



TEXAS: Frequently Asked Questions About the Autism Insurance Reform Law

1. What does Texas Autism Insurance Act do?

At a minimum, the Texas Autism Insurance Act requires a health benefit plan to provide coverage to an enrollee under the age of 10, who is diagnosed with autism spectrum disorder, for all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in a treatment plan recognized by that physician.

Once the enrollee, who is being treated for autism spectrum disorder becomes 10 years of age or older and continues to need treatment, the health benefits plan has the option whether or not to continue providing coverage for his generally recognized services.

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

House Bill 1919 was passed in 2007 and took effect on January 1, 2008. House Bill 451 was passed in 2009 and took effect on January 1, 2010.

3. What coverage is mandated by the Law?

The Texas Autism Insurance Act covers all generally recognized services prescribed in relation to autism spectrum disorder by the enrollee's primary care physician in the treatment plan recommended by that physician.

Generally recognized services may include:

- Evaluation and assessment services;
- Applied behavior analysis;
- Behavior training and behavior management;
- Speech therapy;
- Occupational therapy;
- Physical therapy;
- Medications or nutritional supplements used to address symptoms of autism spectrum disorder.

4. What requirements must the primary care physician satisfy in order for the treatment plan to be recognized under this Act?

An individual providing treatment must be a health care practitioner:

- (1) Who is licensed, certified, or registered by an appropriate agency of this state;

- (2) Whose professional credential is recognized and accepted by an appropriate agency of the United States; or
- (3) Who is certified as a provider under the TRICARE military health system

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

Health plans are classified as either “state-mandated plans” or “consumer choice plans.” State mandated plans require coverage of generally recognized services prescribed in relation to Autism Spectrum Disorder by the enrollee’s primary care physician in the treatment plan recommended by that physician

6. How do I know if my plan is a “consumer choice plan”?

Consumer choice plans are required to provide members with a disclosure statement and a list describing the benefits that are not covered. To be certain of the coverage you have with any plan, refer to your policy or explanation of coverage.

7. What happens if we get our insurance through a "small group" employer (50 or fewer) or through an employer that self-insures?

Small-employers are not required to cover generally recognized services prescribed in relation to autism spectrum disorder.

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

Yes.

9. 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 a generally recognized service, prescribed in relation to autism spectrum disorder, 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.

10. 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)

11. 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)