



ARKANSAS

FREQUENTLY ASKED QUESTIONS ABOUT THE AUTISM INSURANCE REFORM LAW

1. Generally speaking, what does the Arkansas law do?

The law requires all group health plans to cover the diagnosis and treatment for autism spectrum disorder. Diagnosis means medically necessary assessment, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder. Treatment includes medically necessary and evidence-based applied behavior analysis, pharmacy care, psychiatric care, psychological care, therapeutic care, and equipment determined to be necessary for treatment. Applied behavior analysis is limited to a \$50,000 annual cap and to individuals under 18 years of age. Other coverage is not limited by age or dollar cap.

Plans offered through the state's medical exchange that provide essential benefits specified by the new federal healthcare reform act are not required to provide benefits that exceed the federally specified amount. However, plans outside of the exchanges will still need to provide coverage.

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

Plans issued or renewed on or after October 1, 2011 are required to cover services for children with autism spectrum disorder.

3. Will my employer-provided health insurance be required to cover my child's autism services?

Whether private employer-provided health insurance will cover your child's autism depends on how the employer funds and administers the insurance. Private employers have three options for how they provide insurance: (1) they can buy a fully-funded plan from a third-party health insurer (2) they can fund and administer the plan themselves, or (3) they can fund the plan, but hire a third-party to administer the plan

If your employer buys a fully funded plan from a third party insurer (option 1), then they will have to follow the law and cover your child's autism services. However, if your employer "self-funds" the plan (options 2 and 3) it is exempt from the law and

does not need to cover your child's autism services. Unfortunately, it can be hard to tell whether your employer self-funds the plan or not because plans that are purchased fully funded from a third-party insurer and those that are "self-funded" by the employer, but are given to a third-party insurer to administer look the same to the employees. To find out whether your employer-provided plan is self-funded, ask your employer.

4. I work for a small company with only 10 employees, and I get my insurance through my company. Will my company's policy provide coverage for autism?

All group health insurance plans are included in the law, so as long as your employer-provided plan is not "self-funded" (see above) it should provide coverage for autism.

5. Will my child be covered under the mandate if I buy my health insurance through the individual market instead of through my employer?

No, individual plans are not required to provide coverage under the law.

6. I am a state employee or retiree and my family is insured by the State Health Plan. Is my child's coverage included in the mandate?

The law will provide coverage, but only if the state's plan is not self-funded.

7. How do I know if my health benefit plan is a self-funded plan?

To find out whether your employer-provided plan is self-funded, ask your employer. It is often difficult to tell whether your private employer-provided plan is self-funded because plans that are self-funded by the employer but administered by a third-party insurer often look the same as plans that are purchased fully funded from a third-party insurer. For example, an employee covered by a self-funded plan administered by Blue Cross Blue Shield would have the same health insurance card as an employee covered by a fully-funded plan purchased from Blue Cross Blue Shield. Additionally, plan documents that may be provided by your employer are often unclear or inaccurate as to whether the plan is self-funded. Your human resources department should have the information, or they will be able to direct you to someone who can answer the question for you.

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

Covered autism services must be prescribed, provided, or ordered for a specific individual by a licensed physician or a licensed psychologist, and must be determined by that health professional to be medically necessary and evidence-based. The law defines "medically necessary" as expected to "prevent the onset of

...disability,” “reduce or ameliorate the...effects of a...disability,” and “assist to achieve or maintain maximum functional capacity.”

Applied behavior analysis is only covered up to \$50,000 per year, and only for individuals up to 18 years of age.” ABA therapy must be provided by, or under the supervision of, a certified behavior analyst. There are no limits on the number of visits to a provider. There may be other limits, deductibles or copayments, but they cannot be less favorable than those required for other illnesses covered by the plan. The insurers can request review of the medical necessity of the treatment, but not to a greater extent than for other covered illnesses.

9. How will the law be enforced? To whom can I complain if my insurance company doesn't pay?

The Insurance Commissioner has the same enforcement powers granted by law to enforce other insurance laws to insure enforcement of the Act. If your claim has been denied, you should appeal the decision within your insurance company.

You may also file a complaint with the Arkansas Insurance Department at 501-371-2640 or insurance.consumers@arkansas.gov. (<http://www.insurance.arkansas.gov/Consumers/divpage.htm>) You may also want to contact an attorney to inquire as to whether legal action is appropriate.

10. What coverage is mandated by law?

The law requires that group plans provide coverage for medically necessary and evidence-based services for diagnosis and treatment of autism spectrum disorder. Diagnosis includes medically necessary assessments, evaluations, or tests to diagnose whether or not an individual has an autism spectrum disorder. To be evidence-based, treatment has to be subject to research that applies rigorous, systematic, and objective procedures to obtain valid knowledge relevant to autism spectrum disorders. Covered treatment includes:

- Applied behavior analysis supervised by a Board Certified Behavior Analyst
- Pharmacy care
- Psychiatric care
- Psychological care
- Therapeutic care
- Equipment necessary for treatment

11. Is applied behavior analysis (ABA) covered? Does the law say who must supervise my child's ABA therapy program? Must the insurer cover the line therapists?

Applied behavior analysis is only covered up to \$50,000 per year, and only for individuals up to 18 years of age.” ABA therapy must be provided by, or under the supervision of, a certified behavior analyst. Thus the law provides coverage for the

line therapist, so long as the line therapist works under the supervision of a certified behavior analyst.

12. Will all of the autism spectrum diagnosis be covered?

Yes, the law defines “autism spectrum disorder” as any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders including autistic disorder, Asperger’s disorder, and pervasive developmental disorder not otherwise specified.

13. Does autism spectrum disorder have to be the primary diagnosis for the child in order to qualify for coverage?

No, autism spectrum disorder does not have to be the primary diagnosis for the child in order to qualify for coverage.

14. Who determines what services are medically necessary for my child?

Covered autism services must be prescribed, provided, or ordered for a specific individual by a licensed physician or a licensed psychologist, and must be determined by that health professional to be medically necessary and evidence-based.

15. Will an insurance company be able to question my child’s existing autism diagnosis?

Insurers may request a review of your child’s treatment, but not more frequently than for other covered illnesses. And there is nothing in the law that prohibits an insurer from questioning an existing diagnosis. However, under the new healthcare reform law (the Patient Protection and Affordable Care Act) an insurer may not deny coverage because of a pre-existing condition. Additionally, if your insurance plan is covered by the law, they are required to cover any diagnostic evaluations or assessments that you may have to re-take.

16. Will insurance companies be able to deny services if my child is not making “sufficient” progress or has reached a plateau in his/her progress?

Insurance companies may not be able to deny services as long as the services are helping your child maintain function.