17:48-6ii

LEGISLATIVE HISTORY CHECKLIST

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LAWS OF: 2009 **CHAPTER:** 115

NJSA: 17:48-6ii (Requires health benefits coverage for certain therapies for the treatment of autism and other developmental disabilities)

BILL NO: A2238 (Substituted for S1651)

SPONSOR(S) Roberts and others

DATE INTRODUCED: February 25, 2008

COMMITTEE: **ASSEMBLY:** Health and Senior Services; Appropriations

SENATE: Budget and Appropriations

AMENDED DURING PASSAGE: Yes

DATE OF PASSAGE: **ASSEMBLY:** June 25, 2009

SENATE: June 18, 2009

DATE OF APPROVAL: August 13, 2009

FOLLOWING ARE ATTACHED IF AVAILABLE:

FINAL TEXT OF BILL (First Reprint Assembly Committee Substitute enacted)

A2238

SPONSOR'S STATEMENT: (Begins on page 5 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: Yes Health 2-25-08
Approp.5-18-09

SENATE: Yes

(Audio archived recordings of the committee meetings, corresponding to the date of the committee statement, ***may possibly*** be found at www.njleg.state.nj.us)

FLOOR AMENDMENT STATEMENT: No

LEGISLATIVE FISCAL ESTIMATE: Yes

S1651

SPONSOR'S STATEMENT: (Begins on page 5 of original bill) Yes

COMMITTEE STATEMENT: **ASSEMBLY**: No

SENATE: Yes Health 5-18-09
Budget 6-15-09

FLOOR AMENDMENT STATEMENT: No

(continued)

LEGISLATIVE FISCAL ESTIMATE:	Yes	
VETO MESSAGE:	No	
GOVERNOR'S PRESS RELEASE ON SIGNING:	Yes	8-13-09

FOLLOWING WERE PRINTED:

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REPORTS:	No
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LAW/IS 6/23/10

[First Reprint]

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, No. 2238

STATE OF NEW JERSEY
213th LEGISLATURE

ADOPTED MAY 18, 2009

Sponsored by:
Assemblyman JOSEPH J. ROBERTS, JR.
District 5 (Camden and Gloucester)
Assemblyman VINCENT PRIETO
District 32 (Bergen and Hudson)
Assemblywoman JOAN M. VOSS
District 38 (Bergen)
Assemblywoman ELEASE EVANS
District 35 (Bergen and Passaic)

Co-Sponsored by:
Assemblymen Ramos, Biondi, Assemblywomen Pou, Vainieri Huttle, Assemblymen Coutinho, Scalera, Diegnan, Assemblywomen Wagner, Lampitt, Jasey, Assemblymen Chivukula, DeAngelo, Moriarty, Schaer, Conners, Senators Vitale, Weinberg, Baroni, Gordon, Rice, Cunningham, Sweeney and Assemblywoman Greenstein

SYNOPSIS

Requires health benefits coverage for certain therapies for the treatment of autism and other developmental disabilities.

CURRENT VERSION OF TEXT

As reported by the Senate Budget and Appropriations Committee on June 15, 2009, with amendments.

(Sponsorship Updated As Of: 6/26/2009)

AN ACT concerning health benefits coverage for certain therapies for the treatment of autism and other developmental disabilities and supplementing various parts of the statutory law.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. Notwithstanding any other provision of law to the contrary, every hospital service corporation contract that provides hospital and medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide coverage pursuant to the provisions of this section.

a. The hospital service corporation shall provide coverage for expenses incurred in screening and diagnosing autism or another developmental disability.

b. When the covered person's primary diagnosis is autism or another developmental disability, the hospital service corporation shall provide coverage for expenses incurred for medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan. Coverage of these therapies shall not be denied on the basis that the treatment is not restorative.

c. When the covered person is under 21 years of age and the covered person's primary diagnosis is autism, the hospital service corporation shall 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, subject to the provisions of this subsection.

(1) Except as provided in paragraph (3) of this subsection, the benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the contract, but shall not be subject to limits on the number of visits that a covered person may make to a provider of behavioral interventions.

(2) The benefits provided pursuant to this subsection shall not be denied on the basis that the treatment is not restorative.

(3) (a) The maximum benefit amount for a covered person in any calendar year through 2011 shall be $36,000.

EXPLANATION – Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
[1] Senate SBA committee amendments adopted June 15, 2009.

(b) Commencing on January 1, 2012, the maximum benefit amount shall be subject to an adjustment, to be promulgated by the Commissioner of Banking and Insurance and published in the New Jersey Register no later than February 1 of each calendar year, which shall be equal to the change in the consumer price index for all urban consumers for the nation, as prepared by the United States Department of Labor, for the calendar year preceding the calendar year in which the adjustment to the maximum benefit amount is promulgated.

(c) The adjusted maximum benefit amount shall apply to a contract that is delivered, issued, executed, or renewed, or approved for issuance or renewal, in the 12-month period following the date on which the adjustment is promulgated.

(d) Notwithstanding the provisions of this paragraph to the contrary, a hospital service corporation shall not be precluded from providing a benefit amount for a covered person in any calendar year that exceeds the benefit amounts set forth in subparagraphs (a) and (b) of this paragraph.

d. The treatment plan required pursuant to subsections b. and c. of this section shall include all elements necessary for the hospital service corporation to appropriately provide benefits, including, but not limited to: a diagnosis; proposed treatment by type, frequency, and duration; the anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated; and the treating physician's signature. The hospital service corporation may only request an updated treatment plan once every six months from the treating physician to review medical necessity, unless the hospital service corporation and the treating physician agree that a more frequent review is necessary due to emerging clinical circumstances.

e. The provisions of subsections b. and c. of this section shall not be construed as limiting benefits otherwise available to a covered person.

f. The provisions of subsections b. and c. of this section shall not be construed to**'[**:**]'** require that benefits be provided to reimburse the cost of services provided under an individualized family service plan or an individualized education program**'[**;**]**,**'** or affect any requirement to provide those services**'**; except that the benefits provided pursuant to those subsections shall include coverage for expenses incurred by participants in an individualized family service plan through a family cost share**'**.

g. The coverage required under this section may be subject to utilization review, including periodic review, by the hospital service corporation of the continued medical necessity of the specified therapies and interventions.

h. The provisions of this section shall apply to all contracts in which the hospital service corporation has reserved the right to change the premium.

2. Notwithstanding any other provision of law to the contrary, every medical service corporation contract that provides hospital and medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide coverage pursuant to the provisions of this section.

a. The medical service corporation shall provide coverage for expenses incurred in screening and diagnosing autism or another developmental disability.

b. When the covered person's primary diagnosis is autism or another developmental disability, the medical service corporation shall provide coverage for expenses incurred for medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan. Coverage of these therapies shall not be denied on the basis that the treatment is not restorative.

c. When the covered person is under 21 years of age and the covered person's primary diagnosis is autism, the medical service corporation shall 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, subject to the provisions of this subsection.

(1) Except as provided in paragraph (3) of this subsection, the benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the contract, but shall not be subject to limits on the number of visits that a covered person may make to a provider of behavioral interventions.

(2) The benefits provided pursuant to this subsection shall not be denied on the basis that the treatment is not restorative.

(3) (a) The maximum benefit amount for a covered person in any calendar year through 2011 shall be $36,000.

(b) Commencing on January 1, 2012, the maximum benefit amount shall be subject to an adjustment, to be promulgated by the Commissioner of Banking and Insurance and published in the New Jersey Register no later than February 1 of each calendar year, which shall be equal to the change in the consumer price index for all urban consumers for the nation, as prepared by the United States Department of Labor, for the calendar year preceding the calendar year in which the adjustment to the maximum benefit amount is promulgated.

(c) The adjusted maximum benefit amount shall apply to a contract that is delivered, issued, executed, or renewed, or approved for issuance or renewal, in the 12-month period following the date on which the adjustment is promulgated.

(d) Notwithstanding the provisions of this paragraph to the contrary, a medical service corporation shall not be precluded from providing a benefit amount for a covered person in any calendar year that exceeds the benefit amounts set forth in subparagraphs (a) and (b) of this paragraph.

d. The treatment plan required pursuant to subsections b. and c. of this section shall include all elements necessary for the medical service corporation to appropriately provide benefits, including, but not limited to: a diagnosis; proposed treatment by type, frequency, and duration; the anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated; and the treating physician's signature. The medical service corporation may only request an updated treatment plan once every six months from the treating physician to review medical necessity, unless the medical service corporation and the treating physician agree that a more frequent review is necessary due to emerging clinical circumstances.

e. The provisions of subsections b. and c. of this section shall not be construed as limiting benefits otherwise available to a covered person.

f. The provisions of subsections b. and c. of this section shall not be construed to[1] **[**:**]**[1] require that benefits be provided to reimburse the cost of services provided under an individualized family service plan or an individualized education program[1] **[**;**]**[1] or affect any requirement to provide those services[1]; except that the benefits provided pursuant to those subsections shall include coverage for expenses incurred by participants in an individualized family service plan through a family cost share[1].

g. The coverage required under this section may be subject to utilization review, including periodic review, by the medical service corporation of the continued medical necessity of the specified therapies and interventions.

h. The provisions of this section shall apply to all contracts in which the medical service corporation has reserved the right to change the premium.

3. Notwithstanding any other provision of law to the contrary, every health service corporation contract that provides hospital and medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to P.L.1985, c.236 (C.17:48E-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide coverage pursuant to the provisions of this section.

a. The health service corporation shall provide coverage for expenses incurred in screening and diagnosing autism or another developmental disability.

b. When the covered person's primary diagnosis is autism or another developmental disability, the health service corporation shall provide coverage for expenses incurred for medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan. Coverage of these therapies shall not be denied on the basis that the treatment is not restorative.

c. When the covered person is under 21 years of age and the covered person's primary diagnosis is autism, the health service corporation shall 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, subject to the provisions of this subsection.

(1) Except as provided in paragraph (3) of this subsection, the benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the contract, but shall not be subject to limits on the number of visits that a covered person may make to a provider of behavioral interventions.

(2) The benefits provided pursuant to this subsection shall not be denied on the basis that the treatment is not restorative.

(3) (a) The maximum benefit amount for a covered person in any calendar year through 2011 shall be $36,000.

(b) Commencing on January 1, 2012, the maximum benefit amount shall be subject to an adjustment, to be promulgated by the Commissioner of Banking and Insurance and published in the New Jersey Register no later than February 1 of each calendar year, which shall be equal to the change in the consumer price index for all urban consumers for the nation, as prepared by the United States Department of Labor, for the calendar year preceding the calendar year in which the adjustment to the maximum benefit amount is promulgated.

(c) The adjusted maximum benefit amount shall apply to a contract that is delivered, issued, executed, or renewed, or approved for issuance or renewal, in the 12-month period following the date on which the adjustment is promulgated.

(d) Notwithstanding the provisions of this paragraph to the contrary, a health service corporation shall not be precluded from providing a benefit amount for a covered person in any calendar year that exceeds the benefit amounts set forth in subparagraphs (a) and (b) of this paragraph.

d. The treatment plan required pursuant to subsections b. and c. of this section shall include all elements necessary for the health service corporation to appropriately provide benefits, including, but not limited to: a diagnosis; proposed treatment by type, frequency, and duration; the anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated; and the

treating physician's signature. The health service corporation may only request an updated treatment plan once every six months from the treating physician to review medical necessity, unless the health service corporation and the treating physician agree that a more frequent review is necessary due to emerging clinical circumstances.

e. The provisions of subsections b. and c. of this section shall not be construed as limiting benefits otherwise available to a covered person.

f. The provisions of subsections b. and c. of this section shall not be construed to[1] **[**:**]**[1] require that benefits be provided to reimburse the cost of services provided under an individualized family service plan or an individualized education program[1] **[**;**]**[1] or affect any requirement to provide those services[1]; except that the benefits provided pursuant to those subsections shall include coverage for expenses incurred by participants in an individualized family service plan through a family cost share[1].

g. The coverage required under this section may be subject to utilization review, including periodic review, by the health service corporation of the continued medical necessity of the specified therapies and interventions.

h. The provisions of this section shall apply to all contracts in which the health service corporation has reserved the right to change the premium.

4. Notwithstanding any other provision of law to the contrary, every individual health insurance policy that provides hospital and medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to chapter 26 of Title 17B of the New Jersey Statutes, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide coverage pursuant to the provisions of this section.

a. The insurer shall provide coverage for expenses incurred in screening and diagnosing autism or another developmental disability.

b. When the insured's primary diagnosis is autism or another developmental disability, the insurer shall provide coverage for expenses incurred for medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan. Coverage of these therapies shall not be denied on the basis that the treatment is not restorative.

c. 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 interventions based on the principles of applied behavioral analysis and related structured behavioral programs, as prescribed through a treatment plan, subject to the provisions of this subsection.

(1) Except as provided in paragraph (3) of this subsection, the benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the policy, but shall not be subject to limits on the number of visits that a insured may make to a provider of behavioral interventions.

(2) The benefits provided pursuant to this subsection shall not be denied on the basis that the treatment is not restorative.

(3) (a) The maximum benefit amount for an insured in any calendar year through 2011 shall be $36,000.

(b) Commencing on January 1, 2012, the maximum benefit amount shall be subject to an adjustment, to be promulgated by the Commissioner of Banking and Insurance and published in the New Jersey Register no later than February 1 of each calendar year, which shall be equal to the change in the consumer price index for all urban consumers for the nation, as prepared by the United States Department of Labor, for the calendar year preceding the calendar year in which the adjustment to the maximum benefit amount is promulgated.

(c) The adjusted maximum benefit amount shall apply to a policy that is delivered, issued, executed, or renewed, or approved for issuance or renewal, in the 12-month period following the date on which the adjustment is promulgated.

(d) Notwithstanding the provisions of this paragraph to the contrary, an insurer shall not be precluded from providing a benefit amount for an insured in any calendar year that exceeds the benefit amounts set forth in subparagraphs (a) and (b) of this paragraph.

d. The treatment plan required pursuant to subsections b. and c. of this section shall include all elements necessary for the insurer to appropriately provide benefits, including, but not limited to: a diagnosis; proposed treatment by type, frequency, and duration; the anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated; and the treating physician's signature. The insurer may only request an updated treatment plan once every six months from the treating physician to review medical necessity, unless the insurer and the treating physician agree that a more frequent review is necessary due to emerging clinical circumstances.

e. The provisions of subsections b. and c. of this section shall not be construed as limiting benefits otherwise available to an insured.

f. The provisions of subsections b. and c. of this section shall not be construed to**'[:]'** require that benefits be provided to reimburse the cost of services provided under an individualized family service plan or an individualized education program**'[;]'** or affect any requirement to provide those services**'**; except that the benefits provided pursuant to those subsections shall include coverage for expenses incurred by participants in an individualized family service plan through a family cost share**'**.

g. The coverage required under this section may be subject to utilization review, including periodic review, by the insurer of the continued medical necessity of the specified therapies and interventions.

h. The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

5. Notwithstanding any other provision of law to the contrary, every group health insurance policy that provides hospital and medical expense benefits and is delivered, issued, executed, or renewed in this State pursuant to chapter 27 of Title 17B of the New Jersey Statutes, or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide coverage pursuant to the provisions of this section.

a. The insurer shall provide coverage for expenses incurred in screening and diagnosing autism or another developmental disability.

b. When the insured's primary diagnosis is autism or another developmental disability, the insurer shall provide coverage for expenses incurred for medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan. Coverage of these therapies shall not be denied on the basis that the treatment is not restorative.

c. 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 interventions based on the principles of applied behavioral analysis and related structured behavioral programs, as prescribed through a treatment plan, subject to the provisions of this subsection.

(1) Except as provided in paragraph (3) of this subsection, the benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the policy, but shall not be subject to limits on the number of visits that a insured may make to a provider of behavioral interventions.

(2) The benefits provided pursuant to this subsection shall not be denied on the basis that the treatment is not restorative.

(3) (a) The maximum benefit amount for an insured in any calendar year through 2011 shall be $36,000.

(b) Commencing on January 1, 2012, the maximum benefit amount shall be subject to an adjustment, to be promulgated by the Commissioner of Banking and Insurance and published in the New Jersey Register no later than February 1 of each calendar year, which shall be equal to the change in the consumer price index for all urban consumers for the nation, as prepared by the United States Department of Labor, for the calendar year preceding the calendar year in which the adjustment to the maximum benefit amount is promulgated.

(c) The adjusted maximum benefit amount shall apply to a policy that is delivered, issued, executed, or renewed, or approved for issuance or renewal, in the 12-month period following the date on which the adjustment is promulgated.

(d) Notwithstanding the provisions of this paragraph to the contrary, an insurer shall not be precluded from providing a benefit amount for an insured in any calendar year that exceeds the benefit amounts set forth in subparagraphs (a) and (b) of this paragraph.

d. The treatment plan required pursuant to subsections b. and c. of this section shall include all elements necessary for the insurer to appropriately provide benefits, including, but not limited to: a diagnosis; proposed treatment by type, frequency, and duration; the anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated; and the treating physician's signature. The insurer may only request an updated treatment plan once every six months from the treating physician to review medical necessity, unless the insurer and the treating physician agree that a more frequent review is necessary due to emerging clinical circumstances.

e. The provisions of subsections b. and c. of this section shall not be construed as limiting benefits otherwise available to an insured.

f. The provisions of subsections b. and c. of this section shall not be construed to**'[**:**]'** require that benefits be provided to reimburse the cost of services provided under an individualized family service plan or an individualized education program**'[**;**],'** or affect any requirement to provide those services**'**; except that the benefits provided pursuant to those subsections shall include coverage for expenses incurred by participants in an individualized family service plan through a family cost share**'**.

g. The coverage required under this section may be subject to utilization review, including periodic review, by the insurer of the continued medical necessity of the specified therapies and interventions.

h. The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

6. Notwithstanding any other provision of law to the contrary, an individual health benefits plan that provides hospital and medical expense benefits and is delivered, issued, executed, renewed, or approved for issuance or renewal in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide coverage pursuant to the provisions of this section.

a. The carrier shall provide coverage for expenses incurred in screening and diagnosing autism or another developmental disability.

b. When the covered person's primary diagnosis is autism or another developmental disability, the carrier shall provide coverage for expenses incurred for medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan. Coverage of these therapies shall not be denied on the basis that the treatment is not restorative.

c. When the covered person is under 21 years of age and the covered person's primary diagnosis is autism, the carrier shall 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, subject to the provisions of this subsection.

(1) Except as provided in paragraph (3) of this subsection, the benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, but shall not be subject to limits on the number of visits that a covered person may make to a provider of behavioral interventions.

(2) The benefits provided pursuant to this subsection shall not be denied on the basis that the treatment is not restorative.

(3) (a) The maximum benefit amount for a covered person in any calendar year through 2011 shall be $36,000.

(b) Commencing on January 1, 2012, the maximum benefit amount shall be subject to an adjustment, to be promulgated by the Commissioner of Banking and Insurance and published in the New Jersey Register no later than February 1 of each calendar year, which shall be equal to the change in the consumer price index for all urban consumers for the nation, as prepared by the United States Department of Labor, for the calendar year preceding the calendar year in which the adjustment to the maximum benefit amount is promulgated.

(c) The adjusted maximum benefit amount shall apply to a health benefits plan that is delivered, issued, executed, or renewed, or approved for issuance or renewal, in the 12-month period following the date on which the adjustment is promulgated.

(d) Notwithstanding the provisions of this paragraph to the contrary, a carrier shall not be precluded from providing a benefit amount for a covered person in any calendar year that exceeds the benefit amounts set forth in subparagraphs (a) and (b) of this paragraph.

d. The treatment plan required pursuant to subsections b. and c. of this section shall include all elements necessary for the carrier to appropriately provide benefits, including, but not limited to: a diagnosis; proposed treatment by type, frequency, and duration; the anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated; and the treating physician's signature. The carrier may only request an updated treatment plan

once every six months from the treating physician to review medical necessity, unless the carrier and the treating physician agree that a more frequent review is necessary due to emerging clinical circumstances.

e. The provisions of subsections b. and c. of this section shall not be construed as limiting benefits otherwise available to a covered person.

f. The provisions of subsections b. and c. of this section shall not be construed to[1] **[**:**]** [1] require that benefits be provided to reimburse the cost of services provided under an individualized family service plan or an individualized education program[1] **[**;**]**, [1] or affect any requirement to provide those services[1]; except that the benefits provided pursuant to those subsections shall include coverage for expenses incurred by participants in an individualized family service plan through a family cost share[1].

g. The coverage required under this section may be subject to utilization review, including periodic review, by the carrier of the continued medical necessity of the specified therapies and interventions.

h. The provisions of this section shall apply to those health benefits plans in which the carrier has reserved the right to change the premium.

7. Notwithstanding any other provision of law to the contrary, a small employer health benefits plan that provides hospital and medical expense benefits and is delivered, issued, executed, renewed, or approved for issuance or renewal in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide coverage pursuant to the provisions of this section.

a. The carrier shall provide coverage for expenses incurred in screening and diagnosing autism or another developmental disability.

b. When the covered person's primary diagnosis is autism or another developmental disability, the carrier shall provide coverage for expenses incurred for medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan. Coverage of these therapies shall not be denied on the basis that the treatment is not restorative.

c. When the covered person is under 21 years of age and the covered person's primary diagnosis is autism, the carrier shall 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, subject to the provisions of this subsection.

(1) Except as provided in paragraph (3) of this subsection, the benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the health benefits plan, but shall not be subject to limits on the number of visits that a covered person may make to a provider of behavioral interventions.

(2) The benefits provided pursuant to this subsection shall not be denied on the basis that the treatment is not restorative.

(3) (a) The maximum benefit amount for a covered person in any calendar year through 2011 shall be $36,000.

(b) Commencing on January 1, 2012, the maximum benefit amount shall be subject to an adjustment, to be promulgated by the Commissioner of Banking and Insurance and published in the New Jersey Register no later than February 1 of each calendar year, which shall be equal to the change in the consumer price index for all urban consumers for the nation, as prepared by the United States Department of Labor, for the calendar year preceding the calendar year in which the adjustment to the maximum benefit amount is promulgated.

(c) The adjusted maximum benefit amount shall apply to a health benefits plan that is delivered, issued, executed, or renewed, or approved for issuance or renewal, in the 12-month period following the date on which the adjustment is promulgated.

(d) Notwithstanding the provisions of this paragraph to the contrary, a carrier shall not be precluded from providing a benefit amount for a covered person in any calendar year that exceeds the benefit amounts set forth in subparagraphs (a) and (b) of this paragraph.

d. The treatment plan required pursuant to subsections b. and c. of this section shall include all elements necessary for the carrier to appropriately provide benefits, including, but not limited to: a diagnosis; proposed treatment by type, frequency, and duration; the anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated; and the treating physician's signature. The carrier may only request an updated treatment plan once every six months from the treating physician to review medical necessity, unless the carrier and the treating physician agree that a more frequent review is necessary due to emerging clinical circumstances.

e. The provisions of subsections b. and c. of this section shall not be construed as limiting benefits otherwise available to a covered person.

f. The provisions of subsections b. and c. of this section shall not be construed to**'[**:**]'** require that benefits be provided to reimburse the cost of services provided under an individualized family service plan or an individualized education program**'[**;**]**.**'** or affect any requirement to provide those services**'**; except that the benefits provided pursuant to those subsections shall include

coverage for expenses incurred by participants in an individualized family service plan through a family cost share[1].

g. The coverage required under this section may be subject to utilization review, including periodic review, by the carrier of the continued medical necessity of the specified therapies and interventions.

h. The provisions of this section shall apply to those health benefits plans in which the carrier has reserved the right to change the premium.

8. Notwithstanding any other provision of law to the contrary, a health maintenance organization enrollee agreement that provides health care services and is delivered, issued, executed, or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Banking and Insurance, on or after the effective date of this act, shall provide coverage pursuant to the provisions of this section.

a. The health maintenance organization shall provide coverage for health care services for screening and diagnosing autism or another developmental disability.

b. When the enrollee's primary diagnosis is autism or another developmental disability, the health maintenance organization shall provide coverage for medically necessary occupational therapy, physical therapy, and speech therapy services, as prescribed through a treatment plan. Coverage of these therapies shall not be denied on the basis that the treatment is not restorative.

c. When the enrollee is under 21 years of age and the enrollee's primary diagnosis is autism, the health maintenance organization shall provide coverage for medically necessary behavioral interventions based on the principles of applied behavioral analysis and related structured behavioral programs, as prescribed through a treatment plan, subject to the provisions of this subsection.

(1) Except as provided in paragraph (3) of this subsection, the coverage provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the contract, but shall not be subject to limits on the number of visits that an enrollee may make to a provider of behavioral interventions.

(2) The coverage provided pursuant to this subsection shall not be denied on the basis that the treatment is not restorative.

(3) (a) The maximum coverage amount for an enrollee in any calendar year through 2011 shall be $36,000.

(b) Commencing on January 1, 2012, the maximum coverage amount shall be subject to an adjustment, to be promulgated by the Commissioner of Banking and Insurance and published in the New Jersey Register no later than February 1 of each calendar year, which shall be equal to the change in the consumer price index for all urban consumers for the nation, as prepared by the United States Department of Labor, for the calendar year preceding the calendar

year in which the adjustment to the maximum benefit amount is promulgated.

(c) The adjusted maximum coverage amount shall apply to a contract that is delivered, issued, executed, or renewed, or approved for issuance or renewal, in the 12-month period following the date on which the adjustment is promulgated.

(d) Notwithstanding the provisions of this paragraph to the contrary, a health maintenance organization shall not be precluded from providing a coverage amount for an enrollee in any calendar year that exceeds the coverage amounts set forth in subparagraphs (a) and (b) of this paragraph.

d. The treatment plan required pursuant to subsections b. and c. of this section shall include all elements necessary for the health maintenance organization to appropriately provide coverage for health care services, including, but not limited to: a diagnosis; proposed treatment by type, frequency, and duration; the anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated; and the treating physician's signature. The health maintenance organization may only request an updated treatment plan once every six months from the treating physician to review medical necessity, unless the health maintenance organization and the treating physician agree that a more frequent review is necessary due to emerging clinical circumstances.

e. The provisions of this subsections b. and c. of this section shall not be construed as limiting coverage for health care services otherwise available to an enrollee.

f. The provisions of subsections b. and c. of this section shall not be construed to**'[:]'** require that benefits be provided to reimburse the cost of services provided under an individualized family service plan or an individualized education program**'[;],'** or affect any requirement to provide those services**'**; except that the benefits provided pursuant to those subsections shall include coverage for expenses incurred by participants in an individualized family service plan through a family cost share**'**.

g. The coverage required under this section may be subject to utilization review, including periodic review, by the health maintenance organization of the continued medical necessity of the specified therapies and interventions.

h. The provisions of this section shall apply to those enrollee agreements in which the health maintenance organization has reserved the right to change the premium.

9. Notwithstanding any other provision of law to the contrary, the State Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act that provides hospital or medical expense benefits shall provide coverage pursuant to the provisions of this section.

a. The contract shall provide coverage for expenses incurred in screening and diagnosing autism or another developmental disability.

b. When the covered person's primary diagnosis is autism or another developmental disability, the contract shall provide coverage for expenses incurred for medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan. Coverage of these therapies shall not be denied on the basis that the treatment is not restorative.

c. When the covered person is under 21 years of age and the covered person's primary diagnosis is autism, the contract shall 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, subject to the provisions of this subsection.

(1) Except as provided in paragraph (3) of this subsection, the benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the contract, but shall not be subject to limits on the number of visits that a covered person may make to a provider of behavioral interventions.

(2) The benefits provided pursuant to this subsection shall not be denied on the basis that the treatment is not restorative.

(3) (a) The maximum benefit amount for a covered person in any calendar year through 2011 shall be $36,000.

(b) Commencing on January 1, 2012, the maximum benefit amount shall be subject to an adjustment, to be promulgated by the Commissioner of Banking and Insurance and published in the New Jersey Register no later than February 1 of each calendar year, which shall be equal to the change in the consumer price index for all urban consumers for the nation, as prepared by the United States Department of Labor, for the calendar year preceding the calendar year in which the adjustment to the maximum benefit amount is promulgated.

(c) The adjusted maximum benefit amount shall apply to a contract that is delivered, issued, executed, or renewed, or approved for issuance or renewal, in the 12-month period following the date on which the adjustment is promulgated.

(d) Notwithstanding the provisions of this paragraph to the contrary, the commission shall not be precluded from providing a benefit amount for a covered person in any calendar year that exceeds the benefit amounts set forth in subparagraphs (a) and (b) of this paragraph.

d. The treatment plan required pursuant to subsections b. and c. of this section shall include all elements necessary for the carrier to appropriately provide benefits, including, but not limited to: a diagnosis; proposed treatment by type, frequency, and duration; the

anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated; and the treating physician's signature. The carrier may only request an updated treatment plan once every six months from the treating physician to review medical necessity, unless the carrier and the treating physician agree that a more frequent review is necessary due to emerging clinical circumstances.

e. The provisions of subsections b. and c. of this section shall not be construed as limiting benefits otherwise available to a covered person.

f. The provisions of subsections b. and c. of this section shall not be construed to'[:]' require that benefits be provided to reimburse the cost of services provided under an individualized family service plan or an individualized education program'[;]2,' or affect any requirement to provide those services'; except that the benefits provided pursuant to those subsections shall include coverage for expenses incurred by participants in an individualized family service plan through a family cost share'.

g. The coverage required under this section may be subject to utilization review, including periodic review, by the carrier of the continued medical necessity of the specified therapies and interventions.

10. Notwithstanding any other provision of law to the contrary, the School Employees' Health Benefits Commission shall ensure that every contract purchased by the commission on or after the effective date of this act that provides hospital or medical expense benefits shall provide coverage pursuant to the provisions of this section..

a. The contract shall provide coverage for expenses incurred in screening and diagnosing autism or another developmental disability.

b. When the covered person's primary diagnosis is autism or another developmental disability, the contract shall provide coverage for expenses incurred for medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan. Coverage of these therapies shall not be denied on the basis that the treatment is not restorative.

c. When the covered person is under 21 years of age and the covered person's primary diagnosis is autism, the contract shall 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, subject to the provisions of this subsection.

(1) Except as provided in paragraph (3) of this subsection, the benefits provided pursuant to this subsection shall be provided to the same extent as for any other medical condition under the

contract, but shall not be subject to limits on the number of visits that a covered person may make to a provider of behavioral interventions.

(2) The benefits provided pursuant to this subsection shall not be denied on the basis that the treatment is not restorative.

(3) (a) The maximum benefit amount for a covered person in any calendar year through 2011 shall be $36,000.

(b) Commencing on January 1, 2012, the maximum benefit amount shall be subject to an adjustment, to be promulgated by the Commissioner of Banking and Insurance and published in the New Jersey Register no later than February 1 of each calendar year, which shall be equal to the change in the consumer price index for all urban consumers for the nation, as prepared by the United States Department of Labor, for the calendar year preceding the calendar year in which the adjustment to the maximum benefit amount is promulgated.

(c) The adjusted maximum benefit amount shall apply to a contract that is delivered, issued, executed, or renewed, or approved for issuance or renewal, in the 12-month period following the date on which the adjustment is promulgated.

(d) Notwithstanding the provisions of this paragraph to the contrary, the commission shall not be precluded from providing a benefit amount for a covered person in any calendar year that exceeds the benefit amounts set forth in subparagraphs (a) and (b) of this paragraph.

d. The treatment plan required pursuant to subsections b. and c. of this section shall include all elements necessary for the carrier to appropriately provide benefits, including, but not limited to: a diagnosis; proposed treatment by type, frequency, and duration; the anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated; and the treating physician's signature. The carrier may only request an updated treatment plan once every six months from the treating physician to review medical necessity, unless the carrier and the treating physician agree that a more frequent review is necessary due to emerging clinical circumstances.

e. The provisions of subsections b. and c. of this section shall not be construed as limiting benefits otherwise available to a covered person.

f. The provisions of subsections b. and c. of this section shall not be construed to[1] **[**:**]** [1] require that benefits be provided to reimburse the cost of services provided under an individualized family service plan or an individualized education program[1] **[**;**]**, [1] or affect any requirement to provide those services[1]; except that the benefits provided pursuant to those subsections shall include coverage for expenses incurred by participants in an individualized family service plan through a family cost share[1].

g. The coverage required under this section may be subject to utilization review, including periodic review, by the carrier of the continued medical necessity of the specified therapies and interventions.

11. This act shall take effect on the 180th day after enactment.

8. Notwithstanding any other provision of law to the contrary, a health maintenance organization enrollee agreement that provides health care services and is delivered, issued, executed or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Health and Senior Services, on or after the effective date of this act, shall, when the covered person's primary diagnosis is Autistic Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, Pervasive Developmental Disorder - Not Otherwise Specified or Rhett's Syndrome, provide coverage for expenses incurred for the following treatments when prescribed as medically necessary by the covered person's physician: physical therapy; speech therapy; occupational therapy; and evidence-based behavioral interventions.

The health care services shall be provided to the same extent as for any other medical condition under the enrollee agreement.

The provisions of this section shall apply to those enrollee agreements in which the health maintenance organization has reserved the right to change the premium.

9. Notwithstanding any other provision of law to the contrary, the State Health Benefits Commission shall, when the covered person's primary diagnosis is Autistic Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, Pervasive Developmental Disorder - Not Otherwise Specified or Rhett's Syndrome, provide coverage for expenses incurred for the following treatments when prescribed as medically necessary by the covered person's physician: physical therapy; speech therapy; occupational therapy; and evidence-based behavioral interventions.

These benefits shall be provided to the same extent as for any other medical condition under the program.

10. This act shall take effect on the 90th day after enactment.

SPONSOR'S STATEMENT

This bill requires health insurers to provide health benefits coverage for expenses incurred for certain treatments when prescribed as medically necessary by the covered person's physician upon a diagnosis of autism. When the covered person's primary diagnosis is Autistic Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, Pervasive Developmental Disorder - Not Otherwise Specified or Rhett's Syndrome, the covered treatments would include: physical therapy; speech therapy; occupational therapy; and evidence-based behavioral interventions. Insurers covered by the bill include: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small

Employer Health Benefits Programs; and the State Health Benefits Program.

ASSEMBLY HEALTH AND SENIOR SERVICES COMMITTEE

STATEMENT TO

ASSEMBLY, No. 2238

STATE OF NEW JERSEY

DATED: FEBRUARY 25, 2008

The Assembly Health and Senior Services Committee reports favorably Assembly Bill No. 2238.

This bill requires health insurers to provide health benefits coverage for expenses incurred for certain treatments when prescribed as medically necessary by the covered person's physician upon a diagnosis of autism.

This requirement applies to: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; and the State Health Benefits Program.

The bill provides that when the covered person's primary diagnosis is Autistic Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, Pervasive Developmental Disorder - Not Otherwise Specified or Rhett's Syndrome, the covered treatments would include: physical therapy; speech therapy; occupational therapy; and evidence-based behavioral interventions.

The bill takes effect on the 90th day after enactment.

MINORITY STATEMENT

Submitted by Assemblyman Munoz, Assemblywoman Angelini, and Assemblyman Polistina

The sponsors of this bill should be commended for their dedication to assisting individuals with autism and their families.

However, at this time, the State is facing very serious financial difficulties. The Governor has ordered his cabinet officers to recommend reductions in departmental spending and has directed the State Treasurer to work with the Legislature to identify additional savings.

This bill will have a significant monetary impact on the State. The bill requires health benefits coverage for certain therapies and applied behavioral analysis for the treatment of certain autism disorders. According to a fiscal estimate prepared by the Office of Legislative Services, this bill will cost the State Health Benefits Program $36.7

million in FY2008 and $40.3 million in FY2009 (including State and local costs). Additionally, according to a report issued by the Mandated Health Benefits Advisory Commission, "a certain number of people, approximately 4,200, might lose coverage solely as a result of the cost increase associated with this mandate." It is also unclear if the therapies listed in the bill are currently covered under existing mandate statutes.

Until such time as Governor Corzine delivers his Fiscal Year 2009 State budget to the Legislature, neither the members of this committee, nor the Legislature generally, should endorse any additional spending initiatives. We are, therefore, compelled to withhold support for this particular legislation at this time.

ASSEMBLY APPROPRIATIONS COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, No. 2238

STATE OF NEW JERSEY

DATED: MAY 18, 2009

The Assembly Appropriations Committee reports favorably an Assembly Committee Substitute for Assembly Bill No. 2238.

This substitute requires health insurers to provide health benefits coverage for expenses incurred for medically necessary therapies for covered persons with autism and other developmental disabilities.

The substitute provides specifically as follows:

- Its provisions apply to: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; the State Health Benefits Program; and the School Employees' Health Benefits Program.
- The insurer is to provide coverage for expenses incurred in screening and diagnosing autism or another developmental disability.
- When the covered person's diagnosis is autism or another developmental disability, the covered treatments are to include medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan; and coverage of these therapies is not to be denied on the basis that the treatment is not restorative.
- When the covered person is under 21 years of age and the covered person's diagnosis is autism, the covered treatments are to include medically necessary behavioral interventions based on the principles of applied behavioral analysis and related structured behavioral programs, as prescribed through a treatment plan, subject to the provisions of this substitute.
- The benefits provided for behavioral interventions for a covered person under 21 years of age:

-- are to be provided to the same extent as for any other medical condition under the contract or policy, except as provided in the substitute, but are not to be subject to limits on the number of visits that a covered person may make to a provider of behavioral interventions; and

-- are not to be denied on the basis that the treatment is not restorative.

- With respect to these benefits provided for behavioral interventions:

-- The maximum benefit for a covered person in any calendar year through 2011 is $36,000;

-- Commencing on January 1, 2012, the maximum benefit amount will be subject to an adjustment, to be promulgated by the Commissioner of Banking and Insurance and published in the New Jersey Register no later than February 1 of each calendar year, which is equal to the change in the consumer price index for all urban consumers for the nation, as prepared by the United States Department of Labor, for the calendar year preceding the calendar year in which the adjustment to the maximum benefit amount is promulgated;

-- The adjusted maximum benefit amount will apply to a contract or policy that is delivered, issued, executed, or renewed, or approved for issuance or renewal, in the 12-month period following the date on which the adjustment is promulgated;

-- Notwithstanding the provisions of this substitute to the contrary, an insurer is not precluded from providing a benefit amount for a covered person in any calendar year that exceeds the benefit amounts set forth above;

-- The treatment plan required pursuant to the substitute is to include all elements necessary for the insurer to appropriately provide benefits, including, but not limited to: a diagnosis; proposed treatment by type, frequency, and duration; the anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated; and the treating physician's signature. The insurer may only request an updated treatment plan once every six months from the treating physician to review medical necessity, unless the insurer and the treating physician agree that a more frequent review is necessary due to emerging clinical circumstances; and

-- The provisions of this substitute are not to be construed as limiting benefits otherwise available to a covered person.

- The provisions of this substitute are not to be construed to: require that benefits be provided to reimburse the cost of services provided under an individualized family service plan or an individualized education program; or affect any requirement to provide those services.
- The coverage required under this substitute may be subject to utilization review, including periodic review, by the health insurer of the continued medical necessity of the specified therapies and interventions.
- The substitute takes effect on the 180th day after enactment.

FISCAL IMPACT

The Office of Legislative Services (OLS) has not been provided with an estimate from the Division of Pensions and Benefits in the

Department of Treasury based on the contents of this substitute. At this time and based on the available information, the OLS is unable to make an independent estimate.

This substitute is identical to Senate Bill No. 1651 (SCS) (Vitale/Weinberg), which was reported favorably by the Senate Health, Human Services and Senior Citizens Committee on this date.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

ASSEMBLY COMMITTEE SUBSTITUTE FOR
ASSEMBLY, No. 2238

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 15, 2009

The Senate Budget and Appropriations Committee reports favorably Assembly Bill No. 2238 (ACS), with committee amendments.

This substitute, with committee amendments, requires health insurers to provide health benefits coverage for expenses incurred for medically necessary therapies for covered persons with autism and other developmental disabilities.

The substitute provides specifically as follows:

- Its provisions apply to: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; the State Health Benefits Program; and the School Employees' Health Benefits Program.
- The insurer is to provide coverage for expenses incurred in screening and diagnosing autism or another developmental disability.
- When the covered person's diagnosis is autism or another developmental disability, the covered treatments are to include medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan; and coverage of these therapies is not to be denied on the basis that the treatment is not restorative.
- When the covered person is under 21 years of age and the covered person's diagnosis is autism, the covered treatments are to include medically necessary behavioral interventions based on the principles of applied behavioral analysis and related structured behavioral programs, as prescribed through a treatment plan, subject to the provisions of this substitute.
- The benefits provided for behavioral interventions for a covered person under 21 years of age:

-- are to be provided to the same extent as for any other medical condition under the contract or policy, except as provided in the

substitute, but are not to be subject to limits on the number of visits that a covered person may make to a provider of behavioral interventions; and

-- are not to be denied on the basis that the treatment is not restorative.

- With respect to these benefits provided for behavioral interventions:

-- The maximum benefit for a covered person in any calendar year through 2011 is $36,000;

-- Commencing on January 1, 2012, the maximum benefit amount will be subject to an adjustment, to be promulgated by the Commissioner of Banking and Insurance and published in the New Jersey Register no later than February 1 of each calendar year, which is equal to the change in the consumer price index for all urban consumers for the nation, as prepared by the United States Department of Labor, for the calendar year preceding the calendar year in which the adjustment to the maximum benefit amount is promulgated;

-- The adjusted maximum benefit amount will apply to a contract or policy that is delivered, issued, executed, or renewed, or approved for issuance or renewal, in the 12-month period following the date on which the adjustment is promulgated;

-- Notwithstanding the provisions of this substitute to the contrary, an insurer is not precluded from providing a benefit amount for a covered person in any calendar year that exceeds the benefit amounts set forth above;

-- The treatment plan required pursuant to the substitute is to include all elements necessary for the insurer to appropriately provide benefits, including, but not limited to: a diagnosis; proposed treatment by type, frequency, and duration; the anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated; and the treating physician's signature. The insurer may only request an updated treatment plan once every six months from the treating physician to review medical necessity, unless the insurer and the treating physician agree that a more frequent review is necessary due to emerging clinical circumstances; and

-- The provisions of this substitute are not to be construed as limiting benefits otherwise available to a covered person.

- The provisions of this substitute are not to be construed to require that benefits be provided to reimburse the cost of services provided under an individualized family service plan or an individualized education program, or affect any requirement to provide those services; except that the required benefits do include coverage for expenses incurred by participants in an individualized family service plan through a family cost share.
- The coverage required under this substitute may be subject to utilization review, including periodic review, by the health insurer of the continued medical necessity of the specified therapies and interventions.

- The substitute takes effect on the 180th day after enactment.

As amended and reported by the committee, this substitute is identical to Senate Bill No. 1651 (SCS), as also amended and reported by the committee on this date.

COMMITTEE AMENDMENTS

The committee amendments to the substitute clarify that the required benefits include coverage for expenses incurred by participants in an individualized family service plan through a family cost share.

FISCAL IMPACT

The Office of Legislative Services (OLS) has not been provided with an estimate from the Division of Pensions and Benefits in the Department of the Treasury based on the contents of this substitute bill or the proposed committee amendment. At this time and based on the available information, the OLS is unable to make a precise estimate of the fiscal impact of the substitute.

The OLS notes that potentially significant cost increases to State and local governments will result, principally from the requirement that governmental as well as private sector health insurers provide health care benefits for behavioral interventions, up to $36,000 per year, for the treatment of children younger than 21 years of age diagnosed with autism. For the State and those local entities participating in the State Health Benefits Program (SHBP) and the School Employees Health Benefits Program (SEHBP), assuming full utilization by all covered individuals, costs could increase in the aggregate by amounts approaching $85.8 million annually. For costs to reach this level, the autism prevalence in children covered by the SHBP/SEHBP would mirror the prevalence rate of 1 in 94 children in New Jersey (as measured by the federal Centers for Disease Control and Prevention), resulting in an eligible population of 2,384 out of 224,992 children, and claimed services would attain the maximum for each child. In the short run, it is likely that a lesser cost impact would result since full utilization is not likely to occur immediately. Over time, costs are likely to increase as more eligible children receive insured services and as inflation-based adjustments are made to the annual benefits ceiling.

LEGISLATIVE FISCAL ESTIMATE

[First Reprint]

ASSEMBLY COMMITTEE SUBSTITUTE

ASSEMBLY, No. 2238

STATE OF NEW JERSEY
213th LEGISLATURE

DATED: JUNE 24, 2009

SUMMARY

Synopsis: Requires health benefits coverage for certain therapies for the treatment of autism and other developmental disabilities.

Type of Impact: Expenditure increase: State General Fund, local government funds.

Agencies Affected: Department of the Treasury, Division of Pensions and Benefits; local government entities.

Office of Legislative Services Estimate

Fiscal Impact	FY 2010	FY 2011	FY 2012
State Cost	Indeterminate but significant, annually - See comments below.		
Local Cost	Indeterminate but significant, annually - See comments below.		

- The Office of Legislative Services (OLS) estimates an indeterminate but significant aggregate annual cost increase for State and local governments as a result of this bill.

- The OLS notes that total State and local government costs through participation in the State Health Benefits Program (SHBP) and the School Employees Health Benefits Program (SEHBP) could approach $42.9 million (State $20 million and local $22.9 million) in FY 2010 assuming a January 1, 2010 effective date, reflecting half-year costs, and $85.8 million (State $40 million and local $45.8 million) in FY 2011, reflecting full-year costs. This assumes an autism prevalence rate of 1 in 94, in accordance with statistics from the federal Centers for Disease Control and Prevention, resulting in a potential population of 2,384 out of 224,992 children covered under the SHBP/SEHBP who could be diagnosed with autism, and further assumes that all eligible, covered individuals receive the maximum provided benefit immediately upon enactment of the legislation.

- The OLS further notes that not all eligible, covered individuals are likely to receive the maximum benefit provided. However, there is likely to be an increase over time in the consumption of benefits within the eligible population.

- The bill's principle cost factor is a beginning maximum annual benefit of $36,000 for persons up to 21 years of age, with a primary diagnosis of autism for expenses incurred for medically necessary behavioral interventions based on the principles of applied behavioral analysis and related structured behavioral programs. This limit is to be adjusted annually beginning January 1, 2012 by an inflation adjustment in accordance with a specified formula.

- This fiscal estimate reflects potential costs associated with the SHBP/SEHBP only. Thus, the costs to local governments that contract with a commercial health care benefit provider, for example, are not reflected in this fiscal note. The OLS is not able to estimate the number of local government agencies that contract with a commercial health care benefit provider and the cumulative amount of premiums paid by local governments due to a lack of data.

- Although data are not available to permit quantification of the savings to be realized from the benefits provided by this bill, savings may be realized by the Department of Health and Senior Services' Early Intervention Program, because the costs of the program will be shifted to health insurers.

- This bill requires government and private sector health insurers to provide health care benefits coverage for expenses incurred for certain treatments when prescribed as medically necessary by the covered person's physician upon diagnosis of autism and other developmental disabilities including, applied behavioral analysis and occupational, physical, and speech therapy.

BILL DESCRIPTION

Assembly Committee Substitute for Assembly Bill No. 2238 (1R) of 2009 requires health insurers to provide health benefits coverage for expenses incurred for certain treatments when prescribed as medically necessary by the covered person's physician upon diagnosis of autism or other developmental disabilities. When the covered person's diagnosis is autism or other developmental disability, the covered treatments are to include medically necessary occupational, physical, and speech therapy, as prescribed through a treatment plan; and coverage of these therapies is not to be denied on the basis that the treatment is not restorative. When the covered person is under 21 years of age and the covered person's diagnosis is autism, the covered treatments, up to a maximum annual benefit of $36,000, are to include medically necessary behavioral interventions based on the principles of applied behavioral analysis and related structural behavioral programs, as prescribed and specified. The benefits for behavioral interventions are to be provided to the same extent as for any other medical condition, may not be subject to limits on the number of visits, and may not be denied on the basis that the treatment is not restorative. This bill will take affect on the 180th day after enactment.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The OLS estimates an indeterminate but significant increase in State and local government health insurance costs as a result of this bill. State and local governments participating in the State Health Benefits Program and the School Employees Health Benefits Program could experience cost increases approaching in total $42.9 million in FY 2010 (State $20 million and local $22.9 million), reflecting half-year costs, and $85.8 million (State $40 million and local $45.8 million) in FY 2011, reflecting full-year costs. Costs in FY 2012 and thereafter may be higher due to an annual adjustment to the maximum benefit amount for inflation, as specified. This potential cost impact represents an assumption that all eligible, covered individuals receive the maximum provided benefit immediately upon enactment of the legislation, given:

- An assumed prevalence rate of 10.6 per 1,000 (1 in 94) covered children with autism;
- A maximum annual benefit of $36,000 for children under 21 years of age.

According to the Division of Pensions and Benefits, there are 224,920 children covered by the SHBP/SEHBP. Applying the prevalence rate of 1 in 94 to this population results in an estimated population of 2,384 children under 21 years of age who would receive the benefit provided by the bill. It should be noted that this OLS analysis focuses on the mandate in the bill for coverage of "behavioral interventions based on the principles of applied behavioral analysis and related structured behavioral programs." It should be further noted that not all eligible, covered individuals are likely to receive the maximum benefit, as indicated below. However, it is possible that over time the consumption of benefits within the eligible population will increase, and costs will likewise increase.

These assumptions are based on findings in the February 2007 report submitted to the New Jersey Mandated Health Benefits Advisory Commission regarding a review and evaluation of substantially similar legislation (Assembly Bill No. 999 of 2006) that mandated physical, speech, and occupational therapy, and behavioral interventions based on the principles of applied behavioral analysis and related structured behavioral programs. In summary, the evaluation reported that: (1) the prevalence rate for the five diagnoses listed in that bill in New Jersey is currently 1 in 94, based on federal Centers for Disease Control and Prevention reports; and (2) the average annual cost per person is $50,787 for children under five years of age and $33,858 for children between five and nine years of age. The commission reported that, pursuant to statutorily mandated coverage for "biologically-based mental illness" (which includes autism), physical, speech, and occupational therapies are already covered. However, applied behavioral analysis is typically not a covered benefit under health care insurance. Therefore, the commission's review and evaluation focused on the mandate for coverage of applied behavioral analysis. The commission's evaluation did not calculate the cost of the bill to the SHBP.

The consultant to the commission found that estimates vary on the cost of applied behavioral analysis treatments and the use after childhood. Treatment is most successful when started as early as possible after diagnosis and when continued for at least three to five years. An analysis of the autism law in Minnesota and estimates of the recommended hours per week of therapy revealed that applied behavioral analysis treatment would be $50,787 per year for children under the age of five who are receiving 30 hours a week of therapy and $33,858 for children over the age of five. Therapy is estimated to take 20 to 40 hours per week with a minimum level of 25 hours per week for 52 weeks for three to five years. The OLS notes that the average annual benefit for autism spectrum disorder in Minnesota and South Carolina is $50,000. In addition, in Arizona, the average annual benefit for children under the age of five is $50,000 and for children between five and nine years of age is $25,000. In 2008, Pennsylvania passed legislation to require insurance coverage up to $36,000 per year per person for autism spectrum disorder. The State of Washington has introduced legislation to require insurance coverage up to $50,000 per

year per person for autism spectrum disorder. Because therapy is most successful, for younger children under the age of nine and particularly under the age of five, it may be possible that the maximum exposure to the SHBP/SEHBP could be less because of a higher utilization rate by children under nine years of age and a lower utilization rate by children over nine years of age.

The OLS notes that it may be reasonable to assume that long term societal benefits are generated from providing the treatment mandated by the bill because there is a higher probability that children who receive treatment will be able to integrate into society and thereby reduce future social and economic costs. While there may be societal benefits over time, the costs of this bill would be incurred by the SHBP/SEHBP and other insurers. Although data are not available to assess the potential extent of the savings to be realized from the benefits provided by this bill, savings may be realized by the Department of Health and Senior Services' Early Intervention Program, by school districts in special education if early treatment is successful, and by the State and federal government in the Medicaid program. While costs to the SHBP/SEHBP may taper off when children reach school age and are able to receive services through their schools under federally mandated programs, in the long run, the burden of the costs will rest upon the health care providers where the demand for the intensity of the services (preschool age zero to five years of age) provides the greatest benefit.

This estimate reflects potential additional costs associated with the SHBP/SEHBP only. Thus, the additional cost to local governments that contract with commercial health benefit providers is not reflected in this estimate. An estimate of the impact on local governments that contract with commercial health benefit providers cannot be made because information on these private carrier plans and the amount of premiums paid is not available.

Section:	*State Government*
Analyst:	*Kimberly Anne McCord* *Senior Fiscal Analyst*
Approved:	*David J. Rosen* *Legislative Budget and Finance Officer*

This fiscal estimate has been prepared pursuant to P.L. 1980, c.67 (C. 52:13B-1 et seq.).

8. Notwithstanding any other provision of law to the contrary, a health maintenance organization enrollee agreement that provides health care services and is delivered, issued, executed or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.), or approved for issuance or renewal in this State by the Commissioner of Health and Senior Services, on or after the effective date of this act, shall, when the covered person's primary diagnosis is Autistic Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, Pervasive Developmental Disorder - Not Otherwise Specified or Rhett's Syndrome, provide coverage for expenses incurred for the following treatments when prescribed as medically necessary by the covered person's physician: physical therapy; speech therapy; occupational therapy; and evidence-based behavioral interventions.

The health care services shall be provided to the same extent as for any other medical condition under the enrollee agreement.

The provisions of this section shall apply to those enrollee agreements in which the health maintenance organization has reserved the right to change the premium.

9. Notwithstanding any other provision of law to the contrary, the State Health Benefits Commission shall, when the covered person's primary diagnosis is Autistic Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, Pervasive Developmental Disorder - Not Otherwise Specified or Rhett's Syndrome, provide coverage for expenses incurred for the following treatments when prescribed as medically necessary by the covered person's physician: physical therapy; speech therapy; occupational therapy; and evidence-based behavioral interventions.

These benefits shall be provided to the same extent as for any other medical condition under the program.

10. This act shall take effect on the 90th day after enactment.

SPONSORS STATEMENT

This bill requires health insurers to provide health benefits coverage for expenses incurred for certain treatments when prescribed as medically necessary by the covered person's physician upon a diagnosis of autism. When the covered person's primary diagnosis is Autistic Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, Pervasive Developmental Disorder - Not Otherwise Specified or Rhett's Syndrome, the covered treatments would include: physical therapy; speech therapy; occupational therapy; and evidence-based behavioral interventions. Insurers covered by the bill include: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; health benefits plans issued

pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; and the State Health Benefits Program.

SENATE HEALTH, HUMAN SERVICES AND SENIOR CITIZENS COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 1651

STATE OF NEW JERSEY

DATED: MAY 18, 2009

The Senate Health, Human Services and Senior Citizens Committee reports favorably a Senate Committee Substitute for Senate Bill No. 1651.

This committee substitute requires health insurers to provide health benefits coverage for expenses incurred for medically necessary therapies for covered persons with autism and other developmental disabilities.

The substitute provides specifically as follows:

- Its provisions apply to: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; the State Health Benefits Program; and the School Employees' Health Benefits Program.
- The insurer is to provide coverage for expenses incurred in screening and diagnosing autism or another developmental disability.
- When the covered person's diagnosis is autism or another developmental disability, the covered treatments are to include medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan; and coverage of these therapies is not to be denied on the basis that the treatment is not restorative.
- When the covered person is under 21 years of age and the covered person's diagnosis is autism, the covered treatments are to include medically necessary behavioral interventions based on the principles of applied behavioral analysis and related structured behavioral programs, as prescribed through a treatment plan, subject to the provisions of this substitute.
- The benefits provided for behavioral interventions for a covered person under 21 years of age:

-- are to be provided to the same extent as for any other medical condition under the contract or policy, except as provided in the

substitute, but are not to be subject to limits on the number of visits that a covered person may make to a provider of behavioral interventions; and

-- are not to be denied on the basis that the treatment is not restorative.

- With respect to these benefits provided for behavioral interventions:

-- The maximum benefit for a covered person in any calendar year through 2011 is $36,000;

-- Commencing on January 1, 2012, the maximum benefit amount will be subject to an adjustment, to be promulgated by the Commissioner of Banking and Insurance and published in the New Jersey Register no later than February 1 of each calendar year, which is equal to the change in the consumer price index for all urban consumers for the nation, as prepared by the United States Department of Labor, for the calendar year preceding the calendar year in which the adjustment to the maximum benefit amount is promulgated;

-- The adjusted maximum benefit amount will apply to a contract or policy that is delivered, issued, executed, or renewed, or approved for issuance or renewal, in the 12-month period following the date on which the adjustment is promulgated;

-- Notwithstanding the provisions of this substitute to the contrary, an insurer is not precluded from providing a benefit amount for a covered person in any calendar year that exceeds the benefit amounts set forth above;

-- The treatment plan required pursuant to the substitute is to include all elements necessary for the insurer to appropriately provide benefits, including, but not limited to: a diagnosis; proposed treatment by type, frequency, and duration; the anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated; and the treating physician's signature. The insurer may only request an updated treatment plan once every six months from the treating physician to review medical necessity, unless the insurer and the treating physician agree that a more frequent review is necessary due to emerging clinical circumstances; and

-- The provisions of this substitute are not to be construed as limiting benefits otherwise available to a covered person.

- The provisions of this substitute are not to be construed to: require that benefits be provided to reimburse the cost of services provided under an individualized family service plan or an individualized education program; or affect any requirement to provide those services.
- The coverage required under this substitute may be subject to utilization review, including periodic review, by the health insurer of the continued medical necessity of the specified therapies and interventions.
- The substitute takes effect on the 180th day after enactment.

This substitute is identical to the Assembly Bill No. 2238 (ACS) (Roberts/Prieto/Voss), which is pending before the Assembly.

SENATE BUDGET AND APPROPRIATIONS COMMITTEE

STATEMENT TO

SENATE COMMITTEE SUBSTITUTE FOR
SENATE, No. 1651

with committee amendments

STATE OF NEW JERSEY

DATED: JUNE 15, 2009

The Senate Budget and Appropriations Committee reports favorably Senate Bill No. 1651 (SCS), with committee amendments.

This substitute, with committee amendments, requires health insurers to provide health benefits coverage for expenses incurred for medically necessary therapies for covered persons with autism and other developmental disabilities.

The substitute provides specifically as follows:

- Its provisions apply to: health, hospital and medical service corporations; commercial individual and group health insurers; health maintenance organizations; health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs; the State Health Benefits Program; and the School Employees' Health Benefits Program.
- The insurer is to provide coverage for expenses incurred in screening and diagnosing autism or another developmental disability.
- When the covered person's diagnosis is autism or another developmental disability, the covered treatments are to include medically necessary occupational therapy, physical therapy, and speech therapy, as prescribed through a treatment plan; and coverage of these therapies is not to be denied on the basis that the treatment is not restorative.
- When the covered person is under 21 years of age and the covered person's diagnosis is autism, the covered treatments are to include medically necessary behavioral interventions based on the principles of applied behavioral analysis and related structured behavioral programs, as prescribed through a treatment plan, subject to the provisions of this substitute.
- The benefits provided for behavioral interventions for a covered person under 21 years of age:

-- are to be provided to the same extent as for any other medical condition under the contract or policy, except as provided in the substitute, but are not to be subject to limits on the number of visits

that a covered person may make to a provider of behavioral interventions; and

-- are not to be denied on the basis that the treatment is not restorative.

- With respect to these benefits provided for behavioral interventions:

-- The maximum benefit for a covered person in any calendar year through 2011 is $36,000;

-- Commencing on January 1, 2012, the maximum benefit amount will be subject to an adjustment, to be promulgated by the Commissioner of Banking and Insurance and published in the New Jersey Register no later than February 1 of each calendar year, which is equal to the change in the consumer price index for all urban consumers for the nation, as prepared by the United States Department of Labor, for the calendar year preceding the calendar year in which the adjustment to the maximum benefit amount is promulgated;

-- The adjusted maximum benefit amount will apply to a contract or policy that is delivered, issued, executed, or renewed, or approved for issuance or renewal, in the 12-month period following the date on which the adjustment is promulgated;

-- Notwithstanding the provisions of this substitute to the contrary, an insurer is not precluded from providing a benefit amount for a covered person in any calendar year that exceeds the benefit amounts set forth above;

-- The treatment plan required pursuant to the substitute is to include all elements necessary for the insurer to appropriately provide benefits, including, but not limited to: a diagnosis; proposed treatment by type, frequency, and duration; the anticipated outcomes stated as goals; the frequency by which the treatment plan will be updated; and the treating physician's signature. The insurer may only request an updated treatment plan once every six months from the treating physician to review medical necessity, unless the insurer and the treating physician agree that a more frequent review is necessary due to emerging clinical circumstances; and

-- The provisions of this substitute are not to be construed as limiting benefits otherwise available to a covered person.

- The provisions of this substitute are not to be construed to require that benefits be provided to reimburse the cost of services provided under an individualized family service plan or an individualized education program, or affect any requirement to provide those services; except that the required benefits do include coverage for expenses incurred by participants in an individualized family service plan through a family cost share.
- The coverage required under this substitute may be subject to utilization review, including periodic review, by the health insurer of the continued medical necessity of the specified therapies and interventions.
- The substitute takes effect on the 180th day after enactment.

As amended and reported by the committee, this substitute is identical to Assembly Bill No. 2238 (ACS), as also amended and reported by the committee on this date.

COMMITTEE AMENDMENTS

The committee amendments to the substitute clarify that the required benefits include coverage for expenses incurred by participants in an individualized family service plan through a family cost share.

FISCAL IMPACT

The Office of Legislative Services (OLS) has not been provided with an estimate from the Division of Pensions and Benefits in the Department of the Treasury based on the contents of this substitute bill or the proposed committee amendment. At this time and based on the available information, the OLS is unable to make a precise estimate of the fiscal impact of the substitute.

The OLS notes that potentially significant cost increases to State and local governments will result, principally from the requirement that governmental as well as private sector health insurers provide health care benefits for behavioral interventions, up to $36,000 per year, for the treatment of children younger than 21 years of age diagnosed with autism. For the State and those local entities participating in the State Health Benefits Program (SHBP) and the School Employees Health Benefits Program (SEHBP), assuming full utilization by all covered individuals, costs could increase in the aggregate by amounts approaching $85.8 million annually. For costs to reach this level, the autism prevalence in children covered by the SHBP/SEHBP would mirror the prevalence rate of 1 in 94 children in New Jersey (as measured by the federal Centers for Disease Control and Prevention), resulting in an eligible population of 2,384 out of 224,992 children, and claimed services would attain the maximum for each child. In the short run, it is likely that a lesser cost impact would result since full utilization is not likely to occur immediately. Over time, costs are likely to increase as more eligible children receive insured services and as inflation-based adjustments are made to the annual benefits ceiling.

LEGISLATIVE FISCAL ESTIMATE

[First Reprint]

SENATE COMMITTEE SUBSTITUTE FOR

SENATE, No. 1651

STATE OF NEW JERSEY
213th LEGISLATURE

DATED: JUNE 24, 2009

SUMMARY

Synopsis: Requires health benefits coverage for certain therapies for the treatment of autism and other developmental disabilities.

Type of Impact: Expenditure increase: State General Fund, local government funds.

Agencies Affected: Department of the Treasury, Division of Pensions and Benefits; local government entities.

Office of Legislative Services Estimate

Fiscal Impact	FY 2010	FY 2011	FY 2012
State Cost	Indeterminate but significant, annually - See comments below.		
Local Cost	Indeterminate but significant, annually - See comments below.		

- The Office of Legislative Services (OLS) estimates an indeterminate but significant aggregate annual cost increase for State and local governments as a result of this bill.

- The OLS notes that total State and local government costs through participation in the State Health Benefits Program (SHBP) and the School Employees Health Benefits Program (SEHBP) could approach $42.9 million (State $20 million and local $22.9 million) in FY 2010 assuming a January 1, 2010 effective date, reflecting half-year costs, and $85.8 million (State $40 million and local $45.8 million) in FY 2011, reflecting full-year costs. This assumes an autism prevalence rate of 1 in 94, in accordance with statistics from the federal Centers for Disease Control and Prevention, resulting in a potential population of 2,384 out of 224,992 children covered under the SHBP/SEHBP who could be diagnosed with autism, and further assumes that all eligible, covered individuals receive the maximum provided benefit immediately upon enactment of the legislation.

- The OLS further notes that not all eligible, covered individuals are likely to receive the maximum benefit provided. However, there is likely to be an increase over time in the consumption of benefits within the eligible population.

- The bill's principle cost factor is a beginning maximum annual benefit of $36,000 for persons up to 21 years of age, with a primary diagnosis of autism for expenses incurred for medically necessary behavioral interventions based on the principles of applied behavioral analysis and related structured behavioral programs. This limit is to be adjusted annually beginning January 1, 2012 by an inflation adjustment in accordance with a specified formula.

- This fiscal estimate reflects potential costs associated with the SHBP/SEHBP only. Thus, the costs to local governments that contract with a commercial health care benefit provider, for example, are not reflected in this fiscal note. The OLS is not able to estimate the number of local government agencies that contract with a commercial health care benefit provider and the cumulative amount of premiums paid by local governments due to a lack of data.

- Although data are not available to permit quantification of the savings to be realized from the benefits provided by this bill, savings may be realized by the Department of Health and Senior Services' Early Intervention Program, because the costs of the program will be shifted to health insurers.

- This bill requires government and private sector health insurers to provide health care benefits coverage for expenses incurred for certain treatments when prescribed as medically necessary by the covered person's physician upon diagnosis of autism and other developmental disabilities including, applied behavioral analysis and occupational, physical, and speech therapy.

BILL DESCRIPTION

Senate Committee Substitute for Senate Bill No. 1651 (1R) of 2009 requires health insurers to provide health benefits coverage for expenses incurred for certain treatments when prescribed as medically necessary by the covered person's physician upon diagnosis of autism or other developmental disabilities. When the covered person's diagnosis is autism or other developmental disability, the covered treatments are to include medically necessary occupational, physical, and speech therapy, as prescribed through a treatment plan; and coverage of these therapies is not to be denied on the basis that the treatment is not restorative. When the covered person is under 21 years of age and the covered person's diagnosis is autism, the covered treatments, up to a maximum annual benefit of $36,000, are to include medically necessary behavioral interventions based on the principles of applied behavioral analysis and related structural behavioral programs, as prescribed and specified. The benefits for behavioral interventions are to be provided to the same extent as for any other medical condition, may not be subject to limits on the number of visits, and may not be denied on the basis that the treatment is not restorative. This bill will take affect on the 180th day after enactment.

FISCAL ANALYSIS

EXECUTIVE BRANCH

None received.

OFFICE OF LEGISLATIVE SERVICES

The (OLS) estimates an indeterminate but significant increase in State and local government health insurance costs as a result of this bill. State and local governments participating in the State Health Benefits Program and the School Employees Health Benefits Program could experience cost increases approaching in total $42.9 million in FY 2010 (State $20 million and local $22.9 million), reflecting half-year costs, and $85.8 million (State $40 million and local $45.8 million) in FY 2011, reflecting full-year costs. Costs in FY 2012 and thereafter may be higher due to an annual adjustment to the maximum benefit amount for inflation, as specified. This potential cost impact represents an assumption that all eligible, covered individuals receive the maximum provided benefit immediately upon enactment of the legislation, given:

- An assumed prevalence rate of 10.6 per 1,000 (1 in 94) covered children with autism;
- A maximum annual benefit of $36,000 for children under 21 years of age.

According to the Division of Pensions and Benefits, there are 224,920 children covered by the SHBP/SEHBP. Applying the prevalence rate of 1 in 94 to this population results in an estimated population of 2,384 children under 21 years of age who would receive the benefit provided by the bill. It should be noted that this OLS analysis focuses on the mandate in the bill for coverage of "behavioral interventions based on the principles of applied behavioral analysis and related structured behavioral programs." It should be further noted that not all eligible, covered individuals are likely to receive the maximum benefit, as indicated below. However, it is possible that over time the consumption of benefits within the eligible population will increase, and costs will likewise increase.

These assumptions are based on findings in the February 2007 report submitted to the New Jersey Mandated Health Benefits Advisory Commission regarding a review and evaluation of substantially similar legislation (Assembly Bill No. 999 of 2006) that mandated physical, speech, and occupational therapy, and behavioral interventions based on the principles of applied behavioral analysis and related structured behavioral programs. In summary, the evaluation reported that: (1) the prevalence rate for the five diagnoses listed in that bill in New Jersey is currently 1 in 94, based on federal Centers for Disease Control and Prevention reports; and (2) the average annual cost per person is $50,787 for children under five years of age and $33,858 for children between five and nine years of age. The commission reported that, pursuant to statutorily mandated coverage for "biologically-based mental illness" (which includes autism), physical, speech, and occupational therapies are already covered. However, applied behavioral analysis is typically not a covered benefit under health care insurance. Therefore, the commission's review and evaluation focused on the mandate for coverage of applied behavioral analysis. The commission's evaluation did not calculate the cost of the bill to the SHBP.

The consultant to the commission found that estimates vary on the cost of applied behavioral analysis treatments and the use after childhood. Treatment is most successful when started as early as possible after diagnosis and when continued for at least three to five years. An analysis of the autism law in Minnesota and estimates of the recommended hours per week of therapy revealed that applied behavioral analysis treatment would be $50,787 per year for children under the age of five who are receiving 30 hours a week of therapy and $33,858 for children over the age of five. Therapy is estimated to take 20 to 40 hours per week with a minimum level of 25 hours per week for 52 weeks for three to five years. The OLS notes that the average annual benefit for autism spectrum disorder in Minnesota and South Carolina is $50,000. In addition, in Arizona, the average annual benefit for children under the age of five is $50,000 and for children between five and nine years of age is $25,000. In 2008, Pennsylvania passed legislation to require insurance coverage up to $36,000 per year per person for autism spectrum disorder. The State of Washington has introduced legislation to require insurance coverage up to $50,000 per

year per person for autism spectrum disorder. Because therapy is most successful, for younger children under the age of nine and particularly under the age of five, it may be possible that the maximum exposure to the SHBP/SEHBP could be less because of a higher utilization rate by children under nine years of age and a lower utilization rate by children over nine years of age.

The OLS notes that it may be reasonable to assume that long term societal benefits are generated from providing the treatment mandated by the bill because there is a higher probability that children who receive treatment will be able to integrate into society and thereby reduce future social and economic costs. While there may be societal benefits over time, the costs of this bill would be incurred by the SHBP/SEHBP and other insurers. Although data are not available to assess the potential extent of the savings to be realized from the benefits provided by this bill, savings may be realized by the Department of Health and Senior Services' Early Intervention Program, by school districts in special education if early treatment is successful, and by the State and federal government in the Medicaid program. While costs to the SHBP/SEHBP may taper off when children reach school age and are able to receive services through their schools under federally mandated programs, in the long run, the burden of the costs will rest upon the health care providers where the demand for the intensity of the services (preschool age zero to five years of age) provides the greatest benefit.

This estimate reflects potential additional costs associated with the SHBP/SEHBP only. Thus, the additional cost to local governments that contract with commercial health benefit providers is not reflected in this estimate. An estimate of the impact on local governments that contract with commercial health benefit providers cannot be made because information on these private carrier plans and the amount of premiums paid is not available.

Section:	*State Government*
Analyst:	*Kimberly Anne McCord* *Senior Fiscal Analyst*
Approved:	*David J. Rosen* *Legislative Budget and Finance Officer*

This fiscal estimate has been prepared pursuant to P.L. 1980, c.67 (C. 52:13B-1 et seq.).

JON S. CORZINE
Governor

For Immediate Release:
Date: August 13, 2009

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Governor Corzine Signs Legislation Enhancing Insurance Coverage for Autism Screening and Other Developmental Disabilities

NEW BRUNSWICK - Governor Jon S. Corzine today signed legislation requiring New Jersey health insurers to provide diagnostic coverage for screening for autism and other developmental disabilities. The measure, A-2238/S-1651, also includes therapeutic services, including any medically-necessary occupational, physical and speech therapy.

"We have made the diagnosis and treatment of autism spectrum disorders a top priority in New Jersey," Governor Corzine said. "The legislation I am signing today recognizes there must be appropriate resources to treat and care for individuals with autism, and provide their families the support they need. By doing so, we enable those affected with autism to function as independent, productive, and empowered individuals and ease the burden of their loved ones."

Under this bill, insurance companies would be required to provide up to $36,000 per year for medically-necessary behavioral early intervention for all patients with autism, and with other developmental disabilities, who are under 21 years of age. Of 15 states, New Jersey is the first to include other developmental disabilities along with autism in this type of insurance legislation.

"Many New Jersey families already are being stretched to their financial edge - but without health coverage for their loved ones, countless families are bankrupting themselves just to give their child the potential for a bright future," said Assembly Speaker Joseph J. Roberts Jr. (D-Camden). "This measure offers real and meaningful hope that they will not battle alone. Failing to help a child try to overcome the obstacles presented by these disabilities will lead to costlier problems later. Autistic and disabled adults who have not received the proper treatment will leave our families, communities and state with new and more expensive challenges."

Autism is a spectrum of disorders that are complex and lifelong. It is a biologically based disorder that affects the development and functioning of a person's verbal and non-verbal communication skills, social interactions and behavior patterns.

"Thanks to cutting edge medical research, we are discovering new therapies and treatments aimed at unlocking the developmental potential of autistic and developmentally disabled people," said Senator Loretta Weinberg, (D-Bergen), Vice Chairwoman of the Senate Health Committee. "However, for all the progress we are making through medical research, insurance companies continue to maintain barriers between autistic individuals and the treatments that will help them achieve their potential. We must demand that insurance providers live up to the responsibilities they have to their subscribers, and cover those medically-proven treatments and therapies that can help make a difference."

According to the CDC, one in 150 children is diagnosed with an autism spectrum disorder. In New Jersey, it is about 1 in 94, the highest rate in the nation.

"Requiring health insurers to cover therapies for autistic children early in their lives ensures they receive the treatments they most need when it will make the greatest impact," said Assemblyman Vincent Prieto (D-Hudson). "Oftentimes these therapies represent a new lease on life for autistic children and their families."

"Early intervention, including speech, physical and socialization therapy, can make a world of a difference in the lives of young children with autism and other developmental disabilities," said Assemblywoman Joan Voss (D-Bergen) "Early treatment ensures these children learn basic life skills, which can have lifelong impacts, often mitigating some of the challenges faced by many adults with autism."

Research has indicated that early intervention services, which include speech, physical and occupational therapy, help the majority of young children with

autism and other developmental disabilities to learn important skills.

"For the New Jersey families struggling to get the best care and treatment for their autistic and developmentally disabled children, this new law is about making sure insurance providers honor their commitments," said Senator Joseph F. Vitale, (D-Middlesex). "Whenever a treatment or therapy exists that can make such a difference in the lives of kids living with the effects of autism spectrum disorders or other developmental disabilities, insurance providers must step up and provide coverage. This law is about giving access to proven therapies and treatments which can work miracles in the lives of children and allow them to achieve their fullest potential."

In 2007, Governor Corzine signed a package of bills designed to improve autism treatment, training, education and research in the state. These measures resulted in the creation of a statewide autism registry; mandated autism guidelines for healthcare professionals; transfer of the Governor's Council on Medical Research and Treatment of Autism to the Department of Health and Senior Services; funding of six "Centers of Excellence;" development of autism/developmental disabled training for first responders and creation of the Adults with Autism Task Force.

Autism affects people of all races, ethnicities and socio-economic groups and is four times more likely in boys than girls. There are no biological markers or "tests" that detect autism. Clinicians make the diagnosis based on information from the parents and observation of the child. There is no known cause, although researchers believe that several genes possibly combined with environmental influences may be responsible.

"The Legislature and the Governor should be applauded for recognizing this legislation as an incredibly sound and compassionate investment," Speaker Roberts added. "The greatest cost would be the cost of doing nothing, not only for those trying to breakthrough these disorders and their families, but for the taxpayers of New Jersey."

Primary sponsors of the legislation include Assembly Speaker Roberts, Assemblymembers Prieto, Voss and Evans and Senators Weinberg and Vitale.

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