GOLD STANDARD

Generally Accepted Standards of Care:

Aligning Coverage Criteria and Utilization Review Criteria with Clinical Practice

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THE KENNEDY FORUM

Contents

Generally Accepted Standards of Care

Generally Accepted Standards of Care (GASC) provide guidelines for what care patients should receive and when, based on the available evidence. Clinicians use GASC to determine the appropriate care and placement for their patients. Insurers claim to make decisions to reimburse or authorize covered services based on whether they are "medically necessary," purportedly based on GASC. When insurers deviate from GASC in mental health and substance use disorder (MH/SUD) care, people get hurt. States have the opportunity to protect them.

The federal Parity law requires that health insurance plans not limit treatment for MH/SUD care more than they do medical and surgical (M/S) care. To comply with the law, health plans must fairly determine medical necessity, which includes fairness about how GASC is incorporated, what is relied upon as GASC, and how it is applied. For example, if a health insurance plan relied on independent criteria from medical societies to assess GASC and make medical necessity determinations in M/S, they would need to do the same in MH/SUD. Failure to do so would both violate the law and harm access to care.

The Problem

While health insurers generally claim to use GASC in utilization review of mental health (MH) and substance use disorder (SUD) claims, they often rely on for-profit, proprietary, and non-transparent criteria in practice. When these criteria are different from the GASC that health insurers use for M/S medical necessity determinations, this violates the federal Parity law – even if the criteria claim to be similar. For example, an insurer could rely on recommendations from medical societies for M/S and then rely on guidelines developed by a corporation for MH/SUD, even if the corporate guidelines claim to be based on medical societies. This would be a clear violation of the federal Parity law.

For patients, the use of for-profit criteria can lead to unnecessary denials based on any number of non-clinical judgements including the insurer's own economic benefit. This was found in the landmark case, *Wit vs. United Behavioral Health*. Their proprietary nature makes it challenging for regulators to assess trends in health insurer utilization review and parity compliance and to ascertain the validity of individual cases of patients who seek an appeal for their MH/SUD denials. As a result, these criteria go beyond legal violation to actually harm real patients.

The MCG Guidelines are the most commonly used for-profit utilization review product bought by insurers, which claims to be consistent with GASC. In July 2024, the major nonprofit clinical associations – The American Academy of Child & Adolescent Psychiatry (AACAP), the American Association for Community Psychiatry (AACP), American Psychiatric Association (APA), and the American Society of Addiction Medicine (ASAM) - together sent a letter to the federal Department of Labor Employee Benefits Security Administration on the use of faulty proprietary criteria for MHSUD coverage decisions, noting MCG's inability to ensure their criteria aligned with the nonprofit clinical associations' standards: "As our organizations have never been permitted to see or review the MCG criteria, which are labeled as "proprietary" we have no way of determining whether the MCG criteria are "consistent" with those developed by our professional Associations."

The Solution

The gold-standard best practice is that states explicitly require the use of certain GASC when making medical necessity determinations that also align with federal Parity law. GASC should be transparent, fairly applied, and easily streamlined, ensuring plans' utilization review decisions are aligned with clinical standards of care, such that consumers, providers, and regulators can understand the criteria for which determinations on coverage are being made and assessed.

There are many benefits to requiring the use of GASC, which even major health plans have recognized,[1] as critical for being:

- "Externally validated: [LOCUS/CALOCUS/ESCII] criteria were created and are updated based on the changing landscape of evidence informed care, market and regulatory considerations, and feedback from stakeholders across the care system.
- Common Language Drives Improved Care: The use of these guidelines creates a common language for providers with payers, regulators and other stakeholders of the care system, which results in a clearer understanding of patient needs.
- The six dimensions provide a more holistic view of acuity and chronicity of behavioral condition, thereby promoting more appropriate care for patients and a better overall experience."

Federal Laws on GASC

Under federal law, health plans are required to disclose the criteria for medical necessity determinations to any current or potential participant, beneficiary, or contracting provider upon request.[2] The Mental Health Parity and Addiction Equity Act Final Rule also references 'generally recognized independent standards' when discussing coverage of meaningful benefits, defining the core treatments that comprise meaningful benefits as "a standard treatment or course of treatment, therapy, service, or intervention indicated by generally recognized independent standards of current medical practice." While such standards are not explicitly defined, states can additionally ensure definitions and requirements in state law are consistent with generally accepted standards of care and the ICD/DSM. For more information, please see Appendix VI.

State Implementation of GASC

At least seven states have implemented guidelines mandating GASC for all MH/SUDs, as outlined in the Ramstad Model, described below: California, Colorado,[3] Georgia, New Mexico, Oregon, and Virginia, and Washington.[4] Maryland and Illinois require the use of GASC for all health conditions, including MH/SUD.[5] As of 2020, ten additional states have implemented requirements for SUDs[6]: Connecticut, Delaware, New Hampshire, New Jersey, New York, North Carolina, Rhode Island, Tennessee, Texas, and West Virginia.

Gold Standard Law: The Ramstad Model

The **Ramstad Model** [7] is critical for ensuring patients are receiving clinically appropriate medically necessary care for their MH/SUDs, in accordance with federal parity laws.

First, it defines generally accepted standards of care (GASC) with "standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties…" These standards of clinical practice are defined by using non-profit clinical association criteria:

- The ASAM Criteria for SUDs
- Level of Care Utilization System (LOCUS) and Child and Adolescent LOCUS (CALOCUS-CASII-ECSII) for MH

Second, it states that all medical necessity determinations must follow GASC: "a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(iii) Not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider."

Gold Standard Regulations: Safe Harbors[8]

We encourage the use of safe harbors listed in regulations on utilization review standards for level of care coverage determinations. This can be done by simply listing accepted nonprofit clinical criteria directly into regulations. Appendix II shows two examples from California's two health insurance regulators.

Gold Standard Regulations: Gap-Filling Utilization Review Criteria[9]

Gap-filling criteria should be used when there are not established nonprofit professional association utilization review criteria for a MH/SUD condition or service. Gap-filling criteria should be consistent with GASC to ensure that every MH/SUD condition is measured against appropriate clinical standards. Appendix III shows an example of regulations from from the California Department of Insurance.

Additional GASC Protections:

Coverage requirements for frequently denied care.[10]

Regulators should consider listing coverage requirements for frequently denied services and levels of care. This has proven particularly useful for wraparound services like Coordinated Specialty Care and for specific ASAM levels of care such as 3.1 Withdrawal Management. Appendix IV is an example from the California Department of Managed Health Care.

Frequency and duration of treatment reviews.[11]

We encourage regulators to adopt language limiting the frequency and duration of treatment reviews, to align with the model definition of medically necessary treatments that are "*clinically appropriate in terms of type, frequency, extent, site, and duration.*" Doing so would further align with the federal Parity requirement that prohibits more stringent "Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage" for MH/SUD as compared to M/S.[12]

Expanding GASC Protections for All Health Care Services

Following its implementation of the Ramstad Model, Illinois opted to expand the GASC protections for MH/SUD to all health care services through the passage of its Health Care Protection Act.[13] States wishing to follow suit may wish to look towards Illinois' statute. Appendix VI includes sample statutory language to this effect from Illinois and Maryland.

Appendix

Appendix I. **Jim Ramstad Model State Legislation to Advance Mental Health and Addiction Equity by Requiring Compliance with Generally Accepted Standards of Care (PDF)**

Appendix II. **Gold Standard Regulations: Safe Harbors**

California Department of Managed Health Care Services, as FINALIZED January 2024

28 CCR 1300.74.721 Mental Health and Substance Use Disorder Utilization Review Requirements

(c) Clinical criteria developed by the following nonprofit professional associations, or a successor organization thereto, shall be used to make utilization review determinations that are within the scope of the criteria:

(1) American Academy of Child and Adolescent Psychiatry.

(2) American Academy of Family Physicians.

(3) American Academy of Neurology.

(4) American Academy of Pediatrics.

(5) American Academy of Sleep Medicine.

(6) American Association for Community Psychiatry.

(7) American College of Physicians.

(8) American Medical Association.

(9) American Psychiatric Association.

(10) American Psychological Association.

(11) American Society of Addiction Medicine.

(12) Canadian Network for Mood and Anxiety Treatments.

(13) Counsel of Autism Providers.

(14) World Professional Association for Transgender Health.

...

(h) Utilization review determinations concerning service intensity, level of care placement, continued stay, and transfer or discharge that are within the scope of the following instruments shall be considered compliant with Health and Safety Code section 1374.721:

(1) For a primary substance use disorder diagnosis in adolescents and adults, The ASAM Criteria by the American Society of Addiction Medicine.

(2) For a primary mental health diagnosis in adults nineteen (19) years of age and older, Level of Care Utilization System (LOCUS) by the American Association for Community Psychiatry.

(3) For a primary mental health diagnosis in children six (6) to eighteen (18) years of age, Child and Adolescent Level of Care/Service Intensity Utilization System (merged CALOCUS-CASII) by the American Association for Community Psychiatry and the American Academy of Child and Adolescent Psychiatry.

(4) For a primary mental health diagnosis in children five (5) years of age and younger, Early Child Service Intensity Instrument (ECSII) by the American Academy of Child and Adolescent Psychiatry.

California Department of Insurance Regulations, as DRAFTED June 2024

Section 2562.03 Utilization Review Standards for Level of Care Coverage Determinations

(a) Utilization review coverage determinations concerning service type, intensity, level of care placement, continued stay, and transfer or discharge, including any reassessments or redeterminations, that are within the scope of the following instruments shall be made by using the most current version of the instrument designated by the respective nonprofit professional association, exclusive of all other clinical criteria, decision making tools, or applications:

(1) For a primary substance use disorder diagnosis in adolescents and adults, "The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions" by the American Society of Addiction Medicine.

(2) For a primary mental health diagnosis in adults nineteen (19) years of age and older, "Level of Care Utilization System" (LOCUS) by the American Association for Community Psychiatry.

(3) For a primary mental health diagnosis in children six (6) to eighteen (18) years of age, "Child and Adolescent Level of Care/Service Intensity Utilization System" (merged CALOCUS-CASII) by the American Association for Community Psychiatry and the American Academy of Child and Adolescent Psychiatry, or "Child and Adolescent Service Intensity Instrument" (CASII) by the American Academy of Child and Adolescent Psychiatry.

(4) For a primary mental health diagnosis in children five (5) years of age and younger, "Early Child Service Intensity Instrument" (ECSII) by the American Academy of Child and Adolescent Psychiatry.

Note: While not developed at the time of the regulator's issuance of Safe Harbor regulations in January 2024, the REDC Level of Care Criteria are the most detailed, up to date, clinical level of care guidelines for eating disorder care. These criteria define eating disorder levels of care and criteria for admission for each level of care and were vetted across clinical and research evidence as well as across the eating disorders field to gain clinical consensus. We encourage the listing of these criteria as part of allowed nonprofit clinical criteria.

Appendix III. **Gold Standard Regulations: Gap-Filling Utilization Review Criteria**

California Department of Insurance Regulations, as DRAFTED June 2024

Section 2562.04 Gap-Filling Utilization Review Criteria

(a) If nonprofit professional association clinical criteria that determine the medical necessity of a health care benefit or an advancement in a technology or type or level of care for a mental health condition or substance use disorder do not exist, then an insurer may use other clinical criteria to conduct utilization review, provided that:

(1) The gap-filling utilization review criteria are based on current generally accepted standards of mental health and substance use disorder care. An insurer shall document the sources, and evidence supporting the clinical appropriateness, of each of the gap-filling utilization review criteria in a clinical policy.

(2) An insurer develops and maintains, and provides upon request, the following records:

(A) To any requestor, the clinical policy containing the gap-filling utilization review criteria that the insurer uses to perform utilization review of the health care benefit.

(B) To an insured or an insured's authorized representative, and the insured's health care provider, a comparative analysis and all underlying supporting documentation demonstrating that the gap-filling utilization review criteria were designed, and in practice are applied, in compliance with the Mental Health Parity and Addiction Equity Act rule on nonquantitative treatment limitations set forth in subdivision (c)(4) of Section 146.136 of Title 45 of the Code of Federal Regulations.

(C) To an insured or an insured's authorized representative, and the insured's health care provider, a written justification prepared by appropriately qualified health care professionals that includes the following:

1. A description of the nonprofit professional association sources the insurer examined and the process the insurer followed to make its finding that nonprofit professional association clinical criteria that determine the medical necessity of a health care benefit or an advancement in a technology or type or level of care for a mental health condition or substance use disorder do not exist.

2. An explanation of the clinical rationale and evidence supporting the insurer's determination that the gap-filling utilization review criteria are based on current generally accepted standards of mental health and substance use disorder care for determining the medical necessity of a health care benefit or an advancement in a technology or type or level of care for a mental health condition or substance use disorder.

(b) If nonprofit professional association clinical criteria that determine the medical necessity of an existing technology or type or level of care of care exist, those criteria shall be used exclusively to make a utilization review coverage determination unless the specific coverage determination at issue is whether a novel or different application of an existing technology or type or level of care is medically necessary.

(c) An insurer shall perform, and document completion of, each of the following at least annually:

(1) Survey sources of nonprofit professional association clinical criteria for new or revised clinical criteria that determine the medical necessity of a health care benefit or an advancement in a technology or type or level of care that is the subject of each

of the insurer's gap-filling clinical criteria and clinical policies.

(2) If new or revised nonprofit professional association clinical criteria do not exist, evaluate whether the gap-filling utilization review criteria are based on current generally accepted standards of mental health and substance use disorder care and update the clinical policy as necessary.

(3) Review the records maintained pursuant to subdivision (a)(2) of this section for contemporaneity and continued accuracy and update the records as necessary.

Appendix IV. Gold Standard Regulations: Coverage Requirements for Frequently Denied Care

California Department of Managed Health Care, as FINALIZED January 2024

28 CCR 1300.74.72.01 Scope of Required Benefits for Mental Health and Substance Use Disorders

(a) A health plan shall provide coverage of health care benefits for preventing, diagnosing, and treating mental health conditions and substance use disorders as medically necessary for an enrollee, in accordance with current generally accepted standards of mental health and substance use disorder care, including but not limited to, the following:

(1) Basic health care services, including the following:

(A) Emergency health care services as defined by Health and Safety Code section 1317.1 rendered both inside and outside the service area of the applicable network consistent with the Knox-Keene Act.

(B) Urgent care services rendered inside and outside the service area of the of the applicable network consistent with the Knox-Keene Act.

(C) Physician services, including but not limited to consultation and referral to other health care providers and prescription drugs when furnished or administered by a health care provider or facility.

(D) Hospital inpatient services, including services of licensed general acute care, acute psychiatric, and chemical dependency recovery hospitals.

(E) Ambulatory care services, including but not limited to physical therapy, occupational therapy, speech therapy, and infusion therapy.

(F) Diagnostic laboratory services, diagnostic and therapeutic radiologic services, and other diagnostic and therapeutic services.

(G) Home health care service.

(H) Preventive health care services, regardless of whether an enrollee has been diagnosed with a mental health condition or substance use disorder.

(I) Hospice care that is, at a minimum, equivalent to hospice care provided by the federal Medicare Program pursuant to Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et seq.) and implementing regulations adopted for hospice care under Title XVIII of the Social Security Act in Part 418 of Chapter IV of Title 42

(2) Behavioral health treatment for pervasive developmental disorder or autism spectrum disorder pursuant to Health and Safety Code section 1374.73.

(3) Coordinated specialty care for the treatment of first episode psychosis.

(4) Day treatment.

(5) Drug testing, both presumptive and definitive, including for initial and ongoing patient assessment during substance use disorder treatment.

(6) Electroconvulsive therapy.

(7) For gender dysphoria, all health care benefits identified in the most recent edition of the Standards of Care developed by the World Professional Association for Transgender Health.

(8) Inpatient services, including but not limited to all the following:

(A) ASAM inpatient levels of care (3rd edition) for substance use disorder rehabilitation and withdrawal management, or as described in the most recent version of the ASAM Criteria. Substance use disorder rehabilitation and withdrawal management, as described in the most recent version of The ASAM Criteria.

(i) 3.7, medically monitored intensive (adults) or high-intensity (adolescents) inpatient services.

(ii) 4, medically managed intensive inpatient services.

(B) High intensity acute medically managed residential programs (LOCUS and CALOCUS-CASII level 6A (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).

(C) Medically managed extended care residential programs (LOCUS and CALOCUS-CASII level 6B (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).

(9) Intensive community-based treatment, including assertive community treatment and intensive case management.

(10) Intensive home-based treatment.

(11) Intensive outpatient treatment.

(12) Medication management.

(13) Narcotic (opioid) treatment programs.

(14) Outpatient prescription drugs, if coverage for outpatient prescription drugs is provided. Outpatient prescription drugs prescribed for mental health and substance use disorder pharmacotherapy, including office-based opioid treatment.

(15) Outpatient professional services, including but not limited to individual, group, and family substance use and mental health counseling.

(16) Partial hospitalization.

(17) Polysomnography.

(18) Psychiatric health facility services, including structured outpatient services as described in Health and Safety Code section 1250.2.

(19) Psychological and neuropsychological testing.

(20) Reconstructive surgery pursuant to Health and Safety Code section 1367.63. For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which the enrollee identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested.

(21) Residential treatment facility services, including all the following:

(A) Intensive short-term residential services (LOCUS and CALOCUS-CASII level 5A (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).

(B) Moderate intensity intermediate stay residential treatment programs (LOCUS and CALOCUS-CASII level 5B (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).

(C) Moderate intensity long-term residential treatment programs (LOCUS and CALOCUS-CASII level 5C (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).

(D) ASAM residential levels of care (3rd edition), or as described in the most recent version of The ASAM Criteria:

(i) 3.1, clinically managed low intensity residential services.

(ii) 3.3, clinically managed population-specific high intensity residential services.

(iii) 3.5, clinically managed high intensity (adults) or medium intensity (adolescents) residential services.

(22) Schoolsite services for a mental health condition or substance use disorder that are delivered to an enrollee at a schoolsite pursuant to Health and Safety Code section 1374.722.

(23) Transcranial magnetic stimulation.

(24) Withdrawal management services, including all the following ASAM levels (3rd edition), or as described in the most recent version of The ASAM Criteria:

(A) 1-WM, ambulatory withdrawal management without extended on-site monitoring.

(B) 2-WM, ambulatory withdrawal management with extended on-site monitoring.

(C) 3.2-WM, clinically managed residential withdrawal management.

(D) 3.7-WM, medically monitored inpatient withdrawal management.

(E) 4-WM, medically managed intensive inpatient withdrawal management.

Appendix V. **Gold Standard Regulations: Frequency and Duration of Treatment Reviews**

Sample regulatory language: "*Health plans should not conduct utilization review of a case at intervals more frequent than those prescribed or recommended by the relevant nonprofit professional association criteria or guidelines.*"

Appendix VI. **Additional Gold Standard Statutory Language Implementing GASC for All Health Care Services**

The following statutory language requires GASC for all health care services:

Example 1: Maryland Insurance Code § 15-10B-05(a)

[A health plan or insurer shall] submit information that the Commissioner requires including:

…

(11) certification by [a health plan or insurer] that the criteria and standards to be used in conducting utilization review are generally recognized by health care providers practicing in the relevant clinical specialties and are:

(i) objective;

(ii) clinically valid;

(iii) reflected in published peer–reviewed scientific studies and medical literature;

(iv) developed by:

1. a nonprofit health care provider professional medical or clinical specialty society, including through the use of patient placement criteria and clinical practice guidelines; or

2. for criteria not within the scope of a nonprofit health care provider professional medical or clinical specialty society, an organization that works directly with health care providers in the same specialty for the designated criteria who are employed or engaged within the organization or outside the organization to develop the clinical criteria, if the organization:

A. does not receive direct payments based on the outcome of the utilization review; and

B. demonstrates that its clinical criteria are consistent with criteria and standards generally recognized by health care providers practicing in the relevant clinical specialties;

(v) recommended by federal agencies;

(vi) approved by the federal Food and Drug Administration as part of drug labeling;

(vii) taking into account the needs of atypical patient populations and diagnoses, including the unique needs of children and adolescents;

(viii) sufficiently flexible to allow deviations from norms when justified on a case–by–case basis, including the need to use an off–label prescription drug;

(ix) ensuring quality of care of health care services;

(x) reviewed, evaluated, and updated at least annually and as necessary to reflect any changes; and

(xi) in compliance with any other criteria and standards required for coverage under this title, including compliance with § 15–802(d) of this title for the treatment of substance use disorders.

Example 2: Illinois Public Act 103-0650

215 ILCS 134/10. Sec. 10. Definitions:

"Generally accepted standards of care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties for the illness, injury, or condition or its symptoms and comorbidities. Valid, evidence-based sources reflecting generally accepted standards of care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including, but not limited to, patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

"Medically necessary" means that a service or product addresses the specific needs of a patient for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, or condition or its symptoms and comorbidities, including minimizing the progression of an illness, injury, or condition or its symptoms and comorbidities, in a manner that is all of the following:

(1) in accordance with generally accepted standards of care;

(2) clinically appropriate in terms of type, frequency, extent, site, and duration; and

(3) not primarily for the economic benefit of the health care plan, purchaser, or utilization review organization, or for the convenience of the patient, treating physician, or other health care provider.

...

(k) An insurer shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental, emotional, nervous, or substance use disorders or conditions on current generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care.

References

1 Optum Clinical Criteria for Behavioral Health Conditions Use of LOCUS - CALOCUS-CASII - ECSII (L/CC/E Criteria) **https://public.providerexpress.com/content/dam/ope-provexpr/us/pdfs/clinResourcesMain/guidelines/optumLOCG/locg/LCE-FAQs.pdf**

2 42 USC 300gg-26(a)(4)

3 California, Colorado, Illinois, and Washington have implemented the Ramstad Model to its highest fidelity, by specifically outlawing the use of for-profit criteria. Regulators in California have made the outlawed use of such criteria clear in their regulations implementing the statute. See the Appendices for sample regulatory language.

4 **https://www.paritytrack.org/reports/**

5 See Appendix VI for statutory language from Maryland and Illinois.

6 Spotlight on Medical Necessity Criteria for Substance Use Disorders: An Analysis of Requirements for Health Plans to Use Specific Criteria and Assessment Tools to Determine Medical Necessity, Legal Action Center and Partnership to End Addiction, 2020. **https://www.lac.org/assets/files/Spotlight-on-Medical-Necessity-Criteria-for-Substance-Use-Disorder-Treatment.pdf**

7 See Appendix I for Ramstad model language

8 See Appendix II for model regulatory language

9 See Appendix III for model regulatory language

10 See Appendix IV for model regulatory language

11 See Appendix V for model regulatory language

12 45 C.F.R. § 146.136(c)(4)(ii)(H)

13 Illinois Public Act 103-0650: **https://ilga.gov/legislation/publicacts/fulltext.asp?Name=103-0650**