Health Insurance Coverage of Behavioral Health Treatment for People with Autism or PDD/NOS

Information for RCEB families on what types of insurance provide this treatment, how to access services and how to obtain help with copayments

California Senate Bill 946 (SB946) went into effect on July 1, 2012. This bill requires that private health insurers regulated by the State of California pay for behavioral health treatment for those diagnosed with PDD/NOS or autism.

What is private health insurance?

Generally people either have private health insurance through their employer or by purchasing an individual plan for themselves and/or their family. Private health insurance does not include Medi-Cal or Medicare.

What health insurance is regulated by the State of California and who regulates it?

The Department of Managed Health Care and the Department of Insurance regulate plans in California. Most plans where an employer pays a premium to purchase health insurance are regulated by the Department of Managed Health Care. Some plans, generally those purchased by individuals, are regulated by the Department of Insurance.

What health insurance coverage is excluded from the law?

SB 946 specifically excluded Medi-Cal, Healthy Families and CalPERS from this coverage requirement. After the law was passed, Healthy Families and some CalPERS plans were told that they needed to cover these services because of the California mental health parity law which was passed in 1999 (AB88). This law required private health insurance plans to provide equal coverage for physical health and selected mental health conditions. The law required health plans to eliminate the benefit limits and reduce the cost-sharing requirements that have traditionally made mental health benefits less comprehensive than physical health benefits.

Healthy Families is required to cover these services. Please note that in 2013, most children in Healthy Families will transition to Medi-Cal and Healthy Families will no longer exist.

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 (see below) and are not required to offer these services.

Medi-Cal is not required to cover these services.

Plans that are not regulated by the state of California are not required to cover these services

What plans are not regulated by the State of California?

> **Health insurance obtained from out of state.** Out of state plans are regulated by the state in which the policy is issued. Occasionally a parent will work out of state and their insurance will be subject to that state's laws. Over 30 states have laws regarding autism treatment so coverage varies by state.
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> **Self-Funded /Self-Insured plans**. These plans are only subject to federal law. When companies are self-insured, they assume most of the financial risk of providing health benefits to employees. Instead of paying premiums to insurers, they pay claims filed by employees and health care providers. To avoid huge losses, they often sign up for a special kind of "stop loss" insurance that protects them against very large or unexpected claims. They usually use an administrator that looks like a health insurer to manage their claims. They are able to determine what their plans cover and will not be subject to either California law or the provisions of the affordable care act. However, there are a number of self-insured plans that do cover behavioral health treatment for persons with autism/pdd-nos.
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> **Federal employee plans**. These plans are akin to self-funded plans and are not regulated by individual states. Some plans do cover behavioral health treatment.
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> **TRICARE.** Plan for military families. TRICARE was already providing services as part of a settlement agreement on this issue last year. Services are currently limited but changes are anticipated this year.

How are behavioral services accessed through Health insurance?

If your family member has private health insurance, CalPERS or Healthy Families, you will need to contact your health insurance to initiate the process of obtaining behavioral health treatment. Private health insurance is considered by the regional center to be a generic resource that must be used for available services. You can request assistance with this process from your family member's pediatrician, other medical providers, and from the insurance plan's Member Services/Customer Services Department. Your health insurance plan should be able to provide you with a list of their contracted behavioral health providers. You may also want to ask your current behavioral provider if they are contracted with your health insurance for these services.

What if I believe my plan is excluded from the law?
If your family member has Medi-Cal only as health insurance, let your case manager know that there is no other insurance.

If you think your health insurance may be self-funded and not subject to this law,

Ask your employer's human resources department about your insurance.

If you are told the plan is self-funded, ask whether behavioral health treatment for persons with autism or PDD/NOS is paid for by the plan.

Obtain written documentation that the plan is self-funded.

If the plan does not cover behavioral health treatment, obtain a copy of the EVIDENCE OF BENEFITS for the plan that states this or a letter from the administrator documenting this fact

If your health insurance is regulated by another state, share the information with your case manager who will let you know what to do

If your health insurance is through employment with the federal government, provide your insurance card to your case manager. The case manager will have it reviewed to see if the plan covers these services.

Copayments

With the change in law leading to health insurance coverage for behavioral health treatment for autism and PDD/NOS, your family may have co payments for behavioral health treatment. Usually these copayments are a flat rate per day. Some families have co-insurance which is a percentage of the daily cost of service. RCEB will consider funding copayments and co-insurance when planning team agrees that behavioral health treatment is necessary for the individual due to their eligible condition for regional center services.

RCEB will fund copayments for behavioral health treatment that prior to SB 946 would havebeen funded by the regional center. RCEB will not fund copayments for services used ineducational settings

What is the process for having behavioral health treatment copayments funded by RCEB?

Let your case manager know that you want RCEB to fund your copayments

RCEB will consider funding copayments for behavioral health treatment provided after July 1,2012. This process does not apply to any other services.

RCEB will pay the service provider directly for copayments /co-insurance. If they are not a current vendor, RCEB will work with them so we can pay them directly

Copayments will be authorized by the "Plan Year" for your health insurance. Most plan years are January to December.

What documentation do I need to provide?

You will need to provide the following written documentation to your case manager:

A copy of the treatment plan developed by your provider for services paid for by your health insurance. You probably have this in your home binder from your provider.

Information on the frequency of treatment (e.g. 2 days per week). This is usually in the treatment plan

Summary of Benefits for your health insurance detailing the plan year and the out of pocket maximums and copayments for services.

Copy of a bill/billing statement from the provider that indicates the copayments/coinsurance for the service.

For 2013, RCEB will limit the initial authorization for copayments to three months. After this period RCEB will require documentation of the current amounts that have been credited to your son or daughter's out of pocket maximum. The second authorization will be limited to the dollar amount that could be needed to reach the annual maximum. With some health insurers, definitely Kaiser, you may have to bring statements that copayments have been made to Member Services in order to have them credited to the out of pocket maximum.

Your case manager will be your primary contact to obtain an authorization. Occasionally we may need other documentation.