



NEW MEXICO: Frequently Asked Questions About the Autism Insurance Reform Law

1. What does New Mexico's Autism Insurance Law do?

Broadly speaking, it does three things:

(1) It requires private health insurers to provide coverage for the diagnosis and treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis (ABA) for individuals who are 19 years of age or younger or 22 years of age or younger and enrolled in high school.

(2) It requires nonprofit health care plans to cover the costs of diagnosis and treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and ABA for an individual who is 22 or younger and is enrolled in high school.

(3) It provides that an insurer may not deny or refuse to issue health insurance coverage for medically necessary services or refuse to contract with, renew, reissue or otherwise terminate or restrict health insurance coverage for an individual because the individual is diagnosed as having autism spectrum disorder.

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

2. Are there any limitations on this coverage?

Yes. Coverage is subject to the following limitations:

(1) Coverage is limited to treatment prescribed by the insured's treating physician in accordance with a treatment plan;

(2) Coverage is subject to an inflation adjusted maximum benefit of \$36,000 per year and \$200,000 in total lifetime benefits;

(3) Coverage may be subject to other general exclusions and limitations of the insurer's policy or plan, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and utilization review of health care services, including the review of medical necessity, case management and other managed care provisions;

(4) Coverage may be excluded for services received under the federal Individuals with Disabilities Education Act (IDEA) and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children three to 22 years of age who have autism.

3. Does the coverage extend to self-funded health plans?

No. The law only applies to fully-funded health plans governed by state.

4. May Coverage be denied on the basis that services are habilitative or rehabilitative in nature?

No. The law specifically provides that coverage may not be denied on the basis that services are habilitative or rehabilitative in nature.

5. Is there “Mental Health Parity”?

Yes. The law specifically provides that the coverage may not be subject to dollar limits, deductibles or coinsurance provisions that are less favorable to an insured than those that apply to physical illnesses that are generally covered under the policy or contract, except for the limitations specifically listed above.

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

The law goes into effect June 19, 2009.

7. Are there limits on what our 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 the law. For these mandated services though, there will be no limits on the number of visits to an autism service provider. Furthermore, there is a \$36,000 annual cap on coverage and a \$200,000 lifetime cap on coverage. Beginning on January 1, 2011, the lifetime cap will be adjusted upwards annually to account for inflation.

8. What coverage is mandated by the law?

The law requires coverage for diagnostic assessments, speech therapy, occupational therapy, physical therapy and applied behavior analysis. These categories of mandated services are defined in the law. More specifically, the law will cover evaluations and tests needed to diagnose your child’s autism spectrum disorder, as well as the development of a plan to provide health care services to your child. This plan may include, but is not limited to diagnosis, proposed treatment by types, frequency and duration of treatment, the anticipated outcomes stated as goals, the frequency with which the treatment plan will be updated, and the signature of the treating physician.

9. Is applied behavior analysis (ABA) covered?

Yes, the law specifically states that ABA is covered and it also states that services may not be denied on the basis that the services are habilitative or rehabilitative in nature.

10. Will the law allow insurance companies to limit the number of visits to an autism service provider?

No. The law explicitly states that there can be no limit on the number of visits to an autism service provider.

11. Will all of the Autism Spectrum diagnoses be covered, or just those diagnosis with the keyword of “autism”?

Any of the pervasive developmental disorders defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) will be covered, including autistic disorder, Asperger’s disorder, pervasive developmental disorder not otherwise specified, Rett’s disorder, and childhood disintegrative disorder.

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

No, there is no requirement that ASD must be the “primary” diagnosis for the child to qualify for coverage under the Act, all of the pervasive developmental disorders defined in the most recent DSM are covered.

13. Which services are covered by carriers under the law?

The law specifically covers treatment of the covered disorders through speech therapy, occupational therapy, physical therapy and ABA. Furthermore, coverage may not be denied on the basis that the services are habilitative or rehabilitative in nature. The law defines “habilitative or rehabilitative services” as treatment programs that are necessary to develop, maintain, and restore to the maximum extent practicable the functioning of an individual.

14. Up to what age does the law mandate coverage?

Private insurers (health maintenance organizations, blanket or group health insurance policies or contracts, and for profit individual or group health insurance policies, health care plans or certificates of health insurance) must cover individuals up to age 19 or individuals 22 or younger who are enrolled in high school (a school providing instruction for any of the grades nine through twelve). Nonprofit health care plans (an individual or group health insurance policy, health care plan or certificate of health insurance) must cover individuals up to age 22 as long as he or she is enrolled in high school.

15. Is there a certain age by which my child must have been diagnosed with ASD to be covered?

No. The law does not provide a certain age by which your child must have been diagnosed with autism for it to apply.

16. Is Case Management covered?

Case management is not a mandated service under the law. Furthermore, the law specifies that coverage may be subject to general exclusions and limitations of the insurer’s policy or plan, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members and utilization review of health care services, including the review of medical necessity, case management and other managed care provisions.

17. 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 often a review process within the insurance company that may review the services ordered in the treatment plan.

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

The law 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 or psychiatrist.

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

Under the law, coverage may be limited to exclude coverage for services received under the federal Individuals with Disabilities in Education Act. Thus it is possible that your insurance company will require a copy of your child's IEP in order to determine whether services are being received under the IDEA.

20. What is "utilization review"?

"Utilization review" refers to techniques used by health carriers to monitor the use of, or to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings. Some examples of techniques used include ambulatory review, prospective review, retrospective review, second opinion, certification, concurrent review, case management or retrospective review. (Source: National Association of Insurance Commissioners)

21. What is "grievance review"?

"Grievance review" refers to a health carrier's internal processes for the resolution of covered persons' complaints. The complaints may arise out of a utilization review decision or involve the availability, delivery or quality of health care services; claims payment, handling or reimbursement for health care services; or matters pertaining to the contractual relationship between a covered person or health carrier. Some states may call it an "internal appeal" process. (Source: National Association of Insurance Commissioners)