Legislative Analysis

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AUTISM: MANDATE INSURANCE BENEFITS & PROVIDE REIMBURSEMENT TO INSURERS

Senate Bill 414 (Substitute H-1)
Sponsor: Sen. Mike Green

Senate Bill 415 (Substitute H-1)
Sponsor: Sen. Tupac A. Hunter

Senate Bill 981 (Substitute H-1)
Sponsor: Sen. Randy Richardville

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

Complete to 3-26-12

A SUMMARY OF PROPOSED HOUSE SUBSTITUTES FOR SENATE BILLS 414, 415, AND 981

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 17 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 tie-barred to each other.

Senate Bills 414 and 415, which are almost identical, would amend the insurance laws to 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 up to age 18. Moreover, an insurer could limit ASD treatment to an annual benefit maximum as follows: $50,000 a year for an insured less than 7 years old; $40,000 for an insured at least 7 years old but less than 13 years old; or $30,000 for an insured at least 13 years old but less than 18 years old.

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.

Review of services. If an insured is receiving treatment for an ASD, an insurer could, 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 scientific services 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, 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.

Qualified health plans. 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.

Definitions. 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 of Mental Disorders" (DSM) of the American Psychiatric Association: 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.

"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 Incentive 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 incentive program to encourage and provide incentives for 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 Incentive Program. The Program would reimburse insurance carriers and third party administrators (TPAs) in an amount equal to the amount of paid claims paid, after Senate Bills 414 and 415 took effect, 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 ABA 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 Incentive 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.

FISCAL IMPACT:

SB 981 would have a fiscal impact on the Department of Licensing and Regulatory Affairs (LARA), which would administer the Autism Coverage Incentive Program. LARA estimates that it will cost between $500,000 and $1,000,000 to administer the incentive program. SB 981 stipulates that not more than 1% of the annual appropriation to the fund could be used for administrative expenses. However, SB 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.

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