

10100553D

HOUSE BILL NO. 34

Offered January 13, 2010

Prefiled December 18, 2009

A BILL to amend and reenact § 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.16, relating to health insurance coverage for autism spectrum disorder.

Patrons—Marshall, R.G., O'Bannon, Englin and Rust

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4319 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3418.16 as follows:

§ 38.2-3418.16. Coverage for autism spectrum disorder.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the diagnosis and treatment of autism spectrum disorder in individuals under the age of 21, as provided in this section. In addition to the requirements imposed on health insurance issuers by § 38.2-3436, an insurer shall not terminate coverage, or refuse to deliver, issue, amend, adjust, or renew coverage, to an individual solely because the individual is diagnosed with one of the autism spectrum disorders or has received treatment for autism spectrum disorder.

B. For purposes of this section:

"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.

"Autism spectrum disorder" means any pervasive developmental disorder, including (i) autistic disorder, (ii) Asperger's syndrome, (iii) Rett syndrome, (iv) childhood disintegrative disorder, or (v) Pervasive Developmental Disorder - Not Otherwise Specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

"Diagnosis of autism spectrum disorder" means medically necessary assessments, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder.

"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.

"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.

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

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

"Therapeutic care" means services provided by licensed or certified speech therapists, occupational therapists, or physical therapists.

"Treatment for autism spectrum disorder" shall be identified in a treatment plan and includes the following care prescribed, provided, or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed physician, a licensed psychologist, or a licensed clinical social worker who determines the care to be medically necessary: (i) habilitative or rehabilitative care, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, and (v) therapeutic care.

"Treatment plan" means a plan for the treatment of autism spectrum disorder developed by a licensed physician, licensed psychologist, or licensed clinical social worker pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendation of the American Academy of Pediatrics or the American Academy of Child and Adolescent Psychiatry.

C. Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder, an insurer, corporation, or health maintenance organization shall have the right to request a review of that treatment not more than once every 12 months unless the insurer, corporation, or health

59 maintenance organization and the individual's licensed physician, licensed psychologist, or licensed
60 clinical social worker agree that a more frequent review is necessary. The cost of obtaining any review
61 shall be covered under the policy, contract, or plan.

62 D. Coverage under this section will be subject to an annual maximum benefit of \$36,000, unless the
63 insurer, corporation, or health maintenance organization elects to provide coverage in a greater
64 amount. Beginning January 1, 2012, the annual maximum benefit amount will be adjusted annually for
65 inflation by using the Medical Care Component of the United States Department of Labor Consumer
66 Price Index for All Urban Consumers (CPI-U), as calculated by the Commission. Payments made on
67 behalf of a covered individual for any care, treatment, intervention, service, or item other than treatment
68 for autism spectrum disorder will not be applied towards the maximum benefit established under this
69 section. Coverage under this section will not be subject to any visit limits, and shall neither be different
70 nor separate from coverage for any other illness, condition, or disorder for purposes of determining
71 deductibles, lifetime dollar limits, copayment and coinsurance factors, and benefit year maximum for
72 deductibles and copayment and coinsurance factors.

73 E. Nothing shall preclude the undertaking of usual and customary procedures to determine the
74 appropriateness of, and medical necessity for, treatment of autism spectrum disorder under this section,
75 provided that all such appropriateness and medical necessity determinations are made in the same
76 manner as those determinations are made for the treatment of any other illness, condition, or disorder
77 covered by such policy, contract, or plan.

78 F. The provisions of this section shall not apply to (i) short-term travel, accident only, limited, or
79 specified disease policies; (ii) short-term nonrenewable policies of not more than six months' duration;
80 or (iii) policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of
81 the Social Security Act, known as Medicare, or any other similar coverage under state or federal
82 governmental plans.

83 G. The requirements of this section shall apply to all insurance policies, subscription contracts, and
84 health care plans delivered, issued for delivery, reissued, or extended on or after January 1, 2011, and
85 to all such policies, contracts, or plans to which a term is changed or any premium adjustment is made
86 on or after such date.

87 H. Any coverage required pursuant to this section shall be in addition to the coverage required by
88 § 38.2-3418.5 and other provisions of law. This section shall not be construed as diminishing any
89 coverage required by § 38.2-3412.1:01. This section shall not be construed as affecting any obligation
90 to provide services to an individual under an individualized family service plan, an individualized
91 education program, or an individualized service plan.

92 § 38.2-4319. Statutory construction and relationship to other laws.

93 A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this
94 chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218
95 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through
96 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.),
97 §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1306.1,
98 § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of
99 Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800
100 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9
101 through 38.2-3407.16, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1:01, 38.2-3414.1, 38.2-3418.1
102 through 38.2-3418.15, 38.2-3418.16, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision
103 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through
104 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541.1, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et
105 seq.) of Chapter 35, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58
106 (§ 38.2-5800 et seq.) and § 38.2-5903 of this title shall be applicable to any health maintenance
107 organization granted a license under this chapter. This chapter shall not apply to an insurer or health
108 services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200
109 et seq.) of this title except with respect to the activities of its health maintenance organization.

110 B. For plans administered by the Department of Medical Assistance Services that provide benefits
111 pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title
112 except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136,
113 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229,
114 38.2-232, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through
115 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, § 38.2-1306.1,
116 Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et
117 seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et
118 seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6 and
119 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions 1, 2, and 3 of subsection F
120 of § 38.2-3407.10, 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, and 38.2-3407.14,

38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and B of this section shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.