



**SB 946:**  
INSURANCE  
COVERAGE FOR  
AUTSIM SERVICES

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# What is SB946?

- New legislation passed in July 2011
- Law came into effect this July 1, 2012
- Clarifies BHT as a medically necessary treatment under AB88-Mental Health Parity Act 2000
- Requires insurance companies to fund behavior intervention services for persons diagnosed with PDD, Autism or Asperger's disorder

# AB 88: Mental Health Parity Act of 2000

- Listed pervasive development disorder or autism as a “severe mental illness” that must be treated **in parity** with other medical conditions
- In parity means *under the same terms and conditions as other medical disorders*
- Required insurance companies to recognize autism as a mental illness

## SB 946: Defined treatment for AU and PDD

- Defines BHT as an effective medical treatment
- Established standards for providers of these services
- Requires Dept of Managed Health Care (DMHC) to convene an AU Advisory Task Force

## Service Requirements of SB946

- Services are prescribed by physician/psychologist
- Services are delivered by a qualified autism service provider
- Treatment plan includes measurable goals
- Services not used as respite, day care or educational placement

## Why does SB946 impact RC clients?

- Changes the rules/responsibilities for the Regional Center (RC) because of current restrictions in the Welfare and Institutions Code (4659a/c)
- This code clearly states **two** important responsibilities of the RC
  - The RC will pursue all sources of funding and
  - that it is **unlawful** for the RC to fund services that are, by law, funded through another entity

# Welfare and Institutions Code

## Section 4659 (a)

- 4659. (a) Except as otherwise provided in subdivision (b) or (e), the regional center shall identify and pursue all possible sources of funding for consumers receiving regional center services. These sources shall include, but not be limited to, both of the following:

(2) Private entities, to the maximum extent they are liable for the cost of services, aid, **insurance**, or medical assistance to the consumer.

# Welfare and Institutions Code

## Section 4659 (c )

(c) Effective July 1, 2009, notwithstanding any other provision of law or regulation to the contrary, regional centers ***shall not purchase any service*** that would otherwise be available from Medi-Cal, Medicare, the Civilian Health and Medical Program for Uniform Services, In-Home Support Services, California Children's Services, **private insurance**, or a health care service plan when a consumer or a family meets the criteria of this coverage but chooses not to pursue that coverage. If, on July 1, 2009, a regional center is purchasing that service as part of a consumer's individual program plan (IPP), the prohibition shall take effect on October 1, 2009.

## What CVRC has done to transition families?

- Instructed families to contact their insurance provider to begin the transition process
- Trained staff in how to support families through the claim/denial and complaint processes
- Set up tracking systems so that we know where our families are in this process
- Set up a review process for co-pay requests

## Does SB946 apply to all clients of the RC?

- SB946 does not apply to families receiving Medi-Cal **only**
- SB946 does not apply to families in which their insurance is self-funded
- SB946 does not apply to families with children diagnosed with any other developmental disorder

# Healthy Families and CalPERS

- Healthy Families provides private HMO coverage through contracted insurance providers to income-eligible children. As a part of the 2012-2013 State budget, there was agreement to transition children served by Healthy Families into Medi-cal. The timeline for terminations of Healthy Families outlined in trailer bill language is very preliminary and dependent upon approval to changes to Medi-Cal. Funding for behavioral health treatments through insurers funded by Healthy Families remains available in the meantime. As such, **CVRC will pursue funding for these services through those insurers.**
- **The three CalPERS HMO plans (Blue Shield of California Net Value, Blue Shield Access+ and Kaiser Permanente) are required to fund these services.** CalPERS PPO plans (PERS Select, PERS Choice and PERS Care) are self-funded and are not required to offer these services.

## Why don't self-funded policies provide funding?

- Because they don't have to!
- But they can. Employees with this type of plan can (and should) ask their employer to add this benefit to their insurance plan. The more employees that ask, the more likely the employer will consider this change.
- Self-funded policies fall under federal regulations, not state.

## What about co-pays, deductibles and co-insurance?

- As always, CVRC will look at these issues on an individual client basis
- In all cases, treatment plans, EOBs, previous/current service levels, and family hardship will be considered in making funding decisions.
- If CVRC provides funding of co-pays, we will ask for the same reporting/review requirements that are currently in place (i.e. quarterly).

## Bottom Line: The Good News

- Children that weren't able to receive services through the regional center (those diagnosed with PDD and Asperger Syndrome) can now get services through their insurance

## Bottom Line: My Worries

- Children will be diagnosed under three and carry that label for life
- Supervision of services by the insurance companies will **NOT** be conducted by a BCBA or worse-not provided
- CVRC will not have direct access to client progress
- All this is set to sunset in 2014. Then what happens????

# Resources

- SB946 Fact Sheet
- Ca Dept of Insurance Consumer Alert
- <http://www.autismhealthinsurance.org>
- <http://www.autismspeaks.org>
- CA Dept of Managed Health Care  
Help Line: 1-888-466-2219

# Introducing Stephen Marshall

- Social Security Administration