



IOWA

FREQUENTLY ASKED QUESTIONS ABOUT THE AUTISM INSURANCE REFORM LAW

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

The law requires any State employee group plan to cover diagnosis and treatment for autism spectrum disorder for covered individuals less than 21 years of age. There is an annual coverage cap of \$36,000, which must be adjusted for inflation every year beginning in 2014. Coverage includes medically necessary assessment, evaluations, or tests performed by certain licensed health providers to diagnose whether an individual has autism spectrum disorder, and treatment, including medically necessary pharmacy care, psychiatric care, psychological care, rehabilitative care, including applied behavior analysis, and therapeutic care that is either ordered or provided by a licensed health provider, or is provided by an autism service provider or a group or entity that works under an autism service provider. Autism service providers must be either certified behavior analysts or a State licensed health professional.

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

The law goes into effect for the State employee health plan when it is issued or renewed on or after January 1, 2011.

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

The law only applies to the State employee health plan; therefore, if you have private employer-based insurance, your plan will not be required to cover autism services. If you work for the State, your insurance will be required to cover autism services for your child. Coverage must be provided up to \$36,000 per year for children less than 21 years old for medically necessary diagnosis and treatment, including applied behavior analysis.

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?

The law requires only the State employee plan to cover services for autism spectrum disorder. Private group and individual plans are not covered and so are not required to cover these services.

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, the law applies only to the State employee plan, so individual plans are not required to provide coverage for services for autism spectrum disorder.

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?

Yes, under the law the State Health Plan is required to provide coverage for autism spectrum services up to \$36,000 per year for children less than 21 years old. Coverage must be provided for medically necessary diagnosis and treatment, including applied behavior analysis. However, the law does not apply to limited or condition-specific plans.

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

Private insurance is not included in the law, and, therefore, are not required to provide coverage for services for autism spectrum disorder.

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

If your coverage has been denied and you have tried appealing the decision with your insurance company, you may file a complaint with Iowa Insurance Division at <http://www.iid.state.ia.us/complaints/index.asp>. You may also want to contact an attorney to inquire whether legal action is appropriate.

9. What coverage is mandated by law?

The law requires the State Health Plan to cover diagnosis and treatment of autism spectrum disorder up to \$36,000 a year for individuals less than 21 years old. Coverage includes medically necessary assessment, evaluations, or tests performed by certain licensed health providers to diagnose whether an individual has autism spectrum disorder, and treatment including:

- Medically necessary pharmacy care
- Psychiatric care
- Psychological care
- Rehabilitative care, including applied behavior analysis

- Therapeutic care that is either ordered or provided by a licensed health provider, or is provided by an autism service provider or a group or entity that works under an autism service provider.

Autism service providers must be either certified behavior analysts or a State licensed health professional. There cannot be limits on the number of visits to an autism services provider. Insurance companies may require deductibles, copayment and coinsurance, but only to the same extent as it requires them for other medical services covered by the plan. Additionally, the treatment plan, which must be created by a licensed health professional in coordination with the patient, may be reviewed by the insurance company every six months, although the results of diagnosis may not be questioned for 12 months.

10. 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?

Yes, applied behavior analysis is covered as rehabilitative treatment. The ABA therapy must be performed by an individual (or group of individuals) who are certified behavior analysts or State-licensed health professionals. Line therapists who are not certified or licensed will be covered by the law, so long as an "autism service provider" supervises the therapist.

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

Yes, autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified are all included in the definition of autism spectrum disorders, consistent with the Diagnostic and Statistical Manual of Mental Disorders (DSM).

12. 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. Coverage for any health conditions unrelated to or distinguishable from autism spectrum disorder are not affected by this law.

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

Whether a service is medically necessary is initially determined by the provider. However, when deciding whether to cover services, insurers may use their own criteria to determine what is medically necessary.

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

Diagnostic tests performed by a licensed health professional may not be questioned for 12 months unless a licensed health provider determines that more frequent testing is necessary. However, after those 12 months the insurance company may be able to question the diagnosis or require your child to be retested.

15. 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?

The insurance company is allowed to review your child's treatment plan every six months to determine if it is medically necessary. However, treatment may still be medically necessary as long as it prevents loss of attained skill or function.