CONNECTICUT: Frequently Asked Questions About the Autism Insurance Reform Law

1. **What does the Autism Insurance Reform Act do?**

   Broadly speaking, the act requires many private insurers to begin covering the costs of diagnostic assessments for autism and services for individuals with autism who are under the age of 15.

   Insurance providers can limit the coverage for *behavioral therapy* in the following manner:

   - Benefits up to $50,000 per year for a child under 9;
   - Benefits up to $35,000 per year for a child ages 9-12; and
   - Benefits up to $25,000 per year for a child ages 13-14.

2. **When does the law requiring insurance companies to cover services for children with autism spectrum disorder go into effect?**

   The law went into effect on January 1, 2010.

3. **Once the act goes into effect, will my employer-provided health insurance be required to cover my child's autism services?**

   Each group health insurance policy that provides coverage for basic hospital expenses, basic and major medical-surgical expenses, or hospital and medical coverage to subscribers of a health care center will be required to provide coverage for the diagnosis and treatment of autism spectrum disorders.

4. **What happens if we get our insurance through an employer that self-insures?**

   Insurance provided by an employer that self-insures is not subject to the requirements of this act.

5. **What happens if we purchase individual health insurance?**

   As of January 1, 2009, each individual health insurance policy is required to provide coverage for physical therapy, speech therapy, and occupational therapy services for the treatment of autism spectrum disorders to the extent that such services are a covered benefit for other diseases and conditions. Insurance provided by a small employer or an employer that self-insures is not subject to the requirements of this act (i.e., required coverage of behavioral therapy).

6. **Are there limits on what our private insurance is going to be required to cover?**

   Yes. The act lists seven categories of treatments that insurers will be required to cover. There is an annual dollar cap on coverage of behavioral therapies that varies according to age – $50,000 for children under 9; $35,000 for children ages 9-12; and $25,000 for children ages 13-14. There are no limits on the number of visits to a provider. Coverage may be subject to other general limitations and exclusions of the group health insurance policy. However, an insurer cannot place higher copayments, deductibles, or other out-of-pocket expenses on the diagnosis and treatment of an autism spectrum disorder than for the diagnosis and treatment of any other medical, surgical, or physical health condition under the policy.

7. **How will the law be enforced?**

   An insurer that issues a policy that violates this law is subject to a fine of up to $1,000 per offense. The insurance commissioner may also revoke an out-of-state insurer's license for violating the act's provision.

Covered Services

1. **What coverage is mandated by the law?**

   The act requires coverage for the following types of services:

   - Behavioral therapy, including ABA
   - Pharmacy care
   - Direct psychiatric or consultative services
   - Direct psychological or consultative services
   - Physical therapy
   - Speech and language pathology, and
   - Occupational therapy

   Under this law, a policy must cover these services if they are (1) medically necessary, (2) identified and ordered by a licensed physician, psychologist, or clinical social worker for an insured person who has been diagnosed with autism, and (3) based on a treatment plan.

   The act also requires coverage for evaluations and tests needed to diagnose your child's autism disorder.

2. **Is applied behavioral analysis (ABA) covered?**

   Yes, the law's definition of "behavioral therapy" specifically includes ABA.

3. **Will all of the Autism Spectrum diagnoses be covered, or just those diagnoses with the keyword of "autism?"**

   Any of the pervasive developmental disorders defined in the current edition of the Diagnostic and Statistical Manual (DSM) are covered. These include: Autistic Disorder, Rett's Disorder, Childhood Disintegration Disorder, Asperger's Disorder, and Pervasive Developmental Disorder Not Otherwise Specified.

4. **Does Autism Spectrum Disorder (ASD) have to be the primary diagnosis for the child in order to qualify for coverage under the act?**

   No, there is no requirement that ASD be the "primary" diagnosis for your child to qualify for coverage under that act.

5. **Who determines what services are medically necessary?**

   Your child's licensed physician, licensed psychologist, or licensed clinical social worker will order the services that he/she identifies as medically necessary in accordance with your child's treatment plan.

6. **Will the new law require insurance companies to cover the cost of social groups? Must it be prescribed by a physician?**

   The act does not include a "list" of covered services. Rather, the law requires coverage for specific types of services. Therefore, coverage under the bill will be

determined by the insurance company based on the requirements of the law, whether the treatment is medically necessary, and whether the treatment is ordered as part of the child's treatment plan by a licensed physician, licensed psychologist, or licensed clinical social worker.

Private Insurance

1. **On January 1, 2010, will an insurance company be able to question my child's existing autism diagnosis?**

   No, an autism diagnosis shall be valid for a period of not less than twelve months, unless your child's licensed physician, licensed psychologist, or licensed clinical social worker determines a shorter period is appropriate or changes the results of your child's diagnosis.

2. **How often will insurance companies be able to review my child's treatment plan?**

   Insurance providers may review your child's treatment plan not once more than once every six months, unless your child's licensed physician, licensed psychologist, or licensed clinical social worker determines more frequent review is appropriate or changes your child's treatment plan.

Coinsurance, Copayments, Deductibles, and Other Out-of-Pocket Expenses

1. **Can insurance providers charge higher coinsurance, copayments, deductibles, or other out-of-pocket expenses for services for the treatment of ASD?**

   No, insurance providers may not charge higher coinsurance, copayments, deductibles, or other out-of-pocket expenses for coverage for the diagnosis and treatment of an autism spectrum disorder than for the diagnosis and treatment of any other medical, surgical, or physical health condition under the policy.

Other

1. **What is "utilization review"?**

   "Utilization review" refers to techniques used by health carriers to monitor the use of, or to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings. Some examples of techniques used include ambulatory review, prospective review, retrospective review, second opinion, certification, concurrent review, case management or retrospective review. (Source: National Association of Insurance Commissioners)

2. **What is "grievance review"?**

   "Grievance review" refers to a health carrier's internal processes for the resolution of covered persons' complaints. The complaints may arise out of a utilization review decision or involve the availability, delivery or quality of health care services; claims payment, handling or reimbursement for health care services; or matters pertaining to the contractual relationship between a covered person or health carrier. Some states may call it an "internal appeal" process. (Source: National Association of Insurance Commissioners)