



## MISSOURI

### FREQUENTLY ASKED QUESTIONS ABOUT THE AUTISM INSURANCE REFORM LAW

#### **1. Generally speaking, what does the Missouri law do?**

The law requires all group health plans to cover the diagnosis and treatment of autism spectrum disorder. Individual plans are not required to provide coverage, but are required to make coverage available for an additional cost. Covered treatment includes psychiatric care, psychological care, habilitative or rehabilitative care, including applied behavior analysis, therapeutic care, and pharmacy care.

The law also creates the “Behavior Analyst Advisory Board” under the State Committee of Psychologists to license behavior analysts, review complaints, and make recommendations to the committee about behavior analysts.

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

The law requiring coverage of autism spectrum disorder goes into effect for policies 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?**

Small employers (with no more than 50 eligible members) that offer insurance to their employees must provide coverage for autism. However, if providing coverage causes premiums to increase 2.5 percent during any 12-month period, the small employer can ask the Missouri Department of Insurance for a waiver allowing the company an exemption from the law.

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

Individual health plans are not required to cover services for autism spectrum disorder. However, under the law they are required to make such services available for additional costs. When choosing or renewing your policy, ask your provider about the cost to include such services. The law also provides that insurers cannot deny services because of a previous autism spectrum diagnosis.

**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, the State employee health plan is required to provide coverage for diagnosis and treatment of autism spectrum disorder under the law. The plan will cover up to \$40,000 per year for applied behavior analysis for children up to their 19<sup>th</sup> birthday, and there is no limit to coverage of other services for autism spectrum disorder. However, the law does not apply to MO HealthNet, the State's health care plan for low income and vulnerable citizens.

**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?**

Applied behavior analysis is only covered up to \$40,000 per year for children up until their 19<sup>th</sup> birthday. The cap will be adjusted periodically for inflation. There are no monetary or age limits for other services and there are no annual limits on the number of visits. The treatment must be prescribed by the child's physician or psychologist and detailed in a treatment plan that is subject to review at least every six months. Insurers may require cost-sharing, such as deductibles, copayments, and coinsurance, but must not require more than for other physical conditions covered by the plan.

Additionally, if you obtain insurance through a small employer (less than 50 eligible employees) your employer may request a waiver to exempt them from the law after one year if premiums increase by 2.5 percent or more. However, the company must provide coverage for diagnosis and treatment of autism spectrum disorders for at least a full calendar year.

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

The Missouri Department of Insurance can help you determine whether your health plan is subject to the autism law or exempt and can accept complaints. You can call the Insurance Consumer Hotline at 800-726-7390. (<http://insurance.mo.gov/consumer/autismFAQ/>)

If your plan is required by the law to cover services for autism spectrum disorder but your claims continue to be denied, you should contact an attorney to determine whether legal action is appropriate.

## **10. What coverage is mandated by law?**

Group health plans are required to cover diagnosis and treatment for all autism spectrum disorders. Diagnosis includes medically necessary assessments, evaluations, or tests in order to diagnose whether an individual has an autism spectrum disorder. Coverage must be provided for medically necessary treatment ordered by a licensed physician or licensed psychologist, which may include:

- Psychiatric care
- Psychological care
- Habilitative or rehabilitative care, including applied behavior analysis
- Therapeutic care
- Pharmacy care

Coverage for applied behavior analysis is limited to \$40,000 per year for children up to their 19<sup>th</sup> birthday; this limit may be exceeded if the insurer determines that it is

medically necessary and gives prior approval. Other services do not have monetary or age limits.

There are no limits on number of visits, and any services provided for the treatment of autism, including ABA therapy, cannot have a greater deductible, coinsurance or copayment than other physical health care services covered by the plan.

**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. However, coverage for ABA is limited to \$40,000 and is available only for children up to their 19<sup>th</sup> birthday. Line therapists must be directly supervised by a licensed or certified behavior analyst, and any payments or reimbursements should be made to the supervising behavior analyst or the entity or group for which they work in order to be covered. These payments or reimbursements for services provided by a line therapist under the supervision of a licensed or certified behavior analyst must be included in the treatment plan and deemed medically necessary.

**12. Will all of the autism spectrum diagnoses be covered?**

Yes, autism spectrum disorders are defined in the law as a neurobiological disorder (an illness of the nervous system,) which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

**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?**

The physician or psychologist who creates the treatment plan specifies what services they believe are medically necessary, and the insurance company reviews the information using their own criteria. The insurance company will provide coverage for the services they determine to be medically necessary. If your treatment or claim is denied based on "medical necessity," you may appeal the denial. Contact an attorney to see if legal action is appropriate.

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

The law prohibits insurance companies from denying or refusing to issue health insurance coverage for an individual because of an autism spectrum diagnosis. However, under the law, the insurance company has the right to review the treatment plan every six months and this includes the provision information about the diagnosis. The insurance company will review all medical information about the diagnosis so that it can determine the medical necessity of the proposed treatment. The cost of obtaining any review or treatment plan is borne by the carrier.

**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 be able to deny services if your child is not making sufficient progress because they determine what is medically necessary by their own standards and habilitative and rehabilitative care is defined as "necessary to *develop* the functioning of an individual" (emphasis added).