

Insurance and Real Estate Committee

Appropriations Committee

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDERS

SUMMARY: This act requires a group health insurance policy to cover the diagnosis of autism spectrum disorders and expands the requirements on insurers to cover treatment of these disorders. It requires insurers to cover behavioral therapy for a child age 14 or younger and certain prescription drugs and psychiatric and psychological services for insureds with autism. The act permits a policy to set a certain annual dollar maximum for behavioral therapy coverage.

Prior law required a group health insurance policy to cover physical, speech, and occupational therapy services provided to treat autism to the same extent that it covers them for other diseases and conditions. The act removes that limitation, but specifies different conditions for covering the therapies.

The act authorizes an insurer, HMO, hospital or medical service corporation, or fraternal benefit society to review an autism treatment plan's outpatient services in accordance with its utilization review requirements, but not more often than once every six months, unless the insured's licensed physician, psychologist, or clinical social worker agrees a more frequent review is necessary or changes the insured's treatment plan.

The act specifies that it is not to be interpreted as limiting or affecting (1) other covered benefits under the policy, the state mental and nervous condition insurance law, and the birth-to three coverage law; (2) a board of education's obligation to provide services to an autistic student under an individualized education program in accordance with law; or (3) any obligation imposed on a public school by the federal Individual with Disabilities Education Act (20 USC § 1400).

The act also specifies that it must not be interpreted to require a group health insurance policy to reimburse special education and related services provided to an insured under state law that requires boards of education to provide special education programs and services unless state or federal law requires otherwise.

By law, each violation of the act is subject to a fine of up to \$1,000. The insurance commissioner may also revoke an out-of-state insurer's license for violating the act.

EFFECTIVE DATE: January 1, 2010

AUTISM SPECTRUM DISORDERS

The act defines “autism spectrum disorders” as the pervasive developmental disorders set forth in the most recent edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, including autistic disorders, Rett's disorder, childhood disintegrative disorder, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

For purposes of its provisions and the definition of “medical necessity,” the act considers autism spectrum disorder an illness.

DIAGNOSIS

The act defines “diagnosis” as the medically necessary assessment, evaluation, or testing a licensed physician, psychologist, or clinical social worker performs to determine if a person has an autism spectrum disorder. It specifies that a diagnosis is valid for at least 12 months, unless a licensed physician, psychologist, or clinical social worker decides a shorter period is appropriate or changes the insured's diagnosis.

COVERAGE AND CONDITIONS

The act requires a group health insurance policy to cover:

1. behavioral therapy for children under age 15;
2. prescription drugs a licensed physician, physician assistant, or advanced practice registered nurse prescribes to treat autism spectrum disorder symptoms and co-morbidities (diseases or conditions existing together), to the extent the policy covers prescription drugs for other diseases and conditions;
3. direct and consultative psychiatric and psychological services; and
4. physical, speech, and occupational therapy services a licensed physical, speech and language, and occupational therapist provides, respectively.

Under the act, in order for the policy to cover these treatments, they must be (1) medically necessary, (2) identified and ordered by a licensed physician, psychologist, or clinical social worker for an insured person diagnosed with autism; and (3) based on a treatment plan. A licensed physician, psychologist, or clinical social worker must have developed the treatment plan following a comprehensive evaluation or reevaluation of the insured. The act allows the policy to limit the coverage for behavioral therapy to a yearly benefit of (1) \$50,000 for a child who is less than nine years of age, (2) \$35,000 for a child between nine and 13 years of age, and (3) \$25,000 for a child age 13 or 14.

The act specifies that the coverage it requires may be subject to the other general exclusions and limitations of the group health insurance policy, including (1) coordination of benefits, (2) participating provider requirements, (3) restrictions on services provided by family or household

members, and (4) case management provisions. But any utilization review must be performed in accordance with the act.

Behavioral Therapy

The act defines “behavioral therapy” as any interactive behavioral therapy derived from evidence-based research. It includes applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with an autism spectrum disorder that are (1) provided to children under age 15 and (2) provided or supervised by (a) a behavior analyst certified by the Behavior Analyst Certification Board, which is a nonprofit professional credentialing organization, (b) a licensed physician, or (c) a licensed psychologist. Supervision involves at least one hour of face-to-face supervision of the autism services provider for every 10 hours of behavioral therapy provided.

Applied Behavioral Analysis

The act defines “applied behavioral analysis” as designing, implementing, and evaluating environmental modifications using behavioral stimuli and consequences, including direct observation, measurement, and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in behavior.

COVERAGE PROHIBITIONS

The act prohibits a group health insurance policy from:

1. limiting the number of visits to an “autism services provider” (a person, entity, or group that provides treatment for autism spectrum disorders) on any basis other than a lack of medical necessity or
2. imposing a coinsurance, copayment, deductible, or other out-of-pocket expense that places a greater financial burden on an insured for access to the diagnosis and treatment of an autism spectrum disorder than for the diagnosis and treatment of any other medical, surgical, or physical health condition under the policy.

PENALTY

By law, an insurer, HMO, hospital or medical service corporation, or fraternal benefit society, or its officer or agent, that delivers or issues a policy that violates the act is subject to a fine of up to \$1,000 for each offense. The insurance commissioner may also revoke an out-of-state insurer's license for violating the act's provisions (CGS § 38a-548).

APPLICABILITY OF ACT

The act applies to group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical

expenses; (3) major medical expenses; and (4) hospital or medical services, including coverage under an HMO plan.

Due to federal law (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

BACKGROUND

Medically Necessary

The law defines “medically necessary” as health care services that a physician, exercising prudent clinical judgment, would provide to a patient to prevent, evaluate, diagnose, or treat an illness, injury, disease, or its symptoms, and that are:

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site, and duration and considered effective for the patient's illness, injury, or disease;
3. not primarily for the convenience of the patient, physician, or other health care provider; and
4. and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results.

“Generally accepted standards of medical practice” means standards that are (1) based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or (2) otherwise consistent with the standards set forth in policy issues involving clinical judgment.

Related Laws

Mental or Nervous Conditions. Under Connecticut law, insurance must cover the diagnosis and treatment of mental or nervous conditions. It defines “mental or nervous conditions” as mental disorders, as it is used in the *Diagnostic and Statistical Manual of Mental Disorders*. It specifically excludes coverage for (1) mental retardation; (2) learning, motor skills, communication, and caffeine-related disorders; (3) relational problems; and (4) additional conditions not otherwise defined as mental disorders in the DSM-IV-TR (CGS §§ 38a-488a and 38a-514).

Birth-to-Three. Insurance must cover medically necessary early intervention services for a child from birth until age three that are part of an individualized family service plan. Coverage is limited to \$3,200 per child per year, up to \$9,600 for the three years (CGS §§ 38a-490a and 38a-516a).

OLR Tracking: JLK: KM: PF: DF

