



ILLINOIS: Frequently Asked Questions About the Autism Insurance Reform Law

What does Public Act 95 do?

Broadly speaking, the Act does two main things:

1. It requires many private insurers to begin covering the costs of diagnostic assessments for autism and of treatments for individuals with autism who are under the age of 21, up to \$36,000 per year;
2. It requires that early intervention services are provided by certified early intervention specialists as defined in Illinois law.

The specific terms and provisions of this law are described in more detail in this FAQ document.

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

Most sections of the Autism Insurance Act go into effect December 12, 2008, including the provisions that require many insurers to cover services for autism spectrum disorder.

Once the Autism Insurance Act goes into effect, will my employer-provided health insurance be required to cover my child's autism services?

Employers with at least 50 employees and that offer group health insurance coverage are required to offer autism services for children under the age of 21.

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

Insurance companies are not required to cover the costs of services that fall outside the mandated services defined in Act 95. For those mandated services though, there will be no limits on the number of visits to a provider. There is a \$36,000 annual cap on coverage. Beginning December 31, 2009, the cap will be adjusted upwards annually to account for inflation. Coverage may be subject to other limitations and exclusions as long as they are allowed under Act 95.

How will the law be enforced?

The Illinois Insurance Department has strong regulatory powers to enforce the law. In addition, each health insurance company doing business in Illinois is required to submit a compliance report (not sure about this, haven't been able to find info here).

Covered Services

What coverage is mandated by the law?

Act 95 requires coverage for diagnostic assessments, pharmacy care, psychiatric care, psychological care, and therapeutic care. These categories of mandated services are defined in the law. More specifically, the new act will cover evaluations and tests needed to diagnose your child's autism disorder, as well as the development of a plan to provide health care services for your child. This plan may include medically necessary prescribed treatments such as behavioral analysis and rehabilitative care, prescription drugs, psychiatric and psychological services, speech/language therapy, occupational therapy and physical therapy.

Is applied behavioral analysis (ABA) covered?

Yes. The law's definition of rehabilitative care specifically includes ABA.

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

Any of the pervasive development disorders defined in the current edition of the Diagnostic and Statistical Manual (DSM) are covered. These include: autistic disorder, Asperger Syndrome, Childhood Disintegration Disorder and Pervasive Development Disorder (Not Otherwise Specified).

Does Autism Spectrum Disorder (ASD) have to be the primary diagnosis for the child in order to qualify for coverage under Act 95?

No, there is no requirement that ASD must be the "primary" diagnosis for the child to qualify for coverage under Act 95. Behavioral Specialist, Mobile Therapy (I think) and Therapeutic Staff Support are covered by the Illinois program.

Will these services be covered by commercial carriers under Act 95?

Behavioral Specialist Consultation, Mobile Therapy, and Therapeutic Staff Support are all covered services under Act 95 as long as they fall under the definition of "treatment of autism spectrum disorders." This means that they must be determined to be medically necessary and included in a treatment plan. These services could fall into the "rehabilitative care" or "psychological care" categories of care that are included in the Act.

Is Case Management covered?

Case Management is not a mandated service under Act 95.

Who determines what services are medically necessary?

The patient's physician or psychologist indicates on the treatment plan what services are medically necessary, however there is a utilization review process within the insurance company that may review the services ordered on the treatment plan.

If the commercial insurance company denies based on medical necessity, then will the Behavioral Health Managed Care Organization (BHMCO) automatically cover the services through the Medical Assistance program?

If commercial insurers deny based on medical necessity, the decision may be appealed, although the specific process is not outlined in Act 95. The challenge by the insurer must include a physical with expertise in the most current and effective treatments for autism. [I'm assuming you could appeal, but no information is provided about this, so I'll need check somewhere for more information, and for an Illinois equivalent to BHMCO].

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

Act 95 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 or a licensed psychologist/psychiatrist.

Private Insurance

On December 30, 2009, will an insurance company be able to question my child's existing autism diagnosis?

No. Under Act 95, an autism diagnosis shall be valid for an unspecified period unless a licensed physician or licensed psychologist determines a reassessment is necessary and the reassessment indicates otherwise. However, Illinois law allows insurance companies to exclude coverage for pre-existing conditions including autism, for up to 2 years.

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?

No. The law specifically requires coverage of services intended to produce progress as well as those intended to prevent regression.

Will private insurers be developing their own medical necessity criteria?

Private insurers will use their own medical necessity criteria. The patient's physician or psychologist indicates on the treatment plan what services are medically necessary,

however there is a utilization review process within the insurance company that may review the services ordered on the treatment plan.

If my insurance company denies my child's autism diagnostic or treatment services, where can I go for help?

Families can appeal any denial or partial denial of an autism diagnostic or treatment service to your insurance company and obtain a decision on an expedited basis. If your appeal is denied by the insurance company, your family can appeal for an independent, external review. If the independent external review denies your appeal, you can further appeal to a court of competent jurisdiction. [I'm assuming this is applicable for Illinois since administrative appeals is listed under the administrative code].

If a service is denied by a commercial insurer on medical necessity grounds for a child with dual coverage, will Medical Assistance consider itself bound by that decision?

No. If a service is denied by the private insurer, the family should appeal the decision. However, the Medical Assistance program will review the request for services based on the medical documentation provided and will use the MA program regulatory definition of medical necessity to determine MA approval and payment for services.

If a child is being seen by care paid for and coordinated by the commercial insurer and then the \$36,000 cap is reached, will the Behavioral Health Managed Care Organization (BHMCO) be required to approve care for that child with the same provider? At the same rates? What if the provider is not licensed by DPW to provide that service?

Behavioral Health Managed Care Organization under the Health Choices program are required to operate under the definitions and rules of commonwealth's Medical Assistance (MA) program. Commercial insurers can establish their own medical necessity criteria apart from the MA definition. Act 95 is silent on rates. Providers must be enrolled in the MA program to be eligible for reimbursement the service. Overall, Illinois Department of Public Health believes that continuity of care will be better served if the definitions and networks of the MA program (and its BH MCOs) and commercial insurers are similar. DPH is working on many fronts, including the implementation of Act 95, to strengthen the network of autism service providers in Illinois. (I have to check this still, have just found the web-page but there isn't much information).

Adult Basic

How will medications be covered for persons under 21 with ASD in the Adult Basic category? Will the covered medications be limited to medications prescribed for autism? If so, how will it be determined whether the medication is for autism or another condition?

New contracts with the insurers for Adult Basic will not be in place before December 30, 2009 but will include coverage for medications to treat autism spectrum disorder (ASD) conditions. In terms of what drugs would be covered specifically, we will need assistance by clinical experts involved in the diagnosis and treatment of ASD to assist us in that determination. We would limit coverage to those medications needed to treat ASD, the same as we currently provide for medications associated with diabetes in Adult Basic. It is important to note that many 19 and 20 year olds who are not in school and who have this disorder may qualify for SSI since SSA stops deeming parental income to a child at age 18 if they are not in school.

Qualified Providers and Licensing

Which providers and services will be eligible for reimbursement under Act 95?

Reimbursement is required for any mandated service provided pursuant to a comprehensive autism treatment plan and which is provided by qualified professionals. These professionals include licensed physicians, licensed physician assistants, licensed psychologists, licensed clinical social workers, certified registered nurse practitioners and those who work under their direction. Grandfathering clauses are included to ensure continuity of care for services provided by certain unlicensed professionals: those who work at the direction of the licensed professionals listed above, professionals enrolled in the Medical Assistance program, and behavior specialists pending their licensure.

Will current providers be part of the network and can we stay with the same provider when cap is reached?

Current providers are grandfathered as licensed, but they will need to be part of your insurance company's network. When the cap is reached, if you want to stay with that same provider, they will need to be part of the MA network.

How can I be sure that the health care provider has the certification or license necessary to diagnose my child's autism disorder and provide services?

The State Board of Medicine, along with the Department of Professional Regulation, will oversee the licensing and certification of autism health care providers. You should check with your health insurance company to be sure that the company recognizes the health care provider you are using as properly certified or licensed. If the provider is not recognized, you may not be covered for the services provided. During the transition period while the bill is being implemented, providers who offer treatment of autism spectrum disorders and who are enrolled in the Medical Assistance program will be considered eligible providers.

I am a practicing Behavior Specialist in Illinois and would like to apply for this licensure. How do I do this?

The State Board of Medicine in conjunction with the Department of Professional Regulation are developing regulations pertaining to the licensing of Behavior Specialists providing services for children and adolescents with autism. The regulations, specifics and qualifications for this licensure will be forthcoming. Additional information will be posted on the Illinois Insurance Web site (<http://www.insurance.illinois.gov/>) as it becomes available.

When will licensing information for autism health care providers be available?

I'm not sure about this, still looking.

Where can I find Medical Assistance provider enrollment information?

This information can be found at: www.hfs.illinois.gov/medical/apply.html

Is "psychological care" limited to licensed psychologists?

Yes, psychological care is defined as care provided by licensed psychologists.

Does the definition of "psychiatric care" imply that a psychiatrist must be board-certified in order to qualify for coverage?

No, there is no requirement in the definition of "psychiatric care" that implies that the psychiatrist must be board-certified.

For psychiatric and psychological care, what is the definition of "Consultative Services" for ASD?

Consultative means to advise or consult. Consultative Services are advisory to the treating psychiatrist or psychologist.

Is the intent that all Rehabilitative Care will be provided directly by licensed or certified Behavior Specialists?

No, the definition of "autism service provider" includes behavioral specialists who may or may not be currently licensed as well as other provider types.

Are licensed speech language pathologists eligible to provide services under the bill?

Licensed speech language pathologists are eligible to provide services under Act 95 pursuant to a treatment plan, if they are enrolled as a Medical Assistance provider. Private insurers are only required to "contract with and accept as a participating provider any autism service provider within its service area who is also enrolled in the Medical Assistance program who agrees to accept the payment levels, terms and conditions

applicable to the insurer's other participating providers." Private insurers may choose to but are not required to contract with other practicing providers.

Copayments, Deductibles and Co-insurance

I have a child with a diagnosis of autism and I have commercial insurance. Will Medical Assistance cover the cost of the copays and deductibles associated with my commercial coverage for autism services?

Act 95 has no impact on the rules in Illinois' Medical Assistance (MA) program regarding copayments and deductibles. MA will cover copayment, deductible and coinsurance provisions for children with autism exactly as it does today, using the same rules and standards as it does for non-autism related services.

Families should ask themselves two simple questions:

1. Is my child eligible for and enrolled in MA? If the answer is no, MA will not pay for copays or deductibles.
2. Is the service provider enrolled in the MA Program? If the answer is no, MA will not pay the copay because the provider is not part of the MA system. In this case, the family will be responsible for paying the private insurance copay.

If you answer yes to those two questions listed above and are getting your copays covered today, you will continue to get your copays covered under Act 95. Parents should be aware that they cannot pay the provider and then ask to be reimbursed by the MA program. Providers bill MA directly and MA determines if they are eligible.

I am an autism services provider. Are there special rules for provider reimbursement from the Medical Assistance program under Act 95?

Nothing in Act 95 changes the rules or policies on provider reimbursements in the MA program. MA will use the same Third Party Liability (TPL) rules as it does today and as it does with all other services and with other conditions besides autism.

If a child is enrolled in the MA program and the service is medically necessary, the provider must present the claim to the MA program for a determination of secondary MA payment. MA will assess the amount that it will pay on the claim and will provide information to the provider on any additional payment from the MA Program. The amount of the MA payment to the provider, including a zero payment, is considered payment in full and the provider may not seek any additional payment from the family/recipient.

Providers must be enrolled in the MA Program to be eligible to receive payment, including private insurance copayments, from the MA program. The MA program will not pick up the copay for and has no jurisdiction over providers who are not enrolled in the

MA program. Under the rules of the MA program, the combined amount the MA provider receives from the insurance company and the amount paid by the MA Program is considered payment in full. Providers must bill MA, and not the families. All providers who are enrolled in MA have agreed to these rules and they will remain in force.

Other Questions

Will services like Behavioral Specialist and Mobile Therapy be covered under behavioral health benefits or physical health benefits?

Act 95 does not specify whether the required coverage is to be part of the behavioral health or physical health benefit. The decision on which benefit is responsible will be left to the individual insurer.

How is the Third Party Liability being handled in the coordination of benefits between public and private insurers?

Third Party Liability and the coordination of benefits between public and private insurers will occur the same way that it does currently for those individuals who have both private insurance coverage and are eligible for Medical Assistance.

Do I have to give the insurance company a copy of my child's Individualized Education Program?

No. Mandated coverage under Act 95 cannot be made contingent upon coordination of services with an IEP. The law does permit coordination of coverage, but only with the consent of the child's parent or guardian consistent with state and federal law.

Will representatives from commercial insurance plans participate in service plan meetings?

Act 95 does not specify whether or not representatives of the commercial insurance policies may participate in service plan meetings.

If you cannot find the answer you need, please contact the state Department of Health Care and Family Services and/or the Department of Public Health.