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Senate Bill 414 (Substitute S-3 as passed by the Senate)  
Senate Bill 415 (Substitute S-3 as passed by the Senate)  
Senate Bill 981 (Substitute S-1 as passed by the Senate)  
Sponsor: Senator Mike Green (S.B. 414)  
Senator Tupac A. Hunter (S.B. 415)  
Senator Randy Richardville (S.B. 981)  
Committee: Health Policy

Date Completed: 3-15-12

## **CONTENT**

**Senate Bills 414 (S-3) and 415 (S-3) would amend the Nonprofit Health Care Corporation Reform Act and the Insurance Code, respectively, to require a policy, certificate, or contract to provide coverage for the diagnosis and treatment of autism spectrum disorders (ASDs).**

**Senate Bill 981 (S-1) would create the "Autism Coverage Incentive Act" to require the Department of Licensing and Regulatory Affairs (LARA) to create and implement an autism coverage incentive program through which carriers and third-party administrators could seek reimbursement for paid claims for the diagnosis and treatment of ASDs. The bill also would do the following:**

- Create the "Autism Coverage Fund" to provide the reimbursement.
- Require LARA to submit annual reports to the State Budget Director and the Legislature on the funding awarded under the program and the program's administrative costs.
- Limit the amount of the annual appropriation to the Fund that could be used for administrative expenses to 1%.
- Specify a State policy to encourage autism coverage and a legislative intent to further this policy by providing annual appropriations.

All of the bills are tie-barred to each other. Senate Bills 414 (S-3) and 415 (S-3) would take effect on October 1, 2012.

### **Senate Bills 414 (S-3) and 415 (S-3)**

The bills would require a policy, certificate, or contract to provide coverage for the diagnosis and treatment of ASDs. Senate Bill 414 (S-3) would apply to a Blue Cross Blue Shield of Michigan (BCBSM) group or nongroup certificate. Senate Bill 415 (S-3) would apply to an expense-incurred hospital, medical, or surgical group or individual policy or certificate delivered, issued for delivery, or renewed in this State, as well as a health maintenance organization (HMO) group or individual contract.

The bills would prohibit an insurer, HMO, or BCBSM from doing any of the following:

- Limiting the number of visits a member, insured, or enrollee could use for treatment of ASDs covered under the bills.
- Denying or limiting coverage on the basis that it was educational or habilitative in nature.
- Subjecting autism coverage to dollar limits, copays, deductibles, or coinsurance provisions that did not apply to physical illness generally, except as provided for applied behavior analysis.

Coverage for applied behavior analysis could be subject to a maximum annual benefit of \$50,000 per covered insured, enrollee, or member, and could be limited to an individual up to age 18.

Senate Bill 415 (S-3) also would prohibit an insurer and an HMO from terminating coverage or refusing to deliver, execute, issue, amend, adjust, or renew coverage solely because an individual was diagnosed with, or had received treatment for, an ASD.

The bills provide that they would not limit benefits that were otherwise available to an individual under a certificate or policy.

If a member, insured, or enrollee were receiving treatment for an ASD, the bills would allow BCBSM, an insurer, or an HMO to request a review of that treatment consistent with current protocols and to require a treatment plan. The insurer, HMO, or BCBSM would have to bear the cost of obtaining the review, and would have to use evidence-based care and managed care cost-containment practices pursuant to its procedures as long as they were consistent with the bills.

("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 psychologist.)

Beginning January 1, 2014, a qualified health plan offered through an American health benefit exchange established in Michigan pursuant to the "Federal act" would not have to provide the required ASD coverage to the extent that it exceeded the essential health benefit requirements of the Federal act. ("Federal act" would mean the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act, and any regulations promulgated under those Acts.)

Senate Bill 415 (S-3) provides that it would not apply to a short-term or one-time limited duration policy or certificate of not longer than six months. (Under the Insurance Code, such policies generally provide coverage for 185 days or less, are

nonrenewable, do not cover any preexisting conditions, and are available with an immediate effective date without underwriting.)

The bills would define "autism spectrum disorders" as any of the following pervasive developmental disorders as defined by the "Diagnostic and Statistical Manual of Mental Disorders" of the American Psychiatric Association:

- Autistic disorder.
- Asperger's disorder.
- Pervasive developmental disorder not otherwise specified.

"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 ASDs. "Treatment of autism spectrum disorders" would mean evidence-based treatment that includes the following care prescribed or ordered for an individual diagnosed with one of the ASDs by a licensed physician or psychologist who determines the care to be medically necessary:

- Behavioral health treatment.
- Pharmacy care.
- Psychiatric care.
- Psychological care.
- Therapeutic care.

"Behavioral health treatment" would mean evidence-based counseling and treatment programs, including applied behavior analysis, that meet both of the following requirements:

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

"Applied behavior analysis" would 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 relationship between environment and behavior.

"Therapeutic care" would mean evidence-based services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or social worker.

### **Senate Bill 981 (S-1)**

#### Autism Coverage Incentive Program

The bill would require LARA to create and operate an autism coverage incentive program to encourage and provide incentives for carriers and third-party administrators to provide coverage for the diagnosis and treatment of ASDs, and to offset any additional costs that could be incurred as a result of the autism coverage mandate under Senate Bills 414 and 415. The Department would have to create and operate the program within 120 days after Senate Bill 981 (S-1) took effect.

("Carrier" would mean any of the following:

- An insurer or HMO.
- BCBSM.
- A specialty prepaid health plan (i.e., a plan for an eligible Medicaid beneficiary with a serious mental illness, developmental disability, serious emotional disturbance, or substance abuse disorder).
- A group health plan sponsor.

A group health plan sponsor would include a single employer or an employee organization that established or maintained a plan; or, if a plan were established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties.

"Third-party administrator" would mean an entity that processes claims and that may also provide other administrative services under a service contract.)

The Department would have to develop the application, approval, and compliance process necessary to operate and manage the program. The Department also would have to develop and implement the use of an application form to be used by carriers and third-party administrators who sought reimbursement for the coverage of ASDs.

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

The bill would prohibit LARA from making a commitment or exercising its authority under the proposed Act until the Legislature had appropriated sufficient funds to cover it.

#### Reimbursement

Subject to the limitations provided in the bill, the program would have to reimburse carriers and third-party administrators, as approved by LARA, in an amount equal to the amount of paid claims (as defined below) paid for the diagnosis and treatment of ASDs after the effective date of the amendment to the Nonprofit Health Care Corporation Reform Act (proposed by Senate Bill 414). A carrier or third-party administrator would have to apply for approval of funding associated with those paid claims. As part of the application, the applicant would have to include documentation verifying the paid claims for which the applicant was seeking reimbursement. In determining whether to approve an application, LARA could review whether the treatment for which the claims were paid was consistent with current protocols and cost-containment practices of BCBSM, the insurer, or the HMO, as applicable. The Department would have to review and consider applications in the order they were received, and approve or deny an application within 30 days after receiving it.

To the extent there was a cap on the amount of mandated autism coverage (as proposed by Senate Bills 414 and 415), LARA could not approve more than the mandated amount to any carrier or third-party administrator seeking reimbursement for paid claims related to the diagnosis and treatment of ASDs.

If a third-party administrator received any funding under the program, it would have to apply the funding to the benefit of the carrier covering the claim upon which the funding was received.

#### Autism Coverage Fund

The bill would create the Autism Coverage Fund within the State Treasury. The Department of Licensing and Regulatory Affairs would be the Fund administrator for

auditing purposes. The Department could spend Fund money, upon appropriation, only for the purpose of creating, operating, and funding the autism coverage incentive program. A maximum of 1% of the annual appropriation made to the Fund could be used for the purpose of administering the program.

The Department would have to reimburse carriers and third-party administrators from the Fund in the order in which the applications were approved. If there were insufficient money in the Fund to reimburse a carrier or third-party administrator for approved paid claims, reimbursement could not be made. Applications that were approved but not reimbursed could be paid, however, if Fund revenue became available.

The State Treasurer could receive money or other assets from any source for deposit into the Fund. The State Treasurer would have to direct the investment of the Fund, and credit to it any interest and earnings. Money in the Fund at the close of the fiscal year would remain in the Fund and would not lapse to the General Fund.

#### Reporting

By April 1 of each year, LARA would have to submit a report to the State Budget Director and the Senate and House of Representatives Appropriations Committees. The report would have to include all of the following for the preceding calendar year:

- The total number of applications received under the program.
- The number of applications approved and the total amount of funding awarded under the program.
- The amount of administrative costs used to administer the program.

#### Policy

The bill states, "It is the policy of this state to encourage carriers and third party administrators to provide autism coverage. It is the intent of the legislature to further this policy by the provisions of this act and by providing annual appropriations to establish, implement, and administer this act and adequately fund the autism coverage incentive program established by this act."

#### Definitions

"Paid claims" would mean actual payments, net of recoveries, made to a health and medical services provider or reimbursed to an individual by a carrier, third-party administrator, or excess loss or stop loss carrier. "Excess loss" or "stop loss" would mean coverage that provides insurance protection against the accumulation of total claims exceeding a stated dollar level for a group as a whole or protection against a high-dollar claim on any one individual.

Paid claims would not include any of the following:

- Claims paid for services rendered to a nonresident of Michigan or a person covered under a health benefit plan for Federal employees.
- Claims paid for services rendered outside of the State to a Michigan resident.
- Claims paid under a Federal employee health benefit program, Medicare, Medicare Advantage plan, Medicare Part D, Tricare, by the U.S. Veterans Administration, and for high-risk pools established pursuant to the Federal act.
- Health and medical services costs paid by an individual for cost-sharing requirements, including deductibles, coinsurance, or copays.
- Claims paid by, or on behalf of, the State.
- Claims paid that are covered by Medicaid.
- Claims paid for which the carrier or third-party administrator already has been reimbursed or compensated through any increase in premiums or rates or from any other source.
- Beginning January 1, 2014, claims paid for services that are included in the essential health benefits requirements required under the Federal act.

"Health and medical services" would mean one or more of the following:

- Services included in furnishing medical care, dental care, pharmaceutical benefits, or hospitalization, including services provided in a hospital or other medical facility.
- Ancillary services, including ambulatory services and emergency and nonemergency transportation.
- Services provided by a licensed physician or psychologist.

-- Behavioral health services, including mental health and substance abuse services.

Proposed MCL 550.1416e (S.B. 414)  
Proposed MCL 500.3406s (S.B. 415)

Legislative Analyst: Julie Cassidy

## **FISCAL IMPACT**

### **Senate Bills 414 (S-3) and 415 (S-3)**

The estimated fiscal impact of this legislation includes the cost to State and local governments as insurers and potential savings to State and local governments due to positive results from intervention, particularly reductions in special education and mental health expenditures. This estimation process is further complicated because many if not most State and local government employees work for entities that self-insure and thus are not subject to State regulation. (Instead, health benefits provided for employees of self-insured entities are regulated at the Federal level under the Employee Retirement Income Security Act, or ERISA.) This legislation would not affect ERISA plans.

Among the services covered would be behavioral health treatment, pharmaceutical services, and what is known as "applied behavior analysis" (ABA). When provided to individuals diagnosed with autism spectrum disorders, ABA services are intensive services intended to improve an ASD individual's ability to function.

Estimating the cost of the services to State and local government requires taking a universal view, in which the potential cost to all insurers (including ERISA plans) is measured against total expenditures by all insurers (including ERISA plans) to derive a percentage cost increase. That percentage increase can then be used on estimates of State and local insurance costs to derive an estimated fiscal impact. Including ERISA plans in this estimate would be problematic only if the likelihood of ASDs among that segment of the child population were significantly different from the likelihood among non-self-insured individuals. There appears to be no reason to expect a significant difference in the ERISA population. The estimation process also includes the cost for services to Medicaid and MICHild recipients and, given that Supplemental Security Income (SSI)

disability results in categorical eligibility for Medicaid, the total cost might well be somewhat overstated.

The Department of Community Health (DCH), in its presentation to the House Subcommittee on the Department of Community Health on February 28, 2012, estimated that about 4,500 Michigan children between the ages of 2 and 5 have ASDs. The bills, however, would provide coverage up to age 18; thus, the universe of those potentially eligible for services would be much greater than 4,500. The DCH estimate for the average cost of expanded treatment for Medicaid- and MICHild-eligible ASD children is \$17,000 per year per child.

Using this number (which may be low due to Medicaid provider rates being lower than average), and assuming a universe of eligible children closer to 15,000 than 4,500 due to the 18-year age limit, leads to an estimated cost to all insurers of \$255.0 million per year. It is important to note that this \$255.0 million figure is *not* the actual increase in health insurance costs that could occur due to this legislation. This number is clearly overstated as a significant number of the children involved would be publicly insured by Medicaid or MICHild or would belong to self-insured plans and would not be subject to this legislation, and the actual number is likely less than half that amount. The \$255.0 million figure is a useful number, however, to estimate an upper bound on the percentage cost increase.

Looking at the process used by the Senate Fiscal Agency (SFA) to derive the Health Insurance Claims Assessment (HICA) legislation revenue estimate, health expenditures in Michigan are close to \$80.0 billion. Once out-of-pocket costs and Medicare costs are subtracted (as Medicare rarely covers children), the expenditure base is closer to \$50.0 billion. The \$255.0 million figure represents about 0.5% of total health care expenditures. Therefore, a reasonable conclusion is that implementation of the bills would increase health insurance costs by a maximum of 0.5% and likely less than that.

Research in other states resulted in similar conclusions, with an estimated cost increase of \$50 per policy per year reflected in analyses in South Carolina and Wisconsin, with a significantly lower cost estimate of \$5 to \$20 per policy per year in Indiana. These

estimates correspond to rate increases of 0.1% to 0.5%.

In 2011, the SFA estimated that paid health claims for State and local government in Michigan are about \$3.6 billion in State and local revenue. If the 0.5% figure is correct and none of the State and local entities are self-insured, then the legislation would increase State and local expenditures by \$18.0 million per year, with about half of those costs accruing to school districts. Given the general belief that at least half of the public employees in the State work for entities that self-insure, the most useful estimate is that the legislation would increase State and local expenditures by \$9.0 million per year.

The net cost savings from improved outcomes is far more difficult to estimate. Studies have varied on the benefits of ABA and similar interventions. Replication of results has been difficult to achieve and most studies have not been randomized controlled trials. Randomized controlled studies are the most useful studies in evaluating programs and interventions. There do not appear to be any randomized longitudinal trials that would help provide a clear answer to the long-term impact of ABA.

Some of the randomized controlled trials show improvement in intelligence quotient (IQ) and adaptive behavior for a significant portion of the population served (source: British Medical Journal, *Evidence-Based Mental Health*, November 2011). There was less evidence in the randomized controlled studies to support improvement in symptom severity scores and other measures. A nonrandomized Pennsylvania study indicated improvement in symptoms and language and socialization skills (Penn State College of Medicine). Improvements in various areas should lead to lesser need for non-health-related services, in particular special education, in the longer term. Providing a precise estimate of such savings is impossible; the most useful studies are randomized controlled studies and the results speak to impact on measures, not specific expenditures that likely would be reduced due to changes in those measures. As noted, long-term randomized controlled longitudinal studies would be necessary to examine the demand and cost of services and the results of the intervention.

Given the cost of special education and mental health services, minor improvements for a small portion of the ABS population served would result in savings that would almost certainly more than offset the increased insurance cost for State and local governments. Therefore, one would expect the bills to lead to an indeterminate but positive fiscal impact for State and local governments. A more definitive fiscal impact statement would have to be based on a well-designed long-term peer-reviewed randomized controlled longitudinal study.

### **Senate Bill 981 (S-1)**

Senate Bill 981 (S-1) would create some new costs for the Department of Licensing and Regulatory Affairs related to the development and administration of the autism coverage incentive program. Administrative costs could include processing applications for the program, administering payments, and likely other operational expenses. The bill also would establish the Autism Coverage Fund, which would be funded by a legislative appropriation made at a later date. The bill specifies that not more than 1% of the annual appropriation made to the Fund could be spent on administering the autism coverage incentive program. It is not known at this time how much money would be appropriated to the Fund, how much (up to 1%) of that would be used for administration, or if 1% of the appropriation would be sufficient to administer the program. Any administrative costs in excess of 1% of the Fund's annual appropriation would be borne by existing LARA resources.

The cost of Senate Bill 981 (S-1) would equal the amount of public money deposited in the Fund. The bill does not specify the amount as it would be subject to annual appropriations, so the cost of the Fund would be determined by the Legislature through the budgetary process.

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.