

Autism Insurance Act Frequently Asked Questions and Answers

Overview

What does Autism Insurance Act (Act 62) do?

Broadly speaking, Act 62 does three main things:

1. It requires many private insurers to begin covering the costs of diagnostic assessments for autism and of services for individuals with autism who are under the age of 21, up to \$36,000 per year;
2. It requires the Pennsylvania Department of Public Welfare to cover those costs for eligible individuals who have no private insurance coverage, or for individuals whose costs exceed \$36,000 that year; and
3. It requires the Pennsylvania Department of State to license professional behavior specialists and to establish minimum licensure qualifications for them.

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

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

Most sections of the Autism Insurance Act go into effect July 1, 2009, including the provisions that require many insurers to cover services for autism spectrum disorder.

Once the Autism Insurance Act goes into effect, will my employer-provided health insurance be required to cover my child's autism services?

Employers with at least 51 employees and that offer group health insurance coverage are required to offer autism services for children under age 21. If your employer has 50 or fewer employees and you are enrolled in Medical Assistance, the Department of Public Welfare will continue to provide your child's autism services, through the Medical Assistance program. Your child may also be able to receive services through [CHIP](#) or [adultBasic](#), if they qualify.

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

The Department of Public Welfare will provide coverage for your child's autism services as they currently do through the Medical Assistance program.

Are there limits on what our private 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 Act 62. For those mandated services though, there will be no limits on the number of visits to a provider. There is a \$36,000 annual cap on coverage, after which DPW will pick up coverage. Beginning April 1, 2012, the cap will be adjusted upwards annually to account for inflation. Coverage may be subject to other limitations and exclusions as long as they are allowed under Act 62.

How will the law be enforced?

The Pennsylvania Insurance Department has strong regulatory powers to enforce the law. In addition, each health insurance company doing business in Pennsylvania is required to submit a compliance report to the Insurance Department by January 2011.

Covered Services

What coverage is mandated by the law?

Act 62 requires coverage for diagnostic assessments, pharmacy care, psychiatric care, psychological care, rehabilitative care, and therapeutic care. These categories of mandated services are defined in the law. More specifically, the new act will cover evaluations and tests needed to diagnose your child's autism disorder, as well as the development of a plan to provide health care services for your child. This plan may include medically necessary prescribed treatments such as behavioral analysis and rehabilitative care, prescription drugs, blood level tests, psychiatric and psychological services, speech/language therapy, occupational therapy and physical therapy.

Is applied behavioral analysis (ABA) covered?

Yes. The law's definition of rehabilitative care specifically includes ABA.

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

Any of the pervasive development disorders defined in the current edition of the Diagnostic and Statistical Manual (DSM) are covered. These include: autistic disorder, Asperger Syndrome, Rett Syndrome, Childhood Disintegration Disorder and Pervasive Development Disorder (Not Otherwise Specified).

Does Autism Spectrum Disorder (ASD) have to be the primary diagnosis for the child in order to qualify for coverage under Act 62?

No, there is no requirement that ASD must be the "primary" diagnosis for the child to qualify for coverage under Act 62. Behavioral Specialist, Mobile Therapy and Therapeutic Staff Support are covered by Pennsylvania's Medical Assistance program.

Will these services be covered by commercial carriers under Act 62?

Behavioral Specialist Consultation, Mobile Therapy, and Therapeutic Staff Support are all covered services under Act 62 as long as they fall under the definition of "treatment of autism spectrum disorders." This means that they must be determined to be medically necessary and included in a treatment plan. These services could fall into the "rehabilitative care" or "psychological care" categories of care that are included in the Act.

Is Case Management covered?

Case Management is not a mandated service under Act 62.

On July 9, 2009, will an insurance company be able to question my child's existing autism diagnosis?

No. Under Act 62, an autism diagnosis shall be valid for a period of not less than 12 months, unless a licensed physician or licensed psychologist determines a reassessment is necessary and the reassessment indicates otherwise.

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?

No. The law specifically requires coverage of services intended to produce progress as well as those intended to prevent regression.

Will private insurers be developing their own medical necessity criteria?

Private insurers will use their own medical necessity criteria.

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 an autism diagnostic or treatment service 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.

If a service is denied by a commercial insurer on medical necessity grounds for a child with dual coverage, will Medical Assistance consider itself bound by that decision?

No. If a service is denied by the private insurer, the family should appeal the decision. However, the Medical Assistance program will review the request for services based on the medical documentation provided and will use the MA program regulatory definition of medical necessity to determine MA approval and payment for services.

Qualified Providers and Licensing

Which providers and services will be eligible for reimbursement under Act 62?

Reimbursement is required for any mandated service provided pursuant to a comprehensive autism treatment plan and which is provided by qualified professionals. These professionals include licensed physicians, licensed physician assistants, licensed psychologists, licensed clinical social workers, certified registered nurse practitioners and those who work under their direction. Grandfathering clauses are included to ensure continuity of care for services provided by certain unlicensed professionals: those who work at the direction of the licensed professionals listed above, professionals enrolled in the Medical Assistance program, and behavior specialists pending their licensure.

How can I be sure that the health care provider has the certification or license necessary to diagnose my child's autism disorder and provide services?

The State Board of Medicine, along with the Department of Public Welfare, will oversee the licensing and certification of autism health care providers. You should check with your health insurance company to be sure that the company recognizes the health care provider you are using as properly certified or licensed. If the provider is not recognized, you may not be covered for the services provided. During the transition period while the bill is being implemented, providers who offer treatment of autism spectrum disorders and who are enrolled in the Medical Assistance program will be considered eligible providers.

I am a practicing Behavior Specialist in Pennsylvania and would like to apply for this licensure. How do I do this?

The State Board of Medicine in conjunction with the Department of Public Welfare are developing regulations pertaining to the licensing of Behavior Specialists providing services for children and adolescents with autism. The regulations, specifics and qualifications for this licensure will be forthcoming. Additional information will be posted on the PA Autism Insurance Web site (<http://www.dpw.state.pa.us/003670557.aspx?Url=http%3a%2f%2fwww.PAAutismInsurance.org>) as it becomes available.

Is "psychological care" limited to licensed psychologists?

Yes, psychological care is defined as care provided by licensed psychologists.

Does the definition of "psychiatric care" imply that a psychiatrist must be board-certified in order to qualify for coverage?

No, there is no requirement in the definition of "psychiatric care" that implies that the psychiatrist must be board-certified.

For psychiatric and psychological care, what is the definition of "Consultative Services" for ASD?

Consultative means to advise or consult. Consultative Services are advisory to the treating psychiatrist or psychologist.

Is the intent that all Rehabilitative Care will be provided directly by licensed or certified Behavior Specialists?

No, the definition of "autism service provider" includes behavioral specialists who may or may not be currently licensed as well as other provider types.

Other Questions

Will services like Behavioral Specialist and Mobile Therapy be covered under behavioral health benefits or physical health benefits?

Act 62 does not specify whether the required coverage is to be part of the behavioral health or physical health benefit. The decision on which benefit is responsible will be left to the individual insurer.

How is the Third Party Liability being handled in the coordination of benefits between public and private insurers?

Third Party Liability and the coordination of benefits between public and private insurers will occur the same way that it does currently for those individuals who have both private insurance coverage and are eligible for Medical Assistance.

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

No. Mandated coverage under Act 62 cannot be made contingent upon coordination of services with an IEP. The law does permit coordination of coverage, but only with the consent of the child's parent or guardian consistent with state and federal law.

Will representatives from commercial insurance plans participate in service plan meetings?

Act 62 does not specify whether or not representatives of the commercial insurance policies may participate in service plan meetings.

If you cannot find the question or answer you need, please [contact DPW](#).