304.17A-142 Coverage for autism spectrum disorders -- Limitations on coverage -- Utilization review -- Reimbursement not required. (Effective until January 1, 2019)

(1) A large group health benefit plan shall provide coverage of an individual between the ages of one (1) through twenty-one (21) years of age, as required by subsection (2) of this section, for the diagnosis and treatment of autism spectrum disorders. To the extent that the diagnosis and treatment of autism spectrum disorders are not already covered by a health insurance policy, coverage under this section shall be included in health benefit plans that are delivered, executed, issued, amended, adjusted, or renewed within the state on or after thirty (30) days after January 1, 2011. An insurer shall not terminate coverage, or refuse to deliver, execute, issue, amend, adjust, or renew coverage, to an individual solely because the individual is diagnosed with or has received treatment for any of the autism spectrum disorders.

(2) Coverage under this section shall be subject to a maximum annual benefit per covered individual as follows:

(a) For individuals between the ages of one (1) through their seventh birthday, the maximum annual benefit shall be fifty thousand dollars ($50,000) per individual;

(b) For individuals between the ages of seven (7) through twenty-one (21), the maximum benefit shall be one thousand dollars ($1,000), per month per individual; and

(c) These limits shall not apply to other health conditions of the individual and services for the individual not related to the treatment of an autism spectrum disorder.

(3) Coverage under this section shall not be subject to any limits on the number of visits an individual may make to an autism services provider.

(4) Coverage under this section may be subject to copayment, deductible, and coinsurance provisions of a health benefit plan that are no less favorable than those that apply to other medical services covered by the health benefit plan.

(5) This section shall not be construed as limiting benefits that are otherwise available to an individual under a health benefit plan.

(6) Except for inpatient services, if an individual is receiving treatment for autism spectrum disorders:

(a) An insurer shall have the right to request a utilization review of that treatment not more than once every twelve (12) months, unless the insurer and the individual's licensed physician, licensed psychologist, or licensed psychological practitioner agree that a more frequent review is necessary. The cost of obtaining any review shall be borne by the insurer;

(b) Upon request of the reimbursing insurer, an autism services provider shall furnish medical records, clinical notes, or other necessary data that substantiate that initial or continued treatment or services that are medically necessary and are resulting in improved clinical status;

(c) 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, anticipated outcomes stated as goals, and the frequency by which the treatment plan will be updated; and

(d) The treatment plan shall contain specific cognitive, social, communicative, self-care, or behavioral goals that are clearly defined, directly observed, and continually measured and that address the characteristics of the autism spectrum disorder.

(7) This section shall not be construed as requiring coverage for treatment of autism spectrum disorders for individuals covered under an individual or small group health benefit plan, except as provided by KRS 304.17A-143.

(8) Nothing in this section and KRS 304.17A-141 and 304.17A-143 shall be construed as limiting, replacing, or otherwise affecting any obligation to provide services to an individual under an individualized service plan or other publicly funded program. Nothing in this section and KRS 304.17A-141 and 304.17A-143 shall be construed as requiring a health benefit plan to provide benefits for services that are included in an individualized family service plan, an individualized education program, an individualized service plan, or other publicly funded programs. The coverage mandated in this section and KRS 304.17A-141 and 304.17A-143 shall be in addition to any services which an individual is entitled to receive under any such publicly funded programs.

(9) No reimbursement is required under this section for services, supplies, or equipment:

(a) For which the insured has no legal obligation to pay in the absence of this or like coverage;

(b) Provided to the insured by a publicly funded program;

(c) Performed by a relative of an insured for which, in the absence of any health benefits coverage, no charge would be made; and

(d) For services provided by persons who are not licensed as required by law.

Effective: January 1, 2011

History: Created 2010 Ky. Acts ch. 150, sec. 17, effective January 1, 2011.

Legislative Research Commission Note (1/1/2011). 2010 Ky. Acts ch. 150, sec. 17, created a new section of Subtitle 17A of KRS Chapter 304. In subsection (8) of this section there is a citation to "this section and Sections 16 and 18 of this Act." There are also two more citations to "this Act" within this subsection. It seems clear from the context and has been confirmed by the drafter that the other two citations to "this Act" in subsection (8) should also have been to "this section and Sections 16 and 18 of this Act." Sections 16, 17, and 18 of the Act are now codified as KRS 304.17A-141, 304.17A-142 and 304.17A-143. This change has been made by the Reviser of Statutes under the authority of KRS 7.136(1).