AUTISM MANDATES
APPLICABLE STATE STATUTES/BILL NUMBERS

ARIZONA HOUSE BILL 2847:

House Engrossed
State of Arizona
House of Representatives
Forty-eighth Legislature
Second Regular Session
2008
HOUSE BILL 2847
AN ACT
AMENDING TITLE 20, CHAPTER 4, ARTICLE 3, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-826.04; AMENDING TITLE 20, CHAPTER 4, ARTICLE 9, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1057.11; AMENDING TITLE 20, CHAPTER 6, ARTICLE 5, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 20-1402.03 AND 20-1404.03; RELATING TO AUTISM SPECTRUM DISORDER.
(TEXT OF BILL BEGINS ON NEXT PAGE)
H.B. 2847
- 1 -
1 Be it enacted by the Legislature of the State of Arizona:
2 Section 1. Title 20, chapter 4, article 3, Arizona Revised Statutes,
3 is amended by adding section 20-826.04, to read:
4 20-826.04. Subscription contracts; autism spectrum disorder;
5 coverage; exceptions; definitions
6 A. A HOSPITAL SERVICE CORPORATION OR MEDICAL SERVICE CORPORATION SHALL
7 NOT:
8 1. EXCLUDE OR DENY COVERAGE FOR A TREATMENT OR IMPOSE DOLLAR LIMITS,
9 DEDUCTIBLES AND COINSURANCE PROVISIONS BASED SOLELY ON THE DIAGNOSIS OF
10 AUTISM SPECTRUM DISORDER. FOR THE PURPOSES OF THIS PARAGRAPH, "TREATMENT"
11 INCLUDES DIAGNOSIS, ASSESSMENT AND SERVICES.
12 2. EXCLUDE OR DENY COVERAGE FOR MEDICALLY NECESSARY BEHAVIORAL THERAPY
13 SERVICES. TO BE ELIGIBLE FOR COVERAGE, BEHAVIORAL THERAPY SERVICES SHALL BE
14 PROVIDED OR SUPERVISED BY A LICENSED OR CERTIFIED PROVIDER.
15 B. THIS SECTION DOES NOT:
16 1. APPLY TO A SUBSCRIPTION CONTRACT THAT IS ISSUED TO AN INDIVIDUAL OR
17 A SMALL EMPLOYER.
18 2. APPLY TO LIMITED BENEFIT COVERAGE AS DEFINED IN SECTION 20-1137.
19 3. REQUIRE COVERAGE FOR SERVICES PROVIDED OUTSIDE OF THIS STATE.
20 C. THE COVERAGE REQUIRED BY THIS SECTION IS SUBJECT TO ALL THE TERMS
21 AND CONDITIONS OF THE SUBSCRIPTION CONTRACT. NOTHING IN THIS SECTION
22 PREVENTS A CORPORATION FROM IMPOSING DEDUCTIBLES, COINSURANCE OR OTHER COST
23 SHARING IN RELATION TO THE COVERAGE REQUIRED BY THIS SECTION.
24 D. COVERAGE FOR BEHAVIORAL THERAPY IS SUBJECT TO:
25 1. A FIFTY THOUSAND DOLLAR MAXIMUM BENEFIT PER YEAR FOR AN ELIGIBLE
26 PERSON UP TO THE AGE OF NINE.
27 2. A TWENTY-FIVE THOUSAND DOLLAR MAXIMUM BENEFIT PER YEAR FOR AN
28 ELIGIBLE PERSON WHO IS BETWEEN THE AGES OF NINE AND SIXTEEN.
29 E. FOR THE PURPOSES OF THIS SECTION:
30 1. "AUTISM SPECTRUM DISORDER" MEANS ONE OF THE THREE FOLLOWING
31 DISORDERS AS DEFINED IN THE MOST RECENT EDITION OF THE DIAGNOSTIC AND
32 STATISTICAL MANUAL OF MENTAL DISORDERS OF THE AMERICAN PSYCHIATRIC
33 ASSOCIATION:
34 (a) AUTISTIC DISORDER.
35 (b) ASPERGER'S SYNDROME.
36 (c) PERVASIVE DEVELOPMENTAL DISORDER – NOT OTHERWISE SPECIFIED.
37 2. "BEHAVIORAL THERAPY" MEANS INTERACTIVE THERAPIES DERIVED FROM
38 EVIDENCE BASED RESEARCH, INCLUDING APPLIED BEHAVIOR ANALYSIS, WHICH INCLUDES
39 DISCRETE TRIAL TRAINING, PIVOTAL RESPONSE TRAINING, INTENSIVE INTERVENTION
40 PROGRAMS AND EARLY INTENSIVE BEHAVIORAL INTERVENTION.
41 3. "SMALL EMPLOYER" HAS THE SAME MEANING PRESCRIBED IN SECTION
42 20-2301.
H.B. 2847
- 2 -
1 Sec. 2. Title 20, chapter 4, article 9, Arizona Revised Statutes, is

amended by adding section 20-1057.11, to read:
20-1057.11. Health care services organizations; autism spectrum disorder; coverage; exceptions; definitions
A. A HEALTH CARE SERVICES ORGANIZATION SHALL NOT:
1. EXCLUDE OR DENY COVERAGE FOR A TREATMENT OR IMPOSE DOLLAR LIMITS, DEDUCTIBLES AND COINSURANCE PROVISIONS BASED SOLELY ON THE DIAGNOSIS OF AUTISM SPECTRUM DISORDER. FOR THE PURPOSES OF THIS PARAGRAPH, "TREATMENT" INCLUDES DIAGNOSIS, ASSESSMENT AND SERVICES.
2. EXCLUDE OR DENY COVERAGE FOR MEDICALLY NECESSARY BEHAVIORAL THERAPY SERVICES. TO BE ELIGIBLE FOR COVERAGE, BEHAVIORAL THERAPY SERVICES SHALL BE PROVIDED OR SUPERVISED BY A LICENSED OR CERTIFIED PROVIDER.
B. THIS SECTION DOES NOT:
1. APPLY TO AN EVIDENCE OF COVERAGE THAT IS ISSUED TO AN INDIVIDUAL OR A SMALL EMPLOYER.
2. APPLY TO LIMITED BENEFIT COVERAGE AS DEFINED IN SECTION 20-1137.
3. REQUIRE COVERAGE FOR SERVICES PROVIDED OUTSIDE OF THIS STATE.
C. THE COVERAGE REQUIRED BY THIS SECTION IS SUBJECT TO ALL THE TERMS AND CONDITIONS OF THE EVIDENCE OF COVERAGE. NOTHING IN THIS SECTION PREVENTS AN ORGANIZATION FROM IMPOSING DEDUCTIBLES, COINSURANCE OR OTHER COST SHARING IN RELATION TO THE COVERAGE REQUIRED BY THIS SECTION.
D. COVERAGE FOR BEHAVIORAL THERAPY IS SUBJECT TO:
1. A FIFTY THOUSAND DOLLAR MAXIMUM BENEFIT PER YEAR FOR AN ELIGIBLE PERSON UP TO THE AGE OF NINE.
2. A TWENTY-FIVE THOUSAND DOLLAR MAXIMUM BENEFIT PER YEAR FOR AN ELIGIBLE PERSON WHO IS BETWEEN THE AGES OF NINE AND SIXTEEN.
E. FOR THE PURPOSES OF THIS SECTION:
1. "AUTISM SPECTRUM DISORDER" MEANS ONE OF THE THREE FOLLOWING DISORDERS AS DEFINED IN THE MOST RECENT EDITION OF THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS OF THE AMERICAN PSYCHIATRIC ASSOCIATION:
(a) AUTISTIC DISORDER.
(b) ASPERGER'S SYNDROME.
(c) PERVASIVE DEVELOPMENTAL DISORDER – NOT OTHERWISE SPECIFIED.
2. "BEHAVIORAL THERAPY" MEANS INTERACTIVE THERAPIES DERIVED FROM EVIDENCE BASED RESEARCH, INCLUDING APPLIED BEHAVIOR ANALYSIS, WHICH INCLUDES DISCRETE TRIAL TRAINING, PIVOTAL RESPONSE TRAINING, INTENSIVE INTERVENTION PROGRAMS AND EARLY INTENSIVE BEHAVIORAL INTERVENTION.
3. "SMALL EMPLOYER" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-2301.
Sec. 3. Title 20, chapter 6, article 5, Arizona Revised Statutes, is amended by adding sections 20-1402.03 and 20-1404.03, to read:
20-1402.03. Group disability insurers; autism spectrum disorder; coverage; exceptions; definitions
A. A GROUP DISABILITY INSURER SHALL NOT:

1. EXCLUDE OR DENY COVERAGE FOR A TREATMENT OR IMPOSE DOLLAR LIMITS, DEDUCTIBLES AND COINSURANCE PROVISIONS BASED SOLELY ON THE DIAGNOSIS OF AUTISM SPECTRUM DISORDER. FOR THE PURPOSES OF THIS PARAGRAPH, "TREATMENT" INCLUDES DIAGNOSIS, ASSESSMENT AND SERVICES.
2. EXCLUDE OR DENY COVERAGE FOR MEDICALLY NECESSARY BEHAVIORAL THERAPY SERVICES. TO BE ELIGIBLE FOR COVERAGE, BEHAVIORAL THERAPY SERVICES SHALL BE PROVIDED OR SUPERVISED BY A LICENSED OR CERTIFIED PROVIDER.
B. THIS SECTION DOES NOT:
1. APPLY TO A POLICY THAT IS ISSUED TO AN INDIVIDUAL OR A SMALL EMPLOYER.
2. APPLY TO LONG TERM CARE INSURANCE, LIFE INSURANCE, ANNUITIES AND LIMITED BENEFIT COVERAGE AS DEFINED IN SECTION 20-1137.
3. REQUIRE COVERAGE FOR SERVICES PROVIDED OUTSIDE OF THIS STATE.
C. THE COVERAGE REQUIRED BY THIS SECTION IS SUBJECT TO ALL THE TERMS AND CONDITIONS OF THE GROUP DISABILITY CONTRACT. NOTHING IN THIS SECTION PREVENTS A GROUP DISABILITY INSURER FROM IMPOSING DEDUCTIBLES, COINSURANCE OR OTHER COST SHARING IN RELATION TO THE COVERAGE REQUIRED BY THIS SECTION.
D. COVERAGE FOR BEHAVIORAL THERAPY IS SUBJECT TO:
1. A FIFTY THOUSAND DOLLAR MAXIMUM BENEFIT PER YEAR FOR AN ELIGIBLE PERSON UP TO THE AGE OF NINE.
2. A TWENTY-FIVE THOUSAND DOLLAR MAXIMUM BENEFIT PER YEAR FOR AN ELIGIBLE PERSON WHO IS BETWEEN THE AGES OF NINE AND SIXTEEN.
E. FOR THE PURPOSES OF THIS SECTION:
1. "AUTISM SPECTRUM DISORDER" MEANS ONE OF THE THREE FOLLOWING

DISORDERS AS DEFINED IN THE MOST RECENT EDITION OF THE DIAGNOSTIC AND
STATISTICAL MANUAL OF MENTAL DISORDERS OF THE AMERICAN PSYCHIATRIC
ASSOCIATION:
(a) AUTISTIC DISORDER.
(b) ASPERGER'S SYNDROME.
(c) PERVASIVE DEVELOPMENTAL DISORDER – NOT OTHERWISE SPECIFIED.
2. "BEHAVIORAL THERAPY" MEANS INTERACTIVE THERAPIES DERIVED FROM
EVIDENCE BASED RESEARCH, INCLUDING APPLIED BEHAVIOR ANALYSIS, WHICH INCLUDES
DISCRETE TRIAL TRAINING, PIVOTAL RESPONSE TRAINING, INTENSIVE INTERVENTION
PROGRAMS AND EARLY INTENSIVE BEHAVIORAL INTERVENTION.
3. "SMALL EMPLOYER" HAS THE SAME MEANING PRESCRIBED IN SECTION
20-2301.
20-1404.03. Blanket disability insurers; autism spectrum
disorder; coverage; exceptions; definitions
A. A BLANKET DISABILITY INSURER SHALL NOT:
1. EXCLUDE OR DENY COVERAGE FOR A TREATMENT OR IMPOSE DOLLAR LIMITS,
DEDUCTIBLES AND COINSURANCE PROVISIONS BASED SOLELY ON THE DIAGNOSIS OF
AUTISM SPECTRUM DISORDER. FOR THE PURPOSES OF THIS PARAGRAPH, "TREATMENT"
INCLUDES DIAGNOSIS, ASSESSMENT AND SERVICES.
H.B. 2847
- 4 -
2. EXCLUDE OR DENY COVERAGE FOR MEDICALLY NECESSARY BEHAVIORAL THERAPY
SERVICES. TO BE ELIGIBLE FOR COVERAGE, BEHAVIORAL THERAPY SERVICES SHALL BE
PROVIDED OR SUPERVISED BY A LICENSED OR CERTIFIED PROVIDER.
B. THIS SECTION DOES NOT:
1. APPLY TO A POLICY OR CONTRACT THAT IS ISSUED TO AN INDIVIDUAL OR A
SMALL EMPLOYER.
2. APPLY TO LIMITED BENEFIT COVERAGE AS DEFINED IN SECTION 20-1137.
3. REQUIRE COVERAGE FOR SERVICES PROVIDED OUTSIDE OF THIS STATE.
C. THE COVERAGE REQUIRED BY THIS SECTION IS SUBJECT TO ALL THE TERMS
AND CONDITIONS OF THE BLANKET DISABILITY CONTRACT. NOTHING IN THIS SECTION
PREVENTS A BLANKET DISABILITY INSURER FROM IMPOSING DEDUCTIBLES, COINSURANCE
OR OTHER COST SHARING IN RELATION TO THE COVERAGE REQUIRED BY THIS SECTION.
D. COVERAGE FOR BEHAVIORAL THERAPY IS SUBJECT TO:
1. A FIFTY THOUSAND DOLLAR MAXIMUM BENEFIT PER YEAR FOR AN ELIGIBLE
PERSON UP TO THE AGE OF NINE.
2. A TWENTY-FIVE THOUSAND DOLLAR MAXIMUM BENEFIT PER YEAR FOR AN
ELIGIBLE PERSON WHO IS BETWEEN THE AGES OF NINE AND SIXTEEN.
E. FOR THE PURPOSES OF THIS SECTION:
1. "AUTISM SPECTRUM DISORDER" MEANS ONE OF THE THREE FOLLOWING
DISORDERS AS DEFINED IN THE MOST RECENT EDITION OF THE DIAGNOSTIC AND
STATISTICAL MANUAL OF MENTAL DISORDERS OF THE AMERICAN PSYCHIATRIC
ASSOCIATION:
(a) AUTISTIC DISORDER.
(b) ASPERGER'S SYNDROME.
(c) PERVASIVE DEVELOPMENTAL DISORDER – NOT OTHERWISE SPECIFIED.
2. "BEHAVIORAL THERAPY" MEANS INTERACTIVE THERAPIES DERIVED FROM
EVIDENCE BASED RESEARCH, INCLUDING APPLIED BEHAVIOR ANALYSIS, WHICH INCLUDES
DISCRETE TRIAL TRAINING, PIVOTAL RESPONSE TRAINING, INTENSIVE INTERVENTION
PROGRAMS AND EARLY INTENSIVE BEHAVIORAL INTERVENTION.
3. "SMALL EMPLOYER" HAS THE SAME MEANING PRESCRIBED IN SECTION
20-2301.
Sec. 4. Short title
This act shall be known as "Steven's Law".
Sec. 5. Applicability
This act applies to contracts, policies and evidences of coverage
issued or renewed from and after June 30, 2009.

ARKANSAS SB 913 2009:

Stricken language would be deleted from and underlined language would be added to the law as it existed
prior to this session of the General Assembly.
DLP272 03-05-2009 15:54 DLP272
State of Arkansas

87th General Assembly A Bill
Regular Session, 2009 SENATE BILL 913

By: Senator Salmon

For An Act To Be Entitled

AN ACT TO PROVIDE HEALTH INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDERS; AND FOR OTHER PURPOSES.

Subtitle

TO PROVIDE HEALTH INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDERS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 23, Chapter 99, Subchapter 4 is amended to add an additional section to read as follows:

23-99-417. Autism spectrum disorders.

As used in this section:

(a) As used in this section:

(1) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior;

(2) "Autism services provider" means a person, entity, or group that provides treatment of autism spectrum disorders;

(3) "Autism spectrum disorders" means any of the pervasive developmental disorders as defined by the most recent edition of the "Diagnostic and Statistical Manual of Mental Disorders", including:

(A) Autistic disorder;

(B) Asperger's disorder; and

(C) Pervasive developmental disorder not otherwise specified;

(4) "Diagnosis" means medically necessary assessment, evaluations, or tests to diagnose whether an individual has one (1) or more autism spectrum disorders;

(5) "Evidence-based research" means research that applies rigorous, systematic, and objective procedures to obtain valid knowledge relevant to autism spectrum disorders;

(6) "Medically necessary" means reasonably expected to do the following:

(A) Prevent the onset of an illness, condition, injury, or disability;

(B) Reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or

(C) Assist to achieve or maintain maximum functional

capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individuals of the same age;

(7) "Pharmacy care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications;

(8) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

(9) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

(10) "Therapeutic care" means services provided by licensed or certified speech therapists, occupational therapists, or physical therapists; and

(11) "Treatment" includes:

(A) The following care prescribed, provided, or ordered for an individual diagnosed with one (1) or more autism spectrum disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary:

(i) Applied behavior analysis;

(ii) Pharmacy care;

(iii) Psychiatric care;

(iv) Psychological care; and

(v) Therapeutic care; and

(B) Any care for individuals with autism spectrum disorders that is determined by the Department of Health, based upon the department's review of best practices or evidence-based research, to be medically necessary.

(b)(1) A health benefit plan shall provide coverage for the diagnosis and treatment of autism spectrum disorders.

(2) To the extent that the diagnosis and treatment of autism spectrum disorders are not already covered by a health benefit plan, coverage under this section shall be included in a health benefit plan that is delivered, executed, issued, amended, adjusted, or renewed in this state, or outside the state if insuring Arkansas residents, on or after October 1, 2009.

(3) An insurer shall not terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with one (1) or more autism spectrum disorders or has received treatment for one (1) or more autism spectrum disorders.

(c) The coverage required by this section is not subject to:

(1) Any limits on the number of visits an individual may make to an autism services provider; or

(2) Dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to a physical illness generally under a health benefit plan.

(d) This section does not limit benefits that are otherwise available to an individual under a health benefit plan.

(e) Treatment under this section shall not be denied on the basis that the treatment is rehabilitative in nature.

(f)(1) Except for inpatient services, if an individual is receiving

35 treatment for one (1) or more autism spectrum disorders an insurer may
36 request a review of the treatment not more than one (1) time every twelve

(12) months 1 unless the insurer and the individual's licensed physician or
2 licensed psychologist agrees that a more frequent review is necessary.
3 (2) The cost of obtaining the review shall be borne by the
4 insurer.
5 (g) This section does not affect any obligation to provide services to
6 an individual under an individualized family service plan, an individualized
7 education program, or an individualized service plan.
8
9 SECTION 2. Effective date.
10 This act takes effect October 1, 2009.

ARKANSAS SENATE

87th General Assembly - Regular Session, 2009

Amendment Form

* *

Subtitle of Senate Bill No. 913
"TO PROVIDE HEALTH INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDERS."

* *

Amendment No. 1 to Senate Bill No. 913.

Amend Senate Bill No. 913 as originally introduced:
Add Senators G. Jeffress, Madison, Faris, Representative Lindsey as cosponsors of the bill
AND
Page 2, delete lines 9 and 10 and substitute the following:
"relevant to autism spectrum disorders;
(6) "Health benefit plan" does not include an accident-only specified disease, hospital indemnity, Medicare supplement, long-term care, disability income, or other limited-benefit health insurance policy;
(7) "Medically necessary" means reasonably expected to do the"
AND
Page 2, line 20, delete "(7)" and substitute "(8)"
AND
Page 2, line 23, delete "(8)" and substitute "(9)"
AND
Page 2, line 26, delete "(9)" and substitute "(10)"
AND
Page 2, line 29, delete "(10)" and substitute "(11)"
AND
Page 2, line 32, delete "(11)" and substitute "(12)"

AND
Page 3, line 33, delete "rehabilitative" and substitute "habilitative"
The Amendment was read the first time, rules suspended and read the second time and

By: Senator Salmon
DLP/LHA - 03-17-2009 11:04 _____
DLP327 Secretary

CALIFORNIA Ins. Code 10144.5:

California Insurance Code Section 10144.5

(a) Every policy of disability insurance that covers hospital, medical, or surgical expenses in this state that is issued, amended, or renewed on or after July 1, 2000, shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions, as specified in subdivision (c).

(b) These benefits shall include the following:

(1) Outpatient services.

(2) Inpatient hospital services.

(3) Partial hospital services.

(4) Prescription drugs, if the policy or contract includes coverage for prescription drugs.

(c) The terms and conditions applied to the benefits required by this section that shall be applied equally to all benefits under the disability insurance policy shall include, but not be limited to, the following:

(1) Maximum lifetime benefits.

(2) Copayments and coinsurance.

(3) Individual and family deductibles.

(d) For the purposes of this section, "severe mental illnesses" shall include:

(1) Schizophrenia.

(2) Schizoaffective disorder.

(3) Bipolar disorder (manic-depressive illness).

(4) Major depressive disorders.

(5) Panic disorder.

(6) Obsessive-compulsive disorder.

(7) Pervasive developmental disorder or autism.

(8) Anorexia nervosa.

(9) Bulimia nervosa.

(e) For the purposes of this section, a child suffering from, "serious emotional disturbances of a child" shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

(f) (1) For the purpose of compliance with this section, a disability insurer may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.

(2) A disability insurer shall provide the mental health coverage required by this section in its entire in-state service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, disability insurers are

not precluded from requiring insureds who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

(3) Notwithstanding any other provision of law, in the provision of benefits required by this section, a disability insurer may utilize case management, managed care, or utilization review.

(4) Any action that a disability insurer takes to implement this section, including, but not limited to, contracting with preferred provider organizations, shall not be deemed to be an action that would otherwise require licensure as a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(g) This section shall not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies.

Section: Previous 10140.1 10140.5 10141 10142 10143 10144 10144.1 10144.2 10144.3 10144.5 10144.6 10145 10145.2 10145.3 10145.4 Next

Last modified: January 12, 2009

COLORADO SENATE BILL NO. 09-244

First Regular Session
Sixty-seventh General Assembly
STATE OF COLORADO
INTRODUCED

LLS NO. 09-0894.01 Debbie Haskins **SENATE BILL 09-244**

Senate Committees House Committees
Health and Human Services

A BILL FOR AN ACT

101 **CONCERNING HEALTH INSURANCE BENEFITS FOR THE TREATMENT OF**
102 **AUTISM SPECTRUM DISORDERS.**

Bill Summary

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)

Directs that all individual and group sickness and accident insurance policies, health service or indemnity contracts, and managed care plans providing coverage in Colorado (policy or policies) that are issued or renewed on or after July 1, 2010, shall provide coverage for the assessment, diagnosis, and treatment of autism spectrum disorders (ASD). Defines what type of coverage is required for the treatment of ASD, including applied behavior analysis. States that nothing in the statute

SENATE SPONSORSHIP

shall be construed to require or permit a carrier to reduce benefits provided for ASD if a policy already provides coverage that exceeds the requirements of the statute and that nothing shall be construed to prevent an insurance carrier from increasing benefits provided for ASD. States that nothing in the statute shall be construed to limit coverage for physical or mental health benefits covered under a policy.

States that coverage for ASD is subject to the same copayment, deductible, and coinsurance provisions that are applicable under the policy for other medical services for physical injury or sickness covered by the policy. Directs that benefits provided by an insurance carrier for care or treatment of a health condition not diagnosed as ASD are not to be applied toward any ASD maximum benefit amount established under the policy.

Prohibits a carrier from denying or refusing to provide otherwise covered services, refusing to renew or reissue, or otherwise restricting or terminating coverage under a policy to an individual because the individual or his or her dependent is diagnosed with ASD or due to utilization of services for which coverage is mandated. Requires prescribed treatment to be continued during a treatment review or appeal of a decision regarding treatment.

Specifies that services for the treatment of ASD are the primary services for a child who is also eligible for early intervention services, and that early intervention services supplement, but do not replace, services provided under the required coverage for ASD.

Makes issuance or renewal of a policy that excludes coverage for the assessment, diagnosis, and treatment of ASD by an insurance carrier that is subject to the mandated coverage requirement for the treatment for ASD an unfair method of competition and unfair or deceptive act or practice in the business of insurance.

Repeals the statute that provides that treatment for autism was not mandated and, if covered by a policy, was not to be treated as a mental illness.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. 10-16-104 (1.3), Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

10-16-104. Mandatory coverage provisions - definitions.

(1.3) **Early intervention services.** (f) EARLY INTERVENTION SERVICES SHALL BE PROVIDED AS SPECIFIED IN THE ELIGIBLE CHILD'S IFSP, AND SUCH SERVICES SHALL NOT DUPLICATE OR REPLACE TREATMENT FOR

AUTISM SPECTRUM DISORDERS PROVIDED IN ACCORDANCE WITH SUBSECTION (1.4) OF THIS SECTION. SERVICES FOR THE TREATMENT OF AUTISM SPECTRUM DISORDERS PROVIDED IN ACCORDANCE WITH SUBSECTION (1.4) OF THIS SECTION SHALL BE CONSIDERED THE PRIMARY SERVICE TO AN ELIGIBLE CHILD, AND EARLY INTERVENTION SERVICES PROVIDED UNDER THIS SUBSECTION (1.3) SHALL SUPPLEMENT, BUT NOT REPLACE, SERVICES PROVIDED UNDER SUBSECTION (1.4) OF THIS SECTION.

SECTION 2. 10-16-104, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

10-16-104. Mandatory coverage provisions - definitions.

(1.4) **Autism spectrum disorders.** (a) AS USED IN THIS SUBSECTION (1.4), UNLESS THE CONTEXT OTHERWISE REQUIRES:

(I) "APPLIED BEHAVIOR ANALYSIS" MEANS THE DESIGN, IMPLEMENTATION, AND EVALUATION OF ENVIRONMENTAL MODIFICATIONS USING BEHAVIORAL STIMULI AND CONSEQUENCES TO PRODUCE SOCIALLY SIGNIFICANT IMPROVEMENT IN HUMAN BEHAVIOR, INCLUDING THE USE OF DIRECT OBSERVATION, MEASUREMENT, AND FUNCTIONAL ANALYSIS OF THE RELATIONS BETWEEN ENVIRONMENT AND BEHAVIOR.

(II) "AUTISM SERVICES PROVIDER" MEANS ANY PERSON, ENTITY, OR GROUP THAT PROVIDES SERVICES AS DESCRIBED IN SUBPARAGRAPHS (X) TO (XIII) OF THIS PARAGRAPH (a) AS MEDICALLY NECESSARY FOR THE TREATMENT OF AUTISM SPECTRUM DISORDERS. WHEN THE TREATMENT PROVIDED BY THE AUTISM SERVICES PROVIDER IS APPLIED BEHAVIOR ANALYSIS, SUCH PROVIDER SHALL BE PROFESSIONALLY CERTIFIED AS A BEHAVIOR ANALYST BY THE NATIONAL BEHAVIOR ANALYST CERTIFICATION BOARD OR ITS SUCCESSOR ORGANIZATION OR SHALL PROVIDE, IF REQUESTED, DOCUMENTED EVIDENCE OF EQUIVALENT

EDUCATION, PROFESSIONAL TRAINING, AND SUPERVISED EXPERIENCE IN APPLIED BEHAVIOR ANALYSIS. THE PERSON CERTIFIED TO PROVIDE APPLIED BEHAVIOR ANALYSIS OR THE EQUIVALENT PROVIDER SHALL DIRECTLY PROVIDE OR SUPERVISE THE IMPLEMENTATION OF SERVICES TO THE PERSON WITH AUTISM SPECTRUM DISORDER.

(III) "AUTISM SPECTRUM DISORDERS" OR "ASD" MEANS PERVASIVE DEVELOPMENTAL DISORDERS AS DEFINED IN THE MOST RECENT EDITION OF THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, INCLUDING AUTISM,ASPERGER'S DISORDER, AND PERVASIVE DEVELOPMENTAL DISORDER NOT OTHERWISE SPECIFIED.

(IV) "INDIVIDUALIZED EDUCATION PLAN" SHALL HAVE THE SAME MEANING AS PROVIDED IN SECTION 22-20-103, C.R.S.

(V) "INDIVIDUALIZED FAMILY SERVICE PLAN" SHALL HAVE THE SAME MEANING AS PROVIDED IN SECTION 27-10.5-102, C.R.S.

(VI) "INDIVIDUALIZED PLAN" SHALL HAVE THE SAME MEANING AS PROVIDED IN SECTION 27-10.5-102, C.R.S.

(VII) "MEDICALLY NECESSARY" OR "MEDICAL NECESSITY" MEANS ANY CARE, TREATMENT, INTERVENTION, SERVICE, OR ITEM WHICH WILL OR IS REASONABLY EXPECTED TO DO ANY OF THE FOLLOWING:

(A) PREVENT THE ONSET OF AN ILLNESS, CONDITION, INJURY, DISEASE, OR DISABILITY;

(B) REDUCE OR AMELIORATE THE PHYSICAL, MENTAL, OR DEVELOPMENTAL EFFECTS OF AN ILLNESS, CONDITION, INJURY, DISEASE, OR DISABILITY AND MANAGE A CHRONIC CONDITION; OR

(C) ASSIST TO ACHIEVE OR MAINTAIN MAXIMUM FUNCTIONAL ACTIVITY IN PERFORMING DAILY ACTIVITIES.

(VIII) "PHARMACY CARE" MEANS MEDICATIONS PRESCRIBED BY A

PHYSICIAN LICENSED BY THE STATE BOARD OF MEDICAL EXAMINERS UNDER THE "COLORADO MEDICAL PRACTICE ACT", ARTICLE 36 OF TITLE 12, C.R.S.

(IX) "POLICY" OR "POLICIES" MEANS ALL INDIVIDUAL AND GROUP SICKNESS AND ACCIDENT INSURANCE POLICIES PROVIDING COVERAGE WITHIN THIS STATE BY AN ENTITY SUBJECT TO PART 2 OF THIS ARTICLE, ALL INDIVIDUAL AND GROUP HEALTH SERVICE OR INDEMNITY CONTRACTS ISSUED OR RENEWED BY AN ENTITY SUBJECT TO PART 3 OR 4 OF THIS ARTICLE, AND ALL MANAGED CARE PLANS PROVIDING COVERAGE WITHIN THIS STATE.

(X) "PSYCHIATRIC CARE" MEANS DIRECT OR CONSULTATIVE SERVICES PROVIDED BY A PSYCHIATRIST LICENSED BY THE STATE BOARD OF MEDICAL EXAMINERS UNDER THE "COLORADO MEDICAL PRACTICE ACT", ARTICLE 36 OF TITLE 12, C.R.S.

(XI) "PSYCHOLOGICAL CARE" MEANS DIRECT OR CONSULTATIVE SERVICES PROVIDED BY A PSYCHOLOGIST LICENSED BY THE STATE BOARD OF PSYCHOLOGIST EXAMINERS PURSUANT TO PART 3 OF ARTICLE 43 OF TITLE 12,C.R.S., OR A SOCIAL WORKER LICENSED BY THE STATE BOARD OF SOCIAL WORK EXAMINERS PURSUANT TO PART 4 OF ARTICLE 43 OF TITLE 12, C.R.S., OR BY A MARRIAGE AND FAMILY THERAPIST LICENSED BY THE STATE BOARD OF MARRIAGE AND FAMILY THERAPIST EXAMINERS PURSUANT TO PART 5 OF ARTICLE 43 OF TITLE 12, C.R.S.

(XII) "THERAPEUTIC CARE" MEANS SERVICES PROVIDED BY A SPEECH THERAPIST, AN OCCUPATIONAL THERAPIST REGISTERED TO PRACTICE OCCUPATIONAL THERAPY PURSUANT TO ARTICLE 40.5 OF TITLE 12, C.R.S., A PHYSICAL THERAPIST LICENSED TO PRACTICE PHYSICAL THERAPY PURSUANT TO ARTICLE 41 OF TITLE 12, C.R.S., OR AN AUTISM

SERVICES PROVIDER WHO IS PROFESSIONALLY CERTIFIED AS A BEHAVIOR

ANALYST OR HAS THE EQUIVALENT EDUCATION, TRAINING, AND EXPERIENCE AS DESCRIBED IN SUBPARAGRAPH (II) OF THIS PARAGRAPH (a). THERAPEUTIC CARE INCLUDES, BUT IS NOT LIMITED TO, BEHAVIORAL, SPEECH, OCCUPATIONAL, AND PHYSICAL THERAPIES THAT PROVIDE TREATMENT IN THE FOLLOWING AREAS:

(A) SELF-CARE, SELF-SUPPORT NEEDS, AND FEEDING;

(B) PRAGMATIC, RECEPTIVE, AND EXPRESSIVE LANGUAGE;

(C) COGNITIVE FUNCTIONING;

(D) APPLIED BEHAVIOR ANALYSIS, INTERVENTION, AND MODIFICATION;

(E) MOTOR PLANNING;

(F) SOCIAL SKILLS TRAINING RELATED TO HYGIENE AND PERSONAL SAFETY; AND

(G) SENSORY PROCESSING.

(XIII) "TREATMENT FOR AUTISM SPECTRUM DISORDERS" SHALL INCLUDE, BUT IS NOT LIMITED TO, THE FOLLOWING CARE:

(A) EVALUATION AND ASSESSMENT SERVICES;

(B) BEHAVIOR TRAINING AND BEHAVIOR MANAGEMENT, INCLUDING BUT NOT LIMITED TO CONSULTATIONS AND DIRECT CARE AND TREATMENT FOR AUTISM SPECTRUM DISORDERS PROVIDED BY AUTISM SERVICE PROVIDERS. SUCH COVERAGE SHALL BE AT A LEVEL SUFFICIENT TO REDUCE OR AMELIORATE THE PHYSICAL, MENTAL, OR DEVELOPMENTAL EFFECTS OF AN ILLNESS, CONDITION, INJURY, DISEASE, OR DISABILITY AND MANAGE THE CHRONIC CONDITION OR ASSIST AN INDIVIDUAL TO ACHIEVE OR MAINTAIN MAXIMUM FUNCTIONAL ACTIVITY IN PERFORMING DAILY LIVING ACTIVITIES.

(C) HABILITATIVE OR REHABILITATIVE CARE, INCLUDING, BUT NOT LIMITED TO, OCCUPATIONAL THERAPY, PHYSICAL THERAPY, OR SPEECH THERAPY, OR ANY COMBINATION OF THOSE THERAPIES;

(D) PHARMACY CARE AND MEDICATION;

(E) PSYCHIATRIC CARE;

(F) PSYCHOLOGICAL CARE, INCLUDING FAMILY COUNSELING; AND

(G) THERAPEUTIC CARE.

(XIV) "TREATMENT PLAN" MEANS A PLAN FOR AN INDIVIDUAL CONSISTING OF THE INDIVIDUAL'S DIAGNOSIS; PROPOSED TREATMENT BY TYPE, FREQUENCY, AND ANTICIPATED TREATMENT; THE ANTICIPATED OUTCOMES STATED AS GOALS; AND THE FREQUENCY BY WHICH THE TREATMENT PLAN WILL BE UPDATED.

(b) (I) ON OR AFTER JULY 1, 2010, ALL POLICIES ISSUED OR RENEWED IN THIS STATE SHALL PROVIDE COVERAGE FOR THE ASSESSMENT, DIAGNOSIS, AND TREATMENT OF AUTISM SPECTRUM DISORDERS.

(II) NOTHING IN THIS SUBSECTION (1.4) SHALL BE CONSTRUED TO:

(A) REQUIRE OR PERMIT A CARRIER TO REDUCE BENEFITS PROVIDED FOR AUTISM SPECTRUM DISORDERS IF A POLICY ALREADY PROVIDES COVERAGE THAT EXCEEDS THE REQUIREMENTS OF THIS SUBSECTION (1.4);

(B) PREVENT A CARRIER FROM INCREASING BENEFITS PROVIDED FOR AUTISM SPECTRUM DISORDERS; OR

(C) LIMIT COVERAGE FOR PHYSICAL OR MENTAL HEALTH BENEFITS COVERED UNDER A POLICY.

(c) TREATMENT FOR AUTISM SPECTRUM DISORDERS SHALL BE PRESCRIBED OR ORDERED BY A LICENSED PHYSICIAN OR LICENSED CLINICAL PSYCHOLOGIST, OR BY A DOCTORAL DEGREED PROFESSIONAL

WITH A MINIMUM OF FIVE YEARS EXPERIENCE DESIGNING, IMPLEMENTING, AND EVALUATING APPLIED BEHAVIORAL TREATMENT FOR INDIVIDUALS WITH AUTISM SPECTRUM DISORDERS AND THEIR FAMILIES.

(d) A POLICY OFFERED TO RESIDENTS OF THIS STATE PROVIDING BASIC HEALTH CARE SERVICES THAT IS DELIVERED, ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE SHALL NOT PROVIDE SPECIFIC EXCLUSIONS FOR AUTISM SPECTRUM DISORDERS OR IMPOSE ADDITIONAL REQUIREMENTS FOR AUTHORIZATION OF SERVICES THAT OPERATE TO EXCLUDE COVERAGE FOR THE ASSESSMENT, DIAGNOSIS, AND TREATMENT OF AUTISM SPECTRUM DISORDERS. A VIOLATION OF THIS PARAGRAPH (d) SHALL BE AN UNFAIR AND DECEPTIVE PRACTICE PURSUANT TO SECTION 10-3-1104 (1) (gg).

(e) COVERAGE UNDER THIS SUBSECTION (1.4) SHALL BE SUBJECT TO COPAYMENT, DEDUCTIBLE, NETWORK ADEQUACY, AND COINSURANCE PROVISIONS OF A POLICY OF SICKNESS AND ACCIDENT INSURANCE TO THE SAME EXTENT THAT OTHER MEDICAL SERVICES OR PHYSICAL INJURY OR ILLNESS COVERED BY THE POLICY OF SICKNESS AND ACCIDENT INSURANCE ARE SUBJECT TO THESE PROVISIONS.

(f) BENEFITS PROVIDED BY A CARRIER ON BEHALF OF A COVERED INDIVIDUAL FOR ANY CARE, TREATMENT, INTERVENTION, SERVICE, OR ITEM, THE PROVISION OF WHICH WAS FOR THE TREATMENT OF A HEALTH CONDITION NOT DIAGNOSED AS AN AUTISM SPECTRUM DISORDER, SHALL NOT BE APPLIED TOWARD ANY MAXIMUM BENEFIT AMOUNT ESTABLISHED UNDER THIS SUBSECTION (1.4).

(g) A CARRIER MAY NOT DENY OR REFUSE TO PROVIDE OTHERWISE COVERED SERVICES, REFUSE TO RENEW OR REISSUE, OR OTHERWISE RESTRICT OR TERMINATE COVERAGE UNDER A POLICY BECAUSE THE INDIVIDUAL OR HIS OR HER COVERED DEPENDENT IS DIAGNOSED WITH AN

AUTISM SPECTRUM DISORDER OR DUE TO THE INDIVIDUAL'S OR DEPENDENT'S UTILIZATION OF SERVICES FOR WHICH BENEFITS ARE MANDATED BY THIS SUBSECTION (1.4).

(h) UPON REQUEST OF THE CARRIER, AN AUTISM SERVICES PROVIDER SHALL FURNISH MEDICAL RECORDS, CLINICAL NOTES, OR OTHER NECESSARY DATA THAT SUBSTANTIATE THAT CONTINUED MEDICAL TREATMENT IS MEDICALLY NECESSARY AND CONSISTENT WITH THE GOALS OF THE INDIVIDUALIZED TREATMENT PLAN. WHEN TREATMENT IS ANTICIPATED TO REQUIRE CONTINUED SERVICES TO ACHIEVE DEMONSTRABLE PROGRESS OR TO TREAT REGRESSION, THE CARRIER MAY REQUEST A TREATMENT PLAN EXCEPT FOR INPATIENT SERVICES, A CARRIER SHALL HAVE THE RIGHT TO REQUEST A REVIEW OF THE TREATMENT PLAN NOT MORE THAN ONCE EVERY SIX MONTHS, THE COST OF WHICH SHALL BE BORNE BY THE CARRIER. DURING THE PENDENCY OF ANY TREATMENT REVIEW OR ANY APPEAL OF A DECISION REGARDING TREATMENT, A CARRIER SHALL NOT SUSPEND OR TERMINATE COVERAGE, AND THE CARRIER SHALL CONTINUE TO COVER THE PRESCRIBED TREATMENT UNTIL THERE IS A RESOLUTION OF THE TREATMENT REVIEW OR THE APPEAL.

(i) WHEN MAKING A DETERMINATION THAT A TREATMENT MODALITY FOR AUTISM SPECTRUM DISORDERS IS MEDICALLY NECESSARY, A CARRIER SHALL MAKE THE DETERMINATION IN A MANNER THAT IS CONSISTENT WITH THE MANNER USED TO MAKE THAT DETERMINATION WITH RESPECT TO OTHER DISEASES OR ILLNESSES COVERED UNDER THE POLICY, INCLUDING AN APPEALS PROCESS. A CARRIER SHALL NOT DENY COVERAGE FOR APPLIED BEHAVIOR ANALYSIS OR FOR PHYSICAL, SPEECH, OR OCCUPATIONAL THERAPY FOR TREATMENT OF AUTISM SPECTRUM

DISORDERS ON THE GROUNDS THAT IT IS NOT MEDICALLY NECESSARY UNLESS IT HAS COMPLETED A TREATMENT REVIEW WITHIN SIXTY DAYS PRECEDING THE DENIAL. SUCH TREATMENT REVIEW SHALL BE CONDUCTED BY A PHYSICIAN WITH EXPERTISE IN THE MOST CURRENT AND EFFECTIVE TREATMENT MODALITIES FOR AUTISM SPECTRUM DISORDERS.

(j) NOTHING IN THIS SUBSECTION (1.4) SHALL BE CONSTRUED AS AFFECTING ANY OBLIGATION TO PROVIDE SERVICES TO AN INDIVIDUAL UNDER AN INDIVIDUALIZED FAMILY SERVICE PLAN, AN INDIVIDUALIZED EDUCATION PROGRAM, OR AN INDIVIDUALIZED PLAN. THE SERVICES REQUIRED TO BE COVERED BY THIS SUBSECTION (1.4) SHALL BE IN ADDITION TO ANY SERVICES PROVIDED TO AN INDIVIDUAL UNDER AN INDIVIDUALIZED FAMILY SERVICE PLAN, AN INDIVIDUALIZED EDUCATION PROGRAM, OR AN INDIVIDUALIZED PLAN.

SECTION 3. Repeal. 10-16-104.5, Colorado Revised Statutes, is repealed as follows:

10-16-104.5. Autism - treatment - not mental illness. (1) Any sickness and accident insurance policy providing indemnity for disability due to sickness issued by an entity subject to the provisions of part 2 of

this article and any individual or group service or indemnity contracts issued by an entity subject to the provisions of part 3 or 4 of this article which provide coverage for autism shall provide such coverage in the same manner as for any other accident or sickness, other than mental illness, otherwise covered under such policy.

(2) Nothing in this section shall mandate or be construed or interpreted to mandate that any policy, hospital service or indemnity contract, or evidence of coverage must provide coverage for autism.

SECTION 4. 10-3-1104 (1), Colorado Revised Statutes, is

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amended BY THE ADDITION OF A NEW PARAGRAPH to read:

10-3-1104. Unfair methods of competition and unfair or deceptive acts or practices. (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(gg) ISSUING OR RENEWING AN INDIVIDUAL OR GROUP SICKNESS AND ACCIDENT INSURANCE POLICY, SERVICE OR INDEMNITY CONTRACT, OR MANAGED CARE PLAN PROVIDING BASIC HEALTH CARE SERVICES THAT IS SUBJECT TO THE REQUIREMENTS OF SECTION 10-16-104 (1.4) IF THE POLICY, CONTRACT, OR PLAN THAT PROVIDES SPECIFIC EXCLUSIONS FOR AUTISM SPECTRUM DISORDERS OR IMPOSES ADDITIONAL REQUIREMENTS FOR AUTHORIZATION OF SERVICES THAT OPERATE TO EXCLUDE COVERAGE FOR THE ASSESSMENT, DIAGNOSIS, AND TREATMENT OF AUTISM SPECTRUM DISORDERS.

SECTION 5. Act subject to petition - effective date - applicability. (1) This act shall take effect July 1, 2010.

(2) However, if a referendum petition is filed against this act or an item, section, or part of this act during the ninety-day period after final adjournment of the general assembly that is allowed for submitting a referendum petition pursuant to article V, section 1 (3) of the state constitution, then the act, item, section, or part, shall not take effect unless approved by the people at a biennial regular general election and shall take effect on the date specified in subsection (1) or on the date of the official declaration of the vote thereon by proclamation of the governor, whichever is later.

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(3) The provisions of this act shall apply to health insurance policies, health care service or indemnity contracts, or managed care plans issued or renewed on or after the applicable effective date of this act.

FLORIDA STAT. 641.31098 and 627.6686; Bill Number: CS/CS/CS/SB 2654

An act relating to children with disabilities; amending s. 409.906, F.S.; creating the "Window of Opportunity Act"; authorizing the Agency for Health Care Administration to seek federal approval through a state plan amendment to provide home and community-based services for autism spectrum disorder and other developmental disabilities; specifying eligibility criteria; specifying limitations on provision of benefits; requiring reports to the Legislature; requiring legislative approval for implementation of certain provisions; creating s. 624.916, F.S.; creating the "Steven A. Geller Autism Coverage Act"; directing the Office of Insurance Regulation to establish a workgroup to develop and execute a compact relating to coverage for insured persons with developmental disabilities; providing for membership of the workgroup; requiring the workgroup to convene within a specified period of time; directing the office to establish a consumer advisory workgroup and providing purpose thereof; requiring the compact to contain specified components; requiring reports to the Governor and the Legislature; creating s. 627.6686, F.S.; providing health insurance coverage for individuals with autism spectrum disorder; providing definitions; providing coverage for certain screening to diagnose and treat

26 autism spectrum disorder; providing limitations on
27 coverage; providing for eligibility standards for benefits
28 and coverage; prohibiting insurers from denying coverage
29 under certain circumstances; specifying required elements

30 of a treatment plan; providing, beginning January 1, 2011,
31 that the maximum benefit shall be adjusted annually;
32 clarifying that the section may not be construed as
33 limiting benefits and coverage otherwise available to an
34 insured under a health insurance plan; prohibiting the
35 Office of Insurance Regulation from enforcing certain
36 provisions against insurers that are signatories to the
37 developmental disabilities compact by a specified date;
38 creating s. 641.31098, F.S.; providing coverage under a
39 health maintenance contract for individuals with autism
40 spectrum disorder; providing definitions; providing
41 coverage for certain screening to diagnose and treat
42 autism spectrum disorder; providing limitations on
43 coverage; providing for eligibility standards for benefits
44 and coverage; prohibiting health maintenance organizations
45 from denying coverage under certain circumstances;
46 specifying required elements of a treatment plan;
47 providing, beginning January 1, 2011, that the maximum
48 benefit shall be adjusted annually; prohibiting the Office
49 of Insurance Regulation from enforcing certain provisions
50 against health maintenance organizations that are

51 signatories to the developmental disabilities compact by a
52 specified date; providing an effective date.
53
54 Be It Enacted by the Legislature of the State of Florida:
55
56 Section 1. Subsection (26) is added to section 409.906,
57 Florida Statutes, to read:
58 409.906 Optional Medicaid services.--Subject to specific

59 appropriations, the agency may make payments for services which
60 are optional to the state under Title XIX of the Social Security
61 Act and are furnished by Medicaid providers to recipients who are
62 determined to be eligible on the dates on which the services were
63 provided. Any optional service that is provided shall be provided
64 only when medically necessary and in accordance with state and
65 federal law. Optional services rendered by providers in mobile
66 units to Medicaid recipients may be restricted or prohibited by
67 the agency. Nothing in this section shall be construed to prevent
68 or limit the agency from adjusting fees, reimbursement rates,
69 lengths of stay, number of visits, or number of services, or
70 making any other adjustments necessary to comply with the
71 availability of moneys and any limitations or directions provided
72 for in the General Appropriations Act or chapter 216. If
73 necessary to safeguard the state's systems of providing services
74 to elderly and disabled persons and subject to the notice and
75 review provisions of s. 216.177, the Governor may direct the

76 Agency for Health Care Administration to amend the Medicaid state
77 plan to delete the optional Medicaid service known as
78 "Intermediate Care Facilities for the Developmentally Disabled."
79 Optional services may include:
80 (26) HOME AND COMMUNITY-BASED SERVICES FOR AUTISM
SPECTRUM
81 DISORDER AND OTHER DEVELOPMENTAL DISABILITIES.--The agency is
82 authorized to seek federal approval through a Medicaid waiver or
83 a state plan amendment for the provision of occupational therapy,
84 speech therapy, physical therapy, behavior analysis, and behavior
85 assistant services to individuals who are 5 years of age and
86 under and have a diagnosed developmental disability as defined in
87 s. 393.063, autism spectrum disorder as defined in s. 627.6686,

88 or Down syndrome, a genetic disorder caused by the presence of
89 extra chromosomal material on chromosome 21. Causes of the
90 syndrome may include Trisomy 21, Mosaicism, Robertsonian
91 Translocation, and other duplications of a portion of chromosome
92 21. Coverage for such services shall be limited to $36,000
93 annually and may not exceed $108,000 in total lifetime benefits.
94 The agency shall submit an annual report beginning on January 1,
95 2009, to the President of the Senate, the Speaker of the House of
96 Representatives, and the relevant committees of the Senate and
97 the House of Representatives regarding progress on obtaining
98 federal approval and recommendations for the implementation of
99 these home and community-based services. The agency may not

implement this subsection without prior legislative approval.

Section 2. Section 624.916, Florida Statutes, is created to read:

624.916 Developmental disabilities compact.--

(1) This section may be cited as the "Window of Opportunity Act."

(2) The Office of Insurance Regulation shall convene a workgroup by August 31, 2008, for the purpose of negotiating a compact that includes a binding agreement among the participants relating to insurance and access to services for persons with developmental disabilities. The workgroup shall consist of the following:

(a) Representatives of all health insurers licensed under this chapter.

(b) Representatives of all health maintenance organizations licensed under part I of chapter 641.

(c) Representatives of employers with self-insured health

benefit plans.

(d) Two designees of the Governor, one of whom must be a consumer advocate.

(e) A designee of the President of the Senate.

(f) A designee of the Speaker of the House of Representatives.

(3) The Office of Insurance Regulation shall convene a consumer advisory workgroup for the purpose of providing a forum

125 for comment on the compact negotiated in subsection (2). The
126 office shall convene the workgroup prior to finalization of the
127 compact.
128 (4) The agreement shall include the following components:
129 (a) A requirement that each signatory to the agreement
130 increase coverage for behavior analysis and behavior assistant
131 services as defined in s. 409.815(2)(r) and speech therapy,
132 physical therapy, and occupational therapy when medically
133 necessary due to the presence of a developmental disability.
134 (b) Procedures for clear and specific notice to
135 policyholders identifying the amount, scope, and conditions under
136 which coverage is provided for behavior analysis and behavior
137 assistant services as defined in s. 409.815(2)(r) and speech
138 therapy, physical therapy, and occupational therapy when
139 medically necessary due to the presence of a developmental
140 disability.
141 (c) Penalties for documented cases of denial of claims for
142 medically necessary services due to the presence of a
143 developmental disability.
144 (d) Proposals for new product lines that may be offered in
145 conjunction with traditional health insurance and provide a more

146 appropriate means of spreading risk, financing costs, and
147 accessing favorable prices.
148 (5) Upon completion of the negotiations for the compact,
149 the office shall report the results to the Governor, the

President of the Senate, and the Speaker of the House of Representatives.

(6) Beginning February 15, 2009, and continuing annually thereafter, the Office of Insurance Regulation shall provide a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives regarding the implementation of the agreement negotiated under this section. The report shall include:

(a) The signatories to the agreement.

(b) An analysis of the coverage provided under the agreement in comparison to the coverage required under ss. 627.6686 and 641.31098.

(c) An analysis of the compliance with the agreement by the signatories, including documented cases of claims denied in violation of the agreement.

(7) The Office of Insurance Regulation shall continue to monitor participation, compliance, and effectiveness of the agreement and report its findings at least annually.

(8) As used in this section, the term "developmental disabilities" includes:

(a) The term as defined in s. 393.063;

(b) Down syndrome, a genetic disorder caused by the presence of extra chromosomal material on chromosome 21. Causes of the syndrome may include Trisomy 21, Mosaicism, Robertsonian Translocation, and other duplications of a portion of chromosome

21; and

(c) Autism spectrum disorder, as defined in s. 627.6686.

Section 3. Section 627.6686, Florida Statutes, is created to read:

627.6686 Coverage for individuals with autism spectrum disorder required; exception.--

(1) This section and section 641.31098, may be cited as the "Steven A. Geller Autism Coverage Act."

(2) As used in this section, the term:

(a) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

(b) "Autism spectrum disorder" means any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

1. Autistic disorder.

2. Asperger's syndrome.

3. Pervasive developmental disorder not otherwise specified.

(c) "Eligible individual" means an individual under 18 years of age or an individual 18 years of age or older who is in high school who has been diagnosed as having a developmental disability at 8 years of age or younger.

(d) "Health insurance plan" means a group health insurance policy or group health benefit plan offered by an insurer which includes the state group insurance program provided under s. 110.123. The term does not include any health insurance plan offered in the individual market, any health insurance plan that is individually underwritten, or any health insurance plan provided to a small employer.
(e) "Insurer" means an insurer providing health insurance coverage, which is licensed to engage in the business of insurance in this state and is subject to insurance regulation.
(3) A health insurance plan issued or renewed on or after April 1, 2009, shall provide coverage to an eligible individual for:
(a) Well-baby and well-child screening for diagnosing the presence of autism spectrum disorder.
(b) Treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy, and applied behavior analysis. Applied behavior analysis services shall be provided by an individual certified pursuant to s. 393.17 or an individual licensed under chapter 490 or chapter 491.
(4) The coverage required pursuant to subsection (3) is subject to the following requirements:
(a) Coverage shall be limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan.
(b) Coverage for the services described in subsection (3) shall be limited to $36,000 annually and may not exceed $200,000

230 in total lifetime benefits.
231 (c) Coverage may not be denied on the basis that provided

232 services are habilitative in nature.
233 (d) Coverage may be subject to other general exclusions and
234 limitations of the insurer's policy or plan, including, but not
235 limited to, coordination of benefits, participating provider
236 requirements, restrictions on services provided by family or
237 household members, and utilization review of health care
238 services, including the review of medical necessity, case
239 management, and other managed care provisions.
240 (5) The coverage required pursuant to subsection (3) may
241 not be subject to dollar limits, deductibles, or coinsurance
242 provisions that are less favorable to an insured than the dollar
243 limits, deductibles, or coinsurance provisions that apply to
244 physical illnesses that are generally covered under the health
245 insurance plan, except as otherwise provided in subsection (4).
246 (6) An insurer may not deny or refuse to issue coverage for
247 medically necessary services, refuse to contract with, or refuse
248 to renew or reissue or otherwise terminate or restrict coverage
249 for an individual because the individual is diagnosed as having a
250 developmental disability.
251 (7) The treatment plan required pursuant to subsection (4)
252 shall include all elements necessary for the health insurance
253 plan to appropriately pay claims. These elements include, but are
254 not limited to, a diagnosis, the proposed treatment by type, the

255 frequency and duration of treatment, the anticipated outcomes
256 stated as goals, the frequency with which the treatment plan will
257 be updated, and the signature of the treating physician.
258 (8) Beginning January 1, 2011, the maximum benefit under
259 paragraph (4)(b) shall be adjusted annually on January 1 of each
260 calendar year to reflect any change from the previous year in the

261 medical component of the then current Consumer Price Index for
262 all urban consumers, published by the Bureau of Labor Statistics
263 of the United States Department of Labor.
264 (9) This section may not be construed as limiting benefits
265 and coverage otherwise available to an insured under a health
266 insurance plan.
267 (10) The Office of Insurance Regulation may not enforce
268 this section against an insurer that is a signatory no later than
269 April 1, 2009, to the developmental disabilities compact
270 established under s. 624.916. The Office of Insurance Regulation
271 shall enforce this section against an insurer that is a signatory
272 to the compact established under s. 624.916 if the insurer has
273 not complied with the terms of the compact for all health
274 insurance plans by April 1, 2010.
275 Section 4. Section 641.31098, Florida Statutes, is created
276 to read:
277 641.31098 Coverage for individuals with developmental
278 disabilities.--
279 (1) This section and section 627.6686, may be cited as the

280 "Steven A. Geller Autism Coverage Act."
281 (2) As used in this section, the term:
282 (a) "Applied behavior analysis" means the design,
283 implementation, and evaluation of environmental modifications,
284 using behavioral stimuli and consequences, to produce socially
285 significant improvement in human behavior, including, but not
286 limited to, the use of direct observation, measurement, and
287 functional analysis of the relations between environment and
288 behavior.

289 (b) "Autism spectrum disorder" means any of the following
290 disorders as defined in the most recent edition of the Diagnostic
291 and Statistical Manual of Mental Disorders of the American
292 Psychiatric Association:
293 1. Autistic disorder.
294 2. Asperger's syndrome.
295 3. Pervasive developmental disorder not otherwise
296 specified.
297 (b) "Eligible individual" means an individual under 18
298 years of age or an individual 18 years of age or older who is in
299 high school who has been diagnosed as having a developmental
300 disability at 8 years of age or younger.
301 (c) "Health maintenance contract" means a group health
302 maintenance contract offered by a health maintenance
303 organization. This term does not include a health maintenance
304 contract offered in the individual market, a health maintenance

305 contract that is individually underwritten, or a health
306 maintenance contract provided to a small employer.
307 (3) A health maintenance contract issued or renewed on or
308 after April 1, 2009, shall provide coverage to an eligible
309 individual for:
310 (a) Well-baby and well-child screening for diagnosing the
311 presence of autism spectrum disorder.
312 (b) Treatment of autism spectrum disorder through speech
313 therapy, occupational therapy, physical therapy, and applied
314 behavior analysis services. Applied behavior analysis services
315 shall be provided by an individual certified pursuant to s.
316 393.17 or an individual licensed under chapter 490 or chapter
317 491.

318 (4) The coverage required pursuant to subsection (3) is
319 subject to the following requirements:
320 (a) Coverage shall be limited to treatment that is
321 prescribed by the subscriber's treating physician in accordance
322 with a treatment plan.
323 (b) Coverage for the services described in subsection (3)
324 shall be limited to $36,000 annually and may not exceed $200,000
325 in total benefits.
326 (c) Coverage may not be denied on the basis that provided
327 services are habilitative in nature.
328 (d) Coverage may be subject to general exclusions and
329 limitations of the subscriber's contract, including, but not

limited to, coordination of benefits, participating provider requirements, and utilization review of health care services, including the review of medical necessity, case management, and other managed care provisions.

(5) The coverage required pursuant to subsection (3) may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to a subscriber than the dollar limits, deductibles, or coinsurance provisions that apply to physical illnesses that are generally covered under the subscriber's contract, except as otherwise provided in subsection (3).

(6) A health maintenance organization may not deny or refuse to issue coverage for medically necessary services, refuse to contract with, or refuse to renew or reissue or otherwise terminate or restrict coverage for an individual solely because the individual is diagnosed as having a developmental disability.

(7) The treatment plan required pursuant to subsection (4) shall include, but is not limited to, a diagnosis, the proposed treatment by type, the frequency and duration of treatment, the anticipated outcomes stated as goals, the frequency with which the treatment plan will be updated, and the signature of the treating physician.

(8) Beginning January 1, 2011, the maximum benefit under paragraph (4)(b) shall be adjusted annually on January 1 of each calendar year to reflect any change from the previous year in the

355 medical component of the then current Consumer Price Index for
356 all urban consumers, published by the Bureau of Labor Statistics
357 of the United States Department of Labor.
358 (9) The Office of Insurance Regulation may not enforce this
359 section against a health maintenance organization that is a
360 signatory no later than April 1, 2009, to the developmental
361 disabilities compact established under s. 624.916. The Office of
362 Insurance Regulation shall enforce this section against a health
363 maintenance organization that is a signatory to the compact
364 established under s. 624.916 if the health maintenance
365 organization has not complied with the terms of the compact for
366 all health maintenance contracts by April 1, 2010.
367 Section 5. This act shall take effect July 1, 2008.

Florida Senate - 2009 CS for SB 308
By the Committee on Health Regulation; and Senator Ring
588-04449-09 2009308c1

CODING: Words stricken are deletions; words underlined are additions.
1 A bill to be entitled
2 An act relating to autism; creating s. 381.986, F.S.;
3 requiring that a physician refer a minor to an
4 appropriate specialist for screening for autism
5 spectrum disorder under certain circumstances;
6 defining the term "appropriate specialist"; amending
7 ss. 627.6686 and 641.31098, F.S.; requiring certain
8 insurers and health maintenance organizations to
9 provide direct patient access to an appropriate
10 specialist for screening, evaluation of, or diagnosis
11 for autism spectrum disorder; defining the term
12 "direct patient access"; requiring the insurer's
13 policy or the health maintenance organization's
14 contract to provide a minimum number of visits per
15 year for the screening, evaluation of, or diagnosis
16 for autism spectrum disorder; providing an effective
17 date.
18
19 Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 381.986, Florida Statutes, is created to read:

381.986 Screening, evaluation of, or diagnosis for autism spectrum disorder.—

(1) If the parent or legal guardian of a minor who is an eligible individual, as defined in s. 627.6686 or s. 641.31098, believes that the minor exhibits symptoms of autism spectrum disorder, the parent or legal guardian may report his or her observation to a physician licensed in this state. The physician

CODING: Words stricken are deletions; words underlined are additions.

shall immediately refer the minor to an appropriate specialist for screening, evaluation of, or diagnosis for autism spectrum disorder. This section does not apply to a physician providing care under s. 395.1041.

(2) As used in this section, the term "appropriate specialist" means a qualified professional who is experienced in the evaluation of autism spectrum disorder, who has training in validated diagnostic tools, and includes, but is not limited to, a person who is licensed in this state as:

(a) A psychologist;

(b) A psychiatrist;

(c) A neurologist;

(d) A developmental or behavioral pediatrician and who specializes in child neurology;

(e) A speech language pathologist;

(f) An occupational therapist; or

(g) A professional whose licensure is deemed appropriate by the Children's Medical Services Early Steps Program within the Department of Health.

Section 2. Subsection (11) is added to section 627.6686, Florida Statutes, to read:

627.6686 Coverage for individuals with autism spectrum disorder required; exception.—

(11) Notwithstanding any provision of this section to the contrary, an insurer shall provide direct patient access for screening, evaluation of, or diagnosis for autism spectrum disorder to an appropriate specialist, as defined in s. 381.986. As used in this subsection, the term "direct patient access" means the ability of a subscriber or insured to obtain services

CODING: Words stricken are deletions; words underlined are additions.
59 from an in-network provider without a referral or other
60 authorization before receiving services. The insurer's policy
61 shall, pursuant to this subsection, provide a minimum of three
62 visits per policy year for the screening, evaluation of, or
63 diagnosis for autism spectrum disorder.
64 Section 3. Subsection (10) is added to section 641.31098,
65 Florida Statutes, to read:
66 641.31098 Coverage for individuals with developmental
67 disabilities.—
68 (10) Notwithstanding any provision of this section to the
69 contrary, a health maintenance organization shall provide direct
70 patient access for screening, evaluation of, or diagnosis for
71 autism spectrum disorder to an appropriate specialist, as
72 defined in s. 381.986. As used in this subsection, the term
73 "direct patient access" means the ability of a subscriber or
74 insured to obtain services from an in-network provider without a
75 referral or other authorization before receiving services. The
76 health maintenance organization's contract shall, pursuant to
77 this subsection, provide a minimum of three visits per policy
78 year for the screening, evaluation of, or diagnosis for autism
79 spectrum disorder.
80 Section 4. This act shall take effect July 1, 2009.

Florida Senate - 2009 COMMITTEE AMENDMENT

Bill No. SB 308

Ì408414ÉÎ408414

4/6/2009 7:45:00 PM 588-04099-09

LEGISLATIVE ACTION

Senate

Comm: RCS

04/06/2009

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House

The Committee on Health Regulation (Bennett) recommended the

following:

1 Senate Amendment (with title amendment)

2

3 Delete everything after the enacting clause

4 and insert:

5 Section 1. Section 381.986, Florida Statutes, is created to

6 read:

7 381.986 Screening, evaluation of, or diagnosis for autism

8 spectrum disorder.—

9 (1) If the parent or legal guardian of a minor who is an

10 eligible individual, as defined in s. 627.6686 or s. 641.31098,

11 believes that the minor exhibits symptoms of autism spectrum

12 disorder, the parent or legal guardian may report his or her

13 observation to a physician licensed in this state. The physician

14 shall immediately refer the minor to an appropriate specialist

15 for screening, evaluation of, or diagnosis for autism spectrum

16 disorder. This section does not apply to a physician providing

17 care under s. 395.1041.

18 (2) As used in this section, the term "appropriate

19 specialist" means a qualified professional who is experienced in

20 the evaluation of autism spectrum disorder, who has training in

21 validated diagnostic tools, and includes, but is not limited to,

22 a person who is licensed in this state as:

23 (a) A psychologist;

24 (b) A psychiatrist;

25 (c) A neurologist;

(d) A developmental or behavioral pediatrician and who specializes in child neurology;

(e) A speech language pathologist; or

(f) A professional whose licensure is deemed appropriate by the Children's Medical Services Early Steps Program within the Department of Health.

Section 2. Subsection (11) is added to section 627.6686, Florida Statutes, to read:

627.6686 Coverage for individuals with autism spectrum disorder required; exception.—

(11) Notwithstanding any provision of this section to the contrary, an insurer shall provide direct patient access for screening, evaluation of, or diagnosis for autism spectrum disorder to an appropriate specialist, as defined in s. 381.986. As used in this subsection, the term "direct patient access"

means the ability of a subscriber or insured to obtain services from an in-network provider without a referral or other authorization before receiving services. The insurer's policy shall, pursuant to this subsection, provide a minimum of three visits per policy year for the screening, evaluation of, or diagnosis for autism spectrum disorder.

Section 3. Subsection (10) is added to section 641.31098, Florida Statutes, to read:

641.31098 Coverage for individuals with developmental disabilities.—

51 (10) Notwithstanding any provision of this section to the
52 contrary, a health maintenance organization shall provide direct
53 patient access for screening, evaluation of, or diagnosis for
54 autism spectrum disorder to an appropriate specialist, as
55 defined in s. 381.986. As used in this subsection, the term
56 "direct patient access" means the ability of a subscriber or
57 insured to obtain services from an in-network provider without a
58 referral or other authorization before receiving services. The
59 health maintenance organization's contract shall, pursuant to
60 this subsection, provide a minimum of three visits per policy
61 year for the screening, evaluation of, or diagnosis for autism
62 spectrum disorder.
63 Section 4. This act shall take effect July 1, 2009.
64
65 ========== T I T L E A M E N D M E N T ==========
66 And the title is amended as follows:
67 Delete everything before the enacting clause
68 and insert:
69 A bill to be entitled

70 An act relating to autism; creating s. 381.986, F.S.;
71 requiring that a physician refer a minor to an
72 appropriate specialist for screening for autism
73 spectrum disorder under certain circumstances;
74 defining the term "appropriate specialist"; amending
75 ss. 627.6686 and 641.31098, F.S.; requiring certain

76 insurers and health maintenance organizations to
77 provide direct patient access to an appropriate
78 specialist for screening, evaluation of, or diagnosis
79 for autism spectrum disorder; defining the term
80 "direct patient access"; requiring the insurer's
81 policy or the health maintenance organization's
82 contract to provide a minimum number of visits per
83 year for the screening, evaluation of, or diagnosis
84 for autism spectrum disorder; providing an effective
85 date.

Florida Senate - 2008 SB 2654

31-00327D-08 20082654__

CODING: Words stricken are deletions; words underlined are additions.

1 A bill to be entitled
2 An act relating to autism spectrum disorder; providing a
3 short title; creating s. 627.6686, F.S.; providing
4 definitions; requiring health insurance plans to provide
5 coverage for screening, diagnosis, intervention, and
6 treatment of autism spectrum disorder in certain children;
7 requiring a treatment plan; prohibiting an insurer from
8 denying or refusing coverage or refusing to renew or
9 reissue or terminate coverage based on a diagnosis of
10 autism spectrum disorder; providing coverage limitations;
11 providing treatment plan requirements; limiting the
12 frequency of requests for updating a treatment plan;
13 providing eligibility requirements; providing a maximum
14 benefit that is adjusted annually; providing for
15 application; providing an effective date.

16

17 Be It Enacted by the Legislature of the State of Florida:

18

19 Section 1. This act may be cited as the "Window of

20 Opportunity Act."

21 Section 2. Section 627.6686, Florida Statutes, is created

22 to read:

23 627.6686 Optional coverage for autism spectrum disorder

24 required; exception.--

25 (1) As used in this section, the term:

26 (a) "Applied behavior analysis" means the design,

27 implementation, and evaluation of environmental modifications,

28 using behavioral stimuli and consequences, to produce socially

29 significant improvement in human behavior, including, but not

30 limited to, the use of direct observation, measurement, and

31 functional analysis of the relations between environment and

32 behavior.

33 (b) "Autism spectrum disorder" means any of the following

34 disorders as defined in the most recent edition of the Diagnostic

35 and Statistical Manual of Mental Disorders of the American

36 Psychiatric Association:

37 1. Autistic disorder.

38 2. Asperger's syndrome.

39 3. Pervasive developmental disorder not otherwise

40 specified.

(c) "Health insurance plan" means a group health insurance policy or group health benefit plan offered by an insurer which includes the state group insurance program provided under s. 110.123. The term does not include any health insurance plan offered in the individual market, any health insurance plan that is individually underwritten, or any health insurance plan provided to a small employer.

(d) "Insurer" means an insurer, health maintenance organization, or any other entity providing health insurance coverage which is licensed to engage in the business of insurance in this state and is subject to insurance regulation.

(2) A health insurance plan shall provide coverage for well-baby and well-child screening for diagnosing the presence of autism spectrum disorder and the intervention and treatment of autism spectrum disorder. Coverage provided under this section is limited to treatment that is prescribed by the insured's treating medical physician in accordance with a treatment plan. With regard to a health insurance plan, an insurer may not deny or

refuse to issue coverage for, refuse to contract with, or refuse to renew or reissue or otherwise terminate or restrict coverage for an individual because the individual is diagnosed as having autism spectrum disorder.

(3) The coverage required pursuant to subsection (2) may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to

physical illnesses that are generally covered under the health insurance plan, except as otherwise provided for in subsection (5). However, the coverage required pursuant to subsection (2) may be subject to other general exclusions and limitations of the insurer's policy or plan, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, and utilization review of health care services, including the review of medical necessity, case management, and other managed care provisions.

(4) The treatment plan required pursuant to subsection (2) must include all elements necessary for the health insurance plan to appropriately pay claims. These elements include, but are not limited to, a diagnosis, the proposed treatment by type, the frequency and duration of treatment, the anticipated outcomes stated as goals, the frequency by which the treatment plan will be updated, and the treating medical doctor's signature. A health insurance plan may request an updated treatment plan only once every 6 months from the treating medical doctor for purposes of reviewing medical necessity unless the health insurance plan and

the treating medical doctor agree that a more frequent review is necessary due to emerging clinical circumstances.

(5) To be eligible for benefits and coverage under this section, an individual must be diagnosed as having autistic spectrum disorder at 8 years of age or younger. The benefits and coverage provided pursuant to this section shall be provided to

any eligible person younger than 18 years of age or to any eligible person 18 years of age or older who is in high school. Coverage for behavioral therapy is subject to a maximum benefit of $36,000 per year. Beginning January 1, 2010, this maximum benefit shall be adjusted annually on January 1 of each calendar year to reflect any change from the previous year in the medical component of the then-current Consumer Price Index, All Urban Consumers, as published by the United States Department of Labor's Bureau of Labor Statistics.

Section 3. This act shall take effect January 1, 2009, and applies to health insurance policies or plans issued, renewed, entered into, or delivered on or after that date.

Florida Senate - 2009 COMMITTEE AMENDMENT

Bill No. SB 242

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3/11/2009 6:09:00 PM 586-02584-09

LEGISLATIVE ACTION

Senate

Comm: FAV

03/11/2009

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House

The Committee on Children, Families, and Elder Affairs (Justice)

recommended the following:

1 Senate Amendment (with title amendment)

2

3 Delete everything after the enacting clause

4 and insert:

5 Section 1. Section 381.986, Florida Statutes, is created to

6 read:

7 381.986 Screening, evaluation of, or diagnosis for autism

8 spectrum disorder.—

9 (1) If the parent or legal guardian of a minor who is an

10 eligible individual, as defined in s. 627.6686 or s. 641.31098,

11 believes that the minor exhibits symptoms of autism spectrum

12 disorder, the parent or legal guardian may report his or her

13 observation to a physician licensed in this state. The physician

14 shall immediately refer the minor to an appropriate specialist

15 for screening, evaluation of, or diagnosis for autism spectrum

16 disorder.

17 (2) As used in this section, the term "appropriate

18 specialist" means a qualified professional who is experienced in

19 the evaluation of autism spectrum disorder, who has training in

20 validated diagnostic tools, and includes, but is not limited to,

21 a person who is licensed in this state as:

22 1. A board-certified behavior analyst;

23 2. A psychologist;

24 3. A psychiatrist;

4. A neurologist;

5. A developmental or behavioral pediatrician and who specializes in child neurology;

6. A speech language pathologist; or

7. A licensed professional deemed appropriate by the Children's Medical Services Early Steps Program within the Department of Health.

Section 2. Subsection (11) is added to section 627.6686, Florida Statutes, to read:

627.6686 Coverage for individuals with autism spectrum disorder required; exception.—

(11) Notwithstanding any provision of this section to the contrary, an insurer shall provide direct patient access for screening, evaluation of, or diagnosis for autism spectrum disorder to an appropriate specialist. As used in this subsection, the term "direct patient access" means the ability

of a subscriber or insured to obtain services without a referral or other authorization before receiving services.

Section 3. Subsection (10) is added to section 641.31098, Florida Statutes, to read:

641.31098 Coverage for individuals with developmental disabilities.—

(10) Notwithstanding any provision of this section to the contrary, a health maintenance organization shall provide direct patient access for screening, evaluation of, or diagnosis for

50 autism spectrum disorder to an appropriate specialist. As used
51 in this subsection, the term "direct patient access" means the
52 ability of a subscriber or insured to obtain services without a
53 referral or other authorization before receiving services.
54 Section 4. This act shall take effect July 1, 2009.
55
56 ========== T I T L E A M E N D M E N T ==========
57 And the title is amended as follows:
58 Delete everything before the enacting clause
59 and insert:
60 A bill to be entitled
61 An act relating to autism; creating s. 381.986, F.S.;
62 requiring that a physician refer a minor to an
63 appropriate specialist for screening for autism
64 spectrum disorder under certain circumstances;
65 providing a definition; amending ss. 627.6686 and
66 641.31098, F.S.; requiring certain insurers and health
67 maintenance organizations to provide direct patient
68 access to an appropriate specialist for screening,
69 evaluation of, or diagnosis for autism spectrum

70 disorder; defining the term "direct patient access";
71 providing an effective date.

ILLINOIS PUBLIC ACT. 095-1005
» http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=095-1005

AN ACT concerning health.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The State Employees Group Insurance Act of 1971 is amended by changing Section 6.11 as follows:

(5 ILCS 375/6.11)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356g.5, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, 356z.9, ~~and~~ 356z.10, and 356z.14 of the Illinois Insurance Code. The program of health benefits must comply with Section 155.37 of the Illinois Insurance Code.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08.)

Section 10. The Counties Code is amended by changing Section 5-1069.3 as follows:

(55 ILCS 5/5-1069.3)

Sec. 5-1069.3. Required health benefits. If a county, including a home rule county, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g.5, 356u, 356w, 356x, 356z.6, 356z.9, ~~and~~ 356z.10, and 356z.14 of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this Section is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule county to which this Section applies must comply with every provision of this Section.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08.)

Section 15. The Illinois Municipal Code is amended by changing Section 10-4-2.3 as follows:

(65 ILCS 5/10-4-2.3)

Sec. 10-4-2.3. Required health benefits. If a municipality, including a home rule municipality, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g.5, 356u, 356w, 356x, 356z.6, 356z.9, ~~and~~ 356z.10, and 356z.14 of the Illinois Insurance Code. The requirement that health benefits be covered as provided in this is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule municipality to which this Section applies must comply with every provision of this Section.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08.)

Section 20. The School Code is amended by changing Section 10-22.3f as follows:

(105 ILCS 5/10-22.3f)

Sec. 10-22.3f. Required health benefits. Insurance protection and benefits for employees shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g.5, 356u, 356w, 356x, 356z.6, ~~and~~ 356z.9, and 356z.14 of the Illinois Insurance Code.

(Source: P.A. 95-189, eff. 8-16-07; 95-422, eff. 8-24-07; 95-876, eff. 8-21-08.)

Section 25. The Illinois Insurance Code is amended by adding Section 356z.14 as follows:

(215 ILCS 5/356z.14 new)

Sec. 356z.14. Autism spectrum disorders.

(a) A group or individual policy of accident and health

insurance or managed care plan amended, delivered, issued, or renewed after the effective date of this amendatory Act of the 95th General Assembly must provide individuals under 21 years of age coverage for the diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders to the extent that the diagnosis and treatment of autism spectrum disorders are not already covered by the policy of accident and health insurance or managed care plan.

(b) Coverage provided under this Section shall be subject to a maximum benefit of $36,000 per year, but shall not be subject to any limits on the number of visits to a service provider. After December 30, 2009, the Director of the Division of Insurance shall, on an annual basis, adjust the maximum benefit for inflation using the Medical Care Component of the United States Department of Labor Consumer Price Index for All Urban Consumers. Payments made by an insurer on behalf of a covered individual for any care, treatment, intervention, service, or item, the provision of which was for the treatment of a health condition not diagnosed as an autism spectrum disorder, shall not be applied toward any maximum benefit established under this subsection.

(c) Coverage under this Section shall be subject to copayment, deductible, and coinsurance provisions of a policy of accident and health insurance or managed care plan to the extent that other medical services covered by the policy of accident and health insurance or managed care plan are subject to these provisions.

(d) This Section shall not be construed as limiting benefits that are otherwise available to an individual under a policy of accident and health insurance or managed care plan and benefits provided under this Section may not be subject to dollar limits, deductibles, copayments, or coinsurance provisions that are less favorable to the insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally.

(e) An insurer may not deny or refuse to provide otherwise covered services, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage under an individual contract to provide services to an individual because the individual or their dependent is diagnosed with an autism spectrum disorder or due to the individual utilizing benefits in this Section.

(f) Upon request of the reimbursing insurer, a provider of

treatment for autism spectrum disorders shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is medically necessary and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, the insurer may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

(g) When making a determination of medical necessity for a treatment modality for autism spectrum disorders, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process. During the appeals process, any challenge to medical necessity must be viewed as reasonable only if the review includes a physician with expertise in the most current and effective treatment modalities for autism spectrum disorders.

(h) Coverage for medically necessary early intervention services must be delivered by certified early intervention specialists, as defined in 89 Ill. Admin. Code 500 and any subsequent amendments thereto.

(i) As used in this Section:

"Autism spectrum disorders" means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

"Diagnosis of autism spectrum disorders" means one or more tests, evaluations, or assessments to diagnose whether an individual has autism spectrum disorder that is prescribed, performed, or ordered by (A) a physician licensed to practice medicine in all its branches or (B) a licensed clinical psychologist with expertise in diagnosing autism spectrum disorders.

"Medically necessary" means any care, treatment, intervention, service or item which will or is reasonably expected to do any of the following: (i) prevent the onset of an illness, condition, injury, disease or disability; (ii) reduce or ameliorate the physical, mental or developmental

effects of an illness, condition, injury, disease or disability; or (iii) assist to achieve or maintain maximum functional activity in performing daily activities.

"Treatment for autism spectrum disorders" shall include the following care prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder by (A) a physician licensed to practice medicine in all its branches or (B) a certified, registered, or licensed health care professional with expertise in treating effects of autism spectrum disorders when the care is determined to be medically necessary and ordered by a physician licensed to practice medicine in all its branches:

(1) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.

(2) Psychological care, meaning direct or consultative services provided by a licensed psychologist.

(3) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. As used in this subsection (i), "applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

(4) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas: (i) self care and feeding, (ii) pragmatic, receptive, and expressive language, (iii) cognitive functioning, (iv) applied behavior analysis, intervention, and modification, (v) motor planning, and (vi) sensory processing.

(j) Rulemaking authority to implement this amendatory Act of the 95th General Assembly, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any

purported rule not so adopted, for whatever reason, is

unauthorized.

Section 30. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 137, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 355.2, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.14, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2)(i) the criteria specified in subsection (1)(b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other

acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health

Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(Source: P.A. 94-906, eff. 1-1-07; 94-1076, eff. 12-29-06; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff.

8-21-08.)

Section 35. The Voluntary Health Services Plans Act is amended by changing Section 10 as follows:

(215 ILCS 165/10) (from Ch. 32, par. 604)

Sec. 10. Application of Insurance Code provisions. Health services plan corporations and all persons interested therein or dealing therewith shall be subject to the provisions of Articles IIA and XII 1/2 and Sections 3.1, 133, 140, 143, 143c, 149, 155.37, 354, 355.2, 356g.5, 356r, 356t, 356u, 356v, 356w, 356x, 356y, 356z.1, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.14, 364.01, 367.2, 368a, 401, 401.1, 402, 403, 403A, 408, 408.2, and 412, and paragraphs (7) and (15) of Section 367 of the Illinois Insurance Code.

(Source: P.A. 94-1076, eff. 12-29-06; 95-189, eff. 8-16-07; 95-331, eff. 8-21-07; 95-422, eff. 8-24-07; 95-520, eff. 8-28-07; 95-876, eff. 8-21-08.)

Section 99. Effective date. This Act takes effect upon becoming law.

Effective Date: 12/12/2008

INDIANA BULLETIN 136 – INDIANA CODE IC 27-8-14.2

Information Maintained by the Office of Code Revision Indiana Legislative Services Agency

IC **27-8-14.2**

Chapter 14.2. Insurance Coverage for Pervasive Developmental Disorders

IC 27-8-14.2-1

"Accident and sickness insurance policy" defined

Sec. 1. (a) As used in this chapter, "accident and sickness insurance policy" means an insurance policy that provides one (1) or more of the types of insurance described in IC 27-1-5-1, classes 1(b) and 2(a).

(b) The term does not include the following:

(1) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(2) Coverage issued as a supplement to liability insurance.

(3) Worker's compensation or similar insurance.

(4) Automobile medical payment insurance.

(5) A specified disease policy.

(6) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than six (6) months.

(7) A policy that provides indemnity benefits not based on any expense incurred requirement, including a plan that provides coverage for:

(A) hospital confinement, critical illness, or intensive care; or

(B) gaps for deductibles or copayments.

(8) A supplemental plan that always pays in addition to other coverage.

(9) A student health plan.

(10) An employer sponsored health benefit plan that is:

(A) provided to individuals who are eligible for Medicare; and

(B) not marketed as, or held out to be, a Medicare supplement policy.

As added by P.L.148-2001, SEC.2. Amended by P.L.173-2007, SEC.32.

IC 27-8-14.2-2

"Insured" defined

Sec. 2. As used in this chapter, "insured" means an individual who is entitled to coverage under a policy of accident and sickness insurance.

As added by P.L.148-2001, SEC.2.

IC 27-8-14.2-3

"Pervasive developmental disorder" defined

Sec. 3. As used in this chapter, "pervasive developmental disorder" means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

As added by P.L.148-2001, SEC.2.

IC 27-8-14.2-4

Group coverage required

Sec. 4. (a) An accident and sickness insurance policy that is issued on a group basis must provide coverage for the treatment of a pervasive developmental disorder of an insured. Coverage provided under this section is limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan. An insurer may not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage on an individual under an insurance policy solely because the individual is diagnosed with a pervasive developmental disorder.

(b) The coverage required under this section may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally under the accident and sickness insurance policy.

As added by P.L.148-2001, SEC.2.

IC 27-8-14.2-5

Individual coverage required

Sec. 5. (a) An insurer that issues an accident and sickness insurance policy on an individual basis must offer to provide coverage for the treatment of a pervasive developmental disorder of an insured. Coverage provided under this section is limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan. An insurer may not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage on an individual under an insurance policy solely because the individual is diagnosed with a pervasive developmental disorder.

(b) The coverage that must be offered under this section may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally under the accident and sickness insurance policy.

As added by P.L.148-2001, SEC.2.

Chapter 3 may be viewed at http://www.in.gov/idem/land/risc/user_guide/index.html

DEPARTMENT OF INSURANCE

March 30, 2006

Bulletin 136

Insurance Coverage for Pervasive Developmental Disorders

This Bulletin is directed to all insurance companies that issue accident and sickness insurance policies as defined in IC 27-8-

Nonrule Policy Documents

14.2-1 and to health maintenance organizations (HMOs) as defined in IC 27-13-1-19. Coverage for Pervasive Developmental Disorders (PDD) is a very complex issue. In 2001, the Indiana General Assembly passed P.L.148-2001 adding IC 27-8-14.2 and IC 27-13-7-14.7. These provisions increased insurance coverage for persons suffering with PDD from what was available in the insurance market at that time. As is often the case, the bill that was passed contained compromises from the bills that were introduced, debated and amended. After a bill is passed and the statute is implemented it is not uncommon for interested persons to continue to dispute the meaning of the final language. The Department of Insurance is charged with implementing the provisions of Title 27. The Department must implement the statutes as they are written, giving meaning to each word of the statute. This Bulletin is intended to provide guidance to insurers and to consumers on contract language and administration of claims for the treatment of PDD as required by IC 27-8-14.2 and IC 27-13-7-14.7.

IC 27-8-14.2-4 requires that a group accident and sickness insurance policy must provide coverage for the treatment of PDD of an insured. IC 27-8-14.2-5 requires insurers that issue individual policies of accident and sickness insurance to offer to provide coverage for the treatment of PDD. And, IC 27-13-7-14.7 requires an HMO that provides basic health care services to provide services for the treatment of PDD of an enrollee. Neither insurers nor HMOs can deny or refuse to issue coverage on, refuse to contract with, or refuse to renew, or reissue or otherwise terminate coverage on an individual solely because the individual is diagnosed with PDD.

A written treatment plan for each individual with PDD must be developed and signed by the treating physician. The treatment
plan should be submitted to the insurer or HMO as soon as possible after its development to facilitate the payment of claims. If a nonphysician
recommends the treatment plan, it must be approved and signed by the treating physician. The Department of Insurance
recognizes the insurer's or HMO's right to review the services prescribed under the treatment plan as to medical necessity. The
insurer or HMO shall consult with the treating physician in its consideration of the treatment plan. Any challenge to medical necessity
will be viewed as reasonable only if the review is by a specialist in the treatment of PDD. A specialist includes a clinical employee
such as a medical director or PhD clinical administrator, provider or consultant of the insurer or HMO, and has specialized and
current knowledge of PDD. Any challenge to medical necessity will be treated the same as any other grievance, following the
grievance and appeals process as defined in IC 27-8-28, IC 27-8-29, IC 27-13-10, and IC 27-13-10.1.
The treatment plan must include all elements necessary for the insurer or HMO to appropriately pay claims. These elements
include but are not limited to: a diagnosis, proposed treatment by type(s), frequency and duration of treatment(s), the anticipated
outcomes stated as goals, the frequency by which the treatment plan will be updated, and the treating physician's signature. The
insurer must provide, in writing, its determination regarding coverage for the services and supplies prescribed by the treatment plan
within thirty (30) days of the insurer or HMO receiving the treatment plan. The insurer or HMO shall provide specific contact
information for provider or member questions and shall facilitate filing of claims. An insurer or HMO that fails to provide its
determination on the treatment plan within 30 days may be subject to enforcement action under IC 27-4-1-4.5.
Recognizing that PDD is a neurological condition, services will be provided without interruption, as long as those services are
consistent with the treatment plan and with medical necessity decisions. Service exclusions contained in the insurance policy or HMO
contract that are inconsistent with the treatment plan will be considered invalid as to PDD. However, coverage of services may be
subject to other general exclusions and limitations of the contract or benefit plan, such as coordination of benefits, participating
provider requirements, services provided by family or household members, eligibility, appeals processes, and carved out services
(e.g. if the employer elects not to provide pharmacy coverage for any employees). IC 27-8-14.2-4(b), IC 27-8-14.2-5(b) and IC 27-13-
7-14.7(c) and (e) state that the coverage or services that must be offered "may not be subject to dollar limits, deductibles, or
coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply
to physical illness generally" under the accident and sickness policy or contract with the health maintenance organization. This
provision allows the insurer or HMO to apply dollar limits, deductibles, co-payments and coinsurance as long as the application is
consistent with coverage for physical illness generally. The Department considers dollar limits and visit limits to be synonymous for
the purposes of this bulletin.
It is the Department's position that behavioral therapies such as Applied Behavioral Analysis Services may not be subject to

limitations that apply to therapies such as physical, occupational or speech therapy. Further, Indiana does not currently have a
licensing requirement for persons who perform Applied Behavioral Analysis Services. It is, therefore, inappropriate at this time for
an insurer or HMO to deny a claim based upon the fact that the provider of Applied Behavioral Analysis Services does not hold a
license.
The insurer shall have the right to request an updated treatment plan not more than once every six (6) months from the treating
physician to review medical necessity, unless the insurer or HMO and the provider agree that a more frequent review is necessary
due to emerging clinical circumstances. The cost of obtaining an updated treatment plan at the request of the insurer or HMO shall
be borne by the insurer or HMO. This review does not alter the requirements and rights described in IC 27-8-29, IC 27-13-10 and
IC 27-13-10.1.
It is important for consumers to review their insurance coverage. For persons covered by individual policies, insurers are
required to provide the insured with a copy of their insurance contract. For persons covered by group insurance policies or HMO

contracts, the insurer or HMO is required to provide a copy of the certificate or evidence of coverage. While the insurer is not
required to provide each covered person with a copy of the group insurance contract it should be made available if requested.
The insurance policies and HMO contracts affected by this Bulletin are required to be filed and approved by the Department.
As guidance to the companies the Department approves the following language in its entirety:
1. Pervasive Development Disorder means a neurological condition, including but not limited to Asperger's syndrome and
autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American
Psychiatric Association.
2. Coverage for services will be provided as prescribed by the insured's treating physician in accordance with a treatment plan.
3. Any exclusion within the policy, certificate or contract that is inconsistent with the treatment plan does not apply.
4. The benefits for Pervasive Developmental Disorder will not be subject to dollar limits, deductibles, or coinsurance provisions
that are less favorable than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally under
the accident and sickness insurance policy, certificate or HMO contract.
Any form in conflict with this Bulletin should be revised and filed with the Department. Policies, certificates, contracts,
endorsements, or riders already approved for use may be used until the employer contract is amended, renewed, or terminated.
However, the Department requires effective with the date of this Bulletin any insurer or HMO that is interpreting its policies more
restrictively than the standards of this Bulletin shall adjudicate claims consistent with the provisions of the Bulletin. The Consumer
Protection Unit of the Department encourages individuals to contact the Department with any concerns over the payment of claims.
Each complaint will be reviewed individually for compliance with all applicable statutes.

James Atterholt, Commissioner

LOUISIANA LRS 22:1050/ACT NO. 648, 2008 REGULAR SESSION:

ENROLLED
Page 1 of 4
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are additions.

Regular Session, 2008 **ACT No. 648**

HOUSE BILL NO. 958
BY REPRESENTATIVE FOILAND SENATOR CRAVINS AND REPRESENTATIVES
ANDERS, ARMES, ARNOLD, AUBERT, BOBBY BADON, BALDONE, BARRAS, BARROW, BILLIOT, HENRY BURNS, TIM BURNS, BURRELL, CARTER, CHAMPAGNE, CHANDLER, CHANEY, CONNICK, CORTEZ, CROMER, DANAHAY, DIXON, DOERGE, DOVE, EDWARDS, ELLINGTON, FANNIN, GALLOT, GEYMANN, GISCLAIR, GREENE, ELBERT GUILLORY, MICKEY GUILLORY, HARDY, HARRISON, HAZEL, HENDERSON, HENRY, HILL, HINES,HOFFMANN,HONEY,HOWARD,HUTTER, GIROD JACKSON, JOHNSON, SAM JONES, KATZ, KLECKLEY, LABRUZZO, LAFONTA, LAMBERT, LEBAS, LEGER, LIGI, LITTLE, LOPINTO, LORUSSO, MARCHAND, MCVEA, MONTOUCET, MORRELL, MORRIS, NORTON, PEARSON, PERRY, PONTI, POPE, PUGH, RICHARD, RICHARDSON, RICHMOND, RITCHIE, ROY, SCHRODER, SIMON, GARY SMITH, JANE SMITH, ST. GERMAIN, TALBOT, TEMPLET, TRAHAN, TUCKER, WADDELL, WHITE, WILLIAMS, WILLMOTT, ANDWOOTON AND SENATORS ADLEY, ALARIO, BROOME, CASSIDY, CHAISSON, CHEEK, CROWE, DONAHUE, DORSEY, DUPLESSIS, DUPRE, ERDEY, B. GAUTREAUX, N. GAUTREAUX, GRAY, HEBERT, HEITMEIER, JACKSON, KOSTELKA, LAFLEUR, LONG, MARIONNEAUX, MARTINY, MICHOT, MOUNT, MURRAY, NEVERS, QUINN, RISER, SHAW, SMITH, THOMPSON, AND WALSWORTH

AN ACT

To enact R.S. 22:215.26 and to repeal R.S. 22:669(A)(1)(b)(iii) and (viii), relative to health insurance; to require health insurance policies, contracts, and plans, including health maintenance organization contracts or agreements, to provide coverage of the diagnosis and treatment of autism spectrum disorders in individuals less than seventeen years of age; to provide for certain limitations and exceptions; to delete pervasive developmental disorder or autism and Asperger's Disorder from the

8 definition of severe mental illnesses mandated to be covered; and to provide for
9 related matters.
10 Be it enacted by the Legislature of Louisiana:
11 Section 1. R.S. 22:215.26 is hereby enacted to read as follows:
12 §215.26. Requirement for coverage of diagnosis and treatment of autism spectrum
13 disorders in individuals less than seventeen years of age
14 A.(1) Except as otherwise provided in Subsection H of this Section, any
15 health coverage plan specified in Paragraph (G)(6) of this Sectionwhich is issued for

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are additions.
1 delivery, delivered, renewed, or otherwise contracted for in this state on or after
2 January 1, 2009, shall provide coverage for the diagnosis and treatment of autism
3 spectrum disorders in individuals less than seventeen years of age.
4 (2) No insurer or other issuer of a health coverage plan may terminate
5 coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an
6 individual solelybecause the individual is diagnosedwith one of the autismspectrum
7 disorders or has received treatment for an autism spectrum disorder.
8 B. Coverage under this Section shall not be subject to any limits on the
9 number of visits an individual may make to an autism services provider.
10 C. Coverage under this Section may be subject to copayment, deductible,
11 and coinsurance provisions of a health coverage plan to the extent that othermedical
12 services covered by the plan are subject to these provisions.
13 D.(1) Coverage under this Section shall be subject to a maximum benefit of
14 thirty-six thousand dollars per year and a lifetime maximum benefit of one hundred
15 forty-four thousand dollars.
16 (2) Payments made by an insurer or issuer of a health coverage plan on
17 behalf of a covered individual for any care, treatment, intervention, service, or item
18 unrelated to autism spectrum disorders shall not be applied towards the maximum
19 established under this Subsection.
20 E. This Section shall not be construed as limiting benefits not related to the
21 treatment of autism spectrum disorders that are otherwise available to an individual
22 under a health coverage plan.
23 F. A health coverage plan may review proposed treatment of autism
24 spectrum disorders according to medical necessity criteria that may be based in part
25 on evidence of continued improvement as a result of the treatment. Medical
26 necessity determinations shall be subject to appeal rights as described in R.S.
27 22:3070 et seq.
28 G. As used in this Section:
29 (1) "Applied behavior analysis" means the design, implementation, and
30 evaluation of environmental modifications, using behavioral stimuli and

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are additions.

consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

(2) "Autism services provider" means any person, entity, or group which provides treatment of autism spectrum disorders. When the treatment provided by the autism services provider is applied behavior analysis as defined in this Subsection, such provider shall be certified as a behavior analyst by the Behavior Analyst Certification Board or shall provide, if requested, documented evidence of equivalent education, professional training, and supervised experience in applied behavior analysis.

(3) "Autism spectrum disorders" means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including Autistic Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

(4) "Diagnosis of autism spectrum disorders" means medically necessary assessment, evaluations, or tests to diagnose whether an individual has one of the autism spectrum disorders.

(5) "Habilitative or rehabilitative care" means professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an individual.

(6) "Health coverage plan" means any hospital, health, or medical expense insurance policy, hospital ormedical service contract, employee welfare benefit plan, contract or agreementwith a healthmaintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan and the Office of Group Benefits programs.

(7) "Pharmacy care" means medications prescribed by a licensed physician.

(8) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in this state.

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are additions.

State of Maine Legislature

Summary of LD 1198

Bill Info

LD 1198 (SP 446)

"An Act To Reform Insurance Coverage To Include Diagnosis for Autism Spectrum Disorders"

Sponsored by **Senator Peter Bowman**

Status Summary	
Reference Committee	**Insurance and Financial Services**
Last House Action	**6/13/09** - Carried over to any special or regular session of the 124th Legislature pursuant to Joint Order HP 1053.
Last Senate Action	**6/15/09** - **CARRIED OVER** TO ANY SPECIAL OR REGULAR SESSION OF THE 124th LEGISLATURE PURSUANT TO JOINT ORDER HP 1053, IN CONCURRENCE

An Act To Reform Insurance Coverage To Include Diagnosis for Autism Spectrum Disorders

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24 MRSA §2317-B, sub-§19, as enacted by PL 1999, c. 256, Pt. M, §10, is amended
to read:

19. Title 24-A, chapter 67. Medicare supplement insurance policies, Title 24-A, chapter 67;
and

Sec. 2. 24 MRSA §2317-B, sub-§20, as amended by PL 2003, c. 428, Pt. G, §1, is further
amended to read:

20. Title 24-A, chapters 68 and 68-A. Long-term care insurance, nursing home care
insurance and home health care insurance, Title 24-A, chapters 68 and 68-A.; and

Sec. 3. 24 MRSA §2317-B, sub-§21 is enacted to read:

21. Title 24-A, sections 2847-Q and 4257. Coverage for diagnosis and treatment of autism
spectrum disorders, Title 24-A, sections 2847-Q and 4257.

Sec. 4. 24-A MRSA §2847-Q is enacted to read:

§ 2847-Q. Coverage for the diagnosis and treatment of autism spectrum disorders

1. Definitions. As used in this section, unless the context otherwise indicates, the following
terms have the following meanings.

A. "Applied behavior analysis" means the design, implementation and evaluation of environmental
modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and
functional analysis of the relations between environment and behavior.

B. "Autism spectrum disorders" means any of the pervasive developmental disorders as defined
by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the
American Psychiatric Association, including autistic disorder, Asperger's disorder and pervasive
developmental disorder not otherwise specified.

C. "Treatment of autism spectrum disorders" includes the following types of care prescribed,
provided or ordered for an individual diagnosed with an autism spectrum disorder:

(1) Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning
of an individual to the extent possible;

(2) Prescribed pharmaceuticals;

(3) Counseling services provided by a licensed psychiatrist, psychologist, clinical professional
counselor or clinical social worker; and

(4) Therapy services provided by a licensed or certified speech therapist, occupational therapist
or physical therapist.

2. Required coverage. All group health insurance policies, contracts and certificates must

provide coverage for autism spectrum disorders for an individual covered under the policy, contract or
certificate who is 21 years of age or under in accordance with the following.
A. The policy, contract or certificate must provide coverage for any assessments, evaluations or tests
by a licensed physician or licensed psychologist to diagnose whether an individual has an autism
spectrum disorder.
B. The policy, contract or certificate must provide coverage for the treatment of autism spectrum
disorders when a licensed physician or licensed psychologist has submitted documentation that
the treatment is medically necessary health care as defined in section 4301-A, subsection 10-A.
A licensed physician or licensed psychologist may be required to confirm and document ongoing
medical necessity for coverage provided under this section at least annually.
C. The policy, contract or certificate may not include any limits on the number of visits.
D. The policy, contract or certificate may limit coverage to $36,000 per year, except that, beginning
January 1, 2011, the maximum benefit must be adjusted annually for inflation using the medical
care component of the United States Department of Labor Consumer Price Index for urban wage
earners. An insurer may not apply payments for coverage unrelated to autism spectrum disorders to
any maximum benefit established under this paragraph.

3. Limits; coinsurance; deductibles. Except as otherwise provided in this section, any
policy, contract or certificate that provides coverage for services under this section may contain provisions
for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the
extent that these provisions are not inconsistent with the requirements of this section.

4. Individualized education plan. This section may not be construed to affect any obligation
to provide services to an individual with an autism spectrum disorder under an individualized education
plan or an individualized family service plan.

5. Exceptions. This section does not apply to employee group insurance policies issued to
employers with fewer than 50 employees insured under the group policy.

Sec. 5. 24-A MRSA §4257 is enacted to read:

§ 4257. Coverage for the diagnosis and treatment of autism spectrum disorders

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

B. "Autism spectrum disorders" means any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

C. "Treatment of autism spectrum disorders" includes the following types of care prescribed, provided or ordered for an individual diagnosed with an autism spectrum disorder:

(1) Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible;

(2) Prescribed pharmaceuticals;

(3) Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and

(4) Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist.

2. Required coverage. All group health maintenance organization contracts and certificates must provide coverage for autism spectrum disorders for an individual covered under the contract or certificate who is 21 years of age or under in accordance with the following.

A. The contract or certificate must provide coverage for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder.

B. The contract or certificate must provide coverage for the treatment of autism spectrum disorders when a licensed physician or licensed psychologist has submitted documentation that the treatment is medically necessary health care as defined in section 4301-A, subsection 10-A. A licensed physician or licensed psychologist may be required to confirm and document ongoing medical necessity for coverage provided under this section at least annually.

C. The contract or certificate may not include any limits on the number of visits.

D. The contract or certificate may limit coverage to $36,000 per year, except that, beginning January 1, 2011, the maximum benefit must be adjusted annually for inflation using the medical care component of the United States Department of Labor Consumer Price Index for urban wage earners. A health maintenance organization may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph.

3. Limits; coinsurance; deductibles. Except as otherwise provided in this section, any contract or certificate that provides coverage for services under this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.

4. Individualized education plan. This section may not be construed to affect any obligation to provide services to an individual with an autism spectrum disorder under an individualized education plan or an individualized family service plan.

5. Exceptions. This section does not apply to employee group health maintenance organization contracts issued to employers with fewer than 50 employees insured under the group contract.

Sec. 6. Application. The requirements of this Act apply to all group policies, contracts and certificates subject to this Act that are executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2010. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

SUMMARY

This bill requires group health insurance policies, contracts and certificates covering fewer than 50
members to provide coverage for the diagnosis and treatment of autism spectrum disorders for persons
21 years of age and under. Initially, coverage is subject to a maximum annual benefit of $36,000 per
year; beginning January 1, 2011, the maximum benefit must be adjusted annually for inflation using the
medical care component of the United States Department of Labor Consumer Price Index. The provisions

of this bill apply to group policies, contracts and certificates issued or renewed on or after January 1, 2010.

MARYLAND SECTION 15-835 OF THE INSURANCE ARTICLE:

http://law.justia.com/maryland/codes/gin/15-835.html

Article - Insurance

§ 15-835.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Congenital or genetic birth defect" means a defect existing at or from birth, including a hereditary defect.

(ii) "Congenital or genetic birth defect" includes, but is not limited to:

1. autism or an autism spectrum disorder; and

2. cerebral palsy.

(3) "Habilitative services" means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function.

(4) "Managed care system" means a method that an insurer, a nonprofit health service plan, or a health maintenance organization uses to review and preauthorize a treatment plan that a health care practitioner develops for a covered person using a variety of cost containment methods to control utilization, quality, and claims.

(b) This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) (1) An entity subject to this section shall provide coverage of habilitative services for children under the age of 19 years and may do so through a managed care system.

(2) An entity subject to this section is not required to provide reimbursement for habilitative services delivered through early intervention or school services.

(d) An entity subject to this section shall provide notice annually to its insureds and enrollees about the coverage required under this section.

(e) A determination by an entity subject to this section denying a request for habilitative services or denying payment for habilitative services on the grounds that a condition or disease is not a congenital or genetic birth defect is considered an "adverse decision" under § 15-10A-01 of this article.

http://mhcc.maryland.gov/health_insurance/mandated_1207.pdf

MISSOURI 376.1550 RSMO for Group; 376.811 RSMO:

http://law.justia.com/missouri/codes/t24/3760001550.html

§ 376.1550. — Mental health coverage, requirements--definitions--exclusions.

376.1550. 1. Notwithstanding any other provision of law to the contrary, each health carrier that offers or issues health benefit plans which are delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2005, shall provide coverage for a mental health condition, as defined in this section, and shall comply with the following provisions:

(1) A health benefit plan shall provide coverage for treatment of a mental health condition and shall not establish any rate, term, or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition. Any deductible or out-of-pocket limits required by a health carrier or health benefit plan shall be comprehensive for coverage of all health conditions, whether mental or physical;

(2) The coverages set forth is this subsection:

(a) May be administered pursuant to a managed care program established by the health carrier; and

(b) May deliver covered services through a system of contractual arrangements with one or more providers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri;

(3) A health benefit plan that does not otherwise provide for management of care under the plan or that does not provide for the same degree of management of care for all health conditions may provide coverage for treatment of mental health conditions through a managed care organization; provided that the managed care organization is in compliance with rules adopted by the department of insurance that assure that the system for delivery of treatment for mental health conditions does not diminish or negate the purpose of this section. The rules adopted by the director shall assure that:

(a) Timely and appropriate access to care is available;

(b) The quantity, location, and specialty distribution of health care providers is adequate; and

(c) Administrative or clinical protocols do not serve to reduce access to medically necessary treatment for any insured;

(4) Coverage for treatment for chemical dependency shall comply with sections 376.779, 376.810 to 376.814, and 376.825 to 376.836 and for the purposes of this subdivision the term "health insurance policy" as used in sections 376.779, 376.810 to 376.814, and 376.825 to 376.836, the term "health insurance policy" shall include group coverage.

2. As used in this section, the following terms mean:

(1) "Chemical dependency", the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both;

(2) "Health benefit plan", the same meaning as such term is defined in section 376.1350;

(3) "Health carrier", the same meaning as such term is defined in section 376.1350;

(4) "Mental health condition", any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders except for chemical dependency;

(5) "Managed care organization", any financing mechanism or system that manages care delivery for its members or subscribers, including health maintenance organizations and any other similar health care delivery system or organization;

(6) "Rate, term, or condition", any lifetime or annual payment limits, deductibles, co-payments, coinsurance, and other cost-sharing requirements, out-of-pocket limits, visit limits, and any other financial component of a health benefit plan that affects the insured.

3. This section shall not apply to a health plan or policy that is individually underwritten or provides such coverage for specific individuals and members of their families pursuant to section 376.779, sections 376.810 to 376.814, and sections 376.825 to 376.836, a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policies of six months or less duration, or any other supplemental policy as determined by the director of the department of insurance.

4. Notwithstanding any other provision of law to the contrary, all health insurance policies that cover state employees, including the Missouri consolidated health care plan, shall include coverage for mental illness. Multiyear group policies need not comply until the expiration of their current multiyear term unless the policyholder elects to comply before that time.

5. The provisions of this section shall not be violated if the insurer decides to apply different limits or exclude entirely from coverage the following:

(1) Marital, family, educational, or training services unless medically necessary and clinically appropriate;

(2) Services rendered or billed by a school or halfway house;

(3) Care that is custodial in nature;

(4) Services and supplies that are not immediately nor clinically appropriate; or

(5) Treatments that are considered experimental.

6. The director shall grant a policyholder a waiver from the provisions of this section if the policyholder demonstrates to the director by actual experience over any consecutive twenty-four-month period that compliance with this section has increased the cost of the health insurance policy by an amount that results in a two percent increase in premium costs to the policyholder. The director shall promulgate rules establishing a procedure and appropriate standards for making such a demonstration. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2004, shall be invalid and void.

(L. 2004 H.B. 855)

Missouri Revised Statutes
Chapter 376
Life, Health and Accident Insurance
Section *376.811*

August 28, 2008

Coverage required for chemical dependency by all insurance and health service corporations--minimum standards--offer of coverage may be accepted or rejected by policyholders, companies may offer as standard coverage--mental health benefits provided, when--exclusions.

376.811. 1. Every insurance company and health services corporation doing business in this state shall offer in all health insurance policies benefits or coverage for chemical dependency meeting the following minimum standards:

(1) Coverage for outpatient treatment through a nonresidential treatment program, or through partial- or full-day program services, of not less than twenty-six days per policy benefit period;

(2) Coverage for residential treatment program of not less than twenty-one days per policy benefit period;

(3) Coverage for medical or social setting detoxification of not less than six days per policy benefit period;

(4) The coverages set forth in this subsection may be subject to a separate lifetime frequency cap of not less than ten episodes of treatment, except that such separate lifetime frequency cap shall not apply to medical detoxification in a life-threatening situation as determined by the treating physician and subsequently documented within forty-eight hours of treatment to the reasonable satisfaction of the insurance company or health services corporation; and

(5) The coverages set forth in this subsection:

(a) Shall be subject to the same coinsurance, co-payment and deductible factors as apply to physical illness;

(b) May be administered pursuant to a managed care program established by the insurance company or health services corporation; and

(c) May deliver covered services through a system of contractual arrangements with one or more providers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri.

2. In addition to the coverages set forth in subsection 1 of this section, every insurance company, health services corporation and health maintenance organization doing business in this state shall offer in all health insurance policies, benefits or coverages for recognized mental illness, excluding chemical dependency, meeting the following minimum standards:

(1) Coverage for outpatient treatment, including treatment through partial- or full-day program services, for mental health services for a recognized mental illness rendered by a licensed professional to the same extent as any other illness;

(2) Coverage for residential treatment programs for the therapeutic care and treatment of a recognized mental illness when prescribed by a licensed professional and rendered in a psychiatric residential treatment center licensed by the department of mental health or accredited by the Joint Commission on Accreditation of Hospitals to the same extent as any other illness;

(3) Coverage for inpatient hospital treatment for a recognized mental illness to the same extent as for any other illness, not to exceed ninety days per year;

(4) The coverages set forth in this subsection shall be subject to the same coinsurance, co-payment, deductible, annual maximum and lifetime maximum factors as apply to physical illness; and

(5) The coverages set forth in this subsection may be administered pursuant to a managed care program established by the insurance company, health services corporation or health maintenance organization, and covered services may be delivered through a system of contractual arrangements with one or more providers, community mental health centers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri.

3. The offer required by sections 376.810 to 376.814 may be accepted or rejected by the group or individual policyholder or contract holder and, if accepted, shall fully and completely satisfy and substitute for the coverage under section 376.779. Nothing in sections 376.810 to 376.814 shall prohibit an insurance company, health services corporation or health maintenance organization from including all or part of the coverages set forth in sections 376.810 to 376.814 as standard coverage in their policies or contracts issued in this state.

4. Every insurance company, health services corporation and health maintenance organization doing business in this state shall offer in all health insurance policies mental health benefits or coverage as part of the policy or as a supplement to the policy. Such mental health benefits or coverage shall include at least two sessions per year to a licensed psychiatrist, licensed psychologist, licensed professional counselor, or licensed clinical social worker acting within the scope of such license and under the following minimum standards:

(1) Coverage and benefits in this subsection shall be for the purpose of diagnosis or assessment, but not dependent upon findings; and

(2) Coverage and benefits in this subsection shall not be subject to any conditions of preapproval, and shall be deemed reimbursable as long as the provisions of this subsection are satisfied; and

(3) Coverage and benefits in this subsection shall be subject to the same coinsurance, co-payment and deductible factors as apply to regular office visits under coverages and benefits for physical illness.

5. If the group or individual policyholder or contract holder rejects the offer required by this section, then the coverage shall be governed by the mental health and chemical dependency insurance act as provided in sections 376.825 to 376.836.

6. This section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policy of six months or less duration, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

(L. 1991 S.B. 352 § 7 subsecs. 2, 3, 4, A.L. 1997 H.B. 335, A.L. 1999 H.B. 191, A.L. 2004 H.B. 855)

http://www.house.mo.gov/billtracking/bills091/billpdf/intro/HB0796I.PDF

FIRST REGULAR SESSION

HOUSE BILL NO. 796

95TH GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVES LAMPE (Sponsor) AND GRISAMORE (Co-sponsor).

1650L.011 D. ADAM CRUMBLISS, Chief Clerk

AN ACT

To repeal sections 376.779, 376.810, 376.811, 376.814, 376.825, 376.826, 376.827, 376.830,
376.833, 376.836, and 376.1550, RSMo, and to enact in lieu thereof one new section relating to mental health insurance coverage.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Sections 376.779, 376.810, 376.811, 376.814, 376.825, 376.826, 376.827,
2 376.830, 376.833, 376.836, and 376.1550, RSMo, are repealed and one new section enacted in
3 lieu thereof, to be known as section 376.1550, to read as follows:
376.1550. 1. Notwithstanding any other provision of law to the contrary, each health
2 carrier that offers or issues health benefit plans which are delivered, issued for delivery,
3 continued, or renewed in this state on or after January 1, 2005, shall provide coverage for a
4 mental health condition, as defined in this section, and shall comply with the following
5 provisions:
6 (1) **Except for the limitations specified in this section which may be applied only**
7 **when permissible under federal parity requirements,** a health benefit plan shall provide
8 coverage for treatment of a mental health condition and shall not establish any rate, term, or
9 condition that places a greater financial burden on an insured for access to treatment for a mental
10 health condition than for access to treatment for a physical health condition. Any deductible or
11 out-of-pocket limits required by a health carrier or health benefit plan shall be comprehensive
12 for coverage of all health conditions, whether mental or physical;
13 (2) The coverages set forth is this subsection:
14 (a) May be administered pursuant to a managed care program established by the health
15 carrier; and

16 (b) May deliver covered services through a system of contractual arrangements with one
17 or more providers, hospitals, nonresidential or residential treatment programs, or other mental
18 health service delivery entities, **including but not limited to entities** certified by the department

of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri;

(3) A health benefit plan that does not otherwise provide for management of care under the plan or that does not provide for the same degree of management of care for all health conditions may provide coverage for treatment of mental health conditions through a managed care organization; provided that the managed care organization is in compliance with rules adopted by the department of insurance, financial institutions and professional registration that assure that the system for delivery of treatment for mental health conditions does not diminish or negate the purpose of this section. The rules adopted by the director shall assure that:

(a) Timely and appropriate access to care is available;

(b) The quantity, location, and specialty distribution of health care providers is adequate; and

(c) Administrative or clinical protocols do not serve to reduce access to medically necessary treatment for any insured;

(4) [Coverage for treatment for chemical dependency shall comply with sections 376.779, 376.810 to 376.814, and 376.825 to 376.836 and for the purposes of this subdivision the term "health insurance policy" as used in sections 376.779, 376.810 to 376.814, and 376.825 to 376.836, the term "health insurance policy" shall include group coverage] **If permissible under federal parity requirements, coverage for inpatient or residential treatment of alcoholism may be limited to thirty days or to the total number of days that represents the most current standard of care, whichever is greater;**

(5) Coverage for substance use disorder may be limited as follows if permissible under federal parity requirements:

(a) Coverage for outpatient treatment through a nonresidential treatment program or through partial- or full-day program services may be limited to twenty-six days per policy benefit period;

(b) Coverage for residential treatment programs may be limited to twenty-one days per policy benefit period;

47 **(c) Coverage for medical or social setting detoxification may be limited to six days**
48 **per policy benefit period;**
49 **(d) Coverage for substance use disorder may be subject to a separate lifetime**
50 **frequency cap of not less than ten episodes of treatment; except that, such separate lifetime**
51 **frequency cap shall not apply to medical detoxification in a life-threatening situation as**
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determined by the treating physician and s 52 **ubsequently documented within forty-eight**
53 **hours of treatment to the reasonable satisfaction of the health carrier;**
54 **(6) (a) A health benefit plan shall provide coverage for the diagnosis and treatment**
55 **of autism spectrum disorders.**
56 **(b) To the extent that the diagnosis and treatment of autism spectrum disorders are**
57 **not already covered by a health benefit plan, the coverage required under this subdivision**
58 **shall be included in health benefit plans that are delivered, executed, issued, amended,**
59 **adjusted, or renewed on or after August 28, 2009.**
60 **(c) a. Coverage provided under this subdivision is limited to treatment that is**
61 **ordered by the enrollee's treating licensed physician or licensed psychologist under the**
62 **authority granted under such physician's or psychologist's license and in accordance with**
63 **a treatment plan.**
64 **b. If requested by the health carrier or required under the health benefit plan, the**
65 **treatment plan shall include all elements necessary to appropriately pay claims. Such**
66 **elements include, but are not limited to, a diagnosis, proposed treatment by type,**
67 **frequency, and duration of treatment, and goals.**
68 **c. Except for inpatient services, if an individual is receiving treatment for an autism**
69 **spectrum disorder, the health carrier shall have the right to request a review of such**
70 **treatment not more than once every six months, unless the health carrier and treating**
71 **physician or psychologist agree that a more frequent review is necessary. The cost of**
72 **obtaining any review shall be the responsibility of the health carrier.**
73 **(d) a. Health benefit plans shall provide coverage for applied behavior analysis for**

individuals less than twenty-one years of age if the treatment plan indicates that applied behavior analysis is appropriate.

b. If permissible under federal parity requirements, coverage for applied behavior analysis shall be subject to a maximum benefit of seventy-two thousand dollars per year, but shall not be subject to any limits on the number of visits by an individual to an autism service provider for applied behavior analysis. After December 31, 2010, the director of the department of insurance, financial institutions and professional registration shall annually adjust the maximum benefit for applied behavior analysis for inflation using the Medical Care Component of the United States Department of Labor Consumer Price Index for All Urban Consumers. Inflation adjustments shall be announced no later than December first of each year and shall be effective on January first of the following year.

c. Coverage provided under this subdivision for services other than applied behavior analysis shall not be subject to any limits on the number of visits an individual may make to an autism service provider.

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d. To the extent any payments or reimbursements are b eing made for services rendered by a direct implementer for applied behavior analysis, such payments or reimbursements shall be made to:

(i) The person who is supervising the direct implementer who is certified as a board certified behavior analyst by the Behavior Analyst Certification Board; or

(ii) The entity or group for whom such supervising person works or is associated.

e. Payments made by a health carrier on behalf of a covered individual for anything other than applied behavior analysis shall not be applied toward any maximum benefit established under subparagraph b. of this paragraph.

2. As used in this section, the following terms mean:

(1) ["Chemical dependency", the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both] **"Applied behavior analysis", the design,**

implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior;

(2) "Autism service provider":

(a) Any person, entity, or group that provides diagnostic or treatment services for autism spectrum disorders who is licensed or certified by the state of Missouri;

(b) Any person who is certified as a board certified behavior analyst by the Behavior Analyst Certification Board;

(c) Any person, if not licensed or certified, who shall provide, if requested, documented evidence of equivalent education, professional training, and supervised experience in applied behavior analysis when the treatment provided by the autism service provider is applied behavior analysis; or

(d) A direct implementer;

(3) "Autism spectrum disorders", the same meaning as such term is defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association;

(4) "Day program services", a structured intensive day or evening treatment or partial hospitalization program;

(5) "Diagnosis of a mental condition" or "diagnosis of autism spectrum disorders", assessments, evaluations, or tests necessary to diagnose an individual with a mental health condition, including diagnosis of autism spectrum disorders;

(6) "Direct implementer", an y person who provides diagnostic or treatment **services for autism spectrum disorders who is not licensed or certified, as described in paragraphs (a) and (b) of subdivision (2) of this subsection, and is supervised by a person who is certified as a board certified behavior analyst by the Behavior Analyst Certification Board, whether such analyst supervises as an individual or as an employee or in association with an entity or group;**

(7) "Episode", a distinct course of substance use disorder treatment separated by at least thirty days without treatment;

[(2)] **(8)** "Health benefit plan", the same meaning as such term is defined in section 376.1350;
[(3)] **(9)** "Health carrier", the same meaning as such term is defined in section 376.1350;
[(4)] **(10)** "Mental health condition", any condition or disorder defined by categories listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders
[except for chemical dependency];
[(5)] **(11) "Managed care", the determination of availability of coverage under a health benefit plan through the use of clinical standards to determine the medical necessity of an admission or treatment, and the level and type of treatment, and appropriate setting for treatment, with required authorization on a prospective concurrent or retrospective basis, sometimes involving case management;**
(12) "Managed care organization", any financing mechanism or system that manages care delivery for its members or subscribers, including health maintenance organizations and any
other similar health care delivery system or organization;
[(6)] **(13) "Medical detoxification", hospital inpatient or residential medical care to ameliorate acute medical conditions associated with substance use disorder;**
(14) "Nonresidential treatment program", a program involving structured intensive treatment in a nonresidential setting;
(15) "Rate, term, or condition", any lifetime or annual payment limits, deductibles, co-payments, coinsurance, and other cost-sharing requirements, out-of-pocket limits, visit limits,
and any other financial component of a health benefit plan that affects the insured;
(16) "Residential treatment program", a program involving structured intensive treatment in a residential setting;
(17) "Social setting detoxification", a program in a supportive nonhospital setting designed to achieve detoxification without the use of drugs or other medical intervention to establish a plan of treatment and provide for medical referral when necessary;

(18) "Substance use disorder", the psychological or physiological dependence upon and abuse of drugs, including alcohol which is characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning, or both;
(19) "Treatment of a mental condition" or "treatment of autism spectrum disorders", care prescribed, provided, or ordered for an individual diagnosed with a

mental health condition, including an autism spectrum disorder, by a licensed physician or psychologist under the authority granted under such physician's or psychologist's license, if the care is determined to be medically necessary, including but not limited to:

(a) Applied behavior analysis as defined in this subsection;

(b) Psychiatric care. "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

(c) Psychological care. "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

(d) Habilitative or rehabilitative care. "Habilitative or rehabilitative care" means professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, and restore the functioning of an individual;

(e) Therapeutic care. "Therapeutic care" means services provided by licensed speech therapists, occupational therapists, or physical therapists;

(f) Pharmacy care. "Pharmacy care" means medications or nutritional supplements used to address symptoms of a mental health condition, including an autism spectrum disorder, prescribed by a licensed physician and any health-related services necessary to determine the need or effectiveness of the medications or nutritional supplements.

3. This section shall not apply to [a health plan or policy that is individually underwritten or provides such coverage for specific individuals and members of their families pursuant to section 376.779, sections 376.810 to 376.814, and sections 376.825 to 376.836,] a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy **which is not specifically a policy for coverage of a mental health condition,** hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policies of six months or less

duration, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.

4. Notwithstanding any other provision of law to the contrary, all health insurance policies that cover state employees, including the Missouri consolidated health care plan, shall include coverage for mental illness. Multiyear group policies need not comply until the

expiration of their current multiyear term unless the policyholder elects to comply before that time.

5. The provisions of this section shall not be violated if the insurer decides to apply different limits or exclude entirely from coverage the following:

(1) Marital, family, educational, or training services unless medically necessary and clinically appropriate;

(2) Services rendered or billed by a school or halfway house;

(3) Care that is custodial in nature;

(4) Services and supplies that are not immediately nor clinically appropriate; or

(5) Treatments that are considered experimental**; except that, applied behavior analysis shall not be considered experimental**.

6. The director shall grant a policyholder a waiver from the provisions of this section if the policyholder demonstrates to the director by actual experience over any consecutive twenty-four-month period that compliance with this section has increased the cost of the health insurance policy by an amount that results in a two percent increase in premium costs to the policyholder. The director shall promulgate rules establishing a procedure and appropriate standards for making such a demonstration. Any rule or portion of a rule, as that term is defined in section 536.010, RSMo, that is created under the authority delegated in this section shall become effective only if it complies with and is subject to all of the provisions of chapter 536, RSMo, and, if applicable, section 536.028, RSMo. This section and chapter 536, RSMo, are nonseverable and if any of the powers vested with the general assembly pursuant to chapter 536, RSMo, to review, to delay the effective date, or to disapprove and annul a rule are subsequently held unconstitutional, then the grant of rulemaking authority and any rule proposed or adopted after August 28, 2004, shall be invalid and void.

7. A health carrier shall not deny or refuse to issue coverage on, refuse to contract with, or refuse to renew, reissue, or otherwise terminate or restrict coverage on an individual or such individual's dependent solely because such individual or dependent is diagnosed with a mental health condition, including an autism spectrum disorder. A health carrier shall not deny, delay, or reduce payment for otherwise covered services solely because an individual or an individual's dependent is diagnosed with a mental health condition, including an autism spectrum disorder.

8. Any violation of this section shall be considered a level two violation under section 374.049, RSMo.

[376.779. 1. All health plans or policies that are individually underwritten or provide for such coverage for specific individuals and the members of their families, which provide for hospital treatment, shall provide coverage, while confined in a hospital or in a residential or nonresidential facility

certified by the department of mental health, for treatment of alcoholism on the same basis as coverage for any other illness, except that coverage may be limited to thirty days in any policy or contract benefit period. All Missouri individual contracts issued on or after January 1, 2005, shall be subject to this section. Coverage required by this section shall be included in the policy or contract and payment provided as for other coverage in the same policy or contract notwithstanding any construction or relationship of interdependent contracts or plans affecting coverage and payment of reimbursement prerequisites under the policy or contract.

2. Insurers, corporations or groups providing coverage may approve for payment or reimbursement vendors and programs providing services or treatment required by this section. Any vendor or person offering services or treatment subject to the provisions of this section and seeking approval for payment or reimbursement shall submit to the department of mental health a detailed description of the services or treatment program to be offered. The department of mental health shall make copies of such descriptions available to insurers, corporations or groups providing coverage under the provisions of this section. Each insurer, corporation or group providing coverage shall notify the vendor or person offering service or treatment as to its acceptance or rejection for payment or reimbursement; provided, however, payment or reimbursement shall be made for any service or treatment program certified by the department of mental health. Any notice of rejection shall contain a detailed statement of the reasons for rejection and the steps and procedures necessary for acceptance. Amended descriptions of services or treatment programs to be offered may be filed with the department of mental health. Any vendor or person rejected for approval of payment or reimbursement may modify their description and treatment program

and submit copies of the amended description to the department of mental health and to the insurer, corporation or group which rejected the original description.

3. The department of mental health may issue rules necessary to carry out the provisions of this section. No rule or portion of a rule promulgated under the authority of this section shall become effective unless it has been promulgated pursuant to the provisions of section 536.024, RSMo.

4. All substance abuse treatment programs in Missouri receiving funding from the Missouri department of mental health must be certified by the department.

5. This section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policy of six months or less duration, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.]

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[376.810. As used in sections 376.810 to 376.814, the following terms mean:

(1) "Chemical dependency", the psychological or physiological dependence upon and abuse of drugs, including alcohol, characterized by drug tolerance or withdrawal and impairment of social or occupational role functioning or both;

(2) "Community mental health center", a legal entity certified by the department of mental health or accredited by a nationally recognized organization, through which a comprehensive array of mental health services are provided to individuals;

(3) "Day program services", a structured, intensive day or evening treatment or partial hospitalization program, certified by the department of mental health or accredited by a nationally recognized organization;

(4) "Episode", a distinct course of chemical dependency treatment separated by at least thirty days without treatment;

(5) "Health insurance policy", all health insurance policies or contracts that are individually underwritten or provide such coverage for specific individuals and members of their families, which provide for hospital treatment. For the purposes of subsection 2 of section 376.811, "health insurance policy" shall also include any individually underwritten coverage issued by a health maintenance organization. The provisions of sections 376.810 to 376.814 shall not apply to policies which provide coverage for a specified disease only, other than for mental illness or chemical dependency;

(6) "Licensed professional", a licensed physician specializing in the treatment of mental illness, a licensed psychologist, a licensed clinical social worker or a licensed professional counselor. Only prescription rights under this act shall apply to medical physicians and doctors of osteopathy;

(7) "Managed care", the determination of availability of coverage under

a health insurance policy through the use of clinical standards to determine the medical necessity of an admission or treatment, and the level and type of treatment, and appropriate setting for treatment, with required authorization on a prospective, concurrent or retrospective basis, sometimes involving case management;

(8) "Medical detoxification", hospital inpatient or residential medical care to ameliorate acute medical conditions associated with chemical dependency;

(9) "Nonresidential treatment program", a program certified by the department of mental health involving structured, intensive treatment in a nonresidential setting;

(10) "Recognized mental illness", those conditions classified as "mental disorders" in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, but shall not include mental retardation;

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(11) "Residential tre atment program", a program certified by the department of mental health involving residential care and structured, intensive treatment;

(12) "Social setting detoxification", a program in a supportive nonhospital setting designed to achieve detoxification, without the use of drugs or other medical intervention, to establish a plan of treatment and provide for medical referral when necessary.]

[376.811. 1. Every insurance company and health services corporation doing business in this state shall offer in all health insurance policies benefits or coverage for chemical dependency meeting the following minimum standards:

(1) Coverage for outpatient treatment through a nonresidential treatment program, or through partial- or full-day program services, of not less than twenty-six days per policy benefit period;

(2) Coverage for residential treatment program of not less than twenty-one days per policy benefit period;

(3) Coverage for medical or social setting detoxification of not less than six days per policy benefit period;

(4) The coverages set forth in this subsection may be subject to a separate lifetime frequency cap of not less than ten episodes of treatment, except that such separate lifetime frequency cap shall not apply to medical detoxification in a life-threatening situation as determined by the treating physician and subsequently documented within forty-eight hours of treatment to the reasonable satisfaction of the insurance company or health services corporation; and

(5) The coverages set forth in this subsection:

(a) Shall be subject to the same coinsurance, co-payment and deductible factors as apply to physical illness;

(b) May be administered pursuant to a managed care program established by the insurance company or health services corporation; and

(c) May deliver covered services through a system of contractual arrangements with one or more providers, hospitals, nonresidential or residential

treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri.

2. In addition to the coverages set forth in subsection 1 of this section, every insurance company, health services corporation and health maintenance organization doing business in this state shall offer in all health insurance policies, benefits or coverages for recognized mental illness, excluding chemical dependency, meeting the following minimum standards:

(1) Coverage for outpatient treatment, including treatment through partial- or full-day program services, for mental health services for a recognized mental illness rendered by a licensed professional to the same extent as any other illness;

(2) Coverage for residential treatment programs for the therapeutic care and treatment of a recognized mental illness when prescribed by a licensed professional and rendered in a psychiatric residential treatment center licensed by the department of mental health or accredited by the Joint Commission on Accreditation of Hospitals to the same extent as any other illness;

(3) Coverage for inpatient hospital treatment for a recognized mental illness to the same extent as for any other illness, not to exceed ninety days per year;

(4) The coverages set forth in this subsection shall be subject to the same coinsurance, co-payment, deductible, annual maximum and lifetime maximum factors as apply to physical illness; and

(5) The coverages set forth in this subsection may be administered pursuant to a managed care program established by the insurance company, health services corporation or health maintenance organization, and covered services may be delivered through a system of contractual arrangements with one or more providers, community mental health centers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri.

3. The offer required by sections 376.810 to 376.814 may be accepted or rejected by the group or individual policyholder or contract holder and, if accepted, shall fully and completely satisfy and substitute for the coverage under section 376.779. Nothing in sections 376.810 to 376.814 shall prohibit an insurance company, health services corporation or health maintenance organization from including all or part of the coverages set forth in sections 376.810 to 376.814 as standard coverage in their policies or contracts issued in this state.

4. Every insurance company, health services corporation and health maintenance organization doing business in this state shall offer in all health insurance policies mental health benefits or coverage as part of the policy or as a supplement to the policy. Such mental health benefits or coverage shall include at least two sessions per year to a licensed psychiatrist, licensed psychologist, licensed professional counselor, or licensed clinical social worker acting within

the scope of such license and under the following minimum standards:
(1) Coverage and benefits in this subsection shall be for the purpose of diagnosis or assessment, but not dependent upon findings; and
(2) Coverage and benefits in this subsection shall not be subject to any conditions of preapproval, and shall be deemed reimbursable as long as the provisions of this subsection are satisfied; and
(3) Coverage and benefits in this subsection shall be subject to the same coinsurance, co-payment and deductible factors as apply to regular office visits under coverages and benefits for physical illness.

5. If the group or individual policyholder or contract holder rejects the offer required by this section, then the coverage shall be governed by the mental health and chemical dependency insurance act as provided in sections 376.825 to 376.836.
6. This section shall not apply to a supplemental insurance policy, including a life care contract, accident-only policy, specified disease policy, hospital policy providing a fixed daily benefit only, Medicare supplement policy, long-term care policy, hospitalization-surgical care policy, short-term major medical policy of six months or less duration, or any other supplemental policy as determined by the director of the department of insurance, financial institutions and professional registration.]

[376.814. 1. The department of insurance, financial institutions and professional registration shall promulgate rules and regulations, pursuant to section 376.982 and chapter 536, RSMo, and the department of mental health shall advise the department of insurance, financial institutions and professional registration on the promulgation of said rules and regulations as they pertain to the development and implementation of all standards and guidelines for managed care as set out in sections 376.810 to 376.814, to ensure that all mental health services provided pursuant to sections 376.810 to 376.814 are provided in accordance with chapters 197, 334, 337, RSMo, and section 630.655, RSMo, provided however, that nothing in this act shall prohibit department of mental health licensed or certified facilities or programs from using qualified mental health professionals or other specialty staff persons.
2. Any person who serves or served on a quality assessment and assurance committee required under 42 U.S.C. Sec. 1396r(b)(1)(B) and 42 CFR Sec. 483.75(r), or as amended, shall be immune from civil liability only for acts done directly as a member of such committee so long as the acts are performed in good faith, without malice and are required by the activities of such committee as defined in 42 CFR Sec. 483.75(r).]

[376.825. Sections 376.825 to 376.840 shall be known and may be cited as the "Mental Health and Chemical Dependency Insurance Act".]

[376.826. For the purposes of sections 376.825 to 376.836 the following terms shall mean:

(1) "Director", the director of the department of insurance, financial institutions and professional registration;
(2) "Health insurance policy" or "policy", all health insurance policies or contracts that are individually underwritten or provide such coverage for specific individuals and members of their families, which provide for hospital treatments. The term shall also include any individually underwritten coverage issued by a health maintenance organization. The provisions of sections 376.825 to 376.836

shall not apply to policies which provide coverage for a specified disease only, other than for mental illness or chemical dependency;
(3) "Insurer", an entity licensed by the department of insurance, financial institutions and professional registration to offer a health insurance policy;
(4) "Mental illness", the following disorders contained in the International Classification of Diseases (ICD-9-CM):
(a) Schizophrenic disorders and paranoid states (295 and 297, except 297.3);
(b) Major depression, bipolar disorder, and other affective psychoses (296);
(c) Obsessive compulsive disorder, post-traumatic stress disorder and other major anxiety disorders (300.0, 300.21, 300.22, 300.23, 300.3 and 309.81);
(d) Early childhood psychoses, and other disorders first diagnosed in childhood or adolescence (299.8, 312.8, 313.81 and 314);
(e) Alcohol and drug abuse (291, 292, 303, 304, and 305, except 305.1); and
(f) Anorexia nervosa, bulimia and other severe eating disorders (307.1, 307.51, 307.52 and 307.53);
(g) Senile organic psychotic conditions (290);
(5) "Rate", "term", or "condition", any lifetime limits, annual payment limits, episodic limits, inpatient or outpatient service limits, and out-of-pocket limits. This definition does not include deductibles, co-payments, or coinsurance prior to reaching any maximum out-of-pocket limit.
Any out-of-pocket limit under a policy shall be comprehensive for coverage of mental illness and physical conditions.]

[376.827. 1. Nothing in this bill shall be construed as requiring the coverage of mental illness.
2. Except for the coverage required pursuant to subsection 1 of section 376.779, and the offer of coverage required pursuant to sections 376.810 through 376.814, if any of the mental illness disorders enumerated in subdivision (4) of section 376.826 are provided by the health insurance policy, the coverage provided shall include all the disorders enumerated in subdivision (4) of section 376.826 and shall not establish any rate, term, or condition that places a greater financial burden on an insured for access to evaluation and treatment for mental illness than for access to evaluation and treatment for physical conditions, generally, except that alcohol and other drug abuse services shall have a minimum of thirty days total inpatient treatment and a minimum of twenty total

visits for outpatient treatment for each year of coverage. A lifetime limit equal to four times such annual limits may be imposed. The days allowed for inpatient treatment can be converted for use for outpatient treatment on a two-for-one basis.

3. Deductibles, co-payment or coinsurance amounts for access to evaluation and treatment for mental illness shall not be unreasonable in relation to the cost of services provided.

4. A health insurance policy that is a federally qualified plan of benefits shall be construed to be in compliance with sections 376.825 to 376.836 if the policy is issued by a federally qualified health maintenance organization and the federally qualified health maintenance organization offered mental health coverage as required by sections 376.825 to 376.836. If such coverage is rejected, the federally qualified health maintenance organization shall, at a minimum, provide coverage for mental health services as a basic health service as required by the Federal Public Health Service Act, 42 U.S.C. Section 300e., et seq.

5. Health insurance policies that provide mental illness benefits pursuant to sections 376.825 to 376.840 shall be deemed to be in compliance with the requirements of subsection 1 of section 376.779.

6. The director may disapprove any policy that the director determines to be inconsistent with the purposes of this section.]

[376.830. 1. The coverages set forth in sections 376.825 to 376.840 may be administered pursuant to a managed care program established by the insurance company, health services corporation or health maintenance organization, and covered services may be delivered through a system of contractual arrangements with one or more licensed providers, community mental health centers, hospitals, nonresidential or residential treatment programs, or other mental health service delivery entities certified by the department of mental health, or accredited by a nationally recognized organization, or licensed by the state of Missouri. Nothing in this section shall authorize any unlicensed provider to provide covered services.

2. An insurer may use a case management program for mental illness benefits to evaluate and determine medically necessary and clinically appropriate care and treatment for each patient.

3. Nothing in sections 376.825 to 376.840 shall be construed to require a managed care plan as defined by section 354.600, RSMo, when providing coverage for benefits governed by sections 376.825 to 376.840, to cover services rendered by a provider other than a participating provider, except for the coverage pursuant to subsection 4 of section 376.811. An insurer may contract for benefits provided in sections 376.825 to 376.840 with a managing entity or group of providers for the management and delivery of services for benefits governed by sections 376.825 to 376.840.]

[376.833. 1. The provisions of section 376.827 shall not be violated if

2 the insurer decides to apply different limits or exclude entirely from coverage the
3 following:
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(1) Marital, fa 4 mily, educational, or training services unless medically
5 necessary and clinically appropriate;
6 (2) Services rendered or billed by a school or halfway house;
7 (3) Care that is custodial in nature;
8 (4) Services and supplies that are not medically necessary nor clinically
9 appropriate; or
10 (5) Treatments that are considered experimental.
11 2. The director shall grant a policyholder a waiver from the provisions
12 of section 376.827 if the policyholder demonstrates to the director by actual
13 experience over any consecutive twenty-four-month period that compliance with
14 sections 376.825 to 376.840 has increased the cost of the health insurance policy
15 by an amount that results in a two percent increase in premium costs to the
16 policyholder.]
17
[376.836. 1. The provisions of sections 376.825 to 376.836 apply to
2 applications for coverage made on or after January 1, 2005, and to health
3 insurance policies issued or renewed on or after such date to residents of this
4 state. Multiyear group policies need not comply until the expiration of their
5 current multiyear term unless the policyholder elects to comply before that time.
6 2. This section shall not apply to a supplemental insurance policy,
7 including a life care contract, accident-only policy, specified disease policy,
8 hospital policy providing a fixed daily benefit only, Medicare supplement policy,
9 long-term care policy, hospitalization-surgical care policy, short-term major
10 medical policy of six months or less duration, or any other supplemental policy
11 as determined by the director of the department of insurance, financial
12 institutions and professional registration.
13 3. The provisions of sections 376.825 to 376.836 shall expire on January

14 1, 2011.]

MONTANA Senate Bill No. 0234:

http://data.opi.mt.gov/bills/2009/BillPDF/SB0234.pdf

61st Legislature SB0234
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AN ACT REQUIRING INSURANCE COVERAGE FOR AUTISM SPECTRUM DISORDERS; AMENDING
SECTIONS 33-1-102, 33-22-706, 33-31-111, AND 33-35-306, MCA; AND PROVIDING A DELAYED EFFECTIVE
DATE AND AN APPLICABILITY DATE.
BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Coverage of autism spectrum disorders. (1) Each group disability policy, certificate of
insurance, or membership contract that is delivered, issued for delivery, renewed, extended, or modified in this
state must provide coverage for diagnosis and treatment of autism spectrum disorders for a covered child 18
years of age or younger.
(2) Coverage under this section must be provided to a child who is diagnosed with one of the following
disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:
(a) autistic disorder;
(b) Asperger's disorder; or
(c) pervasive developmental disorder not otherwise specified.
(3) (a) Coverage under this section must include:
(i) habilitative or rehabilitative care that is prescribed, provided, or ordered by a licensed physician or
licensed psychologist, including but not limited to professional, counseling, and guidance services and treatment
programs that are medically necessary to develop and restore, to the maximum extent practicable, the functioning
of the covered child;
(ii) medications prescribed by a physician licensed under Title 37, chapter 3;
(iii) psychiatric or psychological care; and
(iv) therapeutic care that is provided by a speech-language pathologist, audiologist, occupational therapist, or physical therapist licensed in this state.
(b) (i) Habilitative and rehabilitative care includes medically necessary interactive therapies derived from
evidence-based research, including applied behavior analysis, which is also known as Lovaas therapy, discrete
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trial training, pivotal response training, intensive intervention programs, and early intensive behavioral
intervention.
(ii) Applied behavior analysis covered under this section must be provided by an individual who is licensed by the behavior analyst certification board or is certified by the department of public health and human
services as a family support specialist with an autism endorsement.
(4) (a) Coverage for treatment of autism spectrum disorders under this section may be limited to a maximum benefit of:
(i) $50,000 a year for a child 8 years of age or younger; and
(ii) $20,000 a year for a child 9 years of age through 18 years of age.
(b) Benefits provided under this section may not be construed as limiting physical health benefits that
are otherwise available to the covered child.
(5) (a) Coverage under this section may be subject to deductibles, coinsurance, and copayment provisions.
(b) Special deductible, coinsurance, copayment, or other limitations that are not generally applicable to
other medical care covered under the plan may not be imposed on the coverage for autism spectrum disorders
provided for under this section.
(6) When treatment is expected to require continued services, the insurer may request that the treating

physician provide a treatment plan consisting of diagnosis, proposed treatment by type and frequency, the
anticipated duration of treatment, the anticipated outcomes stated as goals, and the reasons the treatment is
medically necessary. The treatment plan must be based on evidence-based screening criteria. The insurer may
ask that the treatment plan be updated every 6 months.
(7) As used in this section, "medically necessary" means any care, treatment, intervention, service, or
item that is prescribed, provided, or ordered by a physician or psychologist licensed in this state and that will or
is reasonably expected to:
(a) prevent the onset of an illness, condition, injury, or disability;
(b) reduce or improve the physical, mental, or developmental effects of an illness, condition, injury, or
disability; or
(c) assist in achieving maximum functional capacity in performing daily activities, taking into account both
the functional capacity of the recipient and the functional capacities that are appropriate for a child of the same
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age.
(8) This section applies to the state employee group insurance program, the university system employee
group insurance program, any employee group insurance program of a city, town, school district, or other political
subdivision of this state, and any self-funded multiple employer welfare arrangement that is not regulated by the
Employee Retirement Income Security Act of 1974, 29 U.S.C. 1001, et seq.
(9) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, specific disease, or long-term care policies.
Section 2. Section 33-1-102, MCA, is amended to read:
**"33-1-102. Compliance required -- exceptions -- health service corporations -- health maintenance
organizations -- governmental insurance programs -- service contracts.** (1) A person may not transact a
business of insurance in Montana or a business relative to a subject resident, located, or to be performed in
Montana without complying with the applicable provisions of this code.
(2) The provisions of this code do not apply with respect to:
(a) domestic farm mutual insurers as identified in chapter 4, except as stated in chapter 4;
(b) domestic benevolent associations as identified in chapter 6, except as stated in chapter 6; and
(c) fraternal benefit societies, except as stated in chapter 7.
(3) This code applies to health service corporations as prescribed in 33-30-102. The existence of the
corporations is governed by Title 35, chapter 2, and related sections of the Montana Code Annotated.
(4) This code does not apply to health maintenance organizations or to managed care community networks, as defined in 53-6-702, to the extent that the existence and operations of those organizations are
governed by chapter 31 or to the extent that the existence and operations of those networks are governed by Title
53, chapter 6, part 7. The department of public health and human services is responsible to protect the interests

of consumers by providing complaint, appeal, and grievance procedures relating to managed care community
networks and health maintenance organizations under contract to provide services under Title 53, chapter 6.
(5) This code does not apply to workers' compensation insurance programs provided for in Title 39,
chapter 71, parts 21 and 23, and related sections.
(6) The department of public health and human services may limit the amount, scope, and duration of
services for programs established under Title 53 that are provided under contract by entities subject to this title.
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The department of public health and human services may establish more restrictive eligibility requirements and
fewer services than may be required by this title.
(7) This Except as otherwise provided in Title 33, chapter 22, this code does not apply to the state employee group insurance program established in Title 2, chapter 18, part 8.
(8) This code does not apply to insurance funded through the state self-insurance reserve fund provided
for in 2-9-202.
(9) (a) This Except as otherwise provided in Title 33, chapter 22, this code does not apply to any arrangement, plan, or interlocal agreement between political subdivisions of this state in which the political
subdivisions undertake to separately or jointly indemnify one another by way of a pooling, joint retention,
deductible, or self-insurance plan.
(b) This Except as otherwise provided in Title 33, chapter 22, this code does not apply to any arrangement, plan, or interlocal agreement between political subdivisions of this state or any arrangement, plan,
or program of a single political subdivision of this state in which the political subdivision provides to its officers,
elected officials, or employees disability insurance or life insurance through a self-funded program.
(10) (a) This code does not apply to the marketing of, sale of, offering for sale of, issuance of, making
of, proposal to make, and administration of a service contract.
(b) A "service contract" means a contract or agreement for a separately stated consideration for a specific duration to perform the repair, replacement, or maintenance of property or to indemnify for the repair,
replacement, or maintenance of property if an operational or structural failure is due to a defect in materials or
manufacturing or to normal wear and tear, with or without an additional provision for incidental payment or
indemnity under limited circumstances, including but not limited to towing, rental, and emergency road service.
A service contract may provide for the repair, replacement, or maintenance of property for damage resulting from
power surges or accidental damage from handling. A service contract does not include motor club service as
defined in 61-12-301.
(11) (a) Subject to 33-18-201 and 33-18-242, this code does not apply to insurance for ambulance
services sold by a county, city, or town or to insurance sold by a third party if the county, city, or town is liable for
the financial risk under the contract with the third party as provided in 7-34-103.

(b) If the financial risk for ambulance service insurance is with an entity other than the county, city, or
town, the entity is subject to the provisions of this code."
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Section 3. Section 33-22-706, MCA, is amended to read:
"33-22-706. (Temporary) Coverage for severe mental illness -- definition. (1) Except as provided
in 33-22-262(3) and subject to 33-22-262(4), a policy or certificate of health insurance or disability insurance that
is delivered, issued for delivery, renewed, extended, or modified in this state must provide a level of benefits for
the necessary care and treatment of severe mental illness, as defined in subsection (6), that is no less favorable
than that level provided for other physical illness generally. Benefits for treatment of severe mental illness may
be subject to managed care provisions contained in the policy or certificate.
(2) Benefits provided pursuant to subsection (1) include but are not limited to:
(a) inpatient hospital services;
(b) outpatient services;
(c) rehabilitative services;
(d) medication;
(e) services rendered by a licensed physician, licensed advanced practice registered nurse with a specialty in mental health, licensed social worker, licensed psychologist, or licensed professional counselor when
those services are part of a treatment plan recommended and authorized by a licensed physician; and
(f) services rendered by a licensed advanced practice registered nurse with prescriptive authority and
specializing in mental health.
(3) Benefits provided pursuant to this section must be included when determining maximum lifetime
benefits, copayments, and deductibles.
(4) (a) This section applies to health service benefits provided by:
(i) individual and group health and disability insurance;
(ii) individual and group hospital or medical expense insurance;
(iii) medical subscriber contracts;
(iv) membership contracts of a health service corporation;
(v) health maintenance organizations; and
(vi) the comprehensive health association created by 33-22-1503.
(b) This section does not apply to the following coverages:
(i) blanket;
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(ii) short-term travel;
(iii) accident only;
(iv) limited or specific disease;
(v) Title XVIII of the Social Security Act (medicare); or
(vi) any other similar coverage under state or federal government plans.
(5) This section does not limit benefits for an illness or condition that does not constitute a severe mental
illness, as defined in subsection (6), but that does constitute a mental illness, as defined in 33-22-702.
(6) As used in this section, "severe mental illness" means the following disorders as defined by the
American psychiatric association:

(a) schizophrenia;
(b) schizoaffective disorder;
(c) bipolar disorder;
(d) major depression;
(e) panic disorder;
(f) obsessive-compulsive disorder; and; and
(g) autism (g) autism.
(7) Coverage for a child with autism who is 18 years of age or younger must comply with [section 1(3)
through (5)] if the child is diagnosed with:
(a) autistic disorder;
(b) Asperger's disorder; or
(c) pervasive developmental disorder not otherwise specified. (Terminates June 30, 2009--sec. 14, Ch.
325, L. 2003.)

33-22-706. (Effective July 1, 2009) Coverage for severe mental illness -- definition. (1) A policy or
certificate of health insurance or disability insurance that is delivered, issued for delivery, renewed, extended, or
modified in this state must provide a level of benefits for the necessary care and treatment of severe mental
illness, as defined in subsection (6), that is no less favorable than that level provided for other physical illness
generally. Benefits for treatment of severe mental illness may be subject to managed care provisions contained
in the policy or certificate.
(2) Benefits provided pursuant to subsection (1) include but are not limited to:
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(a) inpatient hospital services;
(b) outpatient services;
(c) rehabilitative services;
(d) medication;
(e) services rendered by a licensed physician, licensed advanced practice registered nurse with a specialty in mental health, licensed social worker, licensed psychologist, or licensed professional counselor when
those services are part of a treatment plan recommended and authorized by a licensed physician; and
(f) services rendered by a licensed advanced practice registered nurse with prescriptive authority and
specializing in mental health.
(3) Benefits provided pursuant to this section must be included when determining maximum lifetime
benefits, copayments, and deductibles.
(4) (a) This section applies to health service benefits provided by:
(i) individual and group health and disability insurance;
(ii) individual and group hospital or medical expense insurance;
(iii) medical subscriber contracts;
(iv) membership contracts of a health service corporation;
(v) health maintenance organizations; and
(vi) the comprehensive health association created by 33-22-1503.
(b) This section does not apply to the following coverages:
(i) blanket;
(ii) short-term travel;
(iii) accident only;
(iv) limited or specific disease;

(v) Title XVIII of the Social Security Act (medicare); or
(vi) any other similar coverage under state or federal government plans.
(5) This section does not limit benefits for an illness or condition that does not constitute a severe mental
illness, as defined in subsection (6), but that does constitute a mental illness, as defined in 33-22-702.
(6) As used in this section, "severe mental illness" means the following disorders as defined by the
American psychiatric association:
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(a) schizophrenia;
(b) schizoaffective disorder;
(c) bipolar disorder;
(d) major depression;
(e) panic disorder;
(f) obsessive-compulsive disorder; and; and
(g) autism (g) autism.
(7) Coverage for a child with autism who is 18 years of age or younger must comply with [section 1(3)
through (5)] if the child is diagnosed with:
(a) autistic disorder;
(b) Asperger's disorder; or
(c) pervasive developmental disorder not otherwise specified."
Section 4. Section 33-31-111, MCA, is amended to read:
"33-31-111. (Temporary) Statutory construction and relationship to other laws. (1) Except as
otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health
maintenance organization authorized to transact business under this chapter. This provision does not apply to
an insurer or health service corporation licensed and regulated pursuant to the insurance or health service
corporation laws of this state except with respect to its health maintenance organization activities authorized and
regulated pursuant to this chapter.
(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its
representatives is not a violation of any law relating to solicitation or advertising by health professionals.
(3) A health maintenance organization authorized under this chapter is not practicing medicine and is
exempt from Title 37, chapter 3, relating to the practice of medicine.
(4) This chapter does not exempt a health maintenance organization from the applicable certificate of
need requirements under Title 50, chapter 5, parts 1 and 3.
(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary
interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704.
A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701
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through 33-3-704.
(6) This section does not exempt a health maintenance organization from:

(a) prohibitions against interference with certain communications as provided under chapter 1, part 8;
(b) the provisions of Title 33, chapter 22, part 19;
(c) the requirements of 33-22-134 and 33-22-135;
(d) network adequacy and quality assurance requirements provided under chapter 36, except as provided in 33-22-262; or
(e) the requirements of Title 33, chapter 18, part 9.
(7) Except as provided in 33-22-262, the provisions of Title 33, chapter 1, parts 12 and 13, Title 33,
chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212, 33-3-422, 33-3-431, 33-15-308, Title 33, chapter 17, Title
33, chapter 19, 33-22-107, 33-22-129, 33-22-131, 33-22-136, 33-22-141, 33-22-142, 33-22-152, 33-22-244,
33-22-246, 33-22-247, 33-22-514, [section 1], 33-22-521, 33-22-523, 33-22-524, 33-22-526, and 33-22-706 apply
to health maintenance organizations. (Terminates June 30, 2009--sec. 14, Ch. 325, L. 2003.)
33-31-111. (Effective July 1, 2009) Statutory construction and relationship to other laws. (1) Except
as otherwise provided in this chapter, the insurance or health service corporation laws do not apply to a health
maintenance organization authorized to transact business under this chapter. This provision does not apply to
an insurer or health service corporation licensed and regulated pursuant to the insurance or health service
corporation laws of this state except with respect to its health maintenance organization activities authorized and
regulated pursuant to this chapter.
(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority or its
representatives is not a violation of any law relating to solicitation or advertising by health professionals.
(3) A health maintenance organization authorized under this chapter is not practicing medicine and is
exempt from Title 37, chapter 3, relating to the practice of medicine.
(4) This chapter does not exempt a health maintenance organization from the applicable certificate of
need requirements under Title 50, chapter 5, parts 1 and 3.
(5) This section does not exempt a health maintenance organization from the prohibition of pecuniary
interest under 33-3-308 or the material transaction disclosure requirements under 33-3-701 through 33-3-704.
A health maintenance organization must be considered an insurer for the purposes of 33-3-308 and 33-3-701
through 33-3-704.

(6) This section does not exempt a health maintenance organization from:
(a) prohibitions against interference with certain communications as provided under chapter 1, part 8;
(b) the provisions of Title 33, chapter 22, part 19;
(c) the requirements of 33-22-134 and 33-22-135;
(d) network adequacy and quality assurance requirements provided under chapter 36; or
(e) the requirements of Title 33, chapter 18, part 9.
(7) Title 33, chapter 1, parts 12 and 13, Title 33, chapter 2, part 19, 33-2-1114, 33-2-1211, 33-2-1212,

33-3-422, 33-3-431, 33-15-308, Title 33, chapter 17, Title 33, chapter 19, 33-22-107, 33-22-129, 33-22-131,
33-22-136, 33-22-141, 33-22-142, 33-22-152, 33-22-244, 33-22-246, 33-22-247, 33-22-514, [section 1],
33-22-521, 33-22-523, 33-22-524, 33-22-526, and 33-22-706 apply to health maintenance organizations."

Section 5. Section 33-35-306, MCA, is amended to read:

"33-35-306. Application of insurance code to arrangements. (1) In addition to this chapter, self-funded multiple employer welfare arrangements are subject to the following provisions:
(a) 33-1-111;
(b) Title 33, chapter 1, part 4, but the examination of a self-funded multiple employer welfare arrangement is limited to those matters to which the arrangement is subject to regulation under this chapter;
(c) Title 33, chapter 1, part 7;
(d) 33-3-308;
(e) Title 33, chapter 18; except 33-18-242;
(f) Title 33, chapter 19;
(g) 33-22-107, 33-22-131, 33-22-134, 33-22-135, 33-22-141, 33-22-142, and 33-22-152; and
(h) 33-22-512, [section 1], 33-22-525, and 33-22-526.
(2) Except as provided in this chapter, other provisions of Title 33 do not apply to a self-funded multiple
employer welfare arrangement that has been issued a certificate of authority that has not been revoked."

Section 6. Codification instruction. [Section 1] is intended to be codified as an integral part of Title
33, chapter 22, part 5, and the provisions of Title 33, chapter 22, apply to [section 1].
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NEVADA ASSEMBLY BILL 162: http://www.autismvotes.org/atf/cf/%7B2A179B73-96E2-44C3-8816-1B1C0BE5334B%7D/NV%20AB162-%20as%20enrolled.pdf

Assembly Bill No. 162–Assemblymen Ohrenschall, Buckley, Leslie, Woodbury, Conklin; Aizley, Anderson, Arberry, Atkinson, Bobzien, Carpenter, Christensen, Claborn, Denis, Dondero Loop, Goicoechea, Grady, Hambrick, Hardy, Hogan, Horne, Kihuen, Kirkpatrick, Koivisto, Manendo, Mastroluca, McClain, Mortenson, Munford, Oceguera, Parnell, Pierce, Segerblom, Smith and Stewart
Joint Sponsors: Senators Horsford, Schneider, Lee, Wiener, Townsend; Amodei, Breeden, Care, Carlton, Coffin, Copening, Nolan, Parks, Rhoads and Woodhouse
CHAPTER.....
AN ACT relating to insurance; requiring certain policies of health insurance and health care plans to provide an option of coverage for screening for and treatment of autism; authorizing the Board of Psychological Examiners to license behavior analysts and assistant behavior analysts and to certify autism behavior interventionists; increasing the size of the Board of Psychological Examiners from five members to seven members; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law requires certain public and private health care plans and policies of insurance to provide coverage for certain procedures, including colorectal cancer screenings, cytological screening tests and mammograms, in certain circumstances. (NRS 287.027, 287.04335, 689A.04042, 689A.0405, 689B.0367, 689B.0374, 695B.1907, 695B.1912, 695C.1731, 695C.1735, 695G.168) Existing law also requires employers to provide certain benefits to employees, including coverage for the procedures required to be covered by insurers, if the employer provides health benefits for its employees. (NRS 608.1555) **Sections 1-10.5** of this bill require certain health care plans and policies of insurance to also provide an option or a requirement, as applicable, of coverage for the screening for, including the diagnosis of, and the treatment of autism spectrum disorders in certain circumstances.

Sections 12-12.4 and 12.7-14.5 of this bill provide for the licensure of behavior analysts and assistant behavior analysts and the certification of autism behavior interventionists by the Board of Psychological Examiners.

Sections 12.5 and 12.6 of this bill increase the size of the Board of Psychological Examiners from five members to seven members, adding one member who is a licensed behavior analyst and one member who represents the interests of persons or agencies that regularly provide health care to patients who are indigent, uninsured or unable to afford health care.

The provisions of this bill apply prospectively to any policy of insurance or health care plan issued or renewed on or after January 1, 2011, or July 1, 2011, as applicable.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health benefit plan must provide an option of coverage for screening for and diagnosis of autism spectrum disorders and for treatment of autism spectrum disorders for persons covered by the policy under the age of 18 or, if enrolled in high school, until the person reaches the age of 22.

2. Optional coverage provided pursuant to this section must be subject to:

(a) A maximum benefit of not less than $36,000 per year for applied behavior analysis treatment; and

(b) Copayment, deductible and coinsurance provisions and any other general exclusions or limitations of a policy of health insurance to the same extent as other medical services or prescription drugs covered by the policy.

3. A health benefit plan that offers or issues a policy of health insurance which provides coverage for outpatient care shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period for optional coverage for outpatient care related to autism spectrum disorders than is required for other outpatient care covered by the policy; or

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use in the future any of the services listed in subsection 1.

4. Except as provided in subsections 1 and 2, an insurer who

offers optional coverage pursuant to subsection 1 shall not limit the number of visits an insured may make to any person, entity or group for treatment of autism spectrum disorders.
5. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy or therapeutic care that is:
(a) Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and
(b) Provided for a person diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist or behavior analyst.

_ An insurer may request a copy of and review a treatment plan created pursuant to this subsection.
6. Nothing in this section shall be construed as requiring an insurer to provide reimbursement to an early intervention agency or school for services delivered through early intervention or school services.
7. As used in this section:
(a) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.
(b) "Autism spectrum disorders" means a neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified.
(c) "Behavioral therapy" means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or certified autism behavior interventionist.
(d) "Certified autism behavior interventionist" means a person who is certified as an autism behavior interventionist by the Board of Psychological Examiners and who provides behavior therapy under the supervision of:
(1) A licensed psychologist;
(2) A licensed behavior analyst; or
(3) A licensed assistant behavior analyst.
(e) "Evidence-based research" means research that applies

rigorous, systematic and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.
(f) "Habilitative or rehabilitative care" means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.
(g) "Licensed assistant behavior analyst" means a person who holds current certification or meets the standards to be certified as a board certified assistant behavior analyst issued by the Behavior

Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Board of Psychological Examiners and who provides behavioral therapy under the supervision of a licensed behavior analyst or psychologist.
(h) "Licensed behavior analyst" means a person who holds current certification or meets the standards to be certified as a board certified behavior analyst or a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, and who is licensed as a behavior analyst by the Board of Psychological Examiners.
(i) "Prescription care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.
(j) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
(k) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
(l) "Screening for autism spectrum disorders" means medically necessary assessments, evaluations or tests to screen and diagnose whether a person has an autism spectrum disorder.
(m) "Therapeutic care" means services provided by licensed or certified speech pathologists, occupational therapists and physical therapists.
(n) "Treatment plan" means a plan to treat an autism spectrum disorder that is prescribed by a licensed physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst.
Sec. 2. NRS 689A.330 is hereby amended to read as follows:
689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has

informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive [.] , ***and section 1 of this act.***

Sec. 3. Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health benefit plan must provide coverage for screening for and diagnosis of autism spectrum disorders and for treatment of autism spectrum disorders to persons covered by the policy of group health insurance under the age of 18 or, if enrolled in high school, until the person reaches the age of 22.

2. Coverage provided under this section is subject to:

(a) A maximum benefit of $36,000 per year for applied behavior analysis treatment; and

(b) Copayment, deductible and coinsurance provisions and any other general exclusion or limitation of a policy of group health insurance to the same extent as other medical services or prescription drugs covered by the policy.

3. A health benefit plan that offers or issues a policy of group health insurance which provides coverage for outpatient care shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period for coverage for outpatient care related to autism spectrum disorders than is required for other outpatient care covered by the policy; or

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use in the future any of the services listed in subsection 1.

4. Except as provided in subsections 1 and 2, an insurer shall not limit the number of visits an insured may make to any person, entity or group for treatment of autism spectrum disorders.

5. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy or therapeutic care that is:

(a) Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and

(b) Provided for a person diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist or behavior analyst.

_ An insurer may request a copy of and review a treatment plan created pursuant to this subsection.

6. A policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after

January 1, 2011, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with subsections 1 or 2 is void.

7. Nothing in this section shall be construed as requiring an insurer to provide reimbursement to an early intervention agency or school for services delivered through early intervention or school services.

8. As used in this section:

(a) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

(b) "Autism spectrum disorders" means a neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified.

(c) "Behavioral therapy" means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or certified autism behavior interventionist.

(d) "Certified autism behavior interventionist" means a person who is certified as an autism behavior interventionist by the Board of Psychological Examiners and who provides behavior therapy under the supervision of:

(1) A licensed psychologist;

(2) A licensed behavior analyst; or

(3) A licensed assistant behavior analyst.

(e) "Evidence-based research" means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.

(f) "Habilitative or rehabilitative care" means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.

(g) "Licensed assistant behavior analyst" means a person who holds current certification or meets the standards to be certified as

a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Board of Psychological Examiners and who provides behavioral therapy under the supervision of a licensed behavior analyst or psychologist.

(h) "Licensed behavior analyst" means a person who holds current certification or meets the standards to be certified as a board certified behavior analyst or a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and who is licensed as a behavior analyst by the Board of Psychological Examiners.

(i) "Prescription care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

(j) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

(k) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

(l) "Screening for autism spectrum disorders" means medically necessary assessments, evaluations or tests to screen and diagnose whether a person has an autism spectrum disorder.

(m) "Therapeutic care" means services provided by licensed or certified speech pathologists, occupational therapists and physical therapists.

(n) "Treatment plan" means a plan to treat an autism spectrum disorder that is prescribed by a licensed physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst.

Sec. 3.5. Chapter 689C of NRS is hereby amended by adding thereto a new section to read as follows:

1. A health benefit plan must provide coverage for screening for and diagnosis of autism spectrum disorders and for treatment of autism spectrum disorders to persons covered by the health benefit plan under the age of 18 or, if enrolled in high school, until the person reaches the age of 22.

2. Coverage provided under this section is subject to:

(a) A maximum benefit of $36,000 per year for applied

behavior analysis treatment; and
(b) Copayment, deductible and coinsurance provisions and any other general exclusion or limitation of a health benefit plan to the same extent as other medical services or prescription drugs covered by the plan.
3. A health benefit plan that offers or issues a policy of group health insurance which provides coverage for outpatient care shall not:
(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period for coverage for outpatient care related to autism spectrum disorders than is required for other outpatient care covered by the plan; or
(b) Refuse to issue a health benefit plan or cancel a health benefit plan solely because the person applying for or covered by the plan uses or may use in the future any of the services listed in subsection 1.
4. Except as provided in subsections 1 and 2, a carrier shall not limit the number of visits an insured may make to any person, entity or group for treatment of autism spectrum disorders.
5. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy or therapeutic care that is:
(a) Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and
(b) Provided for a person diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist or behavior analyst.
_ A carrier may request a copy of and review a treatment plan created pursuant to this subsection.
6. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2011, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with subsections 1 or 2 is void.
7. Nothing in this section shall be construed as requiring a carrier to provide reimbursement to an early intervention agency or school for services delivered through early intervention or school services.

8. As used in this section:
(a) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and

functional analysis of the relations between environment and behavior.
(b) "Autism spectrum disorders" means a neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified.
(c) "Behavioral therapy" means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or certified autism behavior interventionist.
(d) "Certified autism behavior interventionist" means a person who is certified as an autism behavior interventionist by the Board of Psychological Examiners and who provides behavior therapy under the supervision of:
(1) A licensed psychologist;
(2) A licensed behavior analyst; or
(3) A licensed assistant behavior analyst.
(e) "Evidence-based research" means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.
(f) "Habilitative or rehabilitative care" means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.
(g) "Licensed assistant behavior analyst" means a person who holds current certification or meets the standards to be certified as a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Board of Psychological Examiners and who provides behavioral therapy under the supervision of a licensed behavior analyst or psychologist.

(h) "Licensed behavior analyst" means a person who holds current certification or meets the standards to be certified as a board certified behavior analyst or a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and who is licensed as a behavior analyst by the Board of Psychological Examiners.
(i) "Prescription care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

(j) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
(k) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
(l) "Screening for autism spectrum disorders" means medically necessary assessments, evaluations or tests to screen and diagnose whether a person has an autism spectrum disorder.
(m) "Therapeutic care" means services provided by licensed or certified speech pathologists, occupational therapists and physical therapists.
(n) "Treatment plan" means a plan to treat an autism spectrum disorder that is prescribed by a licensed physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst.
Sec. 4. (Deleted by amendment.)
Sec. 5. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:
1. A health care plan issued by a health maintenance organization must provide coverage for screening for and diagnosis of autism spectrum disorders and for treatment of autism spectrum disorders to persons covered by the health care plan under the age of 18 or, if enrolled in high school, until the person reaches the age of 22.
2. Coverage provided under this section is subject to:
(a) A maximum benefit of $36,000 per year for applied behavior analysis treatment; and
(b) Copayment, deductible and coinsurance provisions and any other general exclusion or limitation of a health care plan to the

same extent as other medical services or prescription drugs covered by the plan.
3. A health care plan issued by a health maintenance organization that provides coverage for outpatient care shall not:
(a) Require an enrollee to pay a higher deductible, copayment or coinsurance or require a longer waiting period for coverage for outpatient care related to autism spectrum disorders than is required for other outpatient care covered by the plan; or
(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use in the future any of the services listed in subsection 1.
4. Except as provided in subsections 1 and 2, a health maintenance organization shall not limit the number of visits an enrollee may make to any person, entity or group for treatment of autism spectrum disorders.

5. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy or therapeutic care that is:
(a) Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and
(b) Provided for a person diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist or behavior analyst.
_ A health maintenance organization may request a copy of and review a treatment plan created pursuant to this subsection.
6. Evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2011, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with subsections 1 or 2 is void.
7. Nothing in this section shall be construed as requiring a health maintenance organization to provide reimbursement to an early intervention agency or school for services delivered through early intervention or school services.
8. As used in this section:
(a) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially

significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.
(b) "Autism spectrum disorders" means a neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified.
(c) "Behavioral therapy" means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or certified autism behavior interventionist.
(d) "Certified autism behavior interventionist" means a person who is certified as an autism behavior interventionist by the Board of Psychological Examiners and who provides behavior therapy under the supervision of:
(1) A licensed psychologist;

(2) A licensed behavior analyst; or
(3) A licensed assistant behavior analyst.
(e) "Evidence-based research" means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.
(f) "Habilitative or rehabilitative care" means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.
(g) "Licensed assistant behavior analyst" means a person who holds current certification or meets the standards to be certified as a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Board of Psychological Examiners and who provides behavioral therapy under the supervision of a licensed behavior analyst or psychologist.
(h) "Licensed behavior analyst" means a person who holds current certification or meets the standards to be certified as a board certified behavior analyst or a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and

who is licensed as a behavior analyst by the Board of Psychological Examiners.
(i) "Prescription care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.
(j) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
(k) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
(l) "Screening for autism spectrum disorders" means medically necessary assessments, evaluations or tests to screen and diagnose whether a person has an autism spectrum disorder.
(m) "Therapeutic care" means services provided by licensed or certified speech pathologists, occupational therapists and physical therapists.
(n) "Treatment plan" means a plan to treat an autism spectrum disorder that is prescribed by a licensed physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst.
Sec. 6. NRS 695C.050 is hereby amended to read as follows:

695C.050 1. Except as otherwise provided in this chapter or in specific provisions of this title, the provisions of this title are not applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision does not apply to an insurer licensed and regulated pursuant to this title except with respect to its activities as a health maintenance organization authorized and regulated pursuant to this chapter.
2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, must not be construed to violate any provision of law relating to solicitation or advertising by practitioners of a healing art.
3. Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and is exempt from the provisions of chapter 630 of NRS.
4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693, 695C.170 to 695C.200, inclusive, ***and section 5 of this act,*** 695C.250 and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or

insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.
5. The provisions of NRS 695C.1694, 695C.1695 and 695C.1731 apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.
Sec. 7. NRS 695C.330 is hereby amended to read as follows:
695C.330 1. The Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization pursuant to the provisions of this chapter if he finds that any of the following conditions exist:
(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to NRS 695C.060, 695C.070 and 695C.140, unless any amendments to those submissions have been filed with and approved by the Commissioner;
(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, ***and section 5 of this act,*** or 695C.207;
(c) The health care plan does not furnish comprehensive health care services as provided for in NRS 695C.060;

(d) The State Board of Health certifies to the Commissioner that the health maintenance organization:
(1) Does not meet the requirements of subsection 2 of NRS 695C.080; or
(2) Is unable to fulfill its obligations to furnish health care services as required under its health care plan;
(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;
(f) The health maintenance organization has failed to put into effect a mechanism affording the enrollees an opportunity to participate in matters relating to the content of programs pursuant to NRS 695C.110;
(g) The health maintenance organization has failed to put into effect the system required by NRS 695C.260 for:

(1) Resolving complaints in a manner reasonably to dispose of valid complaints; and
(2) Conducting external reviews of final adverse determinations that comply with the provisions of NRS 695G.241 to 695G.310, inclusive;
(h) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;
(i) The continued operation of the health maintenance organization would be hazardous to its enrollees;
(j) The health maintenance organization fails to provide the coverage required by NRS 695C.1691; or
(k) The health maintenance organization has otherwise failed to comply substantially with the provisions of this chapter.
2. A certificate of authority must be suspended or revoked only after compliance with the requirements of NRS 695C.340.
3. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of that suspension, enroll any additional groups or new individual contracts, unless those groups or persons were contracted for before the date of suspension.
4. If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation of any kind. The Commissioner may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees to the end that enrollees are afforded the greatest practical opportunity to obtain continuing coverage for health care.
Sec. 8. Chapter 695G of NRS is hereby amended by adding

thereto a new section to read as follows:

1. A health care plan issued by a managed care organization for group coverage must provide coverage for screening for and diagnosis of autism spectrum disorders and for treatment of autism spectrum disorders to persons covered by the health care plan under the age of 18 or, if enrolled in high school, until the person reaches the age of 22.

2. A health care plan issued by a managed care organization for individual coverage must provide an option for coverage for screening for and diagnosis of autism spectrum disorders and for treatment of autism spectrum disorders to persons covered by the

health care plan under the age of 18 or, if enrolled in high school, until the person reaches the age of 22.

3. Coverage provided under this section is subject to:

(a) A maximum benefit of $36,000 per year for applied behavior analysis treatment; and

(b) Copayment, deductible and coinsurance provisions and any other general exclusion or limitation of a health care plan to the same extent as other medical services or prescription drugs covered by the plan.

4. A managed care organization that offers or issues a health care plan which provides coverage for outpatient care shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period for coverage for outpatient care related to autism spectrum disorders than is required for other outpatient care covered by the plan; or

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use in the future any of the services listed in subsection 1.

5. Except as provided in subsections 1, 2 and 3, a managed care organization shall not limit the number of visits an insured may make to any person, entity or group for treatment of autism spectrum disorders.

6. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy or therapeutic care that is:

(a) Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and

(b) Provided for a person diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist or behavior analyst.

_ A managed care organization may request a copy of and review a treatment plan created pursuant to this subsection.

7. An evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2011, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with subsections 1 or 3 is void.

8. Nothing in this section shall be construed as requiring a managed care organization to provide reimbursement to an early intervention agency or school for services delivered through early intervention or school services.

9. As used in this section:

(a) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

(b) "Autism spectrum disorders" means a neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified.

(c) "Behavioral therapy" means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or certified autism behavior interventionist.

(d) "Certified autism behavior interventionist" means a person who is certified as an autism behavior interventionist by the Board of Psychological Examiners and who provides behavior therapy under the supervision of:

(1) A licensed psychologist;

(2) A licensed behavior analyst; or

(3) A licensed assistant behavior analyst.

(e) "Evidence-based research" means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.

(f) "Habilitative or rehabilitative care" means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.

(g) "Licensed assistant behavior analyst" means a person who holds current certification or meets the standards to be certified as a board certified assistant behavior analyst issued by the Behavior

Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst

by the Board of Psychological Examiners and who provides behavioral therapy under the supervision of a licensed behavior analyst or psychologist.
(h) "Licensed behavior analyst" means a person who holds current certification or meets the standards to be certified as a board certified behavior analyst or a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and who is licensed as a behavior analyst by the Board of Psychological Examiners.
(i) "Prescription care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.
(j) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
(k) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
(l) "Screening for autism spectrum disorders" means medically necessary assessments, evaluations or tests to screen and diagnose whether a person has an autism spectrum disorder.
(m) "Therapeutic care" means services provided by licensed or certified speech pathologists, occupational therapists and physical therapists.
(n) "Treatment plan" means a plan to treat an autism spectrum disorder that is prescribed by a licensed physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst.
Sec. 8.5. NRS 695G.090 is hereby amended to read as follows:
695G.090 1. Except as otherwise provided in subsection 3, the provisions of this chapter apply to each organization and insurer that operates as a managed care organization and may include, without limitation, an insurer that issues a policy of health insurance, an insurer that issues a policy of individual or group health insurance, a carrier serving small employers, a fraternal benefit society, a hospital or medical service corporation and a health maintenance organization.
2. In addition to the provisions of this chapter, each managed care organization shall comply with:

(a) The provisions of chapter 686A of NRS, including all obligations and remedies set forth therein; and
(b) Any other applicable provision of this title.
3. The provisions of NRS 695G.164, 695G.200 to 695G.230, inclusive, [and] 695G.430 ***and section 8 of this act*** do not apply to a managed care organization that provides health care services to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a managed care organization from any provision of this chapter for services provided pursuant to any other contract.

Sec. 9. (Deleted by amendment.)

Sec. 9.5. Chapter 287 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada that provides health insurance through a plan of self-insurance must provide coverage for screening for and diagnosis of autism spectrum disorders and for treatment of autism spectrum disorders to persons covered by the plan of self-insurance under the age of 18 or, if enrolled in high school, until the person reaches the age of 22.

2. Coverage provided under this section is subject to:

(a) A maximum benefit of $36,000 per year for applied behavior analysis treatment; and

(b) Copayment, deductible and coinsurance provisions and any other general exclusion or limitation of a plan of self-insurance to the same extent as other medical services or prescription drugs covered by the policy.

3. A governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada that provides health insurance through a plan of self-insurance which provides coverage for outpatient care shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period for coverage for outpatient care related to autism spectrum disorders than is required for other outpatient care covered by the plan of selfinsurance; or

(b) Refuse to issue a plan of self-insurance or cancel a plan of

self-insurance solely because the person applying for or covered by the plan of self-insurance uses or may use in the future any of the services listed in subsection 1.

4. Except as provided in subsections 1 and 2, a governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada that provides health insurance through a plan of self-insurance shall not limit the number of visits an insured may make to any person, entity or group for treatment of autism spectrum disorders.

5. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy or therapeutic care that is:

(a) Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and

(b) Provided for a person diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist or behavior analyst.

_ A governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada that provides health insurance through a plan of self-insurance may request a copy of and review a treatment plan created pursuant to this subsection.

6. A plan of self-insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after July 1, 2011, has the legal effect of including the coverage required by subsection 1, and any provision of the plan of selfinsurance or the renewal which is in conflict with subsections 1 or 2 is void.

7. Nothing in this section shall be construed as requiring a governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada that provides health insurance through a plan of self-insurance to provide reimbursement to an early intervention agency or school for services delivered through early intervention or school services.

8. As used in this section:

(a) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and

behavior.
(b) "Autism spectrum disorders" means a neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder and Pervasive Development Disorder Not Otherwise Specified.
(c) "Behavioral therapy" means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or certified autism behavior interventionist.
(d) "Certified autism behavior interventionist" means a person who is certified as an autism behavior interventionist by the Board of Psychological Examiners and who provides behavior therapy under the supervision of:
(1) A licensed psychologist;
(2) A licensed behavior analyst; or
(3) A licensed assistant behavior analyst.
(e) "Evidence-based research" means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.
(f) "Habilitative or rehabilitative care" means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.
(g) "Licensed assistant behavior analyst" means a person who holds current certification or meets the standards to be certified as a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Board of Psychological Examiners and who provides behavior therapy under the supervision of a licensed behavior analyst or psychologist.

(h) "Licensed behavior analyst" means a person who holds current certification or meets the standards to be certified as a board certified behavior analyst or a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and who is licensed as a behavior analyst by the Board of Psychological Examiners.
(i) "Prescription care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.
(j) "Psychiatric care" means direct or consultative services

provided by a psychiatrist licensed in the state in which the psychiatrist practices.
(k) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
(l) "Screening for autism spectrum disorders" means all medically appropriate assessments, evaluations or tests to diagnose whether a person has an autism spectrum disorder.
(m) "Therapeutic care" means services provided by licensed or certified speech pathologists, occupational therapists and physical therapists.
(n) "Treatment plan" means a plan to treat an autism spectrum disorder that is prescribed by a licensed physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst.
Sec. 10. (Deleted by amendment.)
Sec. 10.5. NRS 287.04335 is hereby amended to read as follows:
287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 689B.255, 695G.150, 695G.160, 695G.164, 695G.170, 695G.171, 695G.173, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, [and] 695G.405 [,] ***and section 8 of this act*** in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.
Sec. 11. (Deleted by amendment.)

Sec. 12. Chapter 641 of NRS is hereby amended by adding thereto the provisions set forth as sections 12.1, 12.2 and 12.3 of this act.
Sec. 12.1. *1. Each application for certification as an autism behavior interventionist must be accompanied by evidence satisfactory to the Board that the applicant:*
(a) Is at least 18 years of age.
(b) Is of good moral character as determined by the Board.
(c) Is a citizen of the United States, or is lawfully entitled to remain and work in the United States.
(d) Has completed satisfactorily a written examination in Nevada law and ethical practice as administered by the Board.
2. Within 120 days after receiving an application and the accompanying evidence from an applicant, the Board shall:
(a) Evaluate the application and accompanying evidence and determine whether the applicant is qualified pursuant to this section for certification as an autism behavior interventionist; and
(b) Issue a written statement to the applicant of its determination.
3. If the Board determines that the qualifications of the

applicant are insufficient for certification, the written statement issued to the applicant pursuant to subsection 2 must include a detailed explanation of the reasons for that determination.

Sec. 12.2. *The Board shall adopt regulations that establish the grounds for disciplinary action for a licensed behavior analyst, licensed assistant behavior analyst or certified autism behavior interventionist.*

Sec. 12.3. *1. A licensed assistant behavior analyst shall not provide or supervise behavior therapy except under the supervision of:*

(a) A licensed psychologist; or

(b) A licensed behavior analyst.

2. A certified autism behavior interventionist shall not provide behavior therapy except under the supervision of:

(a) A licensed psychologist;

(b) A licensed behavior analyst; or

(c) A licensed assistant behavior analyst.

Sec. 12.4. NRS 641.020 is hereby amended to read as follows:

641.020 As used in this chapter, unless the context otherwise requires, the words and terms defined in ***section 1 of this act and*** NRS 641.021 to 641.027, inclusive, have the meanings ascribed to them in those sections.

Sec. 12.5. NRS 641.030 is hereby amended to read as follows:

641.030 The Board of Psychological Examiners, consisting of [five] ***seven*** members appointed by the Governor, is hereby created.

Sec. 12.6. NRS 641.040 is hereby amended to read as follows:

641.040 1. The Governor shall appoint to the Board:

(a) Four members who are licensed psychologists in the State of Nevada with at least 5 years of experience in the practice of psychology after being licensed.

(b) ***One member who is a licensed behavior analyst in the State of Nevada.***

(c) One member who has resided in this State for at least 5 years and who represents the interests of persons or agencies that regularly provide health care to patients who are indigent, uninsured or unable to afford health care.

(d) One member who is a representative of the general public.

2. A person is not eligible for appointment unless he is:

(a) A citizen of the United States; and

(b) A resident of the State of Nevada.

3. The member who is a representative of the general public:

(a) Shall not participate in preparing, conducting or grading any examination required by the Board.

(b) Must not be a psychologist, an applicant or former applicant for licensure as a psychologist, a member of a health profession, the spouse or the parent or child, by blood, marriage or adoption, of a psychologist, or a member of a household that includes a

psychologist.
4. Board members must not have any conflicts of interest or the appearance of such conflicts in the performance of their duties as members of the Board.
Sec. 12.7. NRS 641.100 is hereby amended to read as follows:
641.100 The Board may make and promulgate rules and regulations not inconsistent with the provisions of this chapter governing its procedure, the examination , [and] licensure ***and certification*** of applicants, the granting, refusal, revocation or suspension of licenses [,] ***and certificates*** and the practice of psychology.
Sec. 12.8. NRS 641.110 is hereby amended to read as follows:
641.110 The Board may, under the provisions of this chapter:
1. Examine and pass upon the qualifications of the applicants for licensure [.] ***and certification.***
2. License ***and certify*** qualified applicants.
3. Revoke or suspend licenses [.] ***and certificates.***

4. Collect all fees and make disbursements pursuant to this chapter.
Sec. 13. NRS 641.170 is hereby amended to read as follows:
641.170 1. Each application ***for licensure as a psychologist*** must be accompanied by evidence satisfactory to the Board that the applicant:
(a) Is at least 21 years of age.
(b) Is of good moral character as determined by the Board.
(c) Is a citizen of the United States, or is lawfully entitled to remain and work in the United States.
(d) Has earned a doctorate in psychology from an accredited educational institution approved by the Board, or has other doctorate-level training from an accredited educational institution deemed equivalent by the Board in both subject matter and extent of training.
(e) Has at least 2 years of experience satisfactory to the Board, 1 year of which must be postdoctoral experience in accordance with the requirements established by regulations of the Board.
2. ***Each application for licensure as a behavior analyst must be accompanied by evidence satisfactory to the Board that the applicant:***
(a) Is at least 21 years of age.
(b) Is of good moral character as determined by the Board.
(c) Is a citizen of the United States, or is lawfully entitled to remain and work in the United States.
(d) Has earned a master's degree from an accredited college or university in a field of social science or special education approved by the Board.
(e) Has completed other education, training or experience in accordance with the requirements established by regulations of the

Board.
(f) Has completed satisfactorily a written examination in Nevada law and ethical practice as administered by the Board.
3. Each application for licensure as an assistant behavior analyst must be accompanied by evidence satisfactory to the Board that the applicant:
(a) Is at least 21 years of age.
(b) Is of good moral character as determined by the Board.
(c) Is a citizen of the United States, or is lawfully entitled to remain and work in the United States.
(d) Has earned a bachelor's degree from an accredited college or university in a field of social science or special education approved by the Board.

(e) Has completed other education, training or experience in accordance with the requirements established by regulations of the Board.
(f) Has completed satisfactorily a written examination in Nevada law and ethical practice as administered by the Board.
4. Within 120 days after receiving an application and the accompanying evidence from an applicant, the Board shall:
(a) Evaluate the application and accompanying evidence and determine whether the applicant is qualified pursuant to this section for licensure *;* [as a psychologist;] and
(b) Issue a written statement to the applicant of its determination.
[3.] *5.* The written statement issued to the applicant pursuant to subsection [2] *4* must include:
(a) If the Board determines that the qualifications of the applicant are insufficient for licensure, a detailed explanation of the reasons for that determination.
(b) If the applicant *for licensure as a psychologist* has not earned a doctorate in psychology from an accredited educational institution approved by the Board and the Board determines that his doctorate-level training from an accredited educational institution is not equivalent in subject matter and extent of training, a detailed explanation of the reasons for that determination.
Sec. 14. NRS 641.180 is hereby amended to read as follows:
641.180 1. Except as otherwise provided in this section and NRS 641.190, each applicant for a license *as a psychologist* must pass the Examination for the Professional Practice of Psychology in the form administered by the Association of State and Provincial Psychology Boards and approved for use in this State by the Board. In addition to this written examination, the Board may require an oral examination in whatever applied or theoretical fields it deems appropriate.
2. The examination must be given at least once a year, and may be given more often if deemed necessary by the Board. The

examination must be given at a time and place, and under such supervision, as the Board may determine.
3. The Board shall notify each applicant of the results of his written examination and supply him with a copy of all material information about those results provided to the Board by the Association of State and Provincial Psychology Boards.
4. If an applicant fails the examination, he may request in writing that the Board review his examination.

5. The Board may waive the requirement of a written examination for a person who:
(a) Is licensed in another state;
(b) Has 10 years experience; and
(c) Is a diplomate in the American Board of Professional Psychology or a fellow in the American Psychological Association, or who has other equivalent status as determined by the Board.
Sec. 14.5. NRS 641.370 is hereby amended to read as follows:
641.370 1. The Board shall charge and collect not more than the following fees respectively:
For the written examination, in addition to the actual cost to the Board of the examination $100
For the special [oral] examination, in addition to the actual costs to the Board of the examination 100
For the issuance of an initial license ***or certificate*** 25
For the biennial renewal of a license ***of a psychologist*** 500
For the biennial renewal of a license of a licensed behavior analyst 400
For the biennial renewal of a license of a licensed assistant behavior analyst 275
For the biennial renewal of a certificate of a certified autism behavior interventionist 175
For the restoration of a license suspended for the nonpayment of the biennial fee for the renewal of a license 100
For the registration of a firm, partnership or corporation which engages in or offers to engage in the practice of psychology 300
For the registration of a nonresident to practice as a consultant 100
2. An applicant who passes the examination and is eligible for a license ***or certificate*** shall pay the biennial fee for the renewal of a license ***or certificate*** which must be prorated for the period from the date the license ***or certificate*** is issued to the end of the biennium.
3. In addition to the fees set forth in subsection 1, the Board may charge and collect a fee for the expedited processing of a request or for any other incidental service it provides. The fee must not exceed the cost to provide the service.
Sec. 15. The Board of Psychological Examiners shall begin

licensing behavior analysts and assistant behavior analysts pursuant to section 13 of this act and certifying autism behavior

interventionists pursuant to section 12.1 of this act no later than January 1, 2010.

Sec. 15.3. Notwithstanding the provisions of subsection 7 of section 8 of this act, a plan of self-insurance governed by NRS 287.04335, as amended by section 10.5 of this act, shall not have the legal effect of including the coverage required pursuant to subsection 1 of section 8 of this act unless it is delivered, issued for delivery or renewed on or after July 1, 2011.

Sec. 15.5. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

Sec. 16. 1. This section and sections 1 to 9, inclusive, 10 and 11 to 15, inclusive, of this act become effective:

(a) Upon passage and approval for the purpose of adopting regulations, licensing behavior analysts and assistant behavior analysts and certifying autism behavior interventionists; and

(b) On January 1, 2011, for all other purposes.

2. Sections 9.5, 10.5, 15.3 and 15.5 of this act become effective:

(a) Upon passage and approval for the purposes of adopting regulations; and

(b) On July 1, 2011, for all other purposes.

NEW MEXICO SENATE BILL NO. 39:

http://www.autismvotes.org/atf/cf/%7B2A179B73-96E2-44C3-8816-1B1C0BE5334B%7D/NM%20SB39%20-%20as%20amended%20on%20the%20sen%20floor.pdf

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SENATE FLOOR SUBSTITUTE FOR
SENATE PUBLIC AFFAIRS COMMITTEE SUBSTITUTE FOR
SENATE BILL 39
49TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2009
AN ACT
RELATING TO HEALTH INSURANCE; REQUIRING COVERAGE FOR DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDER.
BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:
Section 1. A new section of Chapter 59A, Article 22 NMSA 1978 is enacted to read:
"[NEW MATERIAL] COVERAGE FOR AUTISM SPECTRUM DISORDER

DIAGNOSIS AND TREATMENT.--
A. An individual or group health insurance policy, health care plan or certificate of health insurance that is delivered, issued for delivery or renewed in this state shall provide coverage to an eligible individual who is nineteen years of age or younger, or an eligible individual who is twenty-two years of age or younger and is enrolled in high school, for:
underscored material = new
[bracketed material] = delete

(1) well-baby and well-child screening for diagnosing the presence of autism spectrum disorder; and
(2) treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis.
B. Coverage required pursuant to Subsection A of this section:
(1) shall be limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan;
(2) shall be limited to thirty-six thousand dollars ($36,000) annually and shall not exceed two hundred thousand dollars ($200,000) in total lifetime benefits. Beginning January 1, 2011, the maximum benefit shall be adjusted annually on January 1 to reflect any change from the previous year in the medical component of the then-current consumer price index for all urban consumers published by the bureau of labor statistics of the United States department of labor;
(3) shall not be denied on the basis that the services are habilitative or rehabilitative in nature;
(4) may be subject to other general exclusions and limitations of the insurer's policy or plan, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by
underscored material = new
[bracketed material] = delete
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family or household members and utilization review of health care services, including the review of medical necessity, case management and other managed care provisions; and
(5) may be limited to exclude coverage for services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services

to children three to twenty-two years of age who have autism spectrum disorder.
C. The coverage required pursuant to Subsection A of this section shall not be subject to dollar limits, deductibles or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles or coinsurance provisions that apply to physical illnesses that are generally covered under the individual or group health insurance policy, health care plan or certificate of health insurance, except as otherwise provided in Subsection B of this section.
D. An insurer shall not deny or refuse to issue health insurance coverage for medically necessary services or refuse to contract with, renew, reissue or otherwise terminate or restrict health insurance coverage for an individual because the individual is diagnosed as having autism spectrum disorder.
E. The treatment plan required pursuant to

Subsection B of this section shall include all elements necessary for the health insurance plan to pay claims appropriately. These elements include, but are not limited to:
(1) the diagnosis;
(2) the proposed treatment by types;
(3) the frequency and duration of treatment;
(4) the anticipated outcomes stated as goals;
(5) the frequency with which the treatment plan will be updated; and
(6) the signature of the treating physician.
F. This section shall not be construed as limiting benefits and coverage otherwise available to an insured under a health insurance plan.
G. The provisions of this section shall not apply to policies intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident only, hospital indemnity or other limited-benefit health insurance policies.
H. As used in this section:
(1) "autism spectrum disorder" means a condition that meets the diagnostic criteria for the pervasive developmental disorders published in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision, also known as DSM-IV-TR, published by the American psychiatric association, including autistic disorder;

Asperger's disorder; pervasive development disorder not otherwise specified; Rett's disorder; and childhood disintegrative disorder;
(2) "habilitative or rehabilitative services" means treatment programs that are necessary to develop, maintain and restore to the maximum extent practicable the functioning of an individual; and
(3) "high school" means a school providing instruction for any of the grades nine through twelve."
Section 2. A new section of Chapter 59A, Article 23 NMSA 1978 is enacted to read:
"[NEW MATERIAL] COVERAGE FOR AUTISM SPECTRUM DISORDER DIAGNOSIS AND TREATMENT.--
A. A blanket or group health insurance policy or contract that is delivered, issued for delivery or renewed in this state shall provide coverage to an eligible individual who is nineteen years of age or younger, or an eligible individual who is twenty-two years of age or younger and is enrolled in high school, for:
(1) well-baby and well-child screening for diagnosing the presence of autism spectrum disorder; and
(2) treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis.
B. Coverage required pursuant to Subsection A of

this section:
(1) shall be limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan;
(2) shall be limited to thirty-six thousand dollars ($36,000) annually and shall not exceed two hundred thousand dollars ($200,000) in total lifetime benefits. Beginning January 1, 2011, the maximum benefit shall be adjusted annually on January 1 to reflect any change from the previous year in the medical component of the then-current consumer price index for all urban consumers published by the bureau of labor statistics of the United States department of labor;
(3) shall not be denied on the basis that the services are habilitative or rehabilitative in nature;
(4) may be subject to other general exclusions and limitations of the insurer's policy or plan, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and utilization review of health

care services, including the review of medical necessity, case management and other managed care provisions; and
(5) may be limited to exclude coverage for services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related
underscored material = new
[bracketed material] = delete

state laws that place responsibility on state and local school boards for providing specialized education and related services to children three to twenty-two years of age who have autism spectrum disorder.
C. The coverage required pursuant to Subsection A of this section shall not be subject to dollar limits, deductibles or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles or coinsurance provisions that apply to physical illnesses that are generally covered under the blanket or group health insurance policy or contract, except as otherwise provided in Subsection B of this section.
D. An insurer shall not deny or refuse to issue health insurance coverage for medically necessary services or refuse to contract with, renew, reissue or otherwise terminate or restrict health insurance coverage for an individual because the individual is diagnosed as having autism spectrum disorder.
E. The treatment plan required pursuant to Subsection B of this section shall include all elements necessary for the health insurance plan to pay claims appropriately. These elements include, but are not limited to:
(1) the diagnosis;
(2) the proposed treatment by types;
(3) the frequency and duration of treatment;
(4) the anticipated outcomes stated as goals;
underscored material = new
[bracketed material] = delete

(5) the frequency with which the treatment plan will be updated; and
(6) the signature of the treating physician.
F. This section shall not be construed as limiting benefits and coverage otherwise available to an insured under a health insurance plan.
G. The provisions of this section shall not apply to policies intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident only, hospital indemnity or other limited-benefit health insurance policies.

H. As used in this section:
(1) "autism spectrum disorder" means a condition that meets the diagnostic criteria for the pervasive developmental disorders published in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision, also known as DSM-IV-TR, published by the American psychiatric association, including autistic disorder; Asperger's disorder; pervasive development disorder not otherwise specified; Rett's disorder; and childhood disintegrative disorder;
(2) "habilitative or rehabilitative services" means treatment programs that are necessary to develop, maintain and restore to the maximum extent practicable the functioning of an individual; and

(3) "high school" means a school providing instruction for any of the grades nine through twelve."
Section 3. A new section of Chapter 59A, Article 46 NMSA 1978 is enacted to read:
"[NEW MATERIAL] COVERAGE FOR AUTISM SPECTRUM DISORDER DIAGNOSIS AND TREATMENT.--
A. An individual or group health maintenance contract that is delivered, issued for delivery or renewed in this state shall provide coverage to an eligible individual who is nineteen years of age or younger, or an eligible individual who is twenty-two years of age or younger and is enrolled in high school, for:
(1) well-baby and well-child screening for diagnosing the presence of autism spectrum disorder; and
(2) treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis.
B. Coverage required pursuant to Subsection A of this section:
(1) shall be limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan;
(2) shall be limited to thirty-six thousand dollars ($36,000) annually and shall not exceed two hundred thousand dollars ($200,000) in total lifetime benefits.

Beginning January 1, 2011, the maximum benefit shall be adjusted annually on January 1 to reflect any change from the

previous year in the medical component of the then-current consumer price index for all urban consumers published by the bureau of labor statistics of the United States department of labor;
(3) shall not be denied on the basis that the services are habilitative or rehabilitative in nature;
(4) may be subject to other general exclusions and limitations of the insurer's policy or plan, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and utilization review of health care services, including the review of medical necessity, case management and other managed care provisions; and
(5) may be limited to exclude coverage for services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children three to twenty-two years of age who have autism spectrum disorder.
C. The coverage required pursuant to Subsection A of this section shall not be subject to dollar limits, deductibles or coinsurance provisions that are less favorable

to an insured than the dollar limits, deductibles or coinsurance provisions that apply to physical illnesses that are generally covered under the individual or group health maintenance contract, except as otherwise provided in Subsection B of this section.
D. An insurer shall not deny or refuse to issue health insurance coverage for medically necessary services or refuse to contract with, renew, reissue or otherwise terminate or restrict health insurance coverage for an individual because the individual is diagnosed as having autism spectrum disorder.
E. The treatment plan required pursuant to Subsection B of this section shall include all elements necessary for the health insurance plan to pay claims appropriately. These elements include, but are not limited to:
(1) the diagnosis;
(2) the proposed treatment by types;
(3) the frequency and duration of treatment;
(4) the anticipated outcomes stated as goals;
(5) the frequency with which the treatment plan will be updated; and
(6) the signature of the treating physician.
F. This section shall not be construed as limiting benefits and coverage otherwise available to an insured under a

health insurance plan.
G. The provisions of this section shall not apply
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to policies intended to supplement major medical group-type coverages such as medicare supplement, long-term care, disability income, specified disease, accident only, hospital indemnity or other limited-benefit health insurance policies.
H. As used in this section:
(1) "autism spectrum disorder" means a condition that meets the diagnostic criteria for the pervasive developmental disorders published in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision, also known as DSM-IV-TR, published by the American psychiatric association, including autistic disorder; Asperger's disorder; pervasive development disorder not otherwise specified; Rett's disorder; and childhood disintegrative disorder;
(2) "habilitative or rehabilitative services" means treatment programs that are necessary to develop, maintain and restore to the maximum extent practicable the functioning of an individual; and
(3) "high school" means a school providing instruction for any of the grades nine through twelve."
Section 4. A new section of Chapter 59A, Article 47 NMSA 1978 is enacted to read:
"[NEW MATERIAL] COVERAGE FOR AUTISM SPECTRUM DISORDER DIAGNOSIS AND TREATMENT.--
A. An individual or group health insurance policy,
underscored material = new
[bracketed material] = delete
SFl/SPAC/SB 39
.176652.2
- 13 -
health care plan or certificate of health insurance delivered or issued for delivery in this state shall provide coverage to an eligible individual who is twenty-two years of age or younger and is enrolled in high school, for:
(1) well-baby and well-child screening for diagnosing the presence of autism spectrum disorder; and
(2) treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis.
B. Coverage required pursuant to Subsection A of this section:
(1) shall be limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan;

(2) shall be limited to thirty-six thousand dollars ($36,000) annually and shall not exceed two hundred thousand dollars ($200,000) in total lifetime benefits. Beginning January 1, 2011, the maximum benefit shall be adjusted annually on January 1 to reflect any change from the previous year in the medical component of the then-current consumer price index for all urban consumers published by the bureau of labor statistics of the United States department of labor;

(3) shall not be denied on the basis that the services are habilitative or rehabilitative in nature;

(4) may be subject to other general exclusions and limitations of the insurer's policy or plan, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and utilization review of health care services, including the review of medical necessity, case management and other managed care provisions; and

(5) may be limited to exclude coverage for services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children three to twenty-two years of age who have autism spectrum disorder.

C. The coverage required pursuant to Subsection A of this section shall not be subject to dollar limits, deductibles or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles or coinsurance provisions that apply to physical illnesses that are generally covered under the individual or group health maintenance contract, except as otherwise provided in Subsection B of this section.

D. An insurer shall not deny or refuse to issue health insurance coverage for medically necessary services or refuse to contract with, renew, reissue or otherwise terminate

or restrict health insurance coverage for an individual because the individual is diagnosed as having autism spectrum disorder.

E. The treatment plan required pursuant to Subsection B of this section shall include all elements necessary for the health insurance plan to pay claims

appropriately. These elements include, but are not limited to:
(1) the diagnosis;
(2) the proposed treatment by types;
(3) the frequency and duration of treatment;
(4) the anticipated outcomes stated as goals;
(5) the frequency with which the treatment
plan will be updated; and
(6) the signature of the treating physician.
F. This section shall not be construed as limiting
benefits and coverage otherwise available to an insured under a
health insurance plan.
G. The provisions of this section shall not apply
to policies intended to supplement major medical group-type
coverages such as medicare supplement, long-term care,
disability income, specified disease, accident only, hospital
indemnity or other limited-benefit health insurance policies.
H. As used in this section:
(1) "autism spectrum disorder" means a
condition that meets the diagnostic criteria for the pervasive
developmental disorders published in the *Diagnostic and*
underscored material = new
[bracketed material] = delete
SFI/SPAC/SB 39
.176652.2
Statistical Manual of Mental Disorders, fourth edition, text
revision, also known as DSM-IV-TR, published by the American
psychiatric association, including autistic disorder;
Asperger's disorder; pervasive development disorder not
otherwise specified; Rett's disorder; and childhood
disintegrative disorder;
(2) "habilitative or rehabilitative services"
means treatment programs that are necessary to develop,
maintain and restore to the maximum extent practicable the
functioning of an individual; and
(3) "high school" means a school providing
instruction for any of the grades nine through twelve."

OHIO HOUSE BILL 1, 1751.68 and 3923.84

As Reported by the House Healthcare Access and Affordability Committee

128th General Assembly
Regular Session

Sub. H. B. No. 8

2009-2010

Representatives Celeste, Garland
Cosponsors: Representatives Okey, Harris, Dyer, Foley, Lundy, Harwood, Koziura, Stebelton, Hagan, Skindell, Stewart, Heard, Mallory, DeBose, Patten, Pryor, Yuko, Pillich, Newcomb, Murray, Phillips, Winburn, Letson, Bolon, Luckie, Williams, B., Slesnick, Moran

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A BILL

To amend section 1739.05 and to enact sections 1751.68 and 3923.84 of the Revised Code to prohibit health insurers from excluding coverage for specified services for individuals diagnosed with an autism spectrum disorder.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That section 1739.05 be amended and sections 1751.68 and 3923.84 of the Revised Code be enacted to read as follows:

Sec. 1739.05. (A) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program may be established only if any of the following applies:

(1) The arrangement has and maintains a minimum enrollment of three hundred employees of two or more employers.

(2) The arrangement has and maintains a minimum enrollment of three hundred self-employed individuals.

(3) The arrangement has and maintains a minimum enrollment of three hundred employees or self-employed individuals in any combination of divisions (A)(1) and (2) of this section.

(B) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program shall comply with all laws applicable to self-funded programs in this state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 3902.01 to 3902.14, 3923.282, 3923.30, 3923.301, 3923.38, 3923.581, 3923.63, 3923.80, 3923.84, 3924.031, 3924.032, and 3924.27 of the Revised Code.

(C) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall solicit enrollments only through agents or solicitors licensed pursuant to Chapter 3905. of the Revised Code to sell or solicit sickness and accident insurance.

(D) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall provide benefits only to individuals who are members, employees of members, or the dependents of members or employees, or are eligible for continuation of coverage under section 1751.53 or 3923.38 of the Revised Code or under Title X of the "Consolidated Omnibus Budget Reconciliation Act of 1985," 100 Stat. 227, 29 U.S.C.A. 1161, as amended.

Sec. 1751.68. (A) Notwithstanding section 3901.71 of the Revised Code, no health insuring corporation policy, contract, or agreement that provides basic health care services that is delivered, issued for delivery, or renewed in this state shall exclude coverage for the screening and diagnosis of autism spectrum disorders or for any of the following services when those services are medically necessary and are prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder by a health care professional licensed or certified under the laws of this state to prescribe, provide, or order such services:

(1) Habilitative or rehabilitative care;

(2) Pharmacy care if the policy, contract, or agreement provides coverage for other prescription drug services;

(3) Psychiatric care;

(4) Psychological care;

(5) Therapeutic care;

(6) Counseling services;

(7) Any additional treatments or therapies adopted by the director of mental retardation and developmental disabilities pursuant to division (I)(4) of section 3923.84 of the Revised Code.

(B) Coverage provided under this section shall not be subject to any limits on the number or duration of visits an individual may make to any autism service provider if the services are medically necessary.

(C) Coverage provided under this section may be subject to any copayment, deductible, and coinsurance provisions of the policy, contract, or agreement to the extent that other medical services covered by the policy, contract, or agreement are subject to those provisions.

(D) Not more than once every twelve months, a health insuring corporation may request a review of any treatment provided under this section except inpatient services unless the insured's licensed physician or licensed psychologist agrees that more frequent review is necessary. The health insuring corporation shall pay for any review requested under this division.

(E) This section shall not be construed as limiting benefits otherwise available under an individual's policy, contract, or agreement.

(F) This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan developed under 20 U.S.C. 1436 or individualized service plan developed under section 5126.31 of the Revised Code, or affecting the duty of a public school to provide a child with a disability with a free appropriate public education under the "Individuals with Disabilities Education Improvement Act of 2004," 20 U.S.C. 1400 et seq., as amended, and Chapter 3323. of the Revised Code.

(G) A health insuring corporation that offers coverage for basic health care services is not required to offer the coverage required under division (A) of this section in combination with the offer of coverage for basic health care services if all of the following apply:

(1) The health insuring corporation submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for the coverage required under division (A) of this section for a period of at least six months independently caused the health insuring corporation's

costs for claims and administrative expenses for the coverage of all covered services to increase by more than one per cent per year.
(2) The health insuring corporation submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (D)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.
(3) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (D)(1) and (2) of this section:
(a) Incurred claims for the coverage required under division (A) of this section for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of all covered services to increase by more than one per cent per year.
(b) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.
Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code.
(H) As used in this section:
(1) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.
(2) "Autism services provider" means any person whose professional scope of practice allows treatment of autism spectrum disorders.
(3) "Autism spectrum disorder" means any of the pervasive developmental disorders as defined by the most recent edition of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, or if that manual is no longer published, a similar diagnostic manual. Autism spectrum disorders includes, but is not limited to, autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, and pervasive developmental disorder.
(4) "Diagnosis of autism spectrum disorders" means medically necessary assessments, evaluations, or tests, including but not limited to genetic and psychological tests to determine whether an individual has an autism spectrum disorder.
(5) "Habilitative or rehabilitative care" means professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, or restore the functioning of an individual to the maximum extent practicable.
(6) "Medically necessary" means the service is based upon evidence; is prescribed, provided, or ordered by a health care professional licensed or certified under the laws of this state to prescribe, provide, or order autism-related services in accordance with accepted standards of practice; and will or is reasonably expected to do any of the following:
(a) Prevent the onset of an illness, condition, injury, or disability;

(b) Reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, or disability;
(c) Assist in achieving or maintaining maximum functional capacity for performing daily activities, taking into account both the functional capacity of the individual and the appropriate functional capacities of individuals of the same age.
(7) "Pharmacy care" means prescribed medications and any medically necessary health-related services used to determine the need or effectiveness of the medications.
(8) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices psychiatry.
(9) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices psychology.
(10) "Therapeutic care" means services, communication devices, or other adaptive devices or equipment provided by a licensed speech-language pathologist, licensed occupational therapist, or licensed physical therapist.
Sec. 3923.84. (A) Notwithstanding section 3901.71 of the Revised Code, no individual or group policy of sickness and accident insurance that is delivered, issued for delivery, or renewed in this state or public employee benefit plan established or modified in this state shall exclude coverage for the screening and diagnosis of autism spectrum disorders or for any of the following services when those services are medically necessary and are prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder by a health care professional licensed or certified under the laws of this state to prescribe, provide, or order such services:
(1) Habilitative or rehabilitative care;
(2) Pharmacy care if the policy, contract, or agreement provides coverage for other prescription drug services;
(3) Psychiatric care;
(4) Psychological care;
(5) Therapeutic care;
(6) Counseling services;
(7) Any additional treatments or therapies adopted by the director of mental retardation and developmental disabilities pursuant to division (I)(4) of this section.
(B) Coverage provided under this section shall not be subject to any limits on the number or duration of visits an individual may make to any autism services provider if the services are medically necessary.
(C) Coverage provided under this section may be subject to any copayment, deductible, and coinsurance provisions of the policy or plan to the extent that other medical services covered by the policy or plan are subject to those provisions.
(D) Not more than once every twelve months, an insurer may request a review of any treatment provided under this section except inpatient services unless the insured's licensed physician or licensed psychologist agrees that more frequent review is necessary. The insurer shall pay for any review requested under this division.
(E) This section shall not be construed as limiting benefits otherwise available under an individual's policy or plan.
(F) This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan developed under 20 U.S.C. 1436 or individualized service plan developed under section 5126.31 of the Revised

Code, or affecting the duty of a public school to provide a child with a disability with a free appropriate public education under the "Individuals with Disabilities Education Improvement Act of 2004," 20 U.S.C. 1400 et seq., as amended, and Chapter 3323. of the Revised Code.

(G) This section does not apply to the offer or renewal of any individual or group policy of sickness and accident insurance that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, medicare, tricare, long-term care, disability income, one-time limited duration policy of not longer than six months, or other policy that offers only supplemental benefits.

(H) A public employee benefit plan or insurer that offers a policy of sickness and accident insurance is not required to offer the coverage required under division (A) of this section if all of the following apply:

(1) The insurer or public employee benefit plan submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for the coverage required under division (A) of this section for a period of at least six months independently caused the costs for claims and administrative expenses for the coverage of all covered services to increase by more than one per cent per year.

(2) The insurer or public employee benefit plan submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (D)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the insurer or public employee benefit plan for the coverage of all covered services.

(3) The superintendent of insurance makes the following determinations from the documentation and opinion submitted pursuant to divisions (D)(1) and (2) of this section:

(a) Incurred claims for the coverage required under division (A) of this section for a period of at least six months independently caused the costs for claims and administrative expenses for the coverage of all covered services to increase by more than one per cent per year.

(b) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the insurer or public employee benefit plan for the coverage of all covered services.

Any determination made by the superintendent under this division is subject to Chapter 119. of the Revised Code.

(I)(1) The director of mental retardation and developmental disabilities shall convene a committee on the coverage of autism spectrum disorders to investigate and recommend treatments or therapies for autism spectrum disorders that the committee believes should be included in the services that health benefit plans and public employee benefit plans are required to cover under division (A) of this section.

(2) The committee shall consist of nine members appointed by the director of mental retardation and developmental disabilities including the director of mental retardation and developmental disabilities, the director of health, at least one licensed physician, licensed psychologist, and parent of an individual diagnosed with an autism spectrum disorder.

(3) The committee shall serve at the pleasure of the director.

(4) The committee shall submit its recommendations to the director of mental retardation and developmental disabilities. The director may adopt rules in accordance with Chapter 119. of the Revised Code to include additional treatments or therapies for autism spectrum disorders in the services that health benefit plans and public employee benefit plans are required to cover under division (A) of this section.

(J) As used in this section:

(1) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(2) "Autism services provider" means any person whose professional scope of practice allows treatment of autism spectrum disorders.

(3) "Autism spectrum disorder" means any of the pervasive developmental disorders as defined by the most recent edition of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, or if that manual is no longer published, a similar diagnostic manual. Autism spectrum disorders includes, but is not limited to, autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, and pervasive developmental disorder.

(4) "Diagnosis of autism spectrum disorders" means medically necessary assessments, evaluations, or tests, including but not limited to genetic and psychological tests to determine whether an individual has an autism spectrum disorder.

(5) "Habilitative or rehabilitative care" means professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, or restore the functioning of an individual to the maximum extent practicable.

(6) "Health benefit plan" has the same meaning as in section 3924.01 of the Revised Code.

(7) "Medically necessary" means the service is based upon evidence; is prescribed, provided, or ordered by a health care professional licensed or certified under the laws of this state to prescribe, provide, or order autism-related services in accordance with accepted standards of practice; and will or is reasonably expected to do any of the following:

(a) Prevent the onset of an illness, condition, injury, or disability;

(b) Reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, or disability;

(c) Assist in achieving or maintaining maximum functional capacity for performing daily activities, taking into account both the functional capacity of the individual and the appropriate functional capacities of individuals of the same age.

(8) "Pharmacy care" means prescribed medications and any medically necessary health-related services used to determine the need or effectiveness of the medications.

(9) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices psychiatry.

(10) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices psychology.

(11) "Therapeutic care" means services, communication devices, or other adaptive devices or equipment provided by a licensed speech-language pathologist, licensed occupational therapist, or licensed physical therapist.

Section 2. That existing section 1739.05 of the Revised Code is hereby repealed.

PENNSYLVANIA HOUSE BILL 1150:

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1150 Session of 2007

INTRODUCED BY D. O'BRIEN, DeWEESE, PALLONE, PHILLIPS, RAPP, SCAVELLO, STURLA, BAKER, BASTIAN, BOYD, BROOKS, CALTAGIRONE, CARROLL, CLYMER, COHEN, CONKLIN, DALEY, DALLY, DeLUCA, DePASQUALE, DONATUCCI, EVERETT, FREEMAN, GEIST, GEORGE, GIBBONS, GINGRICH, GOODMAN, GRUCELA, HALUSKA, HARKINS, HENNESSEY, HERSHEY, JAMES, JOSEPHS, KAUFFMAN, W. KELLER, KENNEY, KIRKLAND, KOTIK, KULA, LEACH, LENTZ, MAHONEY, MANDERINO, MANN, MARKOSEK, MARSHALL, McILHATTAN, MOYER, MURT, MUSTIO, McGEEHAN, MYERS, NAILOR, M. O'BRIEN, PASHINSKI, PAYNE, PETRONE, PRESTON, READSHAW, REICHLEY, ROSS, SCHRODER, SEIP, SHAPIRO, SHIMKUS, M. SMITH, SOLOBAY, SONNEY, STABACK, STEIL, SURRA, TANGRETTI, TRUE, VEREB, WATSON, J. WHITE, WOJNAROSKI, YUDICHAK, MACKERETH AND MANTZ, APRIL 30, 2007

REFERRED TO COMMITTEE ON INSURANCE, APRIL 30, 2007

AN ACT

Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and

repealing existing laws," providing, in health and accident insurance, for autism spectrum disorders coverage.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended by adding a section to read:

Section 635.2. Autism Spectrum Disorders Coverage.--(a) A health insurance policy delivered, issued, executed or renewed in this Commonwealth on or after the effective date of this section shall provide coverage for autism spectrum disorders and include coverage for the following care and services:

(1) Habilitation care.
(2) Psychiatric care.
(3) Psychological care.
(4) Rehabilitation care.
(5) Respite care.
(6) Therapeutic care.
(7) Medications prescribed by a physician or certified nurse practitioner to address symptoms of autism spectrum disorders.

(b) Coverage provided under this section shall be subject to a maximum benefit of three thousand dollars per month for the covered individual, adjusted annually by the average percentage increase or decrease of private medical insurance premiums each year. The limit shall not apply to coverage of the other health conditions of the individual not related to the treatment of autism spectrum disorders.

(c) Coverage under this section shall be subject to copayment, deductible and coinsurance provisions of a health insurance policy to the extent that other medical services covered by the policy are subject to these provisions.

(d) This section shall not be construed as limiting benefits which are otherwise available to an individual under a health insurance policy.

(e) This section shall not apply to the following types of policies:

(1) Accident only.

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(2) Limited benefit.
(3) Credit.
(4) Dental.
(5) Vision.
(6) Specified disease.
(7) Medicare supplement.
(8) CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) supplement.
(9) Long-term care or disability income.
(10) Workers' compensation.

(11) Automobile medical payment.
(12) Hospital indemnity.
(f) This section shall not apply to the Commonwealth's medical assistance program nor to medical assistance managed care contractors under the medical assistance program.
(g) As used in this section:
(1) "Autism spectrum disorders" means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.
(2) "Habilitation care" means care designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home or community-based settings. Habilitation care may be provided for up to twenty-four hours a day based on the needs of the individual receiving the care and includes health, social or home or community-based services or other services needed to insure the optimal functioning of an individual in the individual's home or community-based setting;

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behavioral interventions based on the principles of applied behavioral analysis; and related structured behavioral programs for up to forty hours a week.
(3) "Health insurance policy" means any group health, sickness or accident policy or subscriber contract or certificate issued by an insurance entity subject to one of the following:
(i) This act.
(ii) The act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."
(iii) The act of May 18, 1976 (P.L.123, No.54), known as the "Individual Accident and Sickness Insurance Minimum Standards Act."
(iv) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).
(4) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
(5) "Psychological care" means direct or consultative services provided by a licensed psychologist in the state in which the psychiatrist practices.
(6) "Rehabilitative care" means professional, counseling and guidance services and treatment programs which are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual.
(7) "Respite care" means care furnished in relief of the primary caregiver on an intermittent basis for a limited period

29 to an individual who resides primarily in a private residence
30 when such care will help the individual to continue residing in
20070H1150B1448 - 4 -

1 the private residence. The term includes nursing care or private
2 nursing care provided on a respite basis.
3 (8) "Therapeutic care" means services provided by licensed
4 or certified speech therapists, occupational therapists,
5 physical therapists or behavioral health specialists.
6 Section 2. This act shall take effect in 60 days.

D25L40MSP/20070H1150B1448 - 5 -

TEXAS INSURANCE CODE 1355.015 and 1355.015:

(1) file the consumer choice health benefit plan with the Filings and Operations Division in accordance with:

(A) the Insurance Code Chapter 1271[~~Article 20A.09~~] and Chapter 11 of this title (relating to Health Maintenance Organizations) including the filing fee requirements; and

(B) the Insurance Code Chapter 1701[~~Article 3.42~~] and Chapter 3, Subchapter A of this title (relating to Requirements for Filing of Policy Forms, Riders, Amendments, Endorsements for Life, Accident, and Health Insurance and Annuities) including the filing fee requirements.

(2) (No change.)

Subchapter JJ. Autism Spectrum Disorder Coverage

§21.4401. Purpose and Applicability.

(a) General Purpose. This subchapter implements those provisions of the Insurance Code Chapter 1355, Subchapter A, that relate to autism spectrum disorder coverage. The general purpose of this subchapter is to ensure health benefit plan coverage for the early intervention, treatment, and services of certain child enrollees diagnosed with autism spectrum disorder, as provided in the Insurance Code Chapter 1355, Subchapter A.

(b) Applicability.

(1) This subchapter applies to:

(A) the health benefit plans specified in the Insurance Code §1355.002; and

(B) small employer health benefit plans offered pursuant to the Insurance Code §1501.252(c).

(2) This subchapter does not apply to:

(A) a standard health benefit plan provided under the Insurance Code Chapter 1507, pursuant to the Insurance Code §1355.015(e);

(B) a health benefit plan issued by a health carrier through a health group cooperative under the Insurance Code §1501.058, pursuant to the Insurance Code §1501.0581(i); or

(C) a health benefit plan specified in the Insurance Code §1355.003(a)(1) – (7).

§21.4402. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

(1) Applied behavior analysis--The design, implementation, and evaluation of systematic environmental changes to produce socially significant change in human behavior through skill acquisition and the reduction of problematic behavior. Applied behavior analysis includes direct observation and measurement of behavior and the identification of functional relations between behavior and the environment. Contextual factors, establishing operations, antecedent stimuli, positive reinforcers, and other consequences are used to produce the desired behavior change.

(2) Autism spectrum disorder--As defined in the Insurance Code §1355.001(3).

(3) Enrollee--A person covered by a health benefit plan described by the Insurance Code §1355.002.

(4) Generally recognized services--The term includes, but is not limited to, the following services, when such services are prescribed in accordance with the Insurance Code §1355.015(b) and §21.4403(b) of this subchapter (relating to Required Coverage):

(A) evaluation and assessment services;

(B) applied behavior analysis;

(C) behavior training and behavior management;

(D) speech therapy;

(E) occupational therapy;

(F) physical therapy; or

(G) medications or nutritional supplements used to address symptoms of autism spectrum disorder.

(5) Health care practitioner--A physician, advance practice nurse, physician assistant, or other individual appropriately licensed, registered, or certified, or whose professional credential is recognized and accepted as described by the Insurance Code §1355.015(b).

(6) Neurobiological disorder--As defined in the Insurance Code §1355.001(4).

(7) Primary care physician--A physician selected or otherwise designated as the enrollee's primary care physician pursuant to the provisions of the enrollee's health benefit plan or, if the enrollee's health benefit plan does not contain provisions concerning selection or designation of a primary care physician, a physician selected or otherwise designated to develop a treatment plan for the purpose of treating autism spectrum disorder.

§21.4403. Required Coverage.

(a) Certain Children Enrollees.

(1) At a minimum, a health benefit plan must provide coverage as provided by the Insurance Code §1355.015 to an enrollee who is three years of age or older and younger than six years of age and who is diagnosed with autism spectrum disorder.

(2) Pursuant to the Insurance Code §1355.015(a), if an enrollee who is being treated for autism spectrum disorder becomes six years of age or older and continues to need treatment, the health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code.

(b) Enrollees of Other Ages. A health benefit plan is not precluded from providing coverage of treatment and services described by §1355.015(b) of the Insurance Code for enrollees of other ages.

(c) Medical and Surgical Benefit. In accordance with the Insurance Code §1355.002 and §1355.015(b), a health benefit plan issuer must provide coverage as a

medical and surgical benefit under the health benefit plan for all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in the treatment plan recommended by that physician.

(d) Deductibles, Copayments, and Coinsurance. Pursuant to the Insurance Code §1355.015(d), coverage under this section may be subject to annual deductibles, copayments, and coinsurance that are consistent with annual deductibles, copayments, and coinsurance required for other coverage under the health benefit plan.

§21.4404. Health Care Practitioners.

(a) Health Care Practitioner Who Provides Treatment. Pursuant to the Insurance Code §1355.015(b), a health care practitioner providing treatment for autism spectrum disorder under the Insurance Code Chapter 1355, Subchapter A, and this subchapter must:

(1) be licensed, certified, or registered by an appropriate agency of this state;

(2) have professional credentials that are recognized and accepted by an appropriate agency of the United States; or

(3) be certified as a provider under the TRICARE military health system.

(b) Coverage for Applied Behavior Analysis. A health benefit plan issuer may not deny coverage for services for autism spectrum disorder on the basis that a health care practitioner providing applied behavior analysis does not hold a license issued by

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an agency of this state, as long the health care practitioner otherwise meets one of the requirements of the Insurance Code §1355.015(b).

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offered by the child's employer and for which the amount of the child's premium contribution is no greater than the premium amount for his or her coverage as a dependent under this section.

(b) Notwithstanding par. (a) 1., the coverage requirement under this section applies to an adult child who satisfies all of the following criteria:

1. The child is a full-time student, regardless of age.

2. The child satisfies the criteria under par. (a) 2. and 3.

3. The child was called to federal active duty in the national guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education.

4. The child was under the age of 27 years when called to federal active duty under subd. 3.

(3) PREMIUM DETERMINATION. An insurer or self-insured health plan shall determine the premium for coverage of a dependent who is over 18 years of age on the same basis as the premium is determined for coverage of a dependent who is 18 years of age or younger.

(4) DOCUMENTATION OF CRITERIA SATISFACTION. An insurer or self-insured health plan may require that an applicant or insured seeking coverage of a dependent child provide written documentation, initially and annually thereafter, that the dependent child satisfies the criteria for coverage under this section.

SECTION 3197r. 632.89 (1) (dm) of the statutes is created to read:

632.89 **(1)** (dm) "Licensed mental health professional" means a clinical social worker who is licensed under ch. 457, a marriage and family therapist who is licensed under s. 457.10, or a professional counselor who is licensed under s. 457.12.

SECTION 3197s. 632.89 (1) (e) 3. of the statutes is repealed and recreated to read:

632.89 **(1)** (e) 3. A psychologist licensed under ch. 455.

SECTION 3197t. 632.89 (1) (e) 4. of the statutes is created to read:

632.89 **(1)** (e) 4. A licensed mental health professional practicing within the scope of his or her license under ch. 457 and applicable rules.

SECTION 3197w. 632.895 (12m) of the statutes is created to read:

632.895 **(12m)** TREATMENT FOR AUTISM SPECTRUM DISORDERS. (a) In this subsection:

1. "Autism spectrum disorder" means any of the following:

a. Autism disorder.

b. Asperger's syndrome.

c. Pervasive developmental disorder not otherwise specified.

2. "Insured" includes an enrollee and a dependent with coverage under the disability insurance policy or self-insured health plan.

3. "Intensive-level services" means evidence-based behavioral therapy that is designed to help an individual with autism spectrum disorder overcome the cognitive, social, and behavioral deficits associated with that disorder.

4. "Nonintensive-level services" means evidence-based therapy that occurs after the completion of treatment with intensive-level services and that is designed to sustain and maximize gains made during treatment with intensive-level services or, for an individual who has not and will not receive intensive-level services, evidence-based therapy that will improve the individual's condition.

5. "Physician" has the meaning given in s. 146.34 (1) (g).

(b) Subject to pars. (c) and (d), and except as provided in par. (c), every disability insurance policy, and every self-insured health plan of the state or a county, city, town, village, or school district, shall provide coverage for an insured of treatment for the mental health condition of autism spectrum disorder if the treatment is prescribed by a physician and provided by any of the following who are qualified to provide intensive-level services or nonintensive-level services:

1. A psychiatrist, as defined in s. 146.34 (1) (n).

2. A person who practices psychology, as described in s. 455.01 (5).

3. A social worker, as defined in s. 252.15 (1) (er), who is certified or licensed to practice psychotherapy, as defined in s. 457.01 (8m).

4. A paraprofessional working under the supervision of a provider listed under subds. 1. to 3.

5. A professional working under the supervision of an outpatient mental health clinic certified under s. 51.038.

6. A speech-language pathologist, as defined in s. 459.20 (4).

7. An occupational therapist, as defined in s. 448.96 (4).

(c) 1. The coverage required under par. (b) shall provide at least $50,000 for intensive-level services per insured per year, with a minimum of 30 to 35 hours of care per week for a minimum duration of 4 years, and at least $25,000 for nonintensive-level services per insured per year, except that these minimum coverage monetary amounts shall be adjusted annually, beginning in 2011, to reflect changes in the consumer price index for all urban consumers, U.S. city average, for the medical care group, as determined by the U.S. department of labor. The commissioner shall publish the new minimum coverage amounts under this subdivision each year, beginning in 2011, in the Wisconsin Administrative Register.

2. Notwithstanding subd. 1., the minimum coverage monetary amounts or duration required for treatment under subd. 1. need not be met if it is determined by a supervising professional, in consultation with the

insured's physician, that less treatment is medically appropriate.

(d) The coverage required under par. (b) may be subject to deductibles, coinsurance, or copayments that generally apply to other conditions covered under the policy or plan. The coverage may not be subject to limitations or exclusions, including limitations on the number of treatment visits.

(e) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.

2. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3), or by a preferred provider plan, as defined in s. 609.01 (4), that is not a defined network plan, as defined in s. 609.01 (1b).

3. A long–term care insurance policy.

4. A medicare replacement policy or a medicare supplement policy.

(f) 1. The commissioner shall by rule further define "intensive–level services" and "nonintensive–level services" and define "paraprofessional" for purposes of par. (b) 4. and "qualified" for purposes of providing services under this subsection. The commissioner may promulgate rules governing the interpretation or administration of this subsection.

2. Using the procedure under s. 227.24, the commissioner may promulgate the rules under subd. 1. for the period before the effective date of the permanent rules promulgated under subd. 1., but not to exceed the period authorized under s. 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) (a), (2) (b), and (3), the commissioner is not required to provide evidence that promulgating a rule under this subdivision as an emergency rule is necessary for the preservation of the public peace, health, safety, or welfare and is not required to provide a finding of emergency for a rule promulgated under this subdivision.

Section 3198b. 632.895 (15) (a) of the statutes is amended to read:

632.895 **(15)** (a) Subject to pars. (b) and (c), every disability insurance policy, and every self–insured health plan of the state or a county, city, town, village, or school district, that provides coverage for a person as a dependent of the insured because the person is a full–time student, including the coverage under s. 632.885 (2) (b), shall continue to provide dependent coverage for the person if, due to a medically necessary leave of absence, he or she ceases to be a full–time student.

Section 3198c. 632.895 (15) (c) 5. of the statutes is amended to read:

632.895 **(15)** (c) 5. ~~The~~ Except for a person who has coverage as a dependent under s. 632.885 (2) (b), the person reaches the age at which coverage as a dependent who is a full–time student would otherwise end under the terms and conditions of the policy or plan.

Section 3198d. 632.895 (17) of the statutes is created to read:

632.895 **(17)** CONTRACEPTIVES AND SERVICES. (a) In this subsection, "contraceptives" means drugs or devices approved by the federal food and drug administration to prevent pregnancy.

(b) Every disability insurance policy, and every self–insured health plan of the state or of a county, city, town, village, or school district, that provides coverage of outpatient health care services, preventive treatments and services, or prescription drugs and devices shall provide coverage for all of the following:

1. Contraceptives prescribed by a health care provider, as defined in s. 146.81 (1).

2. Outpatient consultations, examinations, procedures, and medical services that are necessary to prescribe, administer, maintain, or remove a contraceptive, if covered for any other drug benefits under the policy or plan.

(c) Coverage under par. (b) may be subject only to the exclusions, limitations, or cost–sharing provisions that apply generally to the coverage of outpatient health care services, preventive treatments and services, or prescription drugs and devices that is provided under the policy or self–insured health plan.

(d) This subsection does not apply to any of the following:

1. A disability insurance policy that covers only certain specified diseases.

2. A disability insurance policy, or a self–insured health plan of the state or a county, city, town, village, or school district, that provides only limited–scope dental or vision benefits.

3. A health care plan offered by a limited service health organization, as defined in s. 609.01 (3), or by a preferred provider plan, as defined in s. 609.01 (4), that is not a defined network plan, as defined in s. 609.01 (1b).

4. A long–term care insurance policy.

5. A Medicare replacement policy or a Medicare supplement policy.

Section 3199. Chapter 648 of the statutes is created to read:

CHAPTER 648
REGULATION OF CARE MANAGEMENT ORGANIZATIONS

648.01 Definitions. In this chapter:

(1) "Care management organization" means an entity described in s. 46.284 (3m).

(2) "Department" means the department of health services.

(3) "Enrollee" has the meaning given in s. 46.2805 (3).

(4) "Permittee" means a care management organization issued a permit under this chapter.

of health care services that are made on the effective date of this paragraph.

(b) If a health care plan that is in effect on the effective date of this paragraph contains a provision that is inconsistent with the treatment of section 632.845 of the statutes, the treatment of section 632.845 of the statutes first applies to that health care plan on the date on which it is renewed.

(8L) INSURANCE COVERAGE FOR AUTISM TREATMENT. The treatment of sections 609.87 and 632.895 (12m) of the statutes first applies to all of the following:

(a) Except as provided in paragraphs (b) and (c), disability insurance policies that are issued or renewed, and self–insured governmental or school district health plans that are established, extended, modified, or renewed, on the first day of the 5th month beginning after publication.

(b) Disability insurance policies covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are issued or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

(c) Self–insured governmental or school district health plans covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are established, extended, modified, or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

(9f) COVERAGE OF CONTRACEPTIVES AND DEPENDENTS. The treatment of sections 40.51 (8) and (8m), 66.0137 (4), 111.91 (2) (n) and (nm), 120.13 (2) (g), 185.981 (4f), 185.983 (1) (intro.), 609.755, 609.805, 632.885, and 632.895 (17) of the statutes first applies to all of the following:

(a) Except as provided in paragraphs (b) and (c), disability insurance policies that are issued or renewed, and governmental or school district self–insured health plans that are established, extended, modified, or renewed, on the effective date of this paragraph.

(b) Disability insurance policies covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are issued or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

(c) Governmental or school district self–insured health plans covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are established, extended, modified, or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.

2. The day on which the collective bargaining agreement is extended, modified, or renewed.

(9q) COVERAGE OF LICENSED MENTAL HEALTH PROFESSIONALS SERVICES. If a group health insurance policy that is in effect on the effective date of this subsection contains a provision that is inconsistent with the treatment of section 632.89 (1) (dm) and (e) 4. of the statutes, the treatment of section 632.89 (1) (dm) and (e) 4. of the statutes first applies to that insurance policy on the date on which it is renewed.

(10q) COVERAGE OF PSYCHOLOGISTS SERVICES. If a group health insurance policy that is in effect on the effective date of this subsection contains a provision that is inconsistent with the treatment of section 632.89 (1) (e) 3. of the statutes, the treatment of section 632.89 (1) (e) 3. of the statutes first applies to that insurance policy on the date on which it is renewed.

SECTION 9330. Initial applicability; Justice.

(1) CRIME LABORATORIES AND DRUG LAW ENFORCEMENT SURCHARGE. The treatment of section 165.755 (1) (a) of the statutes first applies to violations committed on the effective date of this subsection.

SECTION 9333. Initial applicability; Local Government.

(1m) FIRST CLASS CITY POLICE OFFICER SALARY AFTER DISCHARGE. The treatment of section 62.50 (18) (a) and (b) of the statutes first applies to any member of the police force who is covered by a collective bargaining agreement that contains provisions inconsistent with the treatment of section 62.50 (18) (a) and (b) on the day on which the collective bargaining agreement expires or is extended, modified, or renewed, whichever occurs first.

SECTION 9337. Initial applicability; Natural Resources.

(1) RECYCLING TIPPING FEE. The treatment of section 289.645 (3) of the statutes first applies to solid waste disposed of on October 1, 2009.

(3) WILDLIFE DAMAGE CLAIM PROGRAM. The treatment of section 29.889 (7) (b) 1., 2., and 4. of the statutes first applies to wildlife damage claims filed on the effective date of this subsection.

(3g) CONSTRUCTION AND DEMOLITION WASTE. The treatment of sections 289.64 (4), 289.645 (1) (2), (3), and (7) (a), 289.645 (1), (2), (3) (intro.), and (7) (a), and 289.67 (1) (a), (b), (c), and (f) of the statutes first applies to building waste disposed of on January 1, 2010. **Vetoed In Part**

SECTION 9338. Initial applicability; Public Defender Board. **Vetoed In Part**

(1) AGENCY DESIGNATIONS. The treatment of sections 20.550 (1) (fk), 301.065 (5) (dm), 977.06 (1) (c), 977.06 (1) (c) and (2) (a), 977.07 (2), and 977.085 (3) of