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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1150 Session of 2007

INTRODUCED BY D. O'BRIEN, DeWEESE, PALLONE, PHILLIPS, RAPP, SCAVELLO, STURLA, BAKER, BASTIAN, BOYD, BROOKS, CALTAGIRONE, CARROLL, CLYMER, COHEN, CONKLIN, DALEY, DALLY, DeLUCA, DePASQUALE, DONATUCCI, EVERETT, FREEMAN, GEIST, GEORGE, GIBBONS, GINGRICH, GOODMAN, GRUCELA, HALUSKA, HARKINS, HENNESSEY, HERSHEY, JAMES, JOSEPHS, KAUFFMAN, W. KELLER, KENNEY, KIRKLAND, KOTIK, KULA, LEACH, LENTZ, MAHONEY, MANDERINO, MANN, MARKOSEK, MARSHALL, McILHATTAN, MOYER, MURT, MUSTIO, McGEEHAN, MYERS, NAILOR, M. O'BRIEN, PASHINSKI, PAYNE, PETRONE, PRESTON, READSHAW, REICHLEY, ROSS, SCHRODER, SEIP, SHAPIRO, SHIMKUS, M. SMITH, SOLOBAY, SONNEY, STABACK, STEIL, SURRA, TANGRETTI, TRUE, VEREB, WATSON, J. WHITE, WOJNAROSKI, YUDICHAK, MACKERETH, MANTZ, BARRAR, HORNAMAN, CAUSER, WALKO, HELM, MELIO, DENLINGER, BRENNAN, RAMALEY, DiGIROLAMO, GERGELY, M. KELLER, FRANKEL, FABRIZIO, YOUNGBLOOD, REED, ROAE, CURRY, K SMITH, GALLOWAY, SIPTROTH AND RUBLEY APRIL 30, 2007

AS AMENDED ON SECOND CONSIDERATION, HOUSE OF REPRESENTATIVES, JULY 13, 2007

AN ACT

Amending the act of May 17, 1921 (P.L.682, No.284), entitled "An act relating to insurance; amending, revising, and consolidating the law providing for the incorporation of insurance companies, and the regulation, supervision, and protection of home and foreign insurance companies, Lloyds associations, reciprocal and inter-insurance exchanges, and fire insurance rating bureaus, and the regulation and supervision of insurance carried by such companies, associations, and exchanges, including insurance carried by the State Workmen's Insurance Fund; providing penalties; and repealing existing laws," providing, in health and accident insurance, for autism spectrum disorders coverage and for treatment of autism spectrum disorders; and further providing for quality health care procedures.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. The act of May 17, 1921 (P.L.682, No.284), known as The Insurance Company Law of 1921, is amended by adding sections to read:

Section 635.2. Autism Spectrum Disorders Coverage.--(a) A health insurance policy or government program shall provide to covered individuals or recipients under twenty-one years of age coverage for the diagnosis of autism spectrum disorders and for the treatment of autism spectrum disorders. TO THE EXTENT THAT THE DIAGNOSIS AND TREATMENT OF AUTISM SPECTRUM DISORDERS ARE NOT ALREADY COVERED BY THE HEALTH INSURANCE POLICY OR GOVERNMENT PROGRAM, COVERAGE UNDER THIS SECTION SHALL BE INCLUDED IN HEALTH INSURANCE POLICIES AND CONTRACTS UNDER A GOVERNMENT PROGRAM WHICH ARE DELIVERED, EXECUTED, ISSUED, AMENDED, ADJUSTED OR RENEWED ON OR AFTER ONE HUNDRED EIGHTY DAYS FROM THE EFFECTIVE DATE OF THIS SECTION, EXCEPT THAT THE APPLICABILITY OF THIS SECTION TO GOVERNMENT PROGRAMS SHALL BE CONTINGENT UPON FEDERAL APPROVAL IF NECESSARY. <—

(b) Except for the Commonwealth's medical assistance program established under the act of June 13, 1967 (P.L.31, No.21), known as the "Public Welfare Code," and except for the Children's Health Care Program established under this act, coverage provided under this section shall be subject to a maximum benefit of thirty-six thousand dollars ($36,000) per year but shall not be subject to any limits on the number of visits to an autism service provider. After December 30, 2009, the Insurance Commissioner shall, on an annual basis, adjust the maximum benefit for inflation using the Medical ~~Price Index (MPI) component of the Department of Labor Consumer Price Index (CPI).~~ CARE COMPONENT OF THE UNITED STATES DEPARTMENT OF LABOR CONSUMER PRICE INDEX FOR ALL URBAN CONSUMERS (CPI-U). The <—

commissioner shall submit the adjusted maximum benefit to the Legislative Reference Bureau for publication annually in the Pennsylvania Bulletin no later than April 1 of each calendar year, and the published adjusted maximum benefit shall be applicable in the following calendar year to health insurance policies and government programs subject to this act. Payments made by an insurer on behalf of a covered individual for any care, treatment, intervention, service or item, the provision of which was for the treatment of a health condition unrelated to the covered individual's autism spectrum disorder, shall not be applied toward any maximum benefit established under this subsection.

(c) Coverage under this section shall be subject to copayment, deductible and coinsurance provisions of a health insurance policy or government program to the extent that other medical services covered by the policy or government program are subject to these provisions.

(d) This section shall not be construed as limiting benefits which are otherwise available to an individual under a health insurance policy.

(e) This section shall not apply to the following types of policies:

(1) Accident only.

(2) Limited benefit.

(3) Credit.

(4) Dental.

(5) Vision.

(6) Specified disease.

(7) Medicare supplement.

(8) CHAMPUS (Civilian Health and Medical Program of the

Uniformed Services) supplement.

(9) Long-term care or disability income.

(10) Workers' compensation.

(11) Automobile medical payment.

(12) Hospital indemnity.

(f) As used in this section:

(1) "Applied behavioral analysis" means 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.

(2) "Autism service provider" means any person, entity or group that provides treatment of autism spectrum disorders.

(3) "Autism spectrum disorders" means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

(4) "Diagnosis of autism spectrum disorders" means medically necessary assessments, evaluations or tests in order to diagnose whether an individual has an autism spectrum disorder.

(5) "Evidenced-based research" means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.

(6) "Government program" means any of the following:

(i) The Commonwealth's medical assistance program established under the act of June 13, 1967 (P.L.31, No.21), known as the "Public Welfare Code."

(ii) The adult basic coverage insurance program established

under Chapter 13 of the act of June 26, 2001 (P.L.755, No.77), known as the "Tobacco Settlement Act."

(iii) The Children's Health Care Program established under this act.

(7) "Health insurance policy" means any group health, sickness or accident policy or subscriber contract or certificate issued by an insurance entity subject to one of the following:

(i) This act.

(ii) The act of December 29, 1972 (P.L.1701, No.364), known as the "Health Maintenance Organization Act."

(iii) The act of May 18, 1976 (P.L.123, No.54), known as the "Individual Accident and Sickness Insurance Minimum Standards Act."

(iv) 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations).

(8) "Medically necessary" means any care, treatment, intervention, service or item which is prescribed, provided or ordered by a licensed physician, licensed psychologist or certified registered nurse practitioner in accordance with accepted standards of practice and which will, or is reasonably expected to, do any of the following:

(i) Prevent the onset of an illness, condition, injury or disability.

(ii) Reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

(iii) Assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account

both the functional capacity of the recipient and those functional capacities that are appropriate of recipients of the same age.

(9) "Pharmacy care" means medications prescribed by a licensed physician or certified registered nurse practitioner and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

(10) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

(11) "Psychological care" means direct or consultative services provided by a ~~licensed psychologist~~ PSYCHOLOGIST LICENSED in the state in which the psychologist practices. <—

(12) "Rehabilitative care" means professional, counseling and guidance services and treatment programs, including applied behavioral analysis, which are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual.

(13) "Therapeutic care" means services provided by licensed or certified speech therapists, occupational therapists or physical therapists.

(14) "Treatment for autism spectrum disorders" shall include the following care prescribed, provided or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist or certified registered nurse practitioner if the care is determined to be medically necessary:

(i) Psychiatric care.

(ii) Psychological care.

(iii) Rehabilitative care.

(iv) Therapeutic care.

(v) Pharmacy care.

(vi) Any care, treatment, intervention, service or item for individuals with an autism spectrum disorder which is determined by the Department of Public Welfare, based upon its review of best practices or evidenced-based research, to be medically necessary and which is published in the Pennsylvania Bulletin. Any such care, treatment, intervention, service or item which was not previously covered shall be included in any health insurance policy or contract under a government program delivered, issued, executed or renewed on or after 120 days following the date of its publication in the Pennsylvania Bulletin.

(g) The Department of Public Welfare shall promulgate regulations establishing standards for qualified autism service providers. For purposes of implementing this section, and notwithstanding any other provision of law, THE Secretary of Public Welfare shall promulgate regulations pursuant to section 204(1)(iv) of the act of July 31, 1968 (P.L.769, No.240), referred to as the Commonwealth Documents Law, which shall, for 120 days from the effective date of this act, be exempt from all OF the following acts: <—— <——

(1) Section 205 of the Commonwealth Documents Law.

(2) Section 204(b) of the act of October 15, 1980 (P.L.950, No.164), known as the "Commonwealth Attorneys Act."

(3) The act of June 25, 1982 (P.L.633, No.181), known as the "Regulatory Review Act."

Once the regulations are promulgated, payment for the treatment of autism spectrum disorders covered under this section shall only be made to autism service providers who meet the standards.

~~(h) To the extent that the diagnosis and treatment of autism~~ <—
~~spectrum disorders are not already covered by the health~~
~~insurance policy or government program, coverage under this~~
~~section shall be included in health insurance policies and~~
~~contracts under a government program which are delivered,~~
~~executed, issued, amended, adjusted or renewed on or after one~~
~~hundred twenty days from the effective date of this section,~~
~~except that the applicability of this section to government~~
~~programs shall be contingent upon Federal approval if necessary.~~

~~Section 2116.1. Treatment of Autism Spectrum Disorders.--(a)~~
~~Except for government programs, if an enrollee has obtained a~~
~~referral or other authorization through utilization review from~~
~~a managed care plan or a licensed insurer to receive any care,~~
~~treatment, intervention, service or item for an autism spectrum~~
~~disorder from a health care provider or specialist, the referral~~
~~or other authorization shall constitute a standing referral for~~
~~any subsequent care, treatment, intervention, service or item~~
~~provided by any health care provider or specialist until the~~
~~care, treatment, intervention, service or item for which the~~
~~referral or authorization was approved has reached its~~
~~conclusion.~~

SECTION 2116.1. TREATMENT OF AUTISM SPECTRUM DISORDERS.--(A) <—
EXCEPT FOR INPATIENT SERVICES, IF AN ENROLLEE HAS OBTAINED
AUTHORIZATION THROUGH UTILIZATION REVIEW FROM A MANAGED CARE
PLAN, GOVERNMENT PROGRAM OR A LICENSED INSURER TO RECEIVE ANY
CARE, TREATMENT, INTERVENTION, SERVICE OR ITEM FOR AN AUTISM
SPECTRUM DISORDER, THE AUTHORIZATION SHALL BE VALID FOR TWELVE
MONTHS, UNLESS THE ENROLLEE'S PRIMARY CARE PROVIDER DETERMINES
THAT AN EARLIER RE-EVALUATION IS NECESSARY IN ORDER TO
ADEQUATELY ADDRESS THE CLINICAL NEEDS OF THE ENROLLEE.

(A.1) IN APPLYING SUBSECTION (A), IF WITHIN THE TWELVE-MONTH PERIOD FOLLOWING THE EFFECTIVE DATE OF THIS SECTION A HEALTH INSURANCE POLICY IS DELIVERED, ISSUED, EXECUTED OR RENEWED AND AT THE TIME OF SUCH DELIVERY, ISSUANCE, EXECUTION OR RENEWAL AN ENROLLEE IS RECEIVING ANY INPATIENT OR OUTPATIENT CARE, TREATMENT, INTERVENTION, SERVICE OR ITEM FOR AN AUTISM SPECTRUM DISORDER PURSUANT TO AN AUTHORIZATION OBTAINED FROM A GOVERNMENT PROGRAM, AND THE CARE, TREATMENT, INTERVENTION, SERVICE OR ITEM IS COVERED UNDER THE HEALTH INSURANCE POLICY BEING DELIVERED, ISSUED, EXECUTED OR RENEWED, THE AUTHORIZATION FROM THE GOVERNMENT PROGRAM SHALL REMAIN VALID FOR THE REMAINDER OF THE EXISTING AUTHORIZATION PERIOD AS TO ANY MANAGED CARE PLAN OR PRIVATE INSURER AND SUCH AUTHORIZATION SHALL BE HONORED BY ANY MANAGED CARE PLAN OR PRIVATE INSURER PROVIDING COVERAGE TO THE ENROLLEE.

(b) If a health care provider provides care, treatments, interventions, services or items to an enrollee, the coverage of which is required under section 635.2 and the provider is enrolled in the Commonwealth's medical assistance program but is not a network provider with the enrollee's private insurance plan, the provider shall be reimbursed under the terms and conditions applicable to the plan's participating providers. This requirement shall not be subject to any time limitation or transition period, but shall otherwise be in accord with all terms applicable to nonparticipating providers under the managed care continuity of care provisions then in effect.

Section 2. Section 2121 of the act, added June 17, 1998 (P.L.464, No.68), is amended to read:

Section 2121. Procedures.--(a) A managed care plan shall establish a credentialing process to enroll qualified health

care providers and create an adequate provider network. The process shall be approved by the department and shall include written criteria and procedures for initial enrollment, renewal, restrictions and termination of credentials for health care providers.

(b) [The] Except as provided under subsection (b.1), the department shall establish credentialing standards for managed care plans. The department may adopt nationally recognized accrediting standards to establish the credentialing standards for managed care plans.

(b.1) Pursuant to section 635.2(g), the Department of Public Welfare shall establish standards to be utilized by managed care plans for the credentialing of health care providers providing care, treatments, interventions, services or items to enrollees for an autism spectrum disorder as defined under section 635.2. In addition, the department may require that a managed care plan grant credentials to any health care provider whom the Department of Public Welfare determines meets or exceeds the Department of Public Welfare's credentialing standards.

~~(b.2) With respect to autism service providers, a managed care plan or licensed insurer shall inform credentialing applicants of a decision within ninety days after the complete application has been submitted to the managed care plan or insurer. A managed care plan or insurer shall not require a health care provider to submit an application for credentialing as a result of a change of employers if the provider's new employer is in the managed care plan's service area or network.~~ <—

(c) A managed care plan shall submit a report to the department regarding its credentialing process at least every two (2) years or as may otherwise be required by the department.

(d) A managed care plan shall disclose relevant credentialing criteria and procedures to health care providers that apply to participate or that are participating in the plan's provider network. A managed care plan shall also disclose relevant credentialing criteria and procedures pursuant to a court order or rule. Any individual providing information during the credentialing process of a managed care plan shall have the protections set forth in the act of July 20, 1974 (P.L.564, No.193), known as the "Peer Review Protection Act."

(e) No managed care plan shall exclude or terminate a health care provider from participation in the plan due to any of the following:

(1) The health care provider engaged in any of the activities set forth in section 2113(c).

(2) The health care provider has a practice that includes a substantial number of patients with expensive medical conditions.

(3) The health care provider objects to the provision of or refuses to provide a health care service on moral or religious grounds.

(f) If a managed care plan denies enrollment or renewal of credentials to a health care provider, the managed care plan shall provide the health care provider with written notice of the decision. The notice shall include a clear rationale for the decision.

~~Section 3. This act shall take effect in 180 days.~~ <—

SECTION 3. THIS ACT SHALL TAKE EFFECT AS FOLLOWS: <—

(1) THE FOLLOWING PROVISIONS SHALL TAKE EFFECT IN 90 DAYS:

(I) THE ADDITION OF SECTION 635.2(F) AND (G) OF THE

ACT.

(II) THE AMENDMENT OF SECTION 2121 OF THE ACT.

(III) THIS SECTION.

(2) THE REMAINDER OF THIS ACT SHALL TAKE EFFECT IN 210 DAYS.