[First Reprint]

ASSEMBLY COMMITTEE SUBSTITUTE FOR

ASSEMBLY, No. 2238

STATE OF NEW JERSEY

213th LEGISLATURE

ADOPTED MAY 18, 2009

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

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

SYNOPSIS

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

CURRENT VERSION OF TEXT

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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