ENROLLED ORIGINAL

AN ACT

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IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

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To require health benefit plans to provide coverage for habilitative services for the treatment of congenital or genetic birth defects to enhance the ability of children to function.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Health Insurance Coverage for Habilitative Services for Children Act of 2006".

Sec. 2. Definitions.

For the purposes of this act, the term:

(1)(A) "Adverse decision" means a utilization review determination by a private review agent, a carrier, or a health care provider acting on behalf of a carrier that:

(i) A proposed or delivered health care service covered under the member's contract is or was not medically necessary, appropriate, or efficient;

(ii) May result in noncoverage of the health care service; and

(iii) Does not include a decision concerning a subscriber's status as a member.

(B) A determination denying a request for habilitative services or denying payment for habilitative services because a condition or disease is not a congenital or genetic birth defect is an adverse decision.

(2) "Congenital or genetic birth defect" means a defect existing at or from birth, including a hereditary defect. The term "congenital or genetic birth defect" includes:

(A) Autism or an autism spectrum disorder; and

(B) Cerebral palsy.

(3) "Habilitative services" means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function.

(4) (A) "Health benefit plan" means any accident and health insurance policy or certificate, hospital and medical services corporation contract, health maintenance organization

subscriber contract, plan provided by a multiple employer welfare arrangement, or plan provided by another benefit arrangement.

(B) The term "health benefit plan" does not mean accident only, credit, or disability insurance; coverage of Medicare services or federal employee health plans, pursuant to contracts with the United States government; Medicare supplemental or long-term care insurance; dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; medical expense and loss of income benefits; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(5) "Health insurer" means any person that provides one or more health benefit plans or insurance in the District of Columbia, including an insurer, a hospital and medical services corporation, a fraternal benefit society, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of health insurance subject to the authority of the Commissioner.

(6) "Managed care system" means a method that a health insurer uses to review and preauthorize a treatment plan that a health care practitioner develops for a covered person using a variety of cost containment methods to control utilization, quality, and claims.

Sec. 3. Coverage, notice, applicability, and regulations.

(a) A health insurer shall:

(1) Provide coverage of habilitative services for children under the age of 21 years and may do so through a managed care system;

(2) Not be required to provide reimbursement for habilitative services actually delivered through early intervention or school services; and

(3) Provide notice to its insureds and enrollees about the coverage required under this act.

(b) The coverage shall not be more restrictive than coverage provided for any other illness, condition, or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsuance factors, and benefit year maximum for deductibles and copayments and coinsurance factors.

(c) The Commissioner may issue rules and regulations necessary to implement the provisions of this act.

(d) This act shall apply to all individual and group health benefit plans issued or renewed on the first day of the month beginning on or after 90 days following the effective date of this act.

Sec. 4. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 602(c)(3) of the District of Columbia Home Rule Act approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(3)).

Sec. 5. Effective date.

This act shall take effect following approval by the Mayor (or in the event of a veto by the Mayor, action by the Council to override the veto), a 30-day period of Congressional review as provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of Columbia Register.

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Chairman
Council of the District of Columbia

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Mayor
District of Columbia