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Representatives Celeste, Garland

Cosponsors: Representatives Okey, Harris, Dyer, Foley, Lundy, Harwood, Koziura, Stebelton, Hagan, Skindell, Stewart, Heard, Mallory, DeBose, Patten, Pryor, Yuko, Pillich, Newcomb, Murray, Phillips, Winburn, Letson, Bolon, Luckie, Williams, B., Slesnick, Moran, Belcher, Boyd, Brown, Chandler, Dodd, Domenick, Driehaus, Fende, Gerberry, Sykes, Szollosi, Ujvagi, Weddington, Yates

A B I L L

To amend section 1739.05 and to enact sections 1751.68 and 3923.84 of the Revised Code to prohibit health insurers from excluding coverage for specified services for individuals diagnosed with an autism spectrum disorder.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF OHIO:

Section 1. That section 1739.05 be amended and sections 1751.68 and 3923.84 of the Revised Code be enacted to read as follows:

Sec. 1739.05. (A) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program may be established only if any of the following applies:

(1) The arrangement has and maintains a minimum enrollment of three hundred employees of two or more employers.

(2) The arrangement has and maintains a minimum enrollment of three hundred self-employed individuals.

(3) The arrangement has and maintains a minimum enrollment of three hundred employees or self-employed individuals in any combination of divisions (A)(1) and (2) of this section.

(B) A multiple employer welfare arrangement that is created pursuant to sections 1739.01 to 1739.22 of the Revised Code and that operates a group self-insurance program shall comply with all laws applicable to self-funded programs in this state, including sections 3901.04, 3901.041, 3901.19 to 3901.26, 3901.38, 3901.381 to 3901.3814, 3901.40, 3901.45, 3901.46, 3902.01 to 3902.14, 3923.282, 3923.30, 3923.301, 3923.38, 3923.581, 3923.63, 3923.80, 3923.84, 3924.031, 3924.032, and 3924.27 of the Revised Code.

(C) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall solicit enrollments only through agents or solicitors licensed pursuant to Chapter 3905. of the Revised Code to sell or solicit sickness and accident insurance.

(D) A multiple employer welfare arrangement created pursuant to sections 1739.01 to 1739.22 of the Revised Code shall provide benefits only to individuals who are members, employees of members, or the dependents of members or employees, or are eligible for continuation of coverage under section 1751.53 or 3923.38 of the Revised Code or under Title X of the "Consolidated Omnibus Budget Reconciliation Act of 1985," 100 Stat. 227, 29 U.S.C.A. 1161, as amended.

Sec. 1751.68. (A) Notwithstanding section 3901.71 of the Revised Code, no health insuring corporation policy, contract, or agreement that provides basic health care services that is delivered, issued for delivery, or renewed in this state shall exclude coverage for the screening and diagnosis of autism

spectrum disorders or for any of the following services when those services are medically necessary and are prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder by a health care professional licensed or certified under the laws of this state to prescribe, provide, or order such services:

(1) Habilitative or rehabilitative care;

(2) Pharmacy care if the policy, contract, or agreement provides coverage for other prescription drug services;

(3) Psychiatric care;

(4) Psychological care;

(5) Therapeutic care;

(6) Counseling services;

(7) Any additional treatments or therapies adopted by the director of mental retardation and developmental disabilities pursuant to division (I)(4) of section 3923.84 of the Revised Code.

(B) Coverage provided under this section shall be delineated in a treatment plan developed by the attending psychologist or physician and shall not be subject to any limits on the number or duration of visits an individual may make to any autism service provider, except as delineated in the treatment plan, if the services are medically necessary.

(C) Coverage provided under this section may be subject to any copayment, deductible, and coinsurance provisions of the policy, contract, or agreement to the extent that other medical services covered by the policy, contract, or agreement are subject to those provisions. Coverage provided under this section may be subject to a yearly maximum limitation of thirty-six thousand dollars on claims paid for services related to coverage provided

under this section.

(D)(1) Not more than once every six months, a health insuring corporation may request a review of any treatment provided under this section unless the insured's licensed physician or licensed psychologist agrees that more frequent review is necessary. The health insuring corporation shall pay for any review requested under division (D)(1) of this section.

(2) If requested by the health insuring corporation, the provider shall provide the health insuring corporation with an annual treatment plan.

(3) Inpatient services are not subject to the six-month review limitations under division (D)(1) of this section.

(E) This section shall not be construed as limiting benefits otherwise available under an individual's policy, contract, or agreement.

(F) This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan developed under 20 U.S.C. 1436 or individualized service plan developed under section 5126.31 of the Revised Code, or affecting the duty of a public school to provide a child with a disability with a free appropriate public education under the "Individuals with Disabilities Education Improvement Act of 2004," 20 U.S.C. 1400 et seq., as amended, and Chapter 3323. of the Revised Code.

(G) A health insuring corporation that offers coverage for basic health care services is not required to offer the coverage required under division (A) of this section in combination with the offer of coverage for basic health care services if all of the following apply:

(1) The health insuring corporation submits documentation certified by an independent member of the American academy of

actuaries to the superintendent of insurance showing that incurred claims for the coverage required under division (A) of this section for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of all covered services to increase by more than one per cent per year.

(2) The health insuring corporation submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (G)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

(3) The superintendent of insurance makes both of the following determinations from the documentation and opinion submitted pursuant to divisions (G)(1) and (2) of this section:

(a) Incurred claims for the coverage required under division (A) of this section for a period of at least six months independently caused the health insuring corporation's costs for claims and administrative expenses for the coverage of all covered services to increase by more than one per cent per year.

(b) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the health insuring corporation for the coverage of basic health care services.

Any determination made by the superintendent under division (G)(3) of this section is subject to Chapter 119. of the Revised Code.

(H) The services covered under this section shall not be considered supplemental health care services under division (B)(1) of section 1751.01 of the Revised Code.

(I) As used in this section:

(1) "Applied behavior analysis" means 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 relationship between environment and behavior.

(2) "Autism services provider" means any person whose professional scope of practice allows treatment of autism spectrum disorders, whose services are delineated in the treatment plan under division (B) of this section, and of whom one of the following is true:

(a) The person is licensed, certified, or registered by an appropriate agency of this state to perform the services assigned to the person in the treatment plan.

(b) The person is directly supervised by an individual who is licensed, certified, or registered by an appropriate agency of this state to perform the services assigned to the person in the treatment plan.

(3) "Autism spectrum disorder" means any of the pervasive developmental disorders as defined by the most recent edition of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, or if that manual is no longer published, a similar diagnostic manual. Autism spectrum disorder includes, but is not limited to, autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, and pervasive developmental disorder.

(4) "Diagnosis of autism spectrum disorders" means medically necessary assessments, evaluations, or tests, including, but not limited to, genetic and psychological tests to determine whether

an individual has an autism spectrum disorder.

(5) "Habilitative or rehabilitative care" means professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, or restore the functioning of an individual to the maximum extent practicable.

(6) "Medically necessary" means the service is based upon evidence; is prescribed, provided, or ordered by a health care professional licensed or certified under the laws of this state to prescribe, provide, or order autism-related services in accordance with accepted standards of practice; and will or is reasonably expected to do any of the following:

(a) Prevent the onset of an illness, condition, injury, or disability;

(b) Reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability;

(c) Assist in achieving or maintaining maximum functional capacity for performing daily activities, taking into account both the functional capacity of the individual and the appropriate functional capacities of individuals of the same age.

(7) "Pharmacy care" means prescribed medications and any medically necessary health-related services used to determine the need or effectiveness of the medications.

(8) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices psychiatry.

(9) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices psychology.

(10) "Therapeutic care" means services, communication devices, or other adaptive devices or equipment provided by a licensed speech-language pathologist, licensed occupational therapist, or licensed physical therapist.

Sec. 3923.84. (A) Notwithstanding section 3901.71 of the Revised Code, no individual or group policy of sickness and accident insurance that is delivered, issued for delivery, or renewed in this state or public employee benefit plan established or modified in this state shall exclude coverage for the screening and diagnosis of autism spectrum disorders or for any of the following services when those services are medically necessary and are prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder by a health care professional licensed or certified under the laws of this state to prescribe, provide, or order such services:

(1) Habilitative or rehabilitative care;

(2) Pharmacy care if the policy, contract, or agreement provides coverage for other prescription drug services;

(3) Psychiatric care;

(4) Psychological care;

(5) Therapeutic care;

(6) Counseling services;

(7) Any additional treatments or therapies adopted by the director of mental retardation and developmental disabilities pursuant to division (I)(4) of this section.

(B) Coverage provided under this section shall be delineated in a treatment plan developed by the attending psychologist or physician and shall not be subject to any limits on the number or duration of visits an individual may make to any autism services provider, except as delineated in the treatment plan, if the

services are medically necessary.

(C) Coverage provided under this section may be subject to any copayment, deductible, and coinsurance provisions of the policy or plan to the extent that other medical services covered by the policy or plan are subject to those provisions. Coverage provided under this section may be subject to a yearly maximum limitation of thirty-six thousand dollars on claims paid for services related to coverage provided under this section.

(D)(1) Not more than once every six months, an insurer or public employee benefit plan may request a review of any treatment provided under this section unless the insured's licensed physician or licensed psychologist agrees that more frequent review is necessary. The insurer or public employee benefit plan shall pay for any review requested under division (D)(1) of this section.

(2) If requested by the insurer or public employee benefit plan, the provider shall provide the insurer or public employee benefit plan with an annual treatment plan.

(3) Inpatient services are not subject to the six-month review limitations under division (D)(1) of this section.

(E) This section shall not be construed as limiting benefits otherwise available under an individual's policy or plan.

(F) This section shall not be construed as affecting any obligation to provide services to an individual under an individualized family service plan developed under 20 U.S.C. 1436 or individualized service plan developed under section 5126.31 of the Revised Code, or affecting the duty of a public school to provide a child with a disability with a free appropriate public education under the "Individuals with Disabilities Education Improvement Act of 2004," 20 U.S.C. 1400 et seq., as amended, and Chapter 3323. of the Revised Code.

(G) This section does not apply to the offer or renewal of any individual or group policy of sickness and accident insurance that provides coverage for specific diseases or accidents only, or to any hospital indemnity, medicare supplement, medicare, tricare, long-term care, disability income, one-time limited duration policy of not longer than six months, or other policy that offers only supplemental benefits.

(H) A public employee benefit plan or insurer that offers a policy of sickness and accident insurance is not required to offer the coverage required under division (A) of this section if all of the following apply:

(1) The insurer or public employee benefit plan submits documentation certified by an independent member of the American academy of actuaries to the superintendent of insurance showing that incurred claims for the coverage required under division (A) of this section for a period of at least six months independently caused the costs for claims and administrative expenses for the coverage of all covered services to increase by more than one per cent per year.

(2) The insurer or public employee benefit plan submits a signed letter from an independent member of the American academy of actuaries to the superintendent of insurance opining that the increase in costs described in division (H)(1) of this section could reasonably justify an increase of more than one per cent in the annual premiums or rates charged by the insurer or public employee benefit plan for the coverage of all covered services.

(3) The superintendent of insurance makes both of the following determinations from the documentation and opinion submitted pursuant to divisions (H)(1) and (2) of this section:

(a) Incurred claims for the coverage required under division (A) of this section for a period of at least six months

independently caused the costs for claims and administrative expenses for the coverage of all covered services to increase by more than one per cent per year.

(b) The increase in costs reasonably justifies an increase of more than one per cent in the annual premiums or rates charged by the insurer or public employee benefit plan for the coverage of all covered services.

Any determination made by the superintendent under division (H)(3) of this section is subject to Chapter 119. of the Revised Code.

(I)(1) The director of mental retardation and developmental disabilities shall convene a committee on the coverage of autism spectrum disorders to investigate and recommend treatments or therapies for autism spectrum disorders that the committee believes should be included in the services that health benefit plans and public employee benefit plans are required to cover under division (A) of this section and the qualifications of the providers of those treatments or therapies.

(2) The committee shall consist of nine members appointed by the director of mental retardation and developmental disabilities including the director of mental retardation and developmental disabilities, the director of health, at least one licensed physician, licensed psychologist, and parent of an individual diagnosed with an autism spectrum disorder.

(3) The committee shall serve at the pleasure of the director.

(4) The committee shall submit its recommendations to the director of mental retardation and developmental disabilities. The director may adopt rules in accordance with Chapter 119. of the Revised Code to include additional treatments or therapies for autism spectrum disorders in the services that health benefit

plans and public employee benefit plans are required to cover under division (A) of this section.

(J) As used in this section:

(1) "Applied behavior analysis" means 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 relationship between environment and behavior.

(2) "Autism services provider" means any person whose professional scope of practice allows treatment of autism spectrum disorders, whose services are delineated in the treatment plan under division (B) of this section, and of whom one of the following is true:

(a) The person is licensed, certified, or registered by an appropriate agency of this state to perform the services assigned to the person in the treatment plan.

(b) The person is directly supervised by an individual who is licensed, certified, or registered by an appropriate agency of this state to perform the services assigned to the person in the treatment plan.

(3) "Autism spectrum disorder" means any of the pervasive developmental disorders as defined by the most recent edition of the diagnostic and statistical manual of mental disorders, published by the American psychiatric association, or if that manual is no longer published, a similar diagnostic manual. Autism spectrum disorder includes, but is not limited to, autistic disorder, Asperger's disorder, Rett's disorder, childhood disintegrative disorder, and pervasive developmental disorder.

(4) "Diagnosis of autism spectrum disorders" means medically

necessary assessments, evaluations, or tests, including, but not limited to, genetic and psychological tests to determine whether an individual has an autism spectrum disorder.

(5) "Habilitative or rehabilitative care" means professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, or restore the functioning of an individual to the maximum extent practicable.

(6) "Health benefit plan" has the same meaning as in section 3924.01 of the Revised Code.

(7) "Medically necessary" means the service is based upon evidence; is prescribed, provided, or ordered by a health care professional licensed or certified under the laws of this state to prescribe, provide, or order autism-related services in accordance with accepted standards of practice; and will or is reasonably expected to do any of the following:

(a) Prevent the onset of an illness, condition, injury, or disability;

(b) Reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability;

(c) Assist in achieving or maintaining maximum functional capacity for performing daily activities, taking into account both the functional capacity of the individual and the appropriate functional capacities of individuals of the same age.

(8) "Pharmacy care" means prescribed medications and any medically necessary health-related services used to determine the need or effectiveness of the medications.

(9) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the

psychiatrist practices psychiatry.

(10) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices psychology.

(11) "Therapeutic care" means services, communication devices, or other adaptive devices or equipment provided by a licensed speech-language pathologist, licensed occupational therapist, or licensed physical therapist.

Section 2. That existing section 1739.05 of the Revised Code is hereby repealed.

Section 3. Sections 1 and 2 of this act shall take effect January 1, 2011.