LEGISLATIVE GENERAL COUNSEL
₵ Approved for Filing: D.M. Cheung ₵
₵ 01-24-19 3:48 PM ₵

AUTISM AMENDMENTS

2019 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Curtis S. Bramble

House Sponsor: _____

LONG TITLE

General Description:

This bill amends provisions related to insurance coverage for autism spectrum disorder.

Highlighted Provisions:

This bill:

- requires certain health benefit plans to provide coverage for behavioral health treatment for individuals with an autism spectrum disorder.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-22-642, as last amended by Laws of Utah 2018, Chapter 183

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **31A-22-642** is amended to read:

31A-22-642. Insurance coverage for autism spectrum disorder.

(1) As used in this section:

(a) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially

S.B. 95

significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(b) "Autism spectrum disorder" means pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(c) "Behavioral health treatment" means counseling and treatment programs, including applied behavior analysis, that are:

(i) necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and

(ii) provided or supervised by a:

(A) board certified behavior analyst; or

(B) person licensed under Title 58, Chapter 1, Division of Occupational and Professional Licensing Act, whose scope of practice includes mental health services.

(d) "Diagnosis of autism spectrum disorder" means medically necessary assessments, evaluations, or tests:

(i) performed by a licensed physician who is board certified in neurology, psychiatry, or pediatrics and has experience diagnosing autism spectrum disorder, or a licensed psychologist with experience diagnosing autism spectrum disorder; and

(ii) necessary to diagnose whether an individual has an autism spectrum disorder.

(e) "Pharmacy care" means medications prescribed by a licensed physician and any health-related services considered medically necessary to determine the need or effectiveness of the medications.

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

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

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

(i) "Treatment for autism spectrum disorder":

(i) means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a physician or a licensed

psychologist described in Subsection (1)(d) who determines the care to be medically necessary; and

(ii) includes:

(A) behavioral health treatment, provided or supervised by a person described in Subsection (1)(c)(ii);

(B) pharmacy care;

(C) psychiatric care;

(D) psychological care; and

(E) therapeutic care.

(2) (a) Notwithstanding the provisions of Section 31A-22-618.5, a health benefit plan offered in the individual market or the large group market and entered into or renewed on or after January 1, 2016, and before January 1, 2020, shall provide coverage for the diagnosis and treatment of autism spectrum disorder:

[~~(a)~~] (i) for a child who is at least two years old, but younger than 10 years old; and

[~~(b)~~] (ii) in accordance with the requirements of this section and rules made by the commissioner.

(b) Notwithstanding the provisions of Section 31A-22-618.5, a health benefit plan entered into or renewed on or after January 1, 2020, shall provide coverage for the diagnosis and treatment of autism spectrum disorder in accordance with the requirements of this section and rules made by the commissioner.

(3) The commissioner may adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to set the minimum standards of coverage for the treatment of autism spectrum disorder.

(4) Subject to Subsection (5), the rules described in Subsection (3) shall establish durational limits, amount limits, deductibles, copayments, and coinsurance for the treatment of autism spectrum disorder that are similar to, or identical to, the coverage provided for other illnesses or diseases.

(5) (a) Coverage for behavioral health treatment for a person with an autism spectrum disorder shall cover at least 600 hours a year.

(b) Notwithstanding Subsection (5)(a), for a health benefit plan entered into or renewed on or after January 1, 2020, coverage for behavioral health treatment for a person with an

autism spectrum disorder may not have a limit on the number of hours covered.

(c) Other terms and conditions in the health benefit plan that apply to other benefits covered by the health benefit plan apply to coverage required by this section.

[~~(b)~~] (d) Notwithstanding Section 31A-45-303, a health benefit plan providing treatment under [~~Subsection (5)(a)~~] Subsections (5)(a) and (b) shall include in the plan's provider network both board certified behavior analysts and mental health providers qualified under Subsection (1)(c)(ii).

(6) A health care provider shall submit a treatment plan for autism spectrum disorder to the insurer within 14 business days of starting treatment for an individual. If an individual is receiving treatment for an autism spectrum disorder, an insurer shall have the right to request a review of that treatment not more than once every six months. A review of treatment under this Subsection (6) may include a review of treatment goals and progress toward the treatment goals. If an insurer makes a determination to stop treatment as a result of the review of the treatment plan under this subsection, the determination of the insurer may be reviewed under Section 31A-22-629.

(7) (a) In accordance with Subsection (7)(b), the commissioner shall waive the requirements of this section for all insurers in the individual market or the large group market, if an insurer demonstrates to the commissioner that the insurer's entire pool of business in the individual market or the large group market has incurred claims for the autism coverage required by this section in a 12 consecutive month period that will cause a premium increase for the insurer's entire pool of business in the individual market or the large group market in excess of 1% over the insurer's premiums in the previous 12 consecutive month period.

(b) The commissioner shall waive the requirements of this section if:

(i) after a public hearing in accordance with Title 63G, Chapter 4, Administrative Procedures Act, the commissioner finds that the insurer has demonstrated to the commissioner based on generally accepted actuarial principles and methodologies that the insurer's entire pool of business in the individual market or the large group market will experience a premium increase of 1% or greater as a result of the claims for autism services as described in this section; or

(ii) the attorney general issues a legal opinion that the limits under Subsection (5)(a) or (b) cannot be implemented by an insurer in a manner that complies with federal law.

(8) If a waiver is granted under Subsection (7), the insurer may:

(a) continue to offer autism coverage under the existing plan until the next renewal period for the plan, at which time the insurer:

(i) may delete the autism coverage from the plan without having to re-apply for the waiver under Subsection (7); and

(ii) file the plan with the commissioner in accordance with guidelines issued by the commissioner;

(b) discontinue offering plans subject to Subsection (2), no earlier than the next calendar quarter following the date the waiver is granted, subject to filing guidelines issued by the commissioner; or

(c) nonrenew existing plans that are subject to Subsection (2), in compliance with Subsection 31A-22-618.6(5) or [~~Subsection~~] 31A-22-618.7(3).