SENATE BILL 1660
By Burks

HOUSE BILL 1461

By DeBerry J

AN ACT to amend Tennessee Code Annotated, Title 56, relative to insurance coverage of autism.

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

SECTION 1. Tennessee Code Annotated, Section 56-7-2367, is amended by deleting the section in its entirety and by substituting instead the following:

56-7-2367.

(a) A contract or policy of an insurer that provides benefits for neurological disorders, whether under an individual or group health insurance policy providing coverage on an expense-incurred basis, an individual or group service contract issued by a health maintenance organization or a self-insured group arrangement to the extent not preempted by federal law or a managed health care delivery entity of any type or description that is amended, delivered, issued, or renewed after the effective date of this act must provide individuals under twenty-one (21) years of age coverage for the diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders to the extent that the diagnosis and treatment of autism spectrum disorders are not already covered by the policy of accident and health insurance or managed care plan.

(b) Coverage provided under this section shall be subject to a maximum benefit of thirty-six thousand dollars ($36,0000) per year, but shall not be subject to any limits on the number of visits to a service provider. After December 30, 2010, the commissioner of commerce and insurance shall, on an annual basis, adjust the maximum benefit for inflation using the medical care component of the United States department of labor consumer price index for all urban consumers. Payments made by an insurer on behalf

of a covered individual for any care, treatment, intervention, service, or item, the provision of which was for the treatment of a health condition not diagnosed as an autism spectrum disorder, shall not be applied toward any maximum benefit established under this subsection (b).

(c) Coverage under this section shall be subject to copayment, deductible, and coinsurance provisions of a policy of accident and health insurance or managed care plan to the extent that other medical services covered by the policy of accident and health insurance or managed care plan are subject to these provisions.

(d) This section shall not be construed as limiting benefits that are otherwise available to an individual under a policy of accident and health insurance or managed care plan and benefits provided under this section may not be subject to dollar limits, deductibles, copayments, or coinsurance provisions that are less favorable to the insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illness generally.

(e) An insurer may not deny or refuse to provide otherwise covered services, or refuse to renew, refuse to reissue, or otherwise terminate or restrict coverage under an individual contract to provide services to an individual because the individual or their dependent is diagnosed with an autism spectrum disorder or due to the individual utilizing benefits in this section.

(f) Upon request of the reimbursing insurer, a provider of treatment for autism spectrum disorders shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued medical treatment is medically necessary and is resulting in improved clinical status. When treatment is anticipated to require continued services to achieve demonstrable progress, the insurer may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of

treatment, the anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated.

(g) When making a determination of medical necessity for a treatment modality for autism spectrum disorders, an insurer must make the determination in a manner that is consistent with the manner used to make that determination with respect to other diseases or illnesses covered under the policy, including an appeals process. During the appeals process, any challenge to medical necessity must be viewed as reasonable only if the review includes a physician with expertise in the most current and effective treatment modalities for autism spectrum disorders.

(h) As used in this section:

(1) "Autism spectrum disorders" means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified;

(2) "Diagnosis of autism spectrum disorders" means one (1) or more tests, evaluations, or assessments to diagnose whether an individual has autism spectrum disorder that is prescribed, performed, or ordered by:

(A) A physician licensed to practice medicine in all its branches; or

(B) A licensed clinical psychologist with expertise in diagnosing autism spectrum disorders;

(3) "Medically necessary" means any care, treatment, intervention, service or item which will or is reasonably expected to do any of the following:

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

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

(C) Assist to achieve or maintain maximum functional activity in performing daily activities; and

(4) "Treatment for autism spectrum disorders" includes the following care prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder by:

(A) A physician licensed to practice medicine in all its branches; or

(B) A certified, registered, or licensed health care professional with expertise in treating effects of autism spectrum disorders when the care is determined to be medically necessary and ordered by a physician licensed to practice medicine in all its branches:

(i) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist;

(ii) Psychological care, meaning direct or consultative services provided by a licensed psychologist;

(iii) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. As used in this subdivision (h)(4)(B)(iii), "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 the use of direct observation, measurement, and

functional analysis of the relations between environment and behavior; and

(iv) Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:

(a) Self care and feeding;

(b) Pragmatic, receptive, and expressive language;

(c) Cognitive functioning;

(d) Applied behavior analysis, intervention, and modification;

(e) Motor planning; and

(f) Sensory processing.

(i) The commissioner of commerce and insurance is authorized to promulgate rules and regulations to implement the provisions of this section in accordance with the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

SECTION 2. This act shall take effect January 1, 2010, the public welfare requiring it.