

MAJOR REGULATIONS STANDARDIZED REGULATORY IMPACT ASSESSMENT SUMMARY

DF-131 (NEW 11/13)

STANDARDIZED REGULATORY IMPACT ASSESSMENT SUMMARY

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<p>1. Statement of the need for the proposed major regulation.</p> <p>The purpose of the proposed regulation is to help bring an end to the problem of improper insurer delay and denial of medically necessary treatment for individuals with autism. The proposed regulation seeks to ensure that private insurers comply with the Mental Health Parity Act (MHPA) and fulfill their obligation to provide all medically necessary treatments and services to California's children with autism, subject to financial terms and conditions applicable to all benefits under the policy. Another objective of the proposed regulations is to interpret SB 946 (2011, Steinberg). The regulation will accomplish these objectives by interpreting and making more specific the MHPA and providing guidance to industry, stakeholders and consumers about the scope of the MHPA's provisions as they relate to autism treatment.</p>		
<p>2. The categories of individuals and business enterprises who will be impacted by the proposed major regulation and the amount of the economic impact on each such category.</p> <p>Savings in 2014 (direct impacts, see EIA pg. 9) Government - \$ 80,354,056 Physicians - \$ 9,178,494 Hospitals - \$ 515,375</p> <p>Cost in 2014 (direct impacts, see EIA pg. 9) Households - \$ 19,078,250 Insurers - \$ 51,581,936</p>		
<p>3. Description of all costs and all benefits due to the proposed regulatory change (calculated on an annual basis from estimated date of filing with the Secretary of State through 12 months after the estimated date the proposed major regulation will be fully implemented as estimated by the agency).</p> <p>CDI estimates an immediate savings of \$32M to federal, state, and local government over the first 12 months. CDI estimates a cost to insurers of \$20,481,936 and a cost to households of \$7,575,511 over the first 12 months.</p> <p>The anticipated effects from adoption of the proposed regulations for children and families include the cessation of improper denials of medically necessary treatment for autism and the elimination of unreasonable delays in providing these treatments, which are more likely to be successful when they are begun early. Coverage of early intervention through behavioral, speech, and occupational therapy will enable children with autism to improve in intelligence quotient, cognitive ability, receptive and expressive language skills, and adaptive behavior; and will lessen maladaptive, tantrum or self-injurious behaviors. Other anticipated benefits from adoption of the proposed regulation include the expectation that children will receive improved diagnoses from autistic disorder to pervasive developmental disorder (PDD), and a significant minority of children will recover</p>		

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from autism, resulting in lessening their needs for governmental services throughout their lifetimes.
Providing Clear Guidance to Industry, Stakeholders and Consumers on the Requirements of the MHPA

The proposed regulations have the primary objective of helping to bring an end to the pattern of improper insurer delay and denial of medically necessary treatment for individuals with autism. The proposed regulations make clear the obligations of private insurers under the MHPA to provide medically necessary treatment and services, subject to financial terms and conditions applicable to all benefits under the policy. Furthermore, the regulation seeks to provide guidance to industry, stakeholders and consumers about the scope of the MHPA's provisions as they relate to autism treatment specifically.

Establishing Medical Necessity as the Metric of What Services Must Be Covered

While the MHPA applies to several different diagnoses, the proposed regulations are limited to PDD or autism. Substantively, the proposed regulations benefit insurers and enhance fairness and consistency of decision making by clarifying that medical necessity is the test of whether services must be covered — if treatment of services is not medically necessary, neither the proposed regulations nor the MHPA require that the services of treatment be covered. However, it is conceivable that the regulation could be construed to require coverage when the treatment or services is not medically necessary. Therefore, the proposed regulations expressly do not preclude insurers from utilizing case management, utilization review, and similar techniques.

Prohibition on Annual Visit and Dollar Limits for Medically Necessary Treatment

The proposed regulations further seek to ensure that individuals with autism receive speech and occupational therapy as well as behavioral health treatment subject to certain prohibitions on limiting such services. The proposed regulations specifically prohibit annual visit limits, which are not financial terms or conditions as illustrated in subdivision (c) of the MHPA. Additionally, the proposed regulations prohibit annual dollar limits on such treatments and services which are not equally applicable to all benefits under the policy. Thus, the proposed regulations prohibit these two limitations with respect to autism and counteract insurers' continued imposition of unreasonable visit and dollar limits on ABA therapy, speech and occupational therapies and other vital treatments and services necessary to the health of individuals with autism.

Prohibition on Denials of Behavioral Health Treatment (BHT)

The proposed regulations also help ensure that behavioral health treatment for PDD or autism shall be covered in the same manner and subject to the same requirements. The proposed regulations make clear that BHT for PDD or autism is a requirement under both the MHPA and Insurance Code section 10144.51 (SB 946) and further require that coverage for BHT of a patient diagnosed with PDD or autism must be provided if it is medically necessary, subject to only financial terms and conditions that are equally applicable to all benefits under the policy. The proposed regulations specifically prohibit insurers from denying or delaying BHT on the grounds that such treatment is experimental, investigational or educational. Furthermore, a prohibition against conditioning medically necessary BHT on insurer-imposed cognitive, developmental or IQ testing is proposed to ensure that individuals with PDD or autism receive prompt treatment, without unreasonable delays. Such denials and delays of BHT are inconsistent with the MHPA and SB 946 (Insurance Code sections 10144.5 and 10144.51).

Protection of Public Health

The benefits anticipated to result from the adoption of the proposed regulations include the protection of public health as the provision of medically necessary therapies to California consumers with autism will transform the lives of young children and save state government millions of dollars over the lives of these children as they age. Furthermore, parents of individuals with autism will benefit by being more available to take on full- or part-time work as care for autistic children is coordinated and provided by insurers.

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4. Description of the 12-month period in which the agency estimates the economic impact of the proposed major regulation will exceed \$50 million.

The Department of Insurance estimates that because of the large direct costs and direct benefits of the proposed regulation and the large multipliers associated with these industries, the economic impact of this regulation will be above \$ 50 million in 2014.

5. Description of the agency's baseline:

In CDI's economic model the year 2013 represents our baseline. All insurer rate filings related to mental health treatments for that year were filed before CDI implemented its emergency regulation; as such their impact is attributed to Senate Bill 946. As a baseline, 2013 represents a year in which the economic impact of most prior legislative changes were realized, but still left a gap between what insurers were legally mandated to cover and the amount they were covering. This gap represents the amount insurers were remiss in paying, for which CDI deemed this regulation necessary.

6. For each alternative that the agency considered (including those provided by the public or another governmental agency), please describe:

- a. All costs and all benefits of the alternative
- b. The reason for rejecting alternative

Alternative #1. Retain the status quo.

CDI determined this alternative would have no additional cost or benefit, as no action would be taken. This alternative was rejected because it does nothing to end improper denials of medically necessary treatment for ASD. Furthermore, CDI has been petitioned by the Association of California Healthcare and Life Insurance Companies (ACHLIC) to promulgate regulations regarding the requirements for coverage relating to the treatment of ASD.

Alternative #2. Include all severe mental illnesses enumerated in the MHPA as part of the scope of this regulation.

Expanding the scope of the regulations to include additional diagnoses would almost certainly result in increased costs to insurers. The problem sought to be addressed by the proposed regulations is expressly limited to ASD, specifically, improper denials of behavioral, speech, and occupational therapy. CDI is unaware that these problems have been encountered with respect to other parity diagnoses.

7. A description of the methods by which the agency sought public input. (Please include documentation of that public outreach).

Prior to noticing permanent regulations, the Department sought public input by noticing the corresponding emergency regulations, once in connection with their initial adoption and twice in connection with subsequent readoptions. Additionally, the Department has issued a notice of proposed rulemaking in the permanent rulemaking and on January 8, 2014 held a public hearing. All four notices are attached.

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8. A description of the economic impact method and approach (including the underlying assumptions the agency used and the rationale and basis for those assumptions).

CDI used an annual model to incorporate how insurers responded with premium increases to changes in their requirements to provide mental health care. On a calendar year basis, the new amounts insurers put forward in rate filings for behavioral therapy coverage were \$24 million in 2012 and \$31.1 million (\$24+\$7.1) in 2013. The insurers filed a premium increase in a July 2012 mid-year filing (\$48 million covered for policies issued and renewed for a one-year period beginning July 1, 2012). An additional \$7.1 million was filed for policies issued and renewed in January 2013 for a calendar year. Insurers have two main time frames to adjust premiums, one in July and one in January. (see Table 5 in EIA, pg. 9)

This model was chosen because CDI had collected evidence that some insurance companies were picking up portions of mental health therapy treatments, yet others resisted. However, there was a clear industry trend toward insurers picking up more of the treatment cost, as stricter legislation passed and CDI took enforcement actions. Given that many different variables affected the market at different times, modeling insurers' obligations over time was deemed the most accurate way to display and present the data.

CDI consulted industry experts, online job listings, and available wage data to estimate the annual cost of providing therapy. CDI's actuarial office provided empirical data on the timing and amounts of insurers' rate filings as well as the percentage of cost-sharing between insurers and policyholder copayments. CDI utilized RIMS II multipliers, published by the Bureau of Economic Analysis to calculate the indirect and induced economic impacts.

Agency Signature

Date
1/23/2014

Agency Head (Printed)

Geoffrey Margolis, Deputy Commissioner and Special Counsel