

May 3, 2010

Filed Via Federal eRulemaking Portal: <http://www.regulations.gov>

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-4140-IFC  
P.O. Box 8016  
Baltimore, MD 21244-1850

CC:PA:LPD:PR (REG-120692-09)  
Room 5205  
Internal Revenue Service  
P.O. Box 7604, Ben Franklin Station  
Washington, DC 20044.

Office of Health Plan Standards and Compliance Assistance  
Employee Benefits Security Administration  
Room N-5653  
U.S. Department of Labor  
200 Constitution Avenue, NW.  
Washington, DC 20210  
Attention: RIN 1210-AB30

Re: Interim Final Rules (the “Rules”) Implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

Ladies and Gentlemen:

Like others before us who have provided comments on the Rules, we applaud the efforts of so many individuals and groups who have worked so hard to achieve parity between mental health or substance use disorder (MH/SUD) benefits and medical/surgical benefits.

We are writing you today primarily on behalf of America’s children who cannot help themselves because they have autism spectrum disorders (ASDs). For those who do not know, autism is listed in the *Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR (fourth edition, text revision)* (DSM) as one of the five pervasive developmental disorders referred to as autism spectrum disorders. We are not aware of other comments submitted to you that address the particular needs of children with ASDs. It is important that you consider the needs of these children when you evaluate the impact of the MHPAEA and the Rules with respect to the most severe and persistent mental health conditions. Regardless, the comments that we make in this letter are also intended to benefit other individuals with mental health conditions.

America’s children with ASDs currently represent at least 1% of the population and that percentage continues to grow at a significant rate.<sup>1</sup> These children deserve a better opportunity to live meaningful, happy lives and to become contributing members of society. Children with ASDs cannot pull themselves up by their own bootstraps. But, as reflected in Exhibit A to this letter, significant evidence supports the efficacy of behavioral therapy for treating ASDs. There is a relatively small window of opportunity (starting around age 3) during which intensive behavioral therapy can make a significant difference. While intensive behavioral therapy can continue to have an impact in later years, the return on investment is typically most significant during that window of opportunity.

---

<sup>1</sup> See <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5810a1.htm>. “In 2006, on average, approximately 1% or one child in every 110 in the 11 ADDM sites was classified as having an ASD.” “The average prevalence of ASDs identified among children aged 8 years increased 57% . . . from the 2002 to the 2006 ADDM [Autism and Developmental Disabilities Monitoring Network] surveillance year.”

Most children with ASDs do not get the help they need, despite the often heroic efforts of their families. Most families do not have sufficient financial resources to pay for the intensive behavioral therapy that is necessary to effectively treat ASDs. For the families who can afford to pay, many eventually run out of resources, in part due to no insurance coverage. The stress that such circumstances place on many families in America is extraordinary. The emotions faced by these parents can be devastating, particularly when they are not able to help their children.

Some families believed they were fortunate to work for employers who elected to offer MH/SUD benefits for children with ASDs or to live in a state that adopted legislation that required such benefits. Over the years, the hopes of many of these families were dashed when they learned that, while their plan documents or insurance policies purported to offer such benefits for their children, those benefits were managed in a discriminatory manner so that they received benefits so limited in scope and duration that the benefits were essentially meaningless. It is our understanding that, for many families, this approach has not yet changed in 2010 despite the requirements of the MHPAEA. The predominant strategy adopted by health insurance issuers and third party administrators (TPAs) of group health plans typically appears to be “just say no.” The time and effort (and in some cases legal costs) that it takes to overcome this strategy adds an additional burden to an overburdened family that significantly enhances the effectiveness of this strategy. As a result, the children with ASDs that are beneficiaries of such plans or policies are essentially uninsured - despite the premiums that their families pay.

While the legislation does not offer universal mental health coverage for children as well as mental health parity, the MHPAEA is a piece of the puzzle that can begin to make a difference for these children and their families. The Rules represent an opportunity to help America’s children with ASDs who are the beneficiaries of a group health plan or health insurance policy that purports to offer meaningful benefits. It is essential that the Rules be carefully crafted to close any loopholes that could make the MHPAEA ineffective. Meaningful comprehensive final regulations also need to be adopted as soon as possible. For every year that passes, the window of opportunity closes for far too many children. The opportunity costs associated with that lost opportunity can be staggering. According to Autism Votes, without effective early intervention, the average lifetime cost of an individual who has autism is \$3,200,000, while this cost can be reduced by two-thirds through intensive behavioral therapy.<sup>2</sup>

We have included below our comments on the Rules. With respect to all other aspects of the Rules, we support the rules adopted by the Departments. The numbered paragraphs correspond to numbered paragraphs in the Rules. Our goal is to do what we can to help each of you, the people who are responsible for implementing the MHPAEA, better understand the ramifications of the actions that you take, or elect not to take, when you craft the final rules that implement the MHPAEA, particularly as the rules affect children with ASDs. We hope that these comments are informative and prove useful to you.

---

<sup>2</sup> Autism Votes is an Autism Speaks initiative. See <http://www.autismvotes.org/atf/cf/%7B2A179B73-96E2-44C3-8816-1B1C0BE5334B%7D/Minnesota%20HF%20359%20Summary%20and%20FAQ.pdf>

**Comment #1**

SUPPLEMENTARY INFORMATION:

- II. Overview of the Regulations
- C. Parity Requirements With Respect to Financial Requirements and Treatment Limitations
  - 1. General Parity Requirement for Financial Requirements and Treatment Limitations
  - e. Application to nonquantitative treatment limitations.

**Interim Final Rules**

*“Plans impose a variety of limits affecting the scope or duration of benefits under the plan that are not expressed numerically. Nonetheless, such nonquantitative provisions are also treatment limitations affecting the scope or duration of benefits under the plan. These regulations provide an illustrative list of nonquantitative treatment limitations, including medical management standards; prescription drug formulary design; standards for provider admission to participate in a network; determination of usual, customary, and reasonable amounts; requirements for using lower-cost therapies before the plan will cover more expensive therapies (also known as fail-first policies or step therapy protocols); and conditioning benefits on completion of a course of treatment.*

...

*“Medical management standards are implemented by processes such as preauthorization, concurrent review, retrospective review, case management, and utilization review; the examples feature the application of these requirements to some of these processes.*

...

*“The Departments invite comments on whether additional examples would be helpful to illustrate the application of the nonquantitative treatment limitation rule to other features of medical management or general plan design.”*

**Comment**

Medical management standards are nonquantitative treatment limitations that are implemented to save money. It can be difficult to distinguish medical management standards that comply with the parity requirements of the MHPAEA from those that are discriminatory. As we mentioned previously, some group health plans and health insurance issuers craft plan documents and policies that purport to offer MH/SUD benefits for children with ASDs while they implement discriminatory medical management standards in order to pay minimal, and often meaningless, benefits. The most insidious discrimination that is practiced by group health plans and health insurance companies is the “just say no” strategy. A common version of this strategy requires preauthorization, during which claims personnel continue to say “no” to each preauthorization and claims request until the insured runs out of the patience, time and/or money it takes to fight the battle.

As stated in the Rules in the section entitled “*IV. Economic Impact and Paperwork Burden, C. Executive Order 12866 - Department of Labor and Department of Health and Human Services, 3. Benefits,*” the purpose of the MHPAEA is to end such discriminatory practices:

*“One of Congress’ primary objectives in enacting MHPAEA was to improve access to mental health and substance use disorder benefits by eliminating discrimination that existed with respect to these benefits after MHPA 1996. Congress’ intent in enacting MHPAEA was articulated in a floor statement from Representative Patrick Kennedy (D–RI), one of the chief sponsors of the legislation, who said ‘[a]ccess to mental health services is one of the most important and most neglected civil rights issues facing the Nation. For too long, persons living with mental disorders have suffered discriminatory treatment at all levels of society.’ In a similar statement, Representative James Ramstad (R–MN) said, ‘[i]t’s time to end the discrimination against people who need treatment for mental illness and addiction. It’s time to prohibit health insurers from placing discriminatory barriers on treatment.’” (bold added)*

So far, it has typically been the responsibility of each child’s parents to fight individually pitched battles against insurance companies in their capacities as either health insurance issuers or TPAs for group health plans. The resource allocation in such disputes is misaligned. Many parents do not have the time, the money or the education to undertake a lengthy, costly and complex dispute. Other parents, perceiving a low probability of success despite an apparently valid claim, would rather invest that time and money to treat their child’s ASD. Without access to the tools and assistance that they need to defend their rights under the MHPAEA, too many families will lose a battle they could have won and, as a result, also lose the war against their child’s ASD.

To make matters worse, for those who elect to stand up for their child’s rights against such discriminatory practices, they must find the resources to undertake such disputes. Some will mortgage their homes and their futures. For others, their jobs will suffer. As stated in the Rules in the section entitled “*IV. Economic Impact and Paperwork Burden, C. Executive Order 12866 - Department of Labor and Department of Health and Human Services, 3. Benefits*”:

*“Many people with mental health conditions and substance use disorders are employed and these debilitating conditions have a devastating impact on employee attendance and productivity, which results in lost productivity for employers and lost earnings for employees.”*

The same statement all too easily applies to parents who must battle health insurance issuers or TPAs to defend the rights of a child. Identical issues are faced by adults who are diagnosed with mental health conditions (including ASDs) and must fight similar battles to defend their own rights. Of course, their battle has an added degree of difficulty.

To address such discrimination, the Rules should include provisions that would both diminish the need for such one-at-a-time disputes with health insurance issuers and TPAs as well as level the playing field when such disputes do occur. The Rules should leverage the provisions of the MHPAEA to make a meaningful statement regarding compliance. To determine compliance, the MHPAEA provides to the Department of the Treasury, to the Department of Labor, and to the Department of Health and Human Services (Departments) the power to audit the books and records of group health plans and health

insurance issuers. The MHPAEA also requires the Departments to provide assistance to participants and beneficiaries concerning the requirements of the MHPAEA, including compliance by group health plans and health insurance issuers.

Accordingly, the Rules should require group health plans and health insurance issuers to maintain sufficient data for the Departments to conduct meaningful audits. Such data should be clear, concise, and not omit any fact necessary in order to make the data not materially misleading. Similarly, the Rules should require that group health plans and health insurance issuers make such data available to plan participants and insurance beneficiaries so that they can make better informed health care decisions and better defend their rights under the MHPAEA. Finally, the Departments should include such data in the reports by the Departments to Congressional committees that are mandated by the MHPAEA to take place by January 1, 2012 and every two years thereafter.

More specifically, for example, the Rules should require group health plans and health insurance issuers to compile, maintain, and make available data so that the Departments, plan participants, insurance beneficiaries, and service providers are able to meaningfully evaluate whether the medical management standards reflected in denials of claims for any MH/SUD benefits are applied in a more restrictive manner than the predominant medical management standards reflected in denials of claims for substantially all medical/surgical benefits. The Rules already require group health plans and health insurance companies to disclose, upon request, the generic criteria for all medical necessity determinations and the reasons why a specific claim is denied. The Rules should be amended to require that group health plans and health insurance companies compile and make available online (without disclosing confidential personal information) to plan participants and insurance beneficiaries data such as:

- the ratio of all initially denied requests for preapproval to total requests for preapproval
- how many initially denied requests for preapproval were eventually paid
- the ratio of all approved requests for preapproval to total requests for preapproval
- the ratio of all claims initially denied to total claims
- how many initially denied claims were eventually paid
- the ratio of all claims paid to total claims
- how the criteria for medical necessity determinations were applied, and when and how discretion was exercised, with respect to each claim and request for preapproval that is denied
- the outcome of each dispute regarding a denied request for preapproval or denied claim where, eventually, approval is granted and claims are paid

Such data should be maintained and disclosed separately in a meaningful manner for MH/SUD benefits and for medical/surgical benefits as well as in the aggregate. Such data also should be made available online promptly (preferably monthly and no less frequently than quarterly) and maintained permanently (like public company data on the SEC's website) so that its availability would be meaningful to participants, beneficiaries, and service providers who need the data to dispute denied claims.

## **Comment #2**

### SUPPLEMENTARY INFORMATION:

- II. Overview of the Regulations
- C. Parity Requirements With Respect to Financial Requirements and Treatment Limitations
  - 1. General Parity Requirement for Financial Requirements and Treatment Limitations
    - e. Application to nonquantitative treatment limitations.

### **Interim Final Rules**

*“The Departments received many comments addressing an issue characterized as “scope of services” or “continuum of care”. Some commenters requested, with respect to a mental health condition or substance use disorder that is otherwise covered, that the regulations clarify that a plan is not required to provide benefits for any particular treatment or treatment setting (such as counseling or non-hospital residential treatment) if benefits for the treatment or treatment setting are not provided for medical/surgical conditions. Other commenters requested that the regulations clarify that a participant or beneficiary with a mental health condition or substance use disorder have coverage for the full scope of medically appropriate services to treat the condition or disorder if the plan covers the full scope of medically appropriate services to treat medical/surgical conditions, even if some treatments or treatment settings are not otherwise covered by the plan. Other commenters requested that MHPAEA be interpreted to require that group health plans provide benefits for any evidence based treatment.*

*“The Departments recognize that not all treatments or treatment settings for mental health conditions or substance use disorders correspond to those for medical/surgical conditions. The Departments also recognize that MHPAEA prohibits plans and issuers from imposing treatment limitations on mental health and substance use disorder benefits that are more restrictive than those applied to medical/surgical benefits. These regulations do not address the scope of services issue. The Departments invite comments on whether and to what extent MHPAEA addresses the scope of services or continuum of care provided by a group health plan or health insurance coverage.”*

### **Comment**

The Departments have asked for comments regarding whether the MHPAEA addresses the scope of services or continuum of care provided by a group health plan or health insurance policy. Because general plan design features and medical management standards can be implemented in a manner that limits, without discretion, the scope and duration of the recommended treatment, it is appropriate to address in the Rules the scope of services or continuum of care issue. The Rules should be amended to address the scope of services or continuum of care issue so that health insurance issuers as well as group health plans and their TPAs are not free to impose limitations on available services in order to avoid complying with parity requirements, in particular by directly or indirectly imposing a qualitative or quantitative treatment limitation or a financial requirement that violates the MHPAEA. For example, it is possible to impose direct limits on available services, service providers, or service settings in a manner that result in limits on the frequency of treatment,

duration of a visit, total number of visits, and other similar limits on scope or duration of treatment, as well as limits on annual and lifetime costs for services. Accordingly, depending on the circumstances, how group health plans or health insurance policies address certain scope of services or continuum of care issues should be treated as qualitative or quantitative treatment limitations or financial requirements.

If the Rules do not address the scope of services or continuum of care issue, employers with no mental health care expertise will be able to select freely among optional general plan design features that limit, without exception, the scope and duration of treatment otherwise recommended by a treating healthcare provider. Similarly, health insurance issuers as well as employers and their TPAs can adopt plan design features that limit the scope and duration of treatment by excluding clinically appropriate services, appropriate treatment settings, or qualified service providers without the need to examine data regarding a child's specific needs or critically evaluate determinations of medical necessity by a treating mental health service provider.

ABA Therapy. More specifically, we understand that insurance companies, acting in their separate capacities as either health insurance issuers or TPAs for a group health plan, have disclosed to parents that the insurer/TPA advised their employer clients that the provision of benefits for any one mental health condition does not require the coverage of any particular service to treat the mental health condition. For example, while a plan generically included benefits for treating autism, the TPA denied coverage for applied behavior analysis (ABA) therapy to treat a child diagnosed with severe autism and declared that the employer had elected not to pay for the option to include ABA therapy as a covered service. A representative of the TPA indicated that, in the absence of the ABA therapy option, only less intensive therapies in limited locations by a limited class of service providers were available. The TPA representative also indicated that the TPA did not need to evaluate any determination by the child's treating healthcare provider that ABA therapy was medically necessary. Simply stated, the TPA and employer implemented plan design features regarding scope or services and continuum of care that were designed to limit the frequency and intensity of the services in order to cap the annual and lifetime costs of services.

To be clear, significant evidence supports the efficacy of ABA therapy for treating autism. Please see Exhibit A to this letter for supporting data. Among others, the Surgeon General stated as follows:

*“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. . . . Thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior”*

The National Institutes of Health (NIH), a component of the U.S. Department of Health and Human Services, concluded as follows:

*“One point that most professionals agree on is that early intervention is important; another is that most individuals with ASD respond well to highly structured, specialized programs.”*

A comprehensive, intensive program of ABA therapy can entail 30 to 40 hours per week (more or less depending on the child's needs) to be effective for a child with a severe ASD. Admittedly, such therapy can be expensive, but it may be the only meaningful alternative.

In addition, a comprehensive ABA-based program can utilize different therapies and different strategies for implementing the strategies. For example, Natural Environment Training (NET) may be used in an ABA-based program to address basic life skills, such as being able to eat, drink, dress, potty, and bath/shower independently, as well as more complex skills, such as emotional understanding, perspective taking, and problem solving. NET is most effective outside of a hospital or therapist's office in a setting where the skills being taught are most likely to be utilized. For effective early intervention therapy, a common setting is the child's home. If an insurance policy or a group health plan can freely implement a plan design feature that excludes care in the home, without exception, that scope of services limitation could be used to exclude successful ABA therapy.

For such circumstances, the Rules should clarify that, for example, where ABA therapy is the only clinically appropriate service pursuant to recognized standards of care, then the parity requirements would mandate that ABA therapy be available. In such circumstances, it is unlikely that a meaningful comparison would be appropriate between clinically appropriate standards of care with respect to MH/SUD benefits and clinically appropriate standards of care with respect to medical/surgical benefits.

The Rules already set forth two examples that are meaningful for this analysis. The first example, Example 4, reflects a discriminatory plan design feature that eliminates any discretion (applying recognized clinically appropriate standards of care) with respect to scope of services or continuum of care issues:

***“Example 4. (i) Facts. A plan generally covers medically appropriate treatments. In determining whether prescription drugs are medically appropriate, the plan automatically excludes coverage for antidepressant drugs that are given a black box warning label by the Food and Drug Administration (indicating the drug carries a significant risk of serious adverse effects). For other drugs with a black box warning (including those prescribed for other mental health conditions and substance use disorders, as well as for medical/surgical conditions), the plan will provide coverage if the prescribing physician obtains authorization from the plan that the drug is medically appropriate for the individual, based on clinically appropriate standards of care.***

***“(ii) Conclusion. In this Example 4, the plan violates the rules of this paragraph (c)(4). Although the same nonquantitative treatment limitation—medical appropriateness—is applied to both mental health and substance use disorder benefits and medical/surgical benefits, the plan’s unconditional exclusion of antidepressant drugs given a black box warning is not comparable to the conditional exclusion for other drugs with a black box warning.”***

The second example, Example 3, reflects a non-discriminatory plan design that permits the appropriate exercise of discretion (applying recognized clinically appropriate standards of care) with respect to scope of services or continuum of care issues:

***“Example 3. (i) Facts. A plan generally covers medically appropriate treatments. For both medical/surgical benefits and mental health and substance use disorder benefits, evidentiary standards used in determining whether a treatment is medically appropriate (such as the number of visits or days of coverage) are based on recommendations made by panels of experts with appropriate training and experience in the fields of medicine involved. The evidentiary standards are applied in a manner that may differ based on clinically appropriate standards of care for a condition.***

***“(ii) Conclusion. In this Example 3, the plan complies with the rules of this paragraph (c)(4) because the nonquantitative treatment limitation—medical appropriateness—is the same for both medical/surgical benefits and mental health and substance use disorder benefits, and the processes for developing the evidentiary standards and the application of them to mental health and substance use disorder benefits are comparable to and are applied no more stringently than for medical/surgical benefits. This is the result even if, based on clinically appropriate standards of care, the application of the evidentiary standards does not result in similar numbers of visits, days of coverage, or other benefits utilized for mental health conditions or substance use disorders as it does for any particular medical/surgical condition.”***

Finally, to the extent that the term “recognized clinically appropriate standards of care” in the Rules is not sufficiently a well defined term of art to include ABA therapy, the Rules should be amended to include a standard that includes mental health services such as ABA therapy. Such a change to the Rules is important where, for example, ABA therapy is considered by the child’s treating healthcare provider(s) to be medically necessary and the only meaningful therapy available. Similar changes should be made to require any evidence-based treatment considered by treating healthcare provider(s) to be medically necessary and the only meaningful therapy available.

Qualified Behavioral Therapy Providers. Further, we understand that provisions of group health plans or insurance policies, implemented after the effective date of the MHPAEA, currently exclude all providers who can provide otherwise covered behavioral therapy other than psychologists and psychiatrists. This is another example of a plan design feature regarding scope or services and continuum of care that was designed to limit the frequency and intensity of the services in order to cap the annual and lifetime costs of services. In this case, it is our understanding that, absent separate training, psychologists and psychiatrists are not adequately trained to provide ABA therapy. Typically, they learn about behavioral therapy in school, but do not receive an intensive education and are not required to participate in on-the-job training to be licensed. On the other hand, Board Certified Behavior Analysts (BCBAs) and Board Certified Assistant Behavior Analysts (BCaBAs) are qualified and certified to provide behavioral therapy to treat ASDs. Some psychologists, psychiatrists and other qualified mental health professionals who provide behavioral therapy services are also BCBAs. Some mental health professionals are not. For more information

Department of Health and Human Services  
Department of Labor  
Internal Revenue Service  
May 3, 2010  
Page 10

regarding BCBAAs, BCaBAAs, the Behavior Analyst Certification Board and recommended standards of care provided by BCBAAs & BCaBAAs, please see Exhibit B to this letter.

Mental health professionals that are not BCBAAs may attempt to implement a behavioral-style therapy program by meeting with the parents (typically without observing the child's behavior) and attempting to train the parent to implement the therapy at home. It is our understanding that no evidence supports the efficacy of such a therapy program for treating severe autism. More appropriately, a higher cost BCBA performs a functional analysis by directly observing the behavior where it occurs, and then develops and supervises a data driven therapy program implemented by lower cost BCaBAAs or other qualified personnel.

In addition, we understand that some group health plans or insurance policies, implemented after the effective date of the MHPAEA, currently do not include BCBAAs or BCaBAAs as in-network providers. In addition, these plans and policies typically mandate that, while BCaBAAs and other qualified personnel cannot provide out-of-network covered services, only BCBAAs or other higher cost mental health professionals can provide such out-of-network services. The coinsurance requirements of the plan or policy for out-of-network services are typically set substantially lower than the coinsurance requirements for in-network services. A typically staffed ABA therapy program utilizing qualified, out-of-network service providers could be affordable, while an out-of-network program would not be affordable if only BCBAAs can develop programs and provide the required hours of therapy.

For the same reasons stated above regarding the availability of ABA therapy generally, the Rules should clarify that, for example, where ABA therapy is the only clinically appropriate service pursuant to recognized standards of care, then the MHPAEA's parity requirements would mandate that ABA therapy provided by BCBAAs and BCaBAAs in the manner approved by the Behavior Analyst Certification Board (or by any other qualified practitioner acting legally within the scope of his or her practice in accordance with recognized clinically appropriate standards of care) must be a covered service.

Further, because of the discriminatory processes reflected by the examples above and other similar practices reflected in comments provided by other commenters, the Rules need to address network adequacy requirements to ensure that the requirements for in-network mental health service providers are not applied in a discriminatory manner in order to avoid the parity requirements of the MHPAEA. Manipulation of provider networks in such a discriminatory manner would constitute a non-qualitative treatment limitation. An example of discriminatory network adequacy requirements would be the imposition of a prior authorization requirement that limited each mental health prior authorization to a specified number of therapy sessions. Such a limitation could be implemented in a discriminatory manner by not fully disclosing that additional visits would be available after further pre-approval. Further, such a limitation would be a discriminatory treatment limitation that violated the MHPAEA if the pre-approval requirement was implemented in a manner that more restrictive than prior authorization requirements for medical/surgical benefits.

### **Comment #3**

#### SUPPLEMENTARY INFORMATION:

- II. Overview of the Regulations
- D. Availability of Plan Information

#### **Interim Final Rules**

***“MHPAEA includes two new disclosure provisions for group health plans (and health insurance coverage offered in connection with a group health plan). First, the criteria for medical necessity determinations made under a plan (or health insurance coverage) with respect to mental health or substance use disorder benefits must be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. These regulations repeat the statutory language without substantive change. The Departments invite comments on what additional clarifications might be helpful to facilitate compliance with this disclosure requirement for medical necessity criteria.”***

#### ***Comment***

The Rules should be clear and concise regarding what information is to be disclosed and when.

Currently, for group health plans subject to ERISA, participants and beneficiaries are entitled to disclosure regarding the terms of the plan. According to the United States Department of Labor:<sup>3</sup>

*“One of the most important documents participants are entitled to receive automatically when becoming a participant of an ERISA-covered retirement or health benefit plan or a beneficiary receiving benefits under such a plan, is a summary of the plan, called the summary plan description or SPD. The plan administrator is legally obligated to provide to participants, free of charge, the SPD. The summary plan description is an important document that tells participants what the plan provides and how it operates. It provides information on when an employee can begin to participate in the plan, how service and benefits are calculated, when benefits becomes vested, when and in what form benefits are paid, and how to file a claim for benefits. If a plan is changed, participants must be informed, either through a revised summary plan description, or in a separate document, called a summary of material modifications, which also must be given to participants free of charge.”*

This SDP requirement appears on its face to be helpful for plan participants and beneficiaries. In practice, the SPD requirement often does not operate in their best interests. Certainly, the SPD requirement does not operate in the best interest of potential plan participants. Group health plans often do not make an SPD available during open enrollment. Frequently, a plan will make available during open enrollment a summary of benefits that is significantly shorter than the SPD. Such summaries sometimes even refer to an SPD as the governing document and use defined terms from the SPD or the

---

<sup>3</sup> <http://www.dol.gov/dol/topic/health-plans/planinformation.htm>

plan's contract with its TPA, while the definitions are not included in the summary or otherwise available. Some plans do not make an SPD available until four months after the beginning of the plan year. In such circumstances, the plan administrator and the TPA often claim that ERISA does not mandate that they make the SPD available until the fourth month of the plan year. If that is the requirement under ERISA, the requirement falls short of meeting its intended purpose and should be changed both in this context and under ERISA generally.

Families make crucial decisions regarding health care options during open enrollment. Some families are choosing between material plan alternatives. Others are choosing between plans offered by the employers of both parents. Some families also must decide whether these alternatives are adequate and whether they need to compare their employer alternatives with individual insurance or other alternatives. Such critical decisions will be even more common as different alternatives become available under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. If group health plans or insurance companies are not required to deliver during open enrollment an SPD or substantially similar document describing all material terms relating to benefits, it may be impossible for families to make educated decisions. Participants and beneficiaries often have little alternative but to resort to guessing (which rarely would be considered to be educated guessing). In the context of health care decisions, such a process can lead to catastrophic outcomes.

Specifically with respect to the MHPAEA, as noted above, the criteria for medical necessity determinations made by health insurance issuers as well as group health plans and their TPAs with respect to MH/SUD benefits must be made available by the plan administrator or the insurance company to any current or potential participant, beneficiary or provider. To avoid the SPD issues addressed above, and to be most meaningful, the Rules should be amended to require that this information be included in an SPD or a substantially similar document for health insurance that is not subject to ERISA. Further, the Rules should be amended to require that this information be available during open enrollment and at all times thereafter - before, during, and after the plan year or the year during which the insurance was in force.

Finally, the Rules should require that each delivery of such information pursuant to the MHPAEA must be clear, must be concise, and must not omit any fact necessary in order to make the statements in that delivery not materially misleading to any current or potential participant, beneficiary or provider. In that context, the Rules should clarify that, rather than a summary, group health plans and their TPAs may be required to disclose the substantive policies, procedures and other documents that govern medical necessity determinations.

We note that at least one commenter stated that health insurance companies and TPAs are concerned that this disclosure mandate would require a company to disclose criteria for medical necessity determinations that are considered to be confidential, proprietary, and trade secrets. The argument appears to be that well crafted criteria for medical necessity determinations can give a health insurance company a competitive edge. For public policy reasons, any such proprietary interests should not be given priority over the interests addressed by the MHPAEA. In most circumstances, there are a number of ways that such proprietary interests could be protected while delivering the information to any current or potential participant, beneficiary or provider. However, for circumstances when the interests irreconcilably conflict, we recommend that the Rules state that public policy favors disclosure under the MHPAEA.

#### **Comment #4**

##### SUPPLEMENTARY INFORMATION:

- II. Overview of the Regulations
- D. Availability of Plan Information

#### **Interim Final Rules**

*“MHPAEA also provides that the reason for any denial under a group health plan (or health insurance coverage) of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any participant or beneficiary must be made available, upon request or as otherwise required, by the plan administrator (or the health insurance issuer) to the participant or beneficiary in accordance with regulations. These regulations clarify that, in order for plans subject to ERISA (and health insurance coverage offered in connection with such plans) to satisfy this requirement, disclosures must be made in a form and manner consistent with the rules for group health plans in the ERISA claims procedure regulations, which provide (among other things) that such disclosures must be provided automatically and free of charge. In the case of non-Federal governmental and church plans (which are not subject to ERISA), and health insurance coverage offered in connection with such plans, these regulations provide that compliance with the form and manner of the ERISA claims procedure regulations for group health plans satisfies this disclosure requirement. The Departments invite comments regarding any additional clarifications that would be helpful to facilitate compliance with MHPAEA’s disclosure requirements regarding denials of mental health or substance use disorder benefits.”*

#### ***Comment***

As noted above, under the MHPAEA, the reason for any denial made by health insurance issuers as well as group health plans and their TPAs with respect to MH/SUD benefits of reimbursement or payment for services with respect to MH/SUD benefits in the case of any participant or beneficiary must be made available, upon request or as otherwise required, to the participant or beneficiary. To avoid the SPD issues addressed in Comment #3 above, and to be most meaningful, the Rules should be amended to require that this information be accompanied by an SPD or a substantially similar document for health insurance that is not subject to ERISA. Further, the Rules should be amended to require that this information be available to participants and beneficiaries at all times during and after the plan year or the year during which the insurance was in force.

Further, the Rules should require that each delivery of such information pursuant to the MHPAEA must be clear, must be concise, and must not omit any fact necessary in order to make the statements in that delivery not materially misleading to the participant or beneficiary. In that context, the Rules should clarify that, rather than a summary, group health plans and their TPAs may be required to disclose the entire policy, certificate, contract of insurance, group health plan contract, or other document that governs health insurance or other health care benefits.

**Comment #5**

SUPPLEMENTARY INFORMATION:

- II. Overview of the Regulations
- E. General Applicability Provisions
- 2. Interaction With State Insurance Laws

**Interim Final Rules**

*“The preemption provisions of section 731 of ERISA and section 2723 of the PHS Act (added by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the MHPAEA requirements are not to be “construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement” of MHPAEA. The HIPAA conference report indicates that this is intended to be the “narrowest” preemption of State laws. (See House Conf. Rep. No. 104–736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018.)*

*A State law, for example, that mandates that an issuer offer a minimum dollar amount of mental health or substance use disorder benefits does not prevent the application of MHPAEA. Nevertheless, an issuer subject to MHPAEA may be required to provide mental health or substance use disorder benefits beyond the State law minimum in order to comply with MHPAEA.”*

**Comment**

As noted above, the Rules provide guidance on how the MHPAEA interacts with State insurance laws requiring parity for, or mandating coverage of, MH/SUD benefits. To the extent that the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (PPACA) collectively include mandated MH/SUD benefits, it would be helpful if the Rules were amended to address in a similar manner how the PPACA and the MHPAEA will interact.

## **Comment #6**

### SUPPLEMENTARY INFORMATION:

- II. Overview of the Regulations
- I. Applicability Dates

#### **Interim Final Rules**

*“Because the statutory MHPAEA provisions are self-implementing and are generally effective for plan years beginning after October 3, 2009, many commenters asked for a good faith compliance period from Departmental enforcement until plans (and health insurance issuers) have time to implement changes consistent with these regulations. For purposes of enforcement, the Departments will take into account good-faith efforts to comply with a reasonable interpretation of the statutory MHPAEA requirements with respect to a violation that occurs before the applicability date of paragraph (i) of these regulations. However, this does not prevent participants or beneficiaries from bringing a private action.”*

#### **Comment**

It would be beneficial if the Departments amended the Rules to clarify how to interpret the statutory MHPAEA requirements with respect to a violation that occurs after the effective date of the MHPAEA but before the applicability date of the Rules. Latitude for good-faith efforts to comply makes sense in situations like the following where reasonable interpretation of the statutory language in the MHPAEA could include two interpretations, both of which are addressed in the Rules:

#### ***“2. General Parity Requirement for Financial Requirements and Treatment Limitations***

...

*d. Cumulative financial requirements and quantitative treatment limitations, including deductibles. While financial requirements such as copayments and coinsurance generally apply separately to each covered expense, other financial requirements (in particular, deductibles) accumulate across covered expenses. In the case of deductibles, generally an amount of otherwise covered expenses must be accumulated before the plan pays benefits. Financial requirements and quantitative treatment limitations that determine whether and to what extent benefits are provided based on accumulated amounts are defined in these regulations as cumulative financial requirements and cumulative quantitative treatment limitations. In response to the RFI, the Departments received a number of comments regarding how to apply the parity requirements to cumulative financial requirements, in particular to deductibles (although some also referred to out-of-pocket maximums). The comments reflect two opposing views.*

...

*The Departments carefully considered the positions advanced by both groups of comments regarding separately accumulating and combined deductibles. Given that the statutory language does not preclude either interpretation, the Departments’ view is that prohibiting separately accumulating financial restrictions and quantitative treatment limitations is more consistent with the policy goals that led to the enactment of MHPAEA. Consequently, these*

*regulations provide, in paragraph (c)(3)(v), that a plan may not apply cumulative financial requirements or cumulative quantitative treatment limitations to mental health or substance use disorder benefits in a classification that accumulate separately from any such cumulative financial requirements or cumulative quantitative treatment limitations established for medical/surgical benefits in the same classification.”*

But, in many other sections, the regulations and the commentary in the Rules repeat the statutory language with little or no substantive change:

*“D. Availability of Plan Information (26 CFR 54.9812–1T(d), 29 CFR 2590.712(d), and 45 CFR 146.136(d)) MHPAEA includes two new disclosure provisions for group health plans (and health insurance coverage offered in connection with a group health plan). First, the criteria for medical necessity determinations made under a plan (or health insurance coverage) with respect to mental health or substance use disorder benefits must be made available by the plan administrator (or the health insurance issuer offering such coverage) in accordance with regulations to any current or potential participant, beneficiary, or contracting provider upon request. These regulations repeat the statutory language without substantive change.”*

Where a reasonable interpretation of the statutory MHPAEA requirements includes only one interpretation and the Rules do not expand the scope of that reasonable interpretation, the Rules should be clear that group health plans and health insurance issuers must fully comply with the MHPAEA beginning on the effective date of the MHPAEA. A lack of clarity on this point is likely to result in an increase in the use of the “just say no” strategy (see our Comment #1 above) until the effective date of the final rules implementing the MHPAEA. We recommend that the Departments do what they can to prevent such circumstances.

**Comment #7**

26 CFR Part 54

§ 54.9812 Parity in mental health and substance use disorder benefits (temporary).

29 CFR Part 2590

§ 2590.712 Parity in mental health and substance use disorder benefits (temporary).

45 CFR Part 146

§ 146.136 Parity in mental health and substance use disorder benefits (temporary).

**Interim Final Rules**

***“(e) Applicability—***

*...*

***(3) Scope. This section does not—***

***(i) Require a group health plan to provide any mental health benefits or substance use disorder benefits, and the provision of benefits by a plan for one or more mental health conditions or substance use disorders does not require the plan under this section to provide benefits for any other mental health condition or substance use disorder; or***

***(ii) Affect the terms and conditions relating to the amount, duration, or scope of mental health or substance use disorder benefits under the plan except as specifically provided in paragraphs (b) and (c) of this section.”***

***Comment***

While this comment may only raise a issue of semantics, we recommend that the Rules clarify the intention of the Departments regarding subpart (ii) of subsection 3 (Scope) above as to whether the subsection applies either (1) only to the scope of the Rules, or (2) both to the scope of the Rules and the scope of the MHPAEA. As amended by the MHPAEA, Title 29, Chapter 18, Subchapter I, Subtitle B, Part 7, Subpart B, §1185a (Parity in mental health and substance use disorder benefits) reads as follows:

***“(b) Construction***

***Nothing in this section shall be construed—***

***(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health or substance use disorder benefits; or***

***(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health or substance use disorder benefits, as affecting the terms and conditions of the plan or coverage relating to such benefits under the plan or coverage, except as provided in subsection (a).”***

The use of the term “specifically” in subpart (ii) of subsection 3 (Scope) could be interpreted by the courts or other legal or administrative authorities to reflect the intent of the Departments that the MHPAEA be interpreted no more broadly than as specifically implemented by the Rules.

Department of Health and Human Services  
Department of Labor  
Internal Revenue Service  
May 3, 2010  
Page 18

Because the Departments have not addressed all possible contingencies in the Rules, subpart (ii) of subsection 3 (Scope) should be amended to make a statement substantially similar to the following:

“(ii) Affect the terms and conditions relating to the amount, duration, or scope of mental health or substance use disorder benefits under the plan except as specifically provided in paragraphs (b) and (c) of this section or as may be more generally provided in subsection (a) of the Mental Health Parity and Addiction Equity Act of 2008, Title 29, Chapter 18, Subchapter I, Subtitle B, Part 7, Subpart B, §1185a (Parity in mental health and substance use disorder benefits).”  
(proposed text underlined)

\* \* \* \*

We are submitting these comments anonymously for a number of reasons. Nevertheless, we welcome the opportunity to discuss our comments with you. Please contact us through Butterfly Effects, LLC<sup>4</sup> at (888) 880-9270. Leave a message with your contact information; Butterfly Effects will forward the message to us. We will return your call promptly.

Sincerely,

Concerned Americans

---

<sup>4</sup> <http://www.butterflyeffects.com>. Butterfly Effects provides therapy and tutoring services to individuals of all ages addressing challenges in the areas of academics, behavior, communication, daily living, social and life skills. Butterfly Effects has a staff of over 100 nationally and internationally recognized experts serving individuals of all ages with a broad range of needs throughout the United States and abroad, including Bermuda, Guatemala, Honduras, Italy, and Venezuela. Staff with expertise in the areas of Applied Behavior Analysis, Speech and Language Pathology, Psychology, and other related health services guides program development, while providing oversight to a team of skill program implementers. Focusing on intervention and services for individuals with developmental and learning disorders, Butterfly Effects' centralized platform gives both caregivers and providers the ability to completely manage therapies and programs. Butterfly Effects' directory of professionals offers various therapeutic approaches all designed to improve the lives of the individuals they work with.

## EXHIBIT A

### Efficacy of Behavioral Therapy as a Treatment for Autism

Significant evidence supports the efficacy of behavioral therapy for treating autism.

The Surgeon General stated as follows in 1999:

“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. . . . Only in the past decade have studies shown positive outcomes for very young children with autism. . . . Thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior”<sup>5</sup>

The Kennedy Krieger Institute discussed behavioral therapy and its efficacy as follows:<sup>6</sup>

“Applied Behavior Analysis Defined. Behavior analysis is the systematic study of variables that influence behavior (Sulzer-Azaroff & Mayer, 1991). Applied behavior analysis (ABA) is a discipline concerned with the application of behavioral science in real-world settings such as clinics or schools with the aim of addressing socially important issues such as behavior problems and learning (Baer, Wolf, & Risley, 1968). Procedures derived from the discipline of ABA have been implemented to assess and treat a broad range of behaviors with individuals diagnosed with intellectual and developmental disabilities. However, despite more than 40 years of applied behavior analytic research there continues to be misperceptions about ABA. One misperception is that ABA is a standardized treatment program that is used for a specific type of problem and with specific types of individuals. For example, some incorrectly believe that ABA is a type of therapy or a specific procedure for teaching children with autism, and that it is synonymous with “Lovaas Therapy” or “discrete trial training.” Although discrete trial training represents one type of ABA-based approach, the field of ABA is much broader and includes a range of tactics, methods, and procedures that have been shown to be effective for many different types of problems. Features common to all ABA-based approaches are the objective measurement of behavior, precise control of the environment, and use of procedures based on scientifically established principles of behavior. Any clinical procedure or research investigation adhering to these basic criteria can be considered to be an ABA-based procedure. This includes “functional behavioral assessment,” and approaches such as “Positive Behavioral Support,” and forms of “Behavior Therapy” that rely on direct observation of behavior and analysis of behavior-environment relations.”

“Scientific Support for Applied Behavior Analysis. Over the past 40 years a large body of literature has shown the successful use of ABA-based procedures to reduce problem behavior and increase appropriate skills for individuals with intellectual disabilities (ID), autism, and related disorders. Several review articles and meta-analyses have been published summarizing this large body of literature. . . . Each of these reviews supported efficacy of ABA-based procedures in the assessment and treatment of problem behavior associated with autism, mental retardation, and related disorders. . . . The large body of literature reviewed in these studies provides empirical evidence indicating that procedures developed using ABA-based principles are effective at assessing and treating a variety of socially important behaviors engaged in by individuals with a variety of diagnoses. Furthermore, ABA-based approaches for educating children with autism and related disorders have been extensively researched and empirically supported . . . .”

“Scientific, Professional, and Government Organizations’ Position on Applied Behavior Analysis. Based on the empirical evidence, many scientific, government, and professional agencies and organizations have concluded that ABA-based procedures represent best practices for individuals with autism and mental retardation. For example, the American Association on Intellectual and Developmental Disabilities (formerly the American Association on Mental Retardation),

---

<sup>5</sup> “*Mental Health: A Report of the Surgeon General*”: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Mental Health, 1999. See <http://www.surgeongeneral.gov/library/mentalhealth/chapter3/sec6.html#autism> (Other Mental Disorders in Children and Adolescents – Autism - Treatment).

<sup>6</sup> See the Kennedy Krieger Institute website [http://www.kennedykrieger.org/kki\\_misc.jsp?pid=4761](http://www.kennedykrieger.org/kki_misc.jsp?pid=4761) (attached). Includes citations for and quotes from published reports.

the oldest and largest interdisciplinary organization of professionals concerned with mental retardation and related disabilities, designated ABA-based procedures for the treatment of behavioral problems with individuals with mental retardation and related disorders as “*highly recommended*” (their highest rating). Based on the scientific evidence supporting the efficacy of ABA-based procedures for treating problems associated with mental retardation and autism, various scientific organizations have concluded that ABA-based procedures are highly effective . . . .”

“Empirically Supported Treatments for Problems Associated with Mental Retardation, Autism and Related Disorders. Several academic and trade journals that represent specific medical disciplines have published articles indicating that treatments for autism and mental retardation derived from ABA-based procedures are empirically supported treatments.”

The National Institutes of Health (NIH), a component of the U.S. Department of Health and Human Services concluded as follows:<sup>7</sup>

“There is no single best treatment package for all children with ASD. One point that most professionals agree on is that early intervention is important; another is that most individuals with ASD respond well to highly structured, specialized programs.”

“Among the many methods available for treatment and education of people with autism, applied behavior analysis (ABA) has become widely accepted as an effective treatment. *Mental Health: A Report of the Surgeon General* states, “Thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior”<sup>8</sup> The basic research done by Ivar Lovaas and his colleagues at the University of California, Los Angeles, calling for an intensive, one-on-one child-teacher interaction for 40 hours a week, laid a foundation for other educators and researchers in the search for further effective early interventions to help those with ASD attain their potential. The goal of behavioral management is to reinforce desirable behaviors and reduce undesirable ones.<sup>9, 10,</sup>

In the Article, “Intensive Early Intervention using Behavior Therapy is No Longer Experimental,” Eric V. Larsson, Ph.D. summarized other evidence of efficacy for behavioral therapy:<sup>11</sup>

“Many fad-like interventions have been attempted to treat people who suffer from autism, but most have had little or no tangible results. Therefore it is not surprising that insurance companies and government agencies are hesitant to extend benefits to young children who suffer from autism. However, in 1987, after 25 years of investigation comprising over 400 research studies conducted at University centers throughout the world by many researchers in the field of autism, the UCLA Young Autism Project, under the direction of O. Ivar Lovaas, Ph.D., was able to publish a long-term outcome study showing that 47 percent of the children treated were able to fully recover from autism. By all published accounts, these results were unprecedented. Subsequent research by independent laboratories around the world, is continuing to replicate these profound results and empower families to effectively treat their children.”

“In order to be effective, the behavior therapy program must be intensive and must be delivered in early childhood. In effect, a family which chooses this therapy must organize their household into a 24-hour therapeutic environment for three or more years in order to remediate all of the symptoms of autism. To do so, they require 55 hours per week of extensive, specialized consultation and direct home-based treatment for 50 weeks per year.”

“But as a result of the findings, and the extreme expense required, over the past five years, state and federal agencies and independent review panels have investigated and found that the findings, in their total sum, have been bona fide. In 1999, task forces of the New York State Department of Health and the Maine Administrators of Services for Children with

<sup>7</sup> See the NIH website (<http://www.nimh.nih.gov/health/publications/autism/treatment-options.shtml>). See also the NIH report entitled “*Autism Spectrum Disorders (Pervasive Developmental Disorders)*” (<http://www.nimh.nih.gov/health/publications/autism/nimhautismspectrum.pdf>, beginning on page 18)

<sup>8</sup> “20. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Mental Health, 1999.”

<sup>9</sup> “21. Lovaas OI. Behavioral treatment and normal educational and intellectual functioning in young autistic children. *Journal of Consulting and Clinical Psychology*, 1987; 55: 3-9.”

<sup>10</sup> “22. McEachin JJ, Smith T, Lovaas OI. Long-term outcome for children with autism who received early intensive behavioral treatment. *American Journal on Mental Retardation*, 1993; 97: 359-372.”

<sup>11</sup> See <http://rsaffran.tripod.com/ieibt.html> (attached). Includes citations for and quotes from published reports.

Disabilities each stringently applied scientific standards of proof to the program and found that it alone, of all possible treatments for children with autism, had been proven effective. Also in 1999, U.S. Surgeon General David Satcher promoted the results of the program in his report on Mental Health. (The National Institutes of Mental Health have funded research on this program for over 30 years.) Professional associations such as the American Academy of Child and Adolescent Psychiatry, the American Academy of Neurology, and the American Academy of Pediatrics also followed suit in their development of practice standards. These independent professional review panels are reporting that the intensive early intervention is highly effective in meeting the needs of the children. Each of these agencies have no vested interest in these services, and the panel members have largely been experts in the field who themselves are not treatment providers.”

The Centers for Disease Control and Prevention (CDC) states the following about behavioral therapy:<sup>12</sup>

“There are different types of ABA. Following are some examples:

- **Discrete Trial Training (DTT)**  
DTT is a style of teaching that uses a series of trials to teach each step of a desired behavior or response. Lessons are broken down into their simplest parts and positive reinforcement is used to reward correct answers and behaviors. Incorrect answers are ignored.
- **Early Intensive Behavioral Intervention (EIBI)**  
This is a type of ABA for very young children with an ASD, usually younger than five, and often younger than three.
- **Pivotal Response Training (PRT)**  
PRT aims to increase a child’s motivation to learn, monitor his own behavior, and initiate communication with others. Positive changes in these behaviors should have widespread effects on other behaviors.
- **Verbal Behavior Intervention (VBI)**  
VBI is a type of ABA that focuses on teaching verbal skills.

“Other therapies that can be part of a complete treatment program for a child with an ASD include:

**Developmental, Individual Differences, Relationship-Based Approach (DIR; also called “Floortime”)**

Floortime focuses on emotional and relational development (feelings, relationships with caregivers). It also focuses on how the child deals with sights, sounds, and smells.

**Treatment and Education of Autistic and Communication-Related Handicapped Children (TEAACH)**

TEAACH uses visual cues to teach skills. For example, picture cards can help teach a child how to get dressed by breaking information down into small steps.

**Occupational Therapy**

Occupational therapy teaches skills that help the person live as independently as possible. Skills might include dressing, eating, bathing, and relating to people.

**Sensory Integration Therapy**

Sensory integration therapy helps the person deal with sensory information, like sights, sounds, and smells. Sensory integration therapy could help a child who is bothered by certain sounds or does not like to be touched.

**Speech Therapy**

Speech therapy helps to improve the person’s communication skills. Some people are able to learn verbal communication skills. For others, using gestures or picture boards is more realistic.

**The Picture Exchange Communication System (PECS)**

PECS uses picture symbols to teach communication skills. The person is taught to use picture symbols to ask and answer questions and have a conversation.”

---

<sup>12</sup> See the CDC website: <http://www.cdc.gov/ncbddd/autism/treatment.html>

## EXHIBIT B

### **The Behavior Analyst Certification Board**

The Behavior Analyst Certification Board, Inc. (BACB) is a nonprofit organization established to meet professional credentialing needs identified by behavior analysts, governments, and consumers of behavior analysis services.<sup>13</sup> The BACB provides professional credentialing for BCBAs and BCaBAs:

“The BACB has established uniform content, standards, and criteria for the credentialing process that are designed to meet:

1. The legal standards established through state, federal and case law;
2. The accepted standards for national certification programs; and
3. The "best practice" and ethical standards of the behavior analysis profession.

The field of Behavior Analysis grew out of the scientific study of principles of learning and behavior. It has two main branches: experimental and applied behavior analysis. The experimental analysis of behavior (EAB) is the basic science of this field and has over many decades accumulated a substantial and well-respected body of research literature. This literature provides the scientific foundation for applied behavior analysis (ABA), which is both an applied science that develops methods of changing behavior and a profession that provides services to meet diverse behavioral needs. Briefly, professionals in applied behavior analysis engage in the specific and comprehensive use of principles of learning, including operant and respondent learning, in order to address behavioral needs of widely varying individuals in diverse settings. Examples of these applications include: building the skills and achievements of children in school settings; enhancing the development, abilities, and choices of children and adults with different kinds of disabilities; and augmenting the performance and satisfaction of employees in organizations and businesses.

“APPLIED BEHAVIOR ANALYSIS is a well-developed discipline among the helping professions, with a mature body of scientific knowledge, established standards for evidence-based practice, distinct methods of service, recognized experience and educational requirements for practice, and identified sources of requisite education in universities.

“Board Certified Behavior Analyst (BCBA): The Board Certified Behavior Analyst is an independent practitioner who also may work as an employee or independent contractor for an organization. The BCBA conducts descriptive and systematic (e.g., analogue) behavioral assessments, including functional analyses, and provides behavior analytic interpretations of the results. The BCBA designs and supervises behavior analytic interventions. The BCBA is able to effectively develop and implement appropriate assessment and intervention methods for use in unfamiliar situations and for a range of cases. The BCBA seeks the consultation of more experienced practitioners when necessary. The BCBA teaches others to carry out ethical and effective behavior analytic interventions based on published research and designs and delivers instruction in behavior analysis. BCBAs supervise the work of Board Certified Assistant Behavior Analysts and others who implement behavior analytic interventions.

“Board Certified Assistant Behavior Analyst (BCaBA): The BCaBA conducts descriptive behavioral assessments and is able to interpret the results and design ethical and effective behavior analytic interventions for clients. The BCaBA designs and oversees interventions in familiar cases (e.g., similar to those encountered during their training) that are consistent with the dimensions of applied behavior analysis. The BCaBA obtains technical direction from a BCBA for unfamiliar situations. The BCaBA is able to teach others to carry out interventions once the BCaBA has demonstrated competency with the procedures involved under the direct supervision of a BCBA. The BCaBA may assist a BCBA with the design and delivery of introductory level instruction in behavior analysis. It is mandatory that each BCaBA practice under the supervision of a BCBA.”

---

<sup>13</sup> [http://www.bacb.com/cues/frame\\_about.html](http://www.bacb.com/cues/frame_about.html)