SB 1081

Department of Legislative Services

Maryland General Assembly
2012 Session

FISCAL AND POLICY NOTE

Senate Bill 1081 (Senator Klausmeier)
Finance

Health Insurance - Coverage for Autism Spectrum Disorders

This bill requires insurers, nonprofit health service plans, and health maintenance organizations (carriers) to provide coverage for the diagnosis and evidence-based, medically necessary treatment, including applied behavior analysis (ABA), of autism spectrum disorders (ASD) for children younger than age 13. A carrier may place an annual dollar limit on coverage of $36,000 for children younger than age 8 and $25,000 for children ages 8 through 12. The mandate applies only to a policy or contract for which the State is not required under the federal Patient Protection and Affordable Care Act (ACA) to defray the costs of State-mandated benefits that are in excess of the essential health benefits.

The bill takes effect January 1, 2013, and applies to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after that date.

Fiscal Summary

State Effect: Minimal increase in special fund revenues for the Maryland Insurance Administration (MIA) from the $125 rate form and filing fee in FY 2013. The review of rate filings can be handled within existing MIA resources. State Employee and Retiree Health and Welfare Benefits Program (State plan) expenditures increase by at least $7.6 million (but could increase by as much as $13.7 million) in FY 2014.

($ in millions)	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
SF Revenue	-	$0	$0	$0	$0
GF Expenditure	$0	$4.5	$5.3	$6.3	$7.5
SF Expenditure	$0	$2.3	$2.7	$3.2	$3.8
FF Expenditure	$0	$.8	$1.0	$1.2	$1.4
Net Effect	$0	($7.6)	($9.0)	($10.7)	($12.7)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: Expenditures increase for some local governments to the extent that autism treatment is not already covered.

Small Business Effect: None. The bill does not apply to the small group health insurance market.

Analysis

Bill Summary: Diagnosis of ASDs includes medically necessary assessments, evaluations, or tests to diagnose whether an individual has an ASD. Treatment of ASDs includes habilitative or rehabilitative care prescribed to an individual diagnosed with an ASD as part of a specified treatment plan. "Habilitative or rehabilitative care" means professional, counseling, and guidance services and treatment programs, including behavioral health treatments such as ABA and specified devices. Treatment of ASDs has to be prescribed by a licensed physician, a licensed psychologist, a licensed speech-language pathologist, a board-certified behavior analyst credentialed by the national Behavior Analyst Certification Board, or a licensed certified social worker-clinical. Coverage of ASDs is not subject to limits on the number of visits an individual may make to an autism services provider. This does not prohibit utilization review to determine the duration and intensity of ASD treatment.

Treatment of ASDs may be provided by individuals under the supervision of a licensed psychologist, a board-certified behavior analyst credentialed by the national Behavior Analyst Certification Board, or a licensed certified social worker-clinical.

Carriers must provide annual notice to insureds and enrollees about coverage of ASDs. Carriers may request an updated treatment plan, but not more often than every 12 months, unless the prescribing physician, psychologist, speech-language pathologist, or board-certified behavior analyst agrees that more frequent review is necessary. Carriers must pay the cost of obtaining the updated treatment plan.

Denial of coverage for the diagnosis or treatment of ASDs is an adverse decision and subject to appeal. Carriers are not required to provide reimbursement for ASD services delivered through early intervention or school services.

Current Law: There are 45 mandated health insurance benefits that certain carriers must provide to their enrollees. These mandated benefits include habilitative services for children younger than age 19.

Every four years, the Maryland Health Care Commission (MHCC) examines the fiscal impact of mandated health insurance benefits. MHCC's January 2012 report found that the full cost of all mandated benefits accounts for total premium costs of 18.8% for group

health insurance, 19.6% for individual policies, and 17.9% for the State plan. Coverage for habilitative services accounts for total premium costs of 0.1% for all types of insurance. About half (40% to 60%) of the surveyed employers with self-funded plans provide benefits that comply fully with the habilitative services mandate.

Maryland's small group market Comprehensive Standard Health Benefit Plan (CSHBP) is not subject to mandated benefits applicable to the large group market. Rather, MHCC reviews CSHBP on an annual basis and considers making benefit or cost-sharing changes at that time. CSHBP does cover habilitative services for children younger than age 19 to treat congenital or genetic birth defects.

Background:

Autism Spectrum Disorders: ASDs are developmental disabilities that cause substantial impairments in social interaction and communication and the presence of unusual behaviors and interests. An ASD begins before age three and lasts throughout a person's lifetime. ASDs include autistic disorder, pervasive developmental disorder – not otherwise specified, and Asperger syndrome. ASDs occur in all racial, ethnic, and socioeconomic groups and are four times more likely to occur in boys than in girls. The U.S. Centers for Disease Control and Prevention estimates that the prevalence of ASDs is 1 in 110 children or approximately 1%. While there is no "cure" for ASDs, early diagnosis and intervention may lead to significantly improved outcomes.

Current Services for Children with Autism: Children with autism may access certain services through State and locally administered education programs, as required by the federal Individuals with Disabilities Education Act (IDEA). IDEA parts B and C also require early intervention program services for toddlers and preschool-aged children. Some of the services provided by these programs are similar to those required under the bill; however, the level and intensity of the services may be more limited than those recommended by treating physicians.

The Maryland Medicaid Waiver for Children with Autism Spectrum Disorder provides intensive individual support services, therapeutic integration services, supported employment, respite care, family training, environmental accessibility adaptations, and residential habilitation to qualified individuals with ASDs. The waiver program is targeted to individuals who likely would be institutionalized without supports. In fiscal 2011, the waiver served 901 participants at an average annual per capita cost, including nonwaiver services, of $47,025 in Medicaid expenditures (50% general funds, 50% federal funds). As of December 31, 2011, 3,684 children were on the autism waiver registry (waiting list).

The Developmental Disabilities Administration (DDA) currently serves 1,787 individuals where autism is indicated as their disability category. Another 1,937 individuals with autism indicated as a disability are waiting for a service from DDA. DDA also maintains a Future Needs Registry for individuals with service needs that are more than three years away. There are 974 individuals on this registry who indicate autism as a disability.

Applied Behavior Analysis: ABA is the process of applying interventions based on the principles of learning derived from experimental psychology research to systematically change behavior. According to the American Academy of Pediatrics, the effectiveness of ABA-based intervention in ASDs has been well documented through five decades of research. Children who receive early intensive behavioral treatment have been shown to make substantial, sustained gains in IQ, language, academic performance, and adaptive behavior as well as some measures of social behavior, and their outcomes have been significantly better than those of children in control groups. Others, including several Maryland carriers, believe that ABA is experimental and an educational rather than a medical treatment. Thus, insurance coverage is not typically provided for these services.

MHCC Evaluations of Coverage of Autism Services: A February 2012 analysis conducted by Oliver Wyman on behalf of MHCC provided estimates of the cost of a more limited benefit for ASDs than previously proposed in legislation based on the percentage of the eligible population that is expected to obtain treatment (*i.e.,* a low-, medium-, or high-treatment prevalence). The following descriptions report the cost of the low- and high-treatment prevalence levels for the three options evaluated.

- **Option 1.** Coverage of ASDs, including ABA, for children younger than age 9, with a $36,000 annual limit. Under this scenario, the cost is estimated to be $17.70 to $44.06 per enrollee per year.

- **Option 2.** Coverage of ASDs, including ABA, for children younger than age 13, with a $36,000 annual limit for children younger than age 6 and a $20,000 annual limit for children ages 6 to 12. Under this scenario, the cost is estimated to be $16.62 to $43.53 per enrollee per year.

- **Option 3.** Coverage of ASDs, including ABA, for children younger than age 9, with a $36,000 annual limit for children younger than age 6 and a $20,000 annual limit for children ages 6 to 8. Under this scenario, the cost of the mandate is estimated to be $14.06 to $36.31 per enrollee per year.

Other State Coverage: According to the National Conference of State Legislatures, until 2007, only Indiana required insurance coverage for autism. Currently, 34 states and the District of Columbia have laws related to autism and insurance coverage. At least

29 states (including Pennsylvania, Virginia, and West Virginia) specifically require insurers to provide coverage for the treatment of autism. State laws vary with regard to age limitations and annual limitations on coverage.

Essential Health Benefits: Under federal health care reform, beginning January 1, 2014, all health plans offered through the new health benefit exchange marketplaces must include certain "essential health benefits." Essential health benefits must include items and services within at least 10 specified health categories. One such category is "rehabilitative and habilitative services and devices"; however, these terms are not specifically defined.

Under ACA, each state must pay, for every health plan purchased through the exchange, the additional premium associated with any state-mandated benefit beyond the essential health benefits. States can choose one of four benchmark plans to meet the requirement for essential health benefits: (1) one of the three largest small group plans in the state by enrollment; (2) one of the three largest state employee health benefit plans by enrollment; (3) one of the three largest federal employee health benefit plans by enrollment; or (4) the largest insured commercial non-Medicaid health maintenance organization operating in the state. Any Maryland mandates that apply to the selected benchmark plan will apply to the essential health benefits package in 2014 and 2015. The U.S. Department of Health and Human Services advised in December 2011 that any new mandate enacted during the 2012 legislative session or beyond, or any benefits that do not apply to the benchmark plan, *will not* apply to the essential health benefits package, and thus the State will be liable for the cost of the additional premiums associated with those benefits. Legislative Services notes that this advice could be subject to change. This bill specifically states that the mandate only applies to policies or contracts for which the State *is not* required to defray the costs of State-mandated benefits that are in excess of the essential health benefits. Therefore, the bill will likely not apply to qualified health benefit plans sold in the exchange.

State Fiscal Effect: Although not required to follow health insurance mandates, the State plan generally does. Thus, this analysis assumes that the State plan will follow the bill's requirements. However, since the State plan contract runs on a fiscal-year basis, the ASD benefits specified under the bill will not be included until the fiscal 2014 plan year. According to the Department of Budget and Management (DBM), the State plan already covers much more than most employer plans with regard to treatment of ASDs. However, the State plan does not currently cover ABA.

State plan expenditures will increase by at least $7.6 million (but could increase by as much as $13.7 million) in fiscal 2014 to provide coverage for ASDs, including ABA, as specified under the bill. **Exhibit 1** displays a range of potential expenditures based on four different models that are described in greater detail below.

Exhibit 1
Potential Expenditures for the State Employee and Retiree Health and Welfare Benefit Program under SB 1081/HB 1434
Fiscal 2014-2017
($ in Millions)

Model	FY 2014	FY 2015	FY 2016	FY 2017
Average Annual Cost[1]	$7.6	$9.0	$10.7	$12.7
Oliver Wyman – % Increase[2]	8.0	8.6	9.3	10.0
Oliver Wyman – Premium Increase[3]	8.6	9.3	10.1	10.9
Annual Maximum Cost[4]	13.7	15.0	16.5	18.2

[1]Based on fiscal 2010 claims data for other autism services and an estimated 379 individuals in the State plan with autism in fiscal 2014.
[2]Assumes an increase in medical spending of 0.78% based on a *similar* estimate prepared by Oliver Wyman for the Maryland Health Care Commission. That estimate assumed coverage of ASDs, including ABA, for children younger than age 13, with a $36,000 annual limit for children younger than six, and a $20,000 annual limit for children ages 6 to 12. The estimate is based on a medium treatment prevalence level. This is not the same benefit as proposed by the bill.
[3]Assumes a premium increase of $33.79 per enrollee based on the *similar* estimate prepared by Oliver Wyman, as described above, which is based on a medium treatment prevalence level.
[4]Assumes that all individuals enrolled in the State plan with autism will receive a maximum annual benefit of $36,000.

Source: Department of Legislative Services

Average Annual Cost Model: Based on fiscal 2010 claims data for other autism services, DBM estimates that the average annual cost per child under the bill will be approximately $19,903 in fiscal 2014. In fiscal 2011, the State plan covered approximately 285 individuals diagnosed with autism. Legislative Services assumes that this number has increased by 10% annually to 379 in fiscal 2014. To serve 379 individuals at an average annual cost of $19,903 will cost the State plan $7.6 million in fiscal 2014.

Oliver Wyman – Percentage Increase Model: The coverage proposed under the bill is similar to Option 2 in the February 2012 analysis conducted by Oliver Wyman on behalf of MHCC. That estimate projected the cost of coverage for ASDs, including ABA, for children younger than age 13, with a $36,000 annual limit for children *younger than age 6* and a *$20,000* annual limit for children ages *6* to 12. Under this scenario, total medical spending is anticipated to increase by 0.38% to 1.00%. For a medium treatment prevalence level, the percentage increase is estimated at 0.78%. Based on $811.2 million in State plan expenditures for medical care in fiscal 2011 and assuming 8% annual

inflation, State plan expenditures will increase by $8.0 million in fiscal 2014. Legislative Services notes that actual State plan expenditures would likely be higher than this estimate because the benefits provided under the bill are more generous than those under the Oliver Wyman estimate – extending the annual limit of $36,000 to children through age 7 (rather than age 5) and providing a higher annual limit of $25,000 to children ages 8 through 12 (rather than $20,000 for children ages 6 to 12).

Oliver Wyman – Premium Increase Model: The Oliver Wyman estimate discussed above also projected the cost of coverage on the basis of premium increases per enrollee. Under this scenario, premiums are estimated to increase by $16.62 to $43.53 per enrollee per year or $33.79 for a medium treatment prevalence level. There are 219,371 individuals enrolled in the State plan in fiscal 2012. Assuming 8% annual inflation, State plan expenditures could increase by $8.6 million in fiscal 2014. Legislative Services again notes that actual State plan expenditures would likely be higher than this estimate because the benefits provided under the bill are more generous than those under the Oliver Wyman estimate.

Annual Maximum Cost Model: The bill authorizes carriers to limit coverage under the bill to a maximum of $36,000 per benefit year for children younger than age 8 and $25,000 for children ages 8 through 12. To the extent that all 379 individuals with autism in the State plan were eligible to receive the maximum benefit of $36,000 in fiscal 2014, State plan expenditures would increase by $13.7 million. Legislative Services notes that actual expenditures would likely be less than this estimate as not all of the individuals with autism in the State plan are younger than age 8; however, it represents an estimated upper limit of expenditures.

State plan expenditures are split 59% general funds, 30% special funds, and 11% federal funds.

Legislative Services notes that, while there are believed to be a relatively small number of individuals enrolled in the State plan with ASDs, diagnoses of ASDs are increasing at a rate of 10% to 17% annually. Such growth may be even greater among State plan enrollees. For example, DBM estimated that there were 188 individuals with autism in the State plan in 2009, 220 in 2010, and 285 in 2011. These figures reflect annual increases of 17% and 30%, respectively. Thus, State plan expenditures for an ASD benefit could be heavily influenced by rapid increases in the number of children diagnosed with ASDs in future years.

To the extent that the bill provides children with autism who are currently served in the Medicaid autism waiver or through DDA access to private health insurance coverage for treatments such as intensive individual support services, waiver and DDA resources

could be redirected to allow additional individuals with autism to receive services who otherwise would not.

Local Expenditures: Local government expenditures (for those that purchase fully insured plans from an insurance company) increase for some local governments that do not already cover the treatment of autism.

Additional Information

Prior Introductions: Other bills have been introduced in recent years to mandate health insurance coverage for ASDs. SB 759/HB 783 of 2011, SB 1028/HB 1091 of 2010, and SB 394/HB 273 of 2009 generally would have required coverage for the diagnosis and evidence-based, medically necessary treatment of ASDs, including ABA. SB 1028/HB 1091 of 2010 also authorized carriers, after providing coverage for one year, to apply for an exemption from the mandate if they could prove that costs for the mandate would lead to a premium increase of more than 2% for the following year. Generally, the bills were heard by the Senate Finance and House Health and Government Operations committees, respectively. SB 759 of 2011 received an unfavorable report from the Senate Finance Committee. HB 273 of 2009 and HB 783 of 2011 were withdrawn. No further action was taken on the remaining bills.

Cross File: HB 1434 (Delegate Reznik) - Health and Government Operations.

Information Source(s): American Academy of Pediatrics, Autism Speaks, U.S. Centers for Disease Control and Prevention, National Conference of State Legislatures, Department of Budget and Management, Department of Health and Mental Hygiene, Department of Legislative Services

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