ALAN WILSON
ATTORNEY GENERAL

December 18, 2015

The Honorable Michael W. Gambrell
S.C. House of Representatives
Chairman, Insurance Subcommittee
400 Filter Plant Road
Honea Path, SC 29654

Dear Representative Gambrell:

You have requested the opinion of this Office regarding legislation currently being considered by the General Assembly that would amend S.C. Code Ann. § 38-71-280 (2015). See S. 135, 121st Cong. (S.C. 2015). S.C. Code Ann. § 38-71-280 (2015), ratified on May 31, 2007 and effective July 1, 2008, mandates coverage for autism spectrum disorder care for large group markets. Your question pertains to Section 1311(d)(3)(B)(i) of the Patient Protection and Affordable Care Act ("ACA"), allowing a state to require a qualified health plan offered in the state to cover benefits in addition to essential health benefits[1]. Affordable Care Act § 1311(d)(3)(B)(i), 42 U.S.C.A. § 18031(d)(3)(B). If the state requires qualified health plans to cover additional benefits, Section 1311(d)(3)(B)(ii) requires the state to defray the costs by making payments either to the individual enrolled in the qualified health plan or make payments on behalf of those individuals to the qualified health plan itself. Affordable Care Act § 1331(d)(3)(B)(ii); 42 U.S.C.A. § 18031(d)(3)(B)(ii). However, as part of a transitional period to allow states to adjust to the new ACA requirements, Regulation 45 C.F.R. 155.170(a)(2), promulgated by the Department of Health and Human Services ("HHS"), provides that "a State-required benefit enacted on or before December 31, 2011 is not considered in addition to the essential health benefits." Accordingly, states are not required to assume costs for state-required benefits in addition to essential health benefits enacted on or before December 31, 2011.

As noted above, S.C. Code Ann. § 38-71-280 (2015) – the provision in question mandating coverage for autism spectrum disorder for large group markets – was ratified on May 31, 2007 and took effect on July 1, 2008. Thus, it falls within the December 31, 2011 date set within the ACA regulations providing that states are not required to defray costs for state-required benefits in addition to essential health benefits. While the initial enactment of Section 38-71-280 falls within the December 31, 2011 enactment-date cut off, you question whether the amendments proposed to Section 38-71-280 by S. 135 would thereby create a new benefit enacted after December 31, 2011 requiring state payments for expanded coverage requirements. Our analysis follows.

[1] For further explanation on the requirements of the ACA and required coverage of essential health benefits, see the Law/Analysis section below.

Law/Analysis

Included with your request letter was a Financial Impact Statement for S. 135 prepared by the South Carolina Revenue and Fiscal Affairs Office. Provided within the Statement, it was noted that, "[a]t this time, the answer to these legal questions is unclear. There is no history of a state triggering the reimbursements or precedent for state payments for expanded coverage requirements, and the responsibilities of a state with regard to this component of the ACA has not been established." Our Office's independent research has likewise not revealed interpretation of what constitutes a state mandated benefit considered "in addition to essential health benefits" requiring states to defray of those mandates. As such, we must rely on the rules of statutory interpretation for guidance in determining whether an amendment to a state required benefit initially enacted prior to December 31, 2011 would result in the state being required to defray costs for such state required benefit.

The primary rule of statutory construction is to ascertain and effectuate the intent of the legislature. Hodges v. Rainey, 341 S.C. 79, 85, 533 S.E.2d 578, 581 (2000) (citation omitted). What a legislature says in the text of a statute is considered the best evidence of the legislative intent or will. Id. (quotations omitted). Thus, when a statute is plain and unambiguous, it becomes the duty of the court to apply the statute literally because the legislative design is unmistakable. Martin v. Ellisor, 266 S.C. 377, 381, 223 S.E.2d 415, 417 (1976). "A statute as a whole must receive practical, reasonable, and fair interpretation consonant with the purpose, design, and policy of lawmakers." Sparks v. Palmetto Hardwood, Inc., 406 S.C. 124, 750 S.E.2d 61 (2013).

These fundamental rules of statutory interpretation likewise are applied when interpreting federal statutes. See POM Wonderful LLC v. Coca-Cola Co., 134 S.Ct. 2228 (2014) ("[T]his is a statutory interpretation case and the Court relies on traditional rules of statutory interpretation. That does not change because the case involves multiple federal statutes"). Courts have also been consistent in finding that the rules of statutory construction apply when interpreting regulations. See, e.g., Murphy v. South Carolina Dep't of Health and Env't Control, 396 S.C. 633, 639, 723 S.E.2d 191, 195 (2012) ("Regulations are interpreted using the same rules of construction as statutes"); Powder River Basin Resource Council v. Wyoming Dept. of Envtl. Quality, 226 P.3d 809, 818 (Wyo. 2010) ("The rules of statutory interpretation also apply to the interpretation of administrative rules and regulations") (internal quotations and citations omitted); People v. Morris, 394 Ill.App.3d 678, 680 (Ill. App. Ct. 2009) ("The interpretation of an administrative rule or regulation is a question of law to which the principles of statutory interpretation apply"); Archmoody v. 911 Emergency Servs., 214 Cal.App.3d 1510, 1517 (Cal. Ct. App. 1989) ("The same rules of construction and interpretation which apply to statutes govern the construction and interpretation of rules and regulations of administrative agencies").

Furthermore, courts give significant deference to an agency's interpretations of its own regulations. See Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837, 843, 104 S.Ct. 2778, 2782 (1984) ("We have long recognized that considerable weight should be accorded to an executive department's construction of a statutory scheme if is entrusted to administer"); see also Griggs v. Duke Power Co., 401 U.S. 424, 91 S.Ct. 849 (1971); Bowles v. Seminole Rock & Sand Co., 325 U.S. 410, 65 S.Ct. 1215 (1945). Courts have determined that

by drafting the regulation, it is presumed that the agency has superior expertise developed though implementing the regulation. See Jicarilla Apache Tribe v. Federal Regulatory Comm'n, 578 F.2d 289, 292 (10th Cir. 1978) ("The rule [that an agency's interpretation of its own regulation is entitled to great deference on appeal] is based on the agency's greater expertise in the area they regulate"); Perine v. William Norton Co., Inc., 509 F.2d 114 (2nd Cir. 1974) ("[D]eference is usually justified on the basis of an agency's superior expertise in the area of its authority").

In the ACA, Congress has delegated the Department of Health and Human Services ("HHS") the authority to:

> issue regulations setting standards for meeting the requirements under this title, and the amendments made by this title, with respect to--
> (A) the establishment and operation of Exchanges (including SHOP exchanges);
> (B) the offering of qualified health plans through such Exchanges;
> (C) the establishment of the reinsurance and risk adjustment programs under part E of this subchapter; and
> (D) such other requirements as the Secretary determines appropriate.

42 U.S.C.A. § 18041(a)(1)(A)-(D). The ACA also provides that: "[i]n issuing the regulations under paragraph (1), the Secretary shall consult with the National Association of Insurance Commissioners and its members and with health insurance issuers, consumer organizations, and such other individuals as the Secretary selected in a manner designed to ensure balanced representation among interested parties." Id. at § 18041(a)(2).

With the aforementioned authority in mind, we turn to Regulation 45 C.F.R. § 155.170, implemented by HHS. In pertinent part, it reads as follows:

> (a) Additional required benefits.
> (1) A State may require a QHP [Qualified Health Plan][2] to offer benefits in addition to the essential health benefits.
> (2) A State-required benefit enacted on or before December 31, 2011 is not considered in addition to the essential health benefits.
> (3) The Exchange shall identify which state-required benefits are in excess of EHB [Essential Health Benefits].
>
> (b) Payments. The State must make payments to defray the cost of additional required benefits specified in paragraph (a) of this section to one of the following:
> (1) To an enrollee, as defined in § 155.20 of this subchapter; or
> (2) Directly to the QHP issuer on behalf of the individual described in paragraph (b)(1) of this section.

Placing this Regulation into context for a better understanding of its meaning and its appropriate application, HHS's Center for Consumer Information & Insurance Oversight has explained that the Affordable Care Act requires non- grandfathered health plans in the individual

[2] The term "Qualified Health Plan" or "QHP" as used in 45 C.F.R. § 115.170 is defined as "a health insurance issuer that offers a QHP in accordance with a certification from an Exchange." 45 C.F.R. § 155.20.

and small group markets, both on and off of the Exchange, to cover essential health benefits. The Center for Consumer Information & Insurance Oversight, Information on Essential Health Benefits (EHB) Benchmark Plans, https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html#South Carolina. Essential health benefits are described in 42 U.S.C.A. § 18022. Specifically, this section provides as follows:

> [s]ubject to paragraph (2), the Secretary shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories: (A) Ambulatory patient services. (B) Emergency Services. (C) Hospitalization. (D) Maternity and newborn care. (E) Mental health and substance use disorder services, including behavioral health treatment. (F) Prescription Drugs. (G) Rehabilitative and habilitative services and devices. (H) Laboratory Services. (I) Preventative and wellness services and chronic disease management. (J) Pediatric services, including oral and vision care.

42 U.S.C.A. § 18022. As it is required that states define essential health benefits for policies used in the state, they must do so by selecting an EHB benchmark plan. 45 C.F.R. § 156.100. South Carolina has defaulted to the largest small-group plan in the state: Blue Cross Blue Shield of South Carolina- Business Blue Complete. See CMS.gov Centers for Medicare & Medicaid Services, South Carolina EHB Benchmark Plan, *available at* https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-South-Carolina-Benchmark-Summary.pdf. The South Carolina EHB benchmark plan does not include benefits for autism spectrum disorder. See id.

We also note that for purposes of 45 C.F.R. § 155.170, the term "Exchange" is defined as:

> a governmental agency or non-profit entity that meets the applicable standards of this part and makes QHPs available to qualified individuals and/or qualified employers. Unless otherwise identified, this term includes an Exchange serving the individual market for qualified individuals and a SHOP [Small Business Health Options Program] serving the small group market for qualified employers, regardless of whether the Exchange is established and operated by a State (including a regional Exchange or subsidiary Exchange) or by HHS [Department of Health and Human Services].

45 C.F.R. § 155.20. Put simply, "[t]o increase the availability of affordable insurance plans, the [ACA] provides for the establishment of 'Exchanges,' through which individuals can purchase competitively-priced health care coverage." King v. Burwell, 759 F.3d 358 (4th Cir. 2014) (citing Affordable Care Act §§ 1311, 1321). While a state may elect to establish a state Exchange as set forth in 45 C.F.R. § 155.100, South Carolina has elected to default to the federally-facilitated Health Insurance Exchange. See Letter from Governor Nikki Haley to the U.S. Department of Health & Human Services (November 15, 2012), *available at* http://governor.sc.gov/Documents/Gov%20Nikki%20Haley%20Letter%20to%20HHS%20Secretary.pdf. The federally-facilitated Health Insurance Exchange is administered by Centers for

Medicare & Medicaid Services ("CMS") and its Center for Consumer Information and Oversight ("CCIIO"), a division of HHS. See Centers for the Study of Services v. U.S. Dep't of Health and Human Servs., __ F. Supp.3d __ (D. D.C. 2015).

Based on our review of 45 C.F.R. § 155.170, the plain meaning of the statute authorizes state mandated benefits that are not essential health benefits to still be included as if they were essential health benefits if enacted on or before December 31, 2011. In other words, these state mandates are, as it could be phrased, "grandfathered in." Furthermore, the regulations clearly set forth that the Exchange must make the determination of which state-required benefits are considered in excess of essential health benefits. 45 C.F.R. § 155.170(a)(3). However, it is essential to view the ACA as a whole in understating 45 C.F.R. § 155.170. Of particular importance is that states are required to select an EHB benchmark plan to define its essential health benefits. Thus, it is our belief that any state mandate enacted before December 31, 2011 would have to in fact be applicable to the EHB benchmark plan chosen by the state for the mandate to not be considered a benefit in addition to essential health benefits. For example, if a state has defaulted to the largest *small group market plan* as its EHB benchmark plan, we believe a practical, reasonable, and fair interpretation of 45 C.F.R. § 155.170 would require state mandates enacted prior to December 31, 2011 to be applicable to *small group markets*.

Looking now to S.C. Code Ann. § 38-71-280 (2015), mandating autism spectrum disorder care, it currently provides as follows:

> (A) As used in this section:
> (1) "Autism spectrum disorder" means one of the three following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:
> (a) Autistic Disorder;
> (b) Asperger's Syndrome;
> (c) Pervasive Developmental Disorder--Not Otherwise Specified.
>
> (2) "Insurer" means an insurance company, a health maintenance organization, and any other entity providing health insurance coverage, as defined in Section 38-71-670(6), which is licensed to engage in the business of insurance in this State and which is subject to state insurance regulation.
>
> (3) "Health maintenance organization" means an organization as defined in Section 38-33-20(8).
>
> *(4)* "Health insurance plan" means a group health insurance policy or group health benefit plan offered by an insurer. It includes the State Health Plan, *but does not otherwise include any health insurance plan offered in the individual market as defined in Section 38-71-670(11)*[3], *any health insurance plan that is individually*

[3] "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan. The term includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year unless the state elects to regulate the coverage as coverage issued to small employers, as defined in Section 38-71-1330. S.C. Code Ann. § 38-71-670(11) (2015).

underwritten, or any health insurance plan provided to a small employer, as defined by Section 38-71-1330(17).

(5) "State Health Plan" means the employee and retiree insurance program provided for in Article 5, Chapter 11, Title 1.

(B) A health insurance plan as defined in this section must provide coverage for the treatment of autism spectrum disorder. Coverage provided under this section is limited to treatment that is prescribed by the insured's treating medical doctor in accordance with a treatment plan. With regards to a health insurance plan as defined in this section an insurer may not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew or refuse to reissue or otherwise terminate or restrict coverage on an individual solely because the individual is diagnosed with autism spectrum disorder.

(C) The coverage required pursuant to subsection (B) must not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally under the health insurance plan, except as otherwise provided for in subsection (E). However, the coverage required pursuant to subsection (B) may be subject to other general exclusions and limitations of the health insurance plan, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, utilization review of health care services including review of medical necessity, case management, and other managed care provisions.

(D) The treatment plan required pursuant to subsection (B) must include all elements necessary for the health insurance plan to appropriately pay claims. These elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency, and duration of treatment, the anticipated outcomes stated as goals, the frequency by which the treatment plan will be updated, and the treating medical doctor's signature. The health insurance plan may only request an updated treatment plan once every six months from the treating medical doctor to review medical necessity, unless the health insurance plan and the treating medical doctor agree that a more frequent review is necessary due to emerging clinical circumstances.

(E) To be eligible for benefits and coverage under this section, an individual must be diagnosed with autistic spectrum disorder at age eight or younger. The benefits and coverage provided pursuant to this section must be provided to any eligible person under sixteen years of age. Coverage for behavioral therapy is subject to a fifty thousand dollar maximum benefit per year. Beginning one year after the effective date of this act, this maximum benefit shall be adjusted annually on January first of each calendar year to reflect any change from the previous year in the current Consumer Price Index, All Urban Consumers, as published by the United States Department of Labor's Bureau of Labor Statistics.

(emphasis added).

From review of the current version of S.C. Code Ann. § 38-71-280 (2015) we find it essential to point out that the autism spectrum disorder mandate applies to large group health insurance plans and the State Health Plan. S.C. Code Ann. § 38-71-280(A)(4) (" 'Health insurance plan' means a group health insurance policy or group health benefit plan offered by an insurer. It includes the State Health Plan, *but does not otherwise include any health insurance plan offered in the individual market as defined in Section 38-71-670(11), any health insurance plan that is individually underwritten, or any health insurance plan provided to a small employer, as defined by Section 38-71-1330(17)*"). Therefore, as the mandate does not extend to small group plans, autism spectrum disorder is not included in the South Carolina EHB benchmark plan (again, South Carolina has defaulted to the largest small-group plan in the state: Blue Cross Blue Shield of South Carolina- Business Blue Complete). While our State has a mandate for autism spectrum disorder, under the current version of S.C. Code Ann. § 38-71-280 (2015), the mandate applies to the large group market, not individual and small group policies like those that can be obtained through the Exchange under the ACA.

The amendments to Section 38-71-280 proposed by S. 135 revise the definition of autism spectrum disorder; delete existing eligibility requirements by removing age, cost and eligibility caps; provide a citation to the Section as being "Ryan's Law;" and importantly extend the current coverage mandate to small group policies and individual policies like those obtained on the federal Exchange under the ACA. Specifically, if S. 135 were enacted in its current version, Section 38-71-280 would read as follows:

> (A) As used in this section:
> (1) "Autism spectrum disorder" means any of the pervasive development disorders or autism spectrum disorders as defined by the most recent addition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the edition in effect at the time of diagnosis.
>
> (2) "Insurer" means an insurance company, a health maintenance organization, and any other entity providing health insurance coverage, as defined in Section 38-71-670(6).
>
> (3) "Health maintenance organization" means an organization as defined in Section 38-33-20(8).
>
> *(4) "Health insurance plan" means a group health insurance policy or group health benefit plan offered by an insurer. It includes the State Health Plan.*
>
> (5) "State Health Plan" means the employee and retiree insurance program provided for in Article 5, Chapter 11, Title 1.
>
> (B) A health insurance plan as defined in this section must provide coverage for the treatment of autism spectrum disorder. Coverage provided under this section

> is limited to treatment that is prescribed by the insured's treating medical doctor in accordance with a treatment plan. With regards to a health insurance plan as defined in this section an insurer may not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew or refuse to reissue or otherwise terminate or restrict coverage on an individual solely because the individual is diagnosed with autism spectrum disorder.
>
> (C) The coverage required pursuant to subsection (B) must not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally under the health insurance plan, except as otherwise provided for in subsection (E). However, the coverage required pursuant to subsection (B) may be subject to other general exclusions and limitations of the health insurance plan, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, utilization review of health care services including review of medical necessity, case management, and other managed care provisions.
>
> (D) The treatment plan required pursuant to subsection (B) must include all elements necessary for the health insurance plan to appropriately pay claims. These elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency, and duration of treatment, the anticipated outcomes stated as goals, the frequency by which the treatment plan will be updated, and the treating medical doctor's signature. The health insurance plan may only request an updated treatment plan once every six months from the treating medical doctor to review medical necessity, unless the health insurance plan and the treating medical doctor agree that a more frequent review is necessary due to emerging clinical circumstances.
>
> (E) This section must be known and may be cited as 'Ryan's Law'."

(emphasis added).

Upon review of these proposed amendments, it is without doubt that the intent of the legislature in both the current version of S.C. Code Ann. § 38-71-280 as well as the amendments proposed to Section 38-71-280 in S. 135 accomplish the same objective: mandating coverage for autism spectrum disorder. However, it is also without question that an adoption of these amendments would expand the market that the autism spectrum disorder mandate would apply to, including small group policies and individual policies like those obtained on the Exchange under the ACA. Because the current South Carolina mandate for autism spectrum disorder that was enacted prior to December 31, 2011 does not extend to "*any health insurance plan offered in the individual market as defined in Section 38-71-670(11), any health insurance plan that is individually underwritten, or any health insurance plan provided to a small employer, as defined by Section 38-71-1330(17)*", the mandate is not included as a part of South Carolina's EHB benchmark plan. Therefore, it is the opinion of this Office that a court would find the

amendments proposed by S. 135 would be considered a benefit "in addition to essential benefits" requiring the State to defray the costs of coverage.

Finally, we note that this conclusion is supported in a "FAQ" published by the Department of Health and Human Services, Centers for Medicare & Medicaid Services ("CMS") titled "Frequently Asked Questions on Essential Health Benefit Bulletin." In the FAQ, the question was posed whether States would "be required to defray costs of any State-mandated benefit?" In response, CMS answered:

> [t]he Affordable Care Act requires States to defray the costs of State-mandated benefits in qualified health plans (QHPs) that are in excess of the EHB. If a State were to choose a benchmark plan that does not include all State-mandated benefits, the Affordable Care Act would require the State to defray the costs of those mandated benefits in excess of EHB as defined by the selected benchmark.
>
> States have several benchmark options from which to choose, including the largest small group market plan in the State, which is the default benchmark plan for each State. Generally, insured plans sold in the small group must comply with State mandates to cover benefits. Thus, if a small group market benchmark plan was selected, these mandated benefits would be a part of the State-selected EHB. *However, if there are State mandates that do not apply to the small group market such as mandates that apply only to the individual market or to HMOs, the State would need to defray the costs of those mandates if the mandated benefits were not covered by the selected benchmark.*

Department of Health and Human Services, Centers for Medicare & Medicaid Services, Frequently Asked Questions on Essential Health Benefits Bulletin (Feb. 17, 2012), *available at.* https://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf (emphasis added).

In answering the question "[c]ould a State add State-mandated benefits to State-selected EHB benchmark plan today without having to defray the costs of those mandated benefits" the CMS also supports the conclusions reached in this opinion when it answered:

> No. We intend to clarify that under the proposed approach any State-mandated benefits enacted after December 31, 2011 could not be part of the EHB for 2014 or 2015, unless already included within the benchmark plan regardless of the mandate. *Note that any State-mandated benefits enacted by December 31, 2011 would be part of EHB if applicable to the State-selected EHB benchmark plan.*

Id. (emphasis added). We find these interpretations persuasive being that courts, as explained above, give significant deference to an agency's interpretations of its own regulations.

Conclusion

Based on the foregoing analysis, S.C. Code Ann. § 38-71-280 currently mandates autism spectrum disorder care for large groups markets. For purposes of defining essential health

benefits, South Carolina has defaulted to the largest small group market plan in the state: Blue Cross Blue Shield of South Carolina- Business Blue Complete. Although enacted prior to December 31, 2011, since S.C. Code Ann. § 38-71-280 did not extend the mandate for autism spectrum disorder care to the small group market, the mandate for autism spectrum disorder care is not included in South Carolina's EHB benchmark plan as an essential health benefit. Therefore, it is the opinion of this Office that if S. 135 were passed by our Legislature to expand state mandated coverage for autism spectrum disorder care to individual and small group markets, coverage would be construed under the ACA as a new state-mandated benefit in addition to essential health benefits requiring the State to assume the cost of coverage due to enactment after December 31, 2011. It is our belief that this conclusion is consistent with a practical, reasonable, and fair interpretation of the ACA and its regulations, and importantly, with the interpretations given by the regulating agencies of the ACA to which a court would give great deference.

Very truly yours,

Anne Marie Crosswell

Anne Marie Crosswell
Assistant Attorney General

REVIEWED AND APPROVED BY:

Robert D. Cook
Solicitor General