

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:**

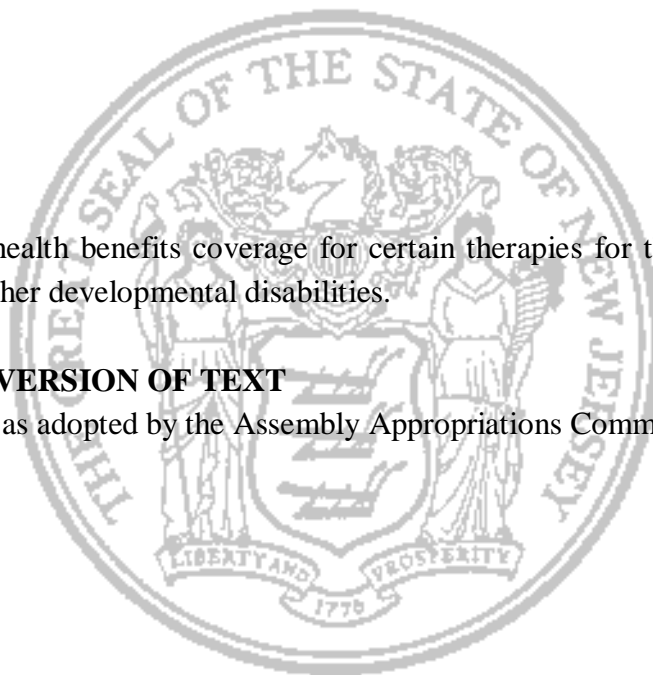
**Assemblymen Ramos, Biondi, Assemblywomen Pou, Vainieri Huttie,  
Assemblymen Coutinho, Scalera, Diegnan, Assemblywomen Wagner,  
Lampitt, Jasey, Assemblymen Chivukula, DeAngelo, Moriarty, Schaer and  
Connors**

**SYNOPSIS**

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

**CURRENT VERSION OF TEXT**

Substitute as adopted by the Assembly Appropriations Committee.



**(Sponsorship Updated As Of: 6/12/2009)**

1 AN ACT concerning health benefits coverage for certain therapies  
2 for the treatment of autism and other developmental disabilities  
3 and supplementing various parts of the statutory law.  
4

5 **BE IT ENACTED** by the Senate and General Assembly of the State  
6 of New Jersey:  
7

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

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

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

26 c. When the covered person is under 21 years of age and the  
27 covered person's primary diagnosis is autism, the hospital service  
28 corporation shall provide coverage for expenses incurred for  
29 medically necessary behavioral interventions based on the  
30 principles of applied behavioral analysis and related structured  
31 behavioral programs, as prescribed through a treatment plan,  
32 subject to the provisions of this subsection.

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

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

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

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

1 Department of Labor, for the calendar year preceding the calendar  
2 year in which the adjustment to the maximum benefit amount is  
3 promulgated.

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

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

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

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

28 f. The provisions of subsections b. and c. of this section shall  
29 not be construed to: require that benefits be provided to reimburse  
30 the cost of services provided under an individualized family service  
31 plan or an individualized education program; or affect any  
32 requirement to provide those services.

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

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

40

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

- 1 a. The medical service corporation shall provide coverage for  
2 expenses incurred in screening and diagnosing autism or another  
3 developmental disability.
- 4 b. When the covered person's primary diagnosis is autism or  
5 another developmental disability, the medical service corporation  
6 shall provide coverage for expenses incurred for medically  
7 necessary occupational therapy, physical therapy, and speech  
8 therapy, as prescribed through a treatment plan. Coverage of these  
9 therapies shall not be denied on the basis that the treatment is not  
10 restorative.
- 11 c. When the covered person is under 21 years of age and the  
12 covered person's primary diagnosis is autism, the medical service  
13 corporation shall provide coverage for expenses incurred for  
14 medically necessary behavioral interventions based on the  
15 principles of applied behavioral analysis and related structured  
16 behavioral programs, as prescribed through a treatment plan,  
17 subject to the provisions of this subsection.
- 18 (1) Except as provided in paragraph (3) of this subsection, the  
19 benefits provided pursuant to this subsection shall be provided to  
20 the same extent as for any other medical condition under the  
21 contract, but shall not be subject to limits on the number of visits  
22 that a covered person may make to a provider of behavioral  
23 interventions.
- 24 (2) The benefits provided pursuant to this subsection shall not  
25 be denied on the basis that the treatment is not restorative.
- 26 (3) (a) The maximum benefit amount for a covered person in  
27 any calendar year through 2011 shall be \$36,000.
- 28 (b) Commencing on January 1, 2012, the maximum benefit  
29 amount shall be subject to an adjustment, to be promulgated by the  
30 Commissioner of Banking and Insurance and published in the New  
31 Jersey Register no later than February 1 of each calendar year,  
32 which shall be equal to the change in the consumer price index for  
33 all urban consumers for the nation, as prepared by the United States  
34 Department of Labor, for the calendar year preceding the calendar  
35 year in which the adjustment to the maximum benefit amount is  
36 promulgated.
- 37 (c) The adjusted maximum benefit amount shall apply to a  
38 contract that is delivered, issued, executed, or renewed, or approved  
39 for issuance or renewal, in the 12-month period following the date  
40 on which the adjustment is promulgated.
- 41 (d) Notwithstanding the provisions of this paragraph to the  
42 contrary, a medical service corporation shall not be precluded from  
43 providing a benefit amount for a covered person in any calendar  
44 year that exceeds the benefit amounts set forth in subparagraphs (a)  
45 and (b) of this paragraph.
- 46 d. The treatment plan required pursuant to subsections b. and c.  
47 of this section shall include all elements necessary for the medical  
48 service corporation to appropriately provide benefits, including, but

1 not limited to: a diagnosis; proposed treatment by type, frequency,  
2 and duration; the anticipated outcomes stated as goals; the  
3 frequency by which the treatment plan will be updated; and the  
4 treating physician's signature. The medical service corporation  
5 may only request an updated treatment plan once every six months  
6 from the treating physician to review medical necessity, unless the  
7 medical service corporation and the treating physician agree that a  
8 more frequent review is necessary due to emerging clinical  
9 circumstances.

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

13 f. The provisions of subsections b. and c. of this section shall  
14 not be construed to: require that benefits be provided to reimburse  
15 the cost of services provided under an individualized family service  
16 plan or an individualized education program; or affect any  
17 requirement to provide those services.

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

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

25

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

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

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

44 c. When the covered person is under 21 years of age and the  
45 covered person's primary diagnosis is autism, the health service  
46 corporation shall provide coverage for expenses incurred for  
47 medically necessary behavioral interventions based on the  
48 principles of applied behavioral analysis and related structured

- 1 behavioral programs, as prescribed through a treatment plan,  
2 subject to the provisions of this subsection.
- 3 (1) Except as provided in paragraph (3) of this subsection, the  
4 benefits provided pursuant to this subsection shall be provided to  
5 the same extent as for any other medical condition under the  
6 contract, but shall not be subject to limits on the number of visits  
7 that a covered person may make to a provider of behavioral  
8 interventions.
- 9 (2) The benefits provided pursuant to this subsection shall not  
10 be denied on the basis that the treatment is not restorative.
- 11 (3) (a) The maximum benefit amount for a covered person in  
12 any calendar year through 2011 shall be \$36,000.
- 13 (b) Commencing on January 1, 2012, the maximum benefit  
14 amount shall be subject to an adjustment, to be promulgated by the  
15 Commissioner of Banking and Insurance and published in the New  
16 Jersey Register no later than February 1 of each calendar year,  
17 which shall be equal to the change in the consumer price index for  
18 all urban consumers for the nation, as prepared by the United States  
19 Department of Labor, for the calendar year preceding the calendar  
20 year in which the adjustment to the maximum benefit amount is  
21 promulgated.
- 22 (c) The adjusted maximum benefit amount shall apply to a  
23 contract that is delivered, issued, executed, or renewed, or approved  
24 for issuance or renewal, in the 12-month period following the date  
25 on which the adjustment is promulgated.
- 26 (d) Notwithstanding the provisions of this paragraph to the  
27 contrary, a health service corporation shall not be precluded from  
28 providing a benefit amount for a covered person in any calendar  
29 year that exceeds the benefit amounts set forth in subparagraphs (a)  
30 and (b) of this paragraph.
- 31 d. The treatment plan required pursuant to subsections b. and c.  
32 of this section shall include all elements necessary for the health  
33 service corporation to appropriately provide benefits, including, but  
34 not limited to: a diagnosis; proposed treatment by type, frequency,  
35 and duration; the anticipated outcomes stated as goals; the  
36 frequency by which the treatment plan will be updated; and the  
37 treating physician's signature. The health service corporation may  
38 only request an updated treatment plan once every six months from  
39 the treating physician to review medical necessity, unless the health  
40 service corporation and the treating physician agree that a more  
41 frequent review is necessary due to emerging clinical  
42 circumstances.
- 43 e. The provisions of subsections b. and c. of this section shall  
44 not be construed as limiting benefits otherwise available to a  
45 covered person.
- 46 f. The provisions of subsections b. and c. of this section shall  
47 not be construed to: require that benefits be provided to reimburse  
48 the cost of services provided under an individualized family service

1 plan or an individualized education program; or affect any  
2 requirement to provide those services.

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

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

10

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

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

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

28 c. When the insured is under 21 years of age and the insured's  
29 primary diagnosis is autism, the insurer shall provide coverage for  
30 expenses incurred for medically necessary behavioral interventions  
31 based on the principles of applied behavioral analysis and related  
32 structured behavioral programs, as prescribed through a treatment  
33 plan, subject to the provisions of this subsection.

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

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

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

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

1 Department of Labor, for the calendar year preceding the calendar  
2 year in which the adjustment to the maximum benefit amount is  
3 promulgated.

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

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

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

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

26 f. The provisions of subsections b. and c. of this section shall  
27 not be construed to: require that benefits be provided to reimburse  
28 the cost of services provided under an individualized family service  
29 plan or an individualized education program; or affect any  
30 requirement to provide those services.

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

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

37

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

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

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

7       c. When the insured is under 21 years of age and the insured's  
8 primary diagnosis is autism, the insurer shall provide coverage for  
9 expenses incurred for medically necessary behavioral interventions  
10 based on the principles of applied behavioral analysis and related  
11 structured behavioral programs, as prescribed through a treatment  
12 plan, subject to the provisions of this subsection.

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

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

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

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

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

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

39       d. The treatment plan required pursuant to subsections b. and c.  
40 of this section shall include all elements necessary for the insurer to  
41 appropriately provide benefits, including, but not limited to: a  
42 diagnosis; proposed treatment by type, frequency, and duration; the  
43 anticipated outcomes stated as goals; the frequency by which the  
44 treatment plan will be updated; and the treating physician's  
45 signature. The insurer may only request an updated treatment plan  
46 once every six months from the treating physician to review  
47 medical necessity, unless the insurer and the treating physician

- 1 agree that a more frequent review is necessary due to emerging  
2 clinical circumstances.
- 3 e. The provisions of subsections b. and c. of this section shall  
4 not be construed as limiting benefits otherwise available to an  
5 insured.
- 6 f. The provisions of subsections b. and c. of this section shall  
7 not be construed to: require that benefits be provided to reimburse  
8 the cost of services provided under an individualized family service  
9 plan or an individualized education program; or affect any  
10 requirement to provide those services.
- 11 g. The coverage required under this section may be subject to  
12 utilization review, including periodic review, by the insurer of the  
13 continued medical necessity of the specified therapies and  
14 interventions.
- 15 h. The provisions of this section shall apply to all policies in  
16 which the insurer has reserved the right to change the premium.  
17
- 18 6. Notwithstanding any other provision of law to the contrary,  
19 an individual health benefits plan that provides hospital and medical  
20 expense benefits and is delivered, issued, executed, renewed, or  
21 approved for issuance or renewal in this State pursuant to P.L.1992,  
22 c.161 (C.17B:27A-2 et seq.), or approved for issuance or renewal in  
23 this State by the Commissioner of Banking and Insurance, on or  
24 after the effective date of this act, shall provide coverage pursuant  
25 to the provisions of this section.
- 26 a. The carrier shall provide coverage for expenses incurred in  
27 screening and diagnosing autism or another developmental  
28 disability.
- 29 b. When the covered person's primary diagnosis is autism or  
30 another developmental disability, the carrier shall provide coverage  
31 for expenses incurred for medically necessary occupational therapy,  
32 physical therapy, and speech therapy, as prescribed through a  
33 treatment plan. Coverage of these therapies shall not be denied on  
34 the basis that the treatment is not restorative.
- 35 c. When the covered person is under 21 years of age and the  
36 covered person's primary diagnosis is autism, the carrier shall  
37 provide coverage for expenses incurred for medically necessary  
38 behavioral interventions based on the principles of applied  
39 behavioral analysis and related structured behavioral programs, as  
40 prescribed through a treatment plan, subject to the provisions of this  
41 subsection.
- 42 (1) Except as provided in paragraph (3) of this subsection, the  
43 benefits provided pursuant to this subsection shall be provided to  
44 the same extent as for any other medical condition under the health  
45 benefits plan, but shall not be subject to limits on the number of  
46 visits that a covered person may make to a provider of behavioral  
47 interventions.

- 1 (2) The benefits provided pursuant to this subsection shall not  
2 be denied on the basis that the treatment is not restorative.
- 3 (3) (a) The maximum benefit amount for a covered person in  
4 any calendar year through 2011 shall be \$36,000.
- 5 (b) Commencing on January 1, 2012, the maximum benefit  
6 amount shall be subject to an adjustment, to be promulgated by the  
7 Commissioner of Banking and Insurance and published in the New  
8 Jersey Register no later than February 1 of each calendar year,  
9 which shall be equal to the change in the consumer price index for  
10 all urban consumers for the nation, as prepared by the United States  
11 Department of Labor, for the calendar year preceding the calendar  
12 year in which the adjustment to the maximum benefit amount is  
13 promulgated.
- 14 (c) The adjusted maximum benefit amount shall apply to a  
15 health benefits plan that is delivered, issued, executed, or renewed,  
16 or approved for issuance or renewal, in the 12-month period  
17 following the date on which the adjustment is promulgated.
- 18 (d) Notwithstanding the provisions of this paragraph to the  
19 contrary, a carrier shall not be precluded from providing a benefit  
20 amount for a covered person in any calendar year that exceeds the  
21 benefit amounts set forth in subparagraphs (a) and (b) of this  
22 paragraph.
- 23 d. The treatment plan required pursuant to subsections b. and c.  
24 of this section shall include all elements necessary for the carrier to  
25 appropriately provide benefits, including, but not limited to: a  
26 diagnosis; proposed treatment by type, frequency, and duration; the  
27 anticipated outcomes stated as goals; the frequency by which the  
28 treatment plan will be updated; and the treating physician's  
29 signature. The carrier may only request an updated treatment plan  
30 once every six months from the treating physician to review  
31 medical necessity, unless the carrier and the treating physician  
32 agree that a more frequent review is necessary due to emerging  
33 clinical circumstances.
- 34 e. The provisions of subsections b. and c. of this section shall  
35 not be construed as limiting benefits otherwise available to a  
36 covered person.
- 37 f. The provisions of subsections b. and c. of this section shall  
38 not be construed to: require that benefits be provided to reimburse  
39 the cost of services provided under an individualized family service  
40 plan or an individualized education program; or affect any  
41 requirement to provide those services.
- 42 g. The coverage required under this section may be subject to  
43 utilization review, including periodic review, by the carrier of the  
44 continued medical necessity of the specified therapies and  
45 interventions.
- 46 h. The provisions of this section shall apply to those health  
47 benefits plans in which the carrier has reserved the right to change  
48 the premium.

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

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

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

18       c. When the covered person is under 21 years of age and the  
19 covered person's primary diagnosis is autism, the carrier shall  
20 provide coverage for expenses incurred for medically necessary  
21 behavioral interventions based on the principles of applied  
22 behavioral analysis and related structured behavioral programs, as  
23 prescribed through a treatment plan, subject to the provisions of this  
24 subsection.

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

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

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

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

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

48       (d) Notwithstanding the provisions of this paragraph to the

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

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

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

19 f. The provisions of subsections b. and c. of this section shall  
20 not be construed to: require that benefits be provided to reimburse  
21 the cost of services provided under an individualized family service  
22 plan or an individualized education program; or affect any  
23 requirement to provide those services.

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

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

31

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

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

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

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

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

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

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

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

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

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

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

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

1 f. The provisions of subsections b. and c. of this section shall  
2 not be construed to: require that coverage be provided to reimburse  
3 the cost of services provided under an individualized family service  
4 plan or an individualized education program; or affect any  
5 requirement to provide those services.

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

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

13  
14 9. Notwithstanding any other provision of law to the contrary,  
15 the State Health Benefits Commission shall ensure that every  
16 contract purchased by the commission on or after the effective date  
17 of this act that provides hospital or medical expense benefits shall  
18 provide coverage pursuant to the provisions of this section.

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

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

28 c. When the covered person is under 21 years of age and the  
29 covered person's primary diagnosis is autism, the contract shall  
30 provide coverage for expenses incurred for medically necessary  
31 behavioral interventions based on the principles of applied  
32 behavioral analysis and related structured behavioral programs, as  
33 prescribed through a treatment plan, subject to the provisions of this  
34 subsection.

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

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

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

45 (b) Commencing on January 1, 2012, the maximum benefit  
46 amount shall be subject to an adjustment, to be promulgated by the  
47 Commissioner of Banking and Insurance and published in the New  
48 Jersey Register no later than February 1 of each calendar year,

1 which shall be equal to the change in the consumer price index for  
2 all urban consumers for the nation, as prepared by the United States  
3 Department of Labor, for the calendar year preceding the calendar  
4 year in which the adjustment to the maximum benefit amount is  
5 promulgated.

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

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

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

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

29 f. The provisions of subsections b. and c. of this section shall  
30 not be construed to: require that benefits be provided to reimburse  
31 the cost of services provided under an individualized family service  
32 plan or an individualized education program; or affect any  
33 requirement to provide those services.

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

38

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

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

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

7       c. When the covered person is under 21 years of age and the  
8 covered person's primary diagnosis is autism, the contract shall  
9 provide coverage for expenses incurred for medically necessary  
10 behavioral interventions based on the principles of applied  
11 behavioral analysis and related structured behavioral programs, as  
12 prescribed through a treatment plan, subject to the provisions of this  
13 subsection.

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

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

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

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

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

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

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

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

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

8 f. The provisions of subsections b. and c. of this section shall  
9 not be construed to: require that benefits be provided to reimburse  
10 the cost of services provided under an individualized family service  
11 plan or an individualized education program; or affect any  
12 requirement to provide those services.

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

17

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