

2011 SESSION

LEGISLATION NOT PREPARED BY DLS
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HB2467

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HOUSE BILL NO. 2467

Offered January 21, 2011

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 38.2-3418.17, relating to health insurance coverage for autism spectrum disorder.*

Patrons—Greason, Rust, Abbott, Anderson, Armstrong, Bulova, Cox, M.K., Dance, Ebbin, Edmunds, Englin, Filler-Corn, Herring, Hope, Howell, W.J., Hugo, Keam, Kory, Marshall, R.G., May, Oder, Plum, Pollard, Scott, J.M., Stolle, Surovell, Torian, Ware, R.L. and Watts

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 38.2-3418.17 as follows:

§ 38.2-3418.17. 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, as provided in this section, provide coverage for the diagnosis of autism spectrum disorder and the treatment of autism spectrum disorder in individuals from age two through age six, subject to the annual maximum benefit limitation set forth in subsection K. If an individual who is being treated for autism spectrum disorder becomes seven years of age or older and continues to need treatment, this section does not preclude coverage of treatment and services. 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 of an individual solely because the individual is diagnosed with autism spectrum disorder 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 relationship 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.

"Behavioral health treatment" means professional, counseling, and guidance services and treatment programs, including applied behavior analysis when provided or supervised by a board certified behavior analyst, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

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

"Medically necessary" means based upon evidence and reasonably expected to do any of the following: (i) prevent the onset of an illness, condition, injury, or disability; (ii) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or (iii) 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.

"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, physical therapists, or clinical social workers.

"Treatment for autism spectrum disorder" shall be identified in a treatment plan and includes the

57 following care prescribed or ordered for an individual diagnosed with autism spectrum disorder by a
58 licensed physician or a licensed psychologist who determines the care to be medically necessary: (i)
59 behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, and (v)
60 therapeutic care.

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

65 C. Except for inpatient services, if an individual is receiving treatment for an autism spectrum
66 disorder, an insurer, corporation, or health maintenance organization shall have the right to request a
67 review of that treatment not more than once every 12 months unless the insurer, corporation, or health
68 maintenance organization and the individual's licensed physician or licensed psychologist agree that a
69 more frequent review is necessary. The cost of obtaining any review shall be covered under the policy,
70 contract, or plan.

71 D. Coverage under this section will not be subject to any visit limits, and shall be neither different
72 nor separate from coverage for any other illness, condition, or disorder for purposes of determining
73 deductibles, lifetime dollar limits, copayment and coinsurance factors, and benefit year maximum for
74 deductibles and copayment and coinsurance factors.

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

80 F. The provisions of this section shall not apply to (i) short-term travel, accident only, limited, or
81 specified disease policies; (ii) short-term nonrenewable policies of not more than six months' duration;
82 (iii) policies, contracts, or plans issued in the individual market or small group markets to employers
83 with 50 or fewer employees; or (iv) policies or contracts designed for issuance to persons eligible for
84 coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar
85 coverage under state or federal governmental plans.

86 G. The requirements of this section shall apply to all insurance policies, subscription contracts, and
87 health care plans delivered, issued for delivery, reissued, or extended on or after January 1, 2012, and
88 to all such policies, contracts, or plans to which a term is changed or any premium adjustment is made
89 on or after such date.

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

95 I. Notwithstanding the provisions of § 2.2-2818.2, this section shall not apply to health coverage
96 offered to state employees pursuant to § 2.2-2818 or to health insurance coverage offered to employees
97 of local governments, local officers, teachers, and retirees, and the dependents of such employees,
98 teachers, and retirees pursuant to § 2.2-1204.

99 J. Notwithstanding any provision of this section to the contrary:

100 1. An insurer, corporation, or health maintenance organization is exempt from providing coverage
101 for behavioral health treatment required under this section and not covered by the insurer, corporation,
102 or health maintenance organization as of December 31, 2011, if:

103 a. An actuary, affiliated with the insurer, corporation, or health maintenance organization, who is a
104 member of the American Academy of Actuaries and meets the American Academy of Actuaries'
105 professional qualification standards for rendering an actuarial opinion related to health insurance rate
106 making, certifies in writing to the Commissioner of Insurance that:

107 (1) Based on an analysis to be completed no more frequently than one time per year by each
108 insurer, corporation, or health maintenance organization for the most recent experience period of at
109 least one year's duration, the costs associated with coverage of behavioral health treatment required
110 under this section, and not covered as of December 31, 2011, exceeded one percent of the premiums
111 charged over the experience period by the insurer, corporation, or health maintenance organization;
112 and

113 (2) Those costs solely would lead to an increase in average premiums charged of more than one
114 percent for all insurance policies, subscription contracts, or health care plans commencing on inception
115 or the next renewal date, based on the premium rating methodology and practices the insurer,
116 corporation, or health maintenance organization employs; and

117 b. The Commissioner approves the certification of the actuary;

118 2. An exemption allowed under subdivision 1 shall apply for a one-year coverage period following

inception or next renewal date of all insurance policies, subscription contracts, or health care plans issued or renewed during the one-year period following the date of the exemption, after which the insurer, corporation, or health maintenance organization shall again provide coverage for behavioral health treatment required under this section;

3. An insurer, corporation, or health maintenance organization may claim an exemption for a subsequent year, but only if the conditions specified in subdivision 1 again are met; and

4. Notwithstanding the exemption allowed under subdivision 1, an insurer, corporation, or health maintenance organization may elect to continue to provide coverage for behavioral health treatment required under this section.

K. Coverage under this section will be subject to an annual maximum benefit of \$35,000, unless the insurer, corporation, or health maintenance organization elects to provide coverage in a greater amount.

L. As of January 1, 2014, to the extent that this section requires benefits that exceed the essential health benefits specified under § 1302(b) of the federal Patient Protection and Affordable Care Act (H.R. 3590), as amended (the ACA), the specific benefits that exceed the specified essential health benefits shall not be required of a qualified health plan when the plan is offered in the Commonwealth by a health carrier through a health benefit exchange established under § 1311 of the ACA. Nothing in this subsection shall nullify application of this section to plans offered outside such an exchange.

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

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this 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 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 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1306.1, § 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 Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.17, 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 through ~~38.2-3418.16~~ 38.2-3418.17, 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, 38.2-3540.2, 38.2-3541.1, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, 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.) except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this 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 through 38.2-225, 38.2-229, 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 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, 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 seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6, and 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions F 1, F 2, and F 3 of subsection F 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, 38.2-3540.2, 38.2-3541.2, 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.) 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.

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

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