State Corporation Commission
2010 Fiscal Impact Statement

1. Bill Number: HB34

House of Origin	X	Introduced	___	Substitute	___	Engrossed
Second House	___	In Committee	___	Substitute	___	Enrolled

2. Patron: Marshall, R.G.

3. Committee: Commerce and Labor

4. Title: **Health insurance; mandated coverage for autism spectrum disorder.**

5. Summary: Requires 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 (HMO) providing a health care plan for health care services to provide coverage for the diagnosis and treatment of autism spectrum disorder in individuals under the age of 21. 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. For services other than inpatient treatment for an autism spectrum disorder, an insurer, corporation, or HMO shall have the right to request a review of that treatment not more than once every 12 months unless the insurer, corporation, or HMO and the individual's licensed physician, licensed psychologist, or licensed clinical social worker agrees that a more frequent review is necessary. The cost of obtaining any review shall be covered under the policy, contract, or plan. Coverage will be subject to an annual maximum benefit of $36,000, unless the insurer, corporation, or HMO elects to provide coverage in a greater amount. Beginning January 1, 2012, the annual maximum benefit amount will be adjusted annually for inflation by using the Medical Care Component of the United States Department of Labor Consumer Price Index for All Urban Consumers (CPI-U), as calculated by the Commission. Payments made on behalf of a covered individual for any care, treatment, intervention, service, or item other than treatment for autism spectrum disorder will not be applied towards the maximum benefit established under this section. Coverage under this section will not be subject to any visit limits, and shall neither be different nor separate from coverage for any other illness, condition, or disorder for purposes of determining deductibles, lifetime dollar limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors. Nothing shall preclude the undertaking of usual and customary procedures to determine the appropriateness of, and medical necessity for, treatment of autism spectrum disorder under this section, provided that all such appropriateness and medical necessity determinations are made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan. The provisions of the legislation shall not apply to (i) short-term travel, accident only, limited, or specified disease policies; (ii) short-term nonrenewable policies of not more than six months' duration; or (iii) policies or contracts designed for issuance to persons eligible for coverage under Medicare, or any other similar coverage under state or federal governmental plans. The requirements of this legislation shall apply to all insurance policies,

subscription contracts, and health care plans delivered, issued for delivery, reissued, or extended on or after January 1, 2011, and to all such policies, contracts, or plans to which a term is changed or any premium adjustment is made on or after such date. Any coverage required pursuant to this section shall be in addition to the coverage required by § 38.2-3418.5 and other provisions of law. The legislation shall not be construed as diminishing any coverage required by § 38.2-3412.1:01. The legislation shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan, an individualized education program (IEP), or an individualized service plan.

6. No Fiscal Impact on the State Corporation Commission

7. Budget amendment necessary: No

8. Fiscal implications: None on the State Corporation Commission

9. Specific agency or political subdivisions affected: State Corporation Commission Bureau of Insurance

10. Technical amendment necessary: House Bill 34 establishes a requirement for an annual adjustment of the annual maximum benefit for this coverage. Beginning January 1, 2012, the annual maximum benefit is to be adjusted for inflation based on the Consumer Price Index for all Urban Consumers (CPI-U). However, it is not clear whether this adjustment is to be applied annually to the statutory annual maximum benefit of $36,000; whether it is to be applied annually to the adjusted amount each year; or whether it is to be applied to the maximum amount provided by the insurer in those contracts that establish an annual maximum greater than $36,000. The bill also calls for the Commission to calculate this adjustment.

Considering that the adjustment for inflation is determined by the U.S. Department of Labor, the Bureau of Insurance suggested to the patron deleting the phrase "as calculated by the Commission" on Line 67, and replacing it with language authorizing the Commission to publish the annual adjusted maximum benefit each year.

The following revision to proposed § 38.2-3418.16 D (Lines 62 through 72) would clarify the Commission's responsibility and would require an annual adjustment for inflation using the CPI-U and applying the appropriate factor to the statutory maximum of $36,000 each year:

> *Coverage under this section will be subject to an annual maximum benefit of $36,000, unless the insurer, corporation, or health maintenance organization elects to provide coverage in a greater amount.* ***Beginning January 1, 2012, the annual maximum benefit amount of $36,000 will be adjusted annually for inflation using the Medical Care Component of the United States Department of Labor Consumer Price Index for All Urban Consumers (CPI-U)****. The* ***Commission shall publish annually the adjusted*** *annual maximum benefit.* ~~*amount will be adjusted annually for inflation by using the*~~

> ~~*Medical Care Component of the United States Department of Labor Consumer Price Index for All Urban Consumers (CPI-U), as calculated by the Commission*~~. *Payments made on behalf of a covered individual for any care, treatment, intervention, service, or item other than treatment for autism spectrum disorder will not be applied towards the maximum benefit established under this section. Coverage under this section will not be subject to any visit limits, and shall neither be different nor separate from coverage for any other illness, condition, or disorder for purposes of determining deductibles, lifetime dollar limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.*

The Bureau of Insurance advised the patron that if he intended that the factor should be applied to an amount other than the statutory annual maximum of $36,000 each year, the above wording would have to be revised accordingly.

11. Other comments: House Bill 34 is similar to 2008 House Bill 83, which was also introduced by Delegate Robert Marshall. HB 83 (2008) mandated coverage for habilitative services for children. The House Committee on Commerce and Labor adopted an amendment in the nature of a substitute to mandate coverage for the diagnosis and treatment of Autism Spectrum Disorder (ASD) in individuals under age 21. The Committee then referred the legislation to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission). The language was referred to as House Bill 83 in the Advisory Commission review process. In addition to providing coverage for the diagnosis and treatment of autism spectrum disorder under the age of 21, HB 83-Amended added that the insurer cannot terminate or otherwise alter coverage solely because an individual is diagnosed with autism (ASD) or has been treated for ASD. HB 83-Amended added two additional disorders to the list of conditions in the ASD definition (Rett syndrome and childhood disintegrative disorder). Also, HB 83-Amended added 1) a limit to the coverage, capping the annual maximum benefit at $36,000; 2) a COLA for inflation beginning 1/1/2011 based on CPI-U; and, 3) a requirement that provisions of the bill are in addition to the provisions in the early intervention mandate, § 38.2-3418.5. The Advisory Commission voted to recommend enactment of the revised version of House Bill 83 by a vote of 6 to 4. The vote was contingent on language being added to the bill to recognize the need to make changes to comply with the federal Mental Health Parity and Addiction Equity Act. These changes were made in 2009 House Bill 1588, which Delegate Marshall also introduced, but the bill was left in Commerce and Labor.

The language in subsection H of House Bill 34 does restate amended language included in House Bill 83-Amended, which states that the mandated benefits of this subsection are in addition to coverage required under § 38.2-3418.5 (coverage for early intervention services). Language introduced in subsection H of HB 34 states that coverage under this subsection shall not diminish any coverage required by § 38.2-3412.1:01 (coverage for biologically based mental health). HB 34 contains a definition of treatment plan that was not included in HB 1588 and language regarding the IEP in subsection H is new in HB 34.

House Bill 34 is currently assigned to House Commerce and Labor Subcommittee #1.

Date: 01/30/10 V. Tompkins
cc: Secretary of Commerce and Trade
Secretary of Health and Human Resources