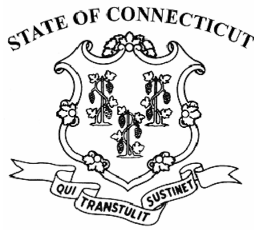

Senate

General Assembly

File No. 238

January Session, 2009

Substitute Senate Bill No. 301

Senate, March 26, 2009

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDERS.

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 Section 38a-514b of the general statutes is repealed and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) "Applied behavior analysis" means the design, implementation
5 and evaluation of environmental modifications, using behavioral
6 stimuli and consequences, including the use of direct observation,
7 measurement and functional analysis of the relationship between
8 environment and behavior, to produce socially significant
9 improvement in human behavior.

10 (2) "Autism services provider" means any person, entity or group
11 that provides treatment for autism spectrum disorders.

12 (3) "Behavioral therapy" means interactive therapies derived from

13 evidence-based research that are provided to children less than
14 thirteen years of age, including, but not limited to, applied behavior
15 analysis that is provided or supervised by a behavior analyst who is
16 certified by the Behavior Analyst Certification Board.

17 (4) "Diagnosis" means the medically necessary assessment,
18 evaluation or testing performed by a licensed physician, licensed
19 psychologist or licensed clinical social worker to determine if an
20 individual has an autism spectrum disorder.

21 (b) Each group health insurance policy providing coverage of the
22 type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-
23 469 that is delivered, issued for delivery, renewed, amended or
24 continued in this state [on or after January 1, 2009,] shall provide
25 coverage for [physical therapy, speech therapy and occupational
26 therapy services for] the diagnosis and treatment of autism spectrum
27 disorders, as set forth in the most recent edition of the American
28 Psychiatric Association's "Diagnostic and Statistical Manual of Mental
29 Disorders". [, to the extent such services are a covered benefit for other
30 diseases and conditions under such policy.]

31 (c) Such policy shall provide coverage for the following treatments,
32 provided such treatments are: Medically necessary; and prescribed or
33 ordered by a licensed physician, licensed psychologist or licensed
34 clinical social worker for an insured who is diagnosed with an autism
35 spectrum disorder, in accordance with a treatment plan developed by
36 a licensed physician, licensed psychologist or licensed clinical social
37 worker in a manner consistent with the most recent report or
38 recommendations of the American Academy of Pediatrics, the
39 American Academy of Child and Adolescent Psychiatry or the
40 American Psychological Association:

41 (1) Behavioral therapy;

42 (2) Medically necessary medications prescribed by a licensed
43 physician;

44 (3) Direct psychiatric or consultative services provided by a
45 psychiatrist licensed in the state in which such psychiatrist practices;

46 (4) Direct psychological or consultative services provided by a
47 psychologist licensed in the state in which such psychologist practices;
48 and

49 (5) Physical therapy, speech therapy and occupational therapy
50 services provided by a medical professional licensed or certified to
51 provide such services.

52 (d) Such policy may limit the coverage for behavioral therapy to a
53 yearly benefit of fifty thousand dollars for a child who is less than nine
54 years of age and thirty-five thousand dollars for a child who is at least
55 nine years of age and less than thirteen years of age.

56 (e) Such policy shall not:

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

61 (2) Impose (A) any limits on the number of medically necessary
62 visits an insured may make to an autism services provider pursuant to
63 a treatment plan, or (B) a coinsurance, copayment, deductible or other
64 out-of-pocket expense for such coverage that is more restrictive than
65 that imposed on substantially all other benefits provided under such
66 policy, except that a high deductible health plan, as that term is used in
67 subsection (f) of section 38a-520, shall not be subject to the deductible
68 limit set forth in this subdivision.

69 (f) (1) Except for treatments and services received by an insured in
70 an inpatient setting, an insurer, health care center, hospital service
71 corporation, medical service corporation or fraternal benefit society
72 may review a treatment plan developed as set forth in subsection (c) of
73 this section for such insured, in accordance with its utilization review
74 requirements, not more than once every six months unless such

75 insured's licensed physician, licensed psychologist or licensed clinical
76 social worker agrees that a more frequent review is necessary. The cost
77 of such review shall be borne by the entity requesting such review.

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

82 (g) Nothing in this section shall be construed to limit or affect (1)
83 any other covered benefits available to an insured under (A) such
84 group health insurance policy, (B) section 38a-514, or (C) section 38a-
85 516a, or (2) any obligation to provide services to an individual under
86 an individualized education program pursuant to section 10-76d.

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

Statement of Legislative Commissioners:
In the first sentence of subsection (c), "treatments" was inserted after "following" for clarity, and 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.-LCO*

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:

Agency Affected	Fund-Effect	FY 10 $	FY 11 $
Developmental Services, Dept.	GF - Savings	1,200,000	2,400,000
State Comptroller - Fringe Benefits	GF - Cost	None, See Out Years	None, See Out Years

Note: GF=General Fund

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 mandate requires coverage of applied behavior analysis (ABA) behavioral therapy for children under 13 years of age as well as certain prescribed drugs and direct psychiatric and psychological services. The bill permits a policy to establish a maximum annual dollar limit for behavioral therapy of $50,000 for children less than 9 years of age and $35,000 for children 9-12 years old. It also specifies that it does not limit or affect other covered benefits including state mental and nervous condition law, state birth-to-three program, or a board of education's obligation to provide individualized education program services.

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.

Autism evaluation and treatment is 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] Presently, one component of this mandate – coverage of ABA services, is almost universally excluded from health coverage. This lack of existing data makes it difficult to establish cost estimates for the required ABA component despite the fact that such behavioral therapies represent the most significant fiscal impact of the bill's mandated benefits. ABA programs are generally geared to pre-school aged children and can involve up to 30-40 hours per week of intensive therapy. As a result, families unable to make such a time commitment may choose to forgo utilizing this enhanced benefit for alternate services.

The Birth to Three Program in the Department of Developmental Services has approximately 275 children receiving autism services. On average the agency spends $2,000 per month per child on the ABA services whose coverage is mandated under the bill. It is anticipated that the bill will increase the insurance reimbursement the state receives for approximately 100 children in the program resulting in a half-year savings of $1.2 million in FY 10 and an annualized savings of $2.4 million in FY 11.

The mandate would likely impact municipalities that have fully insured health plans and do not currently cover the behavioral 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.

---

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

The Out Years

Lack of existing data makes it difficult to establish cost estimates for the mandated ABA component of the bill. It is estimated that the state employee and retiree health plan will incur an annual cost of $1.2 million beginning in FY 12 as a result of expanding coverage for behavioral therapies, including ABA services. It is anticipated that the bill will increase the insurance reimbursement the state receives for the Birth to Three program resulting in an annualized savings of $2.4 million. 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: Department of Developmental Services, Birth to Three website, 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 the State Comptroller.

OLR Bill Analysis

sSB 301

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDERS.

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 behavioral therapy for a child age 12 or younger and certain prescription drugs and psychiatric and psychological services.

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 removes that limitation, but specifies different conditions for coverage of the therapy and other services. It permits a policy to set a certain annual dollar maximum for behavioral therapy 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 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.

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).

EFFECTIVE DATE: January 1, 2010

DIAGNOSIS

The bill 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.

COVERAGE AND CONDITIONS

The bill requires a group health insurance policy to cover:

1. behavioral therapy;
2. medications a licensed physician prescribes;
3. psychiatric and psychological services, direct and consultative, a licensed psychiatrist or psychologist provides; and
4. physical, speech, and occupational therapy services a licensed or certified medical professional provides.

Under the bill, in order for the policy to cover these, 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 defines "behavioral therapy" as interactive therapies derived from evidence-based research, including applied behavioral analysis, a Behavior Analyst Certification Board-certified behavioral therapist supervises or provides for a child under age 13. It permits a policy to limit coverage of behavioral therapy to $50,000 annually for a child under age nine and $35,000 annually for a child who is at least age 9 but under age 13.

The bill defines "applied behavioral analysis" as environmental modification design, implementation, and evaluation 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 bill prohibits a group health insurance policy from:

1. being cancelled or not issued, delivered, renewed, amended, or continued solely because a person is diagnosed with, or receiving treatment for, an autism spectrum disorder;

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 substantially all 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 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. 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 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 sHB 6240, which includes many of this bill's provisions, except coverage for behavioral therapy.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 19 Nay 0 (03/10/2009)