IDOI
ILLINOIS DEPARTMENT OF INSURANCE

Fact Sheet

Autism

March 2020

Note:

This information was developed to provide consumers with general information and guidance about insurance coverages and laws. It is not intended to provide a formal, definitive description or interpretation of Department policy. For specific Department policy on any issue, regulated entities (insurance industry) and interested parties should contact the Department.

For children diagnosed with autism, early intervention and continued treatment are critical. Both Federal and State law impact insurance coverage for autism spectrum disorders. This includes the Federal Patient Protection and Affordable Care Act (ACA) and the Illinois Insurance Code.

The Affordable Care Act

The ACA provides the following basic protections that may be helpful to children with autism spectrum disorders:

Coverage despite pre-existing conditions. Health insurance plans cannot deny or exclude coverage for a pre-existing condition, including autism and related conditions. (42 U.S.C. § 300gg-3). This section is **not** applicable to individual grandfathered plans. A "grandfathered" plan is one that was in existence before March 23, 2010 and which has not been altered since then. This section is **not** applicable to transitional plans. A "transitional" plan is an individual or small group plan that was in effect on October 1, 2013 and has been renewed. In Illinois, transitional plans may be renewed through policy years beginning on or before October 1, 2015.

Free autism screening. All plans sold through exchanges, and most private plans, must provide preventative services for children, without charging a co-payment. (42 U.S.C. § 18022) This includes, among other services (45 C.F.R. § 147.130; HRSA guidelines):

- Autism screening for children at age 18 and 24 months;
- Behavioral assessment for ADD and ADHD;
- Developmental screening for children under 3;
- Hearing and vision screening;
- Behavioral assessments at various ages between birth and age 17.
- This section is not applicable to group or individual grandfathered plans.

No lifetime or annual coverage caps. Plans may not place lifetime or annual limits for essential benefits you receive. (42 U.S.C. § 300gg-11) For most plans, this includes no limits for behavioral therapy. As an exception, individual grandfathered plans are allowed to place annual limits on essential benefits, but they are still not allowed to place lifetime limits.

Children covered until age 26. Young adults, including those with autism, may remain on their parents' insurance up to age 26. (42 U.S.C. § 300gg-14).

Illinois Insurance Code

Illinois statute, 215 ILCS 5/356z.14, provides additional mandates regarding insurance coverage for autism spectrum disorders. The following are frequently asked questions about the Illinois law.

Who Must Offer Autism Benefits that Meet the State's Additional Requirements?

All individual and group health insurance policies and HMO contracts (and voluntary health service organization contracts) must offer coverage for autism spectrum disorders. Health coverage provided to state, county, and municipal employees (and employees subject to the Schools Code (105 ILCS 5/1-1 *et seq.*) must also provide benefits.

The Illinois Autism Coverage Law Does *Not* Apply to:

- Self-insured, non-public single-employer plans.
- Self-insured health and welfare plans, such as union plans.
- Insurance policies or trusts issued in other states.
- Short-term travel policies
- Disability income policies
- Long-term care policies
- Accident-only policies
- Limited or specified disease policies
- Short-term, limited-duration health insurance coverage issued with limited benefits

NOTE: For HMOs, the law ***does*** apply to contracts written outside of Illinois if the HMO member is a resident of Illinois and the HMO has established a provider network in Illinois. To determine if your HMO coverage is required to provide treatment for autism, contact the HMO or check your certificate of coverage.

The Illinois statute does not change the autism-related benefits provided by public health care programs such as FamilyCare, All Kids, or the Illinois Early Intervention Program. Contact the specific program for more information about its autism coverage.

Who Is Covered?

Children under the age of 21 who have health coverage through an individual or group policy, as described above, will receive coverage for the ***diagnosis*** and ***treatment*** of autism spectrum disorders.

What Is Covered?

The law requires coverage for the diagnosis of autism spectrum disorders. For individuals diagnosed with an autism spectrum disorder, the law also requires coverage for the following treatments:

- Psychiatric care provided by a licensed psychiatrist;
- Psychological care provided by a licensed psychologist;
- Habilitative or rehabilitative care, meaning counseling and treatment programs intended to develop, maintain, and restore the functioning of an individual, including Applied Behavioral Analysis (ABA); and
- Therapeutic care, including behavioral, speech, occupational, and physical therapies addressing the following areas:
    - Self-care and feeding
    - Pragmatic, receptive, and expressive language
    - Cognitive functioning
    - Applied behavioral analysis, intervention, and modification
    - Motor planning
    - Sensory processing

Insurance companies and HMOs are required to cover all medically necessary care prescribed by a physician, regardless of the type of provider delivering the treatment. If an individual has been diagnosed as having autism spectrum disorder, meeting the diagnostic criteria in place at the time of diagnosis, and treatment is determined medically necessary, then that individual shall remain eligible for coverage under Illinois law even if subsequent changes to the diagnostic criteria are adopted by the American Psychiatric Association. (215 ILCS 5/356z.14(h-5)).

What Are the Limits of Coverage Under the New Law?

The Illinois statute permitted insurers and HMOs to set an annual cap on autism-related benefits of $36,000 which was increased annually for inflation. The Affordable Care Act, however, now bans annual caps on benefits for "essential benefits" such as mental health and behavioral services. For grandfathered group plans, the ban took place upon renewal of the policy on or after January 1, 2014. However, individual grandfathered plans may still include an annual limit on autism-related services.

- The inflation-adjusted annual limit for 2014 is $42,549.50 for individual grandfathered plans.
- The inflation adjusted annual limit for 2015 is $43,825.99 for individual grandfathered plans.

- The inflation adjusted annual limit for 2016 is $44,877.81 for individual grandfathered plans.
- The inflation adjusted annual limit for 2017 is $46,717.80 for individual grandfathered plans.
- The inflation adjusted annual limit for 2018 is $47,512.00 for individual grandfathered plans.
- The inflation adjusted annual limit for 2019 is $50,734.07 for individual grandfathered plans.

Insurance companies and HMOs must otherwise provide benefits for autism just as they do for other services, and may not impose dollar limits, deductibles, or copayments for the diagnosis or treatment of autism spectrum disorders which differ from the dollar limits, deductibles, or copayments established for other medical services covered (this is known as "parity"). Insurance companies are prohibited from limiting the number of visits to a physician or other service provider.

Is Autism Subject to Pre-Existing Condition Limitations?

Beginning January 1, 2014, the Affordable Care Act prohibited insurers in the individual and group markets (with the exception of grandfathered individual plans and transitional plans,) from imposing pre-existing condition exclusions on enrollees aged 19 or older. For enrollees under the age 19, this prohibition has been in effect since September 23, 2010. Beginning January 1, 2018, Illinois law provides that no policy of individual or group accident and health insurance may impose any preexisting condition exclusions. 215 ILCS 5/356z.27. Even grandfathered and transitional plans are subject to this prohibition on preexisting condition exclusions.

Can Insurers Deny Claims Based on Medical Necessity?

Like coverage for other conditions, coverage for the treatment of autism is subject to insurance company and HMO determinations of medical necessity. A company may deny coverage for a certain treatment if the treatment is not medically necessary or does not result in improved clinical status.

A treatment must be considered medically necessary if it is reasonably expected to:

- Prevent the onset of an illness, condition, injury, disease or disability;
- Reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, disease or disability; or
- Help an individual achieve or maintain maximum functional activity in performing daily activities.

If an insurance company or HMO denies a claim based on an adverse determination of medical necessity, you may appeal the company's decision through its internal appeal process as provided in your insurance plan documentation. The company's decision must be based on a determination made by a physician with expertise in the most current and effective

treatments for autism spectrum disorders. If you exhaust the company's internal appeal process and still end up with an adverse determination, then you may request an external review within four (4) months of the date of the final determination. Please note that the requirements for appeals and external review processes apply to fully insured Illinois policies, but do not apply to self-insured "grandfathered" policies under the ACA.

For information about how to request an external review and what conditions and exclusions apply, consult our External Review Fact Sheet:
http://insurance.illinois.gov/ExternalReview/Fact_sheet.pdf.

For more about Autism, visit our website at http://insurance.illinois.gov,
or contact our Office of Consumer Health Insurance staff at (877) 527-9431