NEW JERSEY: Frequently Asked Questions About the Autism Insurance Reform Law

1. What does the New Jersey's Autism Insurance Act do?

New Jersey's Autism Insurance Act does three main things:

1. It requires many private insurers to begin covering the costs of screening and diagnosing autism spectrum disorders
2. It requires many private insurers to provide coverage for expenses incurred for medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan.
3. It requires many private insurers to provide coverage for expenses incurred for medically necessary behavioral interventions based on the principles of applied behavioral analysis and related structured behavioral programs, as prescribed through a treatment plan.

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

The Act shall take effect February 9, 2010, however benefits may not start right away. For existing plans, the benefits take place on the renewal date of the health plan on, or after, February 9, 2010. For new plans issued on or after February 9, 2010, the Act goes into effect when the new plan is issued.

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

Not all insurance plans are required to provide coverage under the New Jersey Act. Insurance companies regulated by the state of New Jersey and state and local government plans must comply. Health plans that are self-funded or federally-regulated are not required to provide coverage. If your child is enrolled in the FamilyCare Program or you are enrolled in the New Jersey State Health Benefits Program the New Jersey Act applies to your health benefits plan.

4. What do I ask my employer to find out if my plan is covered under the New Jersey Act?

- Is my health plan self-funded or fully insured? Only fully insured plans regulated by the State of New Jersey are required to comply.
- If my health plan is fully insured, in what state is the policy written?
- If my plan is fully insured and written in New Jersey, what is the plan renewal date?
- If your plan is not fully-insured, you can inquire to see if they will voluntarily comply with the law.

5. What coverage is mandated by the law?

The New Jersey Autism Coverage Act requires coverage for screening and diagnosing autism or another developmental disability. When the insured's primary diagnosis is autism, the Act requires coverage for expenses incurred for medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan. When the insured is under 21 years of age and the insured's primary diagnosis is autism, the insurer shall provide coverage for expenses incurred for medically necessary behavioral programs, as prescribed through a treatment plan, subject to provisions of this subsection.

6. Is applied behavioral analysis (ABA) covered?

Yes, if the insured is under 21 years of age. In addition, according to Bulletin No: 10-02 provided by the New Jersey Department of Banking and Insurance, ABA must be administered directly by or under the direct supervision of an individual who is credentialed by the national Behavior Analyst Certification Board as either a Board Certified Behavior Analyst – Doctoral (BCBA-D) or a Board Certified Behavior Analyst (BCBA).

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

Autism and developmental disabilities are covered.

8. Will my early intervention cost share now be covered by insurance?

Families that participate in the New Jersey Early Intervention System (NJEIS) may have a cost associated with the early intervention services identified on their Individualized Family Service Plan (IFSP).

The New Jersey Act includes coverage for expenses incurred through NJEIS family cost participation system. Families will be required to satisfy their family cost obligations directly with the NJEIS and then seek reimbursement for those costs. (Additional information about family cost share can be accessed in Bulletin No: 10-02 provided by the New Jersey Department of Banking and Insurance.

9. Who determines what services are medically necessary?

The patient's physician prescribes the treatment plan. A treatment plan includes a diagnosis, treatment type, frequency and duration and the anticipated goals and outcomes. From the treatment plan, the health plan makes the determination of what services are medically necessary. Additionally, there is a utilization review process once every six months within the insurance company that may review the services ordered on the treatment plan.

10. 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 that benefits will not be denied on the basis that the treatment is not restorative.

11. 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.

12. 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.

13. 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)

14. 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)

If you have questions about implementation in general, according to the New Jersey Division of Business and Insurance, you should contact them directly via electronic mail at legsregs@dobi.state.nj.us. If warranted, the DOBI will issue guidance and may post responses to frequently asked questions to the DOBI's website at www.state.nj.us.dobi/index.html.