California Health Benefits Review Program

Analysis of California Senate Bill (SB) 1034
Health Care Coverage: Autism

A Report to the 2015–2016 California State Legislature

April 15, 2016

CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

Key Findings:

Analysis of California Senate Bill (SB) 1034 Health Care Coverage: Autism

Summary to the 2015–2016 California State Legislature, April 2016

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

AT A GLANCE

Altering a current law that addresses coverage of behavioral health treatment for autism spectrum disorder (ASD), SB 1034 would: (1) require coverage for behavioral health treatment for maintenance of function; (2) prohibit denials based on parent/caregiver nonparticipation; (3) require coverage in all settings; and (4) prohibit plan/insurer review of treatment plans at less than 6-month intervals.

- **Enrollees covered. I**n 2017, 18.3 million of 25.2 million Californians would have state-regulated health insurance that would be subject to SB 1034.
- **Medical effectiveness.** There is insufficient evidence to evaluate the effect of behavioral health treatment for maintaining improvements in outcomes; studies have not considered its effect on maintenance separately from its effect on improving function. A preponderance of evidence suggests parent/caregiver participation is beneficial but that behavioral health treatments improve outcomes regardless of parent/caregiver involvement. A preponderance of evidence suggests that behavioral health treatment is effective in many settings. There is insufficient evidence to evaluate the effect of varying plan/insurer review of treatment plans.

In the first postmandate year, requiring coverage for maintenance behavioral health treatment would have the following effects:

- **Benefit coverage.** 94% of enrollees with health insurance subject to SB 1034 would gain benefit coverage.
- **Utilization.** Utilization would increase to 47 annual hours per 1,000 enrollees (up by 3 hours).
- **Expenditures.** Total premiums and cost sharing would increase by $8.3 million (0.006%).
- **Public Health.** Although the evidence is unclear, it seems reasonable to assume that there would be some improvement of some health outcomes for some enrollees with increased utilization.

Although unquantifiable, the other aspects of SB 1034 might also increase utilization of behavioral health treatment, particularly in the long term.

BACKGROUND

Autism spectrum disorder (ASD) is a developmental disability characterized by deficits in social interactions and communication, sensory processing, stereotypic (repetitive) behaviors or interests, and sometimes cognitive function. The symptoms of ASD fall along a continuum, ranging from mild impairment to profound disability. The estimated overall prevalence of ASD in California is 70.9 per 10,000 people. However, only a subset of the group is responsive to the behavioral health treatments. In addition, many of these persons are Medi-Cal beneficiaries, whose health insurance would not be subject to SB 1034.

BILL SUMMARY

Current law[1] requires coverage of behavioral health treatments for ASD, including interventions such as applied behavioral analysis (ABA). Current law also requires plans and insurers to maintain adequate provider networks that may include what the law defines as "qualified autism service" (QAS) providers supervising/employing QAS professionals and/or QAS paraprofessionals. Current law exempts from compliance the health insurance of enrollees associated with the California Public Employees' Retirement System (CalPERS) and Medi-Cal beneficiaries enrolled in health plans regulated by the California Department of Managed Health Care (DMHC).

SB 1034 would amend the current law in a number of ways. SB 1034 would prohibit plans and insurers from denying coverage for behavioral health treatment for ASD when (1) the purpose is to "maintain" function; (2) due to a lack of parent/caregiver involvement; and (3) due to setting. The current law requires benefit coverage to "develop and restore" function, but does not address maintaining function, parent/caregiver involvement, or setting. SB 1034 would also generally prohibit plans/insurer review of treatment plans more frequently

[1] Health & Safety Code 1374.73 and Insurance Code 10144.51

than every 6 months unless a shorter period is recommended by the QAS provider. Plans and insurers often require treatment plans, and continuing coverage may be based on review of the treatment plan.

SB 1034 would alter the definition of QAS professional such that: (1) regional center[2] vendor status not be required; and (2) to include clinical management and case supervision. In addition, SB 1034 would alter the definitions of QAS professional and QAS paraprofessional to indicate that supervision, but not employment by a QAS provider is required.

SB 1034 would eliminate the current law's exemption for the health insurance of enrollees associated with CalPERS (but would leave the exemption associated with Medi-Cal beneficiaries).

SB 1034 would eliminate the current law's January 1, 2017, sunset date. However, in addition to the law that SB 1034 would alter, the current California mental health parity law[3] also requires coverage for behavioral health treatment for persons with ASD.[4] Therefore, coverage for behavioral health treatment for ASD would be required even if the law that SB 1034 would amend were to sunset.

SB 1034 would apply (see Figure 1) to the health insurance of all enrollees in DMHC-regulated plans and CDI-regulated polices, except those associated with Medi-Cal.

ANALYSIS

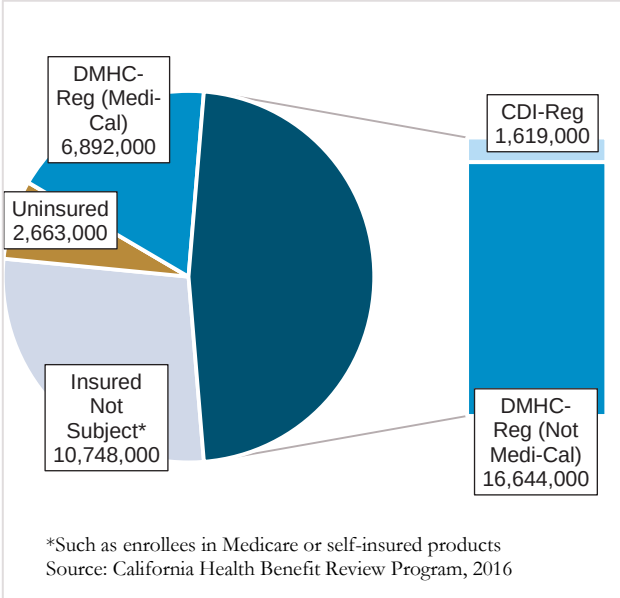
CHBRP has assumed that the current supply of QAS providers, professionals, and paraprofessionals could expand to meet any increase prompted by the changes SB 1034 would make to benefit coverage and subsequent utilization.

Medical Effectiveness

CHBRP found insufficient evidence to determine whether behavioral health treatment aimed at maintaining function derived from intensive behavioral health treatments is effective.

[2] One of the regional centers associated with California's Lanterman Developmental Disabilities Service Act of 1969.
[3] H&SC Section 1374.72 and IC Section 10144.5.
[4] Personal communication, J. Phillips, DMHC, 2016, and J. Figueroa, CDI, February 2013.

Figure 1. CA Health Insurance and SB 1034



*Such as enrollees in Medicare or self-insured products
Source: California Health Benefit Review Program, 2016

Studies have not separately examined its effects on improvement of functioning from its effects on maintenance of improvements in functioning. In light of the large body of evidence from studies with moderately strong research designs that behavioral health treatment improves functioning across multiple domains, it stands to reason that it could also be useful for maintaining functioning.

A preponderance of evidence from studies with moderately strong research designs suggests that parent/caregiver involvement in behavioral health treatment improves outcomes. However, evidence also suggests that behavioral health treatments are more effective than usual care regardless of the degree of parent/caregiver involvement.

There is a preponderance of evidence from studies with moderately strong research designs that behavioral health treatment can be delivered effectively in multiple settings.

There is insufficient evidence to assess the impact of prohibiting health plans from reviewing treatment plans more frequently than every six months.

There is a preponderance of evidence from studies with moderately strong research designs that behavioral health treatment provided by persons who are trained or supervised by experienced behavioral health treatment providers improves outcomes.

Benefit Coverage

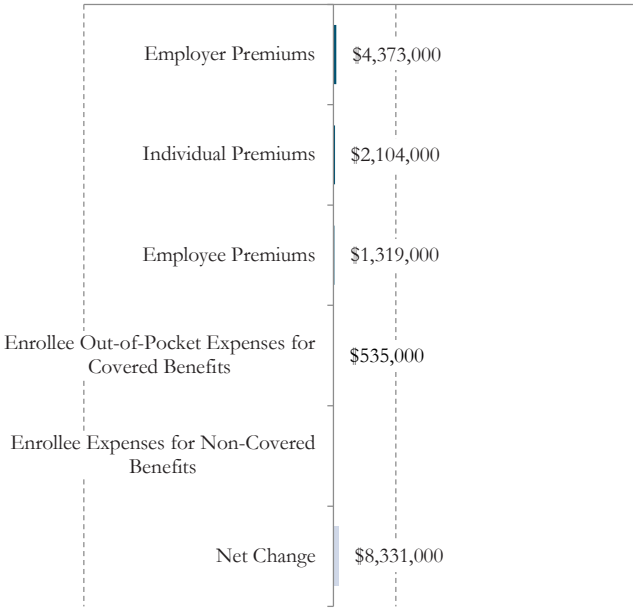
Of the varied requirements SB 1034 would place on DMHC-regulated plans and CDI-regulated insurers, CHBRP can only quantify the impacts of coverage for behavioral health treatment for ASD for maintenance. Currently 6% of enrollees with health insurance that would be subject to SB 1034 have such coverage; postmandate 100% would.

SB 1034's other coverage requirements might have an impact on enrollees' health insurance, but CHBRP is unable to quantify such effects.

Utilization and Expenditures

Post mandate, as a result of the coverage change for behavioral health treatment for ASD for maintenance, assuming that maintenance behavioral health treatment would occur for persons with ASD who use a moderate amount of behavioral health treatment (defined as $10,000–$30,000 per year), CHBRP would expect an initial year increase in utilization from approximately 44 to 47 annual hours per 1,000 enrollees with health insurance subject to SB 1034. Figure 2 displays the resulting change in expenditures.

Figure 2. Expenditure Impacts



Public Health

CHBRP found wide variance in individual outcomes from behavioral health treatment for ASD and insufficient literature from longitudinal studies to indicate that ongoing maintenance therapy is effective or necessary to preserve gains conferred by early intensive behavioral health treatment. Therefore, CHBRP concludes that the overall public health impact of SB 1034 is unknown. However, to the extent that maintenance therapy is comprised of less intensive applications of medically-effective behavioral health treatments, such as applied behavioral analysis (ABA), it would be reasonable to assume that, for some children and adolescents with a history of behavioral health treatment for ASD, maintenance therapy would reinforce and possibly enhance gains in intelligence quotient, adaptive social behaviors, and language skills.

Long-Term Impacts

Although CHBRP can make only directional statements, a number of aspects of SB 1034 could lead to greater increases in utilization of behavioral health treatment in the first year and in years following.

SB 1034's prohibition against denials based on parent/caregiver involvement may increase some enrollees' use of behavioral health treatment as a covered benefit. In addition, the elimination of restrictions on settings may increase use, particularly as public schools could now be covered settings. It is also possible that utilization of maintenance behavioral health treatment among the older population with ASD may increase. Although older people may not currently use behavioral health treatment for skill acquisition purposes, providers may develop an applicable treatment plan for maintenance of gains made through prior courses of behavioral health treatment among their older patients.

Although not quantifiable at this time, expenditure increases would correspond to utilization increases.

Although not quantifiable at this time, increases in utilization of could also be expected to result in some increase in some desirable health outcomes among some persons with ASD.