

Key Findings:

Analysis of California Senate Bill 163 Autism

Summary to the 2019-2020 California State Legislature, March 25, 2019



CONTEXT

AT A GLANCE

Senate Bill (SB) 163 would alter the current law that requires coverage of behavioral health treatment (BHT) for autistic spectrum disorder (ASD). SB 163 would expand the definition of BHT to include treatment modalities based on developmental theory, would make technical changes to definitions related to network adequacy, would prohibit denial of coverage based on either lack of parental/caregiver involvement or treatment setting time, or location, and would end an exemption related to Medi-Cal. CHBRP estimates that of the 24.5 million Californians enrolled in state-regulated health insurance, all have insurance that would be subject to SB 163.

1. **Benefit coverage.** Postmandate, 66% of enrollees could no longer be denied BHT coverage due to lack of parental involvement and 63% could no longer be denied BHT coverage due to setting. In addition, all enrollees would gain coverage for BHT based on developmental theory.
2. **Utilization.** Average annual hours of BHT per 1,000 enrollees with ASD would increase from 127.0 to 129.1.
3. **Expenditures.** Average annual expenditures (premiums and enrollee expenses for covered and noncovered benefits) would increase by \$4,317,000 (0.0027%).
4. **Medical effectiveness.** There is evidence of effectiveness for BHT modalities based on behavioral theory, based on developmental theory, or based on both. There is evidence of effectiveness for BHT delivered in multiple settings. Although outcomes may improve with parent/caregiver involvement, there is evidence that BHT is effective when furnished only by providers.
5. **Public health.** Increases in BHT hours may improve outcomes for some persons with ASD.

Behavioral health treatment (BHT) for autistic spectrum disorder (ASD) is on a continuum — from modalities based on behavioral theory, like applied behavioral analysis (ABA)¹, to modalities based on developmental theory, like developmental social pragmatic model (DSPM). In the middle are modalities based on theory that is both behavioral and developmental, like naturalistic developmental behavioral interventions (NDBI).

A current California law² places requirements on plans and policies regulated by the California Department of Managed Care (DMHC) and the California Department of Insurance (CDI). The law:

- Requires coverage for BHT for ASD and specifies that BHT is inclusive of behavioral modalities, specifying those based on a behavioral theory, (ABA).
- Requires provider networks to include qualified autism service (QAS) providers supervising/employing QAS professionals or QAS paraprofessionals and provides definitions for all three.
- Exempts from compliance the health insurance of Medi-Cal beneficiaries enrolled in plans or policies regulated by DMHC.

Bill Language

SB 163 would alter the current law. SB 163 would:

- Expand the definition of BHT to include modalities based on developmental theory, such as those based on developmental social pragmatic model (DSPM).
- Make technical changes to the definitions of QAS providers, professionals, and paraprofessionals.

¹ Modalities based on ABA are often referred to as “ABA,” but each has its own name.² Health & Safety Code 1374.73 and Insurance Code 10144.51.

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- End the exemption related to Medi-Cal beneficiaries enrolled in DMHC-regulated plans.
- Prohibit denial of coverage for BHT based on:
 - Lack of parental involvement.
 - Setting, location, or time of treatment.

- There is *limited* evidence that Pivotal Response Training improves language and communication.

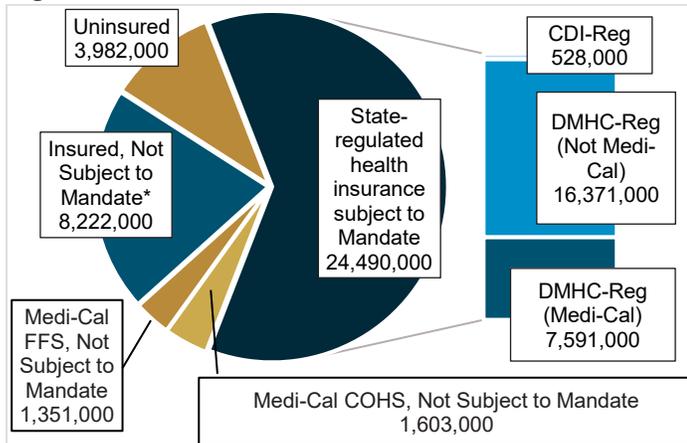
For modalities based on both behavioral and developmental theory (NDBI):

- There is a *preponderance* of evidence that Early Start Denver Model improves language.
- There is a *preponderance* of evidence that Social Skills Group therapy improves social behavior.
- There is *limited* evidence that Project ImPACT improves communication.

For modalities based on developmental theory (DSPM):

- There is a *preponderance* of evidence that DIR®/Floortime™ improves communication, engagement, and relationships.
- There is a *preponderance* of evidence that TEACCH improves adaptive behavior and motor skills.
- There is *limited* evidence that Relationship Developmental Intervention improves communication, social interaction, and academic placement.

Figure A. Health Insurance in CA and SB 163



Source: CHBRP, 2019

Notes: *includes Medicare beneficiaries and enrollees in self-funded products

Medical Effectiveness

Most studies of BHT are observational studies that compare a specific treatment modality to usual care. This makes it difficult to assess the relative effectiveness of modalities based on behavioral versus hybrid versus developmental theory.

More studies of BHT modalities based on behavioral theory have been published than studies of BHT based on developmental theory or hybrid theories. However, regardless of the theoretical framework underpinning a BHT modality, most studies are observational studies which limits the ability to determine whether changes in outcomes experienced by people with ASD are due to receipt of the BHT modality the study assesses versus other factors that may affect outcomes.

For the modalities based on behavioral theory (ABA):

- There is a *preponderance* of evidence that Discrete Trials Training improves intelligence quotient and adaptive behavior.

Although parent and caregiver involvement in BHT may result in greater improvements, BHT improves outcomes regardless of whether parents or caregivers are involved.

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

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 163 in regards to definitions of qualified providers. Provider networks are compliant with the current mandate. Although the bill's provisions could change provider networks due to the alterations in QAS definitions SB 163 would make, CHBRP does not anticipate measurable change within the first year of implementation.

Benefit Coverage

Currently, 100% of enrollees with health insurance that would be subject to SB 163 have coverage for modalities of BHT based on behavioral theory, 95% have coverage for hybrid modalities (behavioral and developmental), and 54% have coverage for modalities based on developmental theory. Postmandate, 100% of enrollees would have coverage for BHT that is compliant with SB 163.

Currently, 34% of enrollees with health insurance that would be subject to SB 163 have coverage for BHT that does not deny coverage for BHT based on lack of parental involvement. Additionally, 37% of enrollees currently have coverage for BHT regardless of the setting for the BHT. Postmandate, 100% of enrollees would have coverage for BHT that is compliant with SB 163.

Utilization

Currently, the average annual hours of BHT per 1,000 enrollees with ASD is 127.0.

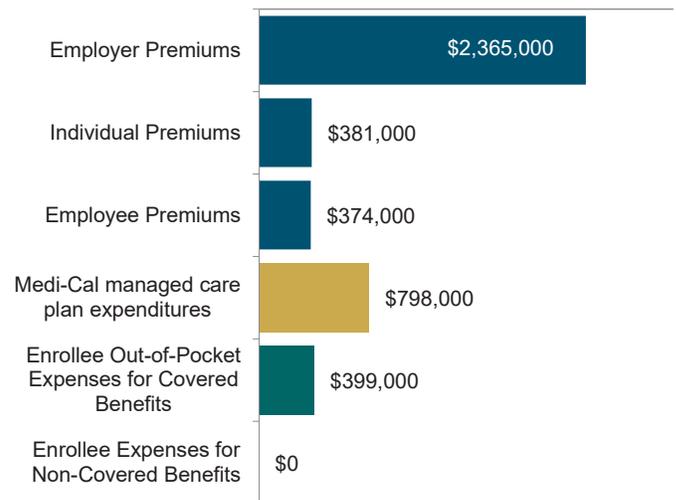
The change in the definition of BHT may alter the mix of used modalities, but is not expected to alter the total number of hours used.

However, CHBRP projects an increase in BHT utilization due to SB 163's prohibition of denials related to parent/caregiver involvement and denials related to treatment setting, time, or location. Since 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 (10-25 hours per week) in that age range. Each provision will separately increase the overall usage hours of BHT among enrollees with ASD under 8 years. Combined, they will raise the overall average annual hours of BHT per 1,000 enrollees with ASD to 129.1 hours.

Expenditures

As noted in Figure B, SB 163 would increase total net annual expenditures (premiums and enrollee expenses for covered and noncovered benefits) by \$4,317,000 (0.0027%) for enrollees with DMHC-regulated plans and CDI-regulated policies.

Figure B. Expenditure Impacts of SB 163



Source: CHBRP, 2019

Medi-Cal

SB 163 would end a current exemption and so require compliant coverage for Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

CalPERS

SB 163 would alter the benefit coverage of CalPERS enrollees in DMHC-regulated plans.

Number of Uninsured in California

As 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 163.

Public Health

Enrollees with ASD who already use BHT would increase their utilization by an *average* of 2.1 hours per year per BHT user in 2020. 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 small increase in utilization in the first 12 months, there is no indication in the research literature that the trends will change much over time. And the overall number of enrollees in DMHC-regulated plans or CDI-regulated policies using BHT with ASD is expected to remain generally constant over time. CHBRP therefore does not estimate any change in long-term impacts in utilization, as 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 the health outcome gains in BHT in younger children with ASD will result in overall lower health care costs over their lifetimes, although this cannot be quantified.

As 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 small increase in new hours of BHT per year (2.8 hours).

Essential Health Benefits and the Affordable Care Act

For two reasons, SB 163 would not trigger financial costs to the state for exceeding EHBs. First, SB 163 alters the terms and conditions of an existing benefit mandate law, but does not require an additional benefit to be covered. Second, the current law that SB 163 would alter expressly indicates that it ceases to function if it exceeds EHBs and SB 163 does not eliminate this clause of the current law. Thus, neither the current law nor the version SB 163 would create would function if deemed to exceed EHBs.