Study of the Impact of Senate Bill 338
Coverage of Children's Early Intervention Therapy Services

Prepared for the New Hampshire Insurance Department

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I. Introduction and Executive Summary

Introduction

The New Hampshire Insurance Department has engaged Reden and Anders (R&A) to study the impact of Senate Bill 338, which mandates that insured individual and group policies provide coverage for children's early intervention (EI) therapy services. EI services include those of physical and occupational therapists, speech-language pathologists, and clinical social workers working with children from birth to 36 months of age.

Based on the letter to the Commissioner of the New Hampshire Insurance Department (NHID) from the New Hampshire Senate, as well as the general statutory requirements for studies of proposed mandates and items which we believe are relevant to NHID's evaluation of the mandate, this study addresses the following issues and questions:

1. What are the social and financial impacts and the medical efficacy of mandating the benefit?

2. What are the effects of balancing the social, financial, and medical efficacy considerations?

3. How does Anthem presently handle EI claims, requests for coverage, and provider referral and credentialing for inclusion in their networks?

4. How do other carriers typically handle provider referral and credentialing for inclusion in their networks for EI providers?

5. What is the projected financial impact if the mandate is changed to include annual benefit limits and/or to subject the services to the plan's copays, deductible, and coinsurance (these out of pocket provisions are referred to below as cost sharing)?

Executive Summary

1. The SB338 mandate as proposed requires that EI services not be subject to a plan's deductible or copayments. We interpret this to include coinsurance as well. Individual plans can cap the benefits at $3,200 per child per year; group plans are not allowed to set an annual or lifetime maximum EI benefit.

2. Table 1 has our projections of the cost impact of the proposed mandate, expressed both as per member per month premium (PMPM) cost and as a percentage of premium. This table assumes that a carrier provides no coverage now for children's EI services.

Introduction and Executive Summary (cont'd)

TABLE 1
PROJECTED 2007 COST OF SB338

		% of Premium		
	PMPM	High Plan	Medium Plan	Low Plan
Individual	$1.12	0.20%	0.25%	0.30%
Small Group	$2.70	0.60%	0.70%	0.80%
Large Group	$2.38	0.60%	0.70%	0.80%

*See Exhibit A for benefits of high, medium, and low plans.

Because SB338 does not allow member cost sharing (deductible, coinsurance, copayments), the mandate cost expressed as a percentage of base plan cost will vary by plan design--the more cost-sharing in the base plan, the lower the base plan cost and the higher the mandate cost as a percentage of the base plan cost. The projected cost for individual policies is less, because SB338 allows these plans to impose a $3,200 annual maximum benefit per child. Exhibit A shows the benefit provisions of the base plans we chose to represent high, medium, and low plans.

3. Some carriers now cover children's EI, without any separate benefit limit but subject to the plans' cost sharing provisions. For these carriers, the added cost of SB338 is less, as shown below:

TABLE 2

SB338 IMPACT IF CARRIER NOW PROVIDES EI COVERAGE SUBJECT TO MEMBER COST-SHARING PROVISIONS *

	High Plan	Medium Plan	Low Plan
Individual	0.05%	0.05%	0.10%
Group	0.20%	0.30%	0.40%

* Assumes no annual benefit limit on EI coverage.

4. As we show in Exhibit B, all of the states that now mandate EI coverage allow carriers to have an annual maximum benefit per child (we found 6 states with a true mandate, not 17). In addition, all states except Massachusetts require that the child either be eligible under Part C of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or have an Individual Family Service Plan (IFSP), which lays out the treatment plan in detail.

5. We asked several carriers about their group EI benefit costs. We adjusted the reported costs to a New Hampshire level and to a level reflecting the SB338 provisions. The adjusted carrier costs ranged from 105% down to 41% and 22% of our projected cost. The last two percentages are based only on Medicaid and Connecticut commercial claims, respectively, and may not be as credible.

Introduction and Executive Summary (cont'd)

6. The legislature may want to consider alternatives to SB338, to reduce its cost impact. Table 3 shows the projected cost impact if the mandate is changed to allow group plans to cap the EI benefits per child per year (as SB338 allows individual plans) and/or to allow plans to apply their plans' cost sharing provisions to EI services. Note that the plan's deductible would have to apply to EI services in a federally qualified HSA plan.

   SB338 does not have an eligibility requirement for the EI benefit. Table 3 also shows the impact on projected costs if the mandate is amended to require either an IFSP or eligibility under IDEA Part C.

TABLE 3
PROJECTED COST IMPACT FOR GROUP PLANS UNDER MANDATE VARIATIONS

	Maximum Annual Benefit Per Child		
	No Max	$5,200	$3,200
Require IFSP or child to be eligible under IDEA Part C			
High Plan	0.55%	0.30%	0.20%
Medium Plan	0.60%	0.35%	0.25%
Low Plan	0.70%	0.40%	0.25%
Allow plan to cap annual benefits per child			
High Plan		0.35%	0.20%
Medium Plan		0.35%	0.25%
Low Plan		0.40%	0.30%
Allow plan to apply its cost sharing provisions			
High Plan	0.40%	0.25%	0.20%
Medium Plan	0.40%	0.25%	0.20%
Low Plan	0.40%	0.25%	0.20%

7. The benefits to the state, the taxpayers, and society as a whole are many. The cost of EI services is less, and the effectiveness of EI is greater, if EI is started as early as possible for a special needs child. EI produces significant gains in a child's ability to learn, build speech and language skills, and develop physically and cognitively. Special needs children who receive timely EI experience less anti-social behavior and juvenile delinquency and a 50% lower need for special education. More of these children complete high school and become less dependent later in life on social welfare programs.

   Various sources, including EI advocacy groups, claim a return to society and the taxpayers ranging from 40% to 80% on dollars spent on EI services to as much as $17 in savings to society for every $1 spent on EI. From internal discussions in R&A, we estimate a long-term return to society and taxpayers of $2.50 to $5.00 for every $1 spent on EI, assuming the benefit is focused on children who truly need EI.

Introduction and Executive Summary (cont'd)

8. Like any state mandate, SB338 applies only to fully insured plans, which are primarily small and medium sized employer groups and individuals. Self-funded groups are exempt from state mandates under ERISA. Based on national data, approximately 50% of all covered employees are in self-funded plans.

9. Some groups and insured individuals will try to offset the added cost of SB338 by reducing other benefits in their plans, such as by raising deductibles or copayments. This is called cost elasticity. We estimate that small employers will reduce their benefits by an average of 0.25% to offset the costs of SB338, and that large employers will reduce their benefits by an average of 0.15%.

10. Anthem does not require preauthorization of EI services. Anthem does not evaluate the services of EI providers differently than they do for other providers. Anthem notes that their New Hampshire plan has a $3,200 per child per year maximum benefit. They believe that this limited benefit mitigates the risk of not requiring preauthorization or doing any special evaluation of services from EI providers.

    Another carrier requires pre-authorization (a treatment plan) for EI services with its gatekeeper, point of service plans, but not with its PPO plans. A third carrier has no special credentialing for EI providers that is different than what they require of other providers. This carrier does not require pre-authorization.

    We believe that carriers should be able to evaluate services from EI providers in the same manner as they evaluate services of other providers, if the benefit provisions are approximately the same. Allowing other carriers to develop a model for EI provider referral and credentialing based on what Anthem now does is feasible, provided that the EI mandate is modified to include an annual maximum benefit per child similar to Anthem's current maximum, since Anthem now relies on this benefit limit to effectively control utilization. Without a limited annual maximum benefit, we believe carriers will need effective means to control utilization, such as by requiring EI providers to submit an IFSP, by allowing carriers to preauthorize all EI services, and by waiving member cost sharing only for services from network providers—services from out of network (OON) providers would require normal plan OON cost sharing.

II. Discussion of Results and Assumptions

ASSUMPTIONS

Table 4 lists the key assumptions we made in projecting the cost of SB338 and variations to the mandate.

TABLE 4
KEY ASSUMPTIONS

Net benefit per child per year for 2007 *		
No member cost sharing		$9,223
With member cost sharing: High Plan		$5,968
With member cost sharing: Medium Plan		$5,324
With member cost sharing: Low Plan		$4,597
Percentage of all members who are children 0-3		5.4%
Percentage of 0-3 members who require EI		4.8%
Utilization increase if no member cost-sharing **		
No policy maximum benefit		15.0%
$5,200/year maximum benefit		7.5%
$3,200/ year maximum benefit		3.8%
Network provider usage rates **		
No policy maximum benefit, no member cost sharing		50.0%
$5,200 or $3,200 max/year and/or member cost sharing		90.0%
Priced-for loss ratios	Individual plans	65.0%
	Small group plans	75.0%
	Large group plans	85.0%

* Assumes no policy maximum benefit per child. Where indicated, net benefits are after member cost sharing.

** Factored into net benefit per child amounts shown above.

Cost per Case and Utilization Adjustments

We started with average past years' costs per EI case from other state programs, trended these to 2007, and adjusted them to New Hampshire levels to carriers' typical provider allowed cost levels. SB338 as written allows no maximum EI benefit per child for group plans and no member cost sharing. In this situation, there is effectively no control over group utilization and no incentive for members to use network providers. We therefore added 15% to the projected group utilization and assumed that members would use network providers only ½ of the time, as opposed to 90% of the time when there are different in-network and OON cost sharing levels.

For individual plans, which SB338 allows to have a $3,200 per child per year maximum benefit, and for an alternative mandate that would allow $3,200-5,200 annual maximum benefits under group plans, we assumed only 3.8% to 7.5% added utilization. For an alternative that would allow member cost sharing or would require preauthorization of EI services based on an IFSP, we assumed no added utilization.

Discussion of Results and Assumptions (cont'd)

For an alternative mandate that would allow member cost sharing, we assumed that network utilization would be at the typical 90% level. For the group alternatives that would allow maximum annual benefits, we assumed that the average patient would use 90% of a $5,200 annual maximum and 100% of a $3,200 annual maximum.

Percentage of Children Age 0-3 Using EI Services

We based the percentage of children age 0-3 that would use EI services on data from the Massachusetts state plan. Eligibility requirements for EI coverage under IDEA Part C can vary by state; Massachusetts has what is regarded as "broad" (more inclusive) eligibility standards. The Massachusetts plan served 5.75% of all children age 0-3 in 2004, and it projects it will serve 5.9% in 2007, through improvements in identifying children in need. In its State Performance Plan for 2005-10, the State Department of Public Health said that "...the large majority of eligible infants and toddlers...have been identified..."

Data from several sources indicates that children in state EI programs are poorer and are more likely to have mothers who received less prenatal care or who suffered from substance abuse than are children in commercially insured individual and group plans. We therefore reduced the 2007 Massachusetts percentage by 11%, to reflect the higher proportion of Medicaid children in state programs compared to the entire population, and by 7.5% to reflect our assumption of higher severity of conditions among the state plan children compared to commercially insured children. The result was an assumption that 4.8% of children 0-3 in individual and group plans will receive EI services.

Impact of Requiring Preauthorization and/or an IFSP

State EI programs have eligibility definitions that are based on Part C of the federal IDEA amendments of 2004. The appendix has these general definitions. Basically, they include either developmental delays or a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. Within this definition, states can broaden or narrow how they determine a developmental delay. Common measurements are a 25% delay or 2 standard deviations (SD) below the mean in one or more developmental area or 20% delay and 1.5 SD in two or more areas.

IDEA Part C typically requires EI providers to prepare an Individual Family Service Plan (IFSP) before they start treatment. The IFSP outlines the expected course of treatment and the milestones that the treatment is expected to achieve.

SB338 as written allows no eligibility or preauthorization requirements for children to receive the mandated benefits. We estimate that the lack of requirements, combined with an unlimited benefit and no cost sharing, will result in 15% excess utilization of services. With an annual benefit maximum, the excess utilization would be less. However, if the mandate is changed to allow carriers to require an IFSP or similar treatment plan, which then is preauthorized, then there should be very little, if any, excess utilization.

Discussion of Results and Assumptions (cont'd)

Additional Cost Due to SB338 and Alternative Mandates

Mandate Alternatives

As we show in Table 1 above, we project that SB338 will add 0.60% to 0.80% to the cost of typical group plans and 0.20% to 0.30% to the cost of typical individual plans. The main drivers of the high group cost are:

- No limit on benefits
- No member cost sharing allowed
- No definition of eligibility or allowance for preauthorization

Changing the mandate to allow the plan to allow the same cost sharing as it does for other services reduces the mandate's cost by 33% to 50%, depending upon the level of cost sharing in plan. The reduction comes in three ways:

1. From the cost sharing itself (the member is paying part of the cost)

2. From higher usage of network providers with discounted fees (in network benefits are better than OON benefits)

3. From less utilization (by paying part of the cost, the member presumably will make more cost-effective care decisions).

Changing the mandate to allow an annual maximum benefit per child will produce lower cost from the impact of the benefit limit. Also, the member will have an incentive to stretch the maximum benefit as far as possible and will therefore be more likely to use discounted network providers and make more cost-effective care decisions.

Cost Data from Carriers

We received PMPM EI costs from two carriers active in Massachusetts and Connecticut, both of which now have EI mandates with annual benefit limits. After adjusting these costs for New Hampshire provider cost levels, trend, no cost sharing, and no benefit limit, the resulting estimated PMPMs were 5% higher and 78% less than our projected cost. The carrier with the higher cost has a significant amount of Massachusetts and Connecticut business. The carrier with the lower projected cost did not include services of mental health providers (for the EI mandate, these would be clinical social workers) and quoted only its Connecticut experience.

We also looked at Rhode Island Medicaid EI claims data. Adjusting this cost in the same way to a New Hampshire commercial plan level produced a cost that was 59% less than our projected cost. We attribute the wide cost variation among these three sources to the fact that these carriers' current costs with benefit limits are very small, under 0.5%, and could easily be over or under reported.

Discussion of Results and Assumptions (cont'd)

Social Impact and Medical Efficacy of EI Coverage

Every source we reviewed indicates that a well-designed EI program focused on special needs children is effective and results in a considerable positive impact on the children, their families, and society as a whole, and yields a savings to taxpayers. Some of these sources were from children's and provider advocacy groups; other sources were state and federal agencies and reports and objective research reports from Rand Corporation.

Also, some of these studies include the results of initiatives that focus more on intensive early education, rather than physical and occupation therapy and mental health services. We considered these sources as additional, but not primary, indicators of the potential impact of EI.

Here are some of the findings and savings claims from these various sources:

- North Carolina Division of Child Development: EI produces substantial gains in physical development, cognitive development, language and speech development, and self-help skills. "More that 20 years of research demonstrates conclusively that EI reaps immediate and long-term benefits for children with disabilities, their families, and society."

- U.S. Department of Education, Office of Special Education Programs: "One year after entry in EI, many children have mastered additional development milestones and have shown improvements in their behavior. Families report their child's communication and motor skills have improved, and over 2/3 of families report that EI has had a lot of impact on the child's development...about half the families felt they were much better off because of the help and information provided through EI."

- Rand Corporation research brief: "Early childhood intervention programs have been shown to yield benefits in academic achievement, behavior, education progression and attainment, delinquency and crime, and labor market success...Well-designed early interventions have been found to generate a return to society ranging from $1.80 to $17.07 for each dollar spent on the program...fewer resources may be spent on grade repetition and special education classes...and [due to] subsequent economic success in adulthood, the government may benefit from higher tax revenues and reduced outlays for social welfare programs and the criminal justice system."

- Rand Corporation monogram report (abstract): "...EI programs—even those that provide services in the first few years of life—have been limited in their ability to demonstrate persistent cognitive effects, and the same is true for the measures of child behavior...Although the IQ effects produced by EI may be short lived, there appears to be strong and longer-lasting benefits in terms of educational outcomes, such as academic achievement and other aspects of school performance."

- New Hampshire Child Advocacy Network: "For every dollar invested, there is a 40% investment return in government savings from special education, reduction in juvenile justice and criminality, welfare and unemployment costs."

Discussion of Results and Assumptions (cont'd)

- National Institute for Early Education Research: Based on studies of the Abecedarian Early Childhood Intervention Project in North Carolina, which is primarily intensive education-based, rather than therapy-mental health care based, "Taxpayers received a four to one return on their investment."

- Kidsource.com website article prepared with funding from the U.S. Department of Education, Office of Education Research and Improvement: "If the most teachable moments or stages of greatest readiness are not taken advantage of, a child may have difficulty learning a particular skill at a later time...The cost [of EI] is less when intervention is earlier because of the remediation and prevention of developmental problems which would have required special services later in life...A 3-year follow-up in Tennessee showed that for every dollar spent on early treatment, $7.00 in savings were realized within 36 months...A recent evaluation of Colorado's state-wide EI services reports a cost savings of $4.00 for every dollar spent within a 3-year period."

Our own estimate for the savings to society and taxpayers from EI services is in the range of $2.50 to $5.00 for every EI dollar spent, if the EI program is focused on those children who truly need the services. Also, we note that these societal savings, or the savings quoted above from other sources, generally do not accrue directly to the payer of the health plans that would cover EI under a mandate. While there may be some savings in later years from fewer mental health and substance abuse services or physical and occupational therapy provided to insured teens and adults, these savings may be reaped by other groups, not by the ones that paid for the EI services to children age 0-3.

According to a 2004 study of the Virginia state program, the EI service distribution by provider (based on cost) is approximately 40% physical and occupational therapy, 28% speech and language pathology, and 32% other services.

Federal data indicate that approximately 51% of children receiving EI services are insured by individual or group plans (i.e., not public programs). Of these, approximately 37% have been turned down for EI coverage by their carriers or health plans.

Balancing Social, Financial, and Medical Efficacy Considerations

While the benefits of EI to the families of special needs children, to state taxpayers, and to society as a whole are large and, by all accounts, are several times the cost of the benefits themselves, these benefits do not necessary accrue to the person or group that buys the coverage. A state mandate like SB338 applies only to insured plans. The largest employers in the state, including the State of New Hampshire, are most likely self-funded and exempt from mandates. Insured plans, which are affected by the mandate, are purchased primarily by individual policyholders and small and medium size employers, who would, in effect, be bearing the cost of services that benefit the entire state.

Discussion of Results and Assumptions (cont'd)

Elasticity of Demand

Under the theory of elasticity of demand, a cost increase will trigger reduced demand for the affected product or service. Studies conducted by the Congressional Budget Office and the Lewin group imply that, for every 1% increase in premium (beyond trend), we would expect a reduction in coverage of 0.2% to 0.3%. This reduction would most likely come in the form of increasing deductibles, copayments, coinsurance, or some combination of these.

We estimate the effect on individual plans to be negligible—less than 0.1% reduction in other benefits to offset the cost of the EI mandate. For group plans, the estimated offsetting reductions would range from 0.15% for a large employer with a high (low cost sharing) plan to 0.25% for a small employer with a low (high cost sharing) plan.

QUESTIONS FROM LETTER TO THE COMMISSIONER FROM THE SENATE

The Senate raised the following questions. We have shortened them here to be more concise.

1. **Does Anthem's current practice review on a case-by-case basis or does it presume that EI services are medically effective?**

   Anthem does not require preauthorization of EI services. The Anthem plan has a $3,200 annual/$$9,600 lifetime EI maximum benefit per child. Anthem believes that these limited benefits sufficiently mitigate the risk, and therefore they do not perform medical necessity reviews for physical, occupational, or speech therapy.

2. **Should there be differences in the manner in which insurers evaluate efficacy of treatment by EI providers?**

   Anthem does not evaluate the services of EI providers differently from what they do for services from other providers. Again, Anthem relies on the policy's limited maximum EI benefits to mitigate the risk of excessive or inappropriate services.

   The responses we received from other carriers are consistent with Anthem's. One carrier has a 90 days per condition lifetime maximum benefit in lieu of a dollar maximum.

   This carrier requires preauthorization of EI services in their plans that have a primary care provider "gatekeeper." Other plans, such as PPO plans, do not require preauthorization.

   Another carrier does not require EI authorizations or special referrals. For its Massachusetts business, this carrier assumes that providers follow the criteria for EI treatment set up by the state Department of Public Health. We assume this includes preparation of an IFSP. This carrier does not perform any special credentialing for EI, relying on the state licensure of these providers. One other carrier we spoke with also does not perform any special credentialing of or preauthorization by EI providers.

Discussion of Results and Assumptions (cont'd)

We note that all of these carriers have policy limits on the EI benefits, which effectively serve as a utilization control. Without these limits, we believe that a policy should require either a formal IFSP or preauthorization of services. Otherwise, based on the responses we received, we do not feel that carriers need to evaluate services from EI providers any differently than they do now with services of other providers.

3. **Will developing a model based on what Anthem does change the role or practices of insurers with regard to control over physician (provider) referral, inclusion in a network, and credentialing? If so, how should the legislation address this?**

We note that Anthem's "model" relies on a very limited $3,000 annual/$9,600 lifetime maximum benefit per child. Other carriers appear to make a similar reliance on benefit limits. The biggest change to carriers' (including Anthem's) current practices would come from SB338's mandated unlimited benefit, especially one requiring no member cost sharing. If one of the Legislature's objective for the EI mandate is to be minimally disruptive to carriers' provider referral and credentialing, then we suggest it consider allowing a maximum annual EI benefit per child and possibly member cost sharing as well. For example, the Massachusetts mandate has a $5,200 per child per year maximum benefit and allows member cost sharing.

III. References

Illinois Department of Human Services: "Report to the General Assembly on the Early Intervention Program for Reporting Period April 30, 2003"

Massachusetts Part C State Performance Plan for 2005-2010

North Carolina Division of Child Development website on early intervention

"Virginia Cost Study Report," by Karleen Goldhammer, Solutions Consulting Group LLC, August 2004

"Washington's Infant Toddler Early Intervention Program Study," December 1, 2000, Washington State Department of Social and Health Services

"Public Insurance Eligibility and Enrollment for Special Health Care Needs Children, " by Amy Davidoff, Alshadye Yemane, and Ian Hill, Health Care Financing Review, Fall 2004

"Characteristics of Children and Families Entering Early Intervention" and "Results Experienced by Children and Families 1 Year After Beginning Early Intervention," U.S. Department of Education, Office of Special Education Programs

"Assessing Costs and Benefits of Early Childhood Intervention Programs," by Lynn Karoly et. al., Rand Corporation (abstract of Monogram Report 1336)

"Proven Benefits of Early Childhood Interventions," Rand Corporation Research Brief 9145

"State and Jurisdictional Eligibility Definitions for Infants and Toddlers with Disabilities Under IDEA," by Jo Shackelford, The National Early Childhood Technical Assistance Center, NECTAC Notes, Issue 21, July 2006

"Early Intervention: The Need for Public-Private Partnership," New Hampshire Child Advocacy Network, 2006

"What is Early Intervention," www.kidsource.com (quoted source of information is the U.S. Department of Education)

"A Benefit-Cost Analysis of the Abecedarian Early Childhood Intervention," National Institute for Early Education Research (www.nieer.org)

Exhibit A

Benefits of Illustrative Plans Used in Study

	High		Medium		Low	
	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network
Deductible	$200	$500	$500	$1,000	$1,250	$2,500
Coinsurance *	10%	30%	20%	40%	20%	40%
Out of Pocket Maximum *	$1,500	$4,000	$2,500	$5,000	$3,000	$6,000
Copayments for						
Physician Office Visits	$15	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Emergency Room	$100	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins	Ded/Coins
Generic Rx	$10	$10	$10	$10	$10	$10
Formulary Brand Rx	$20	$20	$20	$20	$25	$25
Non-formulary Rx	$20	$20	$40	$40	$50	$50

* 2 times for family

Exhibit B

Children's Early Intervention (EI) Services
Review of Existing State Mandates

State	Mandate Effective	Requires Eligibility for IDEA Part C?	Maximum Annual Benefit/Child	Can Carrier Apply Copay, Ded, Coins?
Connecticut [1]	1/1/2004	No	$3,200	Yes
Indiana	[2]			
Massachusetts	1/13/1990 [3]	No	$5,200	Yes
Missouri	1/1/2006	Yes	$3,000	Yes
New Mexico	7/1/2005	Yes	$3,500	Yes
New York	[2]			
Rhode Island	1/1/2005	Yes	$5,000	No [4]
Virginia	7/1/1998	Yes	$5,000	Yes

1. Date of last change in mandate. Original effective date is not known. Individualized family service plan (IFSP) is required.

2. These states do not appear to mandate EI coverage. Rather, they appear to require that, if a health plan covers EI, it must reimburse state and local programs for their EI services.

3. Amended 7/1/2004 with a higher annual maximum benefit.

4. Deductible and coinsurance allowed for HSA-qualified plans.

APPENDIX A

Definitions Related to Eligibility Under Part C of the IDEA Amendments of 2004

Under Part C of IDEA, states *must provide* services to any child "under 3 years of age who needs early intervention services" (IDEA 2004, §632 (5)(A)) because the child:

"(i) is experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in 1 or more of the areas of cognitive development, physical development, communication development, social or emotional development, and adaptive development; or

(ii) has a diagnosed physical or mental condition which as a high probability of resulting in developmental delay" (IDEA 2004, §632 (5)(A)).

A state also may provide services, at its discretion, to at-risk infants and toddlers. An at-risk infant or toddler is defined under Part C as "an individual under 3 years of age who would be at risk of experiencing a substantial development delay if early intervention services were not provided to the individual" (IDEA 2004, §632 (5)(1)).

APPENDIX B

Letter from New Hampshire Senate