Prescription drugs intended to treat any of the disorders
27 covered in subsection (1) of this section to the same extent, and under
28 the same terms and conditions, as other prescription drugs covered by
29 the health benefit plan.

30 (b) For all health benefit plans established or renewed on or after
31 January 1, 2008, for groups of more than fifty employees coverage for:

32 (i) Mental health services. The copayment or coinsurance for
33 mental health services may be no more than the copayment or coinsurance
34 for medical and surgical services otherwise provided under the health
35 benefit plan. Wellness and preventive services that are provided or
36 reimbursed at a lesser copayment, coinsurance, or other cost sharing
37 than other medical and surgical services are excluded from this

1 comparison. If the health benefit plan imposes a maximum out-of-pocket
2 limit or stop loss, it shall be a single limit or stop loss for
3 medical, surgical, and mental health services; and

4 (ii) Prescription drugs intended to treat any of the disorders
5 covered in subsection (1) of this section to the same extent, and under
6 the same terms and conditions, as other prescription drugs covered by
7 the health benefit plan.

8 (c) For all health benefit plans established or renewed on or after
9 July 1, 2010, for groups of more than fifty employees coverage for:

10 (i) Mental health services. The copayment or coinsurance for
11 mental health services may be no more than the copayment or coinsurance
12 for medical and surgical services otherwise provided under the health
13 benefit plan. Wellness and preventive services that are provided or
14 reimbursed at a lesser copayment, coinsurance, or other cost sharing
15 than other medical and surgical services are excluded from this
16 comparison. If the health benefit plan imposes a maximum out-of-pocket
17 limit or stop loss, it shall be a single limit or stop loss for
18 medical, surgical, and mental health services. If the health benefit
19 plan imposes any deductible, mental health services shall be included
20 with medical and surgical services for the purpose of meeting the
21 deductible requirement. Treatment limitations or any other financial
22 requirements on coverage for mental health services are only allowed if
23 the same limitations or requirements are imposed on coverage for
24 medical and surgical services; and

25 (ii) Prescription drugs intended to treat any of the disorders
26 covered in subsection (1) of this section to the same extent, and under
27 the same terms and conditions, as other prescription drugs covered by
28 the health benefit plan.

29 (3) In meeting the requirements of subsection (2)(a) and (b) of
30 this section, health benefit plans may not reduce the number of mental
31 health outpatient visits or mental health inpatient days below the
32 level in effect on July 1, 2002.

33 (4) This section does not prohibit a requirement that mental health
34 services be medically necessary as determined by the medical director
35 or designee, if a comparable requirement is applicable to medical and
36 surgical services.

37 (5) Nothing in this section shall be construed to prevent the
38 management of mental health services.

1 NEW SECTION. Sec. 6. A new section is added to chapter 70.47 RCW
2 to read as follows:

3 (1) For the purposes of this section, "mental health services"
4 means medically necessary outpatient and inpatient services provided to
5 treat mental disorders covered by the diagnostic categories listed in
6 the most current version of the diagnostic and statistical manual of
7 mental disorders, published by the American psychiatric association, on
8 the effective date of this section, or such subsequent date as may be
9 determined by the administrator, by rule, consistent with the purposes
10 of this act, with the exception of the following categories, codes, and
11 services: (a) Substance related disorders; (b) life transition
12 problems, currently referred to as "V" codes, and diagnostic codes 302
13 through 302.9 as found in the diagnostic and statistical manual of
14 mental disorders, 4th edition, published by the American psychiatric
15 association; (c) skilled nursing facility services, home health care,
16 residential treatment, and custodial care; and (d) court ordered
17 treatment, unless the Washington basic health plan's or contracted
18 managed health care system's medical director or designee determines
19 the treatment to be medically necessary.

20 (2)(a) Any schedule of benefits established or renewed by the
21 Washington basic health plan on or after January 1, 2006, shall provide
22 coverage for:

23 (i) Mental health services. The copayment or coinsurance for
24 mental health services may be no more than the copayment or coinsurance
25 for medical and surgical services otherwise provided under the schedule
26 of benefits. Wellness and preventive services that are provided or
27 reimbursed at a lesser copayment, coinsurance, or other cost sharing
28 than other medical and surgical services are excluded from this
29 comparison; and

30 (ii) Prescription drugs intended to treat any of the disorders
31 covered in subsection (1) of this section to the same extent, and under
32 the same terms and conditions, as other prescription drugs covered
33 under the schedule of benefits.

34 (b) Any schedule of benefits established or renewed by the
35 Washington basic health plan on or after January 1, 2008, shall provide
36 coverage for:

37 (i) Mental health services. The copayment or coinsurance for
38 mental health services may be no more than the copayment or coinsurance

1 for medical and surgical services otherwise provided under the schedule
2 of benefits. Wellness and preventive services that are provided or
3 reimbursed at a lesser copayment, coinsurance, or other cost sharing
4 than other medical and surgical services are excluded from this
5 comparison. If the schedule of benefits imposes a maximum out-of-
6 pocket limit or stop loss, it shall be a single limit or stop loss for
7 medical, surgical, and mental health services; and

8 (ii) Prescription drugs intended to treat any of the disorders
9 covered in subsection (1) of this section to the same extent, and under
10 the same terms and conditions, as other prescription drugs covered
11 under the schedule of benefits.

12 (c) Any schedule of benefits established or renewed by the
13 Washington basic health plan on or after July 1, 2010, shall include
14 coverage for:

15 (i) Mental health services. The copayment or coinsurance for
16 mental health services may be no more than the copayment or coinsurance
17 for medical and surgical services otherwise provided under the schedule
18 of benefits. Wellness and preventive services that are provided or
19 reimbursed at a lesser copayment, coinsurance, or other cost sharing
20 than other medical and surgical services are excluded from this
21 comparison. If the schedule of benefits imposes a maximum out-of-
22 pocket limit or stop loss, it shall be a single limit or stop loss for
23 medical, surgical, and mental health services. If the schedule of
24 benefits imposes any deductible, mental health services shall be
25 included with medical and surgical services for the purpose of meeting
26 the deductible requirement. Treatment limitations or any other
27 financial requirements on coverage for mental health services are only
28 allowed if the same limitations or requirements are imposed on coverage
29 for medical and surgical services; and

30 (ii) Prescription drugs intended to treat any of the disorders
31 covered in subsection (1) of this section to the same extent, and under
32 the same terms and conditions, as other prescription drugs covered
33 under the schedule of benefits.

34 (3) In meeting the requirements of subsection (2)(a) and (b) of
35 this section, the Washington basic health plan may not reduce the
36 number of mental health outpatient visits or mental health inpatient
37 days below the level in effect on July 1, 2002.

1 (4) This section does not prohibit a requirement that mental health
2 services be medically necessary as determined by the medical director
3 or designee, if a comparable requirement is applicable to medical and
4 surgical services.

5 (5) Nothing in this section shall be construed to prevent the
6 management of mental health services.

7 Sec. 7. RCW 48.21.240 and 1987 c 283 s 3 are each amended to read
8 as follows:

9 (1) For groups not covered by section 3 of this act, each group
10 insurer providing disability insurance coverage in this state for
11 hospital or medical care under contracts which are issued, delivered,
12 or renewed in this state (~~on or after July 1, 1986,~~) shall offer
13 optional supplemental coverage for mental health treatment for the
14 insured and the insured's covered dependents.

15 (2) Benefits shall be provided under the optional supplemental
16 coverage for mental health treatment whether treatment is rendered by:
17 (a) ~~A ((physician licensed under chapter 18.71 or 18.57 RCW; (b) a~~
18 ~~psychologist licensed under chapter 18.83))~~ licensed mental health
19 provider regulated under chapter 18.57, 18.71, 18.79, 18.83, or 18.225
20 RCW; ((-e)) (b) a community mental health agency licensed by the
21 department of social and health services pursuant to chapter 71.24 RCW;
22 or ((-d)) (c) a state hospital as defined in RCW 72.23.010. The
23 treatment shall be covered at the usual and customary rates for such
24 treatment. The insurer((, health care service contractor, or health
25 maintenance organization)) providing optional coverage under the
26 provisions of this section for mental health services may establish
27 separate usual and customary rates for services rendered by
28 ((physicians licensed under chapter 18.71 or 18.57 RCW, psychologists
29 licensed under chapter 18.83 RCW, and community mental health centers
30 licensed under chapter 71.24 RCW and state hospitals as defined in RCW
31 72.23.010)) the different categories of providers listed in (a) through
32 (c) of this subsection. However, the treatment may be subject to
33 contract provisions with respect to reasonable deductible amounts or
34 copayments. In order to qualify for coverage under this section, a
35 licensed community mental health agency shall have in effect a plan for
36 quality assurance and peer review, and the treatment shall be

1 supervised by (~~a physician licensed under chapter 18.71 or 18.57 RCW~~
2 ~~or by a psychologist licensed under chapter 18.83 RCW~~) one of the
3 categories of providers listed in (a) of this subsection.

4 (3) For groups not covered by section 3 of this act, the group
5 disability insurance contract may provide that all the coverage for
6 mental health treatment is waived for all covered members if the
7 contract holder so states in advance in writing to the insurer.

8 (4) This section shall not apply to a group disability insurance
9 contract that has been entered into in accordance with a collective
10 bargaining agreement between management and labor representatives prior
11 to March 1, 1987.

12 Sec. 8. RCW 48.44.340 and 1987 c 283 s 4 are each amended to read
13 as follows:

14 (1) For groups not covered by section 4 of this act, each health
15 care service contractor providing hospital or medical services or
16 benefits in this state under group contracts for health care services
17 under this chapter which are issued, delivered, or renewed in this
18 state (~~on or after July 1, 1986,~~) shall offer optional supplemental
19 coverage for mental health treatment for the insured and the insured's
20 covered dependents.

21 (2) Benefits shall be provided under the optional supplemental
22 coverage for mental health treatment whether treatment is rendered by:
23 (a) A (~~physician licensed under chapter 18.71 or 18.57 RCW; (b) a~~
24 ~~psychologist licensed under chapter 18.83~~) licensed mental health
25 provider regulated under chapter 18.57, 18.71, 18.79, 18.83, or 18.225
26 RCW; (~~(c)~~) (b) a community mental health agency licensed by the
27 department of social and health services pursuant to chapter 71.24 RCW;
28 or (~~(d)~~) (c) a state hospital as defined in RCW 72.23.010. The
29 treatment shall be covered at the usual and customary rates for such
30 treatment. The (~~insurer~~) health care service contractor (~~or~~
31 health maintenance organization) providing optional coverage under the
32 provisions of this section for mental health services may establish
33 separate usual and customary rates for services rendered by
34 (~~physicians licensed under chapter 18.71 or 18.57 RCW, psychologists~~
35 licensed under chapter 18.83 RCW, and community mental health centers
36 licensed under chapter 71.24 RCW and state hospitals as defined in RCW
37 72.23.010) the different categories of providers listed in (a) through

1 (c) of this subsection. However, the treatment may be subject to
2 contract provisions with respect to reasonable deductible amounts or
3 copayments. In order to qualify for coverage under this section, a
4 licensed community mental health agency shall have in effect a plan for
5 quality assurance and peer review, and the treatment shall be
6 supervised by ~~((a physician licensed under chapter 18.71 or 18.57 RCW~~
7 ~~or by a psychologist licensed under chapter 18.83 RCW))~~ one of the
8 categories of providers listed in (a) of this subsection.

9 (3) For groups not covered by section 4 of this act, the group
10 contract for health care services may provide that all the coverage for
11 mental health treatment is waived for all covered members if the
12 contract holder so states in advance in writing to the health care
13 service contractor.

14 (4) This section shall not apply to a group health care service
15 contract that has been entered into in accordance with a collective
16 bargaining agreement between management and labor representatives prior
17 to March 1, 1987.

18 Sec. 9. RCW 48.46.290 and 1987 c 283 s 5 are each amended to read
19 as follows:

20 (1) For groups not covered by section 5 of this act, each health
21 maintenance organization providing services or benefits for hospital or
22 medical care coverage in this state under group health maintenance
23 agreements which are issued, delivered, or renewed in this state ~~((en~~
24 ~~or after July 1, 1986,))~~ shall offer optional supplemental coverage for
25 mental health treatment to the enrolled participant and the enrolled
26 participant's covered dependents.

27 (2) Benefits shall be provided under the optional supplemental
28 coverage for mental health treatment whether treatment is rendered by
29 the health maintenance organization or the health maintenance
30 organization refers the enrolled participant or the enrolled
31 participant's covered dependents for treatment ~~((to))~~ by: (a) A
32 ~~((physician licensed under chapter 18.71 or 18.57 RCW; (b) a~~
33 ~~psychologist licensed under chapter 18.83))~~ licensed mental health
34 provider regulated under chapter 18.57, 18.71, 18.79, 18.83, or 18.225
35 RCW; ~~((e))~~ (b) a community mental health agency licensed by the
36 department of social and health services pursuant to chapter 71.24 RCW;
37 or ~~((d))~~ (c) a state hospital as defined in RCW 72.23.010. The

1 treatment shall be covered at the usual and customary rates for such
2 treatment. The ((insurer, health care service contractor, or)) health
3 maintenance organization providing optional coverage under the
4 provisions of this section for mental health services may establish
5 separate usual and customary rates for services rendered by
6 ((physicians licensed under chapter 18.71 or 18.57 RCW, psychologists
7 licensed under chapter 18.83 RCW, and community mental health centers
8 licensed under chapter 71.24 RCW and state hospitals as defined in RCW
9 42.23.010)) the different categories of providers listed in (a) through
10 (c) of this subsection. However, the treatment may be subject to
11 contract provisions with respect to reasonable deductible amounts or
12 copayments. In order to qualify for coverage under this section, a
13 licensed community mental health agency shall have in effect a plan for
14 quality assurance and peer review, and the treatment shall be
15 supervised by ((a physician licensed under chapter 18.71 or 18.57 RCW
16 or by a psychologist licensed under chapter 18.83 RCW)) one of the
17 categories of providers listed in (a) of this subsection.

18 (3) For groups not covered by section 5 of this act, the group
19 health maintenance agreement may provide that all the coverage for
20 mental health treatment is waived for all covered members if the
21 contract holder so states in advance in writing to the health
22 maintenance organization.

23 (4) This section shall not apply to a group health maintenance
24 agreement that has been entered into in accordance with a collective
25 bargaining agreement between management and labor representatives prior
26 to March 1, 1987.

27 NEW SECTION. Sec. 10. A new section is added to chapter 48.02 RCW
28 to read as follows:

29 The insurance commissioner may adopt rules to implement sections 3
30 through 5 of this act, except that the rules do not apply to health
31 benefit plans administered or operated under chapter 41.05 or 70.47
32 RCW.

33 NEW SECTION. Sec. 11. A new section is added to chapter 70.47 RCW
34 to read as follows:

35 The administrator may adopt rules to implement section 6 of this
36 act.

1 NEW SECTION. Sec. 12. A new section is added to chapter 41.05 RCW
2 to read as follows:
3 The administrator may adopt rules to implement section 2 of this
4 act.

5 NEW SECTION. Sec. 13. If any provision of this act or its
6 application to any person or circumstance is held invalid, the
7 remainder of the act or the application of the provision to other
8 persons or circumstances is not affected.

Passed by the House January 28, 2005.

Passed by the Senate March 3, 2005.

Approved by the Governor March 9, 2005.

Filed in Office of Secretary of State March 9, 2005.

Exhibit H

Information Summary and Recommendations

Mental Health Parity Mandated Benefits Sunrise Review

November 1998



For more information or additional
copies of this report contact:

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Olympia, Washington 98504-7851

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Mary C. Selecky
Acting Secretary of Health

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EXECUTIVE SUMMARY

PROPOSAL FOR SUNRISE REVIEW

SB 6566 was referred to the department in 1998 for review under the mandated benefits sunrise review law, RCW 48.47. (A revised version of the bill, H-0001, was referred to the department and was used in the review. For simplification, "SB 6566" will be used throughout this report to represent the proposal under review. See Appendix A.) The applicant is the Coalition for Insurance Parity, a statewide group representing mental health providers, consumers, and advocacy organizations around the state. The proposal would require group health plans and the public employees benefit board health plan to (a) provide mental health coverage if they currently do not and (b) cover mental health at the same level that physical health is covered.

The requirement for mental health coverage is broad--"all mental disorders included in the diagnostic and statistical manual of mental disorders"--but the insurance policy may make mental health coverage subject to prior authorization and medical necessity requirements, the same as other services.

The requirement for parity in coverage is also broadly worded, so that it applies to both treatment limitations and various forms of financial participation. (By comparison, the national mental health parity law only restricts annual and lifetime dollar limits.) For example, if there is a \$10 co-pay for office visits, the co-pay for mental health visit must not be more than \$10. In addition, there could be no maximum number of visits on either an inpatient or out patient basis, unless similar requirements were imposed on coverage for medical and surgical services.

CURRENT REGULATION AND PRACTICE

There are currently no state requirements for either providing mental health coverage or specific mandates on the level of coverage, if offered, among the plans that would be covered by this proposal. There is, however, a Federal parity law for groups over 50 (but it does not mandate coverage, only parity if there is coverage), and state mandated offering laws for all groups subject to state Insurance Code. The meaning of "parity" in the federal law is narrow; annual or lifetime dollar limits for mental health services may not be lower than those for medical and surgical care.

Information provided to the department indicates that most health plans, including those impacted by this proposal, if enacted, do cover mental health services but nearly all do so with limits on visits, days, cumulative cost, or other parameters.

FINDINGS AND ANALYSIS

General

1. Applicants made a clear, persuasive case, based on scientific evidence, consumer testimony and experience, and a reasonable actuarial study. The Washington Association of Health Plans expressed reservations about timing in relation to marketplace trends in Washington. Other concerns expressed by commenters appear to be addressed through amendments the applicants are willing to support.
2. Neither federal legislation nor Washington's limited "mandated offering" law has adequately addressed the issues brought forward in the applicant report: mandated coverage for mental health services, and parity with physical health services in the level of coverage provided and the amounts paid by enrollees.

Social Impact

Mental health problems have high prevalence, with variable but often very high impact on health and productive life. Compared to many much narrower proposals for mandated benefits, the potential social benefit from improving access to mental health treatment is unusually high. Evidence presented by the applicant, and independent research conducted by the department, suggests that:

1. A significant portion of the population could, at any time, suffer from a mental disorder;
2. Many persons with mental illness are not receiving adequate treatment, or are receiving treatment later in the development of their disorder, due to lack of insurance coverage;
3. Not being treated early or sufficiently creates secondary problems, such as reduced productivity, homelessness, additional or exacerbated "somatic" problems, and heightened risk of suicide;
4. While it is difficult to gauge "public demand" in the purely economic sense (which would require evidence of willingness to pay), there appears to be high public support for mental health parity, as indicated by surveys, the range of organizations working for the proposal, and indirectly by those who could benefit from it.
5. Mentally ill individuals and their families now often incur severe financial hardships in order to pay the complete cost of treatment for mental illness. Mental health parity would even out this burden through use of the insurance principle, as occurs in the case of other catastrophic illness (for example, cancer).
6. The impact on children and adolescents is particularly important, with potential benefits related to a wide range of self-destructive or acting-out behavior which is of concern to the public and legislators. A recent RAND study (Sturm, 1997 JAMA article) concluded that

children are the main beneficiaries of removing or greatly increasing annual limits for mental health care (which is likely to be one consequence of SB 6566).

Financial Impact

The cost impacts of the proposed legislation are not negligible, and therefore considerable effort was devoted to understanding them. The department concludes that financial impacts are lower than commonly believed, and are fairly presented in the actuarial report and other information presented by the applicant report. Financial impacts also are lower than they would have been a decade ago (when both treatment effectiveness and experience in managing behavioral health benefits were less advanced). The department arrived at its conclusions using the following logic, which attempts to track the range of cost-related question in the statutory sunrise criteria:

1. *Price*: There was no clear evidence provided that the price per unit of mental health services (for example, per visit or hospital day) would either increase or decrease.

2. *Total and "appropriate" service use*: Better coverage would increase the total use of mental health services. It is likely that mental health parity will also increase *appropriate* use of such services for two main reasons: earlier initiation of treatment by individuals who have insurance but now delay treatment for financial reasons, and the influence of managed care practices. The evidence on mental health services offsetting other health care (discussed below) suggests that mental health parity may also decrease the misuse (as well as the cost) of other medical and social services.

The department has no evidence about whether mental health parity would also increase *inappropriate* use of mental health services, but any such tendency would be factored into the empirical (actuarial and research) studies discussed below. In other words, if this happens, its effect is not ignored in the dollar estimates.

3. *Total cost for mental health services only*: All studies reviewed agree that a broad mental health parity mandate, such as the proposal, will increase the total spent for mental health services to some extent. This is the first question regarding financial impact—but not the last question, since increasing mental health services also can reduce or offset spending for other health services, as discussed below (5).

But starting with the narrower question, how much would SB 6566 increase mental health treatment expenditures? The applicant's actuary, PriceWaterhouseCoopers (PWC), analyzed impacts of the proposed mandate separately for different types of health insurance, from fee-for-service (15% of the market) to HMO's or other managed care with a gatekeeper (20% of market). PWC concluded that the overall "composite" impact for all group health insurance would amount to a cost increase of 2.1%. Depending on type of insurance the impact would be from 1.3% to 2.7% (and the added cost per member per month would range from \$1.21 to \$3.47). Note that the 2.1% figure assumes that the mixture of insurance types would stay the same. The increase would be less if some employers or other groups opt for "more

managed" forms of insurance. That would change the mix of insurance types and reduce the composite cost impact. Other relevant studies tend to agree with PWC that comprehensive parity only would increase costs of insurance for mental health parity only should increase about 1% in HMOs or other *tightly managed* systems of care.

As required by the mandated benefit sunrise law, the Health Care Authority provided advice on "the reasonableness and accuracy of cost estimates associated with the proposed mandated benefit." HCA's October 8, 1998 letter indicates concurrence with the conclusions of their actuarial consultant, William M. Mercer, Inc. (Mercer), who stated, "we believe that the estimates contained in the PWC report are at the low end of a 'most likely' range ...[of] 2 to 4% increase in total health care costs."

Mercer also posed several questions, without quantitatively tying them to cost impact. Some are addressed by suggested amendments (See Appendix F). One question deals with the impact of the existing federal and state mandates. Since PWC and other studies use an assessment of actual insurance coverage in the state as their starting point, any impact of the state's "mandated offering" of limited mental health coverage (enacted over ten years ago) would be included. There is no explicit adjustment for the much more recent federal Mental Health Parity Act in the PWC analysis, but if such an adjustment were needed, it would lower the cost impact of SB 6566 by reducing the gap between the status quo and comprehensive parity.

PWC also presented a summary of recent actuarial cost analyses from several national and state-specific studies. The results are in the range suggested by Mercer, 2 - 4%. (See Appendix E)

PWC analysis also summarized the actual cost experience in states that implemented mental health parity statutes. Cost impacts ranged from downward (in two states) to under 0.5% in three. Not all of these mandates are as comprehensive as SB 6566.

A letter from the Association of Washington Health Plans (AWHP) states that "estimates of cost increases associated with implementing mental health parity measures have ranged from as low as 1.3% to as high as 10%." AWHP does not take a position on where in this range the impact of SB 6566 would be, and some of the studies at the "high end" appear to deal with different legislative proposals, older data, and/or market areas with less managed care (and thus higher cost impacts) than Washington.

Based on the total information available to reviewers, the department concludes that both the applicants' actuarial study and Mercer's broader range of 2 - 4% cost increase, are reasonable estimates of cost impact *before allowing for changes in the extent to which behavioral health is managed*. Without further documentation, estimates above 4% are not as convincing.

4. *Premiums for the mental health portion of coverage:* The PWC actuarial study prepared for the applicants makes a distinction between the "gross benefit cost" of the mandated

benefit and the "net benefit cost," including responses by employers (or other groups) intended to keep the premium down. Using the same assumptions as are typically used by Congressional Budget Office, CBW estimated a composite "net benefit cost" impact of less than 1% (and a composite increase in premiums of less than \$1 per member per month). However, some of the methods available to restrain premiums would shift cost to employees through cost sharing, reduction of other benefits (including lower wage increases), or even dropping coverage. Therefore, the department concludes that available analysis of the impact on premiums presents an incomplete view.

5. Total cost of health services. There is significant evidence that increased mental health coverage leads to offsets: reductions in the cost of other components of health care. This is documented in the applicant's report, but these cost reductions are not included in the PWC or other actuarial studies. Some of the studies cited in the applicant report are methodologically strong; but they deal with specific areas of mental health treatment and cannot be assumed to hold for the full breadth of such treatment. The applicant report also documents that there are large, prominent national employers which have concluded that their own choice to institute comprehensive mental health parity in their employee coverage resulted in minimal net cost (or even net savings), when offsets are included. Neither the applicants nor the department estimated overall "offset" for mental health parity legislation.

The department concludes that SB 6566 would lead to reductions in other health care costs, resulting in net impact of SB 6566 lower than otherwise estimated in (3) above. Consideration of offsets makes the applicants' 2.1% estimate more reasonable, and estimates over 4% less believable.

6. Costs and offsets to state government programs. SB 6566 will apply to both Medicaid managed care provided by state regulated health plans and to state employee health care (including the Uniform Medical Plan.) The cost impact on Medicaid will be lower than indicated in the applicant report because Medicaid already covers all medically necessary mental health care with minimal individual cost-sharing. As written, SB 6566 does not apply to Basic Health Plan (though the Coalition for Insurance Parity is considering seeking to include it). The bill's impacts on costs for covering public employees would be similar to those for other large employed groups, but no specific estimate is available.

Mental health parity in private health coverage also may reduce public sector costs in two ways: by delaying or (more rarely) avoiding some individuals' need to fall back on Medicaid as a source of payment for severe mental illness (often in conjunction with SSI disability status); and by possibly averting some episodes of treatment in state mental hospitals. Both of these impacts are quite plausible in cases where private insurance coverage leads to earlier and thereby more effective treatment interventions. The department has no basis to estimate the magnitude of this impact.

Putting aside the issue of including BHP in the bill—see Recommendations—the department finds that mental health parity will not increase, and may reduce expenditures in DSHS (which provides financial support for both Medicaid and state mental hospitals). It

should be noted, however, that mental health parity has the potential, especially in the short term, to increase the costs HCA and Public Employee Benefits Board pay for state employee coverage.

7. *Financial impact on small businesses and their employees:* The cost of SB 6566 will be higher in small groups than in large groups due to the greater risk of adverse selection in small groups, generally higher administrative "load," and relative lack of power to negotiate cost concessions or changes to plans that would compensate for any higher mental health premium costs. The potential differential impact on employees of small firms is serious enough that it receives attention in the department's recommendations.

8. *Affordability of health care coverage:* Affordability refers to the overall ability of businesses, other insurance groups and individuals to buy health care coverage. Affordability depends a great deal on context—what else is going on in the marketplace. Because these conditions change, there is a question of timing concerning this mandate, which is addressed in recommendations. After any short-term changes closely following implementation of a mental health mandate, the department believes that the impact on affordability will likely be small. However, some studies indicate that for every 1% increase in health premiums, approximately 2700 persons in Washington state may lose all health insurance coverage.

Service Efficacy

1. Vast amounts of scientific research exist to indicate that many specific mental health services are effective when appropriately used, and provide meaningful treatment to patients. The mental health field is too broad to make a categorical statement about the effectiveness of all services, but the same is true of non-behavioral medical care.
2. General health status is likely to be improved by the implementation of parity in mental health coverage.

Balancing Benefits and Costs

The department's recommendation is based on a considered judgment that the large and widely distributed benefits of mental health coverage parity outweigh the costs.

RECOMMENDATIONS

1. Because the benefits outweigh the costs, the department recommends enactment of SB 6566, with amendments (See Appendix F) that would:

- a. clarify that "V" codes within DSM IV are not included in the mandate
- b. exclude chemical dependency DSM codes from the mandate
- c. not require a health plan to impose annual cost-sharing if none exists
- d. specify that medical necessity is to be determined by the plan's medical director or designee.

Rationale:

- The department's overall basis for assessing benefits and costs is discussed in Findings and Analysis.
- The argument that physical and mental illnesses should be treated the same in insurance coverage, as a matter of fairness has ethical appeal that goes beyond the sunset criteria.
- The bill requires covering "all mental disorders included in the diagnostic and statistical manual of mental disorders IV or subsequent revisions." That manual (commonly called DSM-IV) includes a variety of codes which are not strictly diagnoses of mental disorders. One major improvement that would go far in reducing ambiguity would be to exclude so-called "V codes," which often deal with exacerbating situations that are not a mental disorder. Such factors clearly should be taken into account in determining appropriate treatment, but would not by themselves constitute a mental condition requiring coverage under the mandate.
- The applicant group has stated that they did not intend to require coverage of substance abuse treatment, but such treatment has coding in DSM-IV. Another proposed amendment would clarify that point.
- Clear definition of medical necessity in relation to the role of health plan medical directors, and modification of overly restrictive language regarding forms of enrollee cost participation, would bring the bill back to its intent of permitting the same kinds of managed care approaches used in general medical care to be applied to behavioral health care, so long as they are not applied in a way that singles out mental disorders.

The department also makes the following suggestions, which are beyond the scope of the sunrise statute and therefore are not formal recommendations.

1. The effective date of SB 6566 needs careful consideration, especially as related to small insurance groups. The department's favorable recommendation above (subject to suggested amendment) is based on a long-term assessment that benefits outweigh costs, in relation to the criteria in statute. However, there are immediate concerns about timing because health insurance premium increases for next year are larger than they have been for several years. The reasons are beyond the scope of this report, but probably include a combination of underlying medical cost inflation, cyclic trends (the "underwriting cycle"), and an adverse risk spiral in some areas of the market. In combination, this may be an especially poor year to institute the mandate. The impact on small businesses and their employees would be especially significant, as discussed in Findings.

This caution about timing does not change the department's recommendation that the mandate be passed, with amendments. The department believes that, long term, the mandate is sensible and should become law. Delayed implementation, especially for small insurance groups, may be adequate response.

2. While SB 6566 does not include the Basic Health Plan, the applicant report asked the department to consider recommending that it be added. The department is not prepared to make a recommendation on adding BHP to the bill at this time. The access benefits would be substantial. Neither the applicant's actuarial analysis nor other available information addresses cost impact in BHP. However, the applicant's consulting actuary verbally confirmed, during the hearing, the department panel's belief that cost impact in BHP would be higher than the "composite" for all insurance, because the starting point in BHP includes substantial limitations. Managing subsidized BHP within appropriated funds with comprehensive mental health parity mandate in place might require serious across-the-board restrictions. This would amount to shifting burden from one group of low-income patients to another in order to strengthen mental health coverage. Additionally, any increases in BHP cost sharing could have a substantial negative impact on affordability of BHP to low-income people, given previous analyses and actual experience.

As for the unsubsidized BHP program, it is a form of individual (not group) insurance—otherwise exempt from the proposed mandate. Unsubsidized BHP is experiencing a premium spiral based on apparent adverse selection, probably as a symptom of other problems in the individual insurance market, which could be exacerbated by adding a major new benefit that would, naturally, draw in new enrollees who need mental health care.

On balance, both because the statutory scope of the review process specifically excludes BHP, and the department does not believe there is adequate information to recommend extending the scope of SB 6566 to either the subsidized or unsubsidized Basic Health Plan, no recommendation is included in this report.

SUMMARY OF MAJOR INFORMATION SOURCES

The report of the applicant group (Washington Coalition for Insurance Parity)

The applicant group submitted a thorough report (See Attachment I) which addresses all statutory sunrise criteria. It is well-argued and addresses many specific topics not highlighted in this report.

Other supportive testimony

The department received letters and testimony supporting the mandate from:

- Consumers and consumer advocates
- Mental health professionals
- Washington State Labor Council and Snohomish Labor Council

Summaries of these comments are in Attachment G. Most of the general points made in these comments are addressed and documented in the applicant group's report. The department's panelists felt they received important additional information from the testimony regarding personal impacts of mental illness, the status of children's mental health care, the views of organized labor, concerns of managed care plans, and coalition efforts underway in some communities including King County and Snohomish County. The testimony also adds evidence of broad, long-standing interest.

Actuarial and cost impact studies

The applicant's actuarial study, Attachment E, related comments of the Health Care Authority and Association of Washington Health Plans (See Attachment G) and other major sources of information on financial impact are discussed in the "Findings and Analysis" section of this report.

Testimony expressing concerns

The comments received from the Health Care Authority, Association of Washington Health Plans, and Group Health Cooperative of Puget Sound address several topics:

- The overall cost impact of SB 6566 (addressed in "Findings and Analysis");
- More technical issues related to cost impact analysis (effect of previous mandates, effect of publicity related to the mandate, costs and savings in non-behavioral health care);
- The overall status of health insurance in Washington, impacts on small employers and their workers (see timing recommendation);

- The breadth of coverage required and whether it includes substance abuse (see Recommendations);
- Apparent drafting errors which would restrict typical managed care approaches to financial participation (see recommended amendments) and create ambiguity about the meaning of "medical necessity" (see Recommendations).

Evidence from other literature reviewed

A large volume of material was submitted by the applicants or obtained by the department (Appendix H) based on the applicants' citations (Appendix I) or other leads. Much of this information was digested where relevant in the applicant's report. The department did not have the time or specialized expertise to undertake a comprehensive independent review, but some members of the review panel read the more rigorous studies with a critical eye in order to improve their basis for making a judgment call.

PARTICIPANTS

Brad Powell, Ret. Psychiatrist
Andrea Stephenson, WA Coalition of Insurance Parity
Judy Thompson, Consumer
Chris Ingersoll, National Assoc. of Social Workers
Laura Groshong, WSSCSW
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Ronald Bachman, Actuary, PriceWaterhouse Coopers
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REVIEW PANEL

Steve Boruchowitz, DOH, Health Systems Quality Assurance

Dan Rubin, DOH, Office of the Secretary

Carol Neva, DOH, Health Systems Quality Assurance

Lisa Anderson, DOH, Health Systems Quality Assurance

Exhibit I



Centers for Disease Control and Prevention
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Diagnostic Criteria



The American Psychiatric Association's Diagnostic and Statistical Manual-IV, Text Revision (DSM-IV-TR) 1 provides standardized criteria to help diagnose ASDs.

Diagnostic Criteria for 299.00 Autistic Disorder

- Six or more items from (1), (2), and (3), with at least two from (1), and one each from (2) and (3):
 - qualitative impairment in social interaction, as manifested by at least two of the following:
 - marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
 - failure to develop peer relationships appropriate to developmental level
 - a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)
 - lack of social or emotional reciprocity
 - qualitative impairments in communication as manifested by at least one of the following:
 - delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime)
 - in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others
 - stereotyped and repetitive use of language or idiosyncratic language
 - lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level
 - restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:
 - encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
 - apparently inflexible adherence to specific, nonfunctional routines or rituals

- stereotyped and repetitive motor manners (e.g., hand or finger flapping or twisting, or complex whole-body movements)
- persistent preoccupation with parts of objects
- Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in social communication, or (3) symbolic or imaginative play.
- The disturbance is not better accounted for by Rett's Disorder or Childhood Disintegrative Disorder.



Diagnostic Criteria for 299.80 Asperger's Disorder

- Qualitative impairment in social interaction, as manifested by at least two of the following:
 - marked impairment in the use of multiple nonverbal behaviors such as eye-to eye gaze, facial expression, body postures, and gestures to regulate social interaction
 - failure to develop peer relationships appropriate to developmental level
 - a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest to other people)
 - lack of social or emotional reciprocity
- Restricted repetitive and stereotyped patterns of behavior, interests and activities, as manifested by at least one of the following:
 - encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity of focus
 - apparently inflexible adherence to specific, nonfunctional routines or rituals
 - stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
 - persistent preoccupation with parts of objects

- The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.
- There is no clinically significant general delay in language (e.g., single words used by age 2 years, communicative phrases used by age 3 years).
- There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behavior (other than in social interaction), and curiosity about the environment in childhood.
- Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia.

299.80 Pervasive Developmental Disorder Not Otherwise Specified (Including Atypical Autism)

This category should be used when there is a severe and pervasive impairment in the development of reciprocal social interaction associated with impairment in either verbal or nonverbal communication skills or with the presence of stereotyped behavior, interests, and activities, but the criteria are not met for a specific Pervasive Developmental Disorder, Schizophrenia, Schizotypal Personality Disorder, or Avoidant Personality Disorder. For example, this category includes "atypical autism" - presentations that do not meet the criteria for Autistic Disorder because of late age at onset, atypical symptomatology, or subthreshold symptomatology, or all of these.

Diagnostic Criteria for 299.80 Rett's Disorder

- All of the following:
 - apparently normal prenatal and perinatal development
 - apparently normal psychomotor development through the first 5 months after birth
 - normal head circumference at birth
- Onset of all of the following after the period of normal development:
 - deceleration of head growth between ages 5 and 48 months
 - loss of previously acquired purposeful hand skills between 5 and 30 months with the subsequent development of stereotyped hand movements (e.g., hand-wringing or hand washing)
 - loss of social engagement early in the course (although often social interaction develops later)
 - appearance of poorly coordinated gait or trunk movements
 - severely impaired expressive and receptive language development with severe psychomotor retardation

Diagnostic Criteria for 299.10 Childhood Disintegrative Disorder

- Apparently normal development for at least the first 2 years after birth as manifested by the presence of age-appropriate verbal and nonverbal communication, social relationships, play, and adaptive behavior.

- Clinically significant loss of previously acquired skills (before age 10 years) in at least two of the following areas:
 - expressive or receptive language
 - social skills or adaptive behavior
 - bowel or bladder control
 - play
 - motor skills
- Abnormalities of functioning in at least two of the following areas:
 - qualitative impairment in social interaction (e.g., impairment in nonverbal behaviors, failure to develop peer relationships, lack of social or emotional reciprocity)
 - qualitative impairments in communication (e.g., delay or lack of spoken language, inability to initiate or sustain a conversation, stereotyped and repetitive use of language, lack of varied make-believe play)
 - restricted, repetitive, and stereotyped patterns of behavior, interest, and activities, including motor stereotypes and mannerisms
- The disturbance is not better accounted for by another specific Pervasive Developmental Disorder or by Schizophrenia

Related Pages

- [Healthcare Provider Homepage \(/ncbddd/autism/hcp.html\)](/ncbddd/autism/hcp.html)
- [Child Development \(/ncbddd/child/\)](/ncbddd/child/)
- [Developmental Disabilities \(/ncbddd/dd/\)](/ncbddd/dd/)
- ["Learn the Signs. Act Early." Campaign \(http://www.cdc.gov/actearly\)](http://www.cdc.gov/actearly)
- [CDC's National Center on Birth Defects and Developmental Disabilities \(/ncbddd/index.html\)](/ncbddd/index.html)

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- 1 American Psychiatric Association. (2000). Pervasive developmental disorders. In Diagnostic and statistical manual of mental disorders (Fourth edition---text revision (DSM-IV-TR). Washington, DC: American Psychiatric Association, 69-70.

Page last reviewed: August 17, 2009

Page last updated: August 17, 2009

Content source: [Division of Birth Defects, National Center on Birth Defects and Developmental Disabilities, Centers for Disease Control and Prevention](#)

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EXHIBIT 8

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THE HONORABLE MICHAEL J. TRICKEY
Motion Date: March 2, 2012
Hearing time: 10:00 a.m.
WITH ORAL ARGUMENT

SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and
K.G., on his own behalf and on behalf of all
similarly situated individuals,

Plaintiffs,

v.

PREMERA BLUE CROSS and LIFEWISE
OF WASHINGTON, Washington
corporations,

Defendants.

No. 11-2-30233-4 SEA

**DEFENDANTS' OPPOSITION TO
PLAINTIFF'S MOTION FOR
PARTIAL SUMMARY JUDGMENT
AND PRELIMINARY INJUNCTION**

DEFENDANTS' OPPOSITION TO MOTION FOR PARTIAL
SUMMARY JUDGMENT AND PRELIMINARY INJUNCTION

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I. INTRODUCTION

Defendants Premera Blue Cross and Lifewise of Washington (collectively, “Defendants”) respectfully ask this Court to deny Plaintiff A.G.’s Motion for Partial Summary Judgment and Preliminary Injunction (the “Motion”). For the reasons set forth in Defendants’ pending Motion to Dismiss (Dkt. No. 5) and below, A.G.’s claim that Defendants violated the Mental Health Parity Act (the “Parity Act”) is contrary to Washington law and unsupported by the summary judgment record. In summary:

- Defendants’ exclusion of neurodevelopmental therapy benefits from A.G.’s individual health plan did not violate the Parity Act because neurodevelopmental therapy is not subject to the Parity Act as a matter of law. Neurodevelopmental therapy is subject to an earlier and separate Washington mandate that requires only *group health plans* to cover neurodevelopmental therapy for children under the age of seven. This mandate permits *individual health plans*, like the one at issue here, to exclude neurodevelopmental therapy. Further, well-established rules of statutory construction and legislative history confirm that the Parity Act did not implicitly repeal the neurodevelopmental therapy mandate.
- Defendants’ exclusion is also enforceable because neurodevelopmental therapy is not a “mental health service” within the meaning of the Parity Act. To be a “mental health service,” a benefit must be “medically necessary ... to treat” autism. A.G. did not satisfy his summary judgment burden of offering undisputed facts to show that neurodevelopmental therapy is medically necessary to treat autism generally or his autism specifically. The fact that Defendants’ automated claims systems mistakenly processed claims for neurodevelopmental therapy as a covered rehabilitation benefit does not show medical necessity because those claims were “auto-adjudicated” and never evaluated for medical necessity.
- Moreover, the Parity Act gives Defendants’ medical director discretion to determine whether a treatment is medically necessary, and Defendants have determined that neurodevelopmental therapy is not medically necessary to treat autism because the services provided by speech, occupational and physical therapists are not considered behavioral health, psychiatric or psychological care, and the scope of practice of these practitioners is not directed towards treatment of a mental health disorder. At a minimum, Defendants’ evidence on this issue creates genuine issues of material fact that preclude summary judgment.
- Because there is no likelihood that A.G. will prevail on the merits (and, indeed, his complaint should be dismissed), A.G. is not entitled to a preliminary injunction. Moreover, and in any event, A.G. has produced no evidence to show that a temporary cessation of speech therapy during the pendency of this action

1 will subject him to irreparable harm, and his failure to invoke his plan's urgent
2 internal appeal provisions, and delay in seeking an injunction in this Court,
similarly demonstrate the lack of need for any immediate injunctive relief.

3 For the reasons set forth more fully below, A.G.'s motion for partial summary judgment and
4 preliminary injunction should be denied, and Defendants' pending motion to dismiss granted.

5 II. EVIDENCE RELIED UPON

6 Defendants rely upon the Declaration of Barbara J. Duffy ("Duffy Decl.") and exhibits
7 thereto, the Declaration of James Tedford ("Tedford Decl."), the Declaration of Nancy Moore
8 ("Moore Decl."), and the Declaration of Dr. Chellie Moat ("Moat Decl."), as well as the
9 records, pleadings and court file in this case.

10 III. FACTS

11 A.G. is thirteen years old, and is a covered beneficiary of an individual health benefit
12 plan A.G.'s parents purchased from Defendants in 2004. J.G. Decl., ¶ 2. In October 2006,
13 A.G. was diagnosed with autism and mixed expressive-receptive language disorder. *Id.*, ¶ 3.
14 A.G. has submitted no medical records or medical opinion with his motion, but, according to
15 A.G.'s father, A.G.'s pediatrician recommended A.G. visit a therapy clinic to determine if he
16 would benefit from neurodevelopmental therapy. *Id.*, ¶ 4. Also according to A.G.'s father,
17 two therapists at the clinic recommended that A.G. receive weekly speech and occupational
18 therapy. *Id.*, ¶ 5. A.G. began receiving speech and occupational therapy in 2007. *Id.*, ¶ 9.

19 A.G.'s individual health plan contains an exclusion for neurodevelopmental therapy
20 benefits ("Neurodevelopmental Therapy Exclusion"). Duffy Decl., Exh. A, pp. 30-31.
21 Although an insurance mandate requires *group* health plans to provide neurodevelopmental
22 therapy benefits to individuals under the age of seven (the "Neurodevelopmental Therapy
23 Mandate"), the legislature has not expanded the Mandate to *individual* health plans.
24 Individual plans are more expensive than group plans and, to remain affordable, tend to
25 provide very basic coverage. *See* Tedford Decl., ¶ 3. The legislature understands this and,
26

1 therefore, has excluded individual plans from various mandates, such as neurodevelopmental
2 therapy, in an attempt to provide affordable options to purchasers. *Id.*, ¶¶ 3-4.

3 Notwithstanding the Neurodevelopmental Therapy Exclusion in A.G.'s individual
4 plan, when A.G.'s therapists sought payment for speech and occupational therapy, Defendants
5 initially paid the claims up to twenty visits per year. J.G. Decl., ¶ 9. This happened because
6 A.G.'s therapists submitted the claims using Current Procedural Terminology ("CPT") codes
7 commonly associated with therapeutic services, not neurodevelopmental therapy. As a result,
8 Defendants' automated claims software processed and automatically paid—or "auto
9 adjudicated"—those claims as routine rehabilitation benefits, which are covered under A.G.'s
10 policy for up to twenty visits per year. Moore Decl., ¶¶ 2-5, 7-8; Moat Decl., ¶ 3; Duffy
11 Decl., Exh. A, pg. 25. None of those auto adjudicated claims were ever reviewed by
12 Defendants for "medical necessity." Moore Decl., ¶¶ 2, 3 & 10; Moat Decl., ¶ 3.

13 Beginning in 2009, A.G.'s therapists began submitting some claims using a different
14 CPT code that triggered a manual review. It was determined that the services associated with
15 this code were for neurodevelopmental therapy, which was not a covered benefit. Defendants
16 denied those claims, but continued to automatically pay claims submitted by A.G.'s therapists
17 using the CPT codes for covered rehabilitation benefits. Moore Decl., ¶¶ 7-8; Moat Decl.,
18 ¶ 4. After a review of a number of claims, however, Defendants discovered that the speech
19 and occupational therapy claims previously paid as a rehabilitation benefit by Defendants'
20 automated claims system were, in fact, claims for neurodevelopmental therapy. Moore Decl.,
21 ¶ 9; Moat Decl., ¶ 4. Under A.G.'s plan, rehabilitation therapy does not include
22 neurodevelopmental therapy. Duffy Decl., Exh. A, pg. 26. Defendants notified A.G.'s
23 parents that all such claims submitted after January 1, 2010 were denied pursuant to the
24 Neurodevelopmental Therapy Exclusion. Moore Decl., ¶ 9; J.G. Decl., ¶¶ 10, 13.

25 Defendants did not consider A.G.'s neurodevelopmental therapy to be a mandated
26 benefit under the Parity Act. The Act requires health plans to provide coverage for services

1 that are “medically necessary” to treat mental health conditions, but allows plan medical
2 directors to determine medical necessity. RCW 48.44.341(4). Defendants and other health
3 plans use the term “medical necessity” to describe what services are covered and outline
4 specific criteria to define that term. Medical necessity decisions are made by physicians and
5 health care professionals, and include an assessment of accepted standards of medical care,
6 clinical appropriateness, efficacy and credible scientific literature published in peer-reviewed
7 literature, generally recognized by the relevant medical community. Whether a particular
8 service is medically necessary is a complex, multifaceted determination that is based on input
9 from medical professionals and sources in the relevant health field. Moat Decl., ¶ 6.

10 As stated in the declaration of Defendants’ Medical Director, the premise that
11 neurodevelopmental therapy is medically necessary to treat autism and, as such, is a “mental
12 health service,” is not uniformly accepted in the medical community. Most treatments for
13 autism are focused on improving co-morbid physical and communication problems that
14 impact the functional status of the individual. Services provided by speech, occupational and
15 physical therapists are not considered behavioral health, psychiatric or psychological care.
16 The scope of practice of these practitioners is not directed towards treatment of mental health
17 disorders. For example, the CPT code used by A.G.’s providers which triggered review by
18 Defendants’ claims department, described above, is educational in nature, and Defendants do
19 not view it as ever medically necessary for individuals with autism. Moat Decl., ¶ 7.

20 IV. ARGUMENT AND AUTHORITY

21 A. A.G.’s Motion For Partial Summary Judgment Should Be Denied.

22 Summary judgment is appropriate only where no genuine issues of material fact exist
23 and the moving party is entitled to judgment as a matter of law. CR 56(c). All facts and
24 reasonable inferences must be considered in the light most favorable to the nonmoving party,
25 and any doubts about the existence of a genuine issue of material fact must be resolved
26 against the moving party. *Atherton Condo. Apartment–Owners Ass’n Bd. of Dirs. v. Blume*

1 *Dev. Co.*, 115 Wn.2d 506, 516, 799 P.2d 250 (1990). The motion should be granted only if
2 reasonable persons could reach but one conclusion from all the evidence. *Chelan County*
3 *Deputy Sheriffs' Ass'n v. County of Chelan*, 109 Wn.2d 282, 295, 745 P.2d 1 (1987). Even
4 where the evidentiary facts are undisputed, if reasonable minds could draw different
5 conclusions from those facts, then summary judgment is not proper. *Id.*

6 1. A.G. Lacks Standing To Request A Declaration Of Rights Beyond The
7 Particular Terms Of His Individual Health Plan.

8 A.G.'s Motion seeks a declaration that Defendants' "exclusion of neurodevelopmental
9 therapies in its non-ERISA contracts is void and unenforceable because the exclusion violates
10 the requirements of the Parity Act." Motion at 3. As a threshold matter, the Motion must be
11 denied to the extent it seeks declaratory relief beyond the terms of A.G.'s individual health
12 plan. The Uniform Declaratory Judgments Act provides that, "[a] person interested under a
13 ... written contract ... or whose rights, status or other legal relations are affected by a ...
14 contract ..., may have determined any question of construction or validity arising under the ...
15 contract" RCW 7.24.020. To have standing, A.G. must establish (1) an actual, present,
16 and existing dispute, (2) between parties having genuine and opposing interests, (3) involving
17 direct and substantial interests, and (4) where a judicial determination will be final and
18 conclusive. *Branson v. Port of Seattle*, 152 Wn.2d 862, 877, 101 P.3d 67 (2004).

19 A.G. has no standing to seek a declaration of rights regarding the meaning or validity
20 of Defendants' "non-ERISA contracts" other than his own. No class action has been certified.
21 A.G. is not a party to those contracts, nor has he made any effort to establish that the terms of
22 his individual health plan are identical to those contained in all of Defendants' "non-ERISA
23 contracts," or why those other contracts are relevant here. While A.G. may have a direct
24 interest in a judicial determination of his contract, he has no cognizable interest in
25 Defendants' other contracts—which are not even before the Court. *See Yakima County (West*
26 *Valley) Fire Protection Dist. No. 12 v. City of Yakima*, 122 Wn.2d 371, 379-380, 858 P.2d

1 245 (1993) (only parties whose interests are directly affected by the outcome of a declaratory
2 judgment action have standing). Thus, regardless of the merits of A.G.'s Motion, his apparent
3 request for class-wide declaratory relief must be denied for lack of standing.

4 2. The Parity Act Does Not Apply To Defendants' Neurodevelopmental Therapy
5 Exclusion As A Matter Of Law.

6 A.G. claims that Defendants violated the Parity Act when they denied A.G. insurance
7 coverage for neurodevelopmental therapy that A.G. alleges is medically necessary to treat his
8 autism. A.G.'s Motion must be denied (and his complaint dismissed) because Defendants'
9 denial of coverage was permitted by the terms of A.G.'s health plan and Washington law.
10 A.G.'s plan expressly excludes neurodevelopmental therapy benefits. That exclusion does not
11 violate the Parity Act because it is not subject to the Act. Rather, neurodevelopmental therapy
12 benefits are subject to a separate Washington insurance mandate, and that mandate permits
13 individual health plans, such as A.G.'s, to exclude coverage for such benefits. The Parity Act
14 did not implicitly repeal or otherwise abrogate the Neurodevelopmental Therapy Mandate.

15 a. *Defendants Denied A.G.'s Request For Neurodevelopmental Therapy*
16 *Benefits Pursuant To The Terms Of His Individual Health Plan.*

17 A.G.'s Motion rests on a claim for neurodevelopmental therapy benefits. Motion at 3.
18 A.G. concedes that his individual health plan expressly excludes coverage for those benefits.
19 *Id.* at 11. A.G. has been a beneficiary of his parents' health plan since 2004, several years
20 before he began receiving neurodevelopmental therapy. J.G. Decl., ¶¶ 2-4. From the
21 beginning, and for the entire relevant period, A.G.'s health plan provided:

22 **EXCLUSIONS**

23 This section of the contract lists those services, supplies or drugs [that]
24 are not covered under this plan.

25 * * *

26 **Learning Disorders and Neurodevelopmental Therapy**

Services, therapy and supplies related to the treatment of learning
disorders, cognitive handicaps, dyslexia, developmental delays or
neurodevelopmental disabilities.

1 Duffy Decl., Exh. A, pp. 30-31. Although A.G.'s health plan was amended in 2008 and 2010
2 to comply with the Parity Act (*id.*, Exhs. B & C), this Neurodevelopmental Therapy
3 Exclusion was not deleted from the plan nor revised. As explained below, the enactment of
4 the Parity Act in 2005 did not affect the validity or enforceability of the Exclusion.

5 *b. The Neurodevelopmental Therapy Mandate Permits Individual Health*
6 *Plans To Exclude Coverage For Neurodevelopmental Therapy.*

7 In 1989, the Washington legislature enacted an insurance mandate requiring some
8 health plans to cover "neurodevelopmental therapies." The Neurodevelopmental Therapy
9 Mandate has three important aspects: (1) the mandate covers "neurodevelopmental therapies,"
10 which it defines as "occupational therapy, speech therapy, and physical therapy"; (2) the
11 mandate applies only to group health plans and to public employee health plans; and (3) the
12 mandate requires those group and public plans to cover neurodevelopmental therapy only for
13 children through the age of six. *See* RCW 41.05.170; RCW 48.21.310; RCW 48.44.450;
14 RCW 48.46.520.¹ Critically, there is not, and has never been, a mandate for individual health
15 plans such as A.G.'s plan. And, as discussed in greater detail in the next section, both before
16 and after enactment of the Parity Act, the legislature has repeatedly refused to expand the
17 Neurodevelopmental Therapy Mandate. In reliance on the Mandate, Defendants offer (and
18 price) individual health plans that expressly exclude neurodevelopmental therapy benefits.

19 The Neurodevelopmental Therapy Mandate, not the Parity Act, controls this case.
20 A.G. seeks coverage for speech and occupational therapy benefits only. Compl., ¶ 14; J.G.
21 Decl., ¶¶ 5, 9-12. Speech and occupational therapy are "neurodevelopmental therapies"
22 within the scope of the Mandate. *See* RCW 48.44.450(2). The legislature determined that

23 ¹ The Mandate was designed to require coverage for young children with
24 developmental disorders - such as Autism Spectrum Disorder or Pervasive Developmental
25 Disorders - because most insurance contracts and health plans did not cover these services as
26 a rehabilitation benefit. Where it applies, the Mandate ends at age six because, once a child
reaches the age of seven, they typically have access to special education programs that
provide these neurodevelopmental therapies in the school system. *See* Moat Decl., ¶ 5.

1 group health plans must cover those therapies for children under the age of seven, but it
2 refused to require individual health plans to do so. While Defendants can offer individual or
3 group health plans that provide coverage greater than what is mandated, they are not required
4 to do so. *Liljestrand v. State Farm Mut. Auto Ins. Co.*, 47 Wn. App. 283, 290 (1987); *see also*
5 *In re Detention of Strand*, 167 Wn.2d 180, 190, 217 P.3d 1159 (2009) (“express inclusion in a
6 statute of the situations in which it applies implies that other situations are intentionally
7 omitted”).² Like any non-mandated benefit, Defendants may exclude neurodevelopmental
8 therapy, and A.G.’s parents were free to choose a different plan if they wanted different
9 coverage. In short, the Neurodevelopmental Therapy Exclusion does not violate Washington
10 law because it is expressly permitted by the Neurodevelopmental Therapy Mandate.

11 *c. The Mental Health Parity Act Did Not Implicitly Repeal The*
12 *Neurodevelopmental Therapy Mandate.*

13 A.G. argues that “[a]fter the Mental Health Parity Act took effect, health carriers were
14 required to re-consider their provision of neurodevelopmental therapies ... and could no
15 longer exclude medically necessary neurodevelopmental therapies for individuals with DSM-
16 IV conditions.” Motion at 13-14. Not so. The Parity Act was originally enacted in 2005, but
17 did not apply to individual health plans until 2008. 2007 Laws, ch. 8. The Parity Act requires
18 plans that cover medical and surgical services to provide coverage for “mental health
19 services” to individuals diagnosed with a condition listed in DSM-IV. RCW 48.44.341(1).
20 The Act mandates this coverage in phases. For plans issued or renewed after January 1, 2008,
21 the Act requires that the co-pay for mental health services be no more than the co-pay for
22 medical and surgical services. RCW 48.44.341(2)(b)(ii). For plans issued or renewed after
23

24 ² Indeed, Defendants specifically stated in A.G.’s plan: “This contract is sold and
25 issued in Washington State as an individual medical plan. It is not issued for use as an
26 employer-sponsored or group health plan. LifeWise specifically disclaims any liability for
state or federal group plan requirements.” Duffy Decl., Exh. A, pp. 35-36.

1 July 1, 2010, the Act states that limitations on coverage for mental health services be the same
2 as those imposed on medical and surgical services. RCW 48.44.341(2)(c)(i).

3 The Parity Act and Neurodevelopmental Therapy Mandate do not “work hand-in-
4 hand,” nor did the Parity Act raise the “floor” for mandated neurodevelopmental therapy
5 benefits. Motion at 13-14. Under A.G.’s construction, Defendants can lawfully *follow* the
6 Neurodevelopmental Therapy Mandate in excluding neurodevelopmental therapy benefits and
7 unlawfully *violate* the Parity Act at the same. That construction does not harmonize the two
8 statutes, but rather results in the effective repeal of the Neurodevelopmental Therapy Mandate
9 in cases like this one. But A.G. does not and cannot point to anything in the text of the Parity
10 Act or its extensive history to suggest that the legislature intended such a drastic result; there
11 is no reference to neurodevelopmental therapy or the Mandate (which pre-dated the Parity Act
12 by 16 years) in the text of the Parity Act, the legislature’s findings, or its bill reports. *See*
13 2007 Laws, ch. 8; RCW 48.44.341; Duffy Decl., Exh. D.³ The legislature has refrained from
14 imposing mandates on individual insurance plans to keep them affordable for those who do
15 not qualify for group coverage. *See* Tedford Decl., ¶ 3-4. It is inconceivable that the
16 legislature intended to override its prior refusal to expand the Neurodevelopmental Therapy
17 Mandate in the field of individual health plans without saying so expressly.

18 For this reason, A.G. relies exclusively on rules of statutory construction to argue that
19 the Parity Act *implicitly* trumps the Neurodevelopmental Therapy Mandate. Motion at 13-14.
20 The rules, however, undermine A.G.’s argument. “Authority is legion that implied repeals of
21 statutes are disfavored and courts have a duty to interpret statutes so as to give them effect.”

22
23 ³ As noted, the Parity Act was originally enacted in 2005, but was limited to large
24 group health plans. It was amended in 2007 to expand the Act to small group and individual
25 health plans. For sake of completeness, Defendants submit the bill reports for the original
26 enactment (SHB 1154) and the 2007 amendment (EHB 1460). Courts may look at legislative
history to determine whether there has been a repeal by implication. *See ATU Legislative
Council of Washington State v. State*, 145 Wn.2d 544, 553, 40 P.3d 656 (2002).

1 *Bellevue Sch. Dist. No. 405 v. Brazier Constr. Co.*, 103 Wn.2d 111, 122, 691 P.2d 178 (1984).

2 Thus, courts find repeal by implication only where:

3 (1) the later act covers the entire subject matter of the earlier
4 legislation, is complete in itself, and is evidently intended to supersede
5 prior legislation on the subject; or (2) the two acts are so clearly
inconsistent with, and repugnant to, each other that they cannot be
reconciled and both given effect by a fair and reasonable construction.

6 *Id.* These criteria are not met. The Parity Act does not cover the entire subject matter of the
7 Mandate. In some ways it is broader, and in other ways it is narrower. The Parity Act
8 requires coverage for unspecified "mental health services," but only for individuals with a
9 DSM-IV diagnosis. RCW 48.44.341. The Mandate requires coverage for specific services
10 (occupational, speech and physical therapy), but has no DSM-IV limitation. RCW 48.44.450.
11 The Mandate, therefore, applies to therapies and individuals not covered by the Parity Act.

12 Further, the two statutes can be read logically to stand "side by side," but not as A.G.
13 suggests. The Mandate, the earlier and specific statute, applies to "neurodevelopmental
14 therapy," *i.e.*, occupational, speech or physical therapy prescribed for neurodevelopmental
15 disorders. Whereas the Parity Act, the later and general statute, applies to "mental health
16 services" other than neurodevelopmental therapy. In short, and consistent with the view of
17 Defendants' Medical Director and other experts, neurodevelopmental therapy is a medical
18 benefit, and not a "mental health service" within the meaning of the Parity Act. Not only does
19 this construction give effect to both statutes, it aligns with another established rule of statutory
20 construction: in cases of possible conflict, courts must give preference to specific statutes
21 over the general ones. *See ETCO, Inc. v. Dep't of Labor & Indus.*, 66 Wn. App. 302, 305-06,
22 831 P.2d 1133 (1992). A.G.'s Motion must be denied on this basis alone.

23 *d. Subsequent Legislative History and Agency Interpretations Confirm*
24 *The Limited Scope Of The Neurodevelopmental Therapy Mandate.*

25 Subsequent legislative efforts confirm that the legislature did not intend the Parity Act
26 to repeal the Neurodevelopmental Therapy Mandate where the purported "mental health

1 service” is, in fact, neurodevelopmental therapy.⁴ If the Parity Act expanded the Mandate,
2 further legislation regarding neurodevelopmental therapy would be unnecessary in the context
3 of mental health services or autism. Yet, *after* enactment of the Parity Act in 2005, there have
4 been repeated efforts to expand the Mandate. Some bills would have required group plans to
5 cover neurodevelopmental therapy for individuals up to age eighteen. *See* Duffy Decl., Exh.
6 E (SB 5750 (2007)); Exh. F (SB 5756 (2011)). Another bill would have expressly required
7 plans to cover neurodevelopmental therapy to treat autism. *Id.*, Exh. G (HB 1412 (2009)).
8 Even other bills would have required group plans to specifically cover treatments for autism,
9 including “services provided by a speech therapist, occupational therapist or physical
10 therapist”—the very same neurodevelopmental therapy addressed in the Mandate. *Id.*, Exh. H
11 (SB 5203 (2009)); Exh. I (SB 5059 (2011)). Not one of these bills passed the legislature.

12 Washington administrative agencies and committees likewise recognize that
13 neurodevelopmental therapy for autism is not a “mental health service” under the Parity Act.⁵
14 In its December 2006 report, the Caring for Washington Individuals with Autism Task Force
15 noted that “[m]any private insurance companies cover neurodevelopmental therapies only
16 through the age of six, and ASD is often excluded from coverage because it is considered by
17 insurance plans to be a non-medical condition that should be handled by the educational
18 system.” Duffy Decl., Exh. J (pg. 32). The Task Force recognized that neither the
19 Neurodevelopmental Therapy Mandate nor the Parity Act mandated such coverage; it found
20 that the legislature needed to “[i]mplement legislation that requires health insurance coverage
21

22 ⁴ *See State v. Clark*, 129 Wn.2d 805, 812-13, 920 P.2d 187 (1996) (subsequent un-
23 enacted legislation may be relevant to construction of prior legislation); *Spokane County*
Health Dist. v. Brockett, 120 Wn.2d 140, 153, 839 P.2d 324 (1992) (same).

24 ⁵ *See Hegwine v. Longview Fibre Co., Inc.*, 162 Wn.2d 340, 349, 172 P.3d 688 (2007)
25 (court will give “great weight” to agency interpretations that do not conflict with legislative
26 intent); *Anfinson v. FedEx Ground Package System, Inc.*, 159 Wn.App. 35, 41, 244 P.3d 32
(2010) (“We give great weight to an agency’s interpretation of a statute absent a compelling
indication that its interpretation conflicts with the legislative intent.”).

1 of evidence based interventions and services for individuals with ASD” *Id.* Similarly,
2 when it issued its final report in December 2007, the Task Force confirmed the lack of any
3 existing mandate and, critically, recommended amending the Mandate as a means of requiring
4 insurers to cover neurodevelopmental therapy as a means of treating autism:

5 Children with autism commonly have a range of medical conditions for which
6 they need treatment. Nationally, 22 states have successfully mandated
7 insurance coverage for evidence based intervention services that benefit
8 children with autism. There is no mandate for insurance coverage within
Washington State.

* * *

8 **Implementation Plan**

9 Objective 1: Improve Insurance Coverage for Individuals with ASD

10 1. Extend insurance benefits to cover interventions for individuals with ASD.

* * *

11 3. Support policies that ensure neurodevelopmental therapy insurance
12 benefits.

13 a. Extend neurodevelopmental therapy benefit including speech-
14 language services, occupational and physical therapy to individuals
aged 18 years. ...

15 Duffy Decl., Exh. K (pp. 7-9; underline added).⁶ Obviously, there would be no need for the
16 legislature to extend the reach of the Neurodevelopmental Therapy Mandate if, as A.G.
17 argues, the legislature already intended the Parity Act to achieve the same result.

18 The Department of Health’s January 2009 Sunrise Review regarding the “Treatment
19 of Autism Spectrum Disorders” came to the same conclusion. In reference to the Parity Act,
20 the DOH stated poignantly: “It is unclear at this time how much (if any) ASD treatment
21 should be covered under this mandate.” Duffy Decl., Exh. L (pp. 8-9). In its recommendation
22

23 ⁶ The Task Force was created in 2005 to, among other things, “study and make
24 recommendations to the legislature regarding the growing incidence of autism and ways to
25 improve the delivery and coordination of autism services in the state.” Laws of 2005, ch. 259,
26 § 2. Of the Task Force’s 14 members, four were members of the legislature, one was a
representative of the Department of Health and one was a member of the Department of
Social and Health Services. See <http://www.doh.wa.gov/cfh/autism/ATF/default.htm>.

1 regarding a possible mandate for ASD coverage, the DOH suggested the legislature “[e]xpend
2 the neurodevelopmental therapy mandate to,” among other things, raise the age limits. *Id.*
3 (pg. 16). There was no recommendation to extend the Mandate to individual health plans.
4 With respect to “[t]reatment related to mental health care or provided by mental health
5 providers” under the Parity Act, the DOH suggested that the legislature “[e]xpend and/or
6 clarify the mental health parity mandate to include treatment for ASD.” *Id.* (pg. 17). In other
7 words, the DOH understood that amendments to the Parity Act were necessary if health plans
8 were to be required to provide coverage for neurodevelopmental therapy as a treatment for
9 autism. As discussed above, the legislature refused to act on those recommendations.

10 The district court’s opinion in *Z.D. v. Group Health Coop.*, ___ F. Supp. 2d ___, 2011
11 WL 5299592 (W.D. Wash. Nov. 4, 2011), upon which A.G. relies, is neither controlling nor
12 convincing. There, the federal court considered the applicability of the Parity Act to an
13 ERISA plan in the context of a motion to dismiss. The court was not presented with the same
14 record as this Court and, indeed, its opinion does not address the legislative history and
15 agency analyses described above. Just as important, the *Z.D.* case involved a challenge to
16 plan limits on a neurodevelopmental therapy benefit contained in a *group* plan. As noted, the
17 Neurodevelopmental Therapy Mandate requires group plans to cover neurodevelopmental
18 therapy for individuals through the age of six, and the issue in the *Z.D.* case was whether the
19 Parity Act raised that “floor.” In the context of an individual plan, however, there is no floor;
20 the Mandate never applied to individual plans to begin with—presumably because the
21 legislature understood that mandating such coverage would increase the cost of such plans
22 beyond the reach of many individuals. *See* Tedford Decl., ¶¶ 3-4. Whether the legislature
23 intended the Parity Act to require individual plans to cover neurodevelopmental therapy in
24 this unique market, where such coverage has been affirmatively and repeatedly rejected in the
25 past, presents a fundamentally different question—one that the *Z.D.* court did not consider.
26 For the reasons stated above, this Court can and should reach a different result.

1 e. *The Office of Insurance Commissioner Has Never Disapproved The*
2 *Neurodevelopmental Therapy Exclusion.*

3 Finally, it should be noted that Defendants submitted the contract form for A.G.'s
4 individual health plan to the Office of Insurance Commissioner ("OIC") for the OIC's review,
5 as required by Washington law. See RCW 48.44.040 ("No registrant shall ... modify any
6 contract, or offer any new contract, until he or she has filed a copy of the ... modified
7 contract, or new contract with the insurance commissioner."); WAC 284-43-920(1)(a)
8 ("Carriers must file with the commissioner every contract form ... [b]efore the contract form
9 is offered for sale to the public ..."). This included the underlying plan agreement that
10 expressly contained the Neurodevelopmental Therapy Exclusion, as well as the 2008 and
11 2010 addenda which, as noted above, provided additional coverage for mental health care
12 pursuant to the Parity Act, but did not otherwise eliminate or amend the Exclusion. See Duffy
13 Decl., Exhs. A-C. The OIC has authority to disapprove the plan if it "contains unreasonable
14 restrictions on the treatment of patients" or "violates any provision of this chapter"—
15 including the Parity Act. RCW 48.44.020(2). The OIC has never disapproved the individual
16 health plan purchased by A.G.'s parents or its Neurodevelopmental Therapy Exclusion.

17 3. Even If The Parity Act Applies To The Neurodevelopmental Therapy
18 Exclusion, Genuine Issues Of Material Fact Preclude Summary Judgment.

19 In the event this Court concludes, as a matter of statutory construction, that the Parity
20 Act applies to Defendants' Neurodevelopmental Therapy Exclusion, it must nonetheless deny
21 A.G.'s Motion because genuine issues of material fact exist regarding the enforceability of the
22 exclusion as a medically necessary treatment for A.G.'s autism.

23 a. *A.G. Did Not Submit Undisputed Evidence That Neurodevelopmental*
24 *Therapy Is A "Mental Health Service" Under The Parity Act.*

25 The Parity Act does not require health plans to provide unlimited benefits to plan
26 individuals diagnosed with autism. The Act requires plans to cover "mental health services,"
which it defines as "medically necessary outpatient or inpatient services provided to treat

1 mental disorders covered” by DSM-IV. RCW 48.44.341(1). Thus, the Neurodevelopmental
2 Therapy Exclusion violates the Parity Act only if neurodevelopmental therapy is “medically
3 necessary ... to treat” autism. *Id.* A.G. wholly failed to carry his burden of bringing forward
4 undisputed evidence to establish that threshold element of his claim. *Young v. Key Pharms.,*
5 *Inc.*, 112 Wn.2d 216, 225, 770 P.2d 182 (1989) (“the moving party bears the initial burden of
6 showing the absence of an issue of material fact”). There is no evidence on this record that
7 (1) neurodevelopmental therapy is medically necessary to treat autism generally, or (2) the
8 neurodevelopmental therapy that A.G. receives is medically necessary to treat his autism
9 specifically. Indeed, Defendants are the only party to submit evidence on this issue, and that
10 evidence shows that neurodevelopmental therapy is not a mental health service.⁷

11 To begin with, A.G. did not support his Motion with any sworn testimony by a
12 physician, therapist or other medical professional, nor did he submit even a single medical
13 record on the issue of medical necessity. The diagnoses and statements purportedly made by
14 A.G.’s pediatrician and therapists, described generally in the declaration of A.G.’s father (*see*
15 *J.G. Decl.*, ¶¶ 3-7), are inadmissible hearsay and cannot be considered by this Court as
16 substantive evidence of medical necessity. CR 56(e) (summary judgment affidavit “shall set
17 forth such facts as would be admissible in evidence”); *Dunlap v. Wayne*, 105 Wn.2d 529, 535,
18 716 P.2d 842 (1986) (when deciding a summary judgment motion, trial court cannot consider
19 inadmissible hearsay). In any event, even if accepted at face value, the declaration says only
20 that A.G.’s pediatrician referred A.G. to a clinic to see if he would “benefit” from therapy,

21 ⁷ Citing to the report of the DOH’s Caring for Washington Individual’s with Autism
22 Task Force, A.G. argues that “[s]peech and occupational therapy are key forms of
23 intervention.” Motion at 10. The Task Force’s recommendation that Washington expand the
24 Neurodevelopmental Therapy Mandate for individuals with autism does not remotely prove
25 that such therapies are “medically necessary.” Moreover, the Mandate imposes a unique and
26 expansive definition of medical necessity that does not apply to the Parity Act: “Benefits
shall be payable for services *for the maintenance of a covered individual* where significant
deterioration in the patient’s condition would result without the service. Benefits shall be
payable to restore *and improve* function.” RCW 41.05.170(3) (emphasis added).

1 and that two therapists “recommended” that A.G. receive speech and occupational therapy.
2 J.G. Decl., ¶¶ 4, 5. There is no statement or evidence before the Court that a physician
3 determined that neurodevelopmental therapy was medically necessary to treat A.G.’s autism.

4 Nor is the lay opinion of A.G.’s father that A.G. benefits from neurodevelopmental
5 therapy sufficient to establish medical necessity. See J.G. Decl., ¶¶ 8, 15-17. There is a
6 difference between a service that A.G.’s parents believe improves A.G.’s functional abilities
7 and “mental health services” that are medically necessary to treat an individual with ASD.
8 Moat Decl., ¶ 8. “In general, expert testimony is required when an essential element in the
9 case is best established by an opinion which is beyond the expertise of a layperson.” *Harris v.*
10 *Robert C. Groth, M.D., Inc., P.S.*, 99 Wn.2d 438, 449, 663 P.2d 113 (1983) (citing 5A K.
11 Tegland, Wash. Prac., Evidence § 300 (1982)). Medical facts in particular must be proven by
12 expert testimony unless they are observable by a layperson’s senses and describable without
13 medical training. *Id.*; also *Bruns v. Paccar, Inc.*, 77 Wn. App. 201, 214, 890 P.2d 469 (1995)
14 (expert testimony is required when an issue involves medically complex factors beyond the
15 knowledge of a lay person). Whether any particular type of service or therapy is medically
16 necessary to treat autism (both generally and as to A.G. specifically) is a medically complex
17 issue beyond the everyday understanding of a lay person. See Moat Decl., ¶ 6. Indeed, as
18 discussed below, that is precisely why Washington law defines “medical necessity” in terms
19 of “generally recognized standards within a relevant health profession.” WAC 284-43-130
20 (17). Only medical professionals are qualified to testify as to those standards.

21 Finally, Defendants never “determined that A.G.’s neurodevelopmental therapies are
22 medically necessary,” nor is there any “finding that the therapies met [Defendants’] medical
23 necessity standards.” Motion at 11. A.G. simply makes too much of the fact that Defendants
24 paid speech and occupational therapy claims in the past. J.G. Decl., ¶¶ 9-13 & Exhs. A & B.
25 Before realizing the nature of those claims, Defendants’ *automated* claims system processed
26 claims submitted by A.G.’s therapists as *rehabilitation* benefits, which are covered under

1 A.G.'s health plan. Moore Decl., ¶¶ 2-7; Moat Decl., ¶ 3. These claims were treated as
2 rehabilitation benefits and "auto adjudicated"—*i.e.*, automatically paid by Defendants' claims
3 software—because A.G.'s therapists submitted the claims using CPT codes associated with
4 covered therapeutic services, not excluded neurodevelopmental therapy. *Id.*⁸ It was only
5 after A.G.'s therapists submitted claims using a CPT code associated with an educational
6 occupational therapy did Defendants manually review the claims and discover that A.G. was
7 receiving neurodevelopmental therapy. Moore Decl., ¶¶ 7-9; Moat Decl., ¶ 4. Defendants
8 denied those claims pursuant to Neurodevelopmental Therapy Exclusion in A.G.'s plan. *Id.*

9 Critically, the claims submitted by A.G.'s therapists that Defendants mistakenly paid
10 as a covered rehabilitation benefit were not assessed for medical necessity. These claims
11 were processed by Defendants' claims software and auto adjudicated for payment based on
12 the CPT codes. Moore Decl., ¶¶ 2, 3, 7 & 10; Moat Decl., ¶ 3. Defendants never performed
13 any kind of assessment of medical necessity, and certainly no determination that the speech or
14 occupational therapy A.G. received was "medically necessary" to treat his autism under the
15 terms of his plan or Parity Act. The same is true with respect to those claims that Defendants
16 later identified as claims for neurodevelopmental therapy; they were denied based on the plan
17 exclusion without a medical necessity determination. Moore Decl., ¶¶ 8-10; Moat Decl., ¶ 4.
18 If anything, the fact that Defendants immediately denied benefits identified as
19 neurodevelopmental therapy belies the inference of medical necessity A.G. asks this Court to
20 draw from his claims history. For this reason too, A.G. has failed to satisfy his burden on
21 summary judgment of coming forward with undisputed evidence of medical necessity.

22 _____
23 ⁸ Defendants paid these claims for up to 20 visits per year, which is the limit specified
24 in A.G. health plan for rehabilitation benefits. Moore Decl., ¶ 7; Duffy Decl., Exh. A, pg. 25.
25 Had Defendants recognized A.G.'s claims for neurodevelopmental therapy as a "mental
26 health service" mandated by the Parity Act, prior to July 1, 2010, A.G.'s plan required
coverage for only 6 outpatient visits. *See* Duffy Decl., Exh. B. The fact that Defendants paid
claims "at least for twenty visits per year" (J.G. Decl., ¶ 9), rather than for 6 visits, confirms
that Defendants treated A.G.'s claims as a covered rehabilitation benefit.

1 b. *Defendants' Medical Directors Determined That Neurodevelopmental*
2 *Therapy Is Not A Mental Health Service Under The Parity Act.*

3 Even had A.G. come forward with *some* evidence to make a prima facie showing that
4 neurodevelopmental therapy is “medically necessary ... to treat” autism (he did not),
5 Defendants’ own evidence on this issue is more than sufficient to defeat summary judgment.
6 The Parity Act expressly gives Defendants’ medical director discretion to make a clinical
7 determination on medical necessity: “This section does not prohibit a requirement that
8 mental health services be medically necessary as determined by the medical director or
9 designee, if a comparable requirement is applicable to medical and surgical services.” RCW
10 48.44.341(4); *also* WAC 284-43-130(17) (“‘Medically necessary’ or ‘medical necessity’ in
11 regard to mental health services ... *is a carrier determination* ...”) (emphasis added).
12 Whether a particular health care service or treatment is medically necessary is a complex,
13 multifaceted determination that is based on input from medical professionals and sources in
14 the relevant health field. Moat Decl., ¶ 6. The term “medical necessity,” in the context of
15 health benefit plan coverage, has a much broader meaning than whether a physician ordered
16 or recommended the service, or that a specific individual derived benefit from it. *Id.*

17 According to the sworn declaration of Defendants’ Medical Director, the premise that
18 neurodevelopmental therapy is medically necessary to treat autism is overly simplistic and not
19 uniformly accepted within the medical community. Moat Decl., ¶ 7. Autism is a complex,
20 multifaceted disorder, the exact cause of which is unknown, although there is increasing
21 evidence that genetic factors may be involved. Most treatment is focused on improving co-
22 morbid physical and communication problems that impact the functional status of the
23 individual. *Id.* Thus, it is Defendants’ determination that services provided by speech,
24 occupational and physical therapists do not constitute behavioral health, psychiatric or
25 psychological care, and the scope of practice of these practitioners is not directed towards
26 treatment of mental health disorders. *Id.* A.G. has presented no contrary evidence. At the

1 very minimum, this testimony—which is the only evidence in this record regarding the
2 threshold issue of medical necessity—is sufficient to defeat summary judgment.⁹

3 **B. A.G.’s Motion For Preliminary Injunction Should Be Denied.**

4 To obtain preliminary injunctive relief, A.G. must demonstrate (1) a clear legal or
5 equitable right; (2) a well-grounded fear of immediate invasion of that right; and (3) that the
6 acts complained of are either resulting in or will result in actual or substantial injury. *San*
7 *Juan County v. No New Gas Tax*, 160 Wn.2d 141, 153, 157 P.3d 831 (2007). The failure to
8 establish any of these criteria requires the denial of injunctive relief. *Id.* A preliminary
9 injunction should not issue in a doubtful case. *Id.* at 153-54. Moreover, an injunction is an
10 equitable remedy and should not be granted where the moving party fails to demonstrate the
11 absence of “a plain, complete, speedy and adequate remedy at law.” *Kucera v. Dep’t of*
12 *Transp.*, 140 Wn.2d 200, 209, 995 P.2d 63 (2000). To facilitate appellate review, if a trial
13 court issues a preliminary injunction, it must enter findings of fact and conclusions of law that
14 set forth its reasoning. *San Juan County*, 160 Wn.2d at 154; CR 65(d).

15 1. A.G. Did Not Demonstrate A Clear Legal Or Equitable Right.

16 In examining whether the moving party has established a clear legal or equitable right,
17 a court examines the likelihood that the moving party will prevail on the merits. *Kucera*, 140
18 Wn.2d at 216 (citing *Rabon v. City of Seattle*, 135 Wn.2d 278, 285, 957 P.2d 621 (1998)).
19 A.G. has not shown a likelihood that he will prevail on the merits. For the reasons set forth in
20 Defendants’ motion to dismiss, A.G.’s claims should be dismissed as a matter of law. But
21

22 ⁹ Defendants cannot cure their failure to establish even a prima facie case of medical
23 necessity by submitting additional declarations or medical documentation on reply brief. The
24 moving party must raise in its summary judgment motion all of the issues on which it believes
25 it is entitled to summary judgment. *White v. Kent Med. Ctr. Inc.*, 61 Wn. App. 163, 168, 810
26 P.2d 4 (1991). “Allowing the moving party to raise new issues in its rebuttal materials is
improper because the nonmoving party has no opportunity to respond.” *Id.* Indeed, A.G. has
not yet responded to Defendants’ discovery requests and, thus, Defendants could not properly
respond to any evidence of medical necessity that A.G. might subsequently submit.

1 even if Defendants' Neurodevelopmental Therapy Exclusion were subject to or unenforceable
2 under the Parity Act, as explained above, A.G. has failed to bring forward any admissible
3 evidence or expert medical opinion to show that the purported "mental health services" he
4 seeks are medically necessary to treat his autism. Until and unless A.G. makes such a
5 showing, he has no "clear legal or equitable" right to mandated coverage under the Parity Act.

6 2. A.G. Has Adequate Remedies At Law.

7 A.G. has adequate remedies at law and cannot show that injunctive relief is necessary
8 to prevent irreparable harm. *Kucera*, 140 Wn.2d at 210 (remedies at law inadequate only
9 where injury is irreparable by monetary damages). With respect to A.G.'s claim against
10 Defendants based on the retroactive denial of neurodevelopmental therapy benefits (*see* J.G.
11 Decl., Exh. A), A.G. plainly has an adequate remedy at law—specifically, a money judgment
12 in the amount of the past medical expenses that A.G.'s therapists have purportedly billed
13 A.G.'s parents. *Id.*, ¶ 18. Moreover, A.G. cannot show that alleged debt can or will impinge
14 on his ability to pay for any therapy or health care going forward: his father admits that
15 A.G.'s therapists have stopped their collection efforts. *Id.*, ¶ 20.

16 With respect to A.G.'s claim for mandatory injunctive relief going forward, the issue
17 is not refusal to provide medical benefits, as A.G. posits, but whether the A.G.'s parents'
18 alleged inability to pay for speech therapy pending a judgment on the merits constitutes
19 irreparable harm.¹⁰ There is a difference between the denial of health insurance and the denial
20 of health care for serious and immediate medical needs; while the loss of health care may
21 justify injunctive relief in some cases, courts generally find irreparable harm only where a
22 plaintiff proves a critical need for healthcare, as opposed to mere financial hardship. *See*

23 _____
24 ¹⁰ A.G.'s parents pay for and A.G. still receives, occupational therapy. A.G.'s father
25 can only speculate about what *might* happen *if* A.G.'s parents stopped paying for that therapy.
26 J.G. Decl., ¶ 15, 17. It is well-established that speculative harm is not grounds for injunctive
relief. *Tyler Pipe Indus., Inc. v. Dep't of Revenue*, 96 Wn.2d 785, 796, 638 P.2d 1213 (1982).
If A.G. is entitled to coverage for such therapy, money damages would be adequate.

1 *Carabillo v. ULLICO Inc. Pension Plan and Trust*, 355 F. Supp. 2d 49, 55 (D.D.C. 2004).
2 Even putting aside the fact that A.G.'s father has not supported his conclusory allegation of
3 financial hardship nor shown a lack of alternative sources of health care or insurance (*see* J.G.
4 Decl., ¶¶ 15 & 20), A.G.'s showing of irreparable harm fails for largely the same reasons
5 discussed above: there is no medical evidence in this record showing that speech therapy is
6 medically necessary or that a temporary cessation in such treatment will subject A.G. to any
7 long-term or residual harm or risk to his medical conditions or mental health.

8 Finally, A.G.'s claim of irreparable harm is undermined by his own refusal to pursue
9 the expedited appeal process available to him under the terms of his individual health plan.
10 Under the plan, A.G. could have internally appealed (and obtained an independent review of)
11 Defendants' decision to deny him neurodevelopmental therapy. If requested by A.G.'s health
12 care provider, A.G. would have been entitled to a decision within 72 hours. Duffy Decl., Exh.
13 A, pg. 39 ("Urgent Appeals). Although A.G.'s father states that Defendants' August 12, 2011
14 letter did not contain any information about his right to appeal (J.G. Decl., ¶ 14), the June 23,
15 2011 Explanation of Benefits letter plainly did. *Id.*, Exh. A ("If you still have concerns after
16 speaking with Customer Service, you ... may file an appeal."). If Defendants' speech therapy
17 were medically necessary and his harm truly irreparable, then A.G. would have exhausted this
18 potential avenue to immediate relief. Instead, A.G. bypassed the appeals process altogether
19 (*see* Compl., ¶ 25), filed suit and then waited four and a half months to seek injunctive relief.
20 A.G.'s request for a preliminary injunction should be denied for this reason as well.¹¹

21
22
23 ¹¹ Even if this Court were to grant A.G. preliminary injunctive relief, it cannot order
24 Defendants to provide A.G. coverage for unlimited neurodevelopmental therapy benefits.
25 The Parity Act does not require unlimited coverage. Rather, as noted above, it expressly
26 states that "[t]reatment limitations or any other financial requirements on coverage for mental
health services are allowed if the same limitations or requirements are imposed on coverage
for medical and surgical services[.]" RCW 48.44.341(2)(c)(i). Not only has A.G. failed to
submit any evidence of medical necessity, there is no evidence regarding what limitations
Defendants may permissibly apply to "mental health services" mandated by the Parity Act.

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V. CONCLUSION

For all the reasons stated above and in Defendants' Motion to Dismiss, Defendants ask this Court to deny A.G.'s Motion for Partial Summary Judgment and Preliminary Injunction and to dismiss A.G.'s complaint with prejudice.

DATED: February 10, 2012

LANE POWELL PC

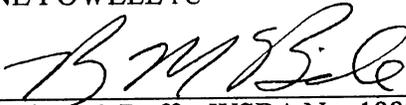
By 
Barbara J. Duffy, WSBA No. 18885
Gwendolyn C. Payton, WSBA No. 26752
Ryan P. McBride, WSBA No. 33280
*Attorneys for Defendants Premera Blue Cross
and Lifewise of Washington*

EXHIBIT 9

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THE HONORABLE MICHAEL J. TRICKEY
Motion Date: March 2, 2010
Hearing Time: 10:00 a.m.
WITH ORAL ARGUMENT

SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and K.G., on his own behalf and on behalf of all similarly situated individuals,

Plaintiffs,

v.

PREMERA BLUE CROSS and LEFWISE OF WASHINGTON, Washington corporations,

Defendants.

No. 11-2-30233-4 SEA

DECLARATION OF BARBARA J. DUFFY IN OPPOSITION TO PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT AND PRELIMINARY INJUNCTION

I, Barbara J. Duffy declare as follows:

1. I am a shareholder at Lane Powell PC, attorneys of record for Premera Blue Cross and Lifewise of Washington, Defendants in the above-captioned matter, am of legal age, competent to testify and have personal knowledge of the matters herein.

2. Attached hereto as Exhibit A is a true and correct copy of the individual health insurance plan that has covered Plaintiff A.G. since January 1, 2007 (the "Plan").

3. Attached hereto as Exhibit B is a true and correct copy of an endorsement to the Plan, effective January 1, 2008.

4. Attached hereto as Exhibit C is a true and correct copy of an endorsement to the Plan, effective July 1, 2010.

1 5. Attached hereto as Exhibit D are true and correct copies of the legislative bill
2 reports for the 2005 Mental Health Parity Act (SHB 1154) and the 2007 amendment to the
3 Mental Health Parity Act (EHB 1460).

4 6. Attached hereto as Exhibit E is a true and correct copy of SB 5760, the bill
5 digest for SB 5760, and the bill report for SB 5760.

6 7. Attached hereto as Exhibit F are true and correct copy of SB 5756 and the bill
7 digest for SB 5756.

8 8. Attached hereto as Exhibit G is a true and correct copy of HB 1412, the bill
9 digest for HB 1412, and the bill report for HB 1412.

10 9. Attached hereto as Exhibit H is a true and correct copy of SB 5203, the bill
11 digest for SB 5203, and the bill report for SB 5203.

12 10. Attached hereto as Exhibit I is a true and correct copy of SB 5059, the bill
13 digest for SB 5059, and the bill report for SB 5059.

14 11. Attached hereto as Exhibit J are true and correct copies of excerpts of the
15 December 2006 first report issued by the Caring for Washington Individuals with Autism
16 Task Force.

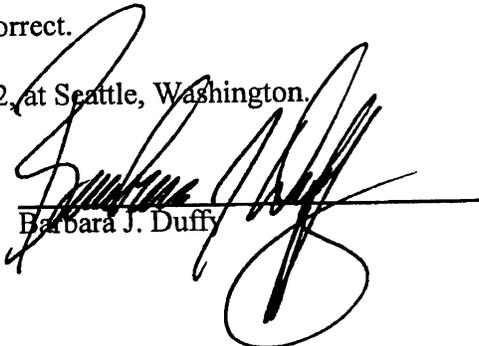
17 12. Attached hereto as Exhibit K are true and correct copies of excerpts of the
18 December 2007 final report issued by the Caring for Washington Individuals with Autism
19 Task Force.

20 13. Attached hereto as Exhibit L are true and correct copies of excerpts of the
21 Department of Health's January 2009 "Treatment of Autism Spectrum Disorders Mandated
22 Benefit Sunrise Review."

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I declare under penalty of perjury under the laws of the United States and the State of Washington that the foregoing is true and correct.

Dated this 8th day of February, 2012, at Seattle, Washington.



Barbara J. Duffy

EXHIBIT A

ADVISORY

Please note: Your contract will appear following this cover page. Please keep in mind, that your contract may be updated from time to time due to several reasons, such as new laws passed, clarification of benefits, etc. All changes require notification to you, the member, and are usually done via an endorsement which then forms a part of the contract. Any endorsements currently applicable to your benefit contract are attached just inside the back cover of your contract booklet. Please take the time to review them whenever accessing your contract to be sure you are accessing the most current information.

EXHIBIT A

**your
benefit
booklet**

2007

**WiseChoices 20
\$1,000 Deductible**

Benefit Booklet
for Individuals and Families
Residing in Washington

LIFEWISE | 
HEALTH PLAN OF WASHINGTON



LifeWise Health Plan of Washington WiseChoices 20 Plan (\$1,000 Deductible) For Individuals And Families Residing in Washington

PLEASE READ THIS CONTRACT CAREFULLY This is a contract between the subscriber and LifeWise Health Plan of Washington and shall be construed in accordance with the laws of the State of Washington. Please read this contract carefully to understand all of your rights and duties and those of LifeWise Health Plan of Washington.

GUARANTEED RENEWABILITY OF COVERAGE Coverage under this contract will not be terminated due to a change in your health. Renewability and termination of coverage are described under the ELIGIBILITY, ENROLLMENT AND TERMINATION section of this contract.

In consideration of timely payment of the full subscription charge, LifeWise Health Plan of Washington agrees to provide the benefits of this contract subject to the terms and conditions appearing on this and the following pages, including any endorsements, amendments, and addenda to this contract which are signed and issued by LifeWise Health Plan of Washington.

LifeWise Health Plan of Washington has issued this contract at Mountlake Terrace, Washington.

Darryl Price
President and Chief Executive Officer
LifeWise Health Plan of Washington

YOUR RIGHT TO RETURN THIS CONTRACT WITHIN TEN DAYS

If, after examining this contract, you are not satisfied with it for any reason, you may return it to LifeWise Health Plan of Washington or the agent through whom it was purchased, within ten days of delivery for a full refund of your subscription charge payment. We will consider the date of delivery to be five days from the postmark date. We will refund your payment within 30 days of the date that LifeWise Health Plan of Washington or our agent received the returned contract, or we will pay an additional ten percent penalty which will be added to your refund. If you return this contract within the ten-day period, it will be void and considered as never effective. We reserve the right to recover any benefits paid by us prior to such action, and deduct such amounts from the subscription charge refund.

(FACE PAGE)

016812(01-2007)

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DEFINITIONS40

WELCOME

Thank you for choosing LifeWise Health Plan of Washington to serve your health care coverage needs.

This contract gives you information on this plan's benefits, provider network, and other information. Please read this contract to familiarize yourself with the provisions of your health care coverage. Terms that have specific meanings in this contract are defined in the Definitions section of this contract.

Should you have any questions regarding the information contained in this contract or any other aspect of your health care coverage with us, please contact our Customer Service Department. You can find the telephone numbers on the back cover of this contract.

We look forward to serving you and your family. Once again, thank you for choosing LifeWise Health Plan of Washington for your health care coverage.

LifeWise Health Plan of Washington

Your Individual Health Care Plan Contract

This document is your contract. Throughout, the term "contract" is used to designate this document. The terms "you" and "your" refer to the covered members under this benefit plan. The terms "we," "us," "our" and "LifeWise" refer to LifeWise Health Plan of Washington.

SUMMARY OF BENEFITS

LifeWise WiseChoices 20 Plan (\$1,000 Deductible)

This summary provides a brief description of this plan's benefits. Please refer to the other sections of this contract for a complete description of covered services, benefits, exclusions, and limitations.

All benefits are based on the allowable charge as described in the Definitions section of this contract.

Lifetime Benefit Maximum and Annual Restoration

Lifetime Benefit Maximum.....\$2,000,000 per Member
 Annual Restoration.....\$5,000 per calendar year

Calendar Year Deductible

LifeWise Preferred (Network) Providers\$1,000 Individual / \$3,000 Family
 Non-Preferred (Non-network) Providers\$3,000 Individual / \$9,000 Family

Copays

Professional Visits (Office or Home) Copay*\$30 per visit
 Acupuncture Services / Spinal and
 Other Manipulative Treatment Copay*\$25 per visit
 Emergency Room Copay\$100 per visit
 Prescription Drug Copays (Retail)\$10 generic/\$45 preferred brand/50% non-preferred brand
 Prescription Drug Copays (Mail Order).....\$25 generic/\$112.50 preferred brand/45% non-preferred brand

(Non-preferred brand-name drugs subject to coinsurance)

* Applies to visits from LifeWise Preferred (Network) providers. Visits from Non-preferred (Non-network) providers are subject to the calendar year deductible and coinsurance for non-preferred (non-network) providers stated above.

Coinsurance Percentage

LifeWise Preferred (Network) Providers 20% of allowable charges
 Non-Preferred (Non-network) Providers 50% of allowable charges

Annual Coinsurance Maximum

LifeWise Preferred (Network) Providers \$8,500 individual / \$25,500 family
 Non-Preferred (Non-network) Providers None (Unlimited)

Copays required by this plan are not included in the annual coinsurance maximum.

Annual Out-of-Pocket Maximum

LifeWise Preferred (Network) Providers \$9,500 individual / \$28,500 family
 Non-Preferred (Non-network) Providers None (Unlimited)

The annual out-of-pocket maximum includes the calendar year deductible and coinsurance. Copays required by this plan are not included in the annual coinsurance maximum.

Benefits With Annual Maximums

The following benefits have annual or lifetime benefit maximums.

Benefit	Maximum
Acupuncture	Up to 12 visits per calendar year
Ambulance Services	Up to \$5,000 per calendar year for ground ambulance (Air ambulance unlimited)
Home Health Care	Up to 130 visits per calendar year (Visits in lieu of inpatient hospitalization unlimited)
Hospice Care	Includes 10 inpatient days and 240 hours respite care per six month period
Medical Equipment, Prosthetics, Orthotics, Supplies	Up to \$5,000 per calendar year
Prescription Drugs	Up to \$3,000 per calendar year for brand name drugs
Rehabilitation Therapy and Chronic Pain Care	Inpatient: Up to 8 days per calendar year Outpatient: Up to 20 visits per calendar year
Skilled Nursing Facility	Up to 45 days per calendar year
Spinal and Other Manipulative Treatment	Up to 12 visits per calendar year
Transplants	\$250,000 lifetime maximum \$75,000 donor charges per transplant \$7,500 for transportation and lodging
Vision Care	Exam: 1 exam every 2 consecutive calendar years Hardware: Up to \$200 every 2 consecutive calendar years

ELIGIBILITY, ENROLLMENT, AND TERMINATION

General Eligibility Requirements

The individuals defined below are eligible to enroll on this contract when we approve their application and approve the results of the Standard Health Questionnaire:

- The subscriber (the person in whose name the application is filed and coverage is established)
- The lawful spouse of the subscriber
- An eligible child under 23 years of age and unmarried. A child is:
 - The biological offspring of either or both the subscriber or spouse
 - The legally adopted child of either or both the subscriber or spouse
 - A child "placed" with the subscriber for the purpose of legal adoption in accordance with state law. "Placed for adoption" means assumption and retention by the subscriber of a legal obligation for total or partial support of a child in anticipation of adoption of such child
 - A child designated by a court of appropriate jurisdiction as the legal ward of the subscriber or spouse
 - A child for whom the subscriber or spouse is required by a medical child support order to provide health coverage

Enrollment and maintenance of coverage on this contract is also contingent on the individuals meeting all of the following requirements:

- They are residents of Washington State.
- "Resident" means a person who lives in the state of Washington, and intends to live in the state permanently or indefinitely. In no event will coverage be extended to a subscriber or dependent who resides in Washington State for the primary purpose of obtaining health care coverage. The confinement of a person in a nursing home, hospital, or other medical institution shall not by itself be sufficient to qualify such person as a resident. We may require proof of residency from time to time. Such proof shall include, but not be limited to, the street address of the individual's residence and not a post office box.
- Their principal residence is located within our service area
- They are not entitled to (enrolled in) Medicare on the date coverage would begin

- They are not 65 years of age or older, and eligible for Medicare on the date coverage would begin

Standard Health Questionnaire

Enrollment on this plan is subject to approval by us of your application and the results of the Standard Health Questionnaire. The Standard Health Questionnaire will not be required in any of the following situations:

- You are applying for this plan due to having exhausted continuation of group health care coverage provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). In this instance, you must submit your application to us within 90 days of exhausting COBRA coverage.
- You are applying for coverage due to having terminated group health care coverage through an employer that is too small to offer COBRA coverage. In order to qualify under this provision, all of the following must be true:
 - Your prior group coverage must have been in effect for at least 24 continuous months without interruption
 - Your coverage ended due to a reduction in work hours, termination of employment (except for gross misconduct), death of employee, divorce/legal separation of employee and spouse, employee entitlement to Medicare, or loss of eligibility as a dependent child
 - Your application is received by us within 90 days of termination of the group plan
- You are applying for coverage because your coverage under a group conversion contract was discontinued. In order for this exception to apply, you must submit your application for coverage to us within 90 days of the date that coverage under the group conversion contract terminates. In addition, your effective date for this individual plan must be on or within 90 days after the date that coverage under the conversion contract terminates.
- You are applying for this plan due to a change in residence from one geographic area of Washington State to another geographic area of Washington State where your prior health insurance plan is not offered. In this instance, you must submit your application within 90 days of your change in residence.
- You are applying for this plan because a health care provider with whom you have established a care relationship and have received treatment from within the past 12 months is no longer part

of your prior plan's network, and that provider is currently part of this plan's provider network. In this instance, you must submit your application within 90 days of your health care provider leaving the prior plan's provider network.

- You are enrolling a biological newborn or adoptive child whose date of birth or date of placement is after the subscriber's effective date of coverage on this plan. In this instance, you must submit the application within 60 days of birth or placement for adoption.
- Continuation of coverage of a former dependent as stated below under Continuation Of Coverage On An Identical Contract.

If you do not submit your enrollment application within the time limits stated above, you must complete the Standard Health Questionnaire, and coverage will be subject to our approval of the results of that Standard Health Questionnaire.

We will evaluate the application and Standard Health Questionnaire (if one is required) to see if they meet our requirements for coverage. If your application is not approved based on the Standard Health Questionnaire, we will advise you of the disapproval, and provide you with information on applying for coverage through the Washington State Health Insurance Pool.

When Coverage Begins

Subscriber and Existing Dependents

Upon approval of the enrollment application, coverage will become effective as follows:

- For applications received by the 5th day of the month, coverage will be effective on the 15th day of that month. In this instance, a pro-rated subscription charge will be applied for the first partial month of coverage.
- For applications received between the 6th and 20th day of the month, coverage will be effective on the first day of the following month. Applications received after the 20th of the month will be effective on the 15th of the following month.

The receipt date will be the date of postmark or the date of delivery to us, whichever is earlier.

New Dependents

Please Note: If a completed application is not submitted within the stated time frames, coverage for the dependents may be subject to our approval of the results of the Standard Health Questionnaire. See Standard Health Questionnaire above.

Biological Newborn Children

The effective date will be the child's date of birth only if we receive a completed application within 60 days of birth. Otherwise, coverage will become effective as described under Subscriber and Existing Dependents.

Adoptive Children

The effective date will be the date of placement with the subscriber only if we receive a completed application within 60 days of the date of placement with the subscriber. Otherwise, coverage will become effective as described under Subscriber and Existing Dependents.

Legal Wards

Children who are legal wards of the subscriber or spouse and meet all stated eligibility requirements will be accepted for coverage when we receive the completed application and copies of the final court-ordered guardianship. Enrollment will be subject to our approval of the results of the Standard Health Questionnaire. See Standard Health Questionnaire above.

The effective date will be the date of the guardianship order if the approved application is received within 60 days of that date. Otherwise, coverage will become effective as described under Subscriber and Existing Dependents.

Children Covered By A Medical Child Support Orders

An application must be submitted to us, along with a copy of the medical child support order. The application may be submitted by the subscriber, the child's custodial parent, or a state agency administering Medicaid. The effective date will be the date of the order only if the application is received within 60 days of the date of the order. Otherwise, coverage will become effective as stated under Subscriber and Existing Dependents.

New Dependents Due To Marriage

Enrollment of new dependents due to marriage is subject to our approval of the Standard Health Questionnaire. See Standard Health Questionnaire earlier in this section.

The effective date will be the date of marriage only if the approved application is received by us within 60 days of the date of the marriage. Otherwise, coverage will become effective as described under Subscriber and Existing Dependents.

Other Provisions Affecting Coverage

Pre-Existing Conditions Waiting Period And Transplant Exclusion Period

Benefits are not available for pre-existing conditions or organ and bone marrow transplants for the periods stated under Waiting and Exclusion Periods in *Limitations and Exclusions*. Please refer to this section for details about these periods.

Term Of Contract

The term of this contract is for one month from its effective date and will renew on a month to month basis. This contract is guaranteed renewable except as stated under When Coverage Ends. No rights are vested under this contract.

Subscription Charges And Grace Period

This contract is issued in consideration of an approved application and the payment of the required subscription charges by or on behalf of the subscriber and enrolled dependents.

A grace period of ten days following the due date is allowed for payment of subsequent subscription charges. If a subsequent payment is not received within this grace period, this contract will, without further notice, terminate as of the last day of the period for which subscription charges were paid rather than at the end of the grace period.

We reserve the right to revise subscription charges annually upon written notice. Such notice may be provided to the subscriber or remitting agent as we may elect. Such changes will become effective on the date stated in the notice, and payment of the revised subscription charges will constitute acceptance of the change.

Subscription charges will also be revised in the following situations:

- A change in the number of enrolled dependents
- The subscriber or dependents enroll in a different LifeWise individual health plan
- A change in government requirements affecting the health plan, including, but not limited to, a mandated change in benefits, eligibility or other plan provisions, or imposition or changes to a tax on our revenue.

When Coverage Ends

Coverage under this contract is guaranteed renewable and will not be terminated, except as described below.

Termination By The Subscriber

The subscriber may terminate this contract by:

- Sending written notice to us. Cancellation will be effective on the first of the month following receipt of the request
- Failing to pay the required subscription charges when due or within the grace period

Termination by LifeWise

Coverage under this contract will terminate when any of the events specified below occurs.

- Nonpayment of subscription charges. Coverage will end without notice as of the last date for which subscription charges were paid.
- Violation of published policies of LifeWise that have been approved by the Washington State Insurance Commissioner
- A member no longer lives in Washington State
- A member commits fraudulent acts as to LifeWise
- A member materially breaches the contract which includes, but is not limited to, failure to continue to meet the provisions stated under General Eligibility Requirements
- Change or implementation of federal or state laws that no longer permit the continued offering of this contract
- We discontinue this contract to all those covered under this contract as allowed by law. In such instance you will be given at least a 90-day notification of the discontinuation. If we discontinue this contract, you may apply for any other individual plan currently offered for sale by us without completion of the Standard Health Questionnaire.
- We withdraw from a service area or from a segment of a service area as allowed by law
- Any other reason allowed by state or federal law

In the event this coverage under this contract is terminated, LifeWise will refund any subscription charges received for dates beyond the contract termination date stated in our notice to you.

Reinstatement of Coverage

If coverage under this contract is terminated for non-payment of subscription charges, reinstatement on this contract may be permitted at LifeWise's discretion, by payment of all past due and current subscription charges. Such reinstatement shall be limited to once every 12 consecutive months.

When reinstatement is not permitted, individuals may re-apply for this plan by completing an application and Standard Health Questionnaire.

Continuation Of Coverage

Member Is Inpatient When Coverage Ends

Notwithstanding any other provisions of this contract, if a member is confined in a covered facility upon termination of the contract, you shall continue to receive benefits for the condition which caused the confinement, until the first of the following occurs:

- Discharge from the facility in which you are confined
- Care has been determined by us to no longer be medically necessary
- Limits of coverage under this contract have been reached. Benefits will not renew upon onset of a new calendar year
- 90 days of benefits have been provided

This provision will not apply if your coverage is terminated due to subscriber cancellation of coverage, nonpayment of subscription charges, violation of published policies, or fraudulent acts. This continuation benefit is not available for a newborn unless that newborn has been enrolled for coverage as described above under When Coverage Begins.

Continued Eligibility For A Disabled Child

Coverage may continue past the limiting age for an unmarried dependent child who is incapable of self-sustaining employment by reason of a developmental or physical disability and who is chiefly dependent upon the subscriber for support and maintenance. The child will continue to be eligible if all of the following are met:

- The subscriber is covered under this plan
- The child became disabled before reaching the limiting age
- Within 31 days of the date the child no longer meets dependent child eligibility requirements, the subscriber furnishes proof of the child's disability and dependency acceptable to us
- The child's subscription charges, if any, continue to be paid

The subscriber provides proof of the child's disability and dependent status when we request it. We will not ask for proof more often than once a year after the two-year period following the date the child qualifies for continuing eligibility.

Continuation Of Coverage On An Identical Contract

Dependent(s) may continue coverage on an identical contract in the following situations:

- If the subscriber terminates coverage for any reason, or in the event of death of the subscriber or divorce of the subscriber and spouse, enrolled dependents under this plan may continue under an identical contract. The dependent(s) must meet all of the eligibility requirements as specified in this contract. If the spouse continues coverage, the spouse's enrollment status will change from dependent to subscriber and any enrolled child may be covered under the spouse's continued coverage. Subscription charges will be assessed at the appropriate rate. If there is no spouse, or the spouse does not continue coverage, each enrolled child may continue coverage as a subscriber, and subscription charges will be assessed at the appropriate subscriber rate.
- A dependent child, who no longer is eligible as a dependent under this contract for reasons such as reaching the age of 23, marriage, or is no longer primarily dependent on the subscriber for support, may continue coverage on an identical contract as a subscriber, providing all eligibility requirements, as specified in this contract, are met. The child's enrollment status will change from dependent to subscriber, and subscription charges will be assessed at the appropriate subscriber rate.

To continue coverage, an enrollment application must be submitted to us prior to the date coverage would end as a dependent. Dependents continuing coverage under an identical contract in the situations stated above will not be subject to the results of the Standard Health Questionnaire.

Certificate Of Prior Health Coverage

When your individual coverage terminates, we will send you a "Certificate of Prior Health Coverage" stating the period of individual coverage you had with us. You may need to provide a copy of the certificate when enrolling in a plan that has a pre-existing conditions waiting period. Your new carrier will use the certificate to determine if you qualify to receive credit toward the pre-existing conditions waiting period of your new health plan. Keep the certificate in a safe place. Should you lose your original certificate, you may request a copy from us, free of charge, within 24 months of the date your coverage terminated.

HOW DOES CHOOSING A PROVIDER AFFECT MY BENEFITS?

To help you manage the cost of health care, we've contracted with a network of health care facilities

and professionals. Throughout this contract, those providers are referred to as "LifeWise Preferred Providers." They are also known as "network" or "in-network" providers.

This plan's benefits and your out-of-pocket expenses depend on the providers you seek care from. Throughout this section you'll find important information on how to control costs and your out-of-pocket expenses, and how the providers you choose can affect this plan's benefits.

This plan makes available to you sufficient numbers and types of providers to give you access to all covered services in compliance with applicable Washington State regulations governing access to providers. Our provider networks include hospitals, physicians, and other types of licensed or certified health care providers.

Your choice of a particular provider may affect your out-of-pocket costs because different providers may have different allowable charges even though they have an agreement with us. You'll never have to pay more than your share of the allowable charge when you use LifeWise Preferred Providers.

When You Get Care In Washington

LifeWise Preferred Providers

You'll always get the highest level of benefits and the lowest out-of-pocket costs when you get covered services and supplies from LifeWise Preferred providers.

To locate a LifeWise Preferred Provider, please refer to our printed provider directory, or visit our Web site at www.lifewisewa.com.

LifeWise Preferred Providers agree to accept our allowable charge for covered services and supplies. You will not be billed for amounts over the allowable charge. You will be responsible for deductibles, coinsurance, copays, and for services not covered by this plan, as described in this contract.

Other Providers

If you decide not to use a LifeWise Preferred Provider, you may choose any state-licensed or certified provider (please see the Definitions section in this contract). However, if the provider you choose isn't part of our provider network (a non-preferred or non-network provider), in most cases you will receive a lower benefit level, unless otherwise stated below. You will also be responsible to pay any amounts above the allowable charge.

The following covered services and/or providers

will always be covered at the highest applicable in-network benefit level applied to the allowable charge for covered services and supplies (please see the Definitions section of this contract for the description of allowable charge):

- Emergency care. If you have a medical emergency" (please see the Definitions section in this contract), this plan provides worldwide coverage at the in-network benefit level.
- Treatment of an accidental injury, limited to services received on the day of or within two days following the date of the accidental injury
- Certain categories or types of providers for which contracting agreements are not available. These types of providers aren't included in our provider directory.
- Services associated with admission by a LifeWise Preferred Provider to a LifeWise preferred hospital that are provided by hospital-based providers
- Facility and hospital-based provider services at any of our contracted hospitals if you're admitted by a LifeWise Preferred Provider who doesn't have admitting privileges at a LifeWise-contracted hospital

Benefit Level Exceptions for Non-Emergency Care

LifeWise may, at its discretion, agree to provide in-network benefits for non-emergency services from providers who are not part of our network. This is called a "benefit level exception" and may be granted when a LifeWise provider is not reasonably available to you.

You or your health care provider may request a benefit level exception. Such requests must be made before you get the service or supply.

If we approve the request, benefits for covered services and supplies will be provided at the in-network benefit level. Payment of your claim will be based on your eligibility and benefits available at the time you get the service or supply. You will be responsible for amounts applied towards your calendar year deductible, coinsurance, copays, amounts that exceed the benefit maximums, amounts above the allowable charge and charges for non-covered services. If we deny the request, in-network benefits won't be provided.

Please contact Customer Service for all benefit level exceptions for non-emergent care requests.

Please Note: Services from Non-preferred (Non-network) providers, even when paid at the in-network benefit level, are subject to the allowable charge. You will be responsible to pay any

amounts over the allowable charge.

Other Important Information About Selecting Providers

The benefits of this plan are based on the allowable charge (please see the Definitions section in this contract). If you receive services from a provider who does not have a contracting agreement with us, you are responsible to pay all amounts over the allowable charge. This is in addition to any applicable copays, deductibles, coinsurance, or services and supplies not covered by this plan.

When You Get Care Outside Washington

Except as specifically stated in this contract, benefits for covered services received from providers who are located outside Washington State are paid at the non-preferred (out-of-network) benefit level.

The only exceptions are:

- Treatment of a medical emergency (see Definitions)
- Treatment of an accidental injury, limited to services received on the day of or within two days following the date of the accidental injury

When you receive services from providers located outside Washington State, you are responsible for all amounts above our allowable charge.

LifeWise has contracting agreements with selected providers located in the states of Alaska, Arizona and Oregon. Services from these providers will be paid at the preferred (in-network) benefit level. These providers will also not bill you for any amounts over our allowable charge.

To locate a contracting provider in Alaska, Arizona or Oregon, contact Customer Service or check our web site at www.lifewisewa.com.

WHAT TYPES OF EXPENSES AM I RESPONSIBLE FOR PAYING?

This section of your contract explains the types of expenses this plan requires you to pay. To prevent unexpected out-of-pocket expenses, it's important for you to understand what you're responsible for.

Copays

"Copays" are a fixed dollar amount you are required to pay for certain services. Copays do not apply toward this plan's calendar year deductible, coinsurance, coinsurance maximum, or out-of-pocket maximum. This plan requires a copay for

the following services:

- **Professional Visits (Home and Office)** You pay a copay of \$30 for each professional visit (home or office) received from LifeWise Preferred (Network) Providers.
- **Acupuncture Services** You pay a copay of \$25 for each visit from LifeWise Preferred (Network) Providers.
- **Spinal and Other Manipulative Treatment** You pay a copay of \$25 for each visit from LifeWise Preferred (Network) Providers.

Professional visits, acupuncture or spinal and other manipulative treatment from Non-preferred (Non-network) providers are subject to the out-of-network calendar year deductible and coinsurance stated in this contract.

- **Emergency Room Visits** You pay a \$100 copay for each visit to a hospital emergency room. This copay is in addition to the plan's in-network calendar year deductible and coinsurance.

The emergency room copay is waived if you are admitted to the hospital as an inpatient directly from the emergency room.

- **Prescription Drugs** You pay the following copays per prescription or refill:

Participating Retail Pharmacies

Generic Drugs.....	\$10
Preferred Brand Name Drugs.....	\$45
Non-Preferred Brand Name Drugs.....	50%

Medco By Mail/Mail-Order Pharmacy

Generic Drugs.....	\$25
Preferred Brand Name Drugs.....	\$112.50
Non-Preferred Brand Name Drugs.....	45%

(Non-preferred brand-name drugs are subject to coinsurance)

Calendar Year Deductible

The "calendar year deductible" is the amount of allowable charges incurred for covered services for which each member is responsible each calendar year before this plan provides certain benefits.

The calendar year deductible is subject to the following provisions:

- There are separate deductible amounts for service from LifeWise Preferred (Network) providers and Non-preferred (Non-network) providers.
- Family members will be required to meet the family deductible. Once the family deductible is met, the calendar year deductible is met for all enrolled family members. As with the individual

deductible, the family deductible only applies to services from Non-Preferred (Non-network) Providers.

- Amounts credited to the calendar year deductible during the last three months of a calendar year will be credited toward the calendar year deductible requirement for the next calendar year
- Amounts credited to the calendar year deductible will accrue to the annual benefit maximums for those benefits which have a day or visit maximum. Benefits with a dollar-based benefit maximums will not accrue until the calendar year deductible has been met.
- The following do not accrue toward the calendar year deductible:
 - Copays
 - Coinsurance
 - Amounts that exceed the allowable charge
 - Amounts for services or supplies not covered by this plan

This plan requires the following calendar year deductibles:

LifeWise Preferred (Network) Providers

The individual calendar year deductible is \$1,000.
The maximum family deductible is \$3,000

Non-Preferred (Non-network) Providers

The individual calendar year deductible is \$3,000 per member. The maximum family deductible is \$9,000.

Coinsurance

"Coinsurance" is a defined percentage of allowable charges for covered services and supplies you are responsible to pay. Coinsurance does not include deductibles or copays required by this plan.

This plan has different coinsurance levels for preferred (network) and non-preferred (non-network) providers:

LifeWise Preferred (Network) Providers

Coinsurance is 20% of allowable charges.

Non-Preferred (Non-network) Providers

Coinsurance is 50% of allowable charges.

Coinsurance Maximum

The "coinsurance maximum" is the maximum amount of coinsurance an individual or family will have to pay each calendar year for covered services from LifeWise Preferred (network) providers.

Once the coinsurance maximum has been met, benefits covered services from LifeWise Preferred (network) Providers are provided at 100% of allowable charges for the remainder of the calendar year.

The coinsurance maximum for this plan is as follows:

LifeWise Preferred (Network) Providers

The coinsurance maximum is \$8,500 per individual per calendar year. The maximum family coinsurance maximum is \$25,500 per calendar year.

Copays required by this plan will continue to apply even when the coinsurance maximum has been met.

Please Note: Coinsurance required in the Prescription Drugs benefit does not accrue toward the coinsurance maximum.

Non-Preferred (Non-network) Providers

There is no coinsurance maximum for services of non-preferred (non-network) providers.

Out-of-Pocket Maximum

The "out-of-pocket maximum" is the maximum amount an individual or family will have to pay each calendar year for covered services from LifeWise Preferred (network) providers. It consists of the calendar year deductible and coinsurance applicable to services from LifeWise Preferred (Network) providers.

The out-of-pocket maximum for this plan is as follows:

LifeWise Preferred (Network) Providers

The out-of-pocket maximum is \$9,500 per individual per calendar year. The maximum family out-of-pocket maximum is \$28,500 per calendar year.

Copays required by this plan will continue to apply even when the out-of-pocket maximum has been met.

Please Note: Coinsurance required in the Prescription Drugs benefit does not accrue toward the out-of-pocket maximum.

Non-Preferred (Non-network) Providers

There is no out-of-pocket maximum for services of non-Preferred (non-network) providers.

BENEFIT DESCRIPTION

This section of the contract describes the specific

benefits this plan provides, and your cost shares (amounts you are required to pay) for each type of service. Benefits are available only for the covered services stated in this section. Benefits are subject to applicable deductibles, coinsurance, copays, limitations, exclusions, and all other provisions stated in this contract.

All benefits of this plan are based on the allowable charge.

Conditions For Payment Of Benefits

We provide benefits for covered services and supplies, up to the allowable charge, received in the treatment of injury, illness, or disease when such services or supplies meet all of the following conditions:

- They must meet our definition of "medically necessary." (See Definitions.) Inpatient care is only covered when you require care that could not be provided in an outpatient setting without adversely affecting your condition or the quality of care you would receive.
- They are received on or after your effective date under this contract
- They must not be included in or subject to a waiting or exclusion period, be listed as an exclusion, exceed the benefit maximums, or be listed as a limitation as described in this contract

Care Facilitation

Care Facilitation services work to help ensure that you receive appropriate and cost-effective medical care. Your role in the Care Facilitation process is simple, but important.

This plan's benefits do not require preauthorization for coverage. You must be eligible on the dates of service and services must be medically necessary. We encourage you to call Customer Service to verify that you meet the required criteria for benefits and to help us identify inpatient admissions which might benefit from case management, described below.

Case Management

Case Management works cooperatively with you and your physician to consider effective alternatives to hospitalization and other high-cost care to make more efficient use of this plan's benefits. The decision to provide benefits for these alternatives is within our sole discretion. Your participation in a treatment plan through Case Management is voluntary. If an agreement is reached, you or your legal representative, your physician and other providers participating in the treatment plan will be required to sign written

agreements which set forth the terms under which benefits will be provided.

Lifetime Maximum And Automatic Restoration

The lifetime benefit maximum available to any one member is \$2,000,000. Benefits provided under the Prescription Drugs benefit do not accrue toward the plan's lifetime maximum. However, brand-name drugs are subject to an annual benefit maximum. See the Prescription Drugs benefit.

Certain benefits of this plan have separate benefit maximums which will also apply to the lifetime maximum. See Specific Benefits for more information.

Each January 1, up to \$5,000 of your lifetime maximum that has been previously paid by us will be restored. This restoration occurs regardless of your health.

Specific Benefits

This plan's benefits are provided only for the following services, supplies or drugs described in this section.

Acupuncture Services

LifeWise Preferred (Network) Providers:
Benefits are subject to a copay of \$25 per visit.

Non-Preferred (Non-Network) Providers:
Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

Benefits are provided for acupuncture services up to a maximum of 12 visits per member per calendar year. Services must be medically necessary to relieve pain, induce surgical anesthesia, or to treat a covered illness, injury, or condition.

Ambulance Services

LifeWise Preferred (Network) Providers:
Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-Network) Providers:
Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Benefits for ground ambulance services are provided up to a maximum of \$5,000 per calendar year for all services combined. Benefits for air ambulance services are not subject to an annual limit.

Benefits are provided for medically necessary services and supplies, including licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat your condition, when any other mode of transportation would endanger your health or safety. Benefits are also provided for transportation from one medical facility to another, as necessary for your condition.

This benefit only covers the member that requires transportation.

Ambulatory Surgical Centers

LifeWise Preferred (Network) Providers: Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

Benefits are provided for services and supplies furnished by an ambulatory surgical center.

Blood and Blood Derivatives

LifeWise Preferred (Network) Providers: Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

Benefits are provided for the cost of blood and blood derivatives.

Contraceptive Management Services

LifeWise Preferred (Network) Providers: Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

See Professional Visits for benefits for office visits.

Covered services include the following:

- Implantable and injectable contraceptives (including hormonal implants) and related services received from a health care provider.
- Emergency contraception methods (oral or injectable) when furnished by a health care provider

- Sterilization procedures. (These are covered on the same basis as other surgeries. See the Surgical Services benefit.)

Prescription contraceptives (including emergency contraception) and prescription barrier devices, such as diaphragms and cervical caps, dispensed by a licensed pharmacy are covered on the same basis as any other covered prescription drug. Please see the Prescription Drugs benefit.

This benefit doesn't cover:

- Non-prescription contraceptive drugs, supplies or devices
- Sterilization reversal
- Testing, diagnosis, and treatment of infertility, including fertility enhancement services, procedures, supplies and drugs

Dental Injury Services

LifeWise Preferred (Network) Providers: Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

See Professional Visits for benefits for office visits.

Benefits are limited to dental services that are necessary due to an injury to teeth gums, or jaw. Benefits are limited to the reparation or repair of the natural tooth structure when such repair is performed within 12 months of the injury.

These services are only covered when all of the following are true:

- They're necessary as a result of an injury
- They're performed within the scope of the provider's license
- They're not required due to damage from biting or chewing
- They're rendered on natural teeth that were free from decay and otherwise functionally sound at the time of the injury. "Functionally sound" means that the affected teeth don't have:
 - Extensive restoration, veneers, crowns or splints
 - Periodontal disease or other condition that, in our judgment, would cause the tooth to be in a weakened state prior to the injury

Please Note: An injury does not include damage caused by biting or chewing, even if due to a foreign object in food.

If necessary services can't be completed within 12 months of an injury, coverage may be extended if your dental care meets our extension criteria. We must receive extension requests within 12 months of the injury date.

Diabetes Health Education

LifeWise Preferred (Network) Providers: Benefits are provided at 100% of allowable charges. The calendar year deductible and coinsurance are waived.

Non-Preferred (Non-network) Providers: Benefits are provided at 100% of allowable charges. The calendar year deductible and coinsurance are waived.

Benefits are available for outpatient self-management training and education for diabetes.

Benefits for nutritional counseling and therapy related to diabetes are provided under the Nutritional Therapy benefit.

Diagnostic Services And Mammography

Benefits are provided for diagnostic and mammography services, including administration and interpretation. This benefit covers the following services:

- Laboratory and pathology services for preventive or diagnostic purposes
- Imaging and scans (such as X-rays and EKGs) for preventive or diagnostic purposes
- Cervical and prostate cancer screening procedures when recommended by a health care provider
- Diagnostic and screening mammography when recommended by a health care provider

Preventive Diagnostic Services

LifeWise Preferred (Network) Providers: Benefits are provided at 100% of allowable charges.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

Preventive diagnostic services are laboratory tests and imaging done for preventive or screening purposes, as determined by LifeWise, based on U.S. Preventive Services Task Force (USPSTF) guidelines. These guidelines are available by contacting us. Examples are pap smears, prostate-specific antigen (PSA) testing and cholesterol screening.

Other Diagnostic Services

LifeWise Preferred (Network) Providers: Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

Mammography

LifeWise Preferred (Network) Providers: Benefits are subject to coinsurance of 20% of allowable charges. The calendar year deductible is waived.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

The Diagnostic Services and Mammography benefit doesn't cover allergy testing.

Diagnostic surgeries and scope insertion procedures, such as an endoscopy, are covered under the Surgical Services benefit.

When covered outpatient diagnostic services are billed by an outpatient facility or emergency room and received in combination with other hospital or emergency room services benefits are provided under the Hospital Outpatient or Emergency Room Services benefits.

Diagnostic services included in a global maternity billing are covered under the Obstetrical Care benefit.

Emergency Room Services

LifeWise Preferred (Network) Providers: Benefits are subject to the emergency room copay of \$100 plus the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges for each visit.

Non-Preferred (Non-network) Providers: Benefits are subject to the emergency room copay of \$100 plus the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges for each visit.

The emergency room copay will be waived if a hospital admits you as an inpatient directly from the emergency room.

This benefit is provided for emergency room facility services, including related services and supplies, such as surgical dressings and drugs, furnished by and used in the emergency room. Also covered

under this benefit are medically necessary detoxification services.

A "medical emergency" is the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. (A "prudent layperson" is someone who has an average knowledge of health and medicine.)

Examples of a medical emergency are severe pain, suspected heart attacks, and fractures. Examples of a non-medical emergency are minor cuts and scrapes.

Home and Hospice Care

LifeWise Preferred (Network) Providers: Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

Home health and hospice benefits are provided as described below, or when provided as an alternative to inpatient hospitalization or other institutional care.

Home health and hospice care must be part of a written plan of care prescribed, periodically reviewed, and approved by a physician (M.D. or D.O.).

Benefits are provided up to the maximums shown below for covered services furnished and billed by a home health agency, home health care provider, or hospice that is Medicare-certified or is licensed or certified by the state it operates in.

Covered employees of a home health agency and hospice are a registered nurse; a licensed practical nurse; a licensed physical therapist or occupational therapist; a certified respiratory therapist; a speech therapist certified by the American Speech, Language, and Hearing Association; a home health aide directly supervised by one of the above providers (performing services prescribed in the plan of care to achieve the desired medical results); and a person with a master's degree in social work. Also included in this benefit is medical equipment and supplies provided and billed by the home health or hospice agency. (Such equipment and supplies are not subject to the benefit

maximums stated in the Medical Equipment and Supplies benefit.)

Home Health Care This benefit provides up to 130 intermittent home visits per member each calendar year by a home health care provider or one or more of the home health agency employees above. Home health care provided as an alternative to inpatient hospitalization or other institutional care is not subject to this limit. Other therapeutic services, such as respiratory therapy and phototherapy provided by a home health agency, are also covered under this benefit.

Hospice Care Benefits for a terminally ill member are 6 months of covered hospice care. Benefits may be provided for an additional 6 months of care in cases where the member is facing imminent death or is entering remission. This limit does not apply to hospice care furnished as an alternative to inpatient hospitalization or other institutional care. The initial 6-month period starts on the first day of covered hospice care. Covered hospice services are:

- In-home intermittent hospice visits by one or more of the hospice employees above. These services don't count toward the 130 intermittent home visit limit shown above under Home Health Care.
- Inpatient hospice care up to a maximum of 10 days. This benefit provides for inpatient services and supplies used while you're a hospice inpatient, such as solutions, medications or dressings, when ordered by the attending physician.
- Respite care up to a maximum of 240 hours, to relieve anyone who lives with and cares for the terminally ill member

Insulin and Other Home and Hospice Care Provider Prescribed Drugs Benefits are provided for prescription drugs and insulin furnished and billed by a home health care provider, home health agency or hospice.

This benefit doesn't cover:

- Over-the-counter drugs, solutions and nutritional supplements
- Services provided to someone other than the ill or injured member
- Services of family members or volunteers
- Services, supplies or providers not in the written plan of care or not named as covered in this benefit
- Custodial care, except for hospice care services
- Nonmedical services, such as spiritual, bereavement, legal or financial counseling

- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care; and transportation services
- Dietary assistance, such as "Meals on Wheels," or nutritional guidance

Hospital Inpatient Care

LifeWise Preferred (Network) Providers:
Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-network) Providers:
Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

Benefits are provided for the following services:

- Room and board expenses, including general duty nursing and special diets
- Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards
- Operating room, surgical supplies, hospital anesthesia services and supplies, drugs, dressings, equipment and oxygen
- Diagnostic and therapeutic services
- Blood, blood derivatives and their administration

For inpatient hospital obstetrical care and newborn care, please see the Obstetrical Care and Newborn Care benefits.

This benefit doesn't cover:

- Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient hospital facilities, or unless your medical condition makes inpatient care medically necessary
- Any days of inpatient care that exceed the length of stay that is, in our judgment, medically necessary to treat your condition

Hospital Outpatient Care

LifeWise Preferred (Network) Providers:
Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-network) Providers:
Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

This benefit is provided for operating, procedure and recovery rooms; plus services and supplies

such as surgical dressings and drugs furnished by and used while at the hospital.

Infusion Therapy

LifeWise Preferred (Network) Providers:
Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-network) Providers:
Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

This benefit is provided for outpatient professional services, supplies, drugs and solutions required for infusion therapy. Infusion therapy (also known as intravenous therapy) is the administration of fluids into a vein by means of a needle or catheter, most often used for the following purposes:

- To maintain fluid and electrolyte balance
- To correct fluid volume deficiencies after excessive loss of body fluids
- Members that are unable to take sufficient volumes of fluids orally
- Prolonged nutritional support for members with gastrointestinal dysfunction

This benefit doesn't cover over-the-counter drugs, solutions and nutritional supplements.

Mastectomy and Breast Reconstruction Services

LifeWise Preferred (Network) Providers:
Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-network) Providers:
Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

Benefits are provided for mastectomy necessary due to disease, illness or injury. For any member electing breast reconstruction in connection with a mastectomy, this benefit covers:

- Reconstruction of the breast on which mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses (not subject to the benefit maximum stated in the Medical Equipment and Supplies benefit)
- Physical complications of all stages of mastectomy, including lymphedemas

Services are to be provided in a manner

determined in consultation with the attending physician and the patient.

Medical Equipment and Supplies

LifeWise Preferred (Network) Providers: Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

Benefits are provided up to a maximum of \$5,000 per member each calendar year. This maximum does not apply to equipment, supplies, foot orthotics or therapeutic shoes prescribed for the treatment of diabetes. This benefit does not include medical equipment or supplies provided as part of home health care. See the Home Health and Hospice Care benefit for coverage information.

Covered items include:

Medical and Respiratory Equipment Benefits are provided for the rental of such equipment (including fitting expenses), but not to exceed the purchase price, when medically necessary and prescribed by a physician for therapeutic use in direct treatment of a covered illness or injury. We may also provide benefits for the initial purchase of equipment, in lieu of rental.

Examples of medical and respiratory equipment are a wheelchair, hospital-type bed, traction equipment, ventilators, and diabetic equipment such as blood glucose monitors, insulin pumps and accessories to pumps, and insulin infusion devices.

In cases where an alternative type of equipment is less costly and serves the same medical purpose, we'll provide benefits only up to the lesser amount.

Repair or replacement of medical and respiratory equipment medically necessary due to normal use or growth of a child is covered.

Medical Supplies, Orthotics (Other Than Foot), and Orthopedic Appliances Covered items include, but aren't limited to, dressings, braces, splints, rib belts and crutches, as well as related fitting expenses.

For hypodermic needles, lancets, test strips, testing agents and alcohol swabs benefit information, please see the Prescription Drugs benefit.

Prosthetics Benefits for external prosthetic devices (including fitting expenses) are provided when such devices are used to replace all or part

of an absent body limb or to replace all or part of the function of a permanently inoperative or malfunctioning body organ. Benefits will only be provided for the initial purchase of a prosthetic device, unless the existing device can't be repaired, or replacement is prescribed by a physician because of a change in your physical condition.

Please Note: This benefit does not include prosthetics prescribed or purchased as part of mastectomy or breast reconstruction procedure. Please see the Mastectomy and Breast Reconstruction Services benefit for coverage information.

Foot Orthotics and Therapeutic Shoes Benefits are provided for foot orthotics (shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses when medically necessary for the treatment of diabetic conditions. Benefits are provided for one pair each of orthotics and therapeutic shoes each calendar year.

This benefit doesn't cover:

- Supplies or equipment not primarily intended for medical use
- Disability or handicap modifications or renovations to vehicles or buildings, specialized equipment or services provided primarily for disabled access or accommodation
- Special or extra-cost convenience features
- Items such as exercise equipment, weights and whirlpool baths
- Orthopedic appliances prescribed primarily for use during participation in sports, recreation or similar activities
- Penile prostheses
- Foot orthotics or therapeutic shoes for non-diabetic conditions
- Prosthetics, intraocular lenses, appliances or devices requiring surgical implantation. These items are covered under the Surgical Services benefit. Items provided and billed by a hospital are covered under the Hospital Inpatient Care or Hospital Outpatient Care benefits.

Newborn Care

The benefits of the plan will be provided for newborn care on the same basis as any other covered care, subject to the cost share, limitations and exclusions specified in this contract.

Services must be consistent with accepted medical practice and ordered by the attending provider in consultation with the mother.

Newborn children are covered automatically for the first 3 weeks from birth when the mother is eligible to receive obstetrical care benefits under this plan.

To continue benefits beyond the 3-week period, or if the mother isn't eligible for obstetrical care benefits under this plan, please see the dependent eligibility and enrollment guidelines outlined under Eligibility, Enrollment and Termination.

Benefits include the following:

- Hospital care, including hospital nursery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice. Also covered are any required readmissions to a hospital and outpatient or emergency room services for medically necessary treatment of an illness or injury. (See the "Emergency Room Services" benefit for information on emergency room benefits.)
- Professional care, including inpatient professional services, and follow-up care consistent with accepted medical practice that's ordered by the attending provider, in consultation with the mother. Follow-up care includes services of the attending provider, a home health agency and/or a registered nurse.
- Circumcision

See the Hospital Inpatient Care, Hospital Outpatient Care, Preventive Medical Care and Professional Visits benefits for more information.

Please Note: Attending provider as used in this benefit means a physician (M.D. or D.O.), a physician's assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced registered nurse practitioner (A.R.N.P.).

Nutritional Therapy

LifeWise Preferred (Network) Providers: Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

Benefits are provided for outpatient nutritional therapy services to manage your covered condition, illness or injury, including diabetes.

Obstetrical Care

Benefits are provided on the same basis as any other covered care, subject to the cost share, limitations and exclusions specified in this contract.

Obstetrical care benefits include:

Facility Care

Inpatient hospital, birthing center, outpatient hospital and emergency room services, including post-delivery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice.

Plan benefits are also provided for medically necessary supplies related to home births.

Professional Care including the following services:

- Prenatal care, including diagnostic and screening procedures, and genetic counseling for prenatal diagnosis of congenital disorders of the fetus
- Delivery, including cesarean section, in a medical facility, or delivery in the home
- Postpartum care consistent with accepted medical practice that's ordered by the attending provider, in consultation with the mother. Postpartum care includes services of the attending provider, a home health agency and/or registered nurse.

Please Note: Attending provider as used in this benefit means a physician (M.D. or D.O.), a physician's assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced registered nurse practitioner (A.R.N.P.). If the attending provider bills a global fee that includes prenatal, delivery and/or postpartum services received on multiple dates of service, this plan will cover those services as it would any other surgery. Please see the Surgical Services benefit for details on surgery coverage.

Phenylketonuria (PKU) Dietary Formula

LifeWise Preferred (Network) Providers: Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

Benefits are provided for dietary formula that's medically necessary for the treatment of phenylketonuria (PKU).

This benefit isn't subject to the waiting period for pre-existing conditions, explained in "What's Not Covered?"

Prescription Drugs

This benefit provides coverage for medically necessary prescription drugs, prescriptive oral agents for controlling blood sugar levels, glucagon emergency kits and insulin when prescribed for your use outside of a medical facility and dispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located.

A "prescription drug" is any medical substance that, under federal law, must be labeled as follows: "Caution: Federal law prohibits dispensing without a prescription."

For each new prescription or refill, you pay the following copay or coinsurance:

Participating Retail Pharmacies

Generic Drugs	\$10
Preferred Brand Name Drugs	\$45
Non-Preferred Brand Name Drugs	50%

Medco By Mail/Mail-Order Pharmacy

Generic Drugs	\$25
Preferred Brand Name Drugs	\$112.50
Non-Preferred Brand Name Drugs	45%

The mail order benefit is limited to Medco By Mail, our participating mail order pharmacy.

Coinsurance for non-preferred brand name prescription drugs (retail or mail order) is based on our allowable charge.

Dispensing Limits

Retail Pharmacy	30 day supply
Medco-by-Mail	90 day supply

Limits other than as specified above will be allowed only when the manufacturer's packaging is in other than a 30 or 90 day increment.

In no case will your out-of-pocket expense exceed the total cost of the drug or supply.

This plan requires use of available generic drugs. See "Questions and Answers About Your Prescription Drug Benefits" below for more information.

Non-Participating Pharmacies Covered prescription drugs dispensed from a non-participating pharmacy are subject to the generic or brand name copay or coinsurance specified above, plus additional coinsurance of 40% of allowable charges.

Prescription Drug Benefit Maximum

Benefits for all brand name prescription drugs (preferred brand or non-preferred brand) are

limited to a maximum of \$3,000 per member per calendar year.

Once this benefit maximum is met, no further benefits are available for the calendar year for any brand name drug, regardless of diagnosis or condition.

This calendar year benefit maximum does not apply to:

- Generic drugs (See "Questions and Answers About Your Prescription Drug Benefits" below for a definition of generic drugs.)
- Drugs, testing supplies, needles, syringes, and injection aids necessary for the treatment of diabetes
- Anti-rejection drugs prescribed for use following a solid organ, bone marrow or stem cell transplant
- Oral chemotherapy drugs, and selected anti-nausea/anti-emetic drugs (brand name drugs for which there are no generic alternative) used in conjunction with chemotherapy or radiation therapy. Contact Customer Service for details on which drugs are included in this classification.

How To Use Your Prescription Drug Benefit

Participating Retail Pharmacies For each new prescription or refill, you pay the required copay or coinsurance. We'll pay the participating pharmacy directly.

To avoid paying the retail cost for a prescription drug that's reimbursable by us at a lower allowable charge rate, be sure to use your LifeWise ID card for all prescription drug purchases.

You can locate a participating pharmacy by calling Customer Service, or the toll-free Pharmacy Locator line located on your LifeWise ID card.

Non-Participating Pharmacies You pay the full price for the drugs and submit a claim for reimbursement. Please see the How Do I File A Claim? section in this contract for more information. Reimbursement for covered drugs purchased from a non-participation pharmacy will be subject to the required copay or coinsurance, and be based on our allowable charge.

Medco By Mail/Mail-Order Pharmacy Program

Ask your physician to prescribe needed medications for up to the maximum dispensing limit stated earlier in this benefit, plus refills. If you're presently taking medication, ask your physician for a new prescription. Make sure that you have at least a 14- to 21-day supply on hand for each drug at the time you submit a new prescription or refill to Medco By Mail.

To obtain additional details about the mail-order pharmacy program, you may call our Pharmacy Benefit Administrator's customer service department at 1-800-626-6080 or visit their Web site at www.medco.com

What's Covered This prescription drug benefit provides for the following items when dispensed by a licensed pharmacy for use outside of a medical facility:

- Prescription drugs (Federal Legend and State Restricted Drugs as prescribed by a licensed provider). This benefit includes coverage for off-label use of FDA-approved drugs as provided under this plan's definition of Prescription Drug (please see the Definitions section in this contract).
- Compounded medications of which at least one ingredient is a covered prescription drug
- Prescriptive oral agents for controlling blood sugar levels
- Glucagon and allergy emergency kits
- Prescribed injectable medications for self-administration, such as insulin
- Hypodermic needles, injection aids, syringes and alcohol swabs used for self-administered injectable prescription medications. Also covered are the following disposable diabetic testing supplies: test strips, testing agents and lancets. A separate brand-name copay applies for each type of item dispensed. However, when insulin needles and syringes are dispensed at the same time as covered insulin, a single copay will apply to the insulin, needles and syringes.
- Prescription contraceptive drugs and devices

Exclusions This benefit does not cover any of the following:

- Drugs, medicines, contraceptive or other devices that may be lawfully obtained over the counter (OTC) without a prescription. OTC drugs are excluded even if prescribed by a practitioner
- Vitamins (including prescription vitamins) food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements such as infant formulas or protein supplements. Benefits for formula for treatment of phenylketonuria (PKU) are provided under this plan's medical benefits.
- Drugs for the purpose of cosmetic use, or to promote or stimulate hair growth (e.g. Wrinkles or hair loss)
- Drugs for experimental or investigational use

- Biologicals, blood or blood derivatives
- Any prescription refilled in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider's original order
- Drugs dispensed for use or administration in a health care facility or provider's office, or take-home drugs dispensed and billed by a medical facility.
- Infusion therapy drugs or solutions and drugs requiring parenteral administration or use, and injectable medications. (The exception is injectable drugs for self-administration, such as insulin and glucagon, and human growth hormones.)
- Replacement of lost or stolen medication
- Psychotropic or psychiatric medications, regardless of intended use.
- Drugs for treatment of sexual dysfunction
- Drugs for weight management or treatment of obesity
- Medical equipment or supplies, except for disposable diabetic supplies

Prescription Drug Volume Discount Program

Your prescription drug benefit program is administered for LifeWise by Medco Health Solutions. This program includes rebates on the cost of certain covered drugs that are received by LifeWise. Rebates are used in connection with the operations of LifeWise such as in the determination of future subscription charge rates and the administration by LifeWise of its health plans and the prescription drug program. If your prescription drug plan includes copayments or coinsurance calculated on a percentage basis, or a deductible, rebates are not reflected in your cost share.

Your Right To Safe And Effective Pharmacy Services

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you want more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please call Customer Service. The phone numbers are shown on the back cover of this contract.

If you want to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-

6900. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at 360-236-4825.

Questions And Answers About Your Prescription Drug Benefits

1. **Does this plan exclude certain drugs my health care provider may prescribe, or encourage substitution for some drugs?**

Your prescription drug benefit uses a preferred drug list. (This sometimes is referred to as a "formulary.") We review medical studies, scientific literature and other pharmaceutical information to choose safe and effective drugs for the preferred list.

Please Note: This plan requires the use of "generic drugs" as defined below. When available, a generic drug will be dispensed in place of a brand-name drug. If a generic equivalent isn't manufactured, benefits for the brand name drug will be provided, subject to the applicable copay or coinsurance listed above.

You or the prescribing provider may request a brand-name drug instead of a generic, but if a generic equivalent is available, you'll be required to pay the difference in cost between the brand-name drug and the generic equivalent, in addition to paying the applicable brand-name drug copay or coinsurance.

Please consult with your pharmacist on the higher costs you'll pay if you select a brand-name drug.

A "generic drug" is a prescription drug product manufactured and distributed after the brand-name drug patent of the innovator company has expired. Generic drugs have obtained an AB rating from the U.S. Food and Drug Administration and are considered by the FDA to be therapeutically equivalent to the brand-name product. For the purposes of this plan, classification of a particular drug as a generic is based on generic product availability and cost as compared to the reference brand name drug.

This plan doesn't cover certain categories of drugs. These are listed above under "Exclusions."

2. **When can my plan change the approved drug list (formulary)? If a change occurs, will I have to pay more to use a drug I had been using?**

Our Pharmacy and Therapeutics Committee reviews our preferred drug list frequently throughout the year. This committee includes

medical practitioners and pharmacists from the community. They review current medical studies and pharmaceutical information to decide which drugs to include on the preferred list.

3. **What should I do if I want a change from limitations, exclusions, substitutions or cost increases for drugs specified in this plan?**

The limitations and exclusions applicable to your prescription drug benefit, including categories of drugs for which no benefits are provided, are part of this plan's overall benefit design, and can't be changed. Provisions regarding required use of generic drugs are described above in question #1.

You can appeal any decision you disagree with. Please see the What If I Have A Question Or An Appeal? section in this contract, or call our Customer Service department for information on how to initiate an appeal.

4. **How much do I have to pay to get a prescription filled?**

The amount you pay for covered drugs is described above.

5. **Do I have to use certain pharmacies to pay the least out of my own pocket under this plan?**

Yes. You receive the highest level of benefits when you have your prescriptions filled by participating pharmacies. The majority of pharmacies in Washington are part of our pharmacy network. Your benefit covers prescription drugs dispensed from a non-participating pharmacy, but at a higher out-of-pocket cost to you as explained above.

You can find a participating pharmacy near you by consulting your provider directory, or calling the Pharmacy Locator Line at the toll-free telephone number found on the back of your LifeWise ID card.

6. **How many days' supply of most medications can I get without paying another copay or other repeating charge?**

The dispensing limits (or days' supply) for drugs is described in the "Dispensing Limit" provision above.

In certain circumstances, we may limit benefits to a specific dispensed days' supply, drug, or drug dosage appropriate for a usual course of treatment. We may also limit benefits for certain drugs to specific diagnoses or pharmacies or require

prescriptions to be obtained from an appropriate medical specialist. Benefits for certain drugs may be subject to step therapy where you are required to first try a generic or specified brand name drug.

In making these determinations, we take into consideration medical necessity criteria, the recommendations of the manufacturer, the circumstances of the individual case, U.S. Food and Drug Administration Guidelines, published medical literature and standard reference compendia.

Benefits for refills will be provided only when the member has used three-fourths (75%) of the current supply. The 75% is calculated based on the number of units and days supply dispensed on the last refill.

7. What other pharmacy services does my health plan cover?

This benefit is limited to covered prescription drugs and specified supplies and devices dispensed by a licensed pharmacy. Other services, such as diabetic education or medical equipment, are covered by the medical benefits of this plan, and are described elsewhere in this contract.

Preventive Medical Care

Benefits are provided for routine and preventive services performed on an outpatient basis

LifeWise Preferred (Network) Providers:
Benefits are subject to a copay of \$30 per visit.

Non-Preferred (Non-Network) Providers:
Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

Covered services include:

- Routine physical exams
- Immunizations. Benefits for immunizations are provided at 100% of allowable charges. Benefits are limited to immunizations received from LifeWise Preferred (Network) providers.
- Well-baby and newborn exams
- Physical exams related to school, sports, and employment

For outpatient routine or preventive diagnostic services (including x-ray), screening and diagnostic mammography, and laboratory services benefit information, please see the Diagnostic Services and Mammography benefit.

For contraceptive services, drugs or devices

benefit information, please see the Contraceptive Management and Sterilization Services and Prescription Drugs benefits.

Services that are related to a specific illness, injury or definitive set of symptoms are covered under the non-preventive care medical benefits of this plan.

This benefit doesn't cover:

- Services not named above as covered
- Charges for preventive medical services that exceed what's covered under this benefit
- Physical exams for basic life or disability insurance
- Work-related disability evaluations or medical disability evaluations
- Routine vision or hearing exams
- Immunizations received from Non-Preferred (Non-network) Providers.

Professional Visits

Office, Home and Urgent Care Center Visits

LifeWise Preferred (Network) Providers:
Benefits are subject to a copay of \$30 per visit.

Non-Preferred (Non-Network) Providers:
Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

Benefits include the following:

- Professional home and office visits
- Second opinion consultations from any qualified provider
- Urgent care center visits
- Contraceptive management-related office visits
- Office visits related to dental injuries.

Other Professional Services

LifeWise Preferred (Network) Providers:
Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-network) Providers:
Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

This benefit includes the following professional services:

- Therapeutic injections
- Allergy testing and injections
- Diabetic foot care

- Inpatient professional visits

For benefits for professional surgical procedures performed in a provider's office, surgical suite or other facility benefit information, please see the Surgical Services benefit.

For diagnostic imaging and laboratory services benefit information, please see the Diagnostic Services and Mammography benefit.

For home health or hospice care benefit information, please see the Home Health and Hospice Care benefit.

This benefit doesn't cover:

- Hair analysis or non-prescription drugs or medicines, such as herbal, naturopathic or homeopathic medicines or devices
- Biofeedback services
- Preventive medical care or immunizations
- Acupuncture
- Spinal and other manipulative treatment

Radiation and Chemotherapy

LifeWise Preferred (Network) Providers: Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

Benefits are provided for chemotherapy and radiation therapy services received in a hospital or provider's office. See Transplants for benefits for radiation and chemotherapy services provided in conjunction with a transplant.

Please Note: See the Prescription Drugs for benefit information for prescription drugs dispensed through a pharmacy. This plan has an annual limit for brand-name prescription drugs dispensed through a pharmacy.

Rehabilitation Therapy and Chronic Pain Care

LifeWise Preferred (Network) Providers: Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

Rehabilitation Therapy Benefits for the following

inpatient and outpatient rehabilitation therapy services are provided when such services are medically necessary to either 1) restore and improve a bodily or cognitive function that was previously normal but was lost as a result of an injury, illness or surgery; or 2) treat disorders caused by physical congenital anomalies.

- **Inpatient Care** Benefits for inpatient facility and professional care are available up to 8 days per member each calendar year. Inpatient facility services must be furnished in a specialized rehabilitative unit of a hospital and billed by the hospital or be furnished and billed by another rehabilitation facility approved by us, and will only be covered when services can't be done in a less intensive setting.

When rehabilitation follows acute care in a continuous inpatient stay, this benefit starts on the day that the care becomes primarily rehabilitative. This benefit only covers care you receive within 24 months from the onset of the injury or illness or from the date of the surgery that made rehabilitation necessary. The care must also be part of a written plan of multidisciplinary treatment prescribed and periodically reviewed by a physician specializing in physical medicine and rehabilitation.

- **Outpatient Care** Benefits for outpatient care are subject to all of the following provisions:
 - You must not be confined in a hospital or other medical facility
 - Services must be furnished and billed by a hospital, rehabilitation facility approved by us, physician, or other licensed or certified provider.

When the above criteria are met, benefits will be provided for physical, speech, occupational and massage therapy services, including cardiac and pulmonary rehabilitation, up to a combined maximum benefit of 20 visits per member each calendar year. This benefit includes physical, speech, and occupational assessments and evaluations related to rehabilitation.

For the purposes of counting outpatient visits, "visit" means a session of treatment for each type of therapy. Each type of therapy combined accrues toward the above visit maximum. Multiple therapy sessions on the same day will be counted as one visit, unless provided by different health care providers.

Chronic Pain Care Rehabilitation Therapy benefits are also available for medically necessary treatment of intractable or chronic pain. Benefits for inpatient and outpatient chronic pain care are subject to the above rehabilitation therapy benefit

maximums stated above. However, inpatient services for chronic pain care aren't subject to the 24-month limit.

This benefit doesn't cover:

- Recreational, vocational or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Treatment that isn't actively engaged in by the ill, injured or impaired member
- Gym or swim therapy
- Custodial care
- Inpatient rehabilitation received more than 24 months from the date of onset of your injury or illness, or from the date of your surgery that made the rehabilitation necessary.
- Neurodevelopmental therapy or treatment of neurodevelopmental disabilities

Skilled Nursing Facility Services

LifeWise Preferred (Network) Providers:

Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-network) Providers:

Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

This benefit is only provided when you're at a point in your recovery where inpatient hospital care is no longer medically necessary, but skilled care in a skilled nursing facility is. Your attending physician must actively supervise your care while you're confined in the skilled nursing facility.

Benefits are provided up to 45 days per member each calendar year for services and supplies, including room and board expenses, furnished by and used while confined in a:

- Skilled nursing facility that is a LifeWise Preferred (network) provider
- Medicare-approved skilled nursing facility

This benefit doesn't cover:

- Custodial care
- Care that is primarily for senile deterioration, mental deficiency, retardation or the treatment of chemical dependency

Spinal and Other Manipulative Treatment

LifeWise Preferred (Network) Providers:

Benefits are subject to a copay of \$25 per visit.

Non-Preferred (Non-Network) Providers:

Benefits are subject to the calendar year

deductible of \$3,000 and coinsurance of 50% of allowable charges.

Benefits for spinal and other manipulations are provided up to a combined maximum benefit of 12 visits per member each calendar year. Services must be medically necessary to treat a covered illness, injury or condition.

Rehabilitation therapy (such as massage or physical therapies) provided in conjunction with manipulative treatment will accrue toward the Rehabilitation Therapy and Chronic Pain Care benefits' annual maximums, even when provided during the same visit.

Surgical Services

LifeWise Preferred (Network) Providers:

Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-network) Providers:

Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

This benefit includes all professional surgical services when performed on an inpatient or outpatient basis, in such locations as a hospital, ambulatory surgical facility, surgical suite or provider's office.

Also included in this benefit are anesthesia and postoperative care, cornea transplantation, skin grafts and the transplanting of blood or blood derivatives.

For organ, bone marrow or stem cell transplant procedure benefit information, please see the Transplants benefit. Benefits for mastectomy and related services are described in the Mastectomy and Breast Reconstruction Services benefit.

Transplants

LifeWise Approved Transplant Centers:

Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Transplant services are only covered when provided by an "Approved Transplant Center." See Covered Transplants below.

Transplant Exclusion Period This plan doesn't provide benefits for an organ, bone marrow or stem cell transplant, including any procedure associated with the transplant (for example, testing, blood typing, chemotherapy, radiation or hospitalization), unless you've been covered under this medical contract for 12 consecutive months.

However, this exclusion period doesn't apply if the transplant is needed as a direct result of one of the following:

- An injury that occurs on or after your effective date of coverage under this plan
- A congenital anomaly of a child who's been covered through us since birth. A congenital anomaly of a child who's been covered through us since placement for adoption with the subscriber

Please note: Transplant-related services that are covered under other benefits of this plan are subject to the waiting period for pre-existing conditions (please see the What's Not Covered? section in this contract for more information about this waiting period).

This benefit is subject to a lifetime maximum benefit of \$250,000 for all covered transplants and transplant-related services combined. Services that accrue to this lifetime maximum benefit are also subject to the 12-month exclusion period stated above.

Covered Transplants Solid organ transplants and bone marrow/stem cell reinfusion procedures must not be considered experimental or investigational for the treatment of your condition. (Please see the Definitions section in this contract for the definition of "experimental/investigational services.") We reserve the right to base coverage on all of the following:

- Solid organ transplants and bone marrow/stem cell reinfusion procedures must meet our criteria for coverage. We review the medical indications for the transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives.

The types of solid organ transplants and bone marrow/stem cell reinfusion procedures that currently meet our criteria for coverage are:

- Heart
- Heart/double lung
- Single lung
- Double lung
- Liver
- Kidney
- Pancreas
- Pancreas with kidney
- Bone marrow (autologous and allogeneic)
- Stem cell (autologous and allogeneic)

Please Note: For the purposes of this plan, the term "transplant" doesn't include cornea

transplantation, skin grafts or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure (please see the Surgical Services benefit).

- You've satisfied the transplant exclusion period
- Your medical condition must meet our written standards
- The transplant or reinfusion must be furnished in an approved transplant center. ("Approved transplant center" is a hospital or other provider that's developed expertise in performing solid organ transplants, or bone marrow or stem cell reinfusion, and is approved by us.) We have agreements with approved transplant centers in Washington and Alaska, and we have access to a special network of approved transplant centers around the country. Whenever medically possible, we'll direct you to an approved transplant center that we've contracted with for transplant services.

Of course, if none of our centers or the network centers can provide the type of transplant you need, this benefit will cover a transplant center that meets written approval standards set by us.

- The \$250,000 transplant maximum benefit must not have been reached

Recipient Costs Benefits for transplant or reinfusion related expenses start accruing to the \$250,000 maximum 30 days before the date of a solid organ transplant, or in the case of bone marrow or stem cell procedures, 30 days before the date of reinfusion. Benefits stop accruing to the \$250,000 maximum 180 days from the date of the transplant or reinfusion. Inpatient stays for episodes of rejection related to a solid organ transplant or bone marrow or stem cell reinfusion beyond the 180-day period will also accrue to the \$250,000 maximum. However, the time limits above don't apply to this benefit's coverage for transportation and lodging.

This benefit also provides coverage for anti-rejection drugs administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed.

Donor Costs Procurement expenses are charged against the recipient's \$250,000 maximum and are limited to \$75,000 per transplant. Covered services include selection, removal (harvesting) and evaluation of the donor organ, bone marrow or stem cell; transportation of donor organ, bone marrow and stem cells, including the surgical and harvesting teams; donor acquisition costs such as testing and typing expenses; and storage costs for

bone marrow and stem cells for a period of up to 12 months.

Transportation and Lodging Expenses

Reasonable and necessary expenses for transportation, lodging and meals for the transplant recipient (while not confined) and one companion, except as stated below, are covered but limited as follows:

- The transplant recipient must reside more than 50 miles from the approved transplant center
- The transportation must be to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or necessary post-discharge follow-up
- When the recipient is a dependent minor child, benefits for transportation, lodging and meal expenses for the recipient and 2 companions will be provided up to a maximum of \$125 per day.
- When the recipient isn't a dependent minor child, benefits for transportation, lodging and meal expenses for the recipient and one companion will be provided up to a maximum of \$80 per day.
- Covered transportation, lodging and meal expenses incurred by the transplant recipient and companion(s) are charged against the recipient's \$250,000 maximum and are limited to \$7,500 per transplant

This benefit doesn't cover:

- Services and supplies that are payable by any government, foundation or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers.
- Donor costs for a solid organ transplant or bone marrow or stem cell reinfusion that isn't covered under this benefit, or for a recipient who isn't a member
- Donor costs for which benefits are available under other group or individual coverage
- Non-human or mechanical organs, unless we determine they aren't "experimental or investigational services" (please see the Definitions section in this contract)
- Personal care items

Vision Exams

LifeWise Preferred (Network) Providers: Benefits are provided at 100% of allowable charges.

Non-Preferred (Non-network) Providers: Benefits are provided at 100% of allowable charges.

This benefit covers one routine vision exam per member each 2 consecutive calendar years.

Covered routine exam services include:

- Examination of the outer and inner parts of the eye
- Evaluation of vision sharpness (refraction)
- Binocular balance testing
- Routine tests of color vision, peripheral vision and intraocular pressure
- Case history and recommendations

Vision Hardware

LifeWise Preferred (Network) Providers:

Benefits are provided at 100% of allowable charges.

Non-Preferred (Non-network) Providers:

Benefits are provided at 100% of allowable charges.

This benefit covers vision hardware up to \$200 per member each 2 consecutive calendar years.

Benefits for the vision hardware items listed below are provided when they meet all of these requirements:

- They must be prescribed and furnished by a licensed or certified vision care provider
- They must be named in this benefit as covered
- They must not be excluded from coverage under this plan

What's Covered:

- Prescription eyeglass lenses (single vision, bifocal, trifocal, quadrafocal or lenticular)
- Frames for eyeglasses
- Prescription contact lenses (soft, hard or disposable)
- Prescription safety glasses
- Prescription sunglasses
- Special features, such as tinting or coating
- Fitting of eyeglass lenses to frames
- Fitting of contact lenses to the eyes

The Vision Hardware benefit doesn't cover:

- Services or supplies that aren't named above as covered, or that are covered under other provisions of this plan
- Nonprescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), or non-prescription sunglasses or light-sensitive lenses, even if prescribed

- Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), or pleoptics
- Supplies used for the maintenance of contact lenses
- Services and supplies (including hardware) received after your coverage under this benefit has ended, except when all of the following requirements are met:
 - You ordered covered contact lenses, eyeglass lenses and/or frames before the date your coverage under this benefit or plan ended
 - You received the contact lenses, eyeglass lenses and/or frames within 30 days of the date your coverage under this benefit or plan ended

LIMITATIONS AND EXCLUSIONS

This section explains the waiting and exclusion periods which apply to this plan. It also explains exclusions, which are the services and supplies not covered by this plan.

WAITING AND EXCLUSION PERIODS

Pre-Existing Conditions Waiting Period

A "pre-existing condition" is a any medical condition, illness or injury that existed at any time prior to the effective date of coverage for which medical advice was given, for which a health care provider recommended or provided treatment, or for which a prudent layperson would have sought advice or treatment, within the six (6) month period prior to your effective date.

No benefits are available under this contract for services or supplies furnished for any pre-existing condition (even if the condition worsens) during the first nine (9) months of coverage. This is called the "pre-existing conditions waiting period."

Credit for Prior Health Insurance Coverage

This pre-existing conditions waiting period will be credited (reduced) to the extent you had prior health insurance coverage. This crediting will occur only if the following situations are true:

- You had prior coverage at any time during the sixty-three (63) day period immediately preceding your application for this plan
- The prior coverage was either a group health insurance plan or an individual health insurance plan, other than a catastrophic health insurance plan. This includes a self-insured group plan and the Washington State Health Insurance Pool plan.

And

- The benefits of the prior plan provided equal or greater overall benefit coverage than this plan

You will also receive credit for prior coverage in the following situations:

- You are applying for this plan due to a change in residence from one geographic area of Washington State to another geographic area of Washington State where your prior health insurance plan is not offered. In this instance, you must apply for this plan within 90 days of your change in residence
- You are applying for this plan because a health care provider with whom you have established a care relationship and have received treatment from within the past 12 months is no longer part of your prior plan's network, and that provider is currently part of this plan's provider network. In this instance, you must apply for this plan within 90 days of your health care provider leaving the prior plan's provider network.

Your prior employer or health insurer will provide you with a certificate of health coverage which includes information about your prior health coverage. You may submit other documents to show prior health care coverage if you are unable to obtain a certificate of health coverage. These include explanations of benefit claims or correspondence from a plan or issuer indicating coverage records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that show your beginning and end dates of coverage, and type of benefits provided.

The pre-existing conditions waiting period does not apply to:

- Prenatal care (Please note: obstetrical delivery and postpartum care is subject to the waiting period.)
- Newborn children born after the subscriber's effective date of coverage under this plan, provided they are covered from birth
- Adoptive children who are adopted or placed for adoption after the subscriber's effective date of coverage under this plan, provided they are covered from the date of placement
- Coverage for PKU formula for members with Phenylketonuria
- A HIPAA-Eligible Individual (see Definitions)

If you are confined in a health care facility for treatment of a pre-existing condition at the time your nine-month pre-existing conditions waiting period ends, benefits for that condition will be

provided only for covered services received after the waiting period is met.

Organ and Bone Marrow Transplant Exclusion Period

Benefits for organ and bone marrow transplants are not available during the first 12 consecutive months after your effective date. The only exceptions are in the following situations:

- The transplant is necessary due to an accidental injury that occurs on or after your effective date of coverage under this plan
- The transplant is necessary due to a congenital anomaly of a child who has been covered through us since birth
- The transplant is necessary due to a congenital anomaly of a child who has been covered through us since placement for adoption with the subscriber

Please see the Transplants benefit for more information on the transplant benefit.

EXCLUSIONS

This section of the contract lists those services, supplies or drugs are not covered under this plan.

Amounts That Exceed The Allowable Charge

All benefits of this plan are based on the allowable charge (see Definitions). Benefits are not provided for amounts in excess of the allowable charge.

Benefits From Other Sources

Benefits aren't available under this plan when coverage is available through:

- Motor vehicle medical or motor vehicle no-fault
- Personal injury protection (PIP) coverage
- Commercial liability coverage
- Homeowner policy
- Other type of liability or insurance coverage
- Worker's Compensation or similar coverage

Benefits That Have Been Exhausted

Services, supplies, drugs, and medications furnished in connection with or directly related to a benefit that has been exhausted, or in excess of stated benefit maximums.

Biofeedback

Benefits are not provided for biofeedback, regardless of diagnosis.

Chemical Dependency

Services and supplies for the treatment of chemical dependency, whether or not received as part of a

court-ordered admission. Also excluded is the diagnosis and treatment of caffeine dependency. Emergency medical detoxification treatment is covered under this plan's medical benefits.

Conditions From Professional Sports

Any condition related to semiprofessional or professional athletics, including practice. Semiprofessional athletics are athletics requiring a high level of skill, for which you are paid, even if the activity is not your full-time occupation.

Counseling and Assessments

- Services and supplies related to marital, family, or sexual counseling; vocational counseling; outreach; job training; health education and wellness classes, materials and services; and other counseling or training services, except as specifically stated under the Diabetes Health Education benefit.
- Psychological and neuropsychological assessments or testing. The exception is for a single assessment visit per calendar year related to neurodevelopmental therapy to establish a diagnosis.

Cosmetic and Reconstructive Services

- Services, supplies or drugs provided for cosmetic purposes whether cosmetic or reconstructive in nature, regardless of whether rendered to restore, improve, correct or alter the appearance, shape or function of a body structure, including any direct or indirect complications and aftereffects thereof.

The only exceptions to this exclusion are:

- Repair of a defect that's the direct result of an injury, providing such repair is started within 12 months of the date of the injury
- Repair of a dependent child's congenital anomaly
- Reconstructive breast surgery in connection with a mastectomy. See the Mastectomy and Breast Reconstruction Services benefit.

Custodial Care

Custodial, Domiciliary, or rest care, except as specifically stated under the hospice benefit.

Dental Care

Benefits are not provided for dental services or orthodontia, regardless of origin or cause, except as provided under the Dental Accident benefit.

Benefits for hospital services for dental treatment are only provided when medically necessary due to a member's serious medical condition such as hemophilia or heart disease.

Environmental Therapy

Milieu therapy (treatment designed primarily to provide a change in environment or a controlled environment).

Experimental and Investigative Services

Services or supplies we determine are experimental or investigative on the date furnished. Our determination is based on the criteria stated in the definition of "Experimental/Investigative." (See Definitions.)

If we determine that a service is experimental or investigative, and therefore not covered, you may appeal our decision. We will respond in writing within 20 working days after receipt of a claim or other fully documented request for benefits, or a fully documented appeal. The 20-day period may be extended only with your informed written consent.

This exclusion does not apply to certain services provided as part of oncology clinical trials. Benefit determination is based on the criteria specified in the definition of "Oncology Clinical Trials" in the Definitions section in this contract.

Human Growth Hormone Benefit Limitations

Benefits for human growth hormone are only provided under the Prescription Drugs benefit.

Hearing Examinations and Hearing Aids

Hearing examinations; hearing aids and their fitting and maintenance.

Hospital Admission Limitations

Hospital admissions solely for diagnostic studies, physical examinations, checkups, medical evaluations, or observations, unless:

- The services cannot be provided without the use of a hospital
- There is a medical condition that makes hospital care medically necessary

Infertility or Fertility Enhancement

Services, supplies, and drugs furnished in connection with infertility or fertility enhancement, and any direct or indirect complications of such procedures. This exclusion applies whether or not the condition is a consequence of illness, disease, or injury. This plan does not cover services for diagnosis of fertility problems, fertility-related drugs, donor sperm, artificial insemination, in-vitro fertilization, and gamete intra-fallopian transplant (GIFT).

Also not covered is reversal of prior sterilization, and the direct or indirect complications of such

services.

Learning Disorders and Neurodevelopmental Therapy

Services, therapy and supplies related to the treatment of learning disorders, cognitive handicaps, dyslexia, developmental delay or neurodevelopmental disabilities.

Mental or Psychiatric Conditions

Services and supplies, including inpatient and outpatient care, and drugs, for the treatment of a mental or psychiatric condition, including eating disorders.

Military-Related Disabilities

Services to which you are legally entitled for a military service-connected disability and for which Facilities are reasonably available.

Military Service And War-Related Conditions

Conditions caused by or arising from military, war-related conditions and illegal acts, including :

- Acts of war, declared or undeclared, including acts of armed invasion
- Service in the armed forces of any country, including the air force, army, coast guard, marines, national guard, navy, or civilian forces or units auxiliary thereto
- A member's commission of an act of riot or insurrection
- A member's commission of a felony or act of terrorism

Nicotine Dependency

Smoking cessation services, nicotine dependency cessation treatment, drugs or devices.

Non-Covered Services

Services, supplies, drugs, and medications furnished in connection with or directly related to any condition, service, or supply that is not covered under this contract

Obesity and Weight Management

Services, supplies, drugs, procedures, or any treatment, including surgical treatment, furnished in connection with obesity, morbid obesity or weight management, and any direct or indirect complications from such treatment. This exclusion applies even if you have a condition which would be helped by weight loss.

On-Line or Telephone Consultations

Benefits are not provided for electronic, telephone, on-line or internet medical consultations or

evaluations.

Orthognathic Surgery

Jaw augmentation or reduction (orthognathic surgery) and any direct or indirect complications thereof.

Prescription Drug Benefit Limitations

This plan does not cover:

- Over-the-counter or non-prescription drugs and medications; herbal, naturopathic, or homeopathic medicines or devices; Dietary supplements, except for PKU formula
- Prescription or non-prescription vitamins
- Drugs prescribed for infertility or fertility enhancement
- Psychotropic or psychiatric drugs, regardless of intended use
- Drugs for treatment of sexual dysfunction
- Anorectics (appetite suppressant drugs); drugs for weight management or treatment of obesity
- Any claim or demand for injury or damage arising in connection with the manufacturing, compounding, or dispensing or use of any drug; prescription drugs prescribed or dispensed in a manner contrary to normal medical or pharmaceutical practice
- Drugs prescribed for cosmetic purposes including, but not limited to, drugs for treatment of male pattern baldness or skin changes due to aging;
- Any prescription dispensed in excess of the quantity specified by the physician, or any refill dispensed after one year from the physician's original order
- Brand name drugs dispensed by a pharmacy in excess of the calendar year benefit maximum as stated under the Prescription Drugs benefit

Preventive Care Limitations

Services and supplies, such as examinations, testing (including drug and alcohol testing), and vaccinations which are primarily for non-treatment purposes as determined by us, except as provided under the Preventive Medical Care benefit. Also excluded are immunization from non-LifeWise (non-network) providers.

Private Duty Nursing

Benefits are not provided for private duty or 24-hour nursing care. See the Home Health Care benefit for home nursing care benefits.

Records And Reports

Separate charges from providers for supplying records or reports, except those we request for utilization review.

Routine Foot Care

Routine foot care, orthopedic shoes, and foot orthotics or shoe inserts. The exceptions are orthopedic shoes and inserts specifically provided for treatment of complications of diabetes as described under the Medical Equipment, Prostheses, and Supplies benefit.

Services When This plan Is Not In Effect

Services or supplies received or ordered when this plan is not in effect, or when you are not covered under this contract, except as stated under Continuation of Coverage under Eligibility, Enrollment, and Termination.

Services For Which You Do Not Have To Pay

Services and supplies for which no charge is made, for which none would have been made if this plan were not in effect, or for which you are not legally required to pay.

However, this exclusion does not apply to covered services and supplies which are prepaid through participation under any health care service contract or health maintenance agreement; such services and supplies are subject to the Coordination of Benefits provisions outlined elsewhere in this contract.

Services From Government Facilities

Services and supplies provided by a state or federal hospital which is not a participating facility, except for those services received, furnished, and billed by the hospital for treatment or admission for a medical emergency, or other covered services as required by law or regulation.

Services Not Medically Necessary

Services and places of service that are, in our judgment, not medically necessary for the diagnosis or treatment of an injury or illness, even if not specifically listed as exclusions. This includes coverage for inappropriate inpatient hospital care and court-ordered care, treatment, or testing.

Services Provided By Family Members

Services and supplies that you furnish to yourself or that are furnished to you by a provider who lives in your home or is related to you by blood, marriage or adoption. Examples of such providers are your spouse, parent, or child.

Services Provided for Personal Convenience

- Items for your convenience or that of your family, including medical facility expenses; services of a personal nature or personal care items, such as meals for guests, long-distance telephone charges, radio or television charges, or barber or beautician charges
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as covered under the Home Health and Hospice benefit
- Disability or handicap modifications or renovations to vehicles or buildings, specialized equipment or services provided primarily for disabled access or accommodation

Sex or Gender Reassignment

Services, supplies, drugs, or any type of treatment related to sex transformations and gender reassignment and the direct or indirect complications of such services, supplies or drugs.

Sexual Dysfunction Treatment

Any diagnosis and treatment of sexual dysfunction, including surgery or drugs, regardless of origin or cause, and the direct or indirect complications of such treatment.

Temporomandibular Joint (TMJ) Disorder Treatment

Any services or supplies connected with the diagnosis or treatment of temporomandibular joint (TMJ) disorders.

Vision Care Services

- Routine vision exams, contact lenses, corrective lenses, eyeglasses, and associated services, except as specifically provided under the Vision Exams and Vision Hardware benefits. Also excluded are nonprescription glasses or other special-purpose vision aids.
- Orthoptics, pleoptics, visual analysis therapy and/or training; and surgeries or other procedures performed to improve or change the refractive character of the cornea, including any direct or indirect complications thereof

Work Or Employment-Related Conditions

Any illness, condition, or injury arising out of or in the course of employment, for which you are entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under:

- Occupational coverage required of or voluntarily obtained by the employer

- State or federal workers' compensation acts
- Any legislative act providing compensation for work-related illness or injury

COORDINATION OF BENEFITS

Coordination of Benefits (COB) begins when a member has health care coverage under more than one plan. If, in the absence of this provision, the sum of the benefits available under this plan and the benefits available under all other plans covering you would be greater than the total amount of allowable expenses incurred by that member during the claim determination period, the plans involved will coordinate their benefits according to this provision.

Benefits and services under this plan are subject to the determination of responsibility for the payment of eligible expenses in accordance with the coordination of benefit provisions set forth below. You will not be entitled to benefits from us in excess of those which he or she would have been entitled to if this coordination of benefits provision were not included.

To properly coordinate benefits, claims should be submitted at the same time to each plan.

Definitions Applicable To Coordination Of Benefits

Plans include, but are not limited to, the following sources of benefits which will be recognized for coordination of benefits purposes:

- Group, individual, and blanket disability insurance or health care plans issued by insurers, health care service contractors, and health maintenance organizations
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- Group student coverage provided or sponsored by a school or other educational institution which includes medical benefits for illness or disease
- Government programs for which you are eligible or which is required or provided by any law. This does not include Workers' Compensation or Medicare.

If a member is covered under multiple plans, we will coordinate benefits separately with each plan.

Allowable Expense means the usual, reasonable and customary charge for any necessary health care service or supply when the service or supply is covered at least in part under any of the plans involved.

When a plan provides benefits in the form of

services or supplies rather than cash payments, the reasonable cash value of each service received or supply provided shall be considered an allowable expense.

Claim Determination Period means a calendar year.

Effect On Benefits

An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan is responsible for providing benefits first. This is called the "primary" plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become "secondary." This means they reduce their payment amounts so that the total benefits from all medical plans aren't more than the allowable medical expenses and the total benefits from all dental plans aren't more than the total allowable dental expenses. We will coordinate benefits when you have other health care coverage that is primary over this plan.

Plans should provide benefits in the following order:

FIRST: A plan which does not provide for coordination of benefits will always be primary over a plan which includes a coordination of benefits provision.

NEXT: A plan that covers you as a subscriber shall be primary over the plan which covers you as a dependent.

NEXT: A plan that covers a dependent child shall have the following rules apply:

The Parents Are Not Separated Or Divorced: The plan of the parent whose birthday (excluding year of birth) falls earlier in the year will be primary if that is in accord with the coordination of benefits provision of both plans. Otherwise, the rule set forth in the plan that does not have this provision shall determine the order of benefits.

The Parents Are Separated Or Divorced: If a court decree makes one parent responsible for paying the child's health care costs, that parent's plan will be primary. Otherwise, the plan of the parent with custody will be primary, followed by the plan of the spouse of the parent with custody, followed by the plan of the parent who does not have custody.

If the rules above do not apply, the plan that has covered you for the longest time will be primary, except that the benefits of a plan which covers the subscriber as a laid-off or retired employee, or as

the dependent of such an employee, shall be determined after the benefits of any plan that covers the subscriber as other than a laid-off or retired employee, or as a dependent of such an employee. This applies, however, only when the other plans involved have this provision regarding laid-off or retired employees.

If none of the rules above determine the order of benefits, the plan that has covered an employee or subscriber for the longest time will be primary.

When this provision operates to reduce the total amount of benefits otherwise payable to a member covered under this plan during any claim determination period, each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit maximum of this plan.

Determination Of Other Coverage

At our request, you must furnish information concerning other health insurance coverage in effect for themselves or their dependents. Intentionally false or misleading information concerning other health insurance coverage is grounds for termination of this contract.

Payment To Another Plan

Whenever payments that should have been made under this contract have been provided by another plan, we shall have the right, at our sole discretion, to make payment to the other plan any amount determined to be warranted in order to satisfy the intent of this provision. Any amount so paid shall be considered a benefit provided, and we shall be fully discharged from liability under this contract.

Effect Of Medicare

If there is a determination that a member is entitled to benefits under this contract and Medicare, or this contract, Medicare, and Medicare supplemental coverage, the benefits of this contract shall always be secondary to those provided by Medicare and Medicare supplemental coverage except as provided by law.

GENERAL PROVISIONS

Benefit Modifications

From time to time, we may revise the provisions of this contract. You will receive prior written notice of any revisions to this contract, and 30 days prior written notice of changes to subscription charges.

If the provisions of this contract are amended, modifications will not affect the benefits provided under this contract to a member during

confinement in a facility. Benefit modifications will take effect upon final discharge from the facility, or from any other facility to which you are transferred, provided coverage is still in effect.

No agent of LifeWise or any other entity is authorized to make any changes, additions, or deletions to this contract or to waive any provision of this contract. Changes, alterations, additions, or exclusions can only be done over the signature of an officer of LifeWise. We will only make such changes if we make changes to all contracts issued on this contract's form number.

No rights to receive benefits are vested under this contract.

Benefits Not Transferable

No person other than you is entitled to receive the benefits of this contract. Such right to these benefits is not transferable. Fraudulent use of such benefits will result in cancellation of your eligibility under this contract and appropriate legal action.

Conformity With The Law

This contract is issued and delivered in the state of Washington and is governed by the laws of the state of Washington, except to the extent preempted by federal law. In the event any provision of the contract or any amendment is deemed to be in conflict with applicable state or federal laws or regulations, upon discovery of such conflict the contract will be administered in conformance with the requirements of such laws and regulations as of their effective date.

Evidence Of Medical Necessity

We have the right to require proof of medical necessity from a member receiving benefits under this contract. You or your providers may submit such proof. No benefits will be available under this contract if the proof is not provided or acceptable to us.

Health Care Providers - Independent Contractors

All health care providers who provide services and supplies to a member do so as independent contractors. None of the provisions of this contract are intended to create, nor shall they be deemed or construed to create, any employment or agency relationship between us and the provider of service other than that of independent contractors.

How To File A Claim

Most providers will submit claims to us directly. However, on occasion, you may find it necessary

to submit a claim yourself. To do so should follow these steps:

- Complete a Subscriber Claim Form for each provider. Subscriber Claim Forms are available from by contacting Customer Service.
- Attach the itemized bill. This bill must include the name of the subscriber and patient, dates of service, procedure codes or English nomenclature of each service provided, diagnosis, and itemized charges for each service.

Most claims for members who are entitled to Medicare will be automatically submitted to us. However, if you submit the claim to us, a copy of the Explanation of Medicare Benefits must be included.

Submit claims to the address shown on the back cover of this contract.

Timely Filing Of Claims You should submit all claims within 30 days after the service is completed. We must receive all claims:

- Within 365 days of discharge for hospital or other medical facility expenses, or within 365 days of the date services or supplies were provided
- If you have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits, or as indicated above, whichever is later

We will not provide benefits for claims we receive after the later of these two dates, nor will we provide benefits for claims which were denied by Medicare because they were received past Medicare's submission deadline.

Independent Corporation

The subscriber hereby expressly acknowledges the understanding that this contract constitutes a contract solely between the subscriber and LifeWise Health Plan of Washington.

The subscriber further acknowledges and agrees that he or she has not entered into this contract based upon representations by any person other than us, and that no person, entity, or organization other than us shall be held accountable or liable to the subscriber for any of our obligations to the subscriber created under this contract. This provision shall not create any additional obligations whatsoever on our part other than those obligations created under other provisions of this contract.

Individual Medical Plan

This contract is sold and issued in Washington

State as an individual medical plan. It is not issued for use as an employer-sponsored or group health plan. LifeWise specifically disclaims any liability for state or federal group plan requirements.

This contract does not replace, affect, or supplement any state or federal requirement for worker's compensation, employer's liability, or similar insurance. When an employer is required by law to provide or has the option to provide worker's compensation or similar insurance and does not provide such coverage for its employees, the benefits available under this plan will not be provided for conditions arising out of the course of employment which are or would be covered by such insurance.

Intentionally False Or Misleading Information

If this plan's benefits are paid in error due to any intentionally false or misleading statement, we will be entitled to recover these amounts. See Right of Recovery below.

And, if you make any intentionally false or misleading statement on any application for enrollment under this plan that affect your acceptability for coverage, we may, at our option, deny your claim, reduce the amount of benefits provided for your claim, or rescind your coverage under this plan. ("Rescind" means to cancel coverage back to its effective date, as if it had never existed at all.) We reserve the right to refund subscription charges previously paid and recover claims and administrative costs from the subscriber, person responsible for the intentionally false information, or any person receiving care.

Member Cooperation

All members are under a duty to cooperate in a timely and appropriate manner with us in our administration of benefits or in the event of a lawsuit. Failure to cooperate may constitute a material breach of this contract.

Notice

Any notice we are required to submit to you will be considered delivered if mailed to the subscriber or the remitting agent, as we may elect, at the most recent address appearing on our records. We will use the date of posting in determining the date of our notification. If the subscriber is required to submit notice to us, we will determine our receipt of such notice based on the earlier of postmark or date received at our offices.

Notice Of Information Use And Disclosure

We may collect, use, or disclose certain

information about you. This protected personal information (PPI) may include health information, or personal data such as your address, telephone number or Social Security Number. We may receive this information from, or release it to, health care providers, insurance companies, or other sources.

This information is collected, used or released for conducting routine business operations such as:

- Underwriting and determining your eligibility for benefits and paying claims
- Coordinating benefits with other health care plans
- Conducting care management, case management, or quality reviews
- Fulfilling other legal obligations that are specified under the contract
- This information may also be collected, used or released as required or permitted by law.

To safeguard your privacy, we take care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it. If a disclosure of PPI is not related to a routine business function, we remove anything that could be used to easily identify you or we obtain your prior written authorization. You also have the right to request inspection and/or amendment of records retained by us that contain your PPI. Please contact Customer Service and ask that a request form be mailed to you.

Notice Of Other Coverage

As a condition of receiving benefits under this plan, you must notify us of:

- Any legal action or claim against another party for a condition or injury for which we provided benefits, and the name and address of that party's insurance carrier
- The name and address of any insurance carrier that provides personal injury protection (PIP), underinsured motorist, uninsured motorist, or any other insurance under which you are or may be entitled to recover compensation
- The name of any other group insurance plan(s) under which you are covered

Rights Of Assignment

Notwithstanding any other provision in this contract, and subject to any limitations of state or federal law, in the event that we merge or consolidate with another corporation or entity, or do business with another entity under another name, or transfer this contract to another

corporation or entity, this contract shall remain in full force and effect, and bind the subscriber and the successor corporation or other entity.

We agree to guarantee that all transferred obligations will be performed by the successor corporation or entity according to the terms and conditions of this contract. In consideration for this guarantee, the subscriber consents to the transfer of this contract to such corporation or entity.

Right Of Recovery

We have the right to recover amounts we paid that exceed the amount for which we are liable. Such amounts may be recovered from the subscriber or any other payee, including a provider. Or, such amounts may be deducted from future benefits of the subscriber or any of his or her dependents (even if the original payment was not made on that member's behalf) when the future benefits would otherwise have been paid directly to the subscriber or to a provider that does not have a contract with us.

In addition, if this contract is rescinded as described in **Intentionally False Or Misleading Statements**, we have the right to recover the amount of any claims we paid under this plan and any administrative costs we incurred to pay those claims.

Right To And Payment Of Benefits

All rights to the benefits of this contract are available only to you. They may not be transferred or assigned to anyone else. We will not honor any attempted assignment, garnishment, or attachment of any right of this contract.

At our option and in accordance with the federal and state law, we may pay the benefits of this contract to the subscriber, member, provider, other carrier, or other party legally entitled to such payment under federal or state medical child support laws, or jointly to any of these. Such payment will discharge our obligation to the extent of the amount paid so that we will not be liable to anyone aggrieved by our choice of payee.

Subrogation And Reimbursement

If we make claims payment on your behalf for injury or illness for which another party is liable, or for which uninsured/underinsured motorist (UIM) or personal injury protection (PIP) insurance exists, we are entitled to be repaid for those payments out of any recovery from that liable party. The liable party is also known as the "third party" because it is a party other than you or us. This party includes a UIM carrier because it stands in the shoes of a third party tortfeasor and because we exclude

coverage for such benefits.

Definitions The following terms have specific meanings in this contract:

- **Subrogation** means we may collect directly from third parties to the extent we have paid on your behalf for illnesses or injury caused by the third party.
- **Reimbursement** means that you are obligated under the contract to repay any monies advanced by us from amounts received on your claim.
- **Restitution** means all equitable rights of recovery that we have to the monies advanced under your plan. Because we have paid for your illness or injuries, we are entitled to recover those expenses.

To the fullest extent permitted by law, we are entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of benefits paid by us for the condition. Our right to recover exists regardless of whether it is based on subrogation, reimbursement or restitution. In recovering benefits provided, we may at our election hire our own attorney or be represented by your attorney. We will not pay for any legal costs incurred by you or on your behalf, and you will not be required to pay any portion of the costs incurred by us or on our behalf.

Before accepting any settlement on your claim against a third party, you must notify us in writing of any terms or conditions offered in a settlement, and you must notify the third party of our interest in the settlement established by this provision. You must also cooperate with us in recovering amounts paid by us on your behalf. If you retain an attorney or other agent to represent you in the matter, you must require your attorney or agent to reimburse us directly from the settlement or recovery. If you fail to cooperate fully with us in the recovery of benefits we have paid as described above, you are responsible for reimbursing us for such benefits.

To the extent that you recover from any available third party source, you agree to hold any recovered fund in trust or in a segregated account until our subrogation and reimbursement rights are fully determined.

Agreement To Arbitrate Any disputes that arise as part of this provision will be resolved by arbitration. Both you and we will be bound by the decision of the arbitration proceedings.

Disputes will be resolved by a single arbitrator. Either party may demand arbitration by serving notice of the demand on the other party. Each

party will bear its own costs and share equally in the fees of the arbitrator. Arbitration proceedings pursuant to this provision shall take place in King County, Washington.

This agreement to arbitrate will begin on the effective date of the contract, and will continue until any dispute regarding this plan's subrogation or reimbursement is resolved.

Uninsured/Underinsured Motorist/ Personal Injury Protection Coverage

We have the right to be reimbursed for benefits provided, but only to the extent that benefits are also paid for such services and supplies under the terms of a motor vehicle uninsured motorist and/or underinsured motorist (UIM) policy, personal injury protection (PIP) or similar type of insurance or contract.

Venue

All lawsuits, and legal proceedings, including arbitration proceedings, brought against us by you or anyone claiming any right under this plan must be filed:

- Within 3 years of the date we denied, in writing, the rights or benefits claimed under this plan, or of the completion date of the independent review process if applicable; and
- In the state of Washington or the state where you reside or are employed.

All suits or legal or arbitration proceedings brought by us will be filed within the appropriate statutory period of limitation, and you agree that venue, at our option, will be in King County, the state of Washington.

YOUR IDEAS, QUESTIONS, COMPLAINTS AND APPEALS

As a LifeWise member, you have the right to offer your ideas, ask questions, voice complaints, and submit appeals. Our goal is to listen, resolve your problems, and improve our service to you.

When You Have Ideas

We would like to hear from you on ways we can continue to improve our service. If you have an idea, suggestion, or opinion, please let us know. You can contact us at the addresses and telephone numbers found on the back cover of this contract.

When You Have Questions

Call your provider of care when you have questions about the health care services you

receive. Please call our Customer Service Department with any other questions regarding your individual benefit plan. The telephone numbers are on the back cover of your contract.

When You Have A Complaint

A complaint is an expression of dissatisfaction about a benefit or coverage decision, customer service, or the quality or availability of a health service. The complaint process lets Customer Service quickly and informally correct errors, clarify decisions or benefits, or take steps to improve our service. We recommend, but do not require, that you take advantage of this process when you are not content with a benefit or coverage decision. If Customer Service finds that you need to submit your complaint as a formal appeal, they will tell you.

When you have a complaint, call or write our Customer Service Department. If your complaint is about the quality of care you receive, it will be given to our Clinical Quality Management staff for review. If the complaint is of a non-medical nature relating to a provider, it will be given to our Provider Network staff for review. We will let you know when we have received your written complaint. We may also request more information when needed. When we receive all needed information, we will review your complaint and notify you of the outcome and the reason for it as soon as possible, but in no case more than 30 calendar days.

When You Have An Appeal

An appeal is an oral or written request that we reconsider 1) Our decision on a complaint, or 2) Our decision to deny, modify, reduce, or end payment, coverage, or authorization of coverage. This includes admissions to, and continued stays in, a facility. We must receive your appeal within 180 calendar days of the date you received notice of our decision. If you are appealing a complaint decision, we must receive your appeal within 180 calendar days of the date we gave you that decision.

Although we will accept an appeal made by phone to our Customer Service Department, it is a better idea to put appeals in writing. Please send or deliver all written appeals to the address shown below. We will let you know when we receive your appeal.

Mail appeals to our Appeals Coordinator. The address is on the back cover of your contract.

Appeals Process

Our standard appeals process has two levels of

review.

Level I The Level I Appeal panel will decide most appeals within 30 calendar days. This panel will include health care providers who were not involved in the initial decision. We can extend our review time up to 15 more calendar days if we need more information. You will be notified if a delay occurs.

There are three exceptions to the 30-day time limit:

A decision to change, reduce, or end an ongoing service

We will mail you a response within 14 calendar days of the date we receive your appeal, unless we notify you that we need an extension. The extension will be no more than 30 calendar days from the day we receive your appeal, unless you agree to a longer one.

Denial of an experimental or investigative service

We will mail you a response within 20 calendar days from the date we receive your appeal

Urgent appeals (See Urgent Appeals below)

If you do not agree with the decision reached in our Level I review, you may ask us to perform a Level II review of your appeal. You may also send us more information to support your appeal. You must make your request for a Level II review no more than 60 days after the date you receive our Level I decision. At our discretion, an extension to the 60-day limit may be granted in the event the member needs to obtain additional medical documentation, physician consultations or opinions, if the member is hospitalized or traveling, or for other reasonable cause beyond the member's control.

Level II Your appeal will be reviewed by a LifeWise panel that includes health care providers and is different from the Level I panel. You and/or your authorized representative may meet with the panel. Unless your appeal is deemed urgent (see Urgent Appeals below), the panel will evaluate all the information within 45 calendar days of the date we receive your Level II request.

If you are appealing a decision to deny, change, reduce, or end payment, coverage, or authorization of coverage, you may ask for an independent review instead (see Independent Review below). You may also ask for an independent review if we do not give you our Level I or II decision within the time limits stated. We must receive your request independent review within 60 calendar days of the date the appeal decision was due.

Independent Review Independent reviews are conducted by an independent review organization (IRO), which is an organization of medical experts qualified to review your appeal. We will use IROs that have been certified by the state Department of Health. We will submit your file to the IRO on your behalf and will pay the charges of the IRO. The IRO will give you its decision in writing. We will implement the IRO's determination promptly.

Notice Unless your appeal is deemed urgent, we will mail you a written notice of our Level I and Level II decisions within 5 calendar days after the review is complete.

Urgent Appeals We deem your appeal urgent when your physician or other provider advises us that a delay will harm your health. Level I and II responses on urgent appeals will be given within 72 hours after the appeal is received.

Appeals Of Ongoing Care While you are appealing a decision to change, reduce, or end coverage because the service or level of service is no longer Medically Necessary or appropriate, we will suspend our denial. Our coverage for services received during the appeal period does not and should not be construed to reverse our denial. If our initial decision is upheld, you must repay us all amounts that we have paid for such services. You will also have to pay providers any difference between our Allowable charge and the provider's billed charge.

Please call Customer Service if you have questions or need more information about our complaint or appeal process. The numbers are on the back cover of your contract.

Additional Information About Your Coverage

Your contract provides you with specific information about how your health care plan works. In it you can find detailed descriptions of:

- How to access care under this plan, including from providers who do not contract with us (See **HOW DOES CHOOSING A PROVIDER AFFECT MY BENEFITS?**)
- How to obtain preauthorization for coverage when necessary
- Our confidentiality policies
- How to appeal decisions you don't agree with

In addition, when you applied for or enrolled on this Plan, you received copies of the documents referred to in your contract, such as a provider directory and preferred drug list. If you need another copy of these, please contact Customer Service.

You may request additional information on the following topics:

- Other health care plans offered by us
- A description of the payment arrangements we use to pay health care providers
- A statement of all benefit payments in each year that have been counted toward this Plan's benefit limitations, visit, day, or dollar benefit maximums or other overall limitations
- How we monitor quality and performance, including accreditation status of our plans

Please contact Customer Service if you wish to receive this information. The telephone numbers are on the back cover of your contract.

DEFINITIONS

Allowable Charge

The allowable charge shall mean one of the following:

Providers That Have Contracting Agreements With LifeWise

The allowable charge is the amount agreed upon by us and the provider for medically necessary covered services.

Providers that have contracting agreements with us agree not to bill you for any charges above the amount agreed upon by us and the provider, except for any deductibles, coinsurance, amounts in excess of stated benefit maximums, and charges for noncovered services for which you are responsible.

Your deductibles and coinsurance, and amounts applied toward benefit maximums will be calculated on the basis of the allowable charge.

Providers That Do Not Have Contracting Agreements With LifeWise:

Except as stated below, the allowable charge will be no greater than the maximum allowance we otherwise would have allowed had the medically necessary covered services been furnished by a provider that has a contracting agreement in effect with us.

When you seek services from providers that do not have contracting agreements with us, your liability is for any amount above the allowable charge, and for any deductibles, coinsurance, amounts in excess of stated benefit maximums, and charges for noncovered services.

We reserve the right to determine the allowable charge for any given service.

Ambulatory Surgical Center

A facility that is licensed or certified as required by the state in which it operates, and that meets all of the following:

- It has an organized staff of physicians
- It has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures
- It does not provide inpatient services or accommodations

Calendar Year

The period of 12 consecutive months that starts each January 1 at 12:01 a.m. and ends on the next December 31 at midnight.

Chemical Dependency

An illness characterized by physiological or psychological dependency, or both, on a controlled substance regulated under Chapter 69.50 RCW and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent:

- The user exhibits a loss of self-control over the amount and circumstances of use
- The user develops symptoms of tolerance, or psychological and/or physiological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued
- The user's health is substantially impaired or endangered, or his or her social or economic function is substantially disrupted

Child

The subscriber or spouse's offspring, adopted person(s), or person(s) placed for adoption. A child must also be: unmarried, under 23 years of age, except for children placed for adoption or covered by a medical child support order, be primarily dependent on the subscriber for financial support.

Coinsurance

A cost-sharing requirement under this contract which requires the subscriber and/or members to pay a percentage of the cost of covered services.

Confined (Confinement)

Consecutive days of care received as an inpatient in a facility, or successive admissions due to the same or related causes when discharge from a facility and re-admission to the same or different facilities occurs within a 72-hour period.

Congenital Anomaly

A marked difference from the normal structure of a body part that is physically evident at birth.

Contract

The contract consists of all the following:

- This document
- The completed and signed application and, when required, the Standard Health Questionnaire that is currently on file with us (a copy can be obtained upon request)
- All endorsements, amendments and addenda attached to or issued to become part of this contract

Covered Services

Services, including supplies furnished incident to those services, which are specified in this contract and for which benefits will be provided subject to any applicable deductible, coinsurance, stated benefit maximums, and all terms, conditions, limitations, and exclusions of this contract. The fact that a service is a covered service does not mean that it is medically necessary.

Custodial Care

Care that does not require the regular services of trained medical or allied health care professionals and is designed primarily to assist the patient in the activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, feeding and preparation of special diets, and supervision of medications which are ordinarily self-administered.

Deductible

The amount of the allowable charges incurred for covered services for which the you are responsible before we provide benefits. Amounts in excess of the allowable charge do not accrue toward the deductible.

Dependent

The subscriber's spouse and/or children enrolled for coverage under this contract.

Domiciliary Care

Care provided in a facility solely due to the fact that care in your home is not available or convenient, although otherwise medically appropriate.

Effective Date

The date on which your coverage starts under this contract. This date is established by us and appears on our records.

Exclusion

A provision that states that we have no obligation under this contract to provide any benefits, except as stated within the specific exclusions.

Experimental and Investigative Service

A treatment, procedure, equipment, drug, drug usage, medical device, or supply which meets one or more of the following criteria as determined by us:

- It is a drug or device which cannot be lawfully marketed without the approval of the United States Food and Drug Administration, and has not been granted such approval on the date that it is provided
- The service is subject to oversight by an Institutional Review Board
- Reliable evidence does not demonstrate the efficacy of the service, nor does it define a specific role for the service in clinical evaluation, management, or treatment
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety, or efficacy
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies

"Reliable evidence" includes, but is not limited to, reports and articles published in authoritative medical and scientific literature as determined by us.

Facility (Medical Facility)

A hospital, skilled nursing facility, Approved Treatment facility for chemical dependency, state-approved institution for treatment of mental or psychiatric Conditions, or hospice. Not all health care Facilities are covered under this contract.

HIPAA-Eligible Individual

A person who meets the definition of "eligible individual" as stated in the federal Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 300gg-41(b). An Eligible Individual is someone who meets all of the following requirements:

- Has had 18 or more months of prior health care coverage, the most recent of which was through a group, governmental, or church health plan) with no lapse in coverage of more than 63 days
- Is not eligible for Medicare or any other group coverage
- Was not terminated from their prior coverage

due to nonpayment of premiums or fraud

- Is either ineligible for COBRA or state continuation coverage, or if eligible, has exhausted that coverage

Home Health Agency

An organization which is approved by us to provide approved home health services to a member.

Hospice

A facility or program designed to provide a caring environment for supplying the physical and emotional needs of the terminally ill.

Hospital

A facility in which sick or injured persons are given medical and surgical care, licensed as a hospital by the state where located, and providing 24-hour nursing services by or under the supervision of registered nurses, and which is not a place for Domiciliary Care, custodial care, rest, care of the aged, or care solely for drug abuse or alcoholism.

Illness

A sickness, disease, medical condition, or pregnancy.

Injury

Physical harm caused by a sudden and unforeseen event at a specific time and place. It is independent of illness, except for infection of a cut or wound.

Inpatient

Confined in a medical facility as an overnight bed patient.

LifeWise Health Plan of Washington

A health care service contractor licensed in the State of Washington that underwrites and maintains this health care plan. Also referred to as "we," "us," "our" and "LifeWise" in this contract.

LifeWise Preferred (Network) Provider

A provider who, at the time services are received, has a preferred contract in effect with us to furnish covered services to members.

Important Note: Our network of LifeWise Preferred (network) providers, as well as provider contracting status, are subject to change at any time. Please confirm the status of your provider before services are received by calling our Customer Service Department at the telephone numbers listed on the back cover of this contract.

LifeWise Non-Preferred (Non-Network) Provider

A provider that, at the time services are received has not signed a preferred provider contract with us. Since there are no contracts in effect with these providers, you are responsible for amounts above the allowable charge, deductibles, coinsurance, amounts in excess of stated benefit maximums, and charges for noncovered services and supplies.

Limitation

A restriction to a specific benefit.

Medical Emergency

The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. (A "prudent layperson" is someone who has an average knowledge of health and medicine.)

Examples of a medical emergency are severe pain, suspected heart attacks, and fractures. Examples of a non-medical emergency are minor cuts and scrapes.

Medically Necessary

Covered services and supplies which are, in our judgment, determined to meet all of the following requirements. They must be:

- Essential to the diagnosis or the treatment of an illness, accidental injury, or condition harmful or threatening to your life or health, unless provided for preventive services when specified as covered under this plan
- Appropriate for the medical condition as specified in accordance with authoritative medical or scientific literature
- Medically effective treatment of the diagnosis as demonstrated by:
- Sufficient evidence exists to draw conclusions about the effect of the health intervention on health outcome
- Evidence demonstrates that the health intervention can be expected to produce its intended effects on health outcomes
- Expected beneficial effects of the health intervention on health outcomes outweigh its expected harmful effects
- Cost effective as determined by being the least

costly of the alternative supplies or levels of service which is medically effective and can safely be provided to you. A health intervention is cost effective if there is no other available health intervention that offers a clinically appropriate benefit at a lower cost

- Not primarily for research or data accumulation
- Not primarily for the convenience of you, your family, physician or another provider

For the purposes of determining medical necessity, the following definitions are used:

Health Intervention: An activity undertaken for the primary purpose of preventing, improving, or stabilizing a medical condition. Activities that are primarily custodial, part of normal existence, or undertaken for the convenience of a patient, family, health professional, or third party are not health interventions.

Health Outcome: Results of medical interventions that directly affect your length or quality of life.

Sufficient Evidence: Evidence derived from clinical research that is (1) peer-reviewed, (2) well-controlled, (3) directly or indirectly relates the intervention to health outcomes, and (4) reproducible within and outside of a research setting.

The fact that a physician or other provider provides, prescribes, or recommends a service or supply does not of itself make that service or supply medically necessary or a benefit of this plan.

Member

The subscriber and/or dependents enrolled under this contract. Also referred to as "you."

Mental or Psychiatric Condition

A condition listed in the current edition of *Diagnostic and Statistical Manual (DSM)* published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.

Obstetrical Care

Care furnished during pregnancy (antepartum, delivery, postpartum) or any condition arising from pregnancy. This includes the time during pregnancy and within 45 days following delivery.

Oncology Clinical Trials

Treatment that is part of a scientific study of therapy or intervention in the treatment of cancer being conducted at the phase 2 or phase 3 level in a national clinical trial sponsored by the National

Cancer Institute or institution of similar stature, or trials conducted by established research institutions funded or sanctioned by private or public sources of similar stature. All approvable trials must have Institutional Review Board (IRB) approval by a qualified IRB.

The clinical trial must also be to treat cancer that is either life-threatening or severely and chronically disabling, has a poor chance of a positive outcome using current treatment, and the treatment subject to the clinical trial has shown promise of being effective.

An "oncology clinical trial" does not include expenses for:

- Costs for treatment that are not primarily for the care of the patient (such as lab services performed solely to collect data for the trial).
- Any drug or device provided as part of a phase I oncology clinical trial
- Services, supplies or pharmaceuticals that would not be charged to the member, were there no coverage.
- Services provided in a clinical trial that are fully funded by another source

The member for whom benefits are requested must be enrolled in the trial at the time of treatment for which coverage is being requested. We encourage you, your provider, or the medical facility to ask us for a benefit advisory to determine coverage before you enroll in the clinical trial.

Orthodontia

The branch of dentistry which specializes in tooth arrangement problems, including poor relationships between the upper and lower teeth (malocclusion).

Outpatient

Treatment received in a setting other than an inpatient in a medical facility.

Participating Pharmacy

A licensed pharmacy which contracts with us or our designated pharmacy benefits administrator to provide prescription drug benefits under this plan.

Pharmacy Benefits Administrator

An entity which contracts with us to administer the prescription drug benefits under this plan.

Plan

The benefits, terms, and limitations set forth in this contract.

Prenatal Care

Medical services provided during a pregnancy until the onset of labor. prenatal care does not include services provided during labor, obstetrical delivery, or postpartum care.

Prescription Drug

Any medical substance, the label of which, under the amended Federal Food, Drug, and Cosmetic Act, is required to bear the legend: "Caution: Federal law prohibits dispensing without a prescription." This includes biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication or for the treatment of people with HIV or AIDS.

We also provide benefits for "off-label" use. "Off label" use means the prescribed use of a drug that is other than that stated in its FDA-approved labeling. This includes the administration of prescription drugs for treatment of a covered condition when use of the drug is recognized as effective for treatment of such condition by one of the following standard reference compendia:

- The American Hospital Formulary Service-Drug Information
- The American Medical Association Drug Evaluation
- The United States Pharmacopoeia-Drug Information
- Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services or the Washington State Insurance Commissioner.

If not recognized by one of the standard reference compendia cited above, we may make a determination based on the majority of relevant, peer-reviewed medical literature (original manuscripts of scientific studies published in medical or scientific journals after critical review for scientific accuracy, validity, and reliability by independent, unbiased experts).

We may also base our determination on the rules of the Federal Secretary of Health and Human Services.

We do not cover any drug when the U.S. Food and Drug Administration (FDA) has determined its use to be contra-indicated, or experimental or investigative drugs not otherwise approved for any indication by the FDA.

Provider

A person who is in a provider category regulated under Title 18 or Chapter 70.127 RCW to practice health care-related services consistent with state

law. Such persons are considered health care providers only to the extent required by RCW 48.43.045 and only to the extent services are covered by the provisions of this plan. Also included is an employee or agent of such a person, acting in the course of and within the scope of his or her employment.

Providers also include certain health care facilities and other providers of health care services and supplies, as specifically indicated in the provider category listing below. Health care facilities that are owned and operated by a political subdivision or instrumentality of the State of Washington and other such facilities are included as required by state and federal law.

Covered licensed or certified categories of providers regulated under Title 18 and Chapter 70.127 RCW, will include the following, provided that the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this plan are met:

- Acupuncturists (L.Ac.)
- Audiologists
- Chiropractors (D.C.)
- Counselors
- Dental Hygienists (under the supervision of a D.D.S. or D.M.D.)
- Dentists (D.D.S. or D.M.D.)
- Denturists
- Dietitians and Nutritionists (D. or C.D., or C.N.)
- Home Health Care, Hospice and Home Care Agencies
- Marriage and Family Therapists
- Massage Practitioners (L.M.P.)
- Midwives
- Naturopathic Physicians (N.D.)
- Nurses (R.N., L.P.N., A.R.N.P., or N.P.)
- Nursing Homes
- Occupational Therapists (O.T.A.)
- Ocularists
- Opticians (Dispensing)
- Optometrists (O.D.)
- Osteopathic Physician Assistants (O.P.A.) (under the supervision of a D.O.)
- Osteopathic Physicians (D.O.)
- Pharmacists (R.Ph.)
- Physical Therapists (L.P.T.)
- Physician Assistants (P.A.) (under the supervision of an M.D.)

- Physicians (M.D.)
- Podiatric Physicians (D.P.M.)
- Psychologists (Ph.D.)
- Radiologic Technologists (C.R.T., C.R.T.T., C.R.D.T., C.N.M.T.)
- Respiratory Care Practitioners
- Social Workers
- Speech-Language Pathologists

The following health care facilities and other providers of health care services and supplies will be considered health care providers for the purposes of this plan, as long as they're licensed or certified by the State (unless otherwise stated) that the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this plan are met:

- Ambulance Companies
- Ambulatory Diagnostic, Treatment and Surgical Facilities
- Audiologists (CCC-A or CCC-MSPA)
- Birthing Centers
- Blood Banks
- Community Mental Health Centers
- Drug and Alcohol Treatment Facilities
- Medical Equipment Suppliers
- Hospitals
- Kidney Disease Treatment Centers (Medicare-certified)
- Psychiatric Hospitals
- Speech Therapists (Certified by the American Speech, Language and Hearing Association)

Remitting Agent

An individual or organization which, as an agent for the subscriber, has agreed to collect and remit to us the subscription charges required for coverage under this contract.

Service Area

All counties located in the State of Washington.

Skilled Care

Care which is ordered by a physician, and, in our judgment, requires the medical knowledge and technical training of a registered nurse.

Skilled Nursing Facility

A facility that is licensed in the state in which it operates to provide skilled nursing services and is approved as a skilled nursing facility under the

Medicare Program at the time of your admission.

Spouse

The person who is legally married to the subscriber and is enrolled for coverage under this contract.

Subscriber

The individual who has met the eligibility and residency requirements of this plan and in whose name the application is filed and the coverage established.

Subscription Charge

The monthly rates established by LifeWise as consideration for the benefits offered under this contract.

Temporomandibular Joint (TMJ) Disorder

Those disorders which have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint

EXHIBIT B

Washington Individual Contract Endorsement

This endorsement is attached to and made a part of the following LifeWise Health Plan of Washington (LifeWise) individual health care plan:

WiseChoices 20 Plan, Form #016812(01-2007)

Dear Subscriber:

This contract endorsement describes a change to your LifeWise individual health care contract. Your contract is being amended to comply with new requirements enacted by the Washington State Legislature in 2007. The endorsement revises your individual contract to include coverage for Colorectal Cancer Screenings, Mental Health Care and deletes and replaces the provision for Coordination of Benefits (COB). We have also revised the provision for Standard Health Questionnaire and the definition of Medically Necessary. This individual contract endorsement is effective January 1, 2008.

The contract has been revised as follows:

■ Standard Health Questionnaire

We are modifying the "Standard Health Questionnaire" provision of your contract to clarify when the Standard Health Questionnaire is waived for individuals applying for coverage. Applicants applying due to a loss of coverage through a plan sponsored by an employer group too small to offer COBRA will no longer need to have lost coverage due to a COBRA qualifying event. Any loss of coverage will qualify, so long as all other eligibility requirements are met. This change is required to comply with new requirements enacted by the Washington State Legislature in 2007.

The following provision in your contract (located under "Standard Health Questionnaire" in Eligibility, Enrollment and Termination) is hereby deleted:

"Your coverage ended due to a reduction in work hours, termination of employment (except for gross misconduct), death of employee, divorce/legal separation of employee and spouse, employee entitlement to Medicare, or loss of eligibility as a dependent child."

All other eligibility, enrollment and termination provisions of your plan remain unchanged.

■ Colorectal Cancer Examinations And Screening

Effective January 1, 2008, your plan will provide benefits for colorectal cancer screenings on the same basis as other preventive diagnostic services to comply with Substitute House Bill 1337 enacted by the Washington State Legislature in 2007.

We have added language as part of the "Diagnostic Services and Mammography" provision as follows:

Diagnostic Services And Mammography

Benefits are provided for diagnostic and mammography services, including administration and interpretation. This benefit covers the following services:

- Laboratory and pathology services for preventive or diagnostic purposes
- Imaging and scans (such as X-rays and EKGs) for preventive or diagnostic purposes
- Screening tests for prostate and cervical cancer

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- Colorectal cancer examinations and screening when recommended by a health care provider
- Diagnostic and screening mammography when recommended by a health care provider

Preventive Diagnostic Services

LifeWise Preferred (Network) Providers: Benefits are provided at 100% of allowable charges.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges."

All other provisions of the "Diagnostic Services and Mammography" benefit remain unchanged.

■ Mental Health Care

Effective January 1, 2008 your contract will include coverage for Mental Health Care to comply with mental health parity requirements of Engrossed House Bill 1460. A specific benefit category for "Mental Health Care" will be added to the "Specific Benefits" section of your contract. Benefits for "Mental Health Care" will be subject to the same calendar year deductible, coinsurance or copays as you would pay for inpatient services and outpatient visits for other covered medical conditions and will be provided based on the provisions outlined below:

Benefits are provided for mental health treatment on the same basis as any other service, subject to the inpatient day and outpatient visit limits stated below.

Under the "Summary of Benefits" section we have added the following:

Mental Health Care	Inpatient: Up to 6 days per calendar year
	Outpatient: Up to 6 visits per calendar year

Under the "Specific Benefits" section we have added a provision for "Mental Health Care" which reads as follows:

Mental Health Care

Inpatient Services

LifeWise Preferred (Network) Providers: Benefits are subject to the calendar year deductible of \$1,000 and coinsurance of 20% of allowable charges.

Non-Preferred (Non-network) Providers: Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

Outpatient Professional Visits

LifeWise Preferred (Network) Providers: Benefits are subject to a copay of \$30 per visit.

Non-Preferred (Non-Network) Providers: Benefits are subject to the calendar year deductible of \$3,000 and coinsurance of 50% of allowable charges.

Benefits for treatment of a mental health condition including treatment of eating disorders (such as anorexia nervosa, bulimia or any similar condition), are provided up to the benefit maximums shown below. Covered mental health services include inpatient care, partial hospitalization and outpatient care to manage or lessen the effects of a psychiatric condition. Services must be consistent with published practices that are based on evidence when available or follow clinical guidelines or a consensus of expert opinion published by national mental health professional organizations or other reputable sources. If no such published practices apply, services must be consistent with community standards of practice as determined by us.

Covered services must be furnished by one of the following types of providers:

- Hospital
- Washington state-licensed community mental health agency
- Licensed Physician (M.D. or D.O.)
- Licensed Psychologist (Ph.D.)

- Any other provider listed under the definition of "Provider" (please see the "Definitions" section in this contract) who is licensed or certified by the state in which the care is provided, and who is providing care within the scope of his or her license

Covered services may also be furnished by a state hospital operated and maintained by the State of Washington for the care of the mentally ill.

Benefits are provided up to the following maximums:

Inpatient Care

Up to 6 days per member each calendar year for facility and professional care. As an alternative to inpatient care, this plan covers psychiatric partial days. Two psychiatric partial days will count as one inpatient day.

Outpatient Therapeutic Visits

Up to 8 office or home therapeutic visits per member each calendar year. Also included in this benefit are biofeedback services for generalized anxiety disorder when provided by a qualified provider.

"Outpatient therapeutic visit" (outpatient visit) means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards as defined in the **Physicians Current Procedural Terminology**, published by the American Medical Association.

This benefit doesn't cover:

- Psychological treatment of sexual dysfunctions, including impotence and frigidity
- Biofeedback services for psychiatric conditions other than generalized anxiety disorder
- EEG biofeedback or neurofeedback services
- Services furnished in connection with obesity, even if the obesity is affected by psychological factors
- Family and marital counseling, and family and marital psychotherapy, as distinct from counseling, except when medically necessary to treat the diagnosed mental disorder or disorders of a member
- Mental health residential treatment

Mental Health Services And Your Rights

LifeWise and state law have established standards to assure the competence and professional conduct of mental health service providers, to guarantee your right to informed consent to treatment, to assure the privacy of your medical information, to enable you to know which services are covered under this plan and to know the limitations of your coverage. If you want a more detailed description of covered benefits for mental health services under this plan, or if you have a question or concern about any aspect of your mental health benefits, please contact LifeWise at one of the following telephone numbers:

Local and toll-free number: 1-800-592-8804

Local and toll-free TDD number for the hearing-impaired: 1-800-842-5357

If you want to know more about your rights under the law, or if you think anything you received from us may not conform to the terms of your contract or your rights under the law, you may contact the Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the qualifications or professional conduct of your mental health service provider, please call the State Health Department at 360-236-4010."

■ Prescription Drugs

Effective January 1, 2008, to comply with mental health parity requirements of Engrossed House Bill 1460, drugs prescribed to treat mental health conditions will be covered on the same basis as any other prescription drug, subject to the cost share, dispensing limitations and prescription drug benefit maximum stated in your contract. An additional bullet has been added to the "What's Covered" subsection of the "Prescription Drugs" provision as follows:

We have added a bullet to the "What's Covered" provision:

- Prescription drugs to treat a mental or psychiatric condition

We have deleted the following exclusion:

- Psychotropic or psychiatric medications, regardless of intended use.

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The prescription drug benefit program has also been modified so that member cost shares for prescription drugs are based upon an Allowable Charge that is higher than the price we pay our pharmacy benefit manager for those prescription drugs. We either retain the difference and apply it to the cost of administration of our health plans and prescription drug benefit program or credit the difference to subscription charge rates for the subsequent benefit year. If your prescription drug benefit includes a co-payment, coinsurance calculated on a percentage basis, or a deductible, the amount you pay and your account calculations are based on the Allowable Charge.

The "Prescription Drug Volume Discount Program" provision, found in your contract under the "Prescription Drugs" benefit, is replaced with the following revised provision:

Prescription Drug Volume Discount Program

Your prescription drug benefit program includes per claim rebates that are received by LifeWise from its pharmacy benefit manager. These rebates are taken into account in setting subscription charges or are credited to administrative charges otherwise payable to us and are not reflected in your cost share. The Allowable Charge that your payment is based upon for prescription drugs is higher than the price we pay our pharmacy benefit manager for those prescription drugs. LifeWise either retains the difference and applies it to the cost of administration of our health plans and the prescription drug benefit program or credits the difference to subscription rates for the subsequent benefit year. If your prescription drug benefit includes a co-payment, coinsurance calculated on a percentage basis, or a deductible, the amount you pay and your account calculations are based on the Allowable Charge."

The remainder of the "Prescription Drugs" benefit and the "Prescription Drug Benefit Limitations" exclusion remain unchanged.

■ Limitations and Exclusions

Due to the new mental health care coverage effective January 1, 2008, we have revised the "Exclusions" section which previously listed mental health care as not covered.

Under the "Exclusions" section we have amended the "Biofeedback" exclusion, deleted the exclusion for "Counseling and Assessments" replacing it with a new exclusion titled "Counseling, Educational Or Training Services" and deleted the exclusion for "Mental or Psychiatric Conditions":

Biofeedback

- Benefits are not provided for biofeedback, regardless of diagnosis, except as stated in the Mental Health Care benefit.

Counseling, Educational Or Training Services

- Community wellness classes and programs that promote positive health and lifestyle choices. Examples of these classes and programs are adult, child, and infant CPR, safety, babysitting skills, back pain prevention, stress management, bicycle safety and parenting skills.
- Counseling, education or training services, except as stated under the Diabetes Health Education and Training, Nutritional Therapy and Mental Health Care benefits. This includes vocational assistance and outreach; social, sexual and fitness counseling; and caffeine dependency. Also not covered is family and marital psychotherapy, except when medically necessary to treat the diagnosed mental condition of a member.
- Habilitative, education, or training services or supplies for dyslexia, for attention deficit disorders, and for disorders or delays in the development of a child's language, cognitive, motor or social skills, including evaluations thereof.
- Psychological and neuropsychological assessments or testing. The exception is for a single assessment visit per calendar year to establish a diagnosis.
- Nonmedical services, such as spiritual, bereavement, legal or financial counseling
- Recreational, vocational, or educational therapy; exercise or maintenance-level programs
- Social or cultural therapy
- Gym or swim therapy

■ Medically Necessary

We have revised the definition of "Medically Necessary" in the "Definitions" section of the contract to reflect the current set of criteria that our medical necessity reviews are based on. The definition of "Medically Necessary" has been deleted and replaced with the following:

MEDICALLY NECESSARY

Those covered services and supplies that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

■ Coordination Of Benefits

Effective January 1, 2008 your plan includes a new provision for coordination of benefits due to an amendment of rules of the Washington Administrative Code (WAC) 284-51 enacted by the Washington State Legislature in 2007.

We have deleted the entire "Coordination Of Benefits" provision and replaced it with the following new "What If I Have Other Coverage?" provision:

WHAT IF I HAVE OTHER COVERAGE?

Coordinating Benefits With Other Plans

When you have more than one health plan, "coordination of benefits (COB)" makes sure that the combined payments of all your plans don't exceed your covered health costs. You or your provider should file your claims with each plan at the same time. If you have Medicare, Medicare may submit your claims to your secondary plan.

Definitions

For the purposes of COB:

- A plan is any of the following that provides benefits or services for medical or dental care. If separate contracts are used to provide coordinated coverage for group members, all the contracts are considered parts of the same plan and there is no COB among them. However, if COB rules don't apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB doesn't apply is treated as a separate plan.
- "Plan" means: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or HMOs, closed panel plans or other forms of group coverage; medical care provided by long-term care plans; and Medicare or any other federal governmental plan, as permitted by law.
- "Plan" doesn't mean: Hospital or other fixed indemnity or fixed payment coverage; accident-only coverage; specified disease or accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; non-medical parts of long-term care plans; automobile coverage required by law to provide medical benefits; Medicare supplement policies; Medicaid or other federal governmental plans, unless permitted by law.
- This plan means your plan's health care benefits to which COB applies. A contract may apply one COB process to coordinating certain benefits only with similar benefits and may apply another COB process to coordinate other benefits. All the benefits of your LifeWise plan are subject to COB, but if your plan includes benefits for injuries to teeth, it coordinates these dental benefits separately from medical benefits. These dental benefits are coordinated only with other plans' dental benefits, while medical benefits are coordinated only with other plans' medical benefits.

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- **Primary plan** is a plan that provides benefits as if you had no other coverage.
- **Secondary plan** is a plan that is allowed to reduce its benefits in accordance with COB rules. See "Effect On Benefits" later in this section for rules on secondary plan benefits.
- **Allowable expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any of your plans. When a plan provides benefits in the form of services, the reasonable cash value of each service is an allowable expense and a benefit paid. An amount that isn't covered by any of your plans isn't an allowable expense.
An example of an expense that is not allowable is any amount over the highest of the expense amounts allowed by either the primary or secondary plan. This is true regardless of what method the plans use to set allowable expenses. However, if you have Medicare or a Medicare Advantage plan, the allowable expense set by Medicare or the Medicare Advantage plan must be treated as the highest allowable.
- **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than half of the calendar year, excluding any temporary visitation.

Primary And Secondary Rules

Certain governmental plans, such as Medicaid and TRICARE, are always secondary by law. By law, Medicare is always primary to individual plans. Except as required by law, Medicare supplement plans and other plans that don't coordinate benefits at all must pay as if they were primary.

A plan that doesn't have a COB provision that complies with Washington regulations is primary to a complying plan unless the rules of both plans make the complying plan primary. The exception is group coverage that supplements a package of benefits provided by the same group. Such coverage can be excess to the rest of that group's plan. An example is coverage paired with a closed panel plan to provide out-of-network benefits.

The first of the rules below to apply decides which plan is primary. If you have more than one secondary plan, the rules below also decide the order of the secondary plans to each other.

Non-Dependent Or Dependent The plan that doesn't cover you as a dependent is primary to a plan that does. However, if you have Medicare, and federal law makes Medicare secondary to your dependent coverage and primary to the plan that doesn't cover you as a dependent, then the order is reversed.

Dependent Children Unless a court decree states otherwise, the rules below apply:

- **Birthdate rule** When the parents are married or living together, whether or not they were ever married, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary.
- When the parents are divorced, separated or not living together, whether or not they were ever married:
 - If a court decree makes one parent responsible for the child's health care expenses or coverage, that plan is primary. This rule and the court decree rules below apply to calendar years starting after the plan is given notice of the court decree.
 - If a court decree assigns one parent primary financial responsibility for the child but doesn't mention responsibility for health care expenses, the plan of the parent with financial responsibility is primary.
 - If a court decree makes both parents responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.
 - If a court decree requires joint custody without making one parent responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.
 - If there is no court decree allocating responsibility for the child's expenses or coverage, the rules below apply:
 - The plan covering the custodial parent, first
 - The plan covering the spouse of the custodial parent, second
 - The plan covering the non-custodial parent, third
 - The plan covering the spouse of the non-custodial parent, last
 - If a child is covered by individuals other than parents or stepparents, the above rules apply as if those individuals were the parents.

Continuation Coverage If you have coverage under COBRA or other continuation law, that coverage is secondary to this plan. However, this rule doesn't apply when both plans don't have the rule or when the "non-dependent or dependent" rule can decide which of the plans is primary.

Length Of Coverage The plan that covered you longer is primary to the plan that didn't cover you as long.

If none of the rules above apply, the plans must share the allowable expenses equally.

COB's Effect On Benefits

The primary plan provides its benefits as if you had no other coverage.

A plan may take into account the benefits of another plan only when it is secondary to that plan. The secondary plan is allowed to reduce its benefits so that the total benefits provided by all plans during a calendar year are not more than the total allowable expenses incurred in that year. For each claim, the benefits of the primary and secondary plans must total 100% of the highest allowable expense allowed for the service or supply by either plan. However, the secondary plan is never required to pay more than its benefit in the absence of COB plus any savings accrued from prior claims incurred in the same calendar year.

The secondary plan must credit to its deductible any amounts it would have credited if it had been primary. It must also calculate savings for each claim by subtracting its secondary benefits from the amount it would have provided as primary. It must use these savings to pay any allowable expenses incurred during that calendar year, whether or not they are normally covered.

Certain facts about your other health care coverage are needed to apply the COB rules. We may get the facts we need for COB from, or give them to, other plans, organizations or persons. We don't need to tell or get the consent of anyone to do this. State regulations require each of your other plans and each person claiming benefits under this plan to give us any facts we need for COB.

Right Of Recovery/Facility Of Payment If your other plan makes payments that this plan should have made, we have the right, at our discretion, to remit to the other plan the amount we determine is needed to comply with COB. To the extent of such payments, we are fully discharged from liability under this plan. We also have the right to recover any payment over the maximum amount required under COB. We can recover excess payment from anyone to whom or for whom the payment was made or from any other issuers or plans.

Questions about COB? Contact our Customer Service Department or the Washington Insurance Department."

All other provisions of your contract remain unchanged. This contract endorsement forms a part of your contract. It should be kept with your contract for future reference.

If you have any questions regarding the information contained in this contract endorsement, please contact our Customer Service Department:

Toll Free: 1-800-592-6804
Hearing Impaired TDD 1-800-842-5357

LifeWise Health Plan of Washington



Jeffrey Roe
President and Chief Executive Officer
LifeWise Health Plan of Washington

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EXHIBIT C



Washington Individual Contract Endorsement

Applies to the following LifeWise of Washington individual health care plans:

WiseChoices 0/20 Plan, Form #016809(01-2007)
WiseChoices 0/30 Plan, Form #016988(01-2007)
WiseChoices 20 Plan, Form #016812(01-2007)
WiseChoices 30 Plan, Form #016989(01-2007)
WiseSavings 20 Plan, (\$1,820 Deductible), Form #017968(07-2007)
WiseSavings 20 Plan, (\$3,000 Deductible), Form #016990(01-2007)
WiseSimplicity Plan, (\$10,000 Deductible), Form #019829(08-2009)
WiseChoices Prime Plan, (\$1,500 Deductible), Form #020881 (08-2009)
WiseChoices Prime Plan, (\$3,000 Deductible), Form #020884 (08-2009)

Dear Subscriber:

This contract endorsement describes changes to your LifeWise individual health care contract.

Mental Health Care benefits of your plan will be revised to comply with the new state requirements for equivalent benefits for mental health care treatment. Under this law, member cost-sharing requirements (deductibles, copays, and coinsurance), benefit limits, including network restrictions, may not be more restrictive than the common or most frequent cost-sharing requirements, benefit limits, or network restrictions that apply to medical or surgical benefits.

This individual contract endorsement is effective July 1, 2010.

The contract has been revised as follows:

■ Mental Health Care

Effective July 1, 2010 your contract is amended to reflect coverage for Mental Health Care services as stated above. Benefits for Mental Health Care will be subject to the same calendar year deductible, coinsurance or copays as you would pay for inpatient services and outpatient visits for other covered medical conditions and do not have an annual or separate benefit limit.

The following sections of your contract have been revised.

Under the "Summary of Benefits" section and "Benefits With Annual Maximums" subsection, we have deleted the following:

Mental Health Care

Inpatient: Up to 6 days per calendar year

Outpatient: Up to 6 visits per calendar year.

Under the "Specific Benefits" section we have deleted and replaced the Mental Health benefit as follows:

Inpatient Services

See Hospital Inpatient Care for benefits for inpatient treatment.

Outpatient Professional Visits

See Professional Visits for benefits for office visits.

Benefits for treatment of a mental health condition including treatment of eating disorders (such as anorexia

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EXHIBIT C

nervosa, bulimia or any similar condition), are covered on the same basis as other covered medical services and are provided as shown below. Covered mental health services include inpatient care, partial hospitalization and outpatient care to manage or lessen the effects of a psychiatric condition. Services must be consistent with published practices that are based on evidence when available or follow clinical guidelines or a consensus of expert opinion published by national mental health professional organizations or other reputable sources. If no such published practices apply, services must be consistent with community standards of practice. Benefits for covered Mental Health Care services are not subject to an annual benefit limit.

Covered services must be furnished by one of the following types of providers:

- Hospital
- Washington state-licensed community mental health agency
- Licensed Physician (M.D. or D.O.)
- Licensed Psychologist (Ph.D.)
- Any other provider listed under the definition of "Provider" (please see the "Definitions" section in this contract) who is licensed or certified by the state in which the care is provided, and who is providing care within the scope of his or her license

Covered services may also be furnished by a state hospital operated and maintained by the State of Washington for the care of the mentally ill.

This benefit doesn't cover:

- Psychological treatment of sexual dysfunctions, including impotence and frigidity
- Biofeedback services for psychiatric conditions other than generalized anxiety disorder
- EEG biofeedback or neurofeedback services
- Services furnished in connection with obesity, even if the obesity is affected by psychological factors
- Family and marital counseling, and family and marital psychotherapy, as distinct from counseling, except when medically necessary to treat the diagnosed mental disorder or disorders of a member
- Mental health residential treatment

Mental Health Services And Your Rights

LifeWise and state law have established standards to assure the competence and professional conduct of mental health service providers, to guarantee your right to informed consent to treatment, to assure the privacy of your medical information, to enable you to know which services are covered under this plan and to know the limitations of your coverage. If you want a more detailed description of covered benefits for mental health services under this plan, or if you have a question or concern about any aspect of your mental health benefits, please contact LifeWise at one of the following telephone numbers:

Local and toll-free number: 1-800-592-6804

Local and toll-free TDD number for the hearing-impaired: 1-800-842-5357

If you want to know more about your rights under the law, or if you think anything you received from us may not conform to the terms of your contract or your rights under the law, you may contact the Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the qualifications or professional conduct of your mental health service provider, please call the State Health Department at 360-236-4010."

All other provisions of your contract remain unchanged. This contract endorsement forms a part of your contract. It should be kept with your contract for future reference.

If you have any questions regarding the information contained in this contract endorsement, please contact our Customer Service Department:

Toll Free: 1-800-592-6804
Hearing Impaired TDD 1-800-842-5357

LifeWise Health Plan of Washington

A handwritten signature in black ink, appearing to read "Jeffrey Roe". The signature is written in a cursive, flowing style.

Jeffrey Roe
President and Chief Executive Officer
LifeWise Health Plan of Washington

EXHIBIT D

FINAL BILL REPORT

SHB 1154

C 6 L 05

Synopsis as Enacted

Brief Description: Requiring that insurance coverage for mental health services be at parity with medical and surgical services.

Sponsors: By House Committee on Financial Institutions & Insurance (originally sponsored by Representatives Schual-Berke, Campbell, Kirby, Jarrett, Green, Kessler, Simpson, Clibborn, Hasegawa, Appleton, Moeller, Kagi, Ormsby, Chase, McCoy, Kilmer, Williams, O'Brien, P. Sullivan, Tom, Morrell, Fromhold, Dunshee, Lantz, McIntire, Sells, Murray, Kenney, Haigh, Darneille, McDermott, Dickerson, Santos and Linville).

House Committee on Financial Institutions & Insurance
Senate Committee on Health & Long-Term Care

Background:

Health carriers are not required to provide mental health coverage. Health carriers providing group coverage to employers with 50 or more employees are required to offer optional supplemental coverage for mental health treatment, which can be waived at the request of the employer. If a health carrier does provide mental health coverage, there are no specific mandates on the level of coverage that must be provided under the group coverage.

The administrator of the Basic Health Plan (BHP) is authorized to offer mental health services under the BHP as long as those services, along with chemical dependency and organ transplant services, do not increase the actuarial value of BHP benefits by more than 5 percent. The BHP covers inpatient care in full up to 10 days per calendar year and outpatient care in full up to 12 visits per year. These limits are not found on other hospital inpatient services. The coinsurance rate, applicability of a deductible, and maximum facility charges for mental health benefits are generally consistent with hospital inpatient service charges.

The Washington State Health Care Authority (HCA) administers health care benefits for low income residents through the BHP. The HCA also oversees state employee health insurance programs provided by various private health insurers (e.g., Group Health, Premera, Regence, etc.) as well as the Uniform Medical Plan.

The Office of the Insurance Commissioner (OIC) oversees private health insurance. There are three main categories of insuring entities or "health carriers" that offer health plans that fall under the jurisdiction of the OIC:

- disability insurers;
- health care services contractors; and
- health maintenance organizations.

Optional Supplemental Mental Health Coverage: Generally, health carriers are required to offer optional, supplemental mental health treatment coverage to group purchasers. The coverage extends to insureds and covered dependents. The contract holder for the group may waive coverage for the group. The coverage must be offered at the "usual and customary rates for such treatment" and is subject to other specified requirements and conditions.

Diagnostic and Statistical Manual of Mental Disorders (DSM): The DSM is a manual published by the American Psychiatric Association that covers all recognized mental health disorders affecting both children and adults. It lists the factors known to cause these disorders, presents pertinent statistics, and cites research concerning optimal treatment approaches. The DSM is considered to be the standard reference for mental health professionals who make psychiatric diagnoses.

Summary:

I. OVERVIEW

Group health insurance plans covering over 50 employees are required to provide a level of coverage for mental health services that is equal to the coverage provided for medical and surgical services. The requirements are imposed in three increments between 2006 and 2010. Once the mental health parity requirements are fully implemented in 2010, limitations on mental health services may be imposed by an insurance plan only if the same limitations are imposed on medical and surgical services.

The mental health parity requirements for each type of plan are largely identical and are subject to the same structured phase-in. This mental health parity requirement applies to five categories of group health insurance coverages:

- (1) plans administered by the HCA on behalf of state employees;
- (2) plans provided by disability insurers;
- (3) plans provided by health care services contractors;
- (4) plans provided by health maintenance organizations; and
- (5) benefits provided by the Washington Basic Health Plan.

Small Business Exemption: Health carriers do not have to provide mental health coverage to small businesses with 50 or fewer employees. As a general rule, health carriers must make an offer of optional coverage to any group other than a group of 50 or fewer employees.

II. COVERED MENTAL HEALTH SERVICES

"Mental Health Services" Defined: The required mental health services include medically necessary inpatient and outpatient services provided to treat mental disorders listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. The determination of whether a mental health service is medically necessary in a particular case is subject to the discretion of the medical director of the health plan. The medical necessity standard for mental health care must be comparable to that applied for medical and surgical services.

Exempted Mental Health Services: There are specified types of mental health disorders and treatment categories that are exempted from coverage, including:

- disorders related to substance abuse;
- life transition problems (family/marital issues, occupational/academic problems, etc.);
- residential treatment and custodial care; and
- court ordered treatment (unless medically necessary).

III. FIVE YEAR PHASE-IN

Health coverage is generally offered for one year periods. Parity between mental health and medical and surgical services is achieved in three phases between January 1, 2006, and July 1, 2010. Phase One begins on January 1, 2006. Phase Two begins on January 1, 2008. Phase Three begins on July 1, 2010. The phases are cumulative. The second phase incorporates the coverage requirements of the first phase. The third phase incorporates the coverage requirements of the first two phases. On July 1, 2010, all of the parity provisions will become effective.

Phase One - For Health Benefit Plans Established or Renewed on or After January 1, 2006:

- (1) The copayment or coinsurance for mental health services may not exceed the copayment or coinsurance for medical/surgical services provided under the plan. *Begun in Phase One.*
- (2) Prescription drug coverage for mental health services must be covered to the same extent and under the same conditions as other prescription drug coverage in the health benefit plan. *Begun in Phase One.*

Phase Two - For Health Benefit Plans Established or Renewed on or After January 1, 2008:

- (1) The copayment or coinsurance for mental health services may not exceed the copayment or coinsurance for medical/surgical services provided under the plan. *Begun in Phase One. Maintained in Phase Two.*
- (2) Prescription drug coverage for mental health services must be covered to the same extent and under the same conditions as other prescription drug coverage in the health benefit plan. *Begun in Phase One. Maintained in Phase Two.*
- (3) If the health insurance plan imposes a maximum out of pocket limit or stop loss, the same limit or stop loss must apply to medical, surgical, and mental health services. *Begun in Phase Two.*

Phase Three - For Health Benefit Plans Established or Renewed on or After July 1, 2010:

- (1) The copayment or coinsurance for mental health services may not exceed the copayment or coinsurance for medical/surgical services provided under the plan. *Begun in Phase One. Maintained in Phases Two and Three.*
- (2) Prescription drug coverage for mental health services must be covered to the same extent and under the same conditions as other prescription drug coverage in the health benefit plan. *Begun in Phase One. Maintained in Phases Two and Three.*

(3) If the health insurance plan imposes a maximum out of pocket limit or stop loss, the same limit or stop loss must apply to medical, surgical, and mental health services. *Begun in Phase Two. Maintained in Phase Three.*

(4) If the health insurance plan imposes a deductible, it must be a single deductible covering medical, surgical, and mental health services. *Begun in Phase Three.*

(5) Any treatment limitations or financial requirements must be the same for mental health, medical, or surgical services. *Begun in Phase Three.*

IV. OTHER PROVISIONS

Groups With 50 or Fewer Employees: Health carriers are not required to offer these mental health parity provisions to groups with 50 or fewer employees. Generally, health carriers must offer optional supplemental mental health coverage to these groups. The group contract holder may waive the optional coverage for all insureds.

Rule-making Authority: The Insurance Commissioner, the administrator of the State Health Care Authority, and the administrator of the Basic Health Plan are each granted authority to adopt rules necessary to implement the mental health priority requirements.

Votes on Final Passage:

House	67	25
Senate	40	9

Effective: July 24, 2005

SENATE BILL REPORT

SHB 1154

As Passed Senate, March 3, 2005

Title: An act relating to mental health parity.

Brief Description: Requiring that insurance coverage for mental health services be at parity with medical and surgical services.

Sponsors: House Committee on Financial Institutions & Insurance (originally sponsored by Representatives Schual-Berke, Campbell, Kirby, Jarrett, Green, Kessler, Simpson, Clibborn, Hasegawa, Appleton, Moeller, Kagi, Ormsby, Chase, McCoy, Kilmer, Williams, O'Brien, P. Sullivan, Tom, Morrell, Fromhold, Dunshee, Lantz, McIntire, Sells, Murray, Kenney, Haigh, Darneille, McDermott, Dickerson, Santos and Linville).

Brief History: Passed House: 1/28/05, 67-25.

Committee Activity: Health & Long-Term Care: 2/21/05, 2/24/05 [DP, w/oRec, DNP].

Passed Senate: 3/3/05, 40-9.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: Do pass.

Signed by Senators Keiser, Chair; Thibaudeau, Vice Chair; Deccio, Ranking Minority Member; Brandland, Franklin, Kastama, Kline and Poulsen.

Minority Report: That it be referred without recommendation.

Signed by Senators Johnson and Parlette.

Minority Report: Do not pass. Signed by Senator Benson.

Staff: Jonathan Seib (786-7427)

Background: Current Washington law does not require health carriers to include mental health coverage in any benefit plan. If a carrier nonetheless chooses to include such coverage, the law does not mandate a specific benefit level. The law does require that carriers providing group coverage to employers offer coverage for mental health, but the coverage can be waived by the employer. Where provided, most plans generally limit inpatient mental health coverage to a specified number of days, and outpatient coverage to a specified number of visits. These limitations are not imposed on most other treatment.

The federal Mental Health Parity Act (MHPA) took effect on January 1, 1998, and will sunset on December 31, 2005. Under the MHPA, businesses with more than 50 employees that choose to offer mental health benefits may not impose annual or lifetime dollar limits on those benefits that are lower than the limits set for the medical and surgical benefits that they provide. Cost sharing requirements, and limits on the number of visits or days of coverage, may still vary from other coverage. The requirements of the MHPA do not apply where they would increase costs to a business by more than one percent.

The Basic Health Plan (BHP) is authorized to offer mental health services under as long as those services, along with chemical dependency and organ transplant services, do not increase the actuarial value of BHP benefits by more than 5 percent. Currently, inpatient care requires a 20 percent co-pay (up to \$300 per admittance) for coverage up to 10 days per calendar year, and outpatient care requires a \$15 co-pay for up to 12 visits per year.

The Public Employee Benefits Board (PEBB) provides health coverage to state employees through both fully-insured managed care plans and the self-insured Uniform Medical Plan (UMP). For all (PEBB) plans, inpatient mental health care requires a \$200 per day co-pay (up to \$600) for coverage up to 10 days per year. Outpatient services require either a 10 percent (UMP) or 10 dollar (managed care) per visit co-pay for up to 20 visits per year.

Reflecting concerns that health insurance generally fails to cover mental health services to the same extent as other health care services, state legislation was introduced in 1998 calling for coverage parity. The legislation was referred to the Department of Health for review under the mandated health benefits sunrise review process set forth in statute. The Department of Health issued its final report in November 1998. The report analyzed the efficacy of the mandate, and its social and financial impact, and recommended that the legislation be enacted.

Summary of Bill: Beginning January 1, 2006 a health benefit plan that provides coverage for medical and surgical services must provide coverage for mental health services and prescription drugs to treat mental disorders. The co-pay or coinsurance for mental health services may be no more than the co-pay or coinsurance for medical and surgical services otherwise provided under the plan. Mental health drugs must be covered to the same extent, and under the same terms and conditions, as other prescription drugs covered by the plan.

Beginning January 1, 2008, if the plan imposes a maximum out-of-pocket limit or stop loss, it must be a single limit or stop loss for medical, surgical and mental health services.

Beginning July 1, 2010: (1) if the plan imposes any deductible, mental health services must be included with medical and surgical services for purposes of meeting the deductible requirement; and (2) treatment 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.

"Mental health services" is defined to include medically necessary services to treat any disorders listed in the current version of the diagnostic and statistical manual of mental disorders, except: (1) substance related disorders; (2) life transition problems; (3) nursing home, home health, residential treatment, and custodial care services; and (4) court ordered care that is not medically necessary.

The act applies to the Basic Health Plan, public employee plans issued by the Health Care Authority, and state regulated commercial plans for groups greater than 50.

Current laws mandating the offering of supplemental mental health coverage by carriers are amended to reflect the new requirements of the act.

The Insurance Commissioner and the administrator of the Health Care Authority are authorized to adopt rules implementing the act.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Testimony For: It is time for the distinction to end between mental and physical health. Better mental health coverage will reduce the need for other costly medical treatment. Any cost of the bill will also be more than offset by reduced employee absenteeism and increased productivity. At least 34 other states have enacted mental health parity laws, and none have been repealed. Many of those states have studied the impact of the law and determined that it resulted in only a minor impact on overall health care premiums. Mental illness has a devastating impact on individuals and families that is only made worse when treatment costs are not covered. Untreated mental illness also significantly impacts the criminal justice system. It is important that mental health be covered at similar levels by all carriers to avoid the risk of adverse selection.

Testimony Against: Mandating benefits does not help those who lose their coverage because of the increased cost of coverage. Mandates cannot be viewed in a vacuum, because their cumulative impact is what matters. Washington has one of the highest levels of mandates and regulations placed on health insurance in the country. Mandates are supposed to improve health coverage, but the actual effect is that they reduce the ability to provide coverage by increasing its costs. Others estimate the cost of this legislation to be much higher than the proponents, and comparisons to costs in other states are not accurate. Even a small percentage increase in cost means a lot in actual dollars. Mental illnesses are not like other illnesses. More mental health treatment does not lead to better mental health.

Who Testified: PRO: Representative Schual-Berke, prime sponsor; Randy Revelle, Washington Coalition for Insurance Parity; Ronald Bachman, Price Waterhouse Coopers; Greg Simon, M.D., Pam McEwan, Group Health; Chelene Alkire; Beth Berner; John Rothwell; Joanne Wilson; Colleen McManus; Terri Webster, Ben Bridge Jewelers; Peter Lukevich, Washington Partners in Crisis.

CON: Carolyn Logue, National Federation of Independent Business; Gary Smith, Independent Business Association; Sydney Smith Zvara, Association of Washington Healthcare Plans; Mellani Hughes McAleenan, Association of Washington Business; Richard Warner, Citizens Commission on Human Rights; Mel Sorenson, America's Health Insurance Plans, Washington Association of Health Underwriters.

HOUSE BILL REPORT

SHB 1154

As Passed Legislature

Title: An act relating to mental health parity.

Brief Description: Requiring that insurance coverage for mental health services be at parity with medical and surgical services.

Sponsors: By House Committee on Financial Institutions & Insurance (originally sponsored by Representatives Schual-Berke, Campbell, Kirby, Jarrett, Green, Kessler, Simpson, Clibborn, Hasegawa, Appleton, Moeller, Kagi, Ormsby, Chase, McCoy, Kilmer, Williams, O'Brien, P. Sullivan, Tom, Morrell, Fromhold, Dunshee, Lantz, McIntire, Sells, Murray, Kenney, Haigh, Darnelle, McDermott, Dickerson, Santos and Linville).

Brief History:

Committee Activity:

Financial Institutions & Insurance: 1/18/05, 1/20/05 [DPS].

Floor Activity:

Passed House: 1/28/05, 67-25.

Passed Senate: 3/3/05, 40-9.

Passed Legislature.

Brief Summary of Substitute Bill

- Requires group health insurance plans to provide the same amounts and terms of coverage for mental health services as is provided for medical and surgical services.
- Allows the mental health parity requirements to be phased-in between January 1, 2006, and July 1, 2010.
- Exempts certain types of mental health services from mandatory coverage provisions.
- Exempts groups with 50 or fewer employees from mandatory coverage. Insurers must offer optional mental health coverage to those groups.

HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS & INSURANCE

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 7 members: Representatives Kirby, Chair; Ericks, Santos, Schual-Berke, Simpson, Tom and Williams.

Minority Report: Do not pass. Signed by 2 members: Representatives Roach, Ranking Minority Member; and Serben.

Staff: Jon Hedegard (786-7127).

Background:

State law does not require health carriers to provide mental health coverage. Health carriers providing group coverage to employers are required to offer optional supplemental coverage for mental health treatment, which can be waived at the request of the employer. If a health carrier does provide mental health coverage there is no specific mandates on the level of coverage that must be provided under the group coverage.

The administrator of the Basic Health Plan (BHP) is authorized to offer mental health services under the BHP as long as those services, along with chemical dependency and organ transplant services, do not increase the actuarial value of BHP benefits by more than 5 percent. Currently, inpatient care is covered in full up to 10 days per calendar year, and outpatient care is covered in full up to 12 visits per year. These limits are not found on other hospital inpatient services. The coinsurance rate, applicability of a deductible, and maximum facility charges for mental health benefits are generally consistent with hospital inpatient service charges.

The Washington State Health Care Authority (HCA) is the state agency that administers health care benefits for low income residents through the BHP. The HCA also oversees state employee health insurance programs provided by various private health insurers (e.g., Group Health, Premera, Regence, etc.) as well as the Uniform Medical Plan.

The Office of the Insurance Commissioner (OIC) is the state agency that oversees private health insurance. There are three main categories of insuring entities or "health carriers" that offer health plans that fall under the jurisdiction of the OIC:

- Disability insurers (Chapter 48.21 RCW). An example is Aetna.
- Health care services contractors (Chapter 48.44 RCW). Examples include Premera and Regence.
- Health maintenance organizations (Chapter 48.46 RCW). An example is Group Health.

Optional supplemental mental health coverage: Generally, health carriers are required to offer optional, supplemental mental health treatment coverage to group purchasers. The coverage extends to insureds and covered dependents. The contract holder for the group can waive coverage for the group. The coverage must be offered at the "usual and customary rates for such treatment" and is subject to other specified requirements and conditions.

Diagnostic and Statistical Manual of Mental Disorders (DSM): The DSM is a manual published by the American Psychiatric Association that covers all recognized mental health disorders affecting both children and adults. It lists the factors known to cause these disorders, presents pertinent statistics, and cites research concerning optimal treatment approaches. The DSM is considered to be the standard reference for mental health professionals who make psychiatric diagnoses.

Summary of Substitute Bill:

I. OVERVIEW

The bill requires group health insurance plans with over 50 employees to provide a level of coverage for mental health services that is equal to the coverage provided for medical and surgical services. The requirements are imposed in three increments between 2006 and 2010. Once the mental health parity requirements are fully implemented in 2010, limitations on mental health services may be imposed by an insurance plan only if the same limitations are imposed on medical and surgical services.

The mental health parity requirements for each type of plan are largely identical and are subject to the same structured phase-in. This mental health parity requirement applies to five categories of group health insurance coverages:

- (1) plans administered by the HCA on behalf of state employees;
- (2) plans provided by disability insurers;
- (3) plans provided by health care services contractors;
- (4) plans provided by health maintenance organizations; and
- (5) benefits provided by Washington Basic Health Plan.

Small business exemption: Health carriers do not have to provide mental health coverage to small businesses with 50 or fewer employees. As a general rule, health carriers must make an offer of optional coverage to any group other than a group of 50 or fewer employees.

II. COVERED MENTAL HEALTH SERVICES

"Mental health services" defined: The required mental health services include medically necessary inpatient and outpatient services provided to treat mental disorders listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. The determination of whether or not a mental health service is medically necessary in a particular case is subject to the discretion of the medical director of the health plan. The medical necessity standard for mental health care must be comparable to that applied for medical and surgical services.

Exempted mental health services: There are specified types of mental health disorders and treatment categories that are exempted from coverage, including:

- disorders related to substance abuse;

- life transition problems (family/marital issues, occupational/academic problems, etc.);
- residential treatment and custodial care; and
- court ordered treatment (unless medically necessary).

III. FIVE YEAR PHASE-IN

Health coverage is generally offered for one year periods. Parity between mental health, medical, and surgical services is achieved in three phases between January 1, 2006, and July 1, 2010. Phase One begins on January 1, 2006. Phase Two begins on January 1, 2008. Phase Three begins on July 1, 2010. The phases are cumulative. The second phase incorporates the coverage requirements of the first phase. The third phase incorporates the coverage requirements of the first two phases. On July 1, 2010, all of the parity provisions will become effective.

Phase One - For health benefit plans established or renewed on or after January 1, 2006:

- (1) The copayment or coinsurance for mental health services may not exceed the copayment or coinsurance for medical/surgical services provided under the plan. *Begun in Phase One.*
- (2) Prescription drug coverage for mental health services must be covered to the same extent and under the same conditions as other prescription drug coverage in the health benefit plan. *Begun in Phase One.*

Phase Two - For health benefit plans established or renewed on or after January 1, 2008:

- (1) The copayment or coinsurance for mental health services may not exceed the copayment or coinsurance for medical/surgical services provided under the plan. *Begun in Phase One. Maintained in Phase Two.*
- (2) Prescription drug coverage for mental health services must be covered to the same extent and under the same conditions as other prescription drug coverage in the health benefit plan. *Begun in Phase One. Maintained in Phase Two.*
- (3) If the health insurance plan imposes a maximum out of pocket limit or stop loss, the same limit or stop loss must apply to medical, surgical, and mental health services. *Begun in Phase Two.*

Phase Three - For health benefit plans established or renewed on or after July 1, 2010:

- (1) The copayment or coinsurance for mental health services may not exceed the copayment or coinsurance for medical/surgical services provided under the plan. *Begun in Phase One. Maintained in Phases Two and Three.*
- (2) Prescription drug coverage for mental health services must be covered to the same extent and under the same conditions as other prescription drug coverage in the health benefit plan. *Begun in Phase One. Maintained in Phases Two and Three.*
- (3) If the health insurance plan imposes a maximum out of pocket limit or stop loss, the same limit or stop loss must apply to medical, surgical, and mental health services. *Begun in Phase Two. Maintained in Phase Three.*
- (4) If the health insurance plan imposes a deductible, it must be a single deductible covering medical, surgical, and mental health services. *Begun in Phase Three.*

5) Any treatment limitations or financial requirements must be the same for mental health, medical, or surgical services. *Begun in Phase Three.*

IV. OTHER PROVISIONS

Groups with 50 or fewer employees – Health carriers are not required to offer the mental health parity provisions set forth in the Act to groups with 50 or fewer employees. Generally, health carriers must offer optional supplemental mental health coverage to these groups. The group contract holder may waive the optional coverage for all insureds.

Rule-making authority: The Insurance Commissioner, the administrator of the State Health Care Authority, and the administrator of the Basic Health Plan are each granted authority to adopt rules necessary to implement the Act.

Appropriation: None.

Fiscal Note: Requested on January 14, 2005.

Effective Date: The bill takes effect 90 days after adjournment of session in which bill is passed.

Testimony For: The bill had bipartisan support last year. There are provisions that minimize costs, including provisions that limit treatment to where it is medically necessary and exempt small employers. We know that effective mental health treatment can lessen medical costs of care and costs to society. We commissioned an actuarial study that shows that the costs would be less than 1 percent. Societal benefits include reduced absenteeism, fewer lost work days, and reduced imprisonment. Thirty-three states have some type of mental health parity. One in five of us will suffer from a mental disorder. Most of those will not be treated or not treated adequately. One in five kids have disorders and they are even less likely to receive care. Suicide is the second leading cause of death among adolescents. The mental health recovery rate for kids exceed the recovery rate for physical illnesses. A lack of treatment can lead to lifelong problems. We need to stop the cycle where the police or justice system has to deal with mental health issues that should be addressed in our health system. The cost of imprisonment greatly exceeds the cost of care. The leading cause of hospitalization is mental illness. Insurers won't take on these risks unless compelled to do so. They are afraid of adverse selection and won't offer greater benefits so the market won't respond to the need. The bill exempts employers with less than 50 employees and individual policies. A national expert has studied the issue, he found a 1 percent gross impact and a 0.44 percent net impact. The federal government has found the impact to be about 1 percent in their employee programs. This is the right thing to do. Facilities are closing mental health units due to lack of compensation while people need more care. The costs of implementing mental health parity would be offset by the societal cost savings.

Testimony Against: We are concerned about adding an additional mandate. There are 47 mandates today. Cost estimates for parity vary widely. The study done by the advocates was

based on parity for those who have mental health coverage today. It does not factor those that have no mental health coverage today and will have to provide it under the bill. We haven't had time to analyze the fiscal impacts, but we think the cost impacts more in line with 5 percent increases or more. We are concerned about the effective date of the first phase, we would have trouble getting filings to, and approved by, the Office of the Insurance Commissioner. Purchasers want reduced or stable premiums, this will increase premiums. Increased premiums may increase the number of uninsured. Mandates add costs, there are significant mandates in Washington that add considerably to the costs of premiums. We are skeptical of the cost estimates. We are concerned about the July 1, 2005 effective date. Perhaps 15 percent of premiums are due to mandates. Many large employers self-insure, the more the state regulates health care the greater the number of large groups will choose federal regulation. Mandates increase costs, this can reduce the number of employers who can afford coverage. As mandates increase, it reduces the attractiveness of Washington as a place to do business for out of state health carriers. Cost is our concern. Employers are struggling to provide coverage. If premiums rise, employers will drop coverage.

Persons Testifying: (In support of Original Bill) Representative Schual-Berke, prime sponsor; Randy Revelle, Washington State Parity Coalition; Lucy Homans, Psychological Association; Peter Lukovich, Partners in Crisis; Kevin Glavlin-Coley, Childrens Alliance; Sean Corry, Savage Israel; Len McComb, Washington Health Authority; and Michael Dyer, Service Employees International Union 1199.

(With concerns on Original Bill) Gary Smith, Independent Business Association; and Carolyn Logue National Federation of Independent Business.

(Opposed on Original Bill) Sydney Zvara, Association of Washington Health Care Plans; Mel Sorensen, Americas Health Insurance Plans and Washington Association of Health Underwriters; and Mellani Hughes McAleenan, Association of Washington Business.

(In Support of Substitute Bill) Representative Schual-Berke, prime sponsor.

Persons Signed In To Testify But Not Testifying: None.

FINAL BILL REPORT

EHB 1460

C 8 L 07

Synopsis as Enacted

Brief Description: Extending existing mental health parity requirements to individual and small group plans.

Sponsors: By Representatives Schual-Berke, Hankins, Cody, Campbell, Morrell, Green, Dickerson, Darneille, McDermott, Jarrett, Hudgins, Moeller, Kagi, Rodne, Williams, Ormsby, Haigh, Linville, Wood, Conway, O'Brien, Hasegawa, Santos and Lantz.

House Committee on Health Care & Wellness
Senate Committee on Health & Long-Term Care

Background:

Commercial insurance policies covering more than 50 employees, state employees, and the Basic Health Plan are required to cover mental health services in a manner equal to coverage for other medical and surgical services. This mental health parity requirement first became effective January 1, 2006, with additional phased-in requirements for maximum out-of-pocket limits and a single deductible in 2008 and 2010, respectively.

Forty-eight states require some form of mental health parity for insurance coverage of mental health services or have mental health mandates of some sort. Twenty states, including Washington, provide exemptions from mental health parity requirements for some small groups. In Washington, small group policies are exempt from the required coverage, however insurance carriers are required to offer each small group optional supplemental coverage for mental health treatment.

Summary:

Effective January 1, 2008, insurance policies issued for all individuals, groups, and the Washington State Health Insurance Pool are required to include coverage for mental health services equal to coverage for other medical and surgical services. The requirement for insurance carriers to offer supplemental coverage to small groups is repealed.

Votes on Final Passage:

House	75	22
Senate	41	3

Effective: January 1, 2008

SENATE BILL REPORT EHB 1460

As Reported By Senate Committee On:
Health & Long-Term Care, March 19, 2007

Title: An act relating to extending existing mental health parity requirements to individual and small group plans.

Brief Description: Extending existing mental health parity requirements to individual and small group plans.

Sponsors: Representatives Schual-Berke, Hankins, Cody, Campbell, Morrell, Green, Dickerson, Darneille, McDermott, Jarrett, Hudgins, Moeller, Kagi, Rodne, Williams, Ormsby, Haigh, Linville, Wood, Conway, O'Brien, Hasegawa, Santos and Lantz.

Brief History: Passed House: 2/28/07, 75-22.

Committee Activity: Health & Long-Term Care: 3/19/07 [DP, DNP].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: Do pass.

Signed by Senators Keiser, Chair; Franklin, Vice Chair; Pflug, Ranking Minority Member; Fairley, Kastama, Kohl-Welles, Marr and Parlette.

Minority Report: Do not pass.

Signed by Senator Carrell.

Staff: Mich'l Needham (786-7442)

Background: The 2005 Legislature passed a mental health parity bill requiring that coverage of mental health services be equal to coverage for other medical and surgical services, for commercial insurance policies covering more than 50 employees, and for the public employees and Basic Health programs offered by the Health Care Authority. Requirements first became effective January 1, 2006, with additional phased-in requirements for maximum out-of-pocket limits, and a single deductible, in 2008 and 2010, respectively.

Currently 48 states require some form of mental health parity for insurance coverage of mental health services, or have mental health mandates of some sort. Twenty states, including Washington, provide exemptions for some small groups, variably defined as under 50, 25, 20 or 15.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

In Washington small group policies are exempt from the required coverage; however, insurance carriers are required to offer each small group optional supplemental coverage for mental health treatment.

Summary of Bill: Effective January 1, 2008, insurance policies issued for all groups and individuals are required to include coverage for mental health services equal to coverage for other medical and surgical services. Policies offered by the Washington State Health Insurance Pool (WSHIP) are modified to include mental health services as any other covered service, and specific inpatient and outpatient day limits are removed. The requirement for insurance carriers to offer supplemental coverage to small groups is repealed.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: It is time to cover mental health illness like we cover all other illnesses. The individual market has no mental health coverage at all, and this is unacceptable. Mental health coverage needs to be made available and this can only be accomplished through legislation.

CON: Mental health parity is a mandated benefit increase and it will impose an additional cost burden on small employers who struggle with the costs of health care.

Persons Testifying: PRO: Representative Shual-Berke, prime sponsor.

CON: Mellani McAleenan, Association of Washington Business.

Signed In, Unable To Testify & Submitted Written Testimony: Pam MacEwan, Group Health.

HOUSE BILL REPORT

EHB 1460

As Passed Legislature

Title: An act relating to extending existing mental health parity requirements to individual and small group plans.

Brief Description: Extending existing mental health parity requirements to individual and small group plans.

Sponsors: By Representatives Schual-Berke, Hankins, Cody, Campbell, Morrell, Green, Dickerson, Darneille, McDermott, Jarrett, Hudgins, Moeller, Kagi, Rodne, Williams, Ormsby, Haigh, Linville, Wood, Conway, O'Brien, Hasegawa, Santos and Lantz.

Brief History:

Committee Activity:

Health Care & Wellness: 2/12/07, 2/14/07 [DP].

Floor Activity:

Passed House: 2/28/07, 75-22.

Passed Senate: 3/23/07, 41-3.

Passed Legislature.

Brief Summary of Engrossed Bill

- Requires mental health parity in health plans offered in the individual and small group insurance markets.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass. Signed by 10 members: Representatives Cody, Chair; Morrell, Vice Chair; Hinkle, Ranking Minority Member; Barlow, Campbell, Green, Moeller, Pedersen, Schual-Berke and Seaquist.

Minority Report: Do not pass. Signed by 3 members: Representatives Alexander, Assistant Ranking Minority Member; Condotta and Curtis.

Staff: Dave Knutson (786-7146).

Background:

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Currently, commercial insurance policies covering more than 50 employees, state employees, and the Basic Health Plan are required to cover mental health services in a manner equal to coverage for other medical and surgical services. This mental health parity requirement first became effective January 1, 2006, with additional phased-in requirements for maximum out-of-pocket limits, and a single deductible in 2008 and 2010, respectively.

Currently, 48 states require some form of mental health parity for insurance coverage of mental health services, or have mental health mandates of some sort. Twenty states, including Washington, provide exemptions for some small groups from mental health parity requirements. In Washington, small group policies are exempt from the required coverage, however insurance carriers are required to offer each small group optional supplemental coverage for mental health treatment.

Summary of Engrossed Bill:

Effective January 1, 2008, insurance policies issued for all individuals, groups, and the Washington State Health Insurance Pool are required to include coverage for mental health services equal to coverage for other medical and surgical services. The requirement for insurance carriers to offer supplemental coverage to small groups is repealed.

Appropriation: None.

Fiscal Note: Not requested.

Effective Date: The bill takes effect on January 1, 2008.

Staff Summary of Public Testimony:

(In support) People with a mental illness should be treated the same as people with a physical illness or disability. The small increase in health insurance premiums will be offset by reductions in other publically funded services.

(Opposed) Most mental health treatment is prescription drugs, and they can harm you and keep you dependent. Increased health insurance premiums caused by this new mandate will result in fewer people being able to afford to purchase health coverage.

Persons Testifying: (In support) Randy Revelle, Washington State Coalition for Insurance Parity; Len McComb, Washington State Hospital Association; Sean Corry, Sprague Israel Giles, Incorporated; and Tamera Alkire.

(Opposed) Carole Willey, Holistic Health and Advocacy; Ruth Martin, Citizens' Commission on Human Rights; Nancee Wildermuth, Regence Blue Shield and Pacific Care; and Mel Sorenson, America's Health Insurance Plans and Washington Association of Health Underwriters.

Persons Signed In To Testify But Not Testifying: Gregory Kauffman, Advanced Restoration Company; Bill Daley, Washington Community Action Network; and Jonathan Rosenblum, Service Employees International Union.

EXHIBIT E

SENATE BILL REPORT

SB 5750

As Reported By Senate Committee On:
Health & Long-Term Care, February 22, 2007

Title: An act relating to insurance coverage for neurodevelopmental therapies.

Brief Description: Requiring coverage for neurodevelopmental therapies.

Sponsors: Senators Fairley, Regala, Fraser, Keiser, Marr, Berkey, Rasmussen, Kohl-Welles and Murray.

Brief History:

Committee Activity: Health & Long-Term Care: 2/08/07, 2/22/07 [DP, w/oRec].

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Majority Report: Do pass.

Signed by Senators Keiser, Chair; Franklin, Vice Chair; Pflug, Ranking Minority Member; Fairley, Kastama, Kohl-Welles, Marr and Parlette.

Minority Report: That it be referred without recommendation.

Signed by Senator Carrell.

Staff: Mich'l Needham (786-7442)

Background: In 1990, neurodevelopmental therapy became a mandated benefit for children age six and under, for large group policies. Neurodevelopmental disabilities relate to the development of the central nervous system or brain, and often impact motor, speech, social, and learning skills. Related therapies often include speech, occupational, and physical therapies.

Limited neurodevelopmental therapy is available in schools; however, the therapy services required by the Individuals with Disabilities Education Act are required to be educationally relevant to allow a child to participate in the educational program. They are not intended to address the more general needs of the child.

Summary of Bill: Neurodevelopmental therapies are a covered benefit for children 18 and under, for large group policies, including the policy for state employees.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: This isn't a new mandate. It is just extending the age that children are eligible for coverage. It doesn't make sense to stop serving children at age six. The school system provides very limited services and is too heavily burdened by the special needs of these children to adequately provide the range of services they need. The Department of Health sunrise review completed in 2001 recommended this coverage for all ages, with no age limitation. These types of services are provided for children if they are injured after they are born, irrespective of age, but not if the child is born with the disability.

CON: A delayed effective would allow the carriers to adjust their administrative systems.

Persons Testifying: PRO: Senator Fairley, prime sponsor; Senator Rasmussen; Leanne Roe, Citizens for the Rights of People with Disabilities (ARC) and SEIU 775; Melissa Johnson, Washington Speech and Hearing Association and Physical Therapy Association; Donna Obermeyer, Washington State Special Education Coalition.

CON: Nancee Wildermuth, Regence Blue Shield, Aetna, and PacifiCare.

SB 5750 - DIGEST

Requires coverage for neurodevelopmental therapies.

SENATE BILL 5750

State of Washington

60th Legislature

2007 Regular Session

By Senators Fairley, Regala, Fraser, Keiser, Marr, Berkey, Rasmussen, Kohl-Welles and Murray

Read first time 01/31/2007. Referred to Committee on Health & Long-Term Care.

1 AN ACT Relating to insurance coverage for neurodevelopmental
2 therapies; and amending RCW 41.05.170, 48.21.310, 48.44.450, and
3 48.46.520.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

5 **Sec. 1.** RCW 41.05.170 and 1989 c 345 s 4 are each amended to read
6 as follows:

7 (1) Each health plan offered to public employees and their covered
8 dependents under this chapter which is not subject to the provisions of
9 Title 48 RCW and is established or renewed on or after twelve months
10 after July 23, 1989, shall include coverage for neurodevelopmental
11 therapies for covered individuals age (~~six~~) eighteen and under.

12 (2) Benefits provided under this section shall cover the services
13 of those authorized to deliver occupational therapy, speech therapy,
14 and physical therapy. Benefits shall be payable only where the
15 services have been delivered pursuant to the referral and periodic
16 review of a holder of a license issued pursuant to chapter 18.71 or
17 18.57 RCW or where covered services have been rendered by such
18 licensee. Nothing in this section shall preclude a self-funded plan

1 authorized under this chapter from negotiating rates with qualified
2 providers.

3 (3) Benefits provided under this section shall be for medically
4 necessary services as determined by the self-funded plan authorized
5 under this chapter. Benefits shall be payable for services for the
6 maintenance of a covered individual in cases where significant
7 deterioration in the patient's condition would result without the
8 service. Benefits shall be payable to restore and improve function.

9 (4) It is the intent of this section that the state, as an employer
10 providing comprehensive health coverage including the benefits required
11 by this section, retains the authority to design and employ utilization
12 and cost controls. Therefore, benefits delivered under this section
13 may be subject to contractual provisions regarding deductible amounts
14 and/or copayments established by the self-funded plan authorized under
15 this chapter. Benefits provided under this section may be subject to
16 standard waiting periods for preexisting conditions, and may be subject
17 to the submission of written treatment plans.

18 (5) In recognition of the intent expressed in subsection (4) of
19 this section, benefits provided under this section may be subject to
20 contractual provisions establishing annual and/or lifetime benefit
21 limits. Such limits may define the total dollar benefits available, or
22 may limit the number of services delivered as established by the self-
23 funded plan authorized under this chapter.

24 **Sec. 2.** RCW 48.21.310 and 1989 c 345 s 2 are each amended to read
25 as follows:

26 (1) Each employer-sponsored group policy for comprehensive health
27 insurance which is entered into, or renewed, on or after twelve months
28 after July 23, 1989, shall include coverage for neurodevelopmental
29 therapies for covered individuals age (~~six~~) eighteen and under.

30 (2) Benefits provided under this section shall cover the services
31 of those authorized to deliver occupational therapy, speech therapy,
32 and physical therapy. Benefits shall be payable only where the
33 services have been delivered pursuant to the referral and periodic
34 review of a holder of a license issued pursuant to chapter 18.71 or
35 18.57 RCW or where covered services have been rendered by such
36 licensee. Nothing in this section shall prohibit an insurer from
37 negotiating rates with qualified providers.

1 (3) Benefits provided under this section shall be for medically
2 necessary services as determined by the insurer. Benefits shall be
3 payable for services for the maintenance of an insured in cases where
4 significant deterioration in the patient's condition would result
5 without the service. Benefits shall be payable to restore and improve
6 function.

7 (4) It is the intent of this section that employers purchasing
8 comprehensive health insurance, including the benefits required by this
9 section, together with the insurer, retain authority to design and
10 employ utilization and cost controls. Therefore, benefits delivered
11 under this section may be subject to contractual provisions regarding
12 deductible amounts and/or copayments established by the employer
13 purchasing insurance and the insurer. Benefits provided under this
14 section may be subject to standard waiting periods for preexisting
15 conditions, and may be subject to the submission of written treatment
16 plans.

17 (5) In recognition of the intent expressed in subsection (4) of
18 this section, benefits provided under this section may be subject to
19 contractual provisions establishing annual and/or lifetime benefit
20 limits. Such limits may define the total dollar benefits available or
21 may limit the number of services delivered as agreed by the employer
22 purchasing insurance and the insurer.

23 **Sec. 3.** RCW 48.44.450 and 1989 c 345 s 1 are each amended to read
24 as follows:

25 (1) Each employer-sponsored group contract for comprehensive health
26 care service which is entered into, or renewed, on or after twelve
27 months after July 23, 1989, shall include coverage for
28 neurodevelopmental therapies for covered individuals age ~~((six*))~~
29 eighteen and under.

30 (2) Benefits provided under this section shall cover the services
31 of those authorized to deliver occupational therapy, speech therapy,
32 and physical therapy. Benefits shall be payable only where the
33 services have been delivered pursuant to the referral and periodic
34 review of a holder of a license issued pursuant to chapter 18.71 or
35 18.57 RCW or where covered services have been rendered by such
36 licensee. Nothing in this section shall prohibit a health care service
37 contractor from requiring that covered services be delivered by a

1 provider who participates by contract with the health care service
2 contractor unless no participating provider is available to deliver
3 covered services. Nothing in this section shall prohibit a health care
4 service contractor from negotiating rates with qualified providers.

5 (3) Benefits provided under this section shall be for medically
6 necessary services as determined by the health care service contractor.
7 Benefits shall be payable for services for the maintenance of a covered
8 individual in cases where significant deterioration in the patient's
9 condition would result without the service. Benefits shall be payable
10 to restore and improve function.

11 (4) It is the intent of this section that employers purchasing
12 comprehensive group coverage including the benefits required by this
13 section, together with the health care service contractor, retain
14 authority to design and employ utilization and cost controls.
15 Therefore, benefits delivered under this section may be subject to
16 contractual provisions regarding deductible amounts and/or copayments
17 established by the employer purchasing coverage and the health care
18 service contractor. Benefits provided under this section may be
19 subject to standard waiting periods for preexisting conditions, and may
20 be subject to the submission of written treatment plans.

21 (5) In recognition of the intent expressed in subsection (4) of
22 this section, benefits provided under this section may be subject to
23 contractual provisions establishing annual and/or lifetime benefit
24 limits. Such limits may define the total dollar benefits available or
25 may limit the number of services delivered as agreed by the employer
26 purchasing coverage and the health care service contractor.

27 **Sec. 4.** RCW 48.46.520 and 1989 c 345 s 3 are each amended to read
28 as follows:

29 (1) Each employer-sponsored group contract for comprehensive health
30 care service which is entered into, or renewed, on or after twelve
31 months after July 23, 1989, shall include coverage for
32 neurodevelopmental therapies for covered individuals age (~~six~~)
33 eighteen and under.

34 (2) Benefits provided under this section shall cover the services
35 of those authorized to deliver occupational therapy, speech therapy,
36 and physical therapy. Covered benefits and treatment must be rendered
37 or referred by the health maintenance organization, and delivered

1 pursuant to the referral and periodic review of a holder of a license
2 issued pursuant to chapter 18.71 or 18.57 RCW or where treatment is
3 rendered by such licensee. Nothing in this section shall prohibit a
4 health maintenance organization from negotiating rates with qualified
5 providers.

6 (3) Benefits provided under this section shall be for medically
7 necessary services as determined by the health maintenance
8 organization. Benefits shall be provided for the maintenance of a
9 covered enrollee in cases where significant deterioration in the
10 patient's condition would result without the service. Benefits shall
11 be provided to restore and improve function.

12 (4) It is the intent of this section that employers purchasing
13 comprehensive group coverage including the benefits required by this
14 section, together with the health maintenance organization, retain
15 authority to design and employ utilization and cost controls.
16 Therefore, benefits provided under this section may be subject to
17 contractual provisions regarding deductible amounts and/or copayments
18 established by the employer purchasing coverage and the health
19 maintenance organization. Benefits provided under this section may be
20 subject to standard waiting periods for preexisting conditions, and may
21 be subject to the submission of written treatment plans.

22 (5) In recognition of the intent expressed in subsection (4) of
23 this section, benefits provided under this section may be subject to
24 contractual provisions establishing annual and/or lifetime benefit
25 limits. Such limits may define the total dollar benefits available, or
26 may limit the number of services delivered as agreed by the employer
27 purchasing coverage and the health maintenance organization.

--- END ---

EXHIBIT F

SB 5756 - DIGEST

[Expands insurance coverage of neurodevelopmental
therapies.]

EXHIBIT F

SENATE BILL 5756

State of Washington 62nd Legislature 2011 Regular Session
By Senators Hobbs, Keiser, and Kline

Read first time 02/10/11. Referred to Committee on Health & Long-Term Care.

1 AN ACT Relating to expanding insurance coverage of
2 neurodevelopmental therapies; amending RCW 48.21.310, 48.44.450,
3 48.46.520, and 41.05.170; and providing an effective date.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

5 **Sec. 1.** RCW 48.21.310 and 1989 c 345 s 2 are each amended to read
6 as follows:

7 (1) Each employer-sponsored group policy for comprehensive health
8 insurance which is entered into, or renewed, on or after ((~~twelve~~
9 ~~months after July 23, 1989~~)) January 1, 2012, shall include coverage
10 for neurodevelopmental therapies for covered individuals age ((~~six~~)
11 eighteen and under.

12 (2) Benefits provided under this section shall cover the services
13 of those authorized to deliver occupational therapy, speech therapy,
14 and physical therapy. Benefits shall be payable only where the
15 services have been delivered pursuant to the referral and periodic
16 review of a holder of a license issued pursuant to chapter 18.71 or
17 18.57 RCW or where covered services have been rendered by such
18 licensee. Nothing in this section shall prohibit an insurer from
19 negotiating rates with qualified providers.

1 (3) Benefits provided under this section shall be for medically
2 necessary services as determined by the insurer. Benefits shall be
3 payable for services for the maintenance of an insured in cases where
4 significant deterioration in the patient's condition would result
5 without the service. Benefits shall be payable to restore and improve
6 function.

7 (4) It is the intent of this section that employers purchasing
8 comprehensive health insurance, including the benefits required by this
9 section, together with the insurer, retain authority to design and
10 employ utilization and cost controls. Therefore, benefits delivered
11 under this section may be subject to contractual provisions regarding
12 deductible amounts and/or copayments established by the employer
13 purchasing insurance and the insurer. Benefits provided under this
14 section may be subject to standard waiting periods for preexisting
15 conditions, and may be subject to the submission of written treatment
16 plans.

17 (5) In recognition of the intent expressed in subsection (4) of
18 this section, benefits provided under this section may be subject to
19 contractual provisions establishing annual and/or lifetime benefit
20 limits. Such limits may define the total dollar benefits available or
21 may limit the number of services delivered as agreed by the employer
22 purchasing insurance and the insurer.

23 **Sec. 2.** RCW 48.44.450 and 1989 c 345 s 1 are each amended to read
24 as follows:

25 (1) Each employer-sponsored group contract for comprehensive health
26 care service which is entered into, or renewed, on or after (~~twelve~~
27 ~~months after July 23, 1989~~) January 1, 2012, shall include coverage
28 for neurodevelopmental therapies for covered individuals age (~~six~~)
29 eighteen and under.

30 (2) Benefits provided under this section shall cover the services
31 of those authorized to deliver occupational therapy, speech therapy,
32 and physical therapy. Benefits shall be payable only where the
33 services have been delivered pursuant to the referral and periodic
34 review of a holder of a license issued pursuant to chapter 18.71 or
35 18.57 RCW or where covered services have been rendered by such
36 licensee. Nothing in this section shall prohibit a health care service
37 contractor from requiring that covered services be delivered by a

1 provider who participates by contract with the health care service
2 contractor unless no participating provider is available to deliver
3 covered services. Nothing in this section shall prohibit a health care
4 service contractor from negotiating rates with qualified providers.

5 (3) Benefits provided under this section shall be for medically
6 necessary services as determined by the health care service contractor.
7 Benefits shall be payable for services for the maintenance of a covered
8 individual in cases where significant deterioration in the patient's
9 condition would result without the service. Benefits shall be payable
10 to restore and improve function.

11 (4) It is the intent of this section that employers purchasing
12 comprehensive group coverage including the benefits required by this
13 section, together with the health care service contractor, retain
14 authority to design and employ utilization and cost controls.
15 Therefore, benefits delivered under this section may be subject to
16 contractual provisions regarding deductible amounts and/or copayments
17 established by the employer purchasing coverage and the health care
18 service contractor. Benefits provided under this section may be
19 subject to standard waiting periods for preexisting conditions, and may
20 be subject to the submission of written treatment plans.

21 (5) In recognition of the intent expressed in subsection (4) of
22 this section, benefits provided under this section may be subject to
23 contractual provisions establishing annual and/or lifetime benefit
24 limits. Such limits may define the total dollar benefits available or
25 may limit the number of services delivered as agreed by the employer
26 purchasing coverage and the health care service contractor.

27 **Sec. 3.** RCW 48.46.520 and 1989 c 345 s 3 are each amended to read
28 as follows:

29 (1) Each employer-sponsored group contract for comprehensive health
30 care service which is entered into, or renewed, on or after (~~twelve~~
31 ~~months after July 23, 1989~~) January 1, 2012, shall include coverage
32 for neurodevelopmental therapies for covered individuals age (~~six~~)
33 eighteen and under.

34 (2) Benefits provided under this section shall cover the services
35 of those authorized to deliver occupational therapy, speech therapy,
36 and physical therapy. Covered benefits and treatment must be rendered
37 or referred by the health maintenance organization, and delivered

1 pursuant to the referral and periodic review of a holder of a license
2 issued pursuant to chapter 18.71 or 18.57 RCW or where treatment is
3 rendered by such licensee. Nothing in this section shall prohibit a
4 health maintenance organization from negotiating rates with qualified
5 providers.

6 (3) Benefits provided under this section shall be for medically
7 necessary services as determined by the health maintenance
8 organization. Benefits shall be provided for the maintenance of a
9 covered enrollee in cases where significant deterioration in the
10 patient's condition would result without the service. Benefits shall
11 be provided to restore and improve function.

12 (4) It is the intent of this section that employers purchasing
13 comprehensive group coverage including the benefits required by this
14 section, together with the health maintenance organization, retain
15 authority to design and employ utilization and cost controls.
16 Therefore, benefits provided under this section may be subject to
17 contractual provisions regarding deductible amounts and/or copayments
18 established by the employer purchasing coverage and the health
19 maintenance organization. Benefits provided under this section may be
20 subject to standard waiting periods for preexisting conditions, and may
21 be subject to the submission of written treatment plans.

22 (5) In recognition of the intent expressed in subsection (4) of
23 this section, benefits provided under this section may be subject to
24 contractual provisions establishing annual and/or lifetime benefit
25 limits. Such limits may define the total dollar benefits available, or
26 may limit the number of services delivered as agreed by the employer
27 purchasing coverage and the health maintenance organization.

28 **Sec. 4.** RCW 41.05.170 and 1989 c 345 s 4 are each amended to read
29 as follows:

30 (1) Each health plan offered to public employees and their covered
31 dependents under this chapter which is not subject to the provisions of
32 Title 48 RCW and is established or renewed on or after (~~twelve months~~
33 ~~after July 23, 1989~~) January 1, 2012, shall include coverage for
34 neurodevelopmental therapies for covered individuals age (~~six~~)
35 eighteen and under.

36 (2) Benefits provided under this section shall cover the services
37 of those authorized to deliver occupational therapy, speech therapy,

1 and physical therapy. Benefits shall be payable only where the
2 services have been delivered pursuant to the referral and periodic
3 review of a holder of a license issued pursuant to chapter 18.71 or
4 18.57 RCW or where covered services have been rendered by such
5 licensee. Nothing in this section shall preclude a self-funded plan
6 authorized under this chapter from negotiating rates with qualified
7 providers.

8 (3) Benefits provided under this section shall be for medically
9 necessary services as determined by the self-funded plan authorized
10 under this chapter. Benefits shall be payable for services for the
11 maintenance of a covered individual in cases where significant
12 deterioration in the patient's condition would result without the
13 service. Benefits shall be payable to restore and improve function.

14 (4) It is the intent of this section that the state, as an employer
15 providing comprehensive health coverage including the benefits required
16 by this section, retains the authority to design and employ utilization
17 and cost controls. Therefore, benefits delivered under this section
18 may be subject to contractual provisions regarding deductible amounts
19 and/or copayments established by the self-funded plan authorized under
20 this chapter. Benefits provided under this section may be subject to
21 standard waiting periods for preexisting conditions, and may be subject
22 to the submission of written treatment plans.

23 (5) In recognition of the intent expressed in subsection (4) of
24 this section, benefits provided under this section may be subject to
25 contractual provisions establishing annual and/or lifetime benefit
26 limits. Such limits may define the total dollar benefits available, or
27 may limit the number of services delivered as established by the self-
28 funded plan authorized under this chapter.

29 NEW SECTION. **Sec. 5.** This act takes effect January 1, 2012.

--- END ---

EXHIBIT G

HOUSE BILL REPORT

HB 1412

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to health benefit plan coverage of neurodevelopmental therapies.

Brief Description: Concerning health benefit plan coverage of neurodevelopmental therapies.

Sponsors: Representatives Kagi, Roach, Cody, Roberts, Dickerson, Appleton, Walsh, Green, Hunt, Seaquist, Chase, Morrell, Kessler, Kenney, Simpson and Nelson.

Brief History:

Committee Activity:

Health Care & Wellness: 2/5/09, 2/13/09 [DPS].

Brief Summary of Substitute Bill

- Expands the neurodevelopmental therapy mandate that applies to the Public Employees Benefit Board health programs and group health plans.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 8 members: Representatives Cody, Chair; Driscoll, Vice Chair; Green, Hinkle, Kelley, Moeller, Morrell and Pedersen.

Minority Report: Do not pass. Signed by 3 members: Representatives Ericksen, Ranking Minority Member; Bailey and Herrera.

Staff: Dave Knutson (786-7146)

Background:

Autism is an Autism Spectrum Disorder (ASD) which causes developmental disabilities and numerous social, behavioral, and physical challenges. Individuals with ASD often display unusual behaviors and interests, unusual ways of learning and paying attention, and impaired verbal and non-verbal communication skills. In addition to these behavioral symptoms,

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

individuals with ASD will often have physical ailments such as asthma, digestive disorders, persistent viral infections, and epilepsy.

Signs and symptoms of ASD begin before age three and last throughout life. The ASD occurs in all racial, ethnic, and socioeconomic groups, but is four times more likely to occur in boys than girls. According to a study done by the Centers for Disease Control and Prevention (CDC), one in 150 8-year-olds in the United States had an ASD in 2007. Currently, there is no cure for ASD, but early detection and treatment can greatly improve symptoms and development.

Significant debate exists over the causes of ASD. Scientists believe that both genes and environment play a role in the development of ASD, noting that environmental factors may trigger the expression of certain genes.

Recently, several federal actions have been taken in response to the rising rates of ASD. In 2007 the Expanding the Promise for Individuals with Autism Act was introduced, which provided approximately \$83 million in Fiscal Year 2008 to improve access to comprehensive treatments, interventions, and services for individuals with ASD and their families. In 2006 the Combating Autism Act was enacted, which provides almost \$1 billion over five years for ASD and developmental disabilities research, screening, treatment, and education. The 2000 Children's Health Act established the National Center on Birth Defects and Developmental Disabilities at the CDC and authorized the establishment of Centers of Excellence at both the CDC and the National Institutes of Health to promote research and monitoring efforts related to causes, diagnosis, early detection, prevention, and treatment of ASD.

In response to the growing number of individuals with ASD, states have taken action to address the needs of these individuals. Several states have developed task forces or commissions to further study ASD issues. California created the California Legislative Blue Ribbon Commission on Autism with the goal of addressing the needs of children and adults with ASD. Other states have utilized Home and Community-Based Waivers to make Medicaid funds available to assist individuals with ASD. At least 10 states specifically require insurers to provide coverage for the treatment of ASD. Eight states enacted such legislation during the 2007-2008 legislative session: Arizona, Connecticut, Florida, Illinois, Louisiana, Pennsylvania, South Carolina, and Texas. In addition, some states may require limited coverage for ASD under their mental health parity laws. Massachusetts enacted legislation in 2008 to specify that ASD shall be covered under their mental health parity laws on a nondiscriminatory basis.

The existing statutory health insurance mandate for neurodevelopmental therapies covers physical therapy, occupational therapy, and speech therapy for children up to age six.

The Department of Health (DOH) was requested to conduct a Sunrise review of an ASD insurance mandate that applied to the individual and group health insurance markets in July 2008. The DOH Sunrise review recommended the Legislature not enact the proposed legislation and instead:

1. expand the existing neurodevelopmental therapy mandate to:
 - require increased coverage amounts;

- require the coverage of an Applied Behavior Analysis (ABA) when performed by or under the supervision of nationally certified providers;
- raise or eliminate the age limit for benefits – currently, benefits under this mandate end at age 7; and
- match services currently available to low-income children on Medicaid.

2. expand or clarify the mental health parity mandate to include treatment for ASD.

Summary of Substitute Bill:

The existing neurodevelopmental therapy health insurance mandate that applies to the Public Employees Benefit Board and group health plans is expanded to cover children up to age 18. The mandate will cover ABA treatment and other treatments of developmental disabilities or delays. Carriers are authorized to set reasonable medical necessity criteria, apply the same deductibles, coinsurance and copayments that apply to other covered services, and ensure the treatment plan complements other neurodevelopmental services a child receives through the publicly funded programs.

An annual cap of \$50,000 is applied to covered neurodevelopmental therapies. The relationship between this mandate and the federal Individuals with Disabilities Education Act statute is clarified. If services are provided to a covered child by a school through an Individual Education Plan, the health plan does not have to duplicate those services.

The Department of Health is directed to identify and review evidence-based treatments for Autism Spectrum Disorder every two years and to conduct a Sunrise review to determine the most appropriate method to regulate ABA providers.

Substitute Bill Compared to Original Bill:

The substitute bill clarifies that the mandate is up to age 18 for both Public Employees Benefit Board and private coverage. Treatment plans must be individualized, must be based upon a comprehensive evaluation of the child, and can be reviewed more frequently than quarterly. The original bill limited review to no more frequently than quarterly.

The substitute bill also removes “restore” from the purposes of neurodevelopmental therapies, i.e., and now includes therapies are to improve and to prevent deterioration in functioning. Clarifies the relationship between this mandate and the federal Individuals with Disabilities Education Act statute.

Neurodevelopmental therapy services are limited to \$50,000 per year. Neurodevelopmental therapy benefits can be subject to any cumulative annual or lifetime benefit limits for all services provided under the health plan. Rather than a one-time review to identify evidence-based treatments for children with Autism Spectrum Disorder, the substitute bill makes the Department of Health review a biannual activity so that new evidence can be taken into consideration.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Substitute Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed, except for Section 6, relating to the repeal of the existing neurodevelopmental therapies mandate, which takes effect January 1, 2011.

Staff Summary of Public Testimony:

(In support) This is a reasonable, limited expansion of an existing neurodevelopmental therapy mandate. Children need this treatment up through their 18th birthday to help them succeed in school and in life.

(Opposed) The bill does not go far enough. It should provide coverage for up to \$50,000 per year in Autism Spectrum Disorder (ASD) therapy for children. A child needs Applied Behavior Analysis treatment beginning as soon as they are diagnosed with ASD.

Persons Testifying: (In support) Representative Kagi, prime sponsor; Betsy McAlister, King County Parent Coalition; Patty Gee, Autism Society of Washington; Elaine Aemantrout, Physical Therapy Association of Washington; Pam Mullens, Dynamic Family Services; Kathy Stewart, Occupational Therapy of Washington State; Scott Plack, Group Health; Sydney Smith Zvarra, Association of Washington Health Care Plans; Linda Glas; Felice Orlich, Seattle Children's Hospital; Sandy Dempsey; Carrie Fannin; and Dawn Sidell, Northwest Autism Center.

(Opposed) Arzu Forough, Autism Speaks; and Ethan Pruett, Wyatt Holliday Foundation.

Persons Signed In To Testify But Not Testifying: None.

HB 1412-S - DIGEST

(DIGEST OF PROPOSED 1ST SUBSTITUTE)

Finds that access to appropriate early intervention services significantly improves function in children with developmental delays and developmental disabilities. Health care services, including neurodevelopmental therapies, are an essential component of early intervention services.

Requires each health plan offered to public employees and their covered dependents under chapter 41.05 RCW that is established or renewed on or after January 1, 2011, to include coverage for neurodevelopmental therapies for covered individuals under eighteen years of age.

Requires all group health benefit plans entered into, or renewed, on or after January 1, 2011, to include coverage for neurodevelopmental therapies for covered individuals under eighteen years of age.

Directs the department of health to: (1) Conduct a review under chapter 18.120 RCW (regulation of health professions-- criteria) to determine the most appropriate means to regulate persons who utilize applied behavior analysis for the treatment of persons with an autism spectrum disorder; and

(2) Establish a process to periodically review credible sources of scientific evidence related to effective therapies for treatment of individuals under eighteen years of age with autism spectrum disorder.

H-1910.1

SUBSTITUTE HOUSE BILL 1412

State of Washington

61st Legislature

2009 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Kagi, Roach, Cody, Roberts, Dickerson, Appleton, Walsh, Green, Hunt, Seaquist, Chase, Morrell, Kessler, Kenney, Simpson, and Nelson)

READ FIRST TIME 02/17/09.

1 AN ACT Relating to health benefit plan coverage of
2 neurodevelopmental therapies; adding a new section to chapter 41.05
3 RCW; adding a new section to chapter 48.43 RCW; creating new sections;
4 repealing RCW 41.05.170, 48.21.310, 48.44.450, and 48.46.520; and
5 providing an effective date.

6 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

7 NEW SECTION. **Sec. 1.** The legislature finds that:

8 (1) Access to appropriate early intervention services significantly
9 improves function in children with developmental delays and
10 developmental disabilities. Health care services, including
11 neurodevelopmental therapies, are an essential component of early
12 intervention services.

13 (2) The provision of early intervention services is a shared
14 responsibility of federal and state government, private health
15 insurance, state purchased health care programs, and schools.

16 (3) The existing neurodevelopmental therapy benefit is unreasonably
17 limited, in light of the nature of the diagnoses that
18 neurodevelopmental services are used to treat. Children with medical
19 disorders that result in developmental delays or developmental

1 disabilities have an ongoing need for appropriate neurodevelopmental
2 services that are designed to improve and maintain their ability to
3 function and to prevent deterioration in functioning. The provision of
4 appropriate health care interventions, such as neurodevelopmental
5 therapies, to treat these disorders significantly and positively
6 affects a child's ability to function in an age-appropriate manner.
7 Research demonstrates that the timing of the provision of these
8 interventions is critical to a child's ability to function and the
9 failure to intervene at a meaningful point in a child's development can
10 result in a lost opportunity that cannot be fully compensated for
11 later.

12 NEW SECTION. **Sec. 2.** A new section is added to chapter 41.05 RCW
13 to read as follows:

14 (1) Each health plan offered to public employees and their covered
15 dependents under this chapter that is established or renewed on or
16 after January 1, 2011, must include coverage for neurodevelopmental
17 therapies for covered individuals under eighteen years of age.

18 (2) As used in this section:

19 (a) "Neurodevelopmental therapies" means occupational therapy,
20 speech therapy, physical therapy, applied behavior analysis, and other
21 therapies for the treatment of developmental delays, developmental
22 disabilities, or developmental disorders that are consistent with
23 generally accepted standards of practice, as defined in subsection (5)
24 of this section.

25 (b) "Applied behavior analysis" means the design, implementation,
26 and evaluation of therapeutic programs, using behavioral stimuli and
27 consequences, to produce socially significant improvement in human
28 behavior, including the use of direct observation, measurement, and
29 functional analysis of the relationship between social or learning
30 environment and behavior.

31 (3) Neurodevelopmental therapy benefits are payable when the
32 services have been delivered or supervised by a health professional
33 regulated under Title 18 RCW, pursuant to an individualized written
34 treatment plan developed by a health care provider licensed under
35 chapter 18.71 or 18.57 RCW, or when covered services have been rendered
36 by such licensee. The treatment plan must be developed based upon the
37 results of a comprehensive evaluation or periodic reevaluation of the

1 child. A carrier may require that the treatment plan be reviewed
2 periodically. A carrier may require that neurodevelopmental therapy
3 services be delivered by a health care provider who participates in the
4 carrier's provider network, unless no participating provider is
5 available to deliver covered services. Nothing in this section
6 prohibits a carrier from negotiating rates with qualified providers.

7 (4) The treatment plan should complement and not duplicate any
8 other neurodevelopmental services that a child is receiving through
9 publicly funded programs, including special education. Services that
10 are being provided by a school district to a child through an
11 individual education plan under the federal individuals with
12 disabilities education act do not have to be provided to the child
13 under this section. However, consistent with part C of the federal
14 individuals with disabilities education act, for early intervention
15 services provided to children birth to three years of age, a child's
16 health insurance coverage must be considered the primary payer.

17 (5) Benefits are payable for services to improve age-appropriate
18 functioning, and for maintenance of function in cases where significant
19 deterioration in the child's condition would result without the
20 service. Deductibles, copayments, or coinsurance for neurodevelopmental
21 services may be no more than the deductible, copayment, or coinsurance
22 for other medical services otherwise provided under the health plan.
23 Neurodevelopmental therapy coverage under this section is subject to a
24 maximum benefit of fifty thousand dollars per year. Coverage under
25 this section also may be subject to health benefit plan provisions
26 establishing cumulative annual or lifetime benefit limits for all
27 services provided under the health benefit plan.

28 (6) In determining whether services are medically necessary, the
29 health plan may use reasonable criteria that are in accordance with
30 generally accepted standards of practice, and are clinically
31 appropriate, giving strong consideration to the diagnoses for which
32 neurodevelopmental therapies are prescribed for children, the ongoing
33 nature of such diagnoses, and the use of neurodevelopmental therapy
34 services to improve and prevent deterioration in functioning. As used
35 in this subsection, "generally accepted standards of practice" means
36 standards that are based on credible scientific evidence published in
37 peer-reviewed medical literature generally recognized by the relevant
38 medical community, evidence-based clinical guidelines developed by

1 relevant physician or health care practitioner specialty societies, or
2 other clinical guidelines that are supported by multiple site random
3 controlled trials or other credible research demonstrating that the
4 therapy is effective.

5 NEW SECTION. **Sec. 3.** A new section is added to chapter 48.43 RCW
6 to read as follows:

7 (1) All group health benefit plans entered into, or renewed, on or
8 after January 1, 2011, must include coverage for neurodevelopmental
9 therapies for covered individuals under eighteen years of age.

10 (2) As used in this section:

11 (a) "Neurodevelopmental therapies" means occupational therapy,
12 speech therapy, physical therapy, applied behavior analysis, and other
13 therapies for the treatment of developmental delays, developmental
14 disabilities, or developmental disorders that are consistent with
15 generally accepted standards of practice, as defined in subsection (5)
16 of this section.

17 (b) "Applied behavior analysis" means the design, implementation,
18 and evaluation of therapeutic programs, using behavioral stimuli and
19 consequences, to produce socially significant improvement in human
20 behavior, including the use of direct observation, measurement, and
21 functional analysis of the relationship between the social or learning
22 environment and behavior.

23 (3) Neurodevelopmental therapy benefits are payable when the
24 services have been delivered or supervised by a health professional
25 regulated under Title 18 RCW, pursuant to an individualized written
26 treatment plan developed by a health care provider licensed under
27 chapter 18.71 or 18.57 RCW, or when covered services have been rendered
28 by such licensee. The treatment plan must be developed based upon the
29 results of a comprehensive evaluation or periodic reevaluation of the
30 child. A carrier may require that the treatment plan be reviewed
31 periodically. A carrier may require that neurodevelopmental therapy
32 services be delivered by a health care provider who participates in the
33 carrier's provider network, unless no participating provider is
34 available to deliver covered services. Nothing in this section
35 prohibits a carrier from negotiating rates with qualified providers.

36 (4) The treatment plan should complement and not duplicate any
37 other neurodevelopmental services that a child is receiving through

1 publicly funded programs, including special education. Services that
2 are being provided by a school district to a child through an
3 individual education plan under the federal individuals with
4 disabilities education act do not have to be provided to the child
5 under this section. However, consistent with part C of the federal
6 individuals with disabilities education act, for early intervention
7 services provided to children birth to three years of age, a child's
8 health insurance coverage must be considered the primary payer.

9 (5) Benefits shall be payable for services to restore and improve
10 age-appropriate functioning and for maintenance of function in cases
11 where significant deterioration in the child's condition would result
12 without the service. Deductibles, copayments, or coinsurance for
13 neurodevelopmental services may be no more than the deductible,
14 copayment, or coinsurance for other medical services otherwise provided
15 under the health benefit plan. Neurodevelopmental therapy coverage
16 under this section is subject to a maximum benefit of fifty thousand
17 dollars per year. Coverage under this section also may be subject to
18 health benefit plan provisions establishing cumulative annual or
19 lifetime benefit limits for all services provided under the health
20 benefit plan.

21 (6) In determining whether services are medically necessary, the
22 carrier may use reasonable criteria that are in accordance with
23 generally accepted standards of practice, and are clinically
24 appropriate, giving strong consideration to the diagnoses for which
25 neurodevelopmental therapies are prescribed for children, the ongoing
26 nature of such diagnoses, and the use of neurodevelopmental therapy
27 services to improve and prevent deterioration in functioning. As used
28 in this subsection, "generally accepted standards of practice" means
29 standards that are based on credible scientific evidence published in
30 peer-reviewed medical literature generally recognized by the relevant
31 medical community, evidence-based clinical guidelines developed by
32 relevant physician or health care practitioner specialty societies, or
33 other clinical guidelines that are supported by multiple site random
34 controlled trials or other credible research demonstrating that the
35 therapy is effective.

36 NEW SECTION. **Sec. 4.** The department of health shall conduct a
37 review under chapter 18.120 RCW to determine the most appropriate means

1 to regulate persons who utilize applied behavior analysis for the
2 treatment of persons with an autism spectrum disorder. The review
3 should address, at a minimum, whether applied behavior analysis
4 providers should be regulated through establishment of a new health
5 profession or through establishment of a new classification within an
6 existing health profession, and appropriate education and experience
7 requirements. In determining appropriate education and experience
8 requirements, the department shall give great weight to the
9 certification criteria established by the institute for applied
10 behavior analysis. In developing its recommendations, the department
11 shall consult with interested organizations. The department must
12 submit its recommendations to the governor and the legislature on or
13 before November 15, 2009.

14 NEW SECTION. **Sec. 5.** The department of health shall establish a
15 process to periodically review credible sources of scientific evidence
16 related to effective therapies for treatment of individuals under
17 eighteen years of age with autism spectrum disorder. The results of
18 the review will identify treatment modalities that should be considered
19 to be in accordance with generally accepted standards of practice, as
20 that term is defined in section 2(6) and section 3(6) of this act. The
21 review shall be conducted with substantial involvement of individuals
22 with medical expertise in this field, and with consultation from
23 health care providers, autism researchers, family members of persons
24 with autism spectrum disorders, carriers, the department of social and
25 health services, the health care authority, educators, and other
26 interested persons. The department must report its findings to the
27 governor and the legislature by November 15, 2009, and on a biannual
28 basis thereafter.

29 NEW SECTION. **Sec. 6.** The following acts or parts of acts are each
30 repealed:
31 (1) RCW 41.05.170 (Neurodevelopmental therapies--Employer-sponsored
32 group contracts) and 1989 c 345 s 4;
33 (2) RCW 48.21.310 (Neurodevelopmental therapies--Employer-sponsored
34 group contracts) and 1989 c 345 s 2;
35 (3) RCW 48.44.450 (Neurodevelopmental therapies--Employer-sponsored
36 group contracts) and 1989 c 345 s 1; and

1 (4) RCW 48.46.520 (Neurodevelopmental therapies--Employer-sponsored
2 group contracts) and 1989 c 345 s 3.

3 NEW SECTION. **Sec. 7.** Section 6 of this act takes effect January
4 1, 2011.

--- END ---

EXHIBIT H

SENATE BILL REPORT

SB 5203

As of January 29, 2009

Title: An act relating to insurance coverage for autism spectrum disorders.

Brief Description: Regarding insurance coverage for autism spectrum disorders.

Sponsors: Senators Hobbs, Pflug, Fairley, Haugen, Swecker, Rockefeller, Tom, Marr, Pridemore, King, Delvin, Murray, Kohl-Welles, Regala, McAuliffe, McDermott, Kastama, Becker, Kline, Jarrett, Oemig, Brown, Kauffman, Fraser, Shin, Parlette, Kilmer, Brandland and Roach.

Brief History:

Committee Activity: Health & Long-Term Care: 1/28/09.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Staff: Mich'l Needham (786-7442)

Background: The 1997 Legislature modified the statutory requirements for review of all mandated health insurance benefits. Proposals for additional mandated benefits are subject to a "sunrise review" to be completed by the Department of Health (DOH). Each proposal must be evaluated with criteria established in law that include an assessment of the social impact, the financial impact, and evidence of health care service efficacy.

DOH received a request to complete a sunrise review of a mandated benefit for the treatment of autism spectrum disorders. The final report is available, with a recommendation that the Legislature not enact the proposal. The benefit proposal is reflective of some interest expressed by the Caring for Washington Individuals with Autism Task Force, which issued recommendations in December 2006. The Autism Task Force and the DOH sunrise review recognize autism spectrum disorders as pervasive developmental disorders with a wide range and severity of symptoms. Autism spectrum disorders affect as many as one in 150 children nationally, and three to four times more boys than girls. Treatment can include psychiatric care, neurodevelopmental therapies such as occupational therapy, physical therapy and speech therapy, and treatment for co-occurring medical conditions. Treatment is often not covered or very limited in most insurance plans. Current insurance mandates require neurodevelopmental therapies in group coverage offered through a regulated carrier, with limited coverage for children up through age six.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Summary of Bill: Insurance carriers and health plans offered through the Public Employees Benefits Board program must cover the diagnosis and treatment of autism spectrum disorders for individuals less than 21 years of age. Autism spectrum disorders are defined to mean any of the pervasive developmental disorders defined by the most recent edition of the diagnostic and statistical manual of mental disorders. Coverage must include all medically necessary care which is defined to include any care, treatment, intervention, service, or item that is prescribed, provided, or ordered by a licensed physician or licensed psychologist. Treatment is defined to include any care prescribed, ordered, or provided by a licensed physician or licensed psychologist, including applied behavior analysis and other structured behavior programs, pharmacy care, psychiatric care, psychological care, therapeutic care, and any care determined to be medically necessary in rules developed by DOH.

The coverage may have no limits on the number of provider visits, but is subject to a maximum of \$50,000 per year. The limitations are not to impact those benefits available under the mandated mental health benefits. The Insurance Commissioner must adjust the benefit maximum annually for inflation using the medical care component of the United States Department of Labor consumer price index for all urban consumers.

Insurance carriers have the right to request a review of the treatment no more than every six months, except for inpatient services.

DOH must adopt rules establishing standards for qualified autism services providers. Once rules are adopted, payment for the treatment of autism spectrum disorders can be made only to autism service providers who meet the standards.

Appropriation: None.

Fiscal Note: Not requested.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: The limited coverage available today cuts children off at age seven, leaving them no chance to achieve their maximum ability. The impacts of autism create a societal impact that is bigger than our state budget, that leave long-term effects on society. The burden is largely placed on our school districts today and they are not health providers. Autism is a medical condition and requires an appropriate response in the health care arena.

Early intervention for autism is very important, and makes a tremendous difference in skill development and potential for these children. Autism requires a multidisciplinary approach, and years of research and journal articles have documented the success of applied behavioral therapy. Insurance carriers should not be denying this therapy as experimental. It is time to bring these treatments we know work to people that need them. Evidence suggests that the applied behavioral therapy is more effective than the traditional neurodevelopmental therapies: speech, physical therapy, and occupational therapy. Fifty percent of children who

have received applied behavioral therapy are indistinguishable from other children by first grade; the early intervention makes a difference.

The lack of coverage for these treatments is discriminatory. Coverage should be similar to coverage for other medical conditions. Coverage would also improve the provider capacity and access to providers. There is a national board that certifies providers, the independent Behavior Analyst Certification Board. This national certification is appropriate for Washington providers, in fact there are 63 nationally board certified analysts in Washington now.

Applied behavioral therapy has no Current Procedural Terminology (CPT) code associated with it, but there is coverage and payment approved for psychotherapy, talk therapy with less evidence of effectiveness. Schools should not be expected to provide the behavioral therapy; teachers are not behavioral therapists and they do not have the necessary time to spend with each child.

OTHER: Insurance carriers already provide coverage for some of these services under two mandated benefits, the neurodevelopmental therapies and the mental health parity requirements. An approach in the House that broadens the neurodevelopmental therapies is a clearer approach. The bill is very broad as to the type of services and quantity of services to be covered, and the type of person that can provide services. Operationally, there is a challenge because there is no CPT code associated with applied behavioral therapy.

Persons Testifying: PRO: Senator Hobbs, prime sponsor; Arzu Forough, parent advocate; Dr. Bryan King, Children's Hospital; Dawn Sidell, Northwest Autism Center; Michael Fabrizio, Families for Effective Treatment of Autism; Laila Praino, child with autism; Denise Fulton, Autism Research Institute; Bryan Krikorian, attorney and parent; Lorri Unumb, Autism Speaks; Ethan Pruett, Angela Fish, Wyatt Holliday Foundation; Dale and Connor Pryor, parent and son; Patty Gee, Autism Society of Washington; Teresa Mundel, Dr. Yi Cau, Brandelyn Bergstedt, parents; Beth Shubert, Washington Autism Advocacy.

OTHER: Mel Sorenson, America's Health Insurance Plans; Sydney Zvarra, Association of Washington Healthcare Plans.

Signed In, Unable to Testify & Submitted Written Testimony: PRO: Leslie Emerick, Tamra Warnke, Association of Advanced Practice Psychiatric Nurses; Dr. Gary Stobbe, Autism Spectrum Treatment and Research; Janelle Hall, Patricia Solano-Fah, parents.

SB 5203 - DIGEST

Requires each health plan offered to public employees and their covered dependents under chapter 41.05 RCW which is not subject to the provisions of Title 48 RCW to include coverage for the diagnosis of autism spectrum disorders and treatment of autism spectrum disorders in individuals less than twenty-one years of age.

Requires each health plan offered to the public under chapter 48.21, 48.44, or 48.46 RCW to include coverage for the diagnosis of autism spectrum disorders and treatment of autism spectrum disorders in individuals less than twenty-one years of age.

SENATE BILL 5203

State of Washington 61st Legislature 2009 Regular Session

By Senators Hobbs, Pflug, Fairley, Haugen, Swecker, Rockefeller, Tom, Marr, Pridemore, King, Delvin, Murray, Kohl-Welles, Regala, McAuliffe, McDermott, Kastama, Becker, Kline, Jarrett, Oemig, Brown, Kauffman, Fraser, Shin, Parlette, Kilmer, Brandland, and Roach

Read first time 01/16/09. Referred to Committee on Health & Long-Term Care.

1 AN ACT Relating to insurance coverage for autism spectrum
2 disorders; adding a new section to chapter 41.05 RCW; and adding a new
3 section to chapter 48.43 RCW.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

5 NEW SECTION. **Sec. 1.** A new section is added to chapter 41.05 RCW
6 to read as follows:

7 (1) As used in this section:

8 (a) "Applied behavior analysis" means the design, implementation,
9 and evaluation of environmental modifications, using behavioral stimuli
10 and consequences, to produce socially significant improvement in human
11 behavior, including the use of direct observation, measurement, and
12 functional analysis of the relationship between environment and
13 behavior.

14 (b) "Autism services provider" means a person, entity, or group
15 providing treatment for autism spectrum disorders pursuant to a
16 treatment plan.

17 (c) "Autism spectrum disorders" means any of the pervasive
18 developmental disorders as defined by the most recent edition of the

1 diagnostic and statistical manual of mental disorders, including
2 autistic disorder, Asperger's disorder, and pervasive developmental
3 disorder not otherwise specified.

4 (d) "Diagnosis of autism spectrum disorders" means medically
5 necessary assessments, evaluations, or tests to diagnose whether an
6 individual has one of the autism spectrum disorders.

7 (e) "Medically necessary" means any care, treatment, intervention,
8 service, or item that is prescribed, provided, or ordered by a licensed
9 physician or a licensed psychologist that will, or is reasonably
10 expected to, do any of the following:

11 (i) Prevent the onset of an illness, condition, injury, or
12 disability;

13 (ii) Reduce or ameliorate the physical, mental, or developmental
14 effects of an illness, condition, injury, or disability; or

15 (iii) Assist to achieve or maintain maximum functional capacity in
16 performing daily activities, taking into account both the functional
17 capacity of the individual and the functional capacities that are
18 appropriate for individuals of the same age.

19 (f) "Pharmacy care" means medications prescribed by a licensed
20 physician and any health-related services deemed medically necessary to
21 determine the need or effectiveness of the medications.

22 (g) "Psychiatric care" means direct or consultative services
23 provided by a psychiatrist licensed in the state in which the
24 psychiatrist practices.

25 (h) "Psychological care" means direct or consultative services
26 provided by a psychologist licensed in the state in which the
27 psychologist practices.

28 (i) "Therapeutic care" means direct or consultative services
29 provided by a speech therapist, occupational therapist, or physical
30 therapist licensed or certified in the state in which the therapist
31 practices.

32 (j) "Treatment of autism spectrum disorders" includes the following
33 care prescribed, ordered, or provided by a licensed physician or
34 licensed psychologist who determines the care to be medically
35 necessary:

36 (i) Applied behavior analysis and other structured behavior
37 programs;

38 (ii) Pharmacy care;

- 1 (iii) Psychiatric care;
- 2 (iv) Psychological care;
- 3 (v) Therapeutic care;

4 (vi) Any care for individuals with autism spectrum disorders that
5 is determined by the state health department, based upon its review of
6 best practices or evidence-based research, may be medically necessary
7 and that is published in the Washington State Register. Any such care,
8 treatment, intervention, service, or item that was not previously
9 covered will be included in any health insurance policy delivered,
10 executed, issued, amended, adjusted, or renewed on or after sixty days
11 following the date of its publication in the Washington State Register.

12 (k) "Treatment plan" means a plan for the treatment of autism
13 spectrum disorders developed by a licensed physician or licensed
14 psychologist pursuant to a comprehensive evaluation or reevaluation
15 performed in a manner consistent with the most recent clinical report
16 or recommendations of the American academy of pediatrics.

17 (2) Each health plan offered to public employees and their covered
18 dependents under this chapter which is not subject to the provisions of
19 Title 48 RCW must include coverage for the diagnosis of autism spectrum
20 disorders and treatment of autism spectrum disorders in individuals
21 less than twenty-one years of age. To the extent that the diagnosis of
22 autism spectrum disorders and the treatment of autism spectrum
23 disorders are not already covered by a health insurance policy,
24 coverage under this section will be included in health insurance
25 policies that are delivered, executed, issued, amended, adjusted, or
26 renewed on or after the effective date of this section. No insurer can
27 terminate coverage, or refuse to deliver, execute, issue, amend,
28 adjust, or renew coverage to an individual solely because the
29 individual is diagnosed with one of the autism spectrum disorders or
30 has received treatment for autism spectrum disorders.

31 (3) Coverage under this section will not be subject to any limits
32 on the number of visits an individual may make to an autism services
33 provider.

34 (4) Coverage under this section may be subject to copayment,
35 deductible, and coinsurance provisions of a health insurance policy to
36 the extent that other medical services covered by the health insurance
37 policy are subject to these provisions.

1 (5) This section will not be construed as limiting benefits that
2 are otherwise available to an individual under a health insurance
3 policy, including benefits available under RCW 48.44.341, 48.21.241,
4 and 48.46.291.

5 (6) Coverage under this section will be subject to a maximum
6 benefit of fifty thousand dollars per year. After July 31, 2010, the
7 insurance commissioner will, on an annual basis, adjust the maximum
8 benefit for inflation by using the medical care component of the United
9 States department of labor consumer price index for all urban
10 consumers. The commissioner will submit the adjusted maximum benefit
11 for publication annually no later than October of each calendar year,
12 and the published adjusted maximum benefit will be applicable in the
13 following calendar year to health insurance policies subject to this
14 section. Payments made by an insurer on behalf of a covered individual
15 for any care, treatment, intervention, service, or item unrelated to
16 autism spectrum disorders will not be applied towards any maximum
17 benefit established under this section.

18 (7) Except for inpatient services, if an individual is receiving
19 treatment for autism spectrum disorders, an insurer will have the right
20 to request a review of that treatment not more than once every six
21 months unless the insurer and the individual's licensed physician or
22 licensed psychologist agrees that a more frequent review is necessary.
23 The cost of obtaining any review will be borne by the insurer.

24 (8) The department of health will adopt rules establishing
25 standards for qualified autism services providers. Once the rules are
26 adopted, payment for the treatment of autism spectrum disorders covered
27 under this section will be made only to autism service providers who
28 meet the standards.

29 NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW
30 to read as follows:

31 (1) As used in this section:

32 (a) "Applied behavior analysis" means the design, implementation,
33 and evaluation of environmental modifications, using behavioral stimuli
34 and consequences, to produce socially significant improvement in human
35 behavior, including the use of direct observation, measurement, and
36 functional analysis of the relationship between environment and
37 behavior.

1 (b) "Autism services provider" means a person, entity, or group
2 providing treatment for autism spectrum disorders pursuant to a
3 treatment plan.

4 (c) "Autism spectrum disorders" means any of the pervasive
5 developmental disorders as defined by the most recent edition of the
6 diagnostic and statistical manual of mental disorders, including
7 autistic disorder, Asperger's disorder, and pervasive developmental
8 disorder not otherwise specified.

9 (d) "Diagnosis of autism spectrum disorders" means medically
10 necessary assessments, evaluations, or tests to diagnose whether an
11 individual has one of the autism spectrum disorders.

12 (e) "Medically necessary" means any care, treatment, intervention,
13 service, or item that is prescribed, provided, or ordered by a licensed
14 physician or a licensed psychologist that will, or is reasonably
15 expected to, do any of the following:

16 (i) Prevent the onset of an illness, condition, injury, or
17 disability;

18 (ii) Reduce or ameliorate the physical, mental, or developmental
19 effects of an illness, condition, injury, or disability; or

20 (iii) Assist to achieve or maintain maximum functional capacity in
21 performing daily activities, taking into account both the functional
22 capacity of the individual and the functional capacities that are
23 appropriate for individuals of the same age.

24 (f) "Pharmacy care" means medications prescribed by a licensed
25 physician and any health-related services deemed medically necessary to
26 determine the need or effectiveness of the medications.

27 (g) "Psychiatric care" means direct or consultative services
28 provided by a psychiatrist licensed in the state in which the
29 psychiatrist practices.

30 (h) "Psychological care" means direct or consultative services
31 provided by a psychologist licensed in the state in which the
32 psychologist practices.

33 (i) "Therapeutic care" means direct or consultative services
34 provided by a speech therapist, occupational therapist, or physical
35 therapist licensed or certified in the state in which the therapist
36 practices.

37 (j) "Treatment of autism spectrum disorders" includes the following

1 care prescribed, ordered, or provided by a licensed physician or
2 licensed psychologist who determines the care to be medically
3 necessary:

4 (i) Applied behavior analysis and other structured behavior
5 programs;

6 (ii) Pharmacy care;

7 (iii) Psychiatric care;

8 (iv) Psychological care;

9 (v) Therapeutic care;

10 (vi) Any care for individuals with autism spectrum disorders that
11 is determined by the state health department, based upon its review of
12 best practices or evidence-based research, may be medically necessary
13 and that is published in the Washington State Register. Any such care,
14 treatment, intervention, service, or item that was not previously
15 covered will be included in any health insurance policy delivered,
16 executed, issued, amended, adjusted, or renewed on or after sixty days
17 following the date of its publication in the Washington State Register.

18 (k) "Treatment plan" means a plan for the treatment of autism
19 spectrum disorders developed by a licensed physician or licensed
20 psychologist pursuant to a comprehensive evaluation or reevaluation
21 performed in a manner consistent with the most recent clinical report
22 or recommendations of the American academy of pediatrics.

23 (2) Each health plan offered to the public under chapter 48.21,
24 48.44, or 48.46 RCW must include coverage for the diagnosis of autism
25 spectrum disorders and treatment of autism spectrum disorders in
26 individuals less than twenty-one years of age. To the extent that the
27 diagnosis of autism spectrum disorders and the treatment of autism
28 spectrum disorders are not already covered by a health insurance
29 policy, coverage under this section will be included in health
30 insurance policies that are delivered, executed, issued, amended,
31 adjusted, or renewed on or after the effective date of this section.
32 No insurer can terminate coverage, or refuse to deliver, execute,
33 issue, amend, adjust, or renew coverage to an individual solely because
34 the individual is diagnosed with one of the autism spectrum disorders
35 or has received treatment for autism spectrum disorders.

36 (3) Coverage under this section will not be subject to any limits
37 on the number of visits an individual may make to an autism services
38 provider.

1 (4) Coverage under this section may be subject to copayment,
2 deductible, and coinsurance provisions of a health insurance policy to
3 the extent that other medical services covered by the health insurance
4 policy are subject to these provisions.

5 (5) This section will not be construed as limiting benefits that
6 are otherwise available to an individual under a health insurance
7 policy, including benefits available under RCW 48.44.341, 48.21.241,
8 and 48.46.291.

9 (6) Coverage under this section will be subject to a maximum
10 benefit of fifty thousand dollars per year. After July 31, 2010, the
11 insurance commissioner will, on an annual basis, adjust the maximum
12 benefit for inflation by using the medical care component of the United
13 States department of labor consumer price index for all urban
14 consumers. The commissioner will submit the adjusted maximum benefit
15 for publication annually no later than October of each calendar year,
16 and the published adjusted maximum benefit will be applicable in the
17 following calendar year to health insurance policies subject to this
18 section. Payments made by an insurer on behalf of a covered individual
19 for any care, treatment, intervention, service, or item unrelated to
20 autism spectrum disorders will not be applied towards any maximum
21 benefit established under this section.

22 (7) Except for inpatient services, if an individual is receiving
23 treatment for autism spectrum disorders, an insurer will have the right
24 to request a review of that treatment not more than once every six
25 months unless the insurer and the individual's licensed physician or
26 licensed psychologist agrees that a more frequent review is necessary.
27 The cost of obtaining any review will be borne by the insurer.

28 (8) The department of health will adopt rules establishing
29 standards for qualified autism services providers. Once the rules are
30 adopted, payment for the treatment of autism spectrum disorders covered
31 under this section will be made only to autism service providers who
32 meet the standards.

--- END ---

EXHIBIT I

SENATE BILL REPORT

SB 5059

As of January 25, 2011

Title: An act relating to insurance coverage for autism spectrum disorders.

Brief Description: Regarding insurance coverage for autism spectrum disorders.

Sponsors: Senators Murray, Pflug, Brown, Kastama, Rockefeller, Shin, Hobbs, Delvin, Conway, Chase, Regala, Kline, Haugen, Kohl-Welles, Pridemore, Tom, Fraser, White, McAuliffe and Kilmer.

Brief History:

Committee Activity: Health & Long-Term Care: 1/24/11.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Staff: Mich'l Needham (786-7442)

Background: Autism spectrum disorders are pervasive developmental disorders with a wide range of severity of symptoms. Autism spectrum disorders affect as many as one in 150 children nationally, and three to four times more boys than girls. Treatment can include psychiatric care; neurodevelopmental therapies such as occupational therapy, physical therapy and speech therapy; and treatment for co-occurring medical conditions. Early intensive behavioral intervention or applied behavioral analysis can produce substantial benefits for many children with autism spectrum disorders.

Treatment for the full range of services required is often not covered or limited in most insurance plans. Current state insurance mandates require group policies to cover neurodevelopmental therapies up through age six. Mental health parity requirements for individual and group insurance policies can be limited, and do not generally include applied behavioral analysis.

There are some state services and programs provided for persons with developmental disabilities offered through the Department of Social and Health Services Aging and Disability Services Administration. Autism is included in the statutory definition of a developmental disability. The scope of services provided through the department includes a wide range of services to assist persons with acquiring life skills, and raising the level of physical, mental, social, and vocational functioning. Services can include education, training for employment, and therapies including behavior management. Access to services is

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

restricted by availability of funding, except for access to institutional services, and there is an extensive waiting list for state services.

State statute requires a review of all mandated health insurance benefits, called sunrise reviews to be completed by the Department of Health (DOH). Each proposal for additional mandated benefits must be evaluated with criteria established in law that include an assessment of the social impact, the financial impact, and evidence of health care service efficacy. The DOH completed a sunrise review of a proposal for treatment of autism spectrum disorders in 2008, published in January 2009, recommending not to enact the proposal.

Summary of Bill: All health plans issued by licensed insurance carriers, and self-insured plans offered under the Public Employees Benefits Board (PEBB) program, must include coverage for the diagnosis and treatment of autism spectrum disorders. Coverage must be included in contracts issued or renewed on or after the effective date of the act.

Treatment for autism spectrum disorders includes care and equipment prescribed or ordered by a licensed physician or licensed psychologist, and may include but is not limited to behavioral health treatment, pharmacy care, psychiatric care, therapeutic care, and any care that is demonstrated to be medically necessary. Medically necessary is defined to include a service that may prevent the onset of an illness, condition, injury, or disability; reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or assist in achieving or maintaining maximum functional capacity in performing daily activities.

The benefit plan must not impose limits on the number of visits an individual may make with an autism services provider. Coverage may not be denied on the basis that it is non-restorative, educational, or custodial in nature. Copayments, co-insurance, or deductible amounts must be the same as other cost-sharing provisions in the benefit package. The benefits may not otherwise limit those available under the mental health parity requirements.

Insurance carriers may request a review of the treatment plan no more than every 12 months, unless the insurer and the individual's licensed physician or licensed psychologist agree that a more frequent review is necessary. The cost of the review must be borne by the insurer.

The act shall be known as Shayan's law, an act extending coverage for autism spectrum disorders.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: Autism treatment in this country costs families thousands of dollars. Applied behavior analysis (ABA) can cost in the range of \$50,000 per

year, but children without appropriate treatment and early intervention cost millions over their lifetimes. The prevalence of autism is increasing rapidly, with a tsunami of autism impacts coming. Twenty-three states have adopted some legislation expanding coverage for autism spectrum disorders. Access to the ABA is the key to success for these children. Expanding insurance coverage to include the ABA will save states money with special education budgets and state programs for persons with developmental delays – it will shift costs to private insurance. Although insurance should cover autism services today, most insurance policies exclude autism treatments as habilitative or educational in nature and not fitting within the medical necessity guidelines used today. Expanding the insurance coverage for the full scope of treatment that the children need would help shift costs from school districts. We would not need to sue school districts to provide the extensive special educational supports these children need. You've already endorsed the policy of providing coverage, with the passage of mental health parity laws. Now we need to stand up to insurance companies to re-direct their interpretation of the coverage allowed under these laws. It is not right that there is such a disparity between the haves and have nots – those able to afford the 25 to 40 hours of ABA treatment per week see very different results and opportunities than families that cannot afford the treatment.

CON: The principle concern is the cost impact of a new mandate that is as open as this – there are no limits for the services that must be provided, the bill creates a new autism services provider and it is unclear who certifies or licenses such providers, and the bill expands the current definition of medical necessity beyond any existing medical codes to include custodial and educational services. Adding these services to insurance policies will shift costs to all enrollees that purchase insurance, at a time when many are struggling to maintain coverage that continues to have significant price increases. There may also be a concern with expanding mandates benefits, while the federal essential health benefits are being defined. State mandated benefits above and beyond the essential health benefits will need to be for paid by the state when the new federal requirements are put in place.

OTHER: We think there needs to be more clarity in the language around the providers that can form a treatment plan to ensure the bill does not exclude the continuing use of other provider types that are successfully providing treatment to children with autism, including speech and hearing therapists, physical therapists, and social workers.

Persons Testifying: **PRO:** Senator Murray, prime sponsor; Lorri Unumb, Autism Speaks; Arzu Forough, Washington Autism Alliance; Adam Fah for Dr. Bryan King, Seattle Children's Autism Center; Kathy George, Harrison, Benis and Spence law firm; Bill Krueger for Dr. Stobbe, Seattle Children's Autism Center; Channel Krueger, student; Jill Karsh, parent; Phillip Hall, parent.

CON: Mel Sorensen, American's Health Insurance Plans; Sydney Smith Zvara, Association of Washington Healthcare Plans.

OTHER: Melissa Johnson, Physical Therapy Association and Washington Speech and Hearing Association; Bob Cooper, National Association of Social Workers.

SB 5059 - DIGEST

Extends insurance coverage for autism spectrum disorders.

SENATE BILL 5059

State of Washington 62nd Legislature 2011 Regular Session

By Senators Murray, Pflug, Brown, Kastama, Rockefeller, Shin, Hobbs, Delvin, Conway, Chase, Regala, Kline, Haugen, Kohl-Welles, Pridemore, Tom, Fraser, White, McAuliffe, and Kilmer

Read first time 01/12/11. Referred to Committee on Health & Long-Term Care.

1 AN ACT Relating to insurance coverage for autism spectrum
2 disorders; adding a new section to chapter 41.05 RCW; adding a new
3 section to chapter 48.43 RCW; and creating a new section.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

5 NEW SECTION. **Sec. 1.** This act may be known and cited as Shayan's
6 law, an act extending coverage for autism spectrum disorders.

7 NEW SECTION. **Sec. 2.** A new section is added to chapter 41.05 RCW
8 to read as follows:

9 (1) As used in this section:

10 (a) "Applied behavior analysis" means the design, implementation,
11 and evaluation of environmental modifications, using behavioral stimuli
12 and consequences, to produce socially significant improvement in human
13 behavior, including the use of direct observation, measurement, and
14 functional analysis of the relationship between environment and
15 behavior.

16 (b) "Autism services provider" means any licensed or certified
17 person, entity, or group providing treatment for autism spectrum
18 disorders.

1 (c) "Autism spectrum disorders" means any of the pervasive
2 developmental disorders as defined by the most recent edition of the
3 diagnostic and statistical manual of mental disorders, including
4 autistic disorder, Asperger's disorder, and pervasive developmental
5 disorder not otherwise specified.

6 (d) "Diagnosis of autism spectrum disorders" means medically
7 necessary assessments, evaluations, or tests to diagnose whether an
8 individual has one of the autism spectrum disorders.

9 (e) "Habilitative or rehabilitative care" means professional,
10 counseling, and guidance services and treatment programs, including
11 applied behavior analysis, that are necessary to develop, maintain, and
12 restore, to the maximum extent practicable, the functioning of an
13 individual.

14 (f) "Medically necessary" means reasonably expected to do any of
15 the following:

16 (i) Prevent the onset of an illness, condition, injury, or
17 disability;

18 (ii) Reduce or ameliorate the physical, mental, or developmental
19 effects of an illness, condition, injury, or disability; or

20 (iii) Assist to achieve or maintain maximum functional capacity in
21 performing daily activities, taking into account both the functional
22 capacity of the individual and the functional capacities that are
23 appropriate for individuals of the same age.

24 (g) "Pharmacy care" means medications prescribed by a licensed
25 physician and any health-related services deemed medically necessary to
26 determine the need or effectiveness of the medications.

27 (h) "Psychiatric care" means direct or consultative services
28 provided by a psychiatrist licensed in the state in which the
29 psychiatrist practices.

30 (i) "Psychological care" means direct or consultative services
31 provided by a psychologist licensed in the state in which the
32 psychologist practices.

33 (j) "Therapeutic care" means direct or consultative services
34 provided by a speech therapist, occupational therapist, or physical
35 therapist licensed or certified in the state in which the therapist
36 practices.

37 (k) "Treatment of autism spectrum disorders" means care and

1 equipment prescribed or ordered by a licensed physician or licensed
2 psychologist who determines the care to be medically necessary,
3 including, but not limited to:

- 4 (i) Behavioral health treatment;
- 5 (ii) Pharmacy care;
- 6 (iii) Psychiatric care;
- 7 (iv) Psychological care;
- 8 (v) Therapeutic care;

9 (vi) Any care for individuals with autism spectrum disorders that
10 is demonstrated, based upon best practices or evidence-based research,
11 to be medically necessary.

12 (1) "Treatment plan" means a plan for the treatment of autism
13 spectrum disorders developed by a licensed physician or licensed
14 psychologist pursuant to a comprehensive evaluation or reevaluation
15 performed in a manner consistent with the most recent clinical report
16 or recommendations of the American academy of pediatrics.

17 (2) Each health plan offered to public employees and their covered
18 dependents under this chapter which is not subject to the provisions of
19 Title 48 RCW must include coverage for the diagnosis of autism spectrum
20 disorders and treatment of autism spectrum disorders. To the extent
21 that the diagnosis of autism spectrum disorders and the treatment of
22 autism spectrum disorders are not already covered by a health insurance
23 policy, coverage under this section must be included in health
24 insurance policies that are delivered, executed, issued, amended,
25 adjusted, or renewed on or after the effective date of this section.
26 No insurer can terminate coverage, or refuse to deliver, execute,
27 issue, amend, adjust, or renew coverage to an individual solely because
28 the individual is diagnosed with one of the autism spectrum disorders
29 or has received treatment for autism spectrum disorders.

30 (3) Coverage under this section is not subject to any limits on the
31 number of visits an individual may make to an autism services provider.

32 (4) Coverage under this section may not be denied on the basis that
33 the treatment is nonrestorative, educational, or custodial in nature.

34 (5) Coverage under this section may be subject to copayment,
35 deductible, and coinsurance provisions of a health insurance policy to
36 the extent that other medical services covered by the health insurance
37 policy are subject to these provisions.

1 (6) This section may not be construed as limiting benefits that are
2 otherwise available to an individual under a health insurance policy,
3 including benefits available under RCW 48.21.241, 48.44.341, and
4 48.46.291.

5 (7) Except for inpatient services, if an individual is receiving
6 treatment for autism spectrum disorders, an insurer has the right to
7 request a review of that treatment not more than once every twelve
8 months unless the insurer and the individual's licensed physician or
9 licensed psychologist agree, on an individual basis, that a more
10 frequent review is necessary. The cost of obtaining any review must be
11 borne by the insurer.

12 NEW SECTION. **Sec. 3.** A new section is added to chapter 48.43 RCW
13 to read as follows:

14 (1) As used in this section:

15 (a) "Applied behavior analysis" means the design, implementation,
16 and evaluation of environmental modifications, using behavioral stimuli
17 and consequences, to produce socially significant improvement in human
18 behavior, including the use of direct observation, measurement, and
19 functional analysis of the relationship between environment and
20 behavior.

21 (b) "Autism services provider" means any licensed or certified
22 person, entity, or group providing treatment for autism spectrum
23 disorders.

24 (c) "Autism spectrum disorders" means any of the pervasive
25 developmental disorders as defined by the most recent edition of the
26 diagnostic and statistical manual of mental disorders, including
27 autistic disorder, Asperger's disorder, and pervasive developmental
28 disorder not otherwise specified.

29 (d) "Diagnosis of autism spectrum disorders" means medically
30 necessary assessments, evaluations, or tests to diagnose whether an
31 individual has one of the autism spectrum disorders.

32 (e) "Habilitative or rehabilitative care" means professional,
33 counseling, and guidance services and treatment programs, including
34 applied behavior analysis, that are necessary to develop, maintain, and
35 restore, to the maximum extent practicable, the functioning of an
36 individual.

1 (f) "Medically necessary" means reasonably expected to do any of
2 the following:

3 (i) Prevent the onset of an illness, condition, injury, or
4 disability;

5 (ii) Reduce or ameliorate the physical, mental, or developmental
6 effects of an illness, condition, injury, or disability; or

7 (iii) Assist to achieve or maintain maximum functional capacity in
8 performing daily activities, taking into account both the functional
9 capacity of the individual and the functional capacities that are
10 appropriate for individuals of the same age.

11 (g) "Pharmacy care" means medications prescribed by a licensed
12 physician and any health-related services deemed medically necessary to
13 determine the need or effectiveness of the medications.

14 (h) "Psychiatric care" means direct or consultative services
15 provided by a psychiatrist licensed in the state in which the
16 psychiatrist practices.

17 (i) "Psychological care" means direct or consultative services
18 provided by a psychologist licensed in the state in which the
19 psychologist practices.

20 (j) "Therapeutic care" means direct or consultative services
21 provided by a speech therapist, occupational therapist, or physical
22 therapist licensed or certified in the state in which the therapist
23 practices.

24 (k) "Treatment of autism spectrum disorders" means care and
25 equipment prescribed or ordered by a licensed physician or licensed
26 psychologist who determines the care to be medically necessary,
27 including, but not limited to:

28 (i) Behavioral health treatment;

29 (ii) Pharmacy care;

30 (iii) Psychiatric care;

31 (iv) Psychological care;

32 (v) Therapeutic care;

33 (vi) Any care for individuals with autism spectrum disorders that
34 is demonstrated, based upon best practices or evidence-based research,
35 to be medically necessary.

36 (l) "Treatment plan" means a plan for the treatment of autism
37 spectrum disorders developed by a licensed physician or licensed

1 psychologist pursuant to a comprehensive evaluation or reevaluation
2 performed in a manner consistent with the most recent clinical report
3 or recommendations of the American academy of pediatrics.

4 (2) Each health plan offered to the public under chapter 48.21,
5 48.44, or 48.46 RCW must include coverage for the diagnosis of autism
6 spectrum disorders and treatment of autism spectrum disorders. To the
7 extent that the diagnosis of autism spectrum disorders and the
8 treatment of autism spectrum disorders are not already covered by a
9 health insurance policy, coverage under this section must be included
10 in health insurance policies that are delivered, executed, issued,
11 amended, adjusted, or renewed on or after the effective date of this
12 section. No insurer can terminate coverage, or refuse to deliver,
13 execute, issue, amend, adjust, or renew coverage to an individual
14 solely because the individual is diagnosed with one of the autism
15 spectrum disorders or has received treatment for autism spectrum
16 disorders.

17 (3) Coverage under this section is not subject to any limits on the
18 number of visits an individual may make to an autism services provider.

19 (4) Coverage under this section may not be denied on the basis that
20 the treatment is nonrestorative, educational, or custodial in nature.

21 (5) Coverage under this section may be subject to copayment,
22 deductible, and coinsurance provisions of a health insurance policy to
23 the extent that other medical services covered by the health insurance
24 policy are subject to these provisions.

25 (6) This section may not be construed as limiting benefits that are
26 otherwise available to an individual under a health insurance policy,
27 including benefits available under RCW 48.21.241, 48.44.341, and
28 48.46.291.

29 (7) Except for inpatient services, if an individual is receiving
30 treatment for autism spectrum disorders, an insurer has the right to
31 request a review of that treatment not more than once every twelve
32 months unless the insurer and the individual's licensed physician or
33 licensed psychologist agree, on an individual basis, that a more
34 frequent review is necessary. The cost of obtaining any review must be
35 borne by the insurer.

--- END ---

EXHIBIT J

**Caring for
Washington
Individuals
With Autism Task Force**

Report to the Governor and the Legislature

December 2006

EXHIBIT J

Caring for Washington Individuals With Autism

December 2006

For more information
or additional copies of this report
email: autism.support@doh.wa.gov
or call (360) 236-3571

For people with disabilities, this document is available
on request in other formats. To submit a request, please
call 1-800-525-0127 (TDD/TTY 1-800-833-6388).



DOH 970-144

existing, and approving state insurance coverage for early intervention.

F-3

Implement legislation that requires health insurance coverage of evidence-based interventions and services for individuals with ASD across the lifespan.

Families have to go through much time and effort to have important, evidence-based, necessary therapies and devices approved for their children with ASD. Multi-disciplinary therapies and interventions for adults with ASD are even harder to obtain, and yet they are needed to support the individual with ASD in continuing to develop important life skills and remain a functioning, productive member of the community. Mental health services are a critical element of health care. Employer-based private health insurance plans are generally inadequate in terms of financing ASD services or mental health services, although in Washington a few such plans have recently been created as a result of employer interest and support. Many private insurance companies cover neurodevelopmental therapies only through age six, and ASD is often excluded from coverage because it is considered by insurance plans to be a non-medical condition that should be handled by the educational system.

F-4

Fund community-based organizations that provide culturally effective parent and family support and resource information to families of individuals with ASD.

Families need access to culturally effective family-centered resources, support, and information. Talking with other families continues to be a critical way to get information and support. Individuals with ASD and their siblings and other family members benefit immensely from community supports such as the Autism Society of Washington and its chapters, parent coalitions, Families for Early Autism Treatment (FEAT), Parent to Parent, Fathers Network, Ethnic Outreach Coordinators, cultural brokers, and grass roots autism and family support groups. Partnerships with parent and family support groups and involvement of families in decision making are key aspects of treatment and

EXHIBIT K

Caring for Washington Individuals with Autism Task Force

Report to Governor and Legislature
Priority Recommendations and Implementation Plans

December 2007

EXHIBIT K

Caring for Washington Individuals with Autism

December 2007

For more information or additional copies of this report email:
autism.support@doh.wa.gov or call (360) 236-3571.

For people with disabilities, this document is available on request in
other formats. To submit a request, please call 1-800-525-0127
(TDD/TTY 1-800-833-6388).



DOH 970-143

Chapter 4

Priority Recommendation 1

Ensure all individuals with ASD receive comprehensive health services and coverage within a Medical Home.

Cost Estimates

Estimating costs for mandated insurance benefits would require a Sunrise Review by the Department of Health (48.47.030 RCW).¹⁷ The Caring for Washington Individuals with Autism Task Force will continue to explore the activities described in Objective 2 to increase access to medical homes for individuals with ASD and identify any related costs in the future.

Justification

The ATF chose to make mandating insurance benefits its first priority recommendation. Transforming the way insurance carriers include autism and related conditions within health insurance policy will significantly affect access for the majority of individuals with an autism spectrum or related disorder in our state.

Children with autism commonly have a range of medical conditions for which they need treatment.¹⁸ Nationally, 22 states have successfully mandated insurance coverage for evidence based intervention services that benefit children with autism.¹⁹ There is no mandate for insurance coverage within Washington State. Only four major private insurers in Washington offer any coverage for comprehensive services for children with autism. Only Microsoft, one of the four, is broad in benefit coverage. This could be a model for the state and industry. Many families have no coverage for needed services. This places families under tremendous financial burdens and strain to provide adequate care for their children. The Council for Affordable Health Insurance, in a 2007 report reviewing 10 states mandating insurance coverage, find the incremental cost of mandated benefits for autism at less than one percent.²⁰

¹⁷ Sunrise Review Process. Mandated Health Insurance Benefits. Washington State Department of Health. Accessed November 9, 2007 <http://www.doh.wa.gov/hsqa/sunrise/mandated.htm>

¹⁸ Gurney, J. G., McPheeters, M. L., Davis, M. M. *Parental Report of Health Conditions and Health Care Use Among Children With and Without Autism*. National Survey of Children's Health. *Archives of Pediatrics & Adolescent Medicine*. 2006; Vol. 160: pp. 825-830. Accessed November 21, 2007 from <http://archpedi.ama-assn.org/cgi/content/full/160/8/825>

¹⁹ Steering Committee Legislative Information, Appendix 4f)

²⁰ Bunce, V. C., Wieske, J. P., Prikazsky, V. *Health Insurance Mandates in the States, 2007*. Council for Affordable Health Insurance. Accessed November 21, 2007 from www.cahi.org

Appropriate, financially feasible services are not accessible for many individuals and families within their communities. Barriers to health care access include specific exclusions for autism diagnosis by many private health insurance plans,²¹ no coverage for Applied Behavioral Analysis (ABA) and other autism—related services,²² or denial of coverage for behavioral interventions by licensed PhD clinical psychologists or Board Certified Behavior Analysts (BCBA). All of these barriers contribute to access of care.

Wait-lists in the greater Seattle area typically exceed 6 months. Many families in our state have no access to services. To ensure that all individuals with autism and related conditions receive appropriate, accessible, and affordable services within their communities, insurance coverage for evidenced-based practices, including but not limited to, early intensive behavioral intervention is critical.

The task force believes that everyone deserves to have access to health care that follows sound evidence-based practices, and that the struggle for equality and recognition of autism and appropriate treatment will take both time and effort. Establishing good health policy takes thoughtful and considerate action to accomplish. As such, the task force recognizes that other priority recommendations such as training providers on new screening tools regarding autism may be more immediately attainable. These other steps are important for raising awareness and will help in the developing comprehensive health policy.

Implementation Plan

Objective 1: Improve Insurance Coverage for Individuals with ASD

1. Extend insurance benefits to cover interventions for individuals with ASD.
 - a. Consult with individuals from states such as South Carolina and Pennsylvania where successful legislation mandating state insurance coverage for ASD intervention was passed.
 - b. Mandate coverage of behavioral interventions provided by licensed PhD level clinical psychologists and Board Certified Behavior Analysts (BCBA).
2. Expand Medicaid benefits to promote equity in health care access and encourage providers to serve clients who are enrolled in Medicaid.

²¹ Peele, P. B., Lave, J. R., Kelleher, K. J. *Exclusions and Limitations in Children's Behavioral Health Care Coverage. Psychiatric Services.* 2002. Vol. 53, pp. 591-594. Accessed November 21, 2007 from <http://www.ps.psychiatryonline.org/cgi/content/full/53/5/591>

²² Peele, P. B., Lave, J. R., Kelleher, K. J. *Exclusions and Limitations in Children's Behavioral Health Care Coverage. Psychiatric Services.* 2002. Vol. 53, pp. 591-594. Accessed November 21, 2007 from <http://www.ps.psychiatryonline.org/cgi/content/full/53/5/591>

- a. Increase the number of psychological assessments allowed (currently one per lifetime).
 - b. Increase rate of reimbursement and streamline paperwork and service approval process to encourage more providers to accept Medicaid patients.
 - c. Provide benefits comparable to private insurance, including reimbursement for costs of behavioral intervention.
 - d. Allow coverage of behavioral interventions provided by licensed PhD level clinical psychologists and board certified behavior analysts for individuals with an autism spectrum disorder.
3. Support policies that ensure neurodevelopmental therapy insurance benefits.
 - a. Extend neurodevelopmental therapy benefit including speech-language services, occupational and physical therapy to individuals aged 18 years.
 - b. Include certified behavioral analysts (BCBA) in neurodevelopmental therapy benefits.

Objective 2: Train and provide support to health care providers caring for individuals with ASD and increase access to medical homes.

The ATF recognizes that a medical home supports knowledge of and access to comprehensive services within the community. Providing increased support to health care providers is essential so that they have easily accessible, scientifically sound, reliable information about autism and related disorders. Health care providers need to be able to easily direct patients to the services they need. See Chapter 6 for additional activities to promote medical homes and increase provider knowledge of ASD and related disorders.

1. Improve advanced registered nurse practitioners, physician assistants, and medical school residency training on ASD and related conditions.
 - a. Assess and provide training standards for Washington State programs.
 - b. Collaborate with training programs to increase awareness and surveillance of autism and related conditions.
2. Identify an on-line medical consultation service to provide a quality consultation resource for primary care providers. Service could expand consultative service to primary care providers who serve individuals with autism. Promote use of the service across the state.²³
3. Improve access to high-quality medical homes for individuals with ASD and related disorders.
 - a. Explore successful programs nationally:
 - i. Obtain consultation from the Waisman Center or similar organization.²⁴

²³ Appendix 4c), Identification/Tracking Mid-Term Report

²⁴ Waisman Center. National Medical Home Autism Initiative. Framework, Partnerships, Resources, Publications, What's New. 2007. Accessed October 30, 2007 website <http://www.waisman.wisc.edu/nmhai/index.html>

- ii. Obtain assistance from the National Center on Medical Home Initiatives for Children with Special Needs at the American Academy of Pediatrics.²⁵
- b. Explore regional successful medical home programs such as those available to the armed forces.
- c. Make use of the Medical Home Leadership Network in Washington to pilot successful strategies to increase high quality medical homes throughout the state.²⁶
- d. Use Child Health Notes²⁷ as another possible model to provide more information about autism to primary care providers in Washington.

²⁵ National Center of Medical Home Initiatives for Children with Special Needs. What is a Medical Home. May 24, 2006. American Academy of Pediatrics. Accessed November 1, 2007 from website <http://www.medicalhomeinfo.org/lion.html>

²⁶ Washington State Medical Home. The Medical Home Leadership Network. Washington State Department of Health. 2007. Accessed October 30, 2007 from website http://www.medicalhome.org/leadership/the_mhln.cfm

²⁷ Washington State Medical Home. Child Health Notes. University of Washington & DOH. 2007. Accessed November 9, 2007 from <http://www.medicalhome.org/leadership/chn.cfm>

EXHIBIT L

Information Summary and Recommendations

Treatment of Autism Spectrum Disorders Mandated Benefit Sunrise Review

January 2009



EXHIBIT L

Information Summary and Recommendations

Treatment of Autism Spectrum Disorders Mandated Benefit Sunrise Review

January 2009



For more information or additional
Copies of this report contact:

Office of the Assistant Secretary
PO Box 47850
Olympia, Washington 98504-7850

Phone: 360-236-4612
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Mary C. Selecky
Secretary

There are a number of other available treatments for autism spectrum disorder (ASD) that the proposal did not address. Public testimony suggested the following additional treatments are effective for treating some children with ASD. Please note that evidence of efficacy, and in some cases safety, was not provided for this review:

- Relationship Development Intervention (RDI): A parent-based clinical treatment program in which parents are given tools to effectively teach motivation and relationship intelligence to their child.
- Water Therapy or Aquatic Therapy: Water activities provide sensory input to children with significant sensory difficulties and who over or under-react to stimuli.
- Floortime or Developmental Individual Difference Relationship Model (DIR Model): Involves meeting a child at his or her current developmental level, and building upon a particular set of strengths. By entering into a child's world, support can be given to climb the 'developmental ladder' despite having ASD.
- Hippotherapy: Using horses as a means of treatment. The movement from the horse elicits an adaptive response from the child.
- The Handle Method: Embraces aspects of many other disciplines and therapies and provides an integrated structure for guiding and enhancing neurodevelopmental substrata which support social and academic learning. It also incorporates aspects of personal motivation and aspirations, and of empowering individuals and families to heal themselves.
- Chelation therapy: Removes heavy metals from the body.

Financial burden

The proponent wrote about the financial burden, "In the absence of coverage, out-of-pocket expenses for services can cost upwards of \$50,000 per year. In the process of trying to attain medical treatments and therapies, many risk their homes and the educations of their unaffected children—essentially mortgaging their entire futures."

Many parents spoke at the public hearing and wrote letters describing the extraordinary financial burden of autism. They discussed treatments costing up to \$40,000 to \$100,000 per year for families with children most severely impacted by autism spectrum disorder (ASD). Many families told about being forced into bankruptcy or home foreclosure to pay for treatment. Others spoke of cashing in retirement and college funds, borrowing from extended family, and charging up the maximum on multiple credit cards.

Current coverage

Some of the confusion over coverage for ASD arises from the fact that it is unclear whether treatments should be covered under mental health, physical health, or neurodevelopmental therapies.

Neurodevelopmental therapy mandate:

An insurance mandate already exists in Washington that covers occupational therapy, physical therapy, and speech-language therapy. However, there are limitations to this mandate:

- The mandate ends at age seven, even though the need often continues long after;

- Some insurance carriers only cover a small portion of the therapies necessary to treat ASD. They often limit treatment to \$1,000 to \$2,000 per year and/or limit the number of visits. Effective treatment for children with autism spectrum disorder can far surpass these limits.
- Low income children in Washington eligible for Medicaid have no age limits or therapy limits for neurodevelopmental therapy services.

Mental health parity

There is also a mental health parity mandate. It is unclear at this time how much (if any) ASD treatment should be covered under this mandate. The statute 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 (DSM)...” Autism spectrum disorder is a disorder included in the DSM.

State and federal programs

There are some programs that provide limited treatment for autism spectrum disorder. These include the Infant and Toddler Early Intervention Program’s (ITEIP) Birth to Three Program, some programs through the Department of Social and Health Services, Department of Health’s Children with Special Health Care Needs Program, neurodevelopmental therapy services under Medicaid, and some other ASD coverage under Medicaid.

A number of states have insurance mandates for autism. The Council for Affordable Health Insurance reports 11 states as having mandates. However, the proponent counts eight states as having autism parity mandates. The proponent reports as many as 21 states that have either introduced legislation or are working on legislation for autism parity mandates.

Private insurance

Many parents described the Premera Blue Cross Health Insurance plan offered by Microsoft as being a model for other plans to follow. This plan covers applied behavior analysis (ABA) therapy for children with ASD. Providers must meet strict qualifications including a master’s or doctoral degree in education, psychology, speech/language pathology, behavior analysis or occupational therapy (or have national ABA certification), and 1,500 supervised hours working with children with autism spectrum disorder.

Education or health care?

Anecdotal evidence given during the review indicates that autism spectrum disorder (ASD) treatment is sometimes considered the responsibility of schools. Representatives from the insurance industry and the Health Care Authority questioned whether this is an educational issue, rather than a health care issue.

Limited treatment may be available in schools. However, it is designed, as required by law, to be educationally-relevant. It is designed to allow the child to participate in the educational program. The therapy does not include skills the child may need in other environments such as home, work place, and the community.

DETAILED RECOMMENDATIONS TO THE LEGISLATURE

The legislature should not enact the proposed bill in its current form. Children with autism spectrum disorder (ASD) clearly need increased access and funding for treatment. However, the language of this bill is too vague to allow the department to determine whether the benefits outweigh the costs. In addition, in its current form, the bill would likely fail to offer meaningful guidance to insurers, providers or Department of Health.

The proposed bill poses the following concerns:

1. The bill does not specify what treatments will be covered. The vague and over-broad language in section (3)(m) of the proposed bill does not provide sufficient guidance for insurers, providers, or consumers. The blurred lines between the medical, behavioral, and mental health aspects of ASD would likely cause extensive disputes regarding applicability and appropriate coverage. In addition there are numerous treatment modalities referenced for which there is no proof of efficacy.
2. The bill does not specify what providers could be compensated. Section (3)(o) requires the department to “establish standards to be utilized by health plans for the credentialing of autism service providers.” However, it does not require the department to have licensing or regulatory authority over those providers. Once again, the lack of clarity would likely result in extensive disputes regarding what providers and which services were covered by the mandate.
3. There are existing mandates that should be reviewed that may provide the coverage these families are seeking. These are the neurodevelopmental therapy mandate and the mental health parity mandate.
4. The costs to implement this mandate as proposed are difficult, if not impossible, to determine as is demonstrated by the three vastly different cost estimates.

The concerns listed above could be addressed in the following ways:

1. Expand the neurodevelopmental therapy mandate to:
 - a. Require increased coverage amounts. Currently many health plans limit the dollar amount and/or the number of visits available for these therapies. The limits do not meet the needs of children with ASD.
 - b. Require coverage for applied behavior analysis (ABA) when performed by (or under the supervision of) nationally certified providers. ABA is an effective treatment for ASD when provided by appropriately-educated and experienced professionals. Current standards for national certification ensure adequate training.
 - c. Raise or eliminate the age limit for benefits. Currently, benefits under this mandate end at age seven. Children with ASD often need therapy far past that age in order to become self-sufficient members of society. Treatment should be allowed for a significantly longer period.¹⁸
 - d. Match services currently available to low income children on Medicaid in Washington state.

¹⁸ In 2001, the department conducted a sunrise review that recommended in favor of removing the age limit of six and under for the neurodevelopmental therapy mandate.

2. Expand and/or clarify the mental health parity mandate to include treatment for ASD. ASD is defined as a developmental disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Psychiatric and psychological care is plainly envisioned by the proposed bill. Other therapies, such as ABA, appear to have significant mental health components. Treatment related to mental health care or provided by mental health providers should be covered by this mandate.

EXHIBIT 10

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THE HONORABLE MICHAEL J. TRICKEY
Motion Date: March 2, 2012
Hearing time: 10:00 a.m.
WITH ORAL ARGUMENT

SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and
K.G., on his own behalf and on behalf of all
similarly situated individuals,

Plaintiffs,

v.

PREMERA BLUE CROSS and LIFEWISE
OF WASHINGTON, Washington
corporations,

Defendants.

No. 11-2-30233-4 SEA

**DECLARATION OF NANCY MOORE
IN OPPOSITION TO PLAINTIFF'S
MOTION FOR PARTIAL SUMMARY
JUDGMENT AND PRELIMINARY
INJUNCTION**

I, Nancy Moore, declare as follows:

1. I am a Clinical Nurse Consultant for Integrated Health Management with
Premera Blue Cross. As a Clinical Nurse Consultant, I develop, implement and communicate
about Integrated Health Management programs, products and services with sales associates,
brokers, and employer group clients. As part of this role, I provide medical expertise to support
our insured and self-insured lines of business. I have personal knowledge of the facts stated
herein and am competent to testify.

2. I understand that in this lawsuit, A.G.'s attorneys claim that because certain
claims were paid, there must have been a determination that the claims were medically
necessary for A.G. This is incorrect. This argument reflects a fundamental misunderstanding
of the claims processing system and the reality of the extraordinary number of claims we pay
each day. We pay the majority of our providers' claims through an automated claims payment

DECLARATION OF NANCY MOORE IN OPPOSITION TO PLTF'S
MTN FOR PARTIAL SUMMARY JUDGMENT 1

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1 system and these claims are not subjected to any manual review, including for medical
2 necessity. We do not hold up provider payments to conduct a medical necessity review of each
3 and every claim. Indeed, under Washington law, specifically WAC 284-43-321, Premera is
4 required to pay ninety percent of our clean claims within 30 days.

5 3. I have reviewed the claims history for A.G. to determine whether certain claims
6 he made under his individual health benefit plan were paid and why. As with all of our
7 members, A.G.'s medical providers submit claims to us using Current Procedural Terminology
8 ("CPT") codes. Healthcare providers used CPT codes to identify the type of services they are
9 providing to the individual. The codes are submitted, often electronically, and processed by
10 our claims software. We cannot and do not review every claim for medical necessity. Instead,
11 if the provider submits a claim, and the member's plan provides coverage for that service, the
12 claim is automatically processed for payment—or "auto adjudicated"—by our claims
13 processing software.

14 4. I reviewed A.G.'s claims history and I based this declaration on that review.
15 Although A.G. has been a member since 2004, I only reviewed his claims history since January
16 1, 2006.

17 5. A.G.'s healthcare providers have submitted claims for medical evaluation
18 related to speech and language and for direct care received from physical, occupational and
19 speech therapists. Generally, the claims were coded using CPT codes that are associated with
20 therapeutic activities, such as occupational therapy, physical therapy and speech therapy.

21 6. Although the vast majority of our claims are auto-adjudicated, there is a list of
22 CPT codes that we recommend benefit advisories pre-service and are routed for manual review
23 on a claim, including medical necessity review. For claims using those CPT codes, there is no
24 auto-adjudication.

25 7. Through 2007 and 2008, most of the claims submitted by A.G.'s healthcare
26 providers for occupational therapy, physical therapy and speech therapy were coded as

DECLARATION OF NANCY MOORE IN OPPOSITION TO PLTF'S
MTN FOR PARTIAL SUMMARY JUDGMENT 2

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100407.0381/5285181.1

1 rehabilitation benefits. The claims were auto-adjudicated and paid up to the 20 visit limit.
2 None of these claims were ever reviewed for medical necessity. However, there was a point
3 where the providers began coding some claims differently in a way that triggered a manual
4 review. In 2009, some of A.G.'s providers submitted claims using a CPT code of 97532. CPT
5 97532 is used to identify a treatment for the development of cognitive skills to improve
6 attention, memory, and problem solving, and may include compensatory training and direct
7 treatment. Claims submitted with this code are pended for manual review.

8 8. When a CPT code is tagged for further review, the claim requires a manual
9 review before payment. As a result, A.G.'s claims which included a CPT code of 97532 were
10 reviewed and Premera discovered that the services were not for rehabilitation treatment, but
11 were for neurodevelopmental therapy. Neurodevelopmental therapy is subject to an exclusion
12 in A.G.'s health benefit plan and is not a covered benefit. As a result, these claims were not
13 paid. There was, however, some variation with respect to how A.G.'s provider coded A.G.'s
14 therapy and submitted their claims to Premera. In some cases, if the entire claim included a
15 97532 code, the reviewer realized the entire claim was neurodevelopmental therapy and denied
16 the claims. For others, the claims processor would simply deny payment for the portion of the
17 services attributed to that particular CPT 97532 code. But if claim did not include 97532, it
18 was generally auto-adjudicated and paid under the rehabilitation benefit up to the plan limits.

19 9. In 2011, after a review of a number of claims, the claims reviewer concluded
20 that claims previously paid by the automated claims system as a rehabilitation benefit were not
21 for rehabilitation treatment, but were instead claims for neurodevelopmental therapy and should
22 not have been paid at all. A letter was then sent to A.G.'s parents advising that the claims
23 should not have been paid. That letter is attached as Exhibit B to the Declaration of J.G. filed
24 in support of Plaintiff's Motion For Partial Summary Judgment and Preliminary Injunction.
25
26

DECLARATION OF NANCY MOORE IN OPPOSITION TO PLTF'S
MTN FOR PARTIAL SUMMARY JUDGMENT 3

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10. There was never any review of A.G.'s claims for medical necessity. Instead, they were either automatically paid as a rehabilitation benefit or denied under the neurodevelopmental therapy exclusion.

I declare under penalty of perjury under the laws of the State of Washington and the United States that the foregoing is true and correct.

Dated this 6 day of February, 2012, at Mountlake Terrace, WA.



Nancy Moore

EXHIBIT 11

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THE HONORABLE MICHAEL J. TRICKEY
Motion Date: March 2, 2012
Hearing time: 10:00 a.m.
WITH ORAL ARGUMENT

SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and)
K.G., on his own behalf and on behalf of all)
similarly situated individuals,)

Plaintiffs,)

v.)

PREMERA BLUE CROSS and LIFEWISE)
OF WASHINGTON, Washington)
corporations,)

Defendants.)

No. 11-2-30233-4 SEA

**DECLARATION OF MEDICAL
DIRECTOR DR. CHELLE MOAT IN
OPPOSITION TO PLAINTIFF'S
MOTION FOR PARTIAL SUMMARY
JUDGMENT AND PRELIMINARY
INJUNCTION**

I, Dr. Chelle Moat, hereby declare as follows:

1. I am the Medical Director of Care Management for Premera Blue Cross. I have been with Premera since 2009. As such, I manage the Assistant Medical Directors and medical policy staff. Before I became the Medical Director, I was an Assistant Medical Director at Premera. At Premera, I have been directly involved in individual determinations of whether a particular service is medically necessary based on contract language, and larger policy decisions of whether or when a technology, drug or service is considered medically necessary and therefore covered on our health plans. Over the last 20 years I have been employed by or contracted with various health care insurance carriers in the State of Washington. Throughout those years I have been involved in all aspects of medical necessity determinations.

DECLARATION OF DR. CHELLE MOAT IN OPPOSITION TO
PLTF'S MTN FOR PARTIAL SUMMARY JUDGMENT I

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1 2. I am board certified in Internal Medicine. I completed bachelors' degrees in
2 medical technology and psychology, a Master of Public Health, and Doctorate of Medicine
3 from the University of Washington. I completed internal medicine residency training at the
4 University of Utah in Salt Lake City Utah.

5 3. At Premera, like all other health benefit plan contractors, HMOs and insurance
6 carriers, claims are initially paid through an automated claims management system. Some
7 claims are "auto adjudicated"—*i.e.*, automatically paid or denied—based upon certain
8 parameters related to the CPT code ("Current Procedural Terminology") used and other coded
9 information (like the number of claims previously made during a calendar year), attached
10 diagnosis (ICD-9) codes, and /or the provider type submitting the claim. We do not, nor
11 could we, possibly review every individual claim for medical necessity prior to payment.
12 Claims that are auto adjudicated to pay are paid without any examination of medical records. I
13 have reviewed the Declaration of Nancy Moore who explained the claims history of A.G. As
14 Ms. Moore explains, in the past, when providers submitted claims for occupational therapy,
15 speech therapy or physical therapy for A.G., the claims were generally auto adjudicated and
16 paid under the rehabilitation benefit in his individual health plan due to the way his providers
17 submitted the claims (CPT code and diagnosis codes) and provider type. A.G.'s individual
18 plan covers up to 20 rehabilitation visits each year. Rehabilitation services include specific
19 CPT codes submitted by specific provider types (occupational therapists, physical therapists,
20 and speech therapists). Ms. Moore further explained that, when A.G. reached the visit limit, his
21 claims were automatically denied, as benefit limit reached. Thus, Premera paid these claims as
22 a rehabilitation benefit without any making determination of whether they were medically
23 necessary, based only on the way they were coded and submitted by the provider to Premera.

24 4. As explained by Ms. Moore, there came a point when Premera identified a
25 particular CPT coded procedure related to occupational therapy as requiring additional review
26 to determine whether the procedure was covered by the terms of the health plan. This specific

1 code is set for review as it represents a service that is considered educational rather than
2 medical, and as such is excluded on most of our plans. There were several claims submitted for
3 A.G. using this CPT code which prompted further review by our claims department. It is my
4 understanding that claims submitted using this code were reviewed and determined to be
5 consistent with claims for neurodevelopmental therapy, not rehabilitation benefits, and
6 therefore denied pursuant to the plan exclusion of neurodevelopmental therapy benefits. No
7 claims submitted for A. G. were denied based on a finding of lack of medical necessity.

8 5. Premera covers neurodevelopmental therapy in some, but not all, of its health
9 plans. Coverage for neurodevelopmental therapy is a result of a legislative mandate enacted in
10 1989. That mandate requires group health benefit plans to cover neurodevelopmental therapy
11 (which is defined as speech, occupational or physical therapy) for children under the age of
12 seven. The benefit under statute may be provided with limits (number of visits, dollar amount),
13 and may be subject to review for medical necessity. The neurodevelopmental benefit mandate
14 was designed to provide services specifically for children with developmental disorders - such
15 as Autism Spectrum Disorder (“ASD”), or Pervasive Developmental Disorders (“PDD”), as
16 frequently the rehabilitation benefit (by contract definition) did not cover these diagnoses.
17 Once children reach seven years old they are typically in the school system, where they have
18 access to special education programs that provide these neurodevelopmental therapies. The
19 state mandate for neurodevelopmental therapy does not require individual health benefit plans,
20 like A.G.’s, to provide any coverage for neurodevelopmental therapy benefits.

21 6. I understand in this lawsuit, Plaintiff is asking the Court to determine that
22 neurodevelopmental therapy is a “mental health service,” within the meaning of the
23 Washington Mental Health Parity Act (“MHPA”), on the premise that neurodevelopmental
24 therapy is medically necessary to treat A.G.’s ASD. Premera, and other health plans, use the
25 term “medical necessity” in the member contract to describe what services are covered, and
26 outlines specific criteria further defining the term “medical necessity.” Determinations of

1 medical necessity are made by physicians and health care professionals and include an
2 assessment of accepted standards of medical care, clinical appropriateness, efficacy, and the
3 credible scientific literature published in peer-reviewed literature, generally recognized by the
4 relevant medical community. Whether a particular health care service or treatment is medically
5 necessary is a complex, multifaceted determination that is based on input from medical
6 professionals and sources in the relevant health field. The term "medical necessity," in the
7 context of health plan benefit coverage, has a much broader meaning than whether a physician
8 ordered or recommended the service, or that a specific individual derived benefit from it.

9 7. The premise that neurodevelopmental therapy treats ASD and, as such, is a
10 "mental health service" is overly simplistic and not uniformly accepted within the medical
11 community. PDD and ASD are complex multifaceted disorders, the exact cause which is
12 unknown, although there is increasing evidence that genetic factors may be involved. Most
13 treatment is focused on improving co-morbid physical and communication problems that
14 impact the functional status of the individual. Services provided by speech therapists,
15 occupational therapists and physical therapists are not considered behavioral health, psychiatric
16 or psychological care. The scope of practice of these practitioners is not directed towards
17 treatment of mental health disorders. For example, the CPT code for occupational therapy
18 used by A.G.'s providers which triggered further review by Premera's claims department, as
19 described above, is educational in nature, and Premera does not view it as ever medically
20 necessary for individuals with ASD.

21 8. I have read the declaration submitted by A.G.'s father to the Court, in which he
22 states that A.G. has benefited from and needs the speech and occupational therapy he has
23 received. I understand and appreciate that opinion, but there is a difference between a
24 rehabilitation service that may improve A.G.'s functional abilities and "mental health services"
25 that are medically necessary to treat an individual with ASD.
26

EXHIBIT 12

THE HONORABLE MICHAEL J. TRICKEY
Motion Date: March 2, 2012
Hearing time: 10:00 a.m.
WITH ORAL ARGUMENT

SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and
K.G., on his own behalf and on behalf of all
similarly situated individuals,

Plaintiffs,

v.

PREMERA BLUE CROSS and LIFEWISE
OF WASHINGTON, Washington
corporations,

Defendants.

No. 11-2-30233-4 SEA

**DECLARATION OF JAMES
TEDFORD IN OPPOSITION TO
PLAINTIFF'S MOTION FOR
PARTIAL SUMMARY JUDGMENT
AND PRELIMINARY INJUNCTION**

I, James Tedford, hereby declare as follows:

1. I am a Member Contract Services Manager for defendants. I have worked for
Premera for more than 20 years. In my current capacity I am responsible for ensuring certain
contract language is put into place in our policies and plans. I am also responsible for
assisting our Legal and Regulatory Affairs team in submitting our contracts to the Washington
State Office of the Insurance Commissioner for approval. I have personal knowledge of the
matters set forth in this Declaration.

2. I understand that the Plaintiff in this lawsuit is asking the Court to find that
Premera's individual health insurance plans must cover unlimited neurodevelopmental
therapy.

1 3. The current neurodevelopmental mandate applies only to group plans. It does
2 not apply to individual plans. The individual plan market has been a very difficult one for
3 Premera and other health insurance carriers in the State of Washington. In our view, the
4 reason is that the product can be very expensive and unaffordable to those who are not part of
5 a group plan where they can share risk and experience. So that they can remain affordable,
6 the individual plans tend to be very basic in an effort to keep the costs down. State law
7 currently allows carriers to sell individual "catastrophic plans" in the market that do not
8 include maternity services and prescription drug benefits in an attempt to provide affordable
9 options to purchasers. Other benefit mandates that do not impact the individual plan market
10 include chemical dependency and TMJ treatment. There have been times in Washington
11 where there have been a very limited number of health insurance carriers able to write
12 individual plans in the State of Washington. In the mid 1990s, Washington experimented
13 with healthcare reforms to improve access and reduce the uninsured. The state implemented
14 guaranteed issue with very limited preexisting condition waiting periods, which resulted in
15 significant premium increases and an eventual collapse of the market.

16 4. This, in my opinion, is one reason the legislature has never applied the
17 neurodevelopmental mandate to individual plans since it was passed in 1989.

18 5. I declare under penalty of perjury under the laws of the State of Washington
19 and the United States that the foregoing is true and correct.

20 Dated this 7th day of FEBRUARY, 2012, at Mountlake Terrace, Washington.

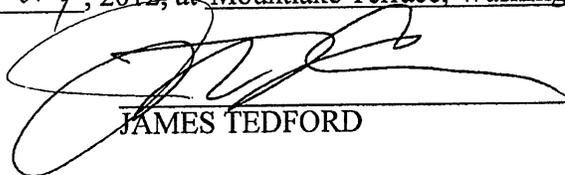
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EXHIBIT 13

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HON. MICHAEL J. TRICKEY
Noted for Hearing: March 2, 2012 @ 10:00 a.m.
With Oral Argument

IN THE SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and K.G.,
on his own behalf and on behalf of all similarly
situated individuals,

Plaintiff,

v.

PREMERA BLUE CROSS and LIFEWISE OF
WASHINGTON, Washington corporations,

Defendants.

NO. 11-2-30233-4 SEA

PLAINTIFF'S REPLY IN SUPPORT OF
MOTION FOR PARTIAL SUMMARY
JUDGMENT AND PRELIMINARY
INJUNCTION

1 **A. Premera’s Neurodevelopmental Exclusion Violates the Parity Act.**

2 Medical necessity is the touchstone to the Parity Act. It is the only reason mental health
3 services for applicable DSM-IV conditions can be denied. RCW 48.44.341(1), (2).¹ If a service
4 used to treat a covered DSM-IV condition *can be* medically necessary, the Parity Act mandates
5 that the service may not be subject to a blanket exclusion. The insurer must instead make an
6 individualized determination of the service’s medical necessity.

7 Plaintiff’s Motion asks the Court to determine three things: (1) A.G.’s autism is a DSM-
8 IV condition covered by the Parity Act; (2) neurodevelopmental therapy services are “mental
9 health services” designed to treat DSM-IV conditions like autism and (3) neurodevelopmental
10 therapies can be medically necessary, such that Premera’s blanket exclusion is illegal. *See*
11 Plaintiff’s Mot., pp. 9-10.

12 Premera does not dispute (1). Its Medical Director, Dr. Chelle Moat, concedes (3):

13 Premera covers neurodevelopmental therapy in some, but not all, of its health
14 plans....subject to review for medical necessity. [It] was designed to provide
15 services specifically for children with developmental disorders—such as Autism
Spectrum Disorder...

16 Moat Decl., ¶5. The Washington Legislature agrees. *See* RCW 48.44.450 (3). So does the
17 Washington Department of Health,² the American Academy of Pediatrics,³ the U.S. Surgeon
18 General,⁴ and courts across the country.⁵

19 _____
20 ¹ “Medically necessary” is a defined term in the Premera contract. It is not whatever Premera decides to cover
21 (or exclude). *See* Premera Resp. p. 4. It does not exclude “auto-adjudication.” *See* Moat Decl., ¶3. It is an
22 individualized determination that, according to Premera’s contract, is made with every claim paid. *See* Duffy Decl.
23 (10/5/11), *Exh. A*, p. 42 (defining “medically necessary” to include a specific determination that the service is
“essential” to the insured’s health), p. 14 (“We provide benefits...when such services...meet *all* of the following
conditions: They must meet our definition of ‘medically necessary’”(emphasis in original); p. 32 (excluding
coverage of services that are not “medically necessary”); p. 35 (“No benefits will be available under this contract if
the proof [of medical necessity] is not provided or acceptable to us”).

24 ² Supp. Hamburger Decl. (2/24/12), *Exh. J*, p. 15 (“Neurodevelopmental therapies are effective in treating
25 ASD [Autism Spectrum Disorders]”).

26 ³ *Id.*, *Exh. K*, pp. 1165-1166 (“People with ASDs have deficits in social communication and treatment by a
speech-language pathologist usually is appropriate;” “traditional occupational therapy is often provided to promote
development of self-care skills...”).

1 Premera only disputes (2), asserting that its medical director has simply decided that
2 neurodevelopmental therapies do not “constitute” behavioral health, psychiatric or
3 psychological care and are therefore not “medically necessary” to treat “mental health services.”
4 Premera Resp., p. 18; Moat Decl., ¶7. Premera may not narrow the statutory definition of
5 “mental health services” by recasting its illegal neurodevelopmental therapy exclusion as a
6 “medical necessity” decision under RCW 48.44.341(4), in order to exclude services necessary to
7 treat an entire class of insureds—those with developmental disabilities.

8 The Parity Act was designed to end such rank discrimination. See Hamburger Decl.
9 (1/13/12), *Exh. H*, p. 7 (Parity is “a matter of fairness”). Its reach was purposefully broad and
10 extended beyond psychiatric disorders to include nearly all disorders in the DSM-IV, including
11 developmental disabilities.⁶ Children, by design, were the intended prime beneficiaries.
12 Hamburger Decl. (1/13/12), *Exh. H*, pp. 2-3. Premera’s claim that it may exclude coverage of a
13 broad category of mental conditions by making a non-individualized, undisclosed “medical
14 necessity” decision to do so, would undermine the entire purpose of the Parity Act, and render
15 Parity a nullity, at least for insureds with developmental disabilities.⁷

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(continuation)

19 ⁴ Hamburger Decl. (1/13/12), *Exh. D*, p. 163 (“[t]he goal of treatment is to promote the child’s social and
20 language development and minimize behaviors that interfere with the child’s functioning and learning”).

21 ⁵ See e.g., *McHenry v. PacificSource Health Plans*, 679 F. Supp. 2d 1226, 1233 (D. Or. 2010) (health plan
22 covered “services related to conditions which may be symptoms of autism, such as speech, physical, and
occupational therapy”); *Bails v. Blue Cross/Blue Shield of Illinois*, 438 F. Supp. 2d 914, 929 (N.D. Ill. 2006)
(insurer required to cover medically necessary speech therapy services for autistic child); *Wheeler v. Aetna Life Ins.*
Co., 2003 WL 21789029 (N.D. Ill. 2003) (same).

23 ⁶ The fact that the legislature explicitly excluded certain conditions, such as substance abuse treatment and
24 DSM-IV “V codes”, is clear evidence that the legislature intended all remaining conditions, including
developmental conditions, to be covered. *State v. Delgado*, 148 Wn.2d 723, 729, 63 P.3d 792 (2003).

25 ⁷ Premera’s assertion that its “medical necessity” definition allows it to exclude all services to treat
26 developmental disabilities conflicts with the understanding that the average person reading the “medical necessity”
definition in the Premera contract would have. *Queen City Farms, Inc. v. Cent. Nat. Ins. Co. of Omaha*, 126 Wn.2d
50, 65, 882 P.2d 703 (1994).

1 Every court considering this issue has found that the Parity Act prohibits such blanket
2 contractual exclusions of neurodevelopmental or behavioral services because those services are
3 “mental health services” and can be medically necessary to treat covered DSM-IV conditions.
4 *See Z.D., ex rel. J.D. v. Group Health Coop.*, __ F. Supp. 2d __, 2011 WL 5299592 (W.D.
5 Wash. 2011) (“Washington law, specifically [the Mental Health Parity Act], requires
6 Defendants to provide coverage for the mental health [neurodevelopmental] services at issue in
7 this case”); Supp. Hamburger Decl. (2/24/12), *Exh. L, D.F. v. Washington Health Care*
8 *Authority, et al.*, No. 10-2-29400-7 SEA, p. 4 (“specific exclusions...that exclude coverage of
9 Applied Behavior Analysis therapy, even when medically necessary ... do not comply with
10 Washington’s Mental Health Parity Act...”).

11 This exact issue has been litigated in New Jersey. *See Markiewicz v. State Health*
12 *Benefits Comm’n*, 915 A.2d 553, 560 (App. Div. 2007). There, the state public employee health
13 plan applied a neurodevelopmental therapy exclusion in its contract to deny coverage of speech
14 therapy for an insured child with pervasive developmental disorder, (PDD) a DSM-IV
15 condition. *Id.* at 555. While New Jersey’s mental health parity law is narrower than
16 Washington’s (limited to “biologically-based mental illness”), it includes autism and PDD. *Id.*
17 at 558. The appellate court found:

18 *...[A]n exclusion from coverage for claims based upon occupational, speech*
19 *and physical therapy offered to developmentally disabled children would render*
20 *meaningless the specific inclusion of PDD and autism within those biologically-*
21 *based mental illnesses subject to the parity statute. The Legislature surely could*
22 *not have intended that the principal treatments for developmental disabilities be*
23 *excluded from coverage simply because those treatments differ in their essential*
24 *nature from treatments applicable to other biologically-based mental illnesses,*
25 *such as the use of psychiatric or psychological therapy and drugs. The fact that*
26 *biologically-based mental illnesses affect development in some and other*
neurological functions in others should not be the determinant of coverage.

Id. at 560 (emphasis added); *see Micheletti v. State Health Benefits Comm’n*, 913 A.2d 842, 851.

1 **B. No Agency has found that the Neurodevelopmental Therapy Act**
2 **“Trumps” the Parity Act.**

3 No state agency has determined that the Parity Act does not apply to
4 neurodevelopmental therapies.⁸ See *Premera Resp.* p. 11-13. *First*, agency deference is only
5 accorded when a statute is ambiguous, and here, neither Act is ambiguous. *Postema v. Pollution*
6 *Control Hearings Bd.*, 142 Wn.2d 68, 77, 11 P.3d 726 (2000). *Second*, the DOH Sunrise
7 Review and OIC’s *inaction* are not “interpretive statements” by the agencies meriting
8 deference. RCW 34.05.010(8). *Third*, DOH found that the Neurodevelopmental Therapy Act
and the Parity Act likely work together, just as Judge Lasnik describes in *Z.D.*:

9 There are existing mandates that should be reviewed that may provide the
10 coverage these families are seeking [for treatment for ASD]. These are the
11 *neurodevelopmental therapy mandate and the mental health parity mandate.*⁹

12 Supp. Hamburger Decl., *Exh. J*, p. 16 (emphasis added). *Fourth*, under RCW 48.18.510,
13 Premera’s non-complying contract provisions are automatically invalidated. Thus, the OIC’s
14 inaction (likely due to limited staffing, funding and other priorities) does not prevent courts
15 from ensuring full compliance with the Insurance Code. See *Seattle-First Nat’l Bank v. Wn. Ins.*
16 *Guaranty Assoc.*, 94 Wn. App. 744, 753, 972 P.2d 1282 (1999).

17 **C. No proof of medical necessity of A.G.’s services is needed.**

18 Plaintiff has met his burden of proof for summary judgment. See *Premera Resp.* p. 15.
19 Plaintiff has demonstrated that neurodevelopmental therapies can be medically necessary in
20 many instances. Even Premera’s Dr. Moat admits it. Moat Decl., ¶5.

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23 ⁸ The Caring for Washington Individuals Task Force is not an agency. RCW 34.05.010(2). Nor is there
evidence that the Task Force’s findings were a formal legal interpretation about the interplay between the Parity
24 Act and the Neurodevelopmental Therapy Act.

25 ⁹ Ironically, it was the Association of Washington Healthcare Plans (of which Premera is a member) that first
26 suggested to the DOH that the Autism Services Mandate legislation was unnecessary because “*Washington already*
has mandates in place that cover services for individuals diagnosed with autism spectrum disorder – including
the mental health parity act of 2005 and the neurodevelopmental benefit mandate.” Supp. Hamburger Decl.,
Exh. J, pp. 89-90 (emphasis added); see <http://awhp-online.com/MemberProfiles/> (as of 2/23/2012).

1 A.G. does not need to prove the medical necessity of his therapies before an injunction
2 can issue. While payment of A.G.'s claims in the past is evidence that the services were
3 medically necessary, *see* fn. 1 above, and Premera offers no evidence that the services were *not*
4 medically necessary, the Court does not need to rule on that issue. Injunctive relief can still be
5 ordered. All the Court need do is enjoin Premera from denying A.G.'s claims for
6 neurodevelopmental therapy on grounds of the illegal exclusion. Under the proposed injunction
7 and Premera's contract, the insurer may, at any time, make an individualized determination that
8 the services are no longer medically necessary. If Premera does, A.G. will be free to appeal the
9 decision using Premera's internal and external appeal procedures.¹⁰

10 **D. Irreparable Harm and Equitable Relief.**

11 The loss of A.G.'s therapy services impacts his health and development in ways that
12 cannot be fully valued by a cash payout. *See* J.G. Decl. (1/13/12), ¶¶15-17; *see also* Hamburger
13 Decl., (1/13/12), *Exh. G*, p. 1 (“[T]he cost of leaving mental disorders untreated or undertreated
14 are significant, and often include ... deteriorating school performance, increased use of other
15 health services, treatment delays leading to more costly treatments...”); *Washington Fed'n of*
16 *State Employees (WSFE), Council 28, AFL-CIO v. State*, 99 Wn.2d 878, 891, 665 P.2d 1337
17 (1983). A.G. has suffered actual and substantial injury—he has already lost his speech therapy
18 and he will lose his occupational therapy if the injunction is not put in place, likely resulting in
19 further, preventable developmental delay.¹¹

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23 ¹⁰ Premera complains that A.G. did not use these procedures before resorting to litigation. Premera Resp.,
24 p. 21. Such an appeal is not required under A.G.'s contract or state law. Any internal administrative appeal would
25 have been futile, as Premera's position is “clear and unequivocal.” *Young v. Regence BlueShield*, 2008 WL
26 4163112, *3 (W.D. Wash. Sept. 2, 2008). External, independent review was also unavailable. RCW 48.43.535(6)
limits external review decisions to only medical necessity determinations, which Premera never made. Moreover,
no external review could have found that Premera's contract exclusion conflicts with state law. *Id.*

¹¹ A.G.'s therapy provider continues to seek payment for the disputed \$24,000 in past therapy claims, despite
representing to J.G. that the account would be put on hold. J.G. Decl. (2/17/12), ¶ 3.

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DATED: February 24, 2012.

SIRIANNI YOUTZ SPOONEMORE

/s/ Eleanor Hamburger
Eleanor Hamburger (WSBA #26478)
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Attorneys for Plaintiff

CERTIFICATE OF SERVICE

I certify, under penalty of perjury and in accordance with the laws of the State of Washington, that on February 24, 2012, I caused a copy of the foregoing document to be served on counsel of record as indicated below:

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DATED: February 24, 2012, at Seattle, Washington.

/s/ Eleanor Hamburger
Eleanor Hamburger (WSBA #26478)

EXHIBIT 14

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HON. MICHAEL J. TRICKEY
Noted for Hearing: March 2, 2012 at 10:00 a.m.
With Oral Argument

IN THE SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and K.G.,
on his own behalf and on behalf of all similarly
situated individuals,

Plaintiff,

v.

PREMERA BLUE CROSS and LIFEWISE OF
WASHINGTON, Washington corporations,

Defendants.

NO. 11-2-30233-4 SEA

SUPPLEMENTAL DECLARATION OF
ELEANOR HAMBURGER IN SUPPORT
OF MOTION FOR PARTIAL SUMMARY
JUDGMENT

I, Eleanor Hamburger, declare that:

1. I am a partner at Sirianni Youtz Spoonemore and am one of the attorneys for Plaintiff in this action.
2. Attached are true and correct copies of the following documents, with underlining where appropriate for the Court's convenience:

Exhibit	Description
J	Excerpt from the Washington State Department of Health's <i>Information Summary and Recommendations concerning Treatment of Autism Spectrum Disorders Mandated Benefits Sunrise Review</i> dated January 2009.
K	Excerpts from Scott M. Myers, M.D., Chris Plauche Johnson, M.D., M.Ed., "Management of Children with Autism Spectrum Disorders" Clinical Report, American Academy of Pediatrics, 120 PEDIATRICS 5 (2007).
L	Order in <i>D.F. et al., v. Washington State Health Care Authority, et al.</i> , No.10-2-29400-7 SEA, dated June 7, 2011.

CERTIFICATE OF SERVICE

I certify, under penalty of perjury and in accordance with the laws of the State of Washington, that on February 24, 2012, I caused a copy of the foregoing document to be served on counsel of record as indicated below:

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DATED: February 24, 2012, at Seattle, Washington.

/s/ Eleanor Hamburger
Eleanor Hamburger (WSBA #26478)

Exhibit J

Information Summary and Recommendations

Treatment of Autism Spectrum Disorders Mandated Benefit Sunrise Review

January 2009



FINDINGS

- Autism Spectrum Disorder (ASD) affects as many as one in 150 children. It's as common as juvenile diabetes, and more common than childhood cancer, Down syndrome, deafness, or cystic fibrosis.
- In many cases, intensive early intervention enables children with ASD to enter mainstream classes in school and to grow into contributing members of society. Without treatment, both families and the state are often required to provide extensive support services for the rest of the child's life.
- Over half of the children institutionalized in Washington have ASD.
- Intensive remediation for autism is not covered by most health insurance plans.
- Many children in Washington with ASD go without treatment and services because the costs are so high and insurance coverage is not generally available.
- The high costs of treatments for ASD cause severe financial hardships for families.
- There have been studies proving efficacy of applied behavior analysis.
- Neurodevelopmental therapies are effective in treating ASD.

- We did not receive information on the efficacy of other treatments for ASD.
- Current coverage included in plans under the neurodevelopmental and mental health parity mandates are often insufficient for treatment of ASD.
- A number of states have enacted insurance mandates for autism spectrum disorders. Some specifically require coverage of applied behavior analysis.
- The limited treatment available in schools is designed, by law to be educationally relevant and allow the child to participate in the educational program. The therapy does not include skills the child may need in other environments such as the home, work place, and community.

DETAILED RECOMMENDATIONS TO THE LEGISLATURE

The legislature should not enact the proposed bill in its current form. Children with autism spectrum disorder (ASD) clearly need increased access and funding for treatment. However, the language of this bill is too vague to allow the department to determine whether the benefits outweigh the costs. In addition, in its current form, the bill would likely fail to offer meaningful guidance to insurers, providers or Department of Health.

The proposed bill poses the following concerns:

1. The bill does not specify what treatments will be covered. The vague and over-broad language in section (3)(m) of the proposed bill does not provide sufficient guidance for insurers, providers, or consumers. The blurred lines between the medical, behavioral, and mental health aspects of ASD would likely cause extensive disputes regarding applicability and appropriate coverage. In addition there are numerous treatment modalities referenced for which there is no proof of efficacy.
2. The bill does not specify what providers could be compensated. Section (3)(o) requires the department to “establish standards to be utilized by health plans for the credentialing of autism service providers.” However, it does not require the department to have licensing or regulatory authority over those providers. Once again, the lack of clarity would likely result in extensive disputes regarding what providers and which services were covered by the mandate.
3. There are existing mandates that should be reviewed that may provide the coverage these families are seeking. These are the neurodevelopmental therapy mandate and the mental health parity mandate.
4. The costs to implement this mandate as proposed are difficult, if not impossible, to determine as is demonstrated by the three vastly different cost estimates.

The concerns listed above could be addressed in the following ways:

1. Expand the neurodevelopmental therapy mandate to:
 - a. Require increased coverage amounts. Currently many health plans limit the dollar amount and/or the number of visits available for these therapies. The limits do not meet the needs of children with ASD.
 - b. Require coverage for applied behavior analysis (ABA) when performed by (or under the supervision of) nationally certified providers. ABA is an effective treatment for ASD when provided by appropriately-educated and experienced professionals. Current standards for national certification ensure adequate training.
 - c. Raise or eliminate the age limit for benefits. Currently, benefits under this mandate end at age seven. Children with ASD often need therapy far past that age in order to become self-sufficient members of society. Treatment should be allowed for a significantly longer period.¹⁸
 - d. Match services currently available to low income children on Medicaid in Washington state.

¹⁸ In 2001, the department conducted a sunrise review that recommended in favor of removing the age limit of six and under for the neurodevelopmental therapy mandate.

- Allow all professional fees to be covered when providing services for children with a diagnosis on the autism spectrum.
- Allow the treating licensed physician along with families, to determine the treatment plan; not the health plan.
- Allow the full extent of “medical necessity” needs of children on the autism spectrum to be in the purview of the health plans. It is not within the scope of the educational system in Washington State to provide for and meet the full extent of needs of persons with autism. Routinely, school districts deny therapeutic services if it is found to be of “medical necessity”.

CHILD wrote that they repeatedly experience families being informed by their school districts that they will not provide therapeutic interventions that fall beyond the scope of special education services mandated in the current RCW. Often this leaves the child lacking access to the critical services that have been identified in the medical care plan by the child’s primary care physician because there is no financial support for the therapies. Allowing all providers to be financially supported for providing the needed therapy assures children receive needed services, both early intervention and continued throughout childhood. In the end, this will result in decreased costs for the family and the community, as the individual learns new skills to be successful in school, at home, and in life.

CHILD also reinforced the fact that autism is a “neuro-biological medical condition” and the individuals with this diagnosis deserve the same type of support as any other medical condition with financial coverage from health plans. They acknowledged that the proposed legislation will not cover all children; yet wrote that they believe it is a great beginning to help many families who otherwise face insurmountable barriers because of the lack of resources.

Written comments from the insurance industry

The Association of Washington Healthcare Plans (AWHP’s) submitted the following comments about the proposal:

“Our members, too, are concerned about the challenges faced by children with autism and their families. We want to approach this issue in a manner that is in their best interest, as well as that of all those we serve. Accordingly, we offer the following input for your consideration.

- **ABA Therapy is generally recognized as being more educational and school-based, rather than medical/mental health in nature.** A major focus of the proposed benefit mandate is ABA therapy, which consists of intensive behavior modification services designed to help improve school readiness and developmental functioning. Accordingly, private insurers should not be solely responsible for providing and covering these services. It is our understanding that the federal Individuals with Disabilities in Education Act (IDEA) guarantees ‘free and appropriate public education’. As part of that requirement, school districts must conduct outreach to pre-school children ages 0 – 3 who may be disabled and need special early intervention services. In addition to identifying children with autism spectrum disorder through this process, the district is expected to supply services to these children and set-up an “individual education program” for disabled children aged 3 – 21. The district must also submit compliance reports to the U.S. Department of Education⁴⁸.
- **Development of a best practice intervention model with special focus on diagnosis and evaluation is needed.** This model should make use of evidence based research and include a comprehensive evaluation or re-evaluation of the child consistent with recommendations of the American Academy of Pediatrics. The treatment plan should be individualized and developed

with input and collaboration from a myriad of different disciplines. The model should also allow for utilization review, case management, medical necessity review, and other care coordination techniques, as appropriate. Additionally, to prevent inappropriate cost-shifting, the model should allow for close coordination with schools and other resources. We want to ensure appropriate optimization and utilization of existing resources and seamless delivery of care across the spectrum of services for the individual.

- **Treatment should be limited to licensed and/or certified providers.** To ensure quality treatment and patient safety, any person or entity providing treatment of autism spectrum disorders should be licensed or certified, and health plans should have the tools necessary to credential those providers. Additionally, we recommend that ABA therapy be provided by behavior specialists that are board certified, such as by the Behavior Analyst Certification Board.
- **Proposed legislation should maintain consistency with the mental health parity statute of 2005; for which autism is one of the covered mental health conditions.** This should include maintaining consistency with all medical necessity and certificate of coverage requirements. Washington's current mental health parity law allows healthcare plans to manage utilization, make medical necessity decisions regarding treatment, and exclude coverage for experimental/investigational treatment – as with any other disease or disorder.
- **Requiring carriers to provide for the coverage of autism care will increase the cost of healthcare and insurance premiums.** Each benefit mandate adds to the overall cost of healthcare and insurance premiums. And, in a time when we are collectively looking to make healthcare more affordable, we believe employers should be able to determine their own benefit plans without additional state mandates. Financial impacts must be strongly considered for any benefit mandate proposal, especially given current economic conditions in our state and the fact that many families and employers are already struggling to afford coverage.
- **Washington already has mandates in place that cover services for individuals diagnosed with autism spectrum disorders --- including the mental health parity statute of 2005, and the neurodevelopmental benefit mandate. We note that some states with new autism mandates, like Arizona, did not previously have such mandates.**

In addition to offering the above input, we would also like to request clarification regarding which populations the proposed legislation would cover.”

Comments in opposition to proposal

(These comments appear as written)

“It appears that the goal is to make health insurance increasingly expensive, until almost no one can afford it. Then, the nanny-state can intervene and impose socialized medicine "in our best interest", along with all its mandates and intrusions into our lives. The reason so many insurance companies already refuse to write health coverage in Washington State is because of the level of bureaucracy. It would be much better to allow the free market to work.

The proposed system will only create one more expensive, cumbersome, monstrous bureaucracy.

There is no perfect solution to all problems. There is a lot of erroneous thinking. It appears some individuals live in a fantasy world where they believe government can solve all their problems. They do not understand that dollars are a finite quantity. Every dollar spent on one purchase may not be available for a higher priority purchase. Some people seem to believe that if they cannot afford to pay their bills that I can afford to pay mine and theirs, too. Another fallacy is that health is directly proportional to the amount of access and health care coverage an individual has. Possibly with the

Exhibit K



CLINICAL REPORT

Management of Children With Autism Spectrum Disorders

Guidance for the Clinician in Rendering
Pediatric Care

Scott M. Myers, MD, Chris Plauché Johnson, MD, MEd, the Council on Children With Disabilities

ABSTRACT

Pediatricians have an important role not only in early recognition and evaluation of autism spectrum disorders but also in chronic management of these disorders. The primary goals of treatment are to maximize the child's ultimate functional independence and quality of life by minimizing the core autism spectrum disorder features, facilitating development and learning, promoting socialization, reducing maladaptive behaviors, and educating and supporting families. To assist pediatricians in educating families and guiding them toward empirically supported interventions for their children, this report reviews the educational strategies and associated therapies that are the primary treatments for children with autism spectrum disorders. Optimization of health care is likely to have a positive effect on rehabilitative progress, functional outcome, and quality of life; therefore, important issues, such as management of associated medical problems, pharmacologic and nonpharmacologic intervention for challenging behaviors or coexisting mental health conditions, and use of complementary and alternative medical treatments, are also addressed.

INTRODUCTION

The term autism spectrum disorders (ASDs) has been used to include the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)*¹ diagnostic categories autistic disorder, Asperger disorder, and pervasive developmental disorder—not otherwise specified.² Recent estimates of the prevalence of ASDs are in the range of 6.5 to 6.6 per 1000, and pediatricians, therefore, are likely to care for children and adolescents with these diagnoses.³⁻⁵ In the companion document to this clinical report,² the American Academy of Pediatrics has summarized pertinent background information on ASDs and emphasized the importance of surveillance and screening as well as other potential physician roles in the diagnostic process. However, the role of the primary health care professional extends beyond recognizing signs of ASDs, referring for diagnostic evaluation, conducting an etiologic investigation, providing genetic counseling, and educating caregivers about ASDs and includes ongoing care and management.

ASDs, similar to other neurodevelopmental disabilities, are generally not "curable," and chronic management is required. Although outcomes are variable and specific behavioral characteristics change over time, most children with ASDs remain within the spectrum as adults and, regardless of their intellectual functioning, continue to experience problems with independent living, employment, social relationships, and mental health.⁶⁻⁸ The primary goals of treatment are to minimize the core features and associated deficits, maximize functional indepen-

www.pediatrics.org/cgi/doi/10.1542/peds.2007-2362

doi:10.1542/peds.2007-2362

All clinical reports from the American Academy of Pediatrics automatically expire 5 years after publication unless reaffirmed, revised, or retired at or before that time.

The guidance in this report does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

Key Words

autism, autism spectrum disorders, Asperger syndrome, pervasive developmental disorders, complementary and alternative medicine, early intervention

Abbreviations

ASD—autism spectrum disorder
TEACCH—Treatment and Education of Autistic and Related Communication Handicapped Children
ABA—applied behavior analysis
DTT—discrete trial training
DIR—developmental, individual-difference, relationship-based
RDI—relationship-development intervention
RT—responsive teaching
SI—sensory integration
EEG—electroencephalography
SSRI—selective serotonin-reuptake inhibitor
CAM—complementary and alternative medicine
PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275). Copyright © 2007 by the American Academy of Pediatrics

the deficits. The Denver model, for example, is based largely on remediating key deficits in imitation, emotion sharing, theory of mind, and social perception by using play, interpersonal relationships, and activities to foster symbolic thought and teach the power of communication.¹² This program has shifted from a center-based treatment unit to service delivery in homes and inclusive school environments. Several studies have demonstrated improvements in cognitive, motor, play, and social skills beyond what would be expected on the basis of initial developmental rates in children who are treated according to the Denver model, but controlled trials are lacking.⁵¹⁻⁵⁴

Relationship-focused early intervention models include Greenspan and Wieder's developmental, individual-difference, relationship-based (DIR) model,⁵⁵ Gutstein and Sheely's relationship-development intervention (RDI),⁵⁶ and the responsive-teaching (RT) curriculum developed by Mahoney et al.^{57,58} The DIR approach focuses on (1) "floor-time" play sessions and other strategies that are purported to enhance relationships and emotional and social interactions to facilitate emotional and cognitive growth and development and (2) therapies to remediate "biologically based processing capacities," such as auditory processing and language, motor planning and sequencing, sensory modulation, and visual-spatial processing. Published evidence of the efficacy of the DIR model is limited to an unblinded review of case records (with significant methodologic flaws, including inadequate documentation of the intervention, comparison to a suboptimal control group, and lack of documentation of treatment integrity and how outcomes were assessed by informal procedures⁵⁵) and a descriptive follow-up study of a small subset (8%) of the original group of patients.⁵⁹ RDI focuses on activities that elicit interactive behaviors with the goal of engaging the child in a social relationship so that he or she discovers the value of positive interpersonal activity and becomes more motivated to learn the skills necessary to sustain these relationships.⁵⁶ Some reviewers have praised the face validity of this model, which targets the core impairment in social reciprocity. However, the evidence of efficacy of RDI is anecdotal; published empirical scientific research is lacking at this time. One study reported beneficial effects of RT on young children with ASDs or other developmental disabilities.⁵⁸ Parents were taught to use RT strategies to encourage their children to acquire and use pivotal developmental behaviors (attention, persistence, interest, initiation, cooperation, joint attention, and affect). Children in both groups improved significantly on nonstandardized play-based measures of cognition and communication and standardized parent ratings of socioemotional functioning. Although a control group was lacking and the potential role of concurrent educational services was unclear, the improvements

were beyond what the authors expected from maturational factors alone.⁵⁸

Speech and Language Therapy

A variety of approaches have been reported to be effective in producing gains in communication skills in children with ASDs.^{9,17,20} Didactic and naturalistic behavioral methodologies (eg, DTT, verbal behavior, natural language paradigm, pivotal response training, milieu teaching) have been studied most thoroughly, but there is also some empirical support for developmental-pragmatic approaches (eg, Social Communication Emotional Regulation Transactional Support, Denver model, RDI, Hanen model).

People with ASDs have deficits in social communication, and treatment by a speech-language pathologist usually is appropriate. Most children with ASDs can develop useful speech, and chronologic age, lack of typical prerequisite skills, failure to benefit from previous language intervention, and lack of discrepancy between language and IQ scores should not exclude a child from receiving speech-language services.⁶⁰ However, traditional, low-intensity pull-out service delivery models often are ineffective, and speech-language pathologists are likely to be most effective when they train and work in close collaboration with teachers, support personnel, families, and the child's peers to promote functional communication in natural settings throughout the day.⁶⁰

The use of augmentative and alternative communication modalities, including gestures, sign language, and picture communication programs, often is effective in enhancing communication.^{17,20,61} The Picture Exchange Communication System (PECS)^{62,63} is used widely. The PECS method incorporates ABA and developmental-pragmatic principles, and the child is taught to initiate a picture request and persist with the communication until the partner responds. Some nonverbal people with ASDs may benefit from the use of voice-output communication aids, but published evidence for these aids is scant.^{20,64} Introduction of augmentative and alternative communication systems to nonverbal children with ASDs does not keep them from learning to talk, and there is some evidence that they may be more stimulated to learn speech if they already understand something about symbolic communication.^{61,62,65}

Social Skills Instruction

There is some objective evidence to support traditional and newer naturalistic behavioral strategies and other approaches to teaching social skills.^{22-24,66-68} Joint attention training may be especially beneficial in young, preverbal children with ASDs, because joint attention behaviors precede and predict social language development.^{69,70} A recent randomized, controlled trial demonstrated that joint attention and symbolic play skills can be taught and that these skills generalize to different

settings and people.⁷¹ Families can facilitate joint attention and other reciprocal social interaction experiences throughout the day in the child's regular activities. Examples of these techniques are described in the American Academy of Pediatrics parent booklet *"Understanding Autism Spectrum Disorders."*⁷²

A social skills curriculum should target responding to the social overtures of other children and adults, initiating social behavior, minimizing stereotyped perseverative behavior while using a flexible and varied repertoire of responses, and self-managing new and established skills.¹⁰ Social skills groups, social stories, visual cueing, social games, video modeling, scripts, peer-mediated techniques, and play and leisure curricula are supported primarily by descriptive and anecdotal literature, but the quantity and quality of research is increasing.^{10,15,73} A number of social skills curricula and guidelines are available for use in school programs and at home.^{10,66,74,75}

Occupational Therapy and Sensory Integration Therapy

Traditional occupational therapy often is provided to promote development of self-care skills (eg, dressing, manipulating fasteners, using utensils, personal hygiene) and academic skills (eg, cutting with scissors, writing). Occupational therapists also may assist in promoting development of play skills, modifying classroom materials and routines to improve attention and organization, and providing prevocational training. However, research regarding the efficacy of occupational therapy in ASDs is lacking. Sensory integration (SI) therapy often is used alone or as part of a broader program of occupational therapy for children with ASDs. The goal of SI therapy is not to teach specific skills or behaviors but to remediate deficits in neurologic processing and integration of sensory information to allow the child to interact with the environment in a more adaptive fashion. Unusual sensory responses are common in children with ASDs, but there is not good evidence that these symptoms differentiate ASDs from other developmental disorders, and the efficacy of SI therapy has not been demonstrated objectively.⁷⁶⁻⁷⁸ Available studies are plagued by methodologic limitations, but proponents of SI note that higher-quality SI research is forthcoming.⁷⁹ "Sensory" activities may be helpful as part of an overall program that uses desired sensory experiences to calm the child, reinforce a desired behavior, or help with transitions between activities.

Comparative Efficacy of Educational Interventions for Young Children

All treatments, including educational interventions, should be based on sound theoretical constructs, rigorous methodologies, and empirical studies of efficacy.¹⁵ Proponents of behavior analytic approaches have been the most active in using scientific methods to evaluate their work, and most studies of comprehensive treat-

ment programs that meet minimal scientific standards involve treatment of preschoolers using behavioral approaches.^{16,38} However, there is still a need for additional research, including large controlled studies with randomization and assessment of treatment fidelity. Empirical scientific support for developmental models and other interventions is more limited, and well-controlled systematic studies of efficacy are needed.

Most educational programs available to young children with ASDs are based in their communities, and often, an "eclectic" treatment approach is used, which draws on a combination of methods including applied behavior analytic methods such as DTT; structured teaching procedures; speech-language therapy, with or without picture communication or related augmentative or alternative communication strategies; SI therapy; and typical preschool activities. Three studies that compared intensive ABA programs (25-40 hours/week) to equally intensive eclectic approaches have suggested that ABA programs were significantly more effective.^{31,32,34} Another study that involved children with ASDs and global developmental delay/mental retardation retrospectively compared a less intensive ABA program (mean: 12 hours) to a comparably intensive eclectic approach and found statistically significant but clinically modest outcomes that favored those in the ABA group.³³ Although the groups of children were similar on key dependent measures before treatment began, these studies were limited because of parent-determined rather than random assignment to treatment group. Additional studies to evaluate and compare educational treatment approaches are warranted.

Programs for Older Children and Adolescents

Some model programs provide programming throughout childhood and into adulthood.¹¹ More commonly, the focus of specialized programs is on early childhood, and published research evaluating comprehensive educational programs for older children and adolescents with ASDs is lacking. However, there is empirical support for the use of certain educational strategies, particularly those that are based on ABA, across all age groups to increase and maintain desirable adaptive behaviors, reduce interfering maladaptive behaviors or narrow the conditions under which they occur, teach new skills, and generalize behaviors to new environments or situations.^{13,21,28}

When children with ASDs move beyond preschool and early elementary programs, educational intervention continues to involve assessment of existing skills, formulation of individualized goals and objectives, selection and implementation of appropriate intervention strategies and supports, assessment of progress, and adaptation of teaching strategies as necessary to enable students to acquire target skills. The focus on achieving social communication competence, emotional and be-

Exhibit L

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

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~~ 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

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;

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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

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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
22 set forth in the Court's May 24, 2011 letter ruling.

IT IS SO ORDERED.

23 DATED this 7th day of June, 2011.

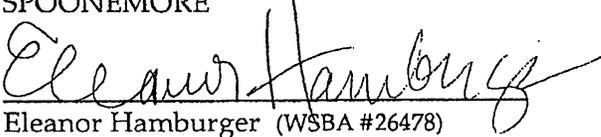
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25 
26 Judge Susan J. Craighead
Superior Court Judge

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

SIRIANNI YOUTZ SPOONEMORE
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1 Presented by:

2 SIRIANNI YOUTZ
3 SPOONEMORE

4 

5 Eleanor Hamburger (WSBA #26478)
6 Richard E. Spoonemore (WSBA #21833)
Attorneys for Plaintiffs

7
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)
Attorneys for Defendants

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

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Exhibit A

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 98104-2312
E-mail: Susan.Craighead@kingcounty.gov

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

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."

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.

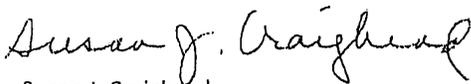
Request for a Permanent Injunction: The court has struggled with the plaintiffs' request for a permanent or, in the alternative, preliminary, injunction. The extent to which the court may resort to injunctive relief in the context of summary judgment is unclear; under CR 56, the court is not supposed 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

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 15



MICHAEL J. TRICKEY
JUDGE OF THE SUPERIOR COURT
KING COUNTY COURTHOUSE
516 THIRD AVE.
SEATTLE, WASHINGTON 98104



March 27, 2012

Eleanor Hamburger
Richard E. Spoonemore
Sirianni Youtz Spoonemoore
999 Third Avenue, Suite 3650
Seattle, WA 98104

Barbara J. Duffy
Gwendolyn C. Payton
Ryan P. McBride
Lane Powell PC
1420 Fifth Avenue, Suite 4100
Seattle, WA 98101

Re: A.G. v. Primera Blue Cross and Lifewise of Washington,
King County cause number 11-2-30233-4 SEA

Counsel:

The court heard oral argument on Defendants' CR 12(b) (6) Motion to Dismiss Plaintiffs' Complaint and Plaintiffs' CR 56 Motion for Partial Summary Judgment and CR 65 Motion for Preliminary Injunction on March 2, 2012. The court took the matters under advisement and now rules as follows.

The court concludes that RCW 48.44.341, the portion of the Mental Health Parity Act which applies to the parties in this case, can be harmonized with RCW 48.44.450, the Neurodevelopmental Therapy Mandate. Neurodevelopmental therapies are "mental health services" designed to treat autism, a DSM-IV mental disorder. These neurodevelopmental therapies may be medically necessary for treating autism.

The court also concludes that it does not have to invalidate RCW 48.44.450 to reach this result. RCW 48.44.450 only creates a minimum level of required coverage. The court does not find the legislative history offered by Defendants' to be persuasive on this issue.

Given the broad mandate regarding mental health services in RCW 48.44.341, the blanket insurance policy exclusion in this case for "[s]ervices, therapy and supplies related to the treatment of . . . developmental delay or neurodevelopmental disabilities" violates Washington public policy. The court deems the exclusion void and unenforceable in this case.

As a result, the court DENIES the Motion to Dismiss and GRANTS the Motion for Partial Summary Judgment.

The Plaintiff A.G. has requests pending with the Defendants' for neurodevelopmental therapy services. Given the court's ruling, the Plaintiff A.G. has demonstrated: 1) a clear legal right, 2) a well-grounded fear of immediate invasion of that right and that 3) a denial of these requests will

result in actual or substantial injury. The court, balancing the interests of the parties and the public, GRANTS Plaintiffs' Motion for Preliminary Injunction.

The terms of the preliminary injunction are that the Defendants shall not apply the neurodevelopmental therapy exclusion to A.G.'s requests for neurodevelopmental therapy while this case is being litigated. The Defendants shall review A.G.'s claims for neurodevelopmental therapy as a mental health benefit consistent with all other provisions of A.G.'s Premera contract, including medical necessity.

The parties shall prepare written orders consistent with the court's rulings and submit them electronically no later than Friday, April 6, 2012.

IT IS SO ORDERED. The court will file this letter ruling electronically in the court file and the court's bailiff will deliver copies to the parties via email.



Judge Michael J. Trickey

EXHIBIT 16

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IN THE SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and
K.G., on his own behalf and on behalf of all
similarly situated individuals,

Plaintiff,

v.

PREMERA BLUE CROSS and LIFEWISE OF
WASHINGTON, Washington corporations,
Defendants.

NO. 11-2-30233-4 SEA

ORDER:

- (1) GRANTING PLAINTIFF'S
MOTION FOR PARTIAL
SUMMARY JUDGMENT;
- (2) DENYING DEFENDANTS'
MOTION TO DISMISS; AND
- (3) ISSUING PRELIMINARY
INJUNCTION

Clerk's Action Required

THIS MATTER came before the Court upon Plaintiff A.G.'s Motion for Partial Summary Judgment and Preliminary Injunction and Defendants' Motion to Dismiss. The Court heard oral argument on March 2, 2012. Plaintiff A.G. is represented by Eleanor Hamburger and Richard E. Spoonemore, SIRIANNI YOUTZ SPOONEMORE. Defendants Premera Blue Cross and Lifewise of Washington ("Defendants") are represented by Barbara J. Duffy, Gwendolyn C. Payton and Ryan P. McBride, LANE POWELL PC.

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I. MATERIAL CONSIDERED

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

- Plaintiffs' Motion for Partial Summary Judgment and Preliminary Injunction;
- the Declaration of J.G. and the exhibits attached thereto;
- the Declaration of Eleanor Hamburger and the exhibits attached thereto;
- Defendant's Opposition to Plaintiff's Motion for Partial Summary Judgment and Preliminary Injunction;
- the Declaration of Barbara J. Duffy dated February 8, 2012 and all exhibits attached thereto;
- the Declaration of Nancy Moore and all exhibits attached thereto;
- the Declaration of Chelle Moat, M.D., and all exhibits attached thereto;
- the Declaration of James Tedford and all exhibits attached thereto;
- Plaintiff's Reply briefing in support of Plaintiff's Motion for Partial Summary Judgment and Preliminary Injunction;
- the Supplemental Declaration of Eleanor Hamburger and all exhibits attached thereto;
- Defendant's Motion to Dismiss;
- the Declaration of Barbara J. Duffy dated October 5, 2011, and any exhibits attached thereto;
- Plaintiffs' Response to Defendants' Cross-Motion for Summary Judgment; and
- Defendants' reply briefing in support of their Motion to Dismiss.

The Court has also considered Plaintiff's Memorandum in Support of Notice of Presentation of Proposed Order dated April 9, 2012, Defendants' Objection to Plaintiff's

1 Proposed Order and Submission of Alternative Proposed Order dated April 9, 2012,
2 and Plaintiff's Reply Re: Presentation of Order dated April 11, 2012.

3 Based on this material, the Court rules on Plaintiff's Motion for Partial Summary
4 Judgment, Defendants' Motion to Dismiss, and Plaintiff's Motion for a Preliminary
5 Injunction as set forth below.

6
7 **II. PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT AND**
8 **DEFENDANTS' MOTION TO DISMISS**

9 As set forth in the letter ruling dated March 27, 2012 and incorporated
10 herein as *Appendix A*, the Court hereby GRANTS Plaintiffs' Motion for Partial Summary
11 Judgment in full and DENIES Defendants' Motion to Dismiss in full:

12 1. Given the broad mandate regarding mental health services in the
13 Mental Health Parity Act, RCW 48.44.341, and pursuant to Washington's Declaratory
14 Judgment Act, RCW 7.24, *et seq.*, Plaintiff A.G. is entitled to a declaration that the
15 exclusion in Defendants' policies for "[s]ervices, therapy and supplies related to the
16 treatment of ... developmental delay or neurodevelopmental disabilities" violates
17 Washington public policy and the Mental Health Parity Act. The Court declares the
18 exclusion void and unenforceable in this case.

19 2. Under the Mental Health Parity Act, Defendants must provide
20 coverage for all medically necessary "mental health services" to the same extent as they
21 provide coverage for other medical and surgical services. Neurodevelopmental
22 therapies are "mental health services" designed to treat autism, a mental disorder listed
23 in the DSM-IV. Since neurodevelopmental therapies may be medically necessary to
24 treat autism, Defendants cannot use a blanket exclusion to deny coverage for those
25 therapies.

1 5. Plaintiff A.G. is and has been insured under an individual policy
2 issued by Lifewise Health Plan of Washington since at least January 1, 2006. J.G. Decl.,
3 ¶2; see Duffy Decl. (10/12/11), ¶2, *Exh. A*.

4 6. Plaintiff A.G. received neurodevelopmental speech and
5 occupational therapy from Valley Medical Center's Children's Therapy Clinic since
6 2007. J.G. Decl., ¶¶4-5. Valley submitted the bills for A.G.'s speech and occupational
7 therapy services to Lifewise, which paid for the services, at least for the first twenty
8 visits. *Id.*, ¶9. Lifewise "auto-adjudicated" these claims without subjecting them to a
9 medical necessity determination.

10 7. In late July, 2011, Plaintiff A.G.'s parents received an envelope with
11 forms called "Explanations of Benefits" (EOBs) from Lifewise. *Id.* ¶10, *Exh. A*. These
12 documents revealed that Lifewise had conducted a retrospective review of the
13 neurodevelopmental therapy provided to A.G. since January 1, 2010, and determined
14 that, in its view, all of the therapy was incorrectly covered. *Id.* The EOBs stated "our
15 medical staff reviewed this claim and determined this service is not covered by your
16 plan." *Id.* In sum, Lifewise determined that nearly \$24,000 in neurodevelopmental
17 therapies had been improperly paid, and that A.G.'s parents were financially
18 responsible for all of the treatment. *Id.*

19 8. A.G.'s father called Lifewise to object to the determination and to
20 request an explanation. *Id.*, ¶¶12-14. On August 12, 2011, Lifewise sent J.G. a letter
21 confirming the decision. Lifewise maintained that there was no coverage for
22 neurodevelopmental therapies because of an explicit exclusion in its policy:

23 This letter is being issued to provide confirmation the
24 following listed of claims (*sic*) were processed incorrectly and
25 will be adjusted as Neurodevelopment[al] therapy is not a
26 covered benefit under the above listed policy.

1 *Id.*, ¶13, *Exh. B*. Lifewise included a copy of the relevant section of A.G.'s contract which
2 contained the only exclusion it relied upon:

3 **EXCLUSIONS**

4 This section of the contract lists those services, supplies or
5 drugs [that] are *not covered* under this plan.

6 ...

7 **Learning Disorders and Neurodevelopmental Therapy**

8 Services, therapy and supplies related to the treatment of
9 learning disorders, cognitive handicaps, dyslexia,
developmental delay or neurodevelopmental disabilities.

10 *Id.*, *Exh. B*, Contract pp. 30-31 (emphasis added); *see also*, Duffy Decl., *Exh. A*, pp. 30-31.

11 9. Since Lifewise retroactively denied coverage of Plaintiff A.G.'s
12 therapy services, his parents have been forced to eliminate his speech therapy. *Id.*, ¶15.
13 His parents may be forced to reduce or eliminate his occupational therapy. *Id.*, ¶17.
14 Valley Medical Center has begun to bill Plaintiff A.G.'s parents for the amount
15 retroactively denied by Premera. *Id.*, ¶¶18; 20. Valley has sent collections notices and
16 calls to Plaintiff A.G.'s parents. *Id.*

17 **B. CR 52(a)(2)(A) Conclusions of Law.**

18 1. A plaintiff is entitled to a preliminary injunction when "(1) he has a
19 clear legal or equitable right, (2) he has a well-grounded fear of immediate invasion of
20 that right, and (3) that the acts he is complaining of have or will result in actual and
21 substantial injury." *DeLong v. Parmelee*, 157 Wn. App. 119, 150-51, 236 P.3d 936, 951-52
22 (2010).

23 2. As set forth in Section II, *above*, the only exclusion relied upon by
24 Defendants to deny coverage to Plaintiff A.G. - the exclusion for "[s]ervices, therapy
25 and supplies related to the treatment of ... developmental delay or neurodevelopmental
26 disabilities" - violates Washington public policy and the Mental Health Parity Act. He
therefore has a "clear legal or equitable right" to coverage.

1 3. Plaintiff A.G. has well-grounded fear of immediate invasion of that
2 right given that Defendants have denied, and continue to deny, coverage of Plaintiff
3 A.G.'s therapy under the neurodevelopmental therapy exclusion.

4 4. Defendants' exclusion has caused Plaintiff A.G. actual and
5 substantial harm and will continue to do so unless enjoined. According to the
6 un rebutted testimony of A.G.'s father, Plaintiff A.G. has already lost access to his
7 speech therapy and his occupational therapy is similarly at risk. Without speech
8 therapy, Plaintiff A.G. struggles with frequent gagging and choking episodes, as well as
9 visual and auditory comprehension problems, including problems with understanding
10 street signs and written instructions. J.G. Decl., ¶¶15-16. The loss of speech and
11 occupational therapy services will harm Plaintiff A.G.'s health and continued
12 development. *See, e.g., LaForest v. Former Clean Air Holding Co., Inc.*, 376 F.3d 48, 55 (2d
13 Cir. 2004). Money damages are insufficient to compensate A.G. for the resulting
14 developmental loss. *See Washington Fed'n of State Employees (WSFE), Council 28, AFL-*
15 *CIO v. State*, 99 Wn. 2d 878, 891, 665 P.2d 1337 (1983) (It is "well nigh irrefutable" that a
16 cancellation of health insurance is an injury that has no remedy at law).

17 5. Under the balancing of the relative interests of the parties and the
18 public, the balance tips in favor of issuing a preliminary injunction. *Kucera v. State,*
19 *Dept. of Transp.*, 140 Wn.2d 200, 209, 995 P.2d 63 (2000). The loss of medically necessary
20 therapies needed to maintain and improve a disabled child's functioning at a critical
21 time in his development causes actual and substantial injury. In contrast, Premera
22 suffers no hardship. Premera suffers no hardship when it is enjoined from enforcing a
23 provision of its contracts that, as this Court has concluded in Section II, violate state law
24 and public policy.

25 6. Any bond requirement is waived under RCW 7.40.080 because "a
26 person's health ... would be jeopardized" without this preliminary injunction.

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IV. CONCLUSION

It is therefore ORDERED that Plaintiffs' Motion for Partial Summary Judgment and Preliminary Injunction is GRANTED in full, and Defendants' Motion to Dismiss is DENIED in full. It is further ORDERED that:

1. The provision contained in Plaintiff A.G.'s health plan that excludes coverage of neurodevelopmental therapies is declared invalid, void and unenforceable by Defendants and their agents.

2. Defendants shall not apply the neurodevelopmental therapy exclusion in Plaintiff A.G.'s contract to his requests for neurodevelopmental therapy services from March 27, 2012, the date of the Court's letter decision, while this litigation is ongoing. Defendants shall review any new claims submitted by Plaintiff A.G. and/or his providers for neurodevelopmental therapy as a mental health benefit and consistent with all other provisions in Plaintiff A.G.'s contract, including medical necessity.

DATED this 17th day of April, 2012.



Michael J. Trickey
Superior Court Judge

Presented by:

SIRIANNI YOUTZ SPOONEMORE

/s/ Richard E. Spoonemore

Eleanor Hamburger (WSBA #26478)

Richard E. Spoonemore (WSBA #21833)

Attorneys for Plaintiff

King County Superior Court
Judicial Electronic Signature Page

Case Number: 11-2-30233-4
Case Title: A G ET AL VS PREMIERA BLUE CROSS ET ANO
Document Title: ORDER GRANT AND DENY MOTIONS & PRELIM
INJ
Signed by Judge: Michael Trickey
Date: 4/17/2012 4:06:4 PM



Judge Michael Trickey

This document is signed in accordance with the provisions in GR 30.

Certificate Hash: 0C874DD3777C2143AC749043E1D4688
Certificate effective date: 3/7/2012 1:38:27 PM
Certificate expiry date: 3/7/2014 1:38:27 PM
Certificate Issued by: CN=Washington State CA B1, OU=State of Washington
CA, O=State of Washington PKI, C=US

EXHIBIT 17

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SUPERIOR COURT OF WASHINGTON FOR KING COUNTY

A.G., by and through his parents, J.G. and K.G., on his own behalf and on behalf of all similarly situated individuals,

Plaintiff,

v.

PREMERA BLUE CROSS and LIFEWISE OF WASHINGTON, Washington corporations,

Defendants.

No. 11-2-30233-4 SEA

~~PROPOSED~~ ORDER
CERTIFYING ORDER FOR
DISCRETIONARY REVIEW
PURSUANT TO RAP 2.3(B)(4)

THIS MATTER came before the Court on Defendants' Motion to Certify Order for Discretionary Review ("Motion"). The Motion requests this Court to certify its April 17, 2012 Order Granting Plaintiff's Motion for Partial Summary Judgment, Denying Defendants' Motion to Dismiss and Issuing Preliminary Injunction ("Order") pursuant to RAP 2.3(b)(4). The Court has considered the Motion, Plaintiff's response, Defendants' reply, as well as the pleadings and record in the court file, and hereby concludes that the Order satisfies the requirements of RAP 2.3(b)(4).

THEREFORE, THIS COURT CERTIFIES that the Order "involves a controlling question of law as to which there is substantial ground for a difference of opinion and that immediate review of the order may materially advance the ultimate termination of the litigation." Specifically, the Order involves the following controlling question of law:

ORDER CERTIFYING ORDER FOR DISCRETIONARY REVIEW - 1

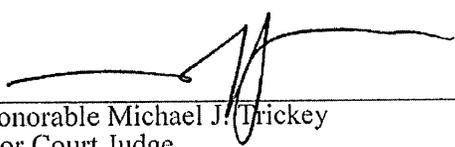
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LANE POWELL PC
1420 FIFTH AVENUE, SUITE 4100
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206.223.7000 FAX: 206.223.7107

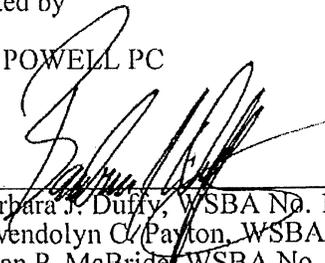
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1. The Neurodevelopmental Therapy Mandate, RCW 48.44.450, does not require individual health plans to provide insurance coverage for neurodevelopmental therapy benefits. Did the Mental Health Parity Act, RCW 48.44.341, implicitly repeal, supersede and/or abrogate the Neurodevelopmental Therapy Mandate so that individual health plans can no longer exclude coverage for neurodevelopmental therapy benefits?

DATED this 27th day of April, 2012.


The Honorable Michael J. Trickey
Superior Court Judge

Presented by
LANE POWELL PC

By 
Barbara J. Duffy, WSBA No. 18885
Gwendolyn C. Payton, WSBA No. 26752
Ryan P. McBride, WSBA No. 33280
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Attorneys for Defendants Premera Blue Cross and Lifewise of Washington

→ Trial court
order of
April 17, 2012
is not stayed
pending for
discretionary
review.
MJK