

Chapter 115, P.L. 2009

(Approved August 13, 2009)

[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,**

(Sponsorship Updated As Of: 6/19/2009)

**Conners, Senators Vitale, Weinberg, Baroni, Gordon, Rice, Cunningham
and Sweeney**

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.

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3

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

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

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.

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1 subject to the provisions of this subsection.

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

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

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

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

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

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

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

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

34 f. The provisions of subsections b. and c. of this section shall
35 not be construed to¹ require that benefits be provided to

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1 reimburse the cost of services provided under an individualized
2 family service plan or an individualized education program¹;] 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 hospital service
9 corporation of the continued medical necessity of the specified
10 therapies and interventions.

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

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

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

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

32 c. When the covered person is under 21 years of age and the
33 covered person's primary diagnosis is autism, the medical service
34 corporation shall provide coverage for expenses incurred for
35 medically necessary behavioral interventions based on the

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- 1 principles of applied behavioral analysis and related structured
2 behavioral programs, as prescribed through a treatment plan,
3 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
7 contract, but shall not be subject to limits on the number of visits
8 that a covered person may make to a provider of behavioral
9 interventions.
- 10 (2) The benefits provided pursuant to this subsection shall not
11 be denied on the basis that the treatment is not restorative.
- 12 (3) (a) The maximum benefit amount for a covered person in
13 any calendar year through 2011 shall be \$36,000.
- 14 (b) Commencing on January 1, 2012, the maximum benefit
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 benefit 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 medical service corporation shall not be precluded from
29 providing a benefit amount for a covered person in any calendar
30 year that exceeds the benefit amounts set forth in subparagraphs (a)
31 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 medical
34 service corporation to appropriately provide benefits, including, but
35 not limited to: a diagnosis; proposed treatment by type, frequency,

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

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

12 f. The provisions of subsections b. and c. of this section shall
13 not be construed to¹ require that benefits be provided to
14 reimburse the cost of services provided under an individualized
15 family service plan or an individualized education program¹; or
16 affect any requirement to provide those services¹; except that the
17 benefits provided pursuant to those subsections shall include
18 coverage for expenses incurred by participants in an individualized
19 family service plan through a family cost share¹.

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

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

27

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

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9

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

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

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

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

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

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

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

34 (c) The adjusted maximum benefit amount shall apply to a
35 contract that is delivered, issued, executed, or renewed, or approved

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1 for issuance or renewal, in the 12-month period following the date
2 on which the adjustment is promulgated.

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

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

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

23 f. The provisions of subsections b. and c. of this section shall
24 not be construed to¹ require that benefits be provided to
25 reimburse the cost of services provided under an individualized
26 family service plan or an individualized education program¹; or
27 affect any requirement to provide those services¹; except that the
28 benefits provided pursuant to those subsections shall include
29 coverage for expenses incurred by participants in an individualized
30 family service plan through a family cost share¹.

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

35 h. The provisions of this section shall apply to all contracts in

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1 which the health service corporation has reserved the right to
2 change the premium.

3

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

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

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

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

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

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

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

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

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

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

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

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

32 f. The provisions of subsections b. and c. of this section shall
33 not be construed to¹ require that benefits be provided to
34 reimburse the cost of services provided under an individualized
35 family service plan or an individualized education program¹; or

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1 affect any requirement to provide those services¹; except that the
2 benefits provided pursuant to those subsections shall include
3 coverage for expenses incurred by participants in an individualized
4 family service plan through a family cost share¹.

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

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

11

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

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

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

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

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

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

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

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

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

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

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

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

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1 clinical circumstances.

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

5 f. The provisions of subsections b. and c. of this section shall
6 not be construed to¹ require that benefits be provided to
7 reimburse the cost of services provided under an individualized
8 family service plan or an individualized education program¹; or
9 affect any requirement to provide those services¹; except that the
10 benefits provided pursuant to those subsections shall include
11 coverage for expenses incurred by participants in an individualized
12 family service plan through a family cost share¹.

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

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

19

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

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

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

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1 the basis that the treatment is not restorative.

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

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

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

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

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

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

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

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1 paragraph.

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

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

16 f. The provisions of subsections b. and c. of this section shall
17 not be construed to¹ require that benefits be provided to
18 reimburse the cost of services provided under an individualized
19 family service plan or an individualized education program¹ or
20 affect any requirement to provide those services¹; except that the
21 benefits provided pursuant to those subsections shall include
22 coverage for expenses incurred by participants in an individualized
23 family service plan through a family cost share¹.

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

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

31

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

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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.

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

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

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

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

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

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

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

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

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

8 f. The provisions of subsections b. and c. of this section shall
9 not be construed to¹ require that benefits be provided to
10 reimburse the cost of services provided under an individualized
11 family service plan or an individualized education program¹ or
12 affect any requirement to provide those services¹; except that the
13 benefits provided pursuant to those subsections shall include
14 coverage for expenses incurred by participants in an individualized
15 family service plan through a family cost share¹.

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

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

23

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

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

34 b. When the enrollee's primary diagnosis is autism or another
35 developmental disability, the health maintenance organization shall

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

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

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

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

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

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

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

33 (d) Notwithstanding the provisions of this paragraph to the
34 contrary, a health maintenance organization shall not be precluded
35 from providing a coverage amount for an enrollee in any calendar

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1 year that exceeds the coverage amounts set forth in subparagraphs
2 (a) and (b) of this paragraph.

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

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

18 f. The provisions of subsections b. and c. of this section shall
19 not be construed to¹ require that benefits be provided to
20 reimburse the cost of services provided under an individualized
21 family service plan or an individualized education program¹; or
22 affect any requirement to provide those services¹; except that the
23 benefits provided pursuant to those subsections shall include
24 coverage for expenses incurred by participants in an individualized
25 family service plan through a family cost share¹.

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

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

33

34 9. Notwithstanding any other provision of law to the contrary,
35 the State Health Benefits Commission shall ensure that every

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- 1 contract purchased by the commission on or after the effective date
- 2 of this act that provides hospital or medical expense benefits shall
- 3 provide coverage pursuant to the provisions of this section.

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- 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.

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

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

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

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

24 f. The provisions of subsections b. and c. of this section shall
25 not be construed to¹ require that benefits be provided to
26 reimburse the cost of services provided under an individualized
27 family service plan or an individualized education program¹; or
28 affect any requirement to provide those services¹; except that the
29 benefits provided pursuant to those subsections shall include
30 coverage for expenses incurred by participants in an individualized
31 family service plan through a family cost share¹.

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

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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

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

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

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

17 d. The treatment plan required pursuant to subsections b. and c.
18 of this section shall include all elements necessary for the carrier to
19 appropriately provide benefits, including, but not limited to: a
20 diagnosis; proposed treatment by type, frequency, and duration; the
21 anticipated outcomes stated as goals; the frequency by which the
22 treatment plan will be updated; and the treating physician's
23 signature. The carrier may only request an updated treatment plan
24 once every six months from the treating physician to review
25 medical necessity, unless the carrier and the treating physician
26 agree that a more frequent review is necessary due to emerging
27 clinical 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 to¹ require that benefits be provided to
33 reimburse the cost of services provided under an individualized
34 family service plan or an individualized education program¹; ² or
35 affect any requirement to provide those services¹; except that the

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- 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.

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

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