



NEVADA: Frequently Asked Questions About the Autism Insurance Reform Law

1. What does Nevada's Autism Insurance Reform Bill (AB 162) do?

The law requires insurance companies to cover evidence-based, medically necessary autism therapies for affected children. Specifically, the statute requires that insurers cover up to \$36,000 per year for Applied Behavior Analysis (ABA). This maximum year benefit will be altered annually based on inflation. Coverage continues until after 18, or up until age 22 if individual the remains enrolled in high school. the law also forbids health insurers from requiring individuals to pay a higher deductible, copayment or coinsurance or endure a longer waiting period for optional care related to autism treatment than is required for other covered out-patient care. Similarly, insurers are forbidden from refusing to issue or canceling a health insurance policy solely because someone on the policy currently uses or may uses autism-related services in the future.

2. What services are covered?

AB 162 covers the diagnosis, screening, and treatment of Autism Spectrum Disorders. Covered treatment is defined as that which is identified in a treatment plan, including medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy or therapeutic care.

3. Does the law cover all of the Autism Spectrum disorders?

Yes, the law covers all conditions currently listed as autism spectrum disorders in the Diagnostic and Statistic Manual of Mental Disorders (DSM). The law defines Autism Spectrum disorders as neurobiological medical conditions including but not limited to autistic disorder, Asperger's Disorder, and Pervasive Development Disorder Not Otherwise Specified. While the statute does not specifically refer to the DSM as many statutes in other states do, the fact that the covered disorders are not limited to those listed above indicates that should the DSM list a new Autism Spectrum disorder in the future, that disorder would likely be covered.

4. Will the law reimburse my early intervention program or school-provided services?

No. The statute explicitly states that it should not be construed to require insurers to reimburse early intervention agencies or schools for the autism-related services that they deliver.

5. When does AB 162 go into effect?

AB 162 goes into effect on January 1, 2011.

6. Once AB 162 goes into effect, will my employer-provided insurance be required to cover my child's autism-related services?

The law applies to fully-funded group health plans governed by state law and to state, county and school district health plans offered to public employees. Health Maintenance Organizations that provide services through managed care to Medicaid recipients under the Nevada State Plan for Medicaid or under the Child's Health Insurance Program are not covered by AB 162.

7. How will AB 162 be enforced?

If a health maintenance organization operates in a manner contrary to that described in the statute, the Commissioner of the State Board of Health may eventually suspend or revoke the insurer's certificate of authority. If an insurer's certificate of authority is revoked, it may not enroll new groups or individuals in its policies in the future. That statute does not include a clear enforcement policy for other insurers.

8. Are there limits on what my insurance company is required to cover under the bill?

Yes. Your insurer is only required to pay for ABA services up to \$36,000 per year. While there is no lifetime limit on what your insurer will cover for ABA, no services will be covered after your child reaches age 18 if he is not in high school, or after your child turns 22 if he remains in high school.

9. What diagnostic tests for Autism will be covered?

AB 162 requires that insurers cover medically necessary evaluations, assessments or tests to screen and diagnose autism spectrum disorders.

10. Who determines what is medically necessary for my child?

Another section of the Louisiana code defines medically necessary health care services that a prudent physician would provide to a patient to prevent, treat or diagnosis a particular condition. These services must be necessary, clinically appropriate, not provided primarily for the patient or provider's convenience, and required to improve or preserve a patients specific condition or existing state of health. Additionally, the services must be the most clinically appropriate level of care may be specifically provided and must be in accordance with generally accepted standards of medical practice.

11. Does Autism have to be my child's primary diagnosis?

No. The statute does not require that autism be your child's primary diagnosis.

12. What services are included under the bill?

The bill covers habilitative or rehabilitative care, including counseling, guidance and professional services and treatment, including ABA, that are necessary to develop, maintain and restore the functioning of the patient to the maximum extent practical. In addition, the statute covers prescription care, defined as medication prescribed by a physician and the services necessary to determine the need for or effectiveness of these medications; psychiatric and psychological care, including direct or consultative services provided by a state-licensed psychiatrist or psychologist; and any medically necessary evaluations, tests, or assessments to screen and diagnose autism spectrum disorders.

13. How are these covered services limited?

As noted above, the statute requires that services be provided by state-licensed providers.

14. Will my insurance cover ABA under AB 162?

The statute defines ABA relatively specifically as the “design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

15. Who can provide my child’s ABA?

AB 162 places some specific limits on who can provide ABA and behavioral therapy. Specifically, ABA must be provided by a licensed-psychologist, licensed behavior analyst, licensed assistant behavior analyst, or certified autism behavior interventionist. If a certified behavioral interventionist provides behavior therapy, he or she must do so under the supervision of a licensed psychologist, licensed behavior analyst, or licensed assistant behavioral analyst.

16. What evidence is required for my child’s treatment to be covered?

AB 162 covers evidence-based autism treatments. The statute defines evidence-based research as research that applies rigorous, systematic and objective procedures to obtain a valid knowledge relevant to autism spectrum disorders.

17. Can my insurance company attempt to deny my child’s ABA treatment under this definition?

If your child’s ABA is not provided by a certified behavioral interventionist supervised by a licensed psychologist, licensed behavior analyst, or licensed assistant behavioral analyst or the licensed psychologist, licensed behavior analyst, or licensed assistant

behavioral analysts him or herself, your insurance company can successfully deny coverage under the law.

18. My child's ABA treatment is not provided or supervised by one of the specified providers. What should I do?

Encourage your child's provider to become certified. Given the widespread impact of this bill, it will benefit them, since children new to ABA must seek out board-certified providers or those supervised by certified providers, physicians, or psychologists to be covered.

19. Will my child's improvement in autism therapy affect what my insurance company covers?

Maybe. AB 162 gives your insurer the right to review your child's treatment plan and improvements may be considered in that process. However, the statute does not specifically permit insurers to discontinue medically necessary coverage.

20. Does autism spectrum disorder have to be the primary diagnosis for my child to receive coverage?

No. The AB162 does not require that an autism spectrum disorder be your child's primary diagnosis.

21. Does the bill permit my insurer to limit the number of visits my child may make to his autism service providers?

Possibly. The statute does not contain a provision explicitly limiting the number of visits that your child may make to his autism services providers. However, your child's autism services are subject to the limitations that your provider may impose on other medical services or prescription coverage. Therefore, if your insurer limits the number of visits to a particular service provider generally, it may limit your autism-related visits.

22. Can my insurance company require that I pay a copay or deductible for my child's autism spectrum disorder treatment?

Yes. The statute specifically provides that your provider may subject autism services to any limitations, co-payments, or exclusions as other medical services or prescriptions provided under the statute.

23. Does the new law cover social groups and other rehabilitative therapies?

Probably. Social groups could fall under the definition of habilitative or rehabilitative care if they take the form of counseling, guidance, and professional services and treatment necessary to develop, maintain or restore the child's functioning. Since many social groups are used for that purpose, it is likely that they would be covered.

24. Will my insurance company be able to question my child's autism diagnosis when the statute is implemented?

Maybe. The statute allows insurance providers to evaluate the treatment plan. Since your child's autism diagnosis is relevant to that plan, it could come into play. However, the statute does not explicitly permit them to do so.

25. Will my insurance provider be able to deny services if my child has reached a plateau in his progress?

Maybe. Since your provider is able to evaluate your child's treatment plan, they may consider a plateau in your child's progress as relevant to that evaluation. However, because the statute requires that insurers cover habilitative or rehabilitative care necessary to maintain the child's functioning, treatment that is only maintaining the child's current condition rather than developing new skills would still be covered under the statute.

26. Who must prescribe my child's autism treatment?

For these services to be covered, the law requires that treatment be prescribed by a licensed physician or licensed psychologist.

27. Who must provide my child's autism treatment?

For your child's autism treatment to be covered, it must be provided by a licensed physician, psychologist, behavior analyst herself or a provider supervised by a licensed physician, psychologist, or behavior analyst.

28. Is psychiatric care limited to a psychiatrist?

Yes. Your child's psychiatric care must be provided by a psychiatrist licensed in Nevada.

29. Is psychological care limited to a psychologist?

Yes. Your child's psychological care must be provided by a psychologist licensed in Nevada.

30. Who can provide my child's habilitative or rehabilitative care?

The statute does not specify who can provide the child's habilitative or rehabilitative care, but ABA must be provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or certified autism behavior interventionist

31. What is "utilization review"?

“Utilization review” refers to techniques used by health carriers to monitor the use of, or to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services, procedures or settings. Some examples of techniques used include ambulatory review, prospective review, retrospective review, second opinion, certification, concurrent review, case management or retrospective review. (Source: National Association of Insurance Commissioners)

32. What is “grievance review”?

“Grievance review” refers to a health carrier’s internal processes for the resolution of covered persons’ complaints. The complaints may arise out of a utilization review decision or involve the availability, delivery or quality of health care services; claims payment, handling or reimbursement for health care services; or matters pertaining to the contractual relationship between a covered person or health carrier. Some states may call it an “internal appeal” process. (Source: National Association of Insurance Commissioners)