

Autism Insurance- Act 62 of 2008 (HB 1150)

This Act was signed into law on July 9, 2008. Its prime sponsor was Speaker of the House, Dennis O'Brien.

Who is covered:

Children and young adults under age 21 who are-

- covered under a employer group health insurance policy (including HMOs & PPOs)
 - that has at least 51 employees- and
 - the policy is not a “self insured” or “ERISA” policy; or
- on Medical Assistance; or
- on CHIP (Children’s Health Insurance Program); or
- on Adult Basic (age 18 or older)

What is covered:

- diagnostic assessments of autism spectrum disorders
 - Defined as: “medically necessary evaluations, assessments or tests performed by a physician, licensed physician assistant, licensed psychologist or certified registered nurse practitioner to diagnose whether an individual has an autism spectrum disorder.”
- Treatment of autism spectrum disorders

What treatments are covered:

- Prescription medications and blood level tests
- Services of a psychiatrist (direct or consultation)
- Services of a psychologist (direct or consultation)
- Applied behavioral analysis
 - “the design, implementation and evaluation or environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.”
- Other “rehabilitative care”
 - “professional services and treatment programs...provided by an autism service provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.”
- Therapies
 - Speech/language pathologists
 - Occupational therapists
 - Physical therapists

Coverage limits:

- \$36,000 per year in autism diagnostic and/or treatment costs (to be adjusted annually for inflation beginning 2012)
- No limit on number of diagnostic/treatment visits (until \$36,000 cap is reached)
- Autism coverage “shall be subject to copayment, deductible and coinsurance provisions, and any other general exclusions or limitations...to the same extent as other medical services covered by the policy or program...”
 - This language appears to give insurers authority to deny some autism treatments (other than ABA) on grounds they are experimental.

Treatment requirements:

- **Must be for an autism spectrum disorder**
 - “any of the pervasive developmental disorders defined in the most recent edition of the ...DSM...including autistic disorder, Asperger’s disorder and pervasive developmental disorder not otherwise specified.”
 - “diagnostic assessment of autism spectrum disorder shall be valid for a period of not less than 12 months, unless a licensed physician or licensed psychologist determines an earlier assessment is necessary.”
- **Must be medically necessary**
 - no definition in the Act
 - however, service definitions, especially of ABA and “rehabilitative care” provide some guidance-
 - For ABA and “rehabilitative care” progress need not be shown. It is sufficient if these services are needed to “prevent loss of attained skill or function”
- **Must be “identified in a treatment plan”**
 - Developed by a physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation
 - Treatment plan may be reviewed by insurer every 6 months. The child’s physician or psychologist who signs off on the treatment plan may agree to a more frequent review.
- **Must be “prescribed, ordered or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner.”**
- **Must be provided by an “autism service provider” or “a person, entity or group that works under the direction of an autism service provider”.**
 - “Autism service provider” means any of the following:
 - A person, entity or group providing treatment of autism spectrum disorders that is “licensed or certified” in PA
 - A person, entity or group currently providing treatment of autism spectrum disorders that is enrolled in Medical Assistance before (grandfather clause)
 - A behavioral specialist in PA providing treatment of autism spectrum disorders (until 1 year after regulations are issued or July 2011, whichever is later)

When coverage begins:

- For commercial health policies, CHIP and Adult Basic: on the date the policy or contract is renewed on or after July 1, 2009.
- Start date not specified for Medical Assistance

Grandfathering current providers:

- Insurers must contract with any autism service provider who:
 - Is in the insured’s “service area”; and
 - Is enrolled in Medical Assistance; and
 - Agrees to accept the payment levels and other terms and conditions applicable to the insurer’s other participating autism providers

Appeals:

- Families can appeal any denial of an autism diagnostic or treatment service to the insurer and obtain a decision within 48 hours (expedited review)

- If appeal is denied by the insurer, family can appeal to the PA Dept. of Insurance and obtain a decision in 4 days (expedited external review).
- If Insurance Department denies appeal, family can appeal to Common Pleas Court.

Other provisions:

- Insurers are not required to cover services just because they are listed in an IEP. However, coverage may not be contingent upon coordination of insurance covered services with services listed in an IEP.
- The Act sets out criteria for being licensed or certified as a “behavioral specialist”.

Prepared by PA Health Law Project
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