Legislative Analysis

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AUTISM: MANDATE INSURANCE BENEFITS & PROVIDE REIMBURSEMENT TO INSURERS

Senate Bill 414 (Substitute H-3)
Sponsor: Sen. Mike Green

Senate Bill 415 (Substitute H-3)
Sponsor: Sen. Tupac A. Hunter

Senate Bill 981 (Substitute H-2)
Sponsor: Sen. Randy Richardville

House Committee: Families, Children, and Seniors
Senate Committee: Health Policy

Revised First Analysis (3-28-12)

BRIEF SUMMARY: The bills would do the following:

- Require group and individual health plans to cover services for autism spectrum disorders (ASD) in a manner similar to physical illnesses.
- Allow health plans to limit coverage for ASD treatment to a yearly maximum based on age, and limit coverage to children through 18 years of age and younger.
- Allow insurers to request, among other things, a review of ASD treatment.
- Provide a limited exemption for qualified health plans offered under the federal Patient Protection and Affordable Care Act.
- Create the Autism Coverage Incentive Act and the Autism Coverage Fund.
- Establish the Autism Coverage Incentive Program, under which insurance carriers could seek reimbursement from the Fund for expenses incurred in providing coverage for ASD.
- Define terms.

The bills are all tie-barred, meaning none could take effect unless all are enacted.

FISCAL IMPACT: Generally, health insurance mandates increase the cost (i.e. premiums) for health insurance customers, although the exact increase of any given mandate is unknown. If the insurance mandate for autism coverage results in increased treatment for individuals with an autism spectrum disorder, which is likely, then state costs in providing services to those afflicted may be reduced. It is difficult to estimate the magnitude, if any, of such savings. Also, it is not known if annual appropriations would be sufficient to cover the anticipated additional administrative expenses of the Department of Licensing and Regulatory Affairs. For a more complete discussion, see ***Fiscal Information***, later in the analysis (Page 8).

THE APPARENT PROBLEM:

Autism is a complex neurological disorder that affects an individual's ability to communicate and develop social relationships. Symptoms vary greatly from person to person and range from mild to profound impairment. Autism spectrum disorders (ASD), which include Asperger's syndrome, occur in all racial and ethnic groups and affect rich and poor. However, the disorder strikes boys four to five times as often as girls.

Once believed to be rare, a new study published in the journal *Pediatrics* October 5, 2009, found 1 in 91 children are now being diagnosed with ASD. The Centers for Disease Control and Prevention currently lists the prevalence rate for diagnosis at one in 80 or one in 240 children, with an average of one in 110 children in the United States.
No known cause has been discovered, though the condition is believed to have a genetic link. There is no cure for autism disorders. Some researchers believe there may also be environmental factors. Regardless of the cause, many children, however, benefit from early interventions. Children who receive appropriate treatment can improve greatly, if not completely. For instance, almost half recover "typical" function, 40 percent make significant improvement, with only about 13 percent of those receiving treatment making little to no progress.

The problem is that far fewer individuals diagnosed with ASD actually receive services. The primary reason for this is that early intensive behavioral intervention therapies, such as Applied Behavior Analysis (ABA) therapy, can cost tens of thousands of dollars a year. Many health insurance policies exclude coverage for ABA and other autism-related services, even though some of the same services (e.g., physical and occupational therapy) are covered services if the individual does not have an autism diagnosis.

In 2008, a study conducted by Easter Seals revealed that 1.5 million Americans have an autism spectrum disorder. Twenty percent (about 300,000) of those were 22 years of age or older at the time of the study. Alarmingly, that means 80 percent (about 1.2 million) were younger than 22 years old. If these persons do not receive appropriate early interventions, they are more likely to remain unemployable, have high medical costs for other physical conditions, experience depression, and have a lifelong reliance on public assistance.

Some feel that since one of every 110 children born this year, and in each of the years to come, are likely to be diagnosed with ASD, the need for greater access to evidence-based therapies becomes clearer. If appropriate treatment means that 87 percent of diagnosed individuals will need no (or limited) public support services at a future time, then costs to society over an individual's lifetime can be greatly mitigated, if not avoided.

According to advocates, an effective way to increase access to appropriate treatment interventions would be to require health plans to provide coverage for evidence-based therapies. Several models, and the experience of some states that have already enacted similar laws, find that mandating insurance coverage for autism-related therapies has a minimal impact on the rates for insurance premiums. To date, 29 states have enacted some form of autism insurance coverage, and legislation is pending in 10 others.

Thus, legislation has been offered that would require individual and employer-sponsored health plans to provide coverage for autism related services.

THE CONTENT OF THE BILLS:

Senate Bills 414 and 415, which are almost identical, would amend the insurance laws to (with some exceptions) require health insurers to provide coverage for the diagnosis and treatment of autism spectrum disorders.

Applicability. The bills apply to group or individual certificates, policies, and contracts delivered, executed, issued, amended, adjusted or renewed in the state beginning 180 days after the bills' effective dates. Senate Bill 415 would also apply to certificates delivered, renewed, etc. outside the state if covering Michigan residents. [Generally speaking, the insurance mandates do not apply to self-funded plans or other plans administered under the federal ERISA law.]

Coverage. There would be no limits on the number of visits a member, insured, or enrollee (hereinafter *insured)* could use for treatment of autism spectrum disorders covered under the bills. Coverage could not be subject to dollar limits, copays, deductibles, or coinsurance provisions that do not apply to physical illness generally. However, coverage for ASD treatment could be limited to an insured through age 18. Moreover, an insurer could limit ASD treatment to an annual benefit maximum as follows: $50,000 a year for an insured through 6 years old; $40,000 for an insured from 7 years old through 12 years old; or $30,000 for an insured from 13 years old through 18 years old.

An insurer would not be required to provide ASD coverage to an insured under more than one of its policies, certificates, or contracts. If an insured was covered under more than one plan, the benefits provided would be subject to the limits specified above when coordinating benefits. In addition, the bills would not require prescription drugs and related services to be covered unless the insured was covered by a prescription drug plan.

The bills stipulate that these benefits cannot be construed as limiting benefits otherwise available to an insured under a certificate.

An insured would have to utilize evidence-based care and managed care cost-containment practices under the insurer's procedures as long as that care and the procedures are consistent with the bills' provisions. Coverage for ASD services could also be subject to other general exclusions and limitations of the certificate or policy including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, and utilization review of health care services such as review of medical necessity, case management, and other managed care provisions.

Under Senate Bill 415, the autism spectrum disorders benefits would not be available to a short-term or one-time limited duration policy or certificate of no longer than six months issued by a commercial insurer or HMO under provisions of the Insurance Code. Further, a commercial insurer or HMO could not terminate coverage or refuse to deliver, execute, issue, amend, or renew coverage solely because an individual was diagnosed with, or had received treatment for, an autism spectrum disorder.

<u>Review of services</u>. If an insured is receiving treatment for an ASD, an insurer <u>could</u>, as a condition to providing the coverage, do all of the following:

- Require a review of that treatment consistent with current protocols and require a treatment plan. The insurer would bear the cost of the review.
- Request the results of the autism diagnostic observation schedule used in the diagnosis of an ASD for that insured and request that the schedule be performed on that insured not more frequently than once every three years. "Autism diagnostic observation schedule" would mean the protocol available through Western Psychological Services (a publisher of assessments, books, and therapy tools) for diagnosing and assessing ASD or any other standardized diagnostic measure for ASD approved by the commissioner of the Office of Financial and Insurance Regulation (OFIR), if the measure is recognized by the health care industry and is an evidence-based diagnostic tool.
- Request that an annual development evaluation be conducted and the results of the evaluation be submitted to the insurer.

<u>Qualified health plans</u>. Beginning January 1, 2014, a qualified health plan offered through an American Health Benefit Exchange established in the state under provisions of the federal Patient Protection and Affordable Care Act could not be required to provide coverage under the bills to the extent the coverage exceeded coverage included in the essential health benefits as required under the federal act or any regulations promulgated under it.

<u>Definitions</u>. Among the many terms defined by the bills are the following:

"Applied behavior analysis" would be defined to mean the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

"Autism spectrum disorders" would mean any of the following pervasive developmental disorders as defined by the Diagnostic and Statistical Manual: autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified.

"Behavior health treatment" would mean evidence-based counseling and treatment programs, including ABA, that meet both of the following requirements:

- are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and,
- are provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

"Diagnosis of autism spectrum disorders" would mean assessments, evaluations, or tests performed by a licensed physician or psychologist to diagnose whether an individual has one of the autism spectrum disorders.

"Diagnostic and Statistical Manual" or "DSM" would mean the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychological Association or other manual that contains common language and standard criteria for the classification of mental disorders and that is approved by the OFIR commissioner.

"Treatment of autism spectrum disorder" would mean evidence-based treatment that included the following care prescribed or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed physician or psychologist who determined the care to be medically necessary: behavioral health treatment; pharmacy care; psychiatric care; psychological care; and therapeutic care. These terms are defined in the bills, as well.

"Treatment plan" would mean a written comprehensive, and individualized intervention plan that incorporates specific treatment goals and objectives and that is developed by a board certified or licensed provider who has the appropriate credentials and who is operating within his or her scope of practice, when the treatment of an ASD is first prescribed or ordered by a licensed physician or licensed psychologist as described in the definition of "treatment of autism spectrum disorders".

Senate Bill 414 would add a new section to the Nonprofit Health Care Corporation Reform Act (MCL 550.1416e), which regulates Blue Cross Blue Shield of Michigan, to apply to group or individual health plans.

Senate Bill 415 would add a new section to the Insurance Code (MCL 500.3406s), which regulates commercial insurers and health maintenance organizations (HMOs), to apply to expense-incurred hospital, medical, or surgical group or individual policies or certificates and HMO contracts.

Senate Bill 981 would create the Autism Coverage Reimbursement Act to encourage insurers to provide autism coverage. Not later than 120 days after the bill's effective date, the Department of Licensing and Regulatory Affairs (LARA) would have to create and operate an autism coverage reimbursement program to encourage insurance carriers to provide coverage for the diagnosis and treatment of autism spectrum disorders (ASD) and -- to the extent coverage is required under the provisions of Senate Bills 414 and 415 -- offset any additional costs that may be incurred as a result of the mandate.

Autism Coverage Reimbursement Program. The Program would reimburse insurance carriers and third party administrators (TPAs) in an amount equal to the amount of paid claims that are paid 180 days after the bill's effective date by the carrier or TPA for the diagnosis of autism spectrum disorders or ASD treatments. On a department-approved form, a carrier or TPA would have to apply for approval of funding associated with paid claims for the diagnosis and treatment of ASD. The application would include the results from a completed autism diagnostic observation schedule or the results from any other annual development evaluation as well as documentation verifying the paid claims for which reimbursement was being sought. The terms "carrier" and "paid claims" are defined in the bill. "Autism diagnostic observation schedule" is defined in Senate Bills 414 and 415.

In making a determination of whether a claim was reimbursable, LARA could review whether the treatment provided was consistent with current protocols and cost-containment practices as described in Senate Bills 414 and 415. Applications would be considered in the order received and approved or denied within 30 days of receipt of the application.

To the extent there is a cap on covered services under Senate Bills 414 and 415, LARA could not approve more than the mandated amount to any carrier or TPA seeking reimbursement from the Program. If a TPA received any funding under the Program, the TPA would have to apply the funding to the benefit of the carrier covering the claim upon which the funding was received.

Program standards, guidelines, templates, and any other forms used by LARA to implement the Program would have to be published and available on LARA's website.

Autism Coverage Fund. The Fund would be created within the state treasury and the state treasurer would direct the fund's investments, but LARA would be the Fund administrator for auditing purposes. Money could be expended from the Fund by LARA only upon appropriation and only for the purpose of creating, operating, and funding the Autism Coverage Reimbursement Program. Money in the Fund at the close of a fiscal year would remain in the Fund and not lapse to the General Fund.

Carriers and TPAs would be reimbursed from the fund in the order in which the applications were approved. Reimbursement for a claim would not be made if there were insufficient money in the Fund; however, a claim that was approved but not reimbursed could be paid if revenue in the Fund became available.

LARA would have to develop and implement a process as specified in the bill to notify carriers, TPAs, and the Legislature that funds in the Program may be insufficient to cover future claims when the department reasonably believes that funds in the Program will be insufficient to pay claims within 60 days.

Duties of LARA. In addition to what has already been described, LARA would have to develop the application, approval, and compliance process necessary to operate and manage the Program. LARA would also have to develop and implement the use of an application form to be used by carriers and TPAs seeking reimbursement for ASD coverage. Not more than one percent of the annual appropriation made to the Fund could be used by LARA for administration of the Program. LARA could not exercise its authority under the act until the Legislature appropriated sufficient funds to cover the same.

Additionally, LARA would have to submit an annual report to the state budget director and the Senate and House of Representatives Standing Committees on Appropriations not later than April 1 that included, but was not limited to, the following information:

- Total number of applications received in the preceding calendar year.
- Number of applications approved and total amount of funding awarded under the Program in the immediately preceding calendar year.
- Amount of administrative costs used to administer the program in the immediately preceding calendar year.

HOUSE COMMITTEE ACTION:

Significant changes to Senate Bills 414 and 415 include extending coverage for ASD services to 18 year olds and capping annual maximums based on the age of the child receiving the services. Revisions to Senate Bill 981 include changing the name of the act to the Autism Coverage Reimbursement Act (instead of Autism Coverage Incentive Act).

BACKGROUND INFORMATION:

Senate Bills 414 and 415 are similar to legislation passed by House of Representatives in the 2009-2010 legislative session (House Bills 4183 and 4476).

Causes of autism

There is no known cause of autism spectrum disorder (ASD), though researchers have long suspected that genes play a role. Recently, researchers discovered a set of gene variants that may be responsible for about 12 to 18 percent of autism cases, according to a study published in an April 28, 2009, issue of the journal *Nature*.

Other environmental factors, such as exposure to chemicals or toxins while in the womb or in early childhood, the mother's diet while pregnant, or the age of the parents when the child was born may also be connected to the increasing rates of autism. Recently, scientists have begun researching a possible link between Vitamin D deficiency and autism.

Vaccines

For several years, much media attention has focused on childhood vaccinations containing thimerosal, a mercury-rich preservative. However, California researchers reported in 2008 that autism rates continued to rise during a 12-year study period (1995 to 2007), even after thimerosal was eliminated from childhood vaccinations in 2001. If thimerosal contributed to the risk of developing ASD, autism rates should have dropped between 2004 and 2007.

The Office of Special Masters of the U.S. Court of Federal Claims, commonly known as the vaccine court, oversees claims for compensation due to vaccine-related injuries. Currently, more than 5,000 cases have been filed with the federal vaccine court claiming that vaccines containing thimerosal and/or the mumps/measles/rubella (MMR) vaccine caused their children's autism. In February 2009, the vaccine court found no evidence in three test cases that vaccines containing thimerosal or the MMR vaccine caused autism. In reaching the decisions in the three cases, the vaccine court reviewed thousands of pages of medical records and scientific literature, as well as testimony from medical experts. In March of 2010, the vaccine court ruled that in the three test cases, thimerosal does not cause autism; this finding supports the consensus of the broader scientific community.

Moreover, the British journal *The Lancet*, which published the article by Dr. Andrew Wakefield in 1998 that first suggested vaccines could cause autism, retracted that research paper in February, 2010. According to an article entitled "Journal Retracts 1998 Paper Linking Autism to Vaccines" published in *The New York Times*, Feb. 3, 2010, "an investigation by a British journalist found financial and scientific conflicts that Dr. Wakefield did not reveal in his paper." For example, part of his research was "paid by lawyers for parents seeking to sue vaccine makers for damages." In addition, the British General Medical Council determined that Dr. Wakefield had subjected child test subjects to unneeded invasive tests, such as lumbar punctures and colonoscopies, for which he had not received ethical approval.

(The vaccine court's rejection of the three test cases should not be confused with the HHS Division of Vaccine Injury Compensation conclusion in 2008 that compensation was appropriate in a case involving a child who had been developing normally but – after receiving multiple vaccines containing thimerosal and the MMR vaccine – was eventually diagnosed with a brain disease with features consistent with ASD. Compensation in that case was awarded based on a finding that the girl had an underlying mitochondrial disorder that, when aggravated by one or more of the vaccines, resulted in regressive encephalopathy with features of ASD.)

FISCAL INFORMATION:

Senate Bills 414 and 415 would have a fiscal impact on state and local budgets to the extent that the bills could be expected to increase health insurance premiums since state and local units of government (including public schools) are the largest purchasers of health insurance in Michigan. However, many state and local public employees work for entities that self-insure and are not affected by Senate Bills 414 and 415.

Generally, health insurance mandates increase the cost (i.e. premiums) for health insurance customers, although the exact increase of any given mandate is unknown. The Council for Affordable Health Insurance, an industry-sponsored research and advocacy association, estimates the increase of premiums in states with autism mandates to be about 1%, with a caveat that the figure may be rising to between 1% and 3%. Alternatively, Autism Speaks, an autism treatment advocacy organization, underwrote a study which estimates the increase in health insurance premiums in Michigan would be between .24% and .5% if Senate Bills 414 and 415 were enacted.

Additionally, if the insurance mandate for autism coverage results in increased treatment for individuals diagnosed with an autism spectrum disorder, which is likely, then costs incurred by the state in providing social services to those afflicted with developmental disorders (including autism spectrum disorders) may be reduced. However, it is extraordinarily difficult to estimate the magnitude, if any, of this potential, second-order, cost savings.

Potential increases in health insurance premiums caused by the autism mandates in Senate Bills 414 and 415 for both public and private insurance purchasers could be (but not required under law to be) mitigated to the extent that reimbursements from the Autism Coverage Fund are paid by LARA under the Autism Coverage Reimbursement Program to carriers providing coverage for autism spectrum disorders. It is not known to what extent reimbursements would be made by LARA since Senate Bill 981 does not specify the level of money appropriated to the fund.

Senate Bill 981 would have a fiscal impact on the Department of Licensing and Regulatory Affairs (LARA) which would administer the Autism Coverage Reimbursement Program. LARA estimates that it will cost between $500,000 and $1,000,000 to administer the program. Senate Bill 981 stipulates that not more than 1% of the annual appropriation to the fund could be used for administrative expenses. However, Senate Bill 981 does not specify how much money would be appropriated for the Autism Coverage Fund or what the source of the appropriation would be, so it is unknown whether 1% of the annual appropriation would be sufficient to cover administrative expenses incurred by LARA.

The Governor's FY 2012-13 Executive Budget Recommendation for the Department of Community Health includes an increase of $34.1 million Gross ($10.1 million GF/GP) to fund autism spectrum disorder treatment for the Medicaid and MIChild eligible children under the age of six. (An informal request from the State Budget Office is that eligibility be increased to age 18). The Recommendation included the creation of a new appropriation line "Autism Services" authorized at $20.5 million Gross ($6.9 million GF/GP) and adds funding to the MIChild appropriation line of $13.5 Gross ($3.2 million GF/GP). The Governor's "Issue Paper" on Community Health autism coverage indicates that approximately 2,000 kids under the age of six would meet the criteria that would be established in Medicaid and MIChild policy. This would equate to an average expenditure of $17,000 per child. Approval from the Centers for Medicare and Medicaid Services would be required for this service expansion.

ARGUMENTS:

For:

The facts are clear and simple: autism is the fastest growing developmental disability worldwide. In the U.S., one in 110 babies born today will be diagnosed with autism spectrum disorder (ASD). Tomorrow, another one in 110 babies born will be diagnosed with ASD, and the day after that, and the day after that. If these children do not receive early and appropriate services, most are likely to need long-term or lifelong services, with many of those needing lifelong public assistance. By some estimates, the cost of caring for a person with autism over his or her lifespan is over $3 million. Already there are over 1.5 million people diagnosed with ASD in the U.S.; over three-fourths of these people are under 22 years of age. This likely will present a huge challenge, if not a crushing burden, on a public health care system already teetering on collapse due to high expenditures for obesity-related illnesses and the number of boomers reaching Medicare age.

However, with early intensive therapies and treatments, about 87 percent of children with an early diagnosis could attain typical functioning, alleviating the need for long-term or lifelong services. Thus, proponents say this really is a case of "pay now or pay later", with the upfront costs of the legislation being far less than what is likely down the road if the bills are not enacted.

Twenty-nine other states mandate autism coverage and legislation is pending in ten others. It is time for Michigan to adopt similar legislation.

Response:

Autism is just one of many brain disorders. And, many individuals with ASD also have one or more diagnosable mental illnesses such as bipolar disorder. If an individual's comorbid mental illnesses are not treated effectively, little progress may be made in treating the ASD. For years, advocates have lobbied for fair and equal treatment under insurance laws for mental illness as for physical illness. Far too many insurance policies exclude mental health treatment as a covered benefit or severely limit annual visits, in addition to placing low lifetime caps on benefits that are inadequate for chronic, lifelong illnesses such as schizophrenia.

In addition, individuals with untreated mental illnesses tend to take poor care of themselves, ending up presenting with serious and advanced diseases that are costly to treat. Studies show that costs to provide physical health treatment to these populations dramatically decrease when they receive appropriate and timely mental health and/or substance abuse treatment. Moreover, persons with a mental illness are less likely to break laws and end up in jail or prison if they receive needed therapies and treatments, thus saving taxpayers additional corrections-related costs. Many states already provide mental health parity and are experiencing dramatic costs savings in their physical health delivery systems. Several states have enacted legislation that provides for mental health parity as well as for ASD. Legislation should not carve out one brain disorder for insurance coverage and ignore others. Therefore, the bills should be amended to include parity for all brain disorders.

Rebuttal:

Under federal law, mental health parity is already required for employer-sponsored health plans for businesses with more than 50 employees.

For:

The legislation is needed for the following reasons:

- Due to exclusions often contained in insurance policies, some estimate that as many as two-thirds of children with autism do not receive needed therapies.

- Without insurance parity, many families are being driven into bankruptcy, home foreclosures, unemployment or loss of promotions (due to the demands of caring for a child with autism).

- Children with autism grow into adults with autism. Though there is no "cure", early and appropriate treatment mitigates the impact on an individual and society.
- Though schools provide some services for children with ASD, they are not equipped to provide all of the intensive services, such as 20 hours or more a week of speech therapy, needed for some individuals.

- Many states (29) already mandate coverage for ASD-related services and have not experienced the surging premium costs touted by opponents.

- Failure to enact the legislation will contribute to Michigan's "brain drain" as leading autism specialists and researchers leave the state or refuse to take positions in the state in favor of jobs in states with insurance parity. Graduates from prestigious autism treatment programs at Western Michigan University and Eastern Michigan University are forced to leave the state to find employment.

- Providing insurance parity will alleviate the stress experienced by parents, thus improving the parent's health, decreasing medical costs for the parents, and enabling them to be more productive at work.

- By some estimates, 90 percent of parents with autistic children are divorced. Appropriate and timely treatment, by mitigating the impact of the child's disorder on the family, will in turn lessen the types of stressors that damage marital relationships.

Against:

Not all would agree that the bills make sense; some oppose insurance mandates in general, saying that businesses should be free to develop the products wanted by their customers – in this case, employers. They also cite independent studies that say higher increases in premium rates are likely if insurers are required to pay for autism treatments. Such increases in premium costs could be detrimental to business owners, especially small businesses, who already struggle to stay alive in the current economic climate. The concern is that more employers could choose to drop health insurance altogether for their employees if the bills were enacted.

Response:

Requiring health insurers to include autism-related services as covered benefits in their products will only add a few dollars to the annual cost of a family premium. Data shows the increase at roughly .79 percent for a family premium; based on a policy premium of $10,000, that is only an additional $79 for a year, or $6.58 a month. Compare $79 a year to the lifetime of productivity by individuals who received appropriate treatment and that the drain on public assistance programs will be decreased, and the need and the logic and the humanity of the legislation becomes very clear and simple, indeed.

Against:

The legislation should not be adopted for the following reasons:

- Some insurance companies already offer products that cover services for an ASD diagnosis, including intensive behavioral therapies. A more appropriate response is to allow insurance companies to develop products that employers will want to purchase for their employees.

- The legislation would only benefit a few with the costs being shouldered by a few employer-sponsored plans—primarily small businesses. The legislation would not apply to people covered under Medicare, Medicaid, state health plans, or other self-insured employer plans that are subject to federal ERISA laws.

Response:

Many self-funded plans have elected to follow their state's mandated coverage for autism-related services. For example, Microsoft, Mayo Clinic, Home Depot, Intel, IBM, and Ohio State University are just a few employers with self-funded plans that now include coverage for ASD services. In addition, the Medicaid and MIChild budget for fiscal year 2012-2013 would include an appropriation to provide ASD services to children meeting eligibility criteria.

POSITIONS:

The following testified, submitted written testimony, or indicated support for the bills:

Henry Ford Health System
Michigan Health and Hospital Association
Michigan State Medical Society
Hope Network
Autism Speaks
Autism Alliance of Michigan
DTE Energy
Beaumont Health System
Noah's Arc
Western Michigan University
Eastern Michigan University
AIM
Department of Licensing and Regulatory Affairs (LARA)

The following testified, submitted written testimony, or indicated support of the concept of the bills, support the bills with mental health parity amendments, or support autism coverage but oppose the bills without mental health parity:

Michigan Chapter National Association of Social Workers

Mental Health Association in Michigan
National Alliance on Mental Illness (NAOMI)
Michigan Partners for Parity
CHADD (Children and Adults with Attention Deficit/Hyperactivity Disorder)
Michigan Psychological Association
Association for Children's Mental Health (ACMH)
Elder Law and Disability Rights Section of the State Bar of Michigan
Michigan Association of School Psychologists
Michigan Association of School Social Workers
School-Community Health Alliance of Michigan

The following testified, submitted written testimony, or indicated opposition to the bills:

Small Business Association of Michigan
Economic Alliance of Michigan
Michigan Chamber of Commerce
Michigan AFL-CIO
United Auto Workers
Blue Cross Blue Shield of Michigan
Michigan Association of Health Plans
General Motors
NFIB-Michigan
Mid-Michigan Health
Michigan Manufacturers Association
Lenawee Community Mental Health Association

Legislative Analyst:	Susan Stutzky
Fiscal Analyst:	Paul Holland
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