

[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,
Connors, 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)

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.

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.

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

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

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

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

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

34 f. The provisions of subsections b. and c. of this section shall
35 not be construed to¹ require that benefits be provided to
36 reimburse the cost of services provided under an individualized
37 family service plan or an individualized education program¹; or
38 affect any requirement to provide those services¹; except that the
39 benefits provided pursuant to those subsections shall include
40 coverage for expenses incurred by participants in an individualized
41 family service plan through a family cost share¹.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 f. The provisions of subsections b. and c. of this section shall
22 not be construed to ¹[':'] require that benefits be provided to
23 reimburse the cost of services provided under an individualized
24 family service plan or an individualized education program ¹[':'],¹ or
25 affect any requirement to provide those services¹; except that the
26 benefits provided pursuant to those subsections shall include
27 coverage for expenses incurred by participants in an individualized
28 family service plan through a family cost share¹.

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

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

36
37 3. Notwithstanding any other provision of law to the contrary,
38 every health service corporation contract that provides hospital and
39 medical expense benefits and is delivered, issued, executed, or
40 renewed in this State pursuant to P.L.1985, c.236 (C.17:48E-1 et
41 seq.), or approved for issuance or renewal in this State by the
42 Commissioner of Banking and Insurance, on or after the effective
43 date of this act, shall provide coverage pursuant to the provisions of
44 this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

18 g. The coverage required under this section may be subject to
19 utilization review, including periodic review, by the health 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 health service corporation has reserved the right to
24 change the premium.

25

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

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

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

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

- 1 (1) Except as provided in paragraph (3) of this subsection, the
2 benefits provided pursuant to this subsection shall be provided to
3 the same extent as for any other medical condition under the policy,
4 but shall not be subject to limits on the number of visits that a
5 insured may make to a provider of behavioral interventions.
- 6 (2) The benefits provided pursuant to this subsection shall not
7 be denied on the basis that the treatment is not restorative.
- 8 (3) (a) The maximum benefit amount for an insured in any
9 calendar year through 2011 shall be \$36,000.
- 10 (b) Commencing on January 1, 2012, the maximum benefit
11 amount shall be subject to an adjustment, to be promulgated by the
12 Commissioner of Banking and Insurance and published in the New
13 Jersey Register no later than February 1 of each calendar year,
14 which shall be equal to the change in the consumer price index for
15 all urban consumers for the nation, as prepared by the United States
16 Department of Labor, for the calendar year preceding the calendar
17 year in which the adjustment to the maximum benefit amount is
18 promulgated.
- 19 (c) The adjusted maximum benefit amount shall apply to a
20 policy that is delivered, issued, executed, or renewed, or approved
21 for issuance or renewal, in the 12-month period following the date
22 on which the adjustment is promulgated.
- 23 (d) Notwithstanding the provisions of this paragraph to the
24 contrary, an insurer shall not be precluded from providing a benefit
25 amount for an insured in any calendar year that exceeds the benefit
26 amounts set forth in subparagraphs (a) and (b) of this paragraph.
- 27 d. The treatment plan required pursuant to subsections b. and c.
28 of this section shall include all elements necessary for the insurer to
29 appropriately provide benefits, including, but not limited to: a
30 diagnosis; proposed treatment by type, frequency, and duration; the
31 anticipated outcomes stated as goals; the frequency by which the
32 treatment plan will be updated; and the treating physician's
33 signature. The insurer may only request an updated treatment plan
34 once every six months from the treating physician to review
35 medical necessity, unless the insurer and the treating physician
36 agree that a more frequent review is necessary due to emerging
37 clinical circumstances.
- 38 e. The provisions of subsections b. and c. of this section shall
39 not be construed as limiting benefits otherwise available to an
40 insured.
- 41 f. The provisions of subsections b. and c. of this section shall
42 not be construed to '[:]' require that benefits be provided to
43 reimburse the cost of services provided under an individualized
44 family service plan or an individualized education program '[:]',¹ or
45 affect any requirement to provide those services¹; except that the
46 benefits provided pursuant to those subsections shall include
47 coverage for expenses incurred by participants in an individualized
48 family service plan through a family cost share¹.

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

5 h. The provisions of this section shall apply to all policies in
6 which the insurer has reserved the right to change the premium.
7

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

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

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

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

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

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

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

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

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

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

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

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

23 f. The provisions of subsections b. and c. of this section shall
24 not be construed to ~~[';']~~ require that benefits be provided to
25 reimburse the cost of services provided under an individualized
26 family service plan or an individualized education program ~~[';'],~~ or
27 affect any requirement to provide those services ~~['; except that the~~
28 benefits provided pursuant to those subsections shall include
29 coverage for expenses incurred by participants in an individualized
30 family service plan through a family cost share¹.

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

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

1 b. When the covered person's primary diagnosis is autism or
2 another developmental disability, the carrier shall provide coverage
3 for 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 covered person is under 21 years of age and the
8 covered person's primary diagnosis is autism, the carrier 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 health
17 benefits plan, but shall not be subject to limits on the number of
18 visits 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 health benefits plan that is delivered, issued, executed, or renewed,
35 or approved for issuance or renewal, in the 12-month period
36 following the date on which the adjustment is promulgated.

37 (d) Notwithstanding the provisions of this paragraph to the
38 contrary, a carrier shall not be precluded from providing a benefit
39 amount for a covered person in any calendar year that exceeds the
40 benefit amounts set forth in subparagraphs (a) and (b) of this
41 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
10 reimburse the cost of services provided under an individualized
11 family service plan or an individualized education program '[;]'; or
12 affect any requirement to provide those services'; except that the
13 benefits provided pursuant to those subsections shall include
14 coverage for expenses incurred by participants in an individualized
15 family service plan through a family cost share¹.

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

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

23

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

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

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

41 c. When the covered person is under 21 years of age and the
42 covered person's primary diagnosis is autism, the carrier shall
43 provide coverage for expenses incurred for medically necessary
44 behavioral interventions based on the principles of applied
45 behavioral analysis and related structured behavioral programs, as
46 prescribed through a treatment plan, subject to the provisions of this
47 subsection.

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

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

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

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

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

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

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

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

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

1 coverage for expenses incurred by participants in an individualized
2 family service plan through a family cost share¹.

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

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

10

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

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

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

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

33 (1) Except as provided in paragraph (3) of this subsection, the
34 coverage 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 an enrollee may make to a provider of behavioral interventions.

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

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

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

- 1 year in which the adjustment to the maximum benefit amount is
2 promulgated.
- 3 (c) The adjusted maximum coverage amount shall apply to a
4 contract that is delivered, issued, executed, or renewed, or approved
5 for issuance or renewal, in the 12-month period following the date
6 on which the adjustment is promulgated.
- 7 (d) Notwithstanding the provisions of this paragraph to the
8 contrary, a health maintenance organization shall not be precluded
9 from providing a coverage amount for an enrollee in any calendar
10 year that exceeds the coverage amounts set forth in subparagraphs
11 (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 health
14 maintenance organization to appropriately provide coverage for
15 health care services, including, but not limited to: a diagnosis;
16 proposed treatment by type, frequency, and duration; the anticipated
17 outcomes stated as goals; the frequency by which the treatment plan
18 will be updated; and the treating physician's signature. The health
19 maintenance organization may only request an updated treatment
20 plan once every six months from the treating physician to review
21 medical necessity, unless the health maintenance organization and
22 the treating physician agree that a more frequent review is
23 necessary due to emerging clinical circumstances.
- 24 e. The provisions of this subsections b. and c. of this section
25 shall not be construed as limiting coverage for health care services
26 otherwise available to an enrollee.
- 27 f. The provisions of subsections b. and c. of this section shall
28 not be construed to '[:]' require that benefits be provided to
29 reimburse the cost of services provided under an individualized
30 family service plan or an individualized education program '[:]' or
31 affect any requirement to provide those services'; except that the
32 benefits provided pursuant to those subsections shall include
33 coverage for expenses incurred by participants in an individualized
34 family service plan through a family cost share¹.
- 35 g. The coverage required under this section may be subject to
36 utilization review, including periodic review, by the health
37 maintenance organization of the continued medical necessity of the
38 specified therapies and interventions.
- 39 h. The provisions of this section shall apply to those enrollee
40 agreements in which the health maintenance organization has
41 reserved the right to change the premium.
- 42
- 43 9. Notwithstanding any other provision of law to the contrary,
44 the State Health Benefits Commission shall ensure that every
45 contract purchased by the commission on or after the effective date
46 of this act that provides hospital or medical expense benefits shall
47 provide coverage pursuant to the provisions of this section.

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

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

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

11 f. The provisions of subsections b. and c. of this section shall
12 not be construed to '[:]' require that benefits be provided to
13 reimburse the cost of services provided under an individualized
14 family service plan or an individualized education program '[:]', or
15 affect any requirement to provide those services'; except that the
16 benefits provided pursuant to those subsections shall include
17 coverage for expenses incurred by participants in an individualized
18 family service plan through a family cost share¹.

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

23
24 10. Notwithstanding any other provision of law to the contrary,
25 the School Employees' Health Benefits Commission shall ensure
26 that every contract purchased by the commission on or after the
27 effective date of this act that provides hospital or medical expense
28 benefits shall provide coverage pursuant to the provisions of this
29 section..

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

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

39 c. When the covered person is under 21 years of age and the
40 covered person's primary diagnosis is autism, the contract shall
41 provide coverage for expenses incurred for medically necessary
42 behavioral interventions based on the principles of applied
43 behavioral analysis and related structured behavioral programs, as
44 prescribed through a treatment plan, subject to the provisions of this
45 subsection.

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

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

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

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

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

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

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

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

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

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

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

5

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