



House of Representatives

General Assembly

File No. 273

January Session, 2009

Substitute House Bill No. 6240

House of Representatives, March 26, 2009

The Committee on Insurance and Real Estate reported through REP. FONTANA, S. of the 87th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR PERSONS WITH AUTISM.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-514b of the general statutes is repealed and
2 the following is substituted in lieu thereof (*Effective January 1, 2010*):

3 (a) As used in this section:

4 (1) "Autism services provider" means any person, entity or group
5 that provides treatment for autism spectrum disorders.

6 (2) "Diagnosis" means the assessment, evaluation or testing
7 performed by a licensed physician, licensed psychologist or licensed
8 clinical social worker to determine if an individual has an autism
9 spectrum disorder.

10 (b) Each group health insurance policy providing coverage of the
11 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-

12 469 that is delivered, issued for delivery, renewed, amended or
13 continued in this state [on or after January 1, 2009,] shall provide
14 coverage for [physical therapy, speech therapy and occupational
15 therapy services for] the diagnosis and treatment of autism spectrum
16 disorders, as set forth in the most recent edition of the American
17 Psychiatric Association's "Diagnostic and Statistical Manual of Mental
18 Disorders"; [to the extent such services are a covered benefit for other
19 diseases and conditions under such policy.] For the purposes of this
20 section and section 38a-513c, an autism spectrum disorder shall be
21 considered an illness.

22 (c) Such policy shall provide coverage for the following treatments,
23 provided such treatments are: Medically necessary; and prescribed or
24 ordered by a licensed physician, licensed psychologist or licensed
25 clinical social worker for an insured who is diagnosed with an autism
26 spectrum disorder, in accordance with a treatment plan developed by
27 a licensed physician, licensed psychologist or licensed clinical social
28 worker in a manner consistent with the most recent report or
29 recommendations of the American Academy of Pediatrics, the
30 American Academy of Child and Adolescent Psychiatry or the
31 American Psychological Association:

32 (1) Prescription drugs ordered by a licensed health care provider
33 with prescriptive authority; and

34 (2) Physical therapy, speech therapy and occupational therapy
35 services, to the extent such services are a covered benefit for other
36 diseases and conditions under such policy.

37 (d) Such policy shall not:

38 (1) Be cancelled or refused to be (A) delivered, (B) issued for
39 delivery, (C) renewed, (D) amended, or (E) continued to an individual
40 solely because such individual has been diagnosed with or has
41 received treatment for an autism spectrum disorder; or

42 (2) Impose (A) any limits on the number of medically necessary

43 visits an insured may make to an autism services provider pursuant to
44 a treatment plan, or (B) a coinsurance, copayment, deductible or other
45 out-of-pocket expense for such coverage that is more restrictive than
46 that imposed on substantially all other benefits provided under such
47 policy, except that a high deductible health plan, as that term is used in
48 subsection (f) of section 38a-520, shall not be subject to the deductible
49 limit set forth in this subdivision.

50 (e) (1) Except for treatments and services received by an insured in
51 an inpatient setting, an insurer, health care center, hospital service
52 corporation, medical service corporation or fraternal benefit society
53 may review a treatment plan developed as set forth in subsection (c) of
54 this section for such insured, in accordance with its utilization review
55 requirements, not more than once every six months unless such
56 insured's licensed physician, licensed psychologist or licensed clinical
57 social worker agrees that a more frequent review is necessary. The cost
58 of such review shall be borne by the entity requesting such review.

59 (2) For the purposes of this section, the results of a diagnosis shall be
60 valid for a period of not less than twelve months, unless a licensed
61 physician, licensed psychologist or licensed clinical social worker
62 determines a shorter period is appropriate.

63 (f) Coverage required under this section may be subject to the other
64 general exclusions and limitations of the group health insurance
65 policy, including, but not limited to, coordination of benefits,
66 participating provider requirements, restrictions on services provided
67 by family or household members, case management and other policy
68 care provisions, except that any utilization review shall be performed
69 in accordance with subsection (e) of this section.

70 (g) Nothing in this section shall be construed to limit or affect (1)
71 any other covered benefits available to an insured under (A) such
72 group health insurance policy, (B) section 38a-514, or (C) section 38a-
73 516a, or (2) any obligation to provide services to an individual under
74 an individualized education program pursuant to section 10-76d.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2010</i>	38a-514b

Statement of Legislative Commissioners:

In subsections (g)(1)(B) and (g)(1)(C), "pursuant to" was deleted for consistency with the drafting conventions of the general statutes.

INS *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact: None in FY 10 & FY 11; Potential Cost in Out Years

Municipal Impact:

Municipalities	Effect	FY 10 \$	FY 11 \$
Various Municipalities	STATE MANDATE - Cost	Potential	Potential

Explanation

This mandate expanding coverage for the diagnosis and treatment of autism spectrum disorders is not anticipated to impact the state employee and retiree health plan until after the plan is renewed on July 1, 2011. The state plan currently covers autism diagnosis as well as physical therapy, speech therapy and occupational therapy for the period of time that the patient continues to make progress. Once it is determined that progress is no longer being made the plan's current coverage ends. This mandate prohibits limiting the number of medically necessary provider visits or reviewing the patient's treatment plan more frequently than every six months.

The state plan currently limits the number of out-of-network visits to 30 per year for physical therapy, speech therapy and occupational therapy for autism as well as all other conditions. As the bill does not require out-of-network coverage of these services, the mandate would not require removal of these out-of-network office visit limits.

Autism evaluation and treatment is presently a mandated benefit in 11 other states. Although mandate legislation varies from state to state, the average additional cost of autism evaluation and treatment

mandates is less than 1% of total premiums.¹

The mandate may impact municipalities that have fully insured health plans and do not currently cover the services required. The coverage requirements effective January 1, 2010 may result in increased premium costs when municipalities enter into new contracts for health insurance. Due to federal law, municipalities with self-insured health plans are exempt from state health insurance benefit mandates.

The Out Years

The potential future cost associated with the expansion of benefits required by the bill cannot be determined at this time. As previously stated, the mandate's coverage requirements may also result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2010. The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

Sources: Municipal Employees Health Insurance Plan (MEHIP) Schedule of Benefits, State Employee Health Plan Subscriber Agreement, "Health Insurance Mandates in the States 2008" by Council for Affordable Health Insurance, Office of Legislative Research, Office of the State Comptroller.

¹ *"Health Insurance Mandates in the States 2008" by Council for Affordable Health Insurance.*

OLR Bill Analysis**sHB 6240*****AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR PERSONS WITH AUTISM.*****SUMMARY:**

This bill broadens what a group health insurance policy must cover regarding autism spectrum disorders. It requires a policy to cover the diagnosis and treatment of autism spectrum disorders, including certain prescription drugs. By law, a group health insurance policy must 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 bill specifies (1) conditions for the prescription drug and physical, speech, and occupational therapy coverage and (2) that a policy's general exclusions and limitations may apply to the required coverage.

The bill prohibits (1) policy cancellation because a covered person has been diagnosed with, or received treatment for, autism and (2) specified coverage limitations or restrictions. It 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. The entity requesting the review must pay the cost of it.

The bill specifies that, for purposes of the law's "medically necessary" definition, an autism spectrum disorder is an illness. The law defines "autism spectrum disorder" as set forth in the American Psychiatric Association's most recent *Diagnostic and Statistical Manual*

of Mental Disorders (see BACKGROUND).

The bill also 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 state birth-to three program or (2) a board of education's obligation to provide services to an autistic student under an individualized education program in accordance with law.

EFFECTIVE DATE: January 1, 2010

DIAGNOSIS

The bill defines "diagnosis" as the 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.

COVERAGE CONDITIONS

Under the bill, in order for prescription drugs and physical, speech, and occupational therapy to be covered services under a group health insurance policy, they must be (1) medically necessary and (2) ordered or prescribed by a licensed physician, psychologist, or clinical social worker for an insured person diagnosed with autism based on a treatment plan. A licensed physician, psychologist, or clinical social worker must have developed the treatment plan in accordance with the American Academy of Pediatrics', American Academy of Child and Adolescent Psychiatry's, or American Psychological Association's most recent report or recommendations.

The bill specifies that the coverage it requires may be subject to the policy's general exclusions and limitations, including coordination of benefits, participating provider requirements, restrictions on services family or household members provide, and case management provisions.

COVERAGE PROHIBITIONS

The bill prohibits a group health insurance policy, solely because a person is diagnosed with, or receiving treatment for, an autism spectrum disorder, from:

1. being cancelled or not issued, delivered, renewed, amended, or continued;
2. imposing a limit on the number of medically necessary visits to an “autism services provider” (a person, entity, or group that provides treatment for autism spectrum disorders); or
3. imposing a coinsurance, copayment, deductible, or other out-of-pocket expense that is more restrictive than that imposed on most other policy benefits.

It specifies that the deductible limit does not apply to a high-deductible health plan designed to be compatible with federally qualified health savings accounts.

The bill specifically says that a policy cannot be cancelled or not issued, delivered, renewed, amended, or continued “to an individual solely because such individual” is diagnosed with, or receiving treatment for, an autism spectrum disorder. However, the bill applies to group health insurance policies, under which a policy is entered into with a policyholder (e.g., an employer or association) for the benefit of its employees or members. Perhaps the bill means to prohibit adverse action if a person covered under the group policy is diagnosed with, or receiving treatment for, autism.

APPLICABILITY OF BILL

The bill applies to group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on and after January 1, 2010 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

Autism Spectrum Disorder

The American Psychiatric Association's most recent *Diagnostic and Statistical Manual of Mental Disorders*, DSM-IV-TR (fourth edition, text revision), refers to autism as a pervasive developmental disorder, more often referred to today as autism spectrum disorder (ASD).

ASD ranges from a severe form, called autistic disorder, to a milder form, Asperger syndrome. If a child has symptoms of either but does not meet the specific diagnostic criteria, the diagnosis is called pervasive developmental disorder not otherwise specified. Other rare, severe disorders that ASD includes are Rett syndrome and childhood disintegrative disorder.

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. 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 DSM-IV-TR. 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).

Related Bill

The Insurance and Real Estate Committee favorably reported sSB 301, which includes most of this bill’s provisions. It also requires coverage for behavioral therapy, including applied behavioral analysis, for an autistic child age 12 or younger.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 19 Nay 0 (03/10/2009)