

Virginia's Insurance Mandate

Virginia's Private Insurance Early Intervention Mandated Benefit Early Intervention Provider Information Guide

Early Intervention System

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EARLY INTERVENTION PROVIDER INFORMATION

VIRGINIA'S PRIVATE INSURANCE EARLY INTERVENTION MANDATED BENEFIT

Effective July 1, 1997, the Code of Virginia §2.1-20.1 required that health insurance coverage for state employees cover early intervention therapy services for infants and toddlers with disabilities who are eligible for Part C of the Individuals with Disabilities Education Act.

Effective July 1, 1998, the Code of Virginia §38.2-3418.5 required that each insurer proposing to issue individual or group accident and sickness insurance policies cover early intervention therapy services for infants and toddlers with disabilities who are eligible for Part C of the Individuals with Disabilities Education Act.

The coverage for both of these mandated benefits are similar but not exactly the same. The attached chart compares the coverage under each of the mandated benefit provisions. The following questions and answers provide an overview of both of Virginia's private insurance early intervention mandated benefit provisions.

Who Is Eligible for Coverage Under Virginia's Private Insurance Early Intervention Mandated Benefit?

Infants and toddlers with disabilities, birth to age three (0 to 36 months), who have been authorized as eligible for Part C of the Individuals with Disabilities Education Act may be covered under the early intervention benefit.

How Does a Private Insurer Know that a Child is Authorized as Eligible for Part C of IDEA?

A comprehensive IFSP must be submitted to the private insurer in order for coverage to be authorized by private insurers. The IFSP must be developed by a local participating Part C provider. A local participating Part C provider is a provider who is under contract with the local Part C fiscal agent/intermediary or who is a party to the local Part C interagency agreement or memorandum of understanding with the local interagency coordinating council for Part C.

How Does a Provider Know if a Private Insurance Policy Includes the Early Intervention Mandated Benefit?

First, all state employees have the early intervention benefit. This includes some local government employees who are included in the state employee benefit plan.

Second, all private insurance policies issued by a private insurer are NOT required to include the early intervention mandated benefit. For example, not all Trigon policies include the early intervention benefit. Only those policies that are issued by companies that are NOT self-insured must offer the benefit to its employees. However, some self-insured companies do include the benefit in their health insurance plan. For example, Trigon administers numerous plans for self-insured companies that have chosen to include

the private insurance benefit for their employees. (See the enclosed attachment State Law vs. Erisa Data for an estimate of the number of Part C eligible children who have coverage under the early intervention mandate.) Therefore, each insurance policy must be looked at on an individual basis to determine if the early intervention mandated benefit is offered.

Third, the early intervention mandated benefit only becomes effective for policies that are written or renewed after the effective date. For example, a small company which has a Sentara policy and is scheduled to renew that policy on January 1, 2000, would not have the early intervention benefit until after the renewal date.

What Steps Should be Taken to Determine if an Individual Insurance Policy Includes the Early Intervention Mandated Benefit?

Providers should take the following steps in determining if an individual insurance policy includes the early intervention mandated benefit:

1. Ask policyholders for information about their employers. Find out the size of the company (e.g., the number of employees). Usually companies over 250 employees are self-insured. Companies that go across state lines are also usually self-insured.
2. Ask policyholders to check with the human resource coordinator for their employers regarding whether or not the early intervention mandated benefit is included in their companies' health care plan. For Trigon policyholders, the early intervention benefit is included in the policyholder's handbook, so remember to ask policyholders to check their insurance handbooks.
3. Ask policyholders to check with the human resource coordinator for their employers regarding the date that their insurance policies were last renewed and when the next date of renewal is.
4. Call the insurance company and provide the insurer with the policyholder's information and ask if the policy includes the early intervention benefit. For example, Trigon Member Services should be able to provide information as to whether or not the early intervention benefit is available.

What Services are Covered under Virginia's Private Insurance Early Intervention Mandated Benefit?

Both early intervention mandated benefit provisions cover the following early intervention therapy services:

Occupational Therapy
Speech Therapy
Physical Therapy
Assistive Technology Services and Devices

In order for these services and devices to be covered, they must be listed on the child's IFSP and they must meet the medically necessary requirements of the benefit.

What is the Definition of Medical Necessity for the Mandated Early Intervention Services Benefit and how is Medical Necessity Determined?

The definition of medical necessity for the early intervention mandated benefit is different from the definition of medical necessity used under traditional insurance benefits. Medically necessary early intervention services under the early intervention mandated benefit is defined as "those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure." This definition of

medical necessity provides parameters for coverage of services by private insurers that are comparable to coverage under Virginia Medicaid. Thus, private insurers and HMOs must ensure that all Part C eligible children and their families receive each covered service, if medically necessary, to treat all conditions, including developmental delay, whether congenital in nature or as result of illness or trauma, and whether required to prevent deterioration or maintain and improve ability and function. In other words, medically necessary services under the mandated benefit are those services designed to "correct or ameliorate" the child's medical condition.

Each insurer uses its own internal procedures for determining medical necessity. For example, Trigon is utilizing the IFSP as the document that determines medical necessity for early intervention services and for pre-authorizing services.

Does the IFSP Early Intervention Service Need to be Provided by a Part C Participating Provider in Order to be Covered Under the Early Intervention Mandated Benefit?

The Code of Virginia does not require that the mandated early intervention therapy service be provided by a Part C participating provider. It does, however, require that the services be on the IFSP. Since families have the right to refuse services offered by the Part C system, requiring that only a Part C participating provider could provide the service was not included in the mandate. If a family, however, chooses to access services by a non-Part C provider, the procedural safeguards offered under Part C regulations are no longer available to the child and family for this service. The Code of Virginia also does not require that private insurers and HMOs reimburse out-of-network providers.

Since a child must be determined eligible by a local Part C participating provider in the local Part C system and an IFSP must be in place in order for a child to be eligible for the early intervention mandated benefit, it is important that Part C providers be included in HMO and private insurance networks. In order to ensure that sufficient qualified pediatric therapy providers are available in each community, each local council is required to encourage existing Part C providers to become providers within various insurance networks when feasible and to invite other pediatric providers who are in insurance networks to become Part C providers. In accordance with federal Part C regulations, any provider that provides a Part C service must agree to comply with Part C requirements in the provision of this service.

What Happens if a Child Uses the Full \$5,000 Cap Under the Private Insurer/HMO Early Intervention Mandated Benefit?

Except for unusual situations, early intervention providers are expected to maintain the same level of therapy services provided for Part C eligible children as were provided prior to the implementation of the early intervention mandated benefit. As requested by the Joint Subcommittee Studying Early Intervention for Infants and Toddlers with disabilities, the Lead Agency gathered actual cost data from localities in order to calculate an average annual cost per child for therapy services and assistive technology services and devices. This annual cost was estimated at \$2,100 per child. As a result, few children should exceed the \$5,000 cap under the private insurer/HMO early intervention benefit.

What Happens to Insurance Coverage When a Child is No Longer Enrolled or Eligible for Part C Early Intervention Services?

The local early intervention system is responsible for determining who notifies the private insurer/HMO when a child is no longer enrolled or eligible for Part C early intervention services. This notification should be provided to the insurer immediately upon discharge from the Part C early intervention system.

For children no longer enrolled or eligible for Part C, private insurers/HMOs provide coverage for therapy services under the conditions of the basic health policy of the subscriber. In doing so, the limitations of the basic policy are applied as well as the traditional definition of medical necessity. For example, a child with

developmental delay and in need of speech therapy would most likely not be covered under the traditional plan benefits once he/she is no longer enrolled or eligible for Part C.

PROVISIONS	STATE	PRIVATE
Effective date	7/1/97	7/1/98-upon contract renewal
Limits coverage to certified Part C eligible children (children who have an IFSP developed by a Part C provider)	YES	YES
Defines medical necessity as "retaining and attaining functioning"	YES	YES
Covers services that are "at-no-cost" (e.g., evaluations and assessments)	NO	NO
Coverage does not apply to lifetime cap or benefits	YES	YES
Provides for co-pays and deductibles to be paid by public funds if necessary	NO	YES
Covers OT, PT, SLP and Assistive Tech Services/Devices	YES	YES
Limits coverage to an annual amount per child	NO	YES - \$5,000
Prohibits exclusion of pre-existing conditions	YES	NO
Defines reimbursement rates	NO	NO
Defines provider networks	NO	NO