



## **WEST VIRGINIA**

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

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

The law requires health insurance plans for groups of 25 or more employees to provide coverage for the diagnosis and treatment of autism spectrum disorders (ASD) for children ages eighteen months through eighteen years when diagnosis is made by age eight. Applied Behavior Analysis (ABA) is subject to an annual limit of \$30,000 for the first three consecutive years of coverage. After three years ABA is limited to \$2,000 per month. Health plans covered by the law include the West Virginia Public Employees Insurance plan, the West Virginia Children's Health Insurance plan, health insurance plans covering groups of 25 or more employees that are not self-insured (see FAQ #3 below), hospital medical and dental plans, and HMO plans. Coverage must include diagnostic tests, evaluations, and assessments necessary to determine whether an individual has ASD and medically necessary treatment when ordered or prescribed by a licensed physician or licensed psychologist for an individual diagnosed with ASD.

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

The effective date for the individuals covered by the Public Employees Health Plan and the Children's Health Insurance Plan is July 1, 2011. All other included health plans must provide coverage whenever they are offered, issued or renewed on or after January 1, 2012.

#### **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 for how they provide insurance. The employer may:

- (1) buy a fully-funded plan from a third-party health insurer,
- (2) fund and administer the plan themselves, or
- (3) 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 your employer self-funds the plan or not 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?**

No, only group health plans that cover 25 or more employees are included in 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?**

No, individual plans are not included under the new law.

**6. I am a state employee or retiree and my family is insured by the West Virginia Public Employees Insurance Plan (PEIP.) Is my child's coverage included in the mandate?**

Yes, the PEIP is required to provide coverage for diagnosis and treatment of autism spectrum disorder for children eighteen months through eighteen years. Federal law mandates parity in the application of certain limits to mental health benefits in all large group policies. However, state and local governmental employers that sponsor health plans have the option to exempt plans from the requirement by self-funding the provision that provides mental health benefits. The West Virginia Public Employees Insurance Agency (PICA) exempted the PEIP from the parity requirement. Nevertheless, the recently enacted state law mandate for autism coverage means that West Virginia public employees and their families will be covered for diagnosis and treatment of ASD.

**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 they will be able to direct you to someone who can answer the question for you.

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

The law only requires coverage for children between the ages of 18 months through 18 years. ABA is covered with an annual limit of \$30,000 for not more than three consecutive years. At the conclusion of three consecutive years following a diagnosis of ASD, ABA is limited to \$2,000 per month until age 18 on the condition that ABA continues to be medically necessary. There is no limitation on the number of visits an individual may have with an autism provider, and insurers may not impose greater cost-sharing requirements for coverage of diagnosis and treatment of autism spectrum disorder than apply to diagnosis and treatment of any other physical or mental health condition. Other provisions of the insurance code allow the carrier to may make determinations of medical necessity and consider the appropriateness of treatment. In addition, the insurance company may implement procedures to rein in the cost of coverage such as, utilization review, use of provider networks, preauthorization for certain treatments, and other recognized cost management tools.

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

If payment for covered services is denied, you should appeal the decision with the insurance company. You may file a complaint with the Consumer Service Division of the West Virginia Offices of the Insurance Commissioner at 1-888-879-9842. A complaint form can be found by following this link:

<http://www.wvinsurance.gov/LinkClick.aspx?fileticket=wOMx-hLTNTU%3d&tabid=351&mid=969>

You may also contact an attorney to inquire if legal action is appropriate.

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

ABA is the only specifically defined treatment that is mandated. However, the law states that insurers must cover all medically necessary assessments for diagnosis and medically necessary treatments that are consistent with a treatment plan developed by a licensed physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation of the individual. To be considered medically necessary the diagnostic assessment or treatment must be ordered by a licensed physician or psychologist.

**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 a covered treatment under the law. ABA is covered with an annual limit of \$30,000 for not more than three consecutive years. After three consecutive years ABA coverage is limited to \$2,000 per month so long as a licensed physician or psychologist determines that continued ABA treatment is medically necessary.

ABA therapy must be provided a board certified behavior analyst or by an applied behavior analysis tutor who works under the supervision of a board certified behavior analyst. The applied behavior analysis tutor must complete at least 40 hours of classroom training in applied behavior analysis techniques in accordance with the Behavior Analyst Certification Board Guidelines for Responsible Conduct for Behavior Analysts and undergo a criminal background check. Also, the tutor and must:

- (1) complete a minimum of 12 semester hours of college coursework in psychology, education, social work, behavioral sciences, human development or related field, and be currently enrolled in a course of study leading to an associates' degree by an accredited college or university; or
- (2) complete a minimum of 48 semester hours of college course in an accredited college or university; or
- (3) hold a high school diploma or GED equivalent and have completed 500 hours of employment providing applied behavior analysis, as verified by a board certified behavior analyst.

Thus, a line therapist who meets the requirements and works under the supervision of a board certified behavior analyst is covered.

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

Yes, the law covers all of the pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including: Autistic Disorder, Rett Syndrome, Childhood Disintegrative Disorder, Asperger Syndrome, and Pervasive Developmental 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 a primary diagnosis in order to qualify for coverage.

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

A licensed physician or licensed psychologist determines what is medically necessary for your child, the determination is subject to review by the insurance company.

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

There is no language in the law that allows an insurer to question an existing diagnosis. However, other provisions of the insurance code allow the carrier to make determinations of medical necessity and appropriateness, and it may use recognized health care quality and cost management tools.

**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 law does not specifically address this question, but the definition of ABA indicates that treatment that is designed to produce socially significant improvement in human behavior is paramount. It is unclear whether treatment that is designed to produce improvement, but only allows the individual to maintain functioning at a plateau, is sufficient for coverage.

Applied Behavior Analysis as defined by the law means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.