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§2 - C.17:48A-7ff
§3 –
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P.L. 2009, CHAPTER 115, *approved August 13, 2009*
Assembly Committee Substitute (*First Reprint*) for
Assembly, No. 2238

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

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 necessary occupational therapy, physical therapy, and speech
2 therapy, as prescribed through a treatment plan. Coverage of these
3 therapies shall not be denied on the basis that the treatment is not
4 restorative.

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

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

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

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

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

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

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

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

1 hospital service corporation and the treating physician agree that a
2 more frequent review is necessary due to emerging clinical
3 circumstances.

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

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

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

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

22

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

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

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

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

48 (1) Except as provided in paragraph (3) of this subsection, the

1 benefits provided pursuant to this subsection shall be provided to
2 the same extent as for any other medical condition under the
3 contract, but shall not be subject to limits on the number of visits
4 that a covered person may make to a provider of behavioral
5 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 a covered person in
9 any 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 contract 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, a medical service corporation shall not be precluded from
25 providing a benefit amount for a covered person in any calendar
26 year that exceeds the benefit amounts set forth in subparagraphs (a)
27 and (b) of this paragraph.

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

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

10

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

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

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

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

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

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

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

46 (b) Commencing on January 1, 2012, the maximum benefit
47 amount shall be subject to an adjustment, to be promulgated by the
48 Commissioner of Banking and Insurance and published in the New

1 Jersey Register no later than February 1 of each calendar year,
2 which shall be equal to the change in the consumer price index for
3 all urban consumers for the nation, as prepared by the United States
4 Department of Labor, for the calendar year preceding the calendar
5 year in which the adjustment to the maximum benefit amount is
6 promulgated.

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

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

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

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

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

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

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

46

47 4. Notwithstanding any other provision of law to the contrary,
48 every individual health insurance policy that provides hospital and

1 medical expense benefits and is delivered, issued, executed, or
2 renewed in this State pursuant to chapter 26 of Title 17B of the New
3 Jersey Statutes, or approved for issuance or renewal in this State by
4 the Commissioner of Banking and Insurance, on or after the
5 effective date of this act, shall provide coverage pursuant to the
6 provisions of this section.

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

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

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

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

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

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

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

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

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

48 d. The treatment plan required pursuant to subsections b. and c.

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

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

14 f. The provisions of subsections b. and c. of this section shall
15 not be construed to '[:]' require that benefits be provided to
16 reimburse the cost of services provided under an individualized
17 family service plan or an individualized education program '[;]'.¹ or
18 affect any requirement to provide those services¹; except that the
19 benefits provided pursuant to those subsections shall include
20 coverage for expenses incurred by participants in an individualized
21 family service plan through a family cost share¹.

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

26 h. The provisions of this section shall apply to all policies in
27 which the insurer has reserved the right to change the premium.
28

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

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

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

46 c. When the insured is under 21 years of age and the insured's
47 primary diagnosis is autism, the insurer shall provide coverage for
48 expenses incurred for medically necessary behavioral interventions

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

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

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

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

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

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

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

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

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

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

1 benefits provided pursuant to those subsections shall include
2 coverage for expenses incurred by participants in an individualized
3 family service plan through a family cost share¹.

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

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

10
11 6. Notwithstanding any other provision of law to the contrary,
12 an individual health benefits plan that provides hospital and medical
13 expense benefits and is delivered, issued, executed, renewed, or
14 approved for issuance or renewal in this State pursuant to P.L.1992,
15 c.161 (C.17B:27A-2 et seq.), or approved for issuance or renewal in
16 this State by the Commissioner of Banking and Insurance, on or
17 after the effective date of this act, shall provide coverage pursuant
18 to the provisions of this section.

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

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

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

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

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

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

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

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

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

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

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

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

29 f. The provisions of subsections b. and c. of this section shall
30 not be construed to '[:]' require that benefits be provided to
31 reimburse the cost of services provided under an individualized
32 family service plan or an individualized education program '[:]',¹ or
33 affect any requirement to provide those services¹; except that the
34 benefits provided pursuant to those subsections shall include
35 coverage for expenses incurred by participants in an individualized
36 family service plan through a family cost share¹.

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

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

44
45 7. Notwithstanding any other provision of law to the contrary,
46 a small employer health benefits plan that provides hospital and
47 medical expense benefits and is delivered, issued, executed,
48 renewed, or approved for issuance or renewal in this State pursuant

1 to P.L.1992, c.162 (C.17B:27A-17 et seq.), or approved for
2 issuance or renewal in this State by the Commissioner of Banking
3 and Insurance, on or after the effective date of this act, shall provide
4 coverage pursuant to the provisions of this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

30

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

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

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

47 c. When the enrollee is under 21 years of age and the enrollee's
48 primary diagnosis is autism, the health maintenance organization

1 shall provide coverage for medically necessary behavioral
2 interventions based on the principles of applied behavioral analysis
3 and related structured behavioral programs, as prescribed through a
4 treatment plan, subject to the provisions of this subsection.

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

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

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

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

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

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

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

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

47 f. The provisions of subsections b. and c. of this section shall
48 not be construed to '[:]' require that benefits be provided to

1 reimburse the cost of services provided under an individualized
2 family service plan or an individualized education program¹; ~~or~~¹ or
3 affect any requirement to provide those services¹; except that the
4 benefits provided pursuant to those subsections shall include
5 coverage for expenses incurred by participants in an individualized
6 family service plan through a family cost share¹.

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

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

14

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

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

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

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

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

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

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

46 (b) Commencing on January 1, 2012, the maximum benefit
47 amount shall be subject to an adjustment, to be promulgated by the
48 Commissioner of Banking and Insurance and published in the New

1 Jersey Register no later than February 1 of each calendar year,
2 which shall be equal to the change in the consumer price index for
3 all urban consumers for the nation, as prepared by the United States
4 Department of Labor, for the calendar year preceding the calendar
5 year in which the adjustment to the maximum benefit amount is
6 promulgated.

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

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

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

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

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

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

42
43 10. Notwithstanding any other provision of law to the contrary,
44 the School Employees' Health Benefits Commission shall ensure
45 that every contract purchased by the commission on or after the
46 effective date of this act that provides hospital or medical expense
47 benefits shall provide coverage pursuant to the provisions of this
48 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 '[;],'
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 11. This act shall take effect on the 180th day after enactment.

25

26

27

28

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