Autism Insurance Law- Act 62 of 2008 (40 P.S. §765h)

This law mandates coverage of autism diagnosis and treatment services under certain insurance plans and policies. The Act was signed into law on July 9, 2008. Its prime sponsor was Speaker of the House, Dennis O'Brien.

Which policies/plans are not covered by the law:

- "Self insured" plans
- Out of state plans/policies
- Plans/policies offered to less than 51 employees

Who is covered:
Children and young adults under age 21 who are-

- covered under a employer group health insurance policy (including HMOs & PPOs)
  - that covers at least 51 employees
    - (not Chambers of Commerce or other associational plans)- and
  - the policy is not a "self insured"
  - the policy was issued or renewed in PA; or
- on Medical Assistance; or
- on CHIP (Children's Health Insurance Program); or
- on Adult Basic (age 18 or older)

What is covered:

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

What treatments are covered:

- Prescription medications and blood level tests
- Services of a psychiatrist (direct or consultation)
- Services of a psychologist (direct or consultation)
- Applied Behavioral Analysis (ABA)
  - "the design, implementation and evaluation or environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior or to prevent loss of attained skill or function, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior."
  - Provider must be licensed in PA

- Other “rehabilitative care”
  - “professional services and treatment programs…provided by an autism service provider to produce socially significant improvements in human behavior or to prevent loss of attained skill or function.”
- Therapies
  - Speech/language pathologists
  - Occupational therapists
  - Physical therapists
- Treatments must be listed in treatment plan in order to be covered
  - Treatment plan must be developed by a physician or licensed psychologist

Who can provide covered services:

- Current providers that provide autism treatment and were enrolled in Medical Assistance on July 9, 2008.
- Are providing autism treatment and become licensed or certified
  - State Board of Medicine has developed licensure regulations for behavior specialists. 49 Pa Code §18.521 et. seq.
  - Behavior specialists defined as: “an individual who designs, implements or evaluates a behavior modification intervention component of a treatment plan….”
  - Persons serving as Behavior Specialist Consultant (“BSC”) under Medical Assistance for a child or youth with an ASD diagnosis must be licensed as a behavior specialist or be licensed as any of the following:
    - psychologist, clinical social worker, professional counselor or marriage and family therapist
    - Bulletin OMHSAS -14-02 (May 23, 2014)

Coverage limits:

- $38,852 for 2017
- These annual caps are probably invalid in many policies under the Mental Health & Addictions Equity Act. *Jarman v. Capital Blue Cross,* Civ. Action No.1:13-CV-0932 (M.D. PA 2014) Several major insurers have eliminated the annual caps including Highmark and Capital Blue Cross.
- No limit on number of diagnostic/treatment visits (until cap is reached)
- Autism coverage “shall be subject to copayment, deductible and coinsurance provisions, and any other general exclusions or limitations…to the same extent as other medical services covered by the policy or program….”
  - This language appears to give insurers authority to deny some autism treatments (other than ABA) on grounds they are experimental.

    - Question of whether this provision permits exclusion of autism therapy (ABA) provided in school currently before the PA Supreme Court. *Burke v. IBC*, 23 EAP 2016.

Treatment requirements:

- Must be for an autism spectrum disorder
    - "any of the pervasive developmental disorders defined in the most recent edition of the …DSM…including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified."
    - "diagnostic assessment of autism spectrum disorder shall be valid for a period of not less than 12 months, unless a licensed physician or licensed psychologist determines an earlier assessment is necessary."
- Must be medically necessary
    - no definition in the Act
    - however, service definitions, especially of ABA and "rehabilitative care" provide some guidance-
        - For ABA and "rehabilitative care" progress need not be shown. It is sufficient if these services are needed to "prevent loss of attained skill or function"
- Must be "identified in a treatment plan"
    - Developed by a physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation
    - Treatment plan may be reviewed by insurer every 6 months. The child's physician or psychologist who signs off on the treatment plan may agree to a more frequent review.
- Must be "prescribed, ordered or provided by a licensed physician, licensed physician assistant, licensed psychologist, licensed clinical social worker or certified registered nurse practitioner."

When coverage begins:

- For commercial health policies, CHIP and Adult Basic: on the date the policy or contract is renewed on or after July 1, 2009.
- July 9, 2008 for Medical Assistance

Grandfathering current providers:

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

Appeals:

- Families can appeal any denial of an autism diagnostic or treatment service to the insurer and obtain a decision within 48 hours (expedited review)
- If appeal is denied by the insurer, family can appeal to the PA Dept. of Insurance for “expedited external review”.
- If Insurance Department or external reviewer denies appeal, family may be able to file case in court under Declaratory Judgment Act. *Burke v. IBC,* 103 A.3d 1267 (Pa. Supreme Ct, 2014)

Other provisions:

- Insurers are not required to cover services just because they are listed in an IEP. However, coverage may not be contingent upon coordination of insurance covered services with services listed in an IEP.

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