

COLORADO: Frequently Asked Questions About the Autism Insurance Reform Law

1. What does C.R.S. 10-16-104 do?

Applies to all children under the age of 19.

Requires most state-regulated group insurance policies to provide coverage for the assessment, diagnosis, and treatment of autism spectrum disorder. Coverage for any care besides applied behavioral analysis cannot be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable than those that apply to physical illness generally under the health insurance plan. Plans must provide at least \$34,000 of coverage per year for applied behavior analysis from birth to age nine. Plans must provide at least \$12,000 of coverage per year for applied behavior analysis a child nine years of age or older until the child is 19.

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

July 1, 2010. It applies to applicable health insurance plans issued or renewed on or after that date.

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

All employer-provided health insurance regulated by the state of Colorado is subject to the mandate. Some employers fund their own health benefit program, which means they do not pay premiums to an insurance company to spread the risk of their employees. These health benefit programs are not regulated by the state of Colorado, but are regulated by the federal government under the Employer Retirement Income Security Act (ERISA). Self-funded employer plans are not covered under the state mandate.

4. How do I know that my health benefit plan is a self-funded plan?

Consult with your employer.

5. How will the law be enforced?

The Colorado Department of Insurance has regulatory authority over state-regulated health insurance programs doing business in Colorado. The Department will use this authority to enforce the law.

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

Insurance companies are required to cover the costs of all treatment prescribed by the insured's treating medical doctor or psychologist at the same rate that their plans cover physical illness with the exception of applied behavior analysis. Insurance companies can limit their coverage of applied behavior analysis to \$34,000 for a child under the age of 9 and \$12,000 for children between the age of 9 and 19.

7. What coverage is mandated by law?

The law defines "treatment for autism spectrum disorders" as including: evaluation and assessment services; behavior training and behavior management, and applied behavior analysis, including consultations, direct care, supervision, or treatment; habilitative or rehabilitative care, including occupational therapy, physical therapy, or speech therapy; pharmacy care and medication (if covered by the insurance plan for other illness); psychiatric care; psychological care, including family counseling; and therapeutic care.

8. Is applied behavioral analysis (ABA) covered?

Yes, the law specifically mentions "applied behavior analysis" and creates a minimum benefit of \$34,000 a year for a child under the age of 9 and \$12,000 for children No, there is no requirement that ASD must be the "primary" diagnosis for the child to qualify for coverage. However, if the child is also diagnosed with a congenital defect or birth abnormality, his or her benefits for habilitative or rehabilitative care are limited to twenty visits per year for each type of therapy - occupational, physical, and speech.

9. Will all of the Autism Spectrum diagnoses be covered, or those diagnoses with the keyword of "autism"?

The law specifically defines "autism spectrum disorder" as including "Autistic Disorder", "Asperger's disorder", and "Atypical Autism as a diagnosis within Pervasive Developmental Disorder-Not Otherwise Specified". Coverage is mandated for all three of these diagnoses.

10. Does Autism Spectrum Disorder have to be the primary diagnosis for the child in order to qualify for coverage?

No, there is no requirement that ASD must be the "primary" diagnosis for the child to qualify for coverage. However, if the child is also diagnosed with a congenital defect or birth abnormality, his or her benefits for habilitative or rehabilitative care are limited to twenty visits per year for each type of therapy - occupational, physical, and speech.

11. Is Case Management covered?

Case Management is not a mandated under C.R.S. 10-16-104(1.4), however, it can be covered under "early intervention services" for the child from birth until the age of 3. The minimum annual benefit for this coverage is \$5,725.

12. 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 a utilization review process within the insurance company that may review the services ordered on the treatment plan.

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

Private Insurance

Diagnoses are subject to utilization review of health care services including review of medical necessity. However, once a diagnosis and treatment plan are agreed upon, the health insurance plan may only request an updated treatment plan once every 6 months from the treating medical doctor to review medical necessity, unless the treating doctor and the health insurance plan agree that a more frequent review is necessary.

14. 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?"

A treatment plan prescribed by a physician is subject to utilization review and medical necessity review. While an insurance company could decide that services are no longer "medically necessary", such a decision would be subject to external review under the Health Carrier External Review Act.

15. Will private insurers be developing their own medical necessity criteria?

Private insurers will use their own medical necessity criteria. The patient's physician or psychologist indicates on the treatment plan what services are medically necessary, however there is a utilization review process within the insurance company that may review the services ordered on the treatment plan.

16. 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)

17. 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)