California Health Benefits Review Program

Analysis of California Senate Bill 399
Pervasive Developmental Disorder or Autism

A Report to the 2017–2018 California State Legislature April 20, 2017

Key Findings:

Analysis of California Senate Bill 399 Pervasive Developmental Disorder or Autism

Summary to the 2017–2018 California State Legislature, April 20, 2017

AT A GLANCE

Senate Bill 399 would alter a current law that requires coverage of behavioral health treatment (BHT) for autistic spectrum disorder (ASD). SB 399 would alter adequate provider network definitions, define BHT as inclusive of case management/supervision, prohibit denial of BHT coverage based on lack of parental/caregiver involvement or treatment setting, and limit plan/insurer review of treatments plans. In 2018, as many as 24 million enrollees in plans or policies regulated by DMHC or CDI will have health insurance that could be subject to SB 399.

1. **Benefit coverage.** Postmandate, 67% of enrollees could no longer be denied BHT coverage due to lack of parental involvement, and 55% could no longer be denied BHT coverage due to setting.
2. **Utilization.** Average annual hours of BHT per 1,000 enrollees with ASD would increase from 85.07 to 86.60 hours.
3. **Expenditures.** Average annual expenditures (premiums and enrollee expenses for covered and noncovered benefits) would increase by $4,684,000 (0.0032%).
4. **Medical effectiveness.** There is a *preponderance* of evidence that intensive BHT can improve cognitive functioning, language, social functioning, and adaptive behaviors. There is *insufficient* evidence to evaluate the impact of prohibiting denial of BHT claims due to a lack of parental/caregiver involvement. There is a preponderance of evidence that BHT can be delivered effectively in multiple settings, including schools.
5. **Public health.** The expected increase in BHT hours may improve some health outcomes, among some users.

Medi-Cal – The interaction of the bill, the current Health & Safety Code benefit mandate it would alter, and the Welfare & Institutions Code are unclear. It is possible that SB 399 could be relevant to the benefit coverage of Med-Cal beneficiaries enrolled in a DMHC-regulated plans (impacts addressed in bullets, above) as well as those associated with the Medi-Cal FFS program or COHS managed care.

CONTEXT

A current benefit mandate in California law,[1] one that SB 399 would alter, requires coverage of behavioral health treatment (BHT) for autistic spectrum disorder (ASD).[2] The current law:

- Requires plan/policy networks to include qualified autism service (QAS) providers, supervising/ employing QAS professionals, or QAS paraprofessionals, and provides definitions for all three; and
- Exempts from compliance the health insurance of enrollees associated with the California Public Employees' Retirement System (CalPERS) or Medi-Cal.

Although SB 399 would not alter the current mandate's explicit exemption from compliance for DMHC-regulated plans enrolling persons associated with CalPERS, the impact of changes to the current mandates and CalPERS' enrollees benefit coverage is complex. See further discussion regarding CalPERS on the following pages.

Although SB 399 would not alter the current mandate's explicit exemption from compliance for DMHC-regulated plans enrolling Medi-Cal beneficiaries, the impact of changes to the current mandate and Medi-Cal beneficiaries' benefit coverage is unclear. See further discussion regarding Medi-Cal on the following pages.

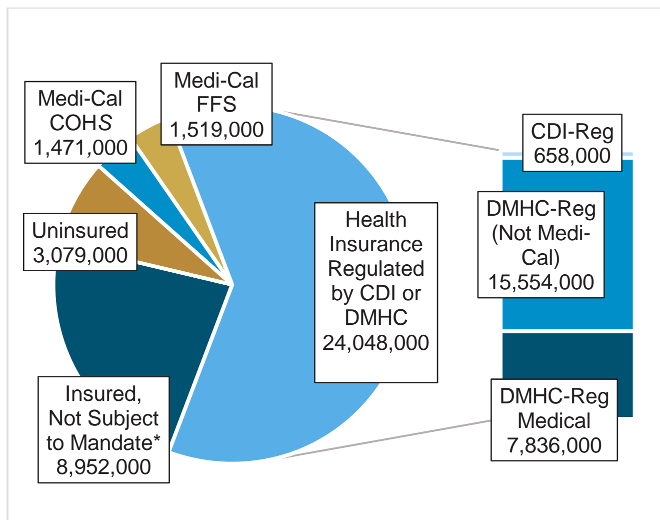
Bill Language

SB 399 would alter the current benefit mandate law (BHT for ASD) in a number of ways. SB 399 would:

[1] Health and Safety Code 1374.73 and Insurance Code 10144.51.
[2] Previously referred to as "pervasive developmental disorder / autism (PDD/A)," CHBRP now uses "ASD" to align with the most current clinical diagnostic designation in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and ICD-10 classification systems.

- Make a number of technical alterations to the definitions of QAS providers, QAS professionals, and QAS paraprofessionals;
- Include as aspects of BHT, clinical case management and case supervision;
- Prohibit denial of coverage for BHT based on:
    - Lack of parental involvement;
    - Setting, location, or time of treatment — though the bill indicates that coverage does not include services delivered by school personnel pursuant to a child's individualized education program (IEP); and
- Prohibit review of treatment plans more than once every 6 months, unless recommended by the QAS provider.

Figure 1. Health Insurance in CA and SB 399



Source: CHBRP, 2017.
Notes: *Includes Medicare beneficiaries and enrollees in self-funded products.

Benefit Coverage, Utilization, and Cost Impacts

CHBRP estimates no measurable change in benefit coverage among enrollees with health insurance that would be subject to SB 399 in regard to: 1) case management and care supervision; 2) limitation of review of treatment plans to no less than 6 months; and 3) definitions of qualified providers. Case management and care supervision are both currently included as covered aspects of BHT for ASD and 6-month review of treatment plans seems common, so CHBRP anticipates no measurable change in related benefit coverage. Provider networks are compliant with the current mandate, and though SB 399 would make possible change in provider networks, CHBRP does not anticipate measurable change within the first year of implementation.

Benefit Coverage

Currently, 33% of enrollees with health insurance that would be subject to SB 399 have coverage for BHT regardless of parent/caregiver involvement. Additionally, 45% of enrollees currently have coverage for BHT regardless of the setting for the BHT. Postmandate, 100% of enrollees would have SB 399–compliant benefit coverage.

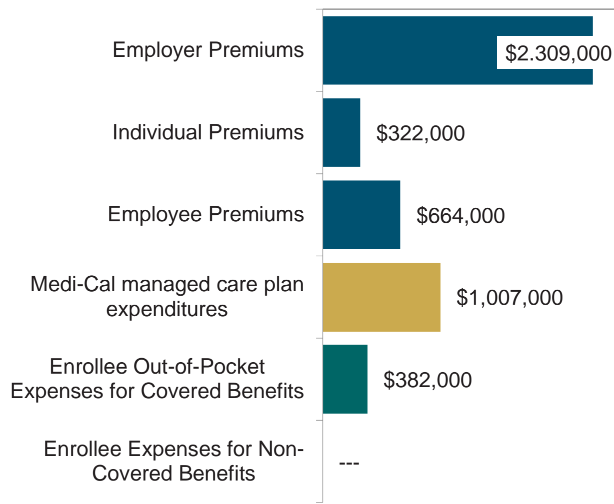
Utilization

Currently, the average annual hours of BHT per 1,000 enrollees is 85.07 hours. CHBRP projects an increase with the change in coverage for BHT that lifts two previous restrictions (denial based on lack of parental involvement and restrictions on setting for BHT). Because BHT is most commonly used by children with ASD who are under 8 years old, CHBRP projects that the increase in average annual number of hours of BHT will derive from an increase in the moderate users of BHT in that age range. Each provision will separately increase the overall usage hours of BHT among enrollees with ASD under 8 years old, Combined, this 6% increase will raise the overall average annual hours of BHT per 1,000 enrollees to 86.60 hours.

Expenditures

As noted in Figure 2, SB 399 would increase total net annual expenditures (premiums and enrollee expenses for covered and noncovered benefits) would increase by $4,684,000 (0.0032%) for enrollees with DMHC-regulated plans and CDI-regulated policies.

Figure 2. Expenditure Impacts of SB 399



Source: CHBRP, 2017.

Medi-Cal

Although SB 399 would not alter the current benefit mandate's explicit exemption from compliance for DMHC-regulated plans enrolling Medi-Cal beneficiaries, the interaction of the current mandate with the Welfare and Institutions Code is unclear. The Welfare and Institutions Code references the current mandate as the source of the definition of BHT for ASD. Therefore, changes to the current mandate could impact the benefit coverage of the Medi-Cal beneficiaries enrolled in DMHC-regulated plans as well as the Medi-Cal beneficiaries enrolled in either County Organized Health System (COHS) managed care or attached to the fee-for-service (FFS) program. For this analysis, CHBRP has included potential impacts on related to Medi-Cal beneficiaries. In addition to the expected increase of $1,007,000 in premiums CHBRP is estimating for the 7.8 million Medi-Cal beneficiaries enrolled in DMHC-regulated plans (a figure that represents a 0.0036% increase in premiums), it seems reasonable to assume that a population proportional increase of $89,000 would occur for the 1.5 million beneficiaries enrolled in COHS managed care. It seems likely that a similar impact would occur for the 1.5 million beneficiaries with health insurance through the FFS program (though the exact amount is unknown).

CalPERS

Although SB 399 would not alter the current benefit mandate's explicit exemption for DMHC-regulated plans regarding the benefit coverage of enrollees associated with CalPERS, the interaction of the current benefit mandate, California's separate Mental Health Parity benefit mandate,[3] and case law[4] are complex. For this analysis, CHBRP assumed that alterations to the current mandate would impact the benefit coverage of the 884,000 CalPERS enrollees in DMHC-plans.[5] CHBRP estimates that SB 399 could increase CalPERS premiums by $166,000 in the first year postmandate.

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of SB 399.

Medical Effectiveness

There is a *preponderance* of evidence that intensive behavioral health therapies are effective in improving outcomes including cognitive functioning, language, social functioning, and adaptive behaviors.

There is *limited* evidence that low-intensity behavioral health therapies are more effective in improving outcomes than usual care.

There is a *preponderance* of evidence that behavioral health therapies delivered by persons with training similar to QAS professionals and paraprofessionals, as well as a variety of other specialized and nonspecialist types of personnel, are effective when carried out under the training and supervision of a QAS provider.

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[3] Health and Safety Code 1374.72 and Insurance Code10144.5.
[4] Consumer Watchdog v. DMHC (2014).
[5] Of the increase in CalPERS employer expenditures, about 56.7% would be state expenditures for CalPERS members who are state employees or their dependents. It should be noted, however, that should CalPERS choose to make similar adjustments for consistency to the benefit coverage of enrollees associated with CalPERS' self-insured products, the fiscal impact on CalPERS could be greater.

There is *limited* evidence that the inclusion of clinical management and case supervision in BHT can improve outcomes such as intellectual ability, learning objectives, and overall treatment fidelity.

There is *insufficient* evidence to assess the impact of reviewing treatment plans no more frequently than every 6 months.

Parents are often trained to help generalize skills in the home and other settings, it stands to reason that parent/caregiver involvement in a child's treatment would equate to more overall BHT for the child, and thus greater improvements. Yet, there is *insufficient* evidence to evaluate the impact of prohibiting denial of BHT claims due to a lack of parental/caregiver involvement.

There is a *preponderance* of evidence that BHT can be delivered effectively in multiple settings, including schools.

Public Health

CHBRP projects that the 14,000 enrollees with ASD who already use BHT would increase their utilization by an *average* of 7.8 hours per year per BHT user in 2018. Based on the evidence, CHBRP finds that such an increase would not likely have a public health impact in the first year, postmandate. However, the increase in BHT hours may improve BHT outcomes such as intelligence quotient (IQ), language skills, socialization, and adaptive behaviors on an individual basis for some persons with ASD.

Long-Term Impacts

After the increase in utilization in the first 12 months, there is no indication in the research literature that the trends will change much over time. CHBRP, therefore, does not estimate any change in long-term impacts in utilization, because the rate of using BHT will also remain generally consistent over time.

Over the long term, the first-year cost increase findings would apply annually thereafter. However, the research literature has shown that BHT in children with autism improves their overall health and functioning over time, including gains made for adolescents. Therefore, it is likely that gains in BHT in younger children with ASD will result in overall lower health care costs over their lifetimes, although this cannot be quantified.

Because more BHT is generally associated with better outcomes, it stands to reason that long-term outcomes of cognitive functioning, language, social functioning, and adaptive behaviors may be improved, on an individual basis, for those enrollees who make use of additional BHT hours due to the removal of alternative setting and parent participation barriers; however, CHBRP projects no public health impact in the long term due to the marginal increase in new hours of BHT per year.

Essential Health Benefits and the Affordable Care Act

For two reasons, SB 399 would not trigger financial costs to the state for exceeding essential health benefits (EHBs). First, SB 399 alters the terms and conditions of an existing benefit mandate, but does not require an additional benefit to be covered. Second, the current law that SB 399 would alter expressly indicates that it ceases to function if it exceeds EHBs, and SB 399 does not eliminate this clause of the current law.