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HOUSE BILL NO. 1940

Offered January 14, 2015
Prefiled January 13, 2015

A BILL to amend and reenact § 38.2-3418.17 of the Code of Virginia, relating to health insurance; coverage for autism spectrum disorder.

Patrons—Greason, Hugo, Yancey, Albo, BaCote, Bulova, Davis, DeSteph, Filler-Corn, Futrell, Herring, Hester, Hope, Howell, James, Keam, Kory, Krupicka, LeMunyon, Lindsey, Lopez, Loupassi, Marshall, R.G., Mason, McClellan, O'Bannon, Plum, Rasoul, Rust, Sickles, Simon, Stolle, Sullivan, Surovell, Torian, Tyler, Villanueva and Yost; Senators: Ebbin and Reeves

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-3418.17 of the Code of Virginia is amended and reenacted 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 *(i) from January 1, 2012, until January 1, 2016,* from age two *years* through age six *years and (ii) from and after January 1, 2016, of any age,* subject to the annual maximum benefit limitation set forth in subsection K *and to the provisions of subsection G*. ~~If~~ *The provisions of the preceding sentence that until January 1, 2016, limit the requirement to provide such coverage to individuals not older than age six shall not be construed to preclude the provision of such coverage to* an individual who is being treated for autism spectrum disorder *and* 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 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 following care prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary: (i) behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v) therapeutic care, and (vi) applied behavior analysis when provided or supervised by a board certified behavior analyst who shall be licensed by the Board of Medicine. The prescribing practitioner shall be independent of the provider of applied behavior analysis.

"Treatment plan" means a plan for the treatment of autism spectrum disorder developed by a licensed physician or a licensed psychologist 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, including an independent review, not more than once every 12 months unless the insurer, corporation, or health maintenance organization and the individual's licensed physician or licensed psychologist agree that a more frequent review is necessary. The cost of obtaining any review, including an independent review, shall be covered under the policy, contract, or plan.

D. Coverage under this section will not be subject to any visit limits, and shall be neither 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.

E. Nothing shall preclude the undertaking of usual and customary procedures, including prior authorization, 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.

F. The provisions of this section 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; (iii) policies, contracts, or plans issued in the individual market or small group markets to employers with 50 or fewer employees; or (iv) policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

G. The requirements of this section *requiring that coverage be provided with regard to individuals from age two years through age six years* shall apply to all insurance policies, subscription contracts, and health care plans delivered, issued for delivery, reissued, or extended on or after January 1, 2012, *but prior to January 1, 2016, and the requirements of this section requiring that coverage be provided without regard to the age of an individual shall apply to all insurance policies, subscription contracts, and health care plans delivered, issued for delivery, reissued, or extended on or after January 1, 2016,* 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.

H. 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. This section shall not be construed as diminishing any coverage required by § 38.2-3412.1:01. This section shall not 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 service plan.

I. Pursuant to the provisions of § 2.2-2818.2, this section shall apply to health coverage offered to state employees pursuant to § 2.2-2818 and to health insurance coverage offered to employees of local governments, local officers, teachers, and retirees, and the dependents of such employees, teachers, and retirees pursuant to § 2.2-1204.

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

1. An insurer, corporation, or health maintenance organization, or a governmental entity providing coverage for such treatment pursuant to subsection I, is exempt from providing coverage for behavioral health treatment required under this section and not covered by the insurer, corporation, health maintenance organization, or governmental entity providing coverage for such treatment pursuant to subsection I as of December 31, 2011, if:

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

(1) Based on an analysis to be completed no more frequently than one time per year by each insurer, corporation, or health maintenance organization, or such governmental entity, for the most recent

experience period of at least one year's duration, the costs associated with coverage of behavioral health treatment required under this section, and not covered as of December 31, 2011, exceeded one percent of the premiums charged over the experience period by the insurer, corporation, or health maintenance organization; and

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

b. The Commissioner approves the certification of the actuary;

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, or such governmental entity, shall again provide coverage for behavioral health treatment required under this section;

3. An insurer, corporation, or health maintenance organization, or such governmental entity, 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, or such a governmental entity, may elect to continue to provide coverage for behavioral health treatment required under this section.

K. Coverage for applied behavior analysis 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.