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January 6, 2016

The Honorable Rob Bonta
Chair, California Assembly Committee on Health
State Capitol, Room 6005
10th and L Streets
Sacramento, CA 95814

Via E-mail only

Dear Assembly Member Bonta:

The California Health Benefits Review Program (CHBRP) was asked by Assembly Health Committee staff on January 5, 2016 to provide additional comments or updates to its 2015 independent, evidence-based analysis of Assembly Bill 796 (Nazarian), *Health Care Coverage: autism and pervasive development disorders*. CHBRP is pleased to provide this letter, but notes the constraints of a very short turn-around time to provide a more complete analysis.

CHBRP's report on the February 26, 2015, version of AB 796 focused on the change the bill would have made to a current benefit mandate's definitions of qualified autism service (QAS) professional and QAS paraprofessional. The January 4, 2016, amendments would not changes definitions of QAS professional and QAS paraprofessional. Instead, the bill would extend the provisions of the current mandate[1] (set to sunset on January 1, 2017) through January 1, 2022.

The current mandate, which was created by the 2011 passage of SB 946 requires coverage for behavioral health treatment, including applied behavioral analysis (ABA) for the treatment of pervasive developmental disorder and autism (PDD/A). For delivery of these services, the current mandate defines QAS professionals, paraprofessionals, and providers.

In 2011, CHBRP was not asked to analyze SB 946. However, earlier that year, CHBRP was asked to analyze similar language (see CHBRP's 2011 reports and letter regarding AB 171, SB 770, and SB TBD-1).

CHBRP's 2011 analysis of similar language focused on intensive behavioral intervention treatments (IBITs), a type of treatment that would include theory-based treatments such as applied behavioral analysis (ABA). CHBRP's later, related analyses (see reports on 2013's SB 126 and 2014's AB 2041) also considered IBIT for PDD/A.

CHBRP's repeated consideration of medical effectiveness has found a preponderance of evidence indicating that IBITs improve outcomes associated with PDD/A. However, the literature on the

[1] Health and Safety Code 1374.73; Insurance Code 10144.51 and 10144.52

effectiveness is difficult to synthesize. Most studies compared IBIT of differing duration and intensity or compared interventions based on different theories of behavior.

CHBRP's key public health finding at that time was that the legislation could produce some improvement in IQ scores and adaptive behaviors for children aged 18 months to 9 years with diagnoses of Autistic Disorder and Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS) due to the effectiveness of intensive behavioral intervention therapy and increased coverage and utilization. The public health impact on persons outside of this age range or with other PDDs was unknown.

Additionally, in CHBRP's analysis of AB 171 and SB TBD 1 found that the bills would:

- Affect IBIT utilization in two ways: it would add new users and, among users with new benefit coverage, would prompt an increase of IBIT hours per week.
- Add new users of IBIT in the under 3 age group. This was because some children under the age of 3 years may not have qualified for related services paid for by the regional centers affiliated with the California Department of Developmental Services (DDS) or by schools affiliated with the California Department of Education (CDE). Milder forms of PDD/A might not have qualified such children for treatment from DDS and they would be too young to receive school-based services.

As the Legislature considers AB 796 as it was amended on January 4, 2016, aspects of California law and federal law that may be relevant include the following:

- First, California's current Essential Health Benefit (EHB) base benchmark plan, effective through December 31, 2016, was influenced by the current benefit mandate (established by SB 946 in 2011). Similarly, California's 2017 EHB base benchmark plan, was influenced by the current benefit mandate. Therefore, the provisions of SB 946 may be relevant to the small-group market and individual market plans and policies required to cover EHBs[2] regardless of whether the current benefit mandate sunsets. This issue may warrant further analysis as well as review by both the California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI).

- Second, in terms of requiring coverage for IBIT as a treatment for PDD/A, there may be overlap between the current benefit mandate and California's mandate regarding mental health parity,[3] which are applicable to all DMHC-regulated plans and all CDI-regulated policies. However, were the provisions of the current benefit mandate (established by 2011's SB 946) to sunset, the definitions of QAS professionals, QAS paraprofessionals, and QAS providers might change, which could affect access to and utilization of IBIT. This issue, too, may warrant further analysis as well as review by both DMHC and CDI.

Thank you for allowing CHBRP the opportunity to further assist.

Sincerely,

Garen L. Corbett, MS
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[2] Coverage of EHBs is not required by large-group market plans and policies or by grandfathered plans and policies in the small-group and individual market.
[3] Health and Safety Code 1374.72; Insurance Code 10123.15 and 10144.5

cc:
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Assembly Member Jimmy Gomez, Chair, Assembly Committee on Appropriations
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