



California's Protection & Advocacy System  
Toll-Free (800) 776-5746

# What does SB 946 (which requires private health plans to provide some services for people with autism) mean for me?

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SB 946, effective July 1, 2012, generally requires health care service plan contracts and health insurance policies to provide coverage for behavioral health treatment for individuals with autism or other pervasive developmental disorders (PDD). This fact sheet solely addresses the impact of this bill on autism related behavioral services. It does not address the other parts of the bill unrelated to autism treatment. SB 946 only applies to health plans under the jurisdiction of the Department of Managed Health Care Services (DMHC) or the Department of Insurance (DI).<sup>1</sup>

The bill is at [http://leginfo.ca.gov/pub/11-12/bill/sen/sb\\_0901-0950/sb\\_946\\_bill\\_20111009\\_chaptered.pdf](http://leginfo.ca.gov/pub/11-12/bill/sen/sb_0901-0950/sb_946_bill_20111009_chaptered.pdf)

## **What specific services are covered by the bill?**

Behavioral services means professional services and treatment programs including applied behavioral analysis (“ABA”) and other evidence-based approaches. The services must meet certain criteria:

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<sup>1</sup> Both DMHC and DI maintain lists of health plans subject to their jurisdiction:  
<http://wpsc.dmhc.ca.gov/hpsearch/viewLicensedHealthPlan.aspx> &  
[http://interactive.web.insurance.ca.gov/webuser/ncdw\\_alpha\\_co\\_line\\$.startup](http://interactive.web.insurance.ca.gov/webuser/ncdw_alpha_co_line$.startup)

- the program must be intended to develop or restore the functioning of a person with autism or PDD;
- the treatment must be prescribed by a licensed physician, surgeon, or psychologist;
- the treatment must be administered by a qualified autism service provider including a professional or paraprofessional supervised by a qualified provider (see below for a discussion of qualified service provider);
- the treatment plan must have:
  - measureable goals;
  - be reviewed at least every six months and include the frequency of review, which must be at least every 6 months;
  - describe the behavioral health impairments to be treated; and
  - include the service type, number of hours, and parent participation needed;
- the treatment must utilize evidence based practices;
- the program must be designed to end when the goals are achieved or no longer appropriate; and
- the program is not to serve as respite, day care, or educational services.<sup>2</sup>

## **Who is covered under this bill?**

People diagnosed with autism or PDD.<sup>3</sup>

## **What is a Qualified Autism Service Provider?**

A qualified autism service provider is a person, entity, or group that is nationally certified<sup>4</sup> to design, supervise or provide treatment for PDD or autism within their experience and competence. The definition also includes a person licensed as a physician, surgeon, physical therapist, occupational therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist

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<sup>2</sup> Health & Safety Code Section 1374.73(c) for plans under the jurisdiction of the Department of Managed Health Care; Insurance Code Section 10144.51(c) for plans under the jurisdiction of the Department of Insurance

<sup>3</sup> Health & Safety Code Section 1374.72(d)(7); Insurance Code Section 10144.5(d)(7)

<sup>4</sup> For example, the Behavior Analyst Certification Board.

who designs, supervises, or provides treatment for PDD or autism within their experience and licensure.<sup>5</sup> This includes behavioral paraprofessionals<sup>6</sup>. Paraprofessionals implement behavioral plans under the supervision of a Certified Behavioral Analyst or Behavior Management Consultant.<sup>7</sup>

## **What Health Care Service Plan Contracts and Health Insurance Policies are covered by the bill?**

All health plans that provide hospital, medical or surgical treatment and that are under the jurisdiction of the Department of Managed Health Care or the Department of Insurance<sup>8</sup> are covered except as outlined below.

## **Are any health plans excluded?**

This bill does not apply to health care plans that do not provide mental or behavioral health services.<sup>9</sup> It also does not apply to Medi-Cal or Healthy Families programs. Lastly, it does not apply to health care plans through the Board of Administration of Public Employees' Retirement System (PERS).<sup>10</sup> Self-insured health plans including union or union-employer benefit plans are not required to follow state health plan coverage laws because the federal Employee Retirement Security Act's or ERISA pre-empts such state laws. See the discussion below.

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<sup>5</sup> Health & Safety Code Section 1374.73(c)(3); Insurance Code Section 10144.51(c)(3)

<sup>6</sup> Paraprofessionals are also called Behavior Management Technicians.

<sup>7</sup> Title 17 C.C.R. Section 54342(b); Insurance Code Section 10144.51(c)(5)

<sup>8</sup> Managed care plans or HMOs are under the jurisdiction of the Department of Managed Health Care (DMHC); Indemnity health plans – that is, plans that do not restrict you to a network of providers – are under the jurisdiction of the California Department of Insurance (CDI). PPO or Preferred Provider Organization plans are indemnity plans and therefore are generally under the jurisdiction of the CDI. However, most Blue Cross and Blue Shield PPO plans are under the jurisdiction of the DMHC.

<sup>9</sup> These are plans that cover services in a single specialized area of health care such as a dental or vision health plan. Health & Safety Code Section 1345(o)

<sup>10</sup> Health & Safety Code Section 1374.73(d); Insurance Code § 10144.51(d)

## **How do I know if my employer's health plan is a self-insured plan? Should I ask my self-insured plan for behavioral health treatment for PDD or autism?**

Read the evidence of coverage booklet you got when you first enrolled in the plan. There should be some reference to the term "self-insured." You may also want to consult with your employer's Human Resources (HR) Department. Knowing if a health plan is a self-insured plan can be confusing because many self-insured plans are administered by an insurance company. Sometimes that same plan also provides a "stop-loss coverage," namely assumption of coverage if health care costs go above a certain amount. Although self-insured plans are not required to follow state health plan laws concerning coverage,<sup>11</sup> many do. If yours does, then the self-insured plan will have benefits comparable to other health plans. It may be worthwhile to ask the plan to cover behavioral health treatment needed for PDD or autism.

## **How do I ask my insurance company or health plan for coverage?**

Discuss the behavioral health treatment services you think are necessary with your primary care doctor or autism specialist, if you have been referred to one. Either your primary care physician or specialist will submit a request for authorization for treatment. Your medical group, Independent Physicians Association ("IPA"), or plan will review the treatment request and either approve or deny coverage. A denial could be based, among other things, on the medical group or plan's conclusion that the service is not medically necessary, experimental, or not a covered benefit. See <http://www.disabilityrightsca.org/pubs/F07201.pdf> for a discussion of the steps you can take if your insurance company denies behavioral health treatment.

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<sup>11</sup> 29 U.S.C. Section 1144(a)

## **I am a regional center client. How can the regional center help me get the services I need?**

Whether or not the primary care physician's request on your behalf for behavioral health treatment is approved will often depend on the medical justification for the service. The regional center can help you show the medical justification for the service. You should ask your Service Coordinator to help you get the documentation that will make an approval more likely. You may also want to have your IPP amended to expressly include the help you may need. For instance, the IPP can say that the regional center will help you by documenting your need for behavioral health treatment including by reviewing the medical justification to see if additional information or an expanded explanation or additional documents are needed.

## **Can the regional center pay for my copays, coinsurance and/or deductibles under the Lanterman Act?**

Yes, as of June 20, 2014, regional center may pay for insurance copays, coinsurance, or deductibles if the service is included in the child's individual program plan or individual family services plan and is needed to ensure that your child receives the service<sup>12</sup> and the following criteria is met for minors:

- 1) The child is covered by a health care service plan or health insurance policy under his or her parent/guardian/caregiver.
- 2) The family's annual gross income is at or below 400 percent of the federal poverty level.
- 3) There is no other third party responsible for the cost.

For adult consumers, regional center may pay for insurance copays, coinsurance or deductibles if the service is included in the individual program plan (IPP) and needed to ensure that the service is received and the following criteria is met:

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<sup>12</sup> Welfare and Institutions Code Sec. 4659.1(a)

- 1) The consumer has an annual gross income of 400 percent of federal poverty level or less.
- 2) There is no other third party responsible for the cost.<sup>13</sup>

## **What if our family has an income over 400 percent of the federal poverty level?**

For families that have an annual income above 400 percent of federal poverty level, the regional center may pay copays, coinsurance or deductibles if needed to maintain the child in the home and one or more of the following applies:

- 1) An extraordinary event occurred that impacts the ability of the parent/guardian/caregiver to pay the copay or coinsurance or to meet the care and supervision needs of the child.
- 2) A catastrophic loss (things like natural disasters or accidents) that temporarily impacts the ability of the parent/guardian/caregiver or adult consumer to pay copays or coinsurance.
- 3) Significant unreimbursed medical costs associated with the child or another child who is a regional center consumer.<sup>14</sup>

## **How does the regional center know what my gross annual income is?**

Families should provide the regional center with a copy of the W-2 Wage Earner Statement, payroll stubs, state income tax return or other proof of income.<sup>15</sup> You should notify the regional center when a change in your income occurs that could result in a change in eligibility.<sup>16</sup>

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<sup>13</sup> Welfare and Institutions Code Sec. 4659.1(b)

<sup>14</sup> Welfare and Institutions Code Sec. 4659.1(c)

<sup>15</sup> Welfare and Institutions Code Sec. 4659.1(d)

<sup>16</sup> Welfare and Institutions Code Sec. 4659.1(e)

## What is the federal poverty level for 2014?

<b>Persons in Family</b>	<b>48 Contiguous States and D.C.</b>	<b>400% of Poverty Level</b>
1	\$11,670	\$46,680
2	15,730	62,920
3	19,790	79,160
4	23,850	95,400
5	27,910	111,640
6	31,970	127,880
7	36,030	144,120
8	40,090	160,360

*Note: For each additional person, add 4,060*

## How can I find the federal poverty level for future years?

You can go to this website for information about the federal poverty level: <http://aspe.hhs.gov/poverty/index.cfm>. 400% of the federal poverty level is the federal poverty level multiplied by 4.

## **Can the regional center help pay for my deductibles under the Lanterman Act?**

Yes, as of June 20, 2014, the law was changed to allow the regional center to pay for deductibles as outlined above.<sup>17</sup>

## **Can a regional center terminate my behavioral services because of SB 946?**

This bill does not automatically affect the services you receive from a regional center.<sup>18</sup> However, if you or your family are eligible for Medi-Cal, Medicare, the Civilian Health and Medical Program for Uniform Services (CHAMPUS—otherwise known as TRICARE), In-Home Support Services (IHSS), California Children’s Services (CCS), private insurance, or a health care service plan, and you or your family choose not to apply for or use these services, then the regional center cannot purchase those services for you.<sup>19</sup>

If you, or your family, show the regional center that Medi-Cal, private insurance, or a health care service plan has denied the behavioral service and the regional center decides that an appeal would have no merit, then regional center can pay for it.<sup>20</sup> If the regional center decides that you should appeal, ask for the regional center’s help.

A regional center can also pay for behavioral services while you, or your family, are trying to get the services from another agency or private insurance either when you have not yet received a denial, or while you or your family are waiting for a final administrative decision and you already provided the regional center with information that you are appealing, or until Medi-Cal, private insurance, or a health care services plan begins to provide the services.

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<sup>17</sup> Welfare and Institutions Code Sec. 4659.1(a)

<sup>18</sup> Health & Safety Code Section 1374.73(a)(4)

<sup>19</sup> Welfare & Institutions Code Section 4659(c)

<sup>20</sup> Welfare & Institutions Code Section 4659(d)

If your regional center wants to change your services by requiring you to use a generic service or your private insurance, the regional center must either hold an IPP meeting and reach agreement with you about the change or give you a written notice of action.<sup>21</sup> The notice must be given 30 days before the change begins.<sup>22</sup> The notice must give you the following information:

- the basic facts about why the regional center is making its decision;
- the reason for the action;
- the effective date; and,
- the specific law, regulation or policy that supports the action.<sup>23</sup>

If you are already receiving the service and you disagree with the regional center's decision and want to continue to receive the service, you must request a fair hearing within 10 days of receiving the notice.<sup>24</sup> Otherwise, the request must be made within 30 days.<sup>25</sup> If exemptions are available and you think you meet an exemption, remember to additionally put "I meet an exemption" into your fair hearing request.

For more important information on how to appeal decisions by the regional center, read our fact sheet, Regional Center Due Process and Hearing Rights at <http://www.disabilityrightsca.org/pubs/F02601.pdf>.

## **Does this mean that either the Early Start Program or local school district can terminate my behavioral services?**

This bill does not automatically impact any services you are receiving from the Early Start Program or the local school district.<sup>26</sup> Any change to your services should go through the IFSP or IEP process. Remember, if you are already receiving a service, you have a right to continue (stay put) that

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<sup>21</sup> Usually, decisions about the services you need must be decided by an IPP team. Welfare and Institutions Code section 4646.4(a)-(c). However, the law says if a regional center wants to reduce, end or change a service in your IPP without your consent, it has to give you a 30 day notice first. Welfare and Institutions Code section 4710

<sup>22</sup> Welfare and Institutions Code section 4710

<sup>23</sup> Welfare and Institutions Code section 4701. The information must also be in the language you understand.

<sup>24</sup> Welfare and Institutions Code section 4715

<sup>25</sup> Welfare and Institutions Code section 4710.5(a)

<sup>26</sup> Health & Safety Code Section 1374.73(a)(3) and (4)

service if you timely appeal a reduction or termination. See Special Education Rights and Responsibilities, Chapter 6 on Disputes, at <http://www.disabilityrightsca.org/pubs/504001Ch06.pdf>, Chapter 12 on Early Start, at <http://www.disabilityrightsca.org/pubs/504001Ch12.pdf>, and <http://www.disabilityrightsca.org/pubs/F01601.pdf>

### **Will SB 946 make it more difficult for a special education student with autism, to obtain behavioral services from a school district?**

SB 946 should not make it more difficult to obtain behavioral services from a school district and it should not delay the process of obtaining these services from a school district.

SB 946 states: “This [law] shall not affect or reduce any obligation to provide services under an individualized education program<sup>27</sup>” under either state or federal law.

The obligation of schools to provide necessary educational, including behavioral, services to a student with autism is strong, even though the student’s insurance coverage may include behavioral services as required by SB 946. Federal special education does not allow school districts to utilize parents’ insurance benefits to pay for services if the parents would be subject to some financial loss as a result.<sup>28</sup> These losses include decreased lifetime coverage or loss of other benefits, increased premiums or policy termination, and out-of-pocket expenses, such as co-pays and deductibles.<sup>29</sup> The U.S. Department of Education has repeatedly stated that school districts may not withhold or deny special education services based on a parent’s refusal to consent to the use of his or her insurance to pay for these services.<sup>30</sup> However, the increased availability of insurance coverage for behavioral services may lead school districts to ask more often about insurance coverage and to ask for parents’ consent to use the

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<sup>27</sup> Health and Safety Code Section 1374.73(a)(4) and Insurance Code Section 10144.51(a)(4), respectively.

<sup>28</sup> *Seals v. Loftis* (E.D. Tenn, 1985) 614 F.Supp. 302; *Raymond S. v. Ramirez* (N.D. Iowa, 1996) 918 F.Supp. 1280.

<sup>29</sup> *Id.*

<sup>30</sup> *Simon*, 17 IDELR 225 (1990), *Conway*, 211 IDELR 438 (1987), *Spinner*, 18 IDELR 310 (1991).

private insurance. Parents do not need to consent to the use of their insurance if it may result in any of the financial losses described above.

Delays in the provision of services are also prohibited by law whether or not the parent has consented to submitting a claim for payment to their insurance for services identified in their child's individualized education program.

*Disability Rights California is funded by a variety of sources, for a complete list of funders, go to <http://www.disabilityrightsca.org/Documents/ListofGrantsAndContracts.html>.*