



MAINE

FREQUENTLY ASKED QUESTIONS ABOUT THE AUTISM INSURANCE REFORM LAW

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

The law requires health insurance plans to cover diagnosis and treatment of autism spectrum disorder for children through 5 years old. Treatments include habilitative and rehabilitative care (including applied behavior analysis, psychiatric care, psychological care, and therapeutic care, when prescribed following a determination of medical necessity by a licensed physician or a licensed psychologist. Coverage for applied behavior analysis (ABA) is limited to \$36,000 per year, but there are no limits on the number of provider visits, and there are no dollar or number of visit limitations on other covered treatments.

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

The law applies to plans 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?

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 when 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 or not your employer self-funds the plan 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 plans, including small group plans, are included under the law. Unless your company's plan is "self-funded" (see above) they are required to provide coverage for autism for children 5 years old and younger.

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

Yes, individual policies have to provide coverage diagnosis and treatment for children 5 years old and under with 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?

Unless the State Health Plan is "self-funded" (see above) the plan is required to provide coverage for autism for children 5 years old and younger.

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 can direct you where to look.

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

Private insurance is only required to cover autism spectrum services for children 5 years old and under, and only has to provide up to \$36,000 per year for applied behavior analysis. All treatment must be determined to be medically necessary by a licensed physician or licensed psychologist. The child's physician or psychologist may be required to demonstrate ongoing medical necessity for coverage at least annually.

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

If your insurance company denies your claim, you may file an appeal within the insurance company. You may also file a complaint with the Maine Bureau of Insurance at <http://www.maine.gov/pfr/insurance/complaint.htm>. Additionally, you may want to contact a lawyer to inquire if legal action is appropriate.

10. What coverage is mandated by law?

Individual and group plans, including HMO plans, are required to cover medically necessary diagnosis and treatment of autism spectrum disorder for children 5 years old and younger. Diagnosis includes assessments, evaluations and tests by a licensed physician or psychologist to diagnose whether an individual has autism spectrum disorder. Treatment includes:

- Habilitative and rehabilitative services, including applied behavior analysis, necessary to develop, maintain, and restore functioning
- Counseling services provided by a licensed health professional
- Therapy services provided by a licensed or certified therapist, and
- Prescription drugs, which are covered only to the extent that the policy would otherwise cover them

Insurers are only required to provide up to \$36,000 per year for ABA therapy, but there are no limits on diagnosis and other treatments. The plan can require deductibles, copayments or coinsurance and "reasonable limits." There is no limit on the number of visits to an autism spectrum service provider.

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?

Yes, applied behavior analysis is covered up to \$36,000 per year for children 5 years old and younger. ABA therapy must be provided by or under the supervision of a nationally certified behavior analyst.

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

Yes, the law covers services for any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM), including autistic disorder, Asperger's disorder, and pervasive development 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. An insurer may not apply payments for coverage unrelated to autism spectrum disorder to the maximum benefit established for ABA therapy.

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

Medically necessary health care is defined in the Maine insurance regulations as “services or products provided . . . for the purpose of preventing, diagnosing, or treating an illness, injury or disease” The products or services must be consistent with generally accepted standards of medical practice, clinically appropriate, scientifically demonstrated to be effective, representative of best practices, and not primarily for convenience of patient or practitioner. (<http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4301-A.html>) Initially, your child’s licensed physician or licensed psychologist determines what treatment is medically necessary, but the insurer may require the physician or psychologist to demonstrate ongoing medical necessity at least annually.

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

Yes, the child’s physician or psychologist may be required to demonstrate ongoing medical necessity for coverage at least annually. While the law does not directly state that a diagnosis may be questioned, a demonstration of ongoing medical necessity may infer question about diagnosis. However, if your insurance plan is covered by the law, the carrier is required to cover the cost of further diagnostic evaluations or assessments. Also keep in mind, 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.

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?

The child’s physician or psychologist may be required to demonstrate ongoing medical necessity for coverage at least annually. However, because habilitative and rehabilitative services are defined as developing, *maintaining*, and restoring the functioning of an individual to the extent possible, as long as your child is at least “maintaining” function the law requires coverage.