



FLORIDA: Frequently Asked Questions About the Autism Insurance Reform Law

What does the Florida Autism Legislation (Senate Bill Number 2654) do?

There are three major components of the Florida Autism Legislation, each with an important function:

(1) **Medicaid Waiver:** Authorizes the Agency for Health Care Administration to seek federal approval for Medicaid coverage of applied behavior analysis and other therapies for children with autism and other developmental disabilities.

(2) **Developmental Disabilities Compact:** Requires the Office of Insurance Regulation to convene a workgroup that will negotiate a developmental disabilities compact binding health insurers and health maintenance organizations to insure persons with autism and other developmental disabilities.

(3) **Autism Mandate:** Mandates coverage for individuals with autism by health insurers and health maintenance organizations that do not sign the compact.

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

What does the Medicaid Provision do?

The Medicaid Provision authorizes the Agency for Health Care Administration to seek federal approval through a Medicaid waiver or a state plan amendment of coverage for occupational therapy, speech therapy, physical therapy, behavior analysis, and behavior assistant services for children five years of age or younger with autism and other developmental disabilities. The new Medicaid coverage is limited to \$36,000 annually and \$108,000 in total lifetime benefits. These numbers will be adjusted for inflation each year.

Are there limitations on the Medicaid Provision?

Yes, coverage is limited to \$36,000 per year and \$108,000 total lifetime benefits. Furthermore, the provision only covers individuals five years of age and under.

How is the Developmental Disabilities Compact (aka the “Window of Opportunity Act”) created?

The Developmental Disabilities Compact required the Office of Insurance Regulation to convene two workgroups. The first workgroup must convene by August 31, 2008 and will negotiate a developmental disabilities compact binding participants to provide insurance and access to services for persons with autism and other disabilities. The workgroup will consist of representatives of all health insurers and health maintenance organizations, representatives of employers with self-insured health benefit plans, two designees of the Governor, one designee of the President of the Senate, and one

designee of the Speaker of the House. The second workgroup will be a consumer advisory workgroup who will comment on the developmental disabilities compact prior to its finalization.

What must the Developmental Disabilities Compact contain?

The compact will contain the following components:

- A requirement that each signatory to the agreement increases coverage for behavior analysis and behavior assistant services, speech therapy, physical therapy, and occupational therapy;
- Procedures for clear and specific notice to policyholders identifying the amount, scope, and conditions under which the services described in the preceding bullet point are provided;
- Penalties for documented cases of denial of claims for medically necessary services for a developmental disability; and
- Proposals for new product lines that may be offered in conjunction with traditional health insurance and that provide a more appropriate means of spreading risk, financing costs, and accessing favorable prices.

How will the Developmental Disabilities Compact be regulated?

Beginning February 15, 2009, and continuing annually thereafter, the Office of Insurance Regulation will report on the implementation of the compact. The Office of Insurance Regulation will monitor participation in, compliance with, and the effectiveness of the compact and will report its findings at least annually.

What does the Autism Mandate (aka “Steven A. Geller Autism Coverage Act”) do?

The Autism Mandate provides that a health insurance plan issued or renewed on or after April 1, 2009 must provide coverage to an eligible individual for diagnosis and treatment of autism spectrum disorder.

When does the Autism Mandate requiring health insurance plans to cover services for autism spectrum disorder go into effect?

All insurance companies and HMOs subject to the mandate must be in compliance by April 1, 2010. The deadline to begin compliance is April 1, 2009.

What kind of treatment does the Autism Mandate cover?

The Autism Mandate specifically covers treatment of autism through speech therapy, occupational therapy, physical therapy, and applied behavior analysis. Furthermore, coverage may not be denied on the basis that the services are habilitative in nature.

Is Applied Behavior Analysis (ABA) covered?

Yes. The Autism Mandate specifically covers ABA.

Who can provide applied behavior analysis?

Certified behavior analysts, psychologists, clinical social workers, and others can provide ABA. Providers must be certified under s. 393. 17 (behavior analysts) or licensed under chapter 490 (psychological services) or chapter 491 (clinical, counseling, or psychotherapy services).

What is applied behavior analysis defined as under the Autism Mandate?

Applied behavior analysis is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

Which autism spectrum disorders does the Autism Mandate cover?

The Autism Mandate covers Autistic disorder, Asperger's syndrome, and Pervasive developmental disorder not otherwise specified as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

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.

Who does the Autism Mandate benefit?

The Autism Mandate benefits children under 18 years of age or in high school who have been diagnosed as having a developmental disability at eight years of age or younger.

How is coverage limited under the Autism Mandate?

Coverage is subject to the following limitations:

- Treatment must be prescribed by the insured's treating physician in accordance with a treatment plan.
- Coverage is limited to \$36,000 annually and may not exceed \$200,000 in total lifetime benefits. These numbers will be adjusted for inflation beginning January 1, 2011.

- Coverage may be subject to other general exclusions and limitations, including coordination of benefits, participating provider requirements, restrictions on services provided by family members, and utilization review, including the review of medical necessity, case management, and other managed care provisions. Coverage, however, may not be denied on the basis that services are habilitative in nature.

Is there “Mental Health Parity”?

Yes, the Autism Mandate specifically provides that coverage may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illnesses, except the limitations described in the previous question.

Can insurers discriminate against a developmentally disabled individual?

No, the Autism Mandate explicitly prohibits insurers from denying or refusing to issue coverage for medically necessary services or for refusing to contract with, renew, or reissue coverage, or for terminating or restricting coverage for an individual because the individual is developmentally disabled.

Can insurers deny coverage on the basis that services are habilitative?

No. The mandate explicitly prohibits denial on the ground that services are habilitative in nature.

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.

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

Does the Autism Mandate limit benefits and/or coverage otherwise available to an insured under a health insurance plan?

No, it explicitly states it does not limit benefits or coverage otherwise available to an insured.

What must the treatment plan include?

The treatment plan written by the insured's treating physician must include all elements necessary for the health insurance plan to appropriately pay claims. These elements include, but are not limited to, a diagnosis, the proposed treatment by type, the 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.

What insurance programs and policies does the Autism Mandate apply to?

The Autism Mandate applies to the state group insurance program (for state officers and employees) and other group health policies, health benefit plans, and health maintenance contracts. It does not apply to individual market contracts or individually underwritten contracts or to contracts provided to small employers (having 50 or fewer employees).

Which health plans are exempt from the autism insurance mandate?

- Insurance companies and HMOs can secure an exemption from the mandate for their insurance policies and contracts if they signed the proposed compact by April 1, 2009, and continue to comply with the compact beginning April 1, 2010. Health plans that purchase insurance policies or HMO contracts from compact signatories will be exempt from the mandate.
- Small employer (50 employees or less) plans are not covered by the plan.
- Self-insured plans are also exempt from the mandate because of a Federal Law (ERISA) that generally preempts state law mandates applicable to employer sponsored benefit plans.
- Insurance offered to individuals and those that are individually underwritten based on the individuals' risk characteristics rather than the typical risk characteristics of a group are specifically exempt.

Which insurers and health maintenance organizations will the Autism Mandate be enforced against?

The Office of Insurance Regulation may not enforce the autism mandate against an insurer or health maintenance organization that signs the developmental disabilities compact by April 1, 2009. The Office of Insurance Regulation must, however, enforce the mandate against an insurer that signs the developmental disabilities compact but does not by April 1, 2010, comply with the terms of the compact for all health insurance plans or health maintenance contracts.

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)

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)