



Senate Fiscal Agency
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BILL



ANALYSIS

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Senate Bills 414, 415, and 981 (as enacted)
Sponsor: Senator Mike Green (S.B. 414)
Senator Tupac A. Hunter (S.B. 415)
Senator Randy Richardville (S.B. 981)
Senate Committee: Health Policy
House Committee: Families, Children, and Seniors

PUBLIC ACTS 99, 100, and 101 of 2012

Date Completed: 5-2-12

RATIONALE

The Centers for Disease Control and Prevention estimates that approximately one in 88 American children are diagnosed with an autism spectrum disorder (ASD). Autism and ASD are general terms for a range of complex brain disorders characterized by difficulties in social interaction, verbal and nonverbal communication, and repetitive behaviors, according to the advocacy organization Autism Speaks. In addition, ASDs can be associated with intellectual disability, difficulties with motor coordination and attention, and physical health issues, such as sleep and gastrointestinal disturbances. Autism is thought to be caused by a combination of genetic and environmental factors and appears to have roots in early brain development; the most noticeable signs and symptoms tend to become apparent between the ages of two and three years.

While there is no cure, early diagnosis and intervention can lead to improved outcomes for people on the autism spectrum. Many parents, however, face significant barriers to getting appropriate treatment for their children with ASDs. Because the majority of insurance plans do not cover the diagnosis and treatment of autism, there are few qualified providers in the State and the treatment is often prohibitively expensive. Therefore, it was suggested that health insurance carriers in Michigan should be required to provide such coverage, and that a State fund should be established to reimburse the insurers for the expenses they incur in providing access to the covered services.

CONTENT

Senate Bills 414 and 415 amended the Nonprofit Health Care Corporation Reform Act and the Insurance Code, respectively, to require a policy, certificate, or contract to provide coverage for the diagnosis and treatment of autism spectrum disorders.

Senate Bill 981 enacted the "Autism Coverage Incentive Act" to require the Department of Licensing and Regulatory Affairs (LARA) to create and implement an autism coverage incentive program through which carriers and third-party administrators can seek reimbursement for paid claims for the diagnosis and treatment of ASDs. The bill also does the following:

- **Creates the "Autism Coverage Fund" to provide the reimbursement.**
- **Requires LARA to develop and implement a process to notify carriers, third-party administrators, and the Legislature when LARA believes that program funds might be insufficient to cover future claims within 60 days.**
- **Requires LARA to submit annual reports to the State Budget Director and the Legislature on the funding awarded under the program and the program's administrative costs.**
- **Limits to 1% the amount of the annual appropriation to the Fund that may be used for administrative expenses.**

The bills took effect on April 18, 2012. Senate Bills 414 and 415 apply to policies, certificates, and contracts delivered, executed, issued, amended, adjusted, or renewed in Michigan beginning 180 days after that date.

All of the bills were tie-barred to each other.

Senate Bills 414 and 415

The bills require a policy, certificate, or contract to provide coverage for the diagnosis and treatment of ASDs. Senate Bill 414 applies to a Blue Cross Blue Shield of Michigan (BCBSM) group or nongroup certificate. Senate Bill 415 applies to an expense-incurred hospital, medical, or surgical group or individual policy or certificate delivered, issued for delivery, or renewed in this State, as well as a health maintenance organization (HMO) group or individual contract.

The bills prohibit an insurer, HMO, or BCBSM from doing any of the following:

- Limiting the number of visits a member, insured, or enrollee may use for treatment of ASDs covered under the bills.
- Denying or limiting coverage on the basis that it is educational or habilitative in nature.
- Subjecting autism coverage to dollar limits, copays, deductibles, or coinsurance provisions that do not apply to physical illness generally, except as otherwise provided.

Coverage for treatment may be limited to an individual through age 18, and may be subject to a maximum annual benefit as follows:

- \$50,000 per covered insured, enrollee, or member through age six.
- \$40,000 from age seven through age 12.
- \$30,000 from age 13 through age 18.

Senate Bill 415 also prohibits an insurer and an HMO from terminating coverage or refusing to deliver, execute, issue, amend, adjust, or renew coverage solely because an individual is diagnosed with, or has received treatment for, an ASD.

The bills provide that they do not limit benefits that are otherwise available to an

individual under a certificate, contract, or policy.

The bills require an insurer, HMO, or BCBSM to use evidence-based care and managed care cost-containment practices pursuant to its procedures as long as they are consistent with the bills. The required coverage may be subject to other general exclusions and limitations of the policy, contract, or certificate, including coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, utilization review of health care services including review of medical necessity, case management, and other managed care provisions.

If a member, insured, or enrollee is receiving treatment for ASD, the bills allow BCBSM, an insurer, or an HMO, as a condition of providing the coverage, to do all of the following:

- Require a review of that treatment consistent with current protocols and require a treatment plan.
- Request the results of the autism diagnostic observation schedule that has been used in the diagnosis of an ASD for that individual.
- Request that the schedule be performed on that individual not more than once every three years.
- Request that an annual development evaluation be conducted and the results submitted to BCBSM or the insurer or HMO.

If an insurer, HMO, or BCBSM requests a treatment review, that entity must bear the cost.

(The bills define "treatment plan" as a written, comprehensive, and individualized intervention plan that incorporates specific treatment goals and objectives and that is developed by a board-certified or licensed provider who has the appropriate credentials and who is operating within his or her scope of practice, when the treatment of an ASD is first prescribed or ordered by a licensed physician or psychologist.

The bills define "autism diagnostic observation schedule" as the protocol available through Western Psychological Services for diagnosing and assessing ASDs or any other standardized diagnostic

measure for ASDs that is approved by the Commissioner of the Office of Financial and Insurance Regulation (OFIR), if he or she determines that the measure is recognized by the health care industry and is an evidence-based diagnostic tool.)

Beginning January 1, 2014, a qualified health plan offered through an American health benefit exchange established in Michigan pursuant to the "Federal act" will not have to provide the required ASD coverage to the extent that it exceeds the essential health benefit requirements of the Federal act. ("Federal act" means the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act, and any regulations promulgated under those Acts.)

Senate Bill 415 provides that it does not apply to a short-term or one-time limited duration policy or certificate of not longer than six months. (Under the Insurance Code, such policies generally provide coverage for 185 days or less, are nonrenewable, do not cover any preexisting conditions, and are available with an immediate effective date without underwriting.)

The bills define "autism spectrum disorders" as any of the following pervasive developmental disorders as defined by the Diagnostic and Statistical Manual (DSM):

- Autistic disorder.
- Asperger's disorder.
- Pervasive developmental disorder not otherwise specified.

("Diagnostic and Statistical Manual" means the DSM of Mental Disorders published by the American Psychiatric Association or other manual that contains common language and standard criteria for the classification of mental disorders and approved by the OFIR Commissioner, if he or she determines that the manual is recognized by the health care industry and the classification of mental disorders is at least as comprehensive as the APA's manual on the bills' effective date.)

The bills define "diagnosis of autism spectrum disorders" as assessments, evaluations, or tests, including the autism diagnostic observation schedule, performed by a licensed physician or psychologist to

diagnose whether an individual has one of the ASDs. "Treatment of autism spectrum disorders" means evidence-based treatment that includes the following care prescribed or ordered for an individual diagnosed with one of the ASDs by a licensed physician or psychologist who determines the care to be medically necessary:

- Behavioral health treatment.
- Pharmacy care.
- Psychiatric care.
- Psychological care.
- Therapeutic care.

"Behavioral health treatment" means evidence-based counseling and treatment programs, including applied behavior analysis (ABA), that meet both of the following requirements:

- Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.
- Are provided or supervised by a board-certified behavior analyst or licensed psychologist, as long as the services performed are commensurate with the psychologist's formal university training and supervised experience.

"Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

"Therapeutic care" means evidence-based services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or social worker.

Senate Bill 981

The Autism Coverage Reimbursement Act requires LARA to create and operate an autism coverage incentive program to encourage and provide incentives for carriers and third-party administrators to provide coverage for the diagnosis and treatment of ASDs, and to offset any additional costs that may be incurred as a result of the autism coverage mandate under Senate Bills 414 and 415. The

Department must create and operate the program within 120 days after the Act took effect.

("Carrier" means any of the following:

- An insurer or HMO.
- BCBSM.
- A specialty prepaid health plan (i.e., a plan for an eligible Medicaid beneficiary with a serious mental illness, developmental disability, serious emotional disturbance, or substance abuse disorder).
- A group health plan sponsor.

A group health plan sponsor includes a single employer or an employee organization that establishes or maintains a plan; or, if a plan is established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties.

"Third-party administrator" means an entity that processes claims and that may also provide other administrative services under a service contract.)

The Department must develop the application, approval, and compliance process necessary to operate and manage the program. The Department also must develop and implement the use of an application form to be used by carriers and third-party administrators who seek reimbursement for the coverage of ASDs. The program standards, guidelines, templates, and any other forms used to implement the program must be published and available on LARA's website.

Subject to the limitations provided in the Act, the program must reimburse carriers and third-party administrators, as approved by LARA, in an amount equal to the amount of paid claims (as defined below) that are paid after the Act's effective date. A carrier or third-party administrator must apply for approval of funding associated with those paid claims. As part of the application, the applicant must include the results from a completed autism diagnostic observation schedule or any other annual development, as well as documentation verifying the paid claims for which the applicant is seeking reimbursement. In determining whether to

approve an application, LARA may review whether the treatment for which the claims were paid is consistent with current protocols and cost-containment practices of BCBSM, the insurer, or the HMO, as applicable. The Department must review and consider applications in the order they are received, and approve or deny an application within 30 days after receiving it.

To the extent there is a cap on the amount of mandated autism coverage (required by Senate Bills 414 and 415), LARA may not approve more than the mandated amount to any carrier or third-party administrator seeking reimbursement for paid claims.

If a third-party administrator receives any funding under the program, it must apply the funding to the benefit of the carrier covering the claim upon which the funding was received.

If LARA determines at the end of a fiscal year that a carrier was not reimbursed fully for paid claims paid due to a shortfall in the reimbursement fund, and the carrier increases its rates in the following year to cover the total amount of the unreimbursed paid claims, the rate increase may not be considered reimbursement or compensation for those claims, if the OFIR Commissioner determines that the increase is a reasonable recoupment of the unreimbursed amount.

The Act creates the Autism Coverage Fund within the State Treasury. The Department of Licensing and Regulatory Affairs must be the Fund administrator for auditing purposes. The Department may spend Fund money, upon appropriation, only for the purpose of creating, operating, and funding the autism coverage incentive program. A maximum of 1% of the annual appropriation made to the Fund may be used for the purpose of administering the program.

The Department must reimburse carriers and third-party administrators from the Fund in the order in which the applications are approved. If there is insufficient money in the Fund to reimburse a carrier or third-party administrator for approved paid claims, reimbursement may not be made. Applications that are approved but not reimbursed may be paid, however, if Fund revenue becomes available.

The State Treasurer may receive money or other assets from any source for deposit into the Fund. The State Treasurer must direct the investment of the Fund, and credit to it any interest and earnings. Money in the Fund at the close of the fiscal year is to remain in the Fund and not lapse to the General Fund.

The Department must develop and implement a process to notify carriers, third-party administrators, and the Legislature that program funds might be insufficient to cover future claims when the Department reasonably believes that the funds will be insufficient within 60 days. At a minimum, the process must do all of the following:

- Identify a specific date by which carriers and third-party administrators will no longer receive reimbursement for submitted claims.
- Outline a clear process indicating the order in which claims pending with the program will be paid.
- Outline a clear process indicating the order in which claims pending when the fund became insufficient will be paid, if funds become available subsequently.

By April 1 of each year, LARA must submit a report to the State Budget Director and the Senate and House of Representatives Appropriations Committees. The report must include all of the following for the preceding calendar year:

- The total number of applications received under the program.
- The number of applications approved and the total amount of funding awarded under the program.
- The amount of administrative costs used to administer the program.

The Department may not make a commitment or implement the program under the Act until the Legislature has appropriated sufficient funds to cover it.

(The Act defines "paid claims" as actual payments, net of recoveries, for the diagnosis and treatment of ASDs made to a provider or reimbursed to an individual by a carrier, third-party administrator, or excess loss or stop loss carrier. "Excess loss" or "stop loss" means coverage that provides insurance protection against the accumulation of total claims exceeding a

stated dollar level for a group as a whole or protection against a high-dollar claim on any one individual.

"Paid claims" does not include any of the following:

- Claims paid for services rendered to a nonresident of Michigan or a person covered under a health benefit plan for Federal employees.
- Claims paid for services rendered outside of the State to a Michigan resident.
- Claims paid under a Federal employee health benefit program, Medicare, Medicare Advantage plan, Medicare Part D, Tricare, by the U.S. Veterans Administration, and for high-risk pools established pursuant to the Federal Act.
- Costs paid by an individual for cost-sharing requirements, including deductibles, coinsurance, or copays.
- Claims paid by, or on behalf of, the State.
- Claims paid that are covered by Medicaid.
- Claims paid for which the carrier or third-party administrator already has been reimbursed or compensated through any increase in premiums or rates or from any other source.
- Beginning January 1, 2014, claims paid for services that are included in the essential health benefits requirements required under the Federal Act.)

MCL 550.1416e (S.B. 414)
500.3406s (S.B. 415)
550.1831-550.1841 (S.B. 981)

ARGUMENTS

(Please note: The arguments contained in this analysis originate from sources outside the Senate Fiscal Agency. The Senate Fiscal Agency neither supports nor opposes legislation.)

Supporting Argument

Reportedly, autism affects more than 15,000 children in Michigan. Early intervention using evidence-based treatments, such as ABA and occupational and speech therapy, has been shown effective in improving outcomes for people with ASDs. These individuals might achieve more in terms of education, communication, and self-care, increasing the likelihood that they can live independently as adults and minimizing their need for taxpayer-funded supports. It is estimated, however, that only 15% of Michigan's children with autism receive the

therapies and services they need. For families of children with ASDs, the costs of diagnosis and treatment can be devastating—evidently, totaling tens of thousands of dollars per year. This burden is magnified if a family has more than one child with autism, or a parent has to quit his or her job to care for a child.

In addition, the absence of autism insurance coverage in Michigan has discouraged the emergence of a viable network of qualified providers, so even the few families who can afford to pay might not have access to treatment. Although several of the State's universities have excellent ABA programs, many people who earn degrees in this field leave Michigan for states with autism coverage mandates and better employment opportunities. The bills will have a positive impact on the State's economy by creating well-paying jobs that attract highly educated people to Michigan, and will help ensure that children with ASDs have access to the services they need.

The onus of providing ASD treatment traditionally has fallen on school systems, which lack the resources and qualified professionals to address the varied needs of children across the autism spectrum. It is a school system's responsibility to educate children, not to provide medical treatment. While schools might play an important role in facilitating educational progress among children with ASDs, autism is a recognized neurodevelopmental disorder and should be treated as a health issue, just like other conditions identified in the DSM. By requiring that autism coverage be included in a comprehensive health insurance policy, the bills will reduce the need for costly special education services in schools and shift primary responsibility for treatment to the more appropriate medical arena.

While the treatment of ASDs might be expensive in the short term, the social costs of not providing treatment are staggering. Reportedly, the expense associated with caring for a person with autism over his or her lifetime is \$3.2 million, much of which is related to adult care services for those who cannot work or live on their own. Ultimately, a significant portion of these expenses falls on public school systems and the State. Experience from states with autism coverage mandates indicates that evidence-based treatment can reduce

lifetime costs by approximately \$2.0 million per person. With appropriate treatment, more than half of those diagnosed with autism can become independent, tax-paying members of society rather than users of taxpayer funded services. The increase in insurance premiums anticipated as a result of the coverage mandate is negligible, and will be a prudent investment in light of the long-term benefits. Expanding access to treatment via the mandate and reimbursement mechanism will reduce the overall financial burden and provide hope for people with autism and their families.

Response: The law should not limit autism coverage to those aged 18 and younger. Some people with ASDs might benefit from treatment after that age, but cannot afford it. Also, music therapy should be specifically included as a covered treatment. Music therapy is evidence-based and has been used successfully for many years to help children with autism develop social, emotional, and communication skills.

Opposing Argument

Expanding access to effective therapies is a worthwhile goal; thus, the legislation should apply to all mental health conditions. Many people with a variety of brain disorders face serious obstacles related to treatment access and affordability. Some insurance plans do not include any mental health coverage, and those that do typically cover mental health services at a lower level than they cover physical health services, resulting in potentially unaffordable out-of-pocket expenses for patients and their families. Mandating insurance coverage for only those with autism, a small segment of the population with brain disorders, is inconsistent and unfair.

Furthermore, many children with ASDs also have a co-occurring mood disorder, and sometimes it is not clear which disorder causes particular symptoms. A holistic approach is necessary to provide truly successful treatment. Therefore, the insurance coverage requirement should apply to therapies for the full range of brain disorders.

Reportedly, the cost of implementing comprehensive mental health parity legislation would be insignificant. Such a law would ensure that all people, including those with ASDs, received the treatment they needed and that all families were protected

from the overwhelming costs of services and the devastating consequences of doing without them.

Response: Until now, autism has been the only chronic condition for which no insurance coverage was provided in Michigan, aside from policies offered by a handful of large employers. Some insurance plans do provide a certain level of coverage for the treatment of other brain disorders, and a general mental health provider network does exist. The bills address an immediate need among the State's population with autism and represent a step toward full mental health parity.

Opposing Argument

The bills represent an inappropriate intrusion of government into decisions made by health insurance purchasers, both group and individual, and will hamper negotiations between employers and workers. The State should not be dictating what level of coverage should be provided or how health services should be paid for. Purchasers should be able to weigh available benefits against costs and determine for themselves which policies best meet their needs.

Rather than expanding access to health care, government insurance mandates actually lead to higher costs, narrower coverage, and fewer people insured. The rising cost of health care is a principal concern for employers. As insurance becomes less affordable, some employers limit benefits, increase employee cost-sharing, or drop coverage altogether. Additional requirements imposed by the State, such as the autism coverage mandate, further drive up costs, leading fewer employers to provide insurance for their workers and ultimately increasing the number of underinsured and uninsured. In addition, under the bills, insurance carriers will have to comply with the coverage mandate even if a shortfall in the Autism Treatment Fund precludes reimbursement, leaving individual and group purchasers, particularly small businesses, to bear the cost.

Furthermore, State insurance mandates actually affect only a small portion of Michigan's population: those who are insured by a private insurer or HMO, or BCBSM. The autism coverage requirement will not have an impact on those covered by Medicaid and MI Child, the uninsured, or

employees of companies large enough to self-insure under the Employee Retirement Income Security Act (ERISA), which preempts State insurance laws. Thus, the bills will increase costs for smaller employers and individuals without extending access to treatment to a significant number of people.

As an alternative to a carrier reimbursement fund, Michigan could expand coverage for children with ASDs under the existing Children's Special Health Care Services program; establish a mechanism to reimburse families directly, whether or not they are covered by private insurance; or implement a scholarship program through which parents could receive funds for treatment through private providers outside of the public school system.

Response: While employers that self-insure under ERISA are not subject to the coverage mandate, the reimbursement mechanism under Senate Bill 981 might give them an incentive to provide autism coverage voluntarily.

Opposing Argument

A State-imposed mandate and reimbursement system should not be necessary; the tremendous social costs of not treating ASDs should be a sufficient incentive for insurance carriers to provide autism coverage on their own. Tax dollars should not be used to reimburse these private companies, as required by Senate Bill 981, especially if that money will be diverted from other government programs to support the Autism Treatment Fund.

Legislative Analyst: Julie Cassidy

FISCAL IMPACT

Senate Bills 414 and 415

The estimated fiscal impact of this legislation includes the cost to State and local governments as insurers and potential savings to State and local governments due to positive results from intervention, particularly reductions in special education and mental health expenditures. This estimation process is further complicated because many if not most State and local government employees work for entities that self-insure and thus are not subject to State regulation. (Instead, health benefits provided for employees of self-insured entities are regulated at the Federal level

under the Employee Retirement Income Security Act, or ERISA.) This legislation will not affect ERISA plans.

Among the services that will be covered are behavioral health treatment, pharmaceutical services, and what is known as "applied behavior analysis" (ABA). When provided to individuals diagnosed with autism spectrum disorders, ABA services are intensive services intended to improve an ASD individual's ability to function.

Estimating the cost of the services to State and local government requires taking a universal view, in which the potential cost to all insurers (including ERISA plans) is measured against total expenditures by all insurers (including ERISA plans) to derive a percentage cost increase. That percentage increase can then be used on estimates of State and local insurance costs to derive an estimated fiscal impact. Including ERISA plans in this estimate would be problematic only if the likelihood of ASDs among that segment of the child population were significantly different from the likelihood among non-self-insured individuals. There appears to be no reason to expect a significant difference in the ERISA population. The estimation process also includes the cost for services to Medicaid and MICHild recipients and, given that Supplemental Security Income (SSI) disability results in categorical eligibility for Medicaid, the total cost might well be somewhat overstated.

The Department of Community Health (DCH), in its presentation to the House Subcommittee on the Department of Community Health on February 28, 2012, estimated that about 4,500 Michigan children between the ages of 2 and 5 have ASDs. The bills, however, will provide coverage up to age 18; thus, the universe of those potentially eligible for services is much greater than 4,500. The DCH estimate for the average cost of expanded treatment for Medicaid- and MICHild-eligible ASD children is \$17,000 per year per child.

Using this number (which may be low due to Medicaid provider rates being lower than average), and assuming a universe of eligible children closer to 15,000 than 4,500 due to the 18-year age limit, leads to an estimated cost to all insurers of \$255.0 million per year. It is important to note that

this \$255.0 million figure is *not* the actual increase in health insurance costs that could occur due to this legislation. This number is clearly overstated as a significant number of the children involved will be publicly insured by Medicaid or MICHild or will belong to self-insured plans and will not be subject to this legislation, and the actual number is likely less than half that amount. The \$255.0 million figure is a useful number, however, to estimate an upper bound on the percentage cost increase.

Looking at the process used by the Senate Fiscal Agency (SFA) to derive the Health Insurance Claims Assessment (HICA) legislation revenue estimate, health expenditures in Michigan are close to \$80.0 billion. Once out-of-pocket costs and Medicare costs are subtracted (as Medicare rarely covers children), the expenditure base is closer to \$50.0 billion. The \$255.0 million figure represents about 0.5% of total health care expenditures. Therefore, a reasonable conclusion is that implementation of the bills will increase health insurance costs by a maximum of 0.5% and likely less than that.

Research in other states resulted in similar conclusions, with an estimated cost increase of \$50 per policy per year reflected in analyses in South Carolina and Wisconsin, with a significantly lower cost estimate of \$5 to \$20 per policy per year in Indiana. These estimates correspond to rate increases of 0.1% to 0.5%.

In 2011, the SFA estimated that paid health claims for State and local government in Michigan are about \$3.6 billion in State and local revenue. If the 0.5% figure is correct and none of the State and local entities are self-insured, then the legislation will increase State and local expenditures by \$18.0 million per year, with about half of those costs accruing to school districts. Given the general belief that at least half of the public employees in the State work for entities that self-insure, the most useful estimate is that the legislation will increase State and local expenditures by \$9.0 million per year.

The net cost savings from improved outcomes is far more difficult to estimate. Studies have varied on the benefits of ABA and similar interventions. Replication of results has been difficult to achieve and most studies have not been randomized

controlled trials. Randomized controlled studies are the most useful studies in evaluating programs and interventions. There do not appear to be any randomized longitudinal trials that would help provide a clear answer to the long-term impact of ABA.

Some of the randomized controlled trials show improvement in intelligence quotient (IQ) and adaptive behavior for a significant portion of the population served (source: British Medical Journal, *Evidence-Based Mental Health*, November 2011). There was less evidence in the randomized controlled studies to support improvement in symptom severity scores and other measures. A nonrandomized Pennsylvania study indicated improvement in symptoms and language and socialization skills (Penn State College of Medicine). Improvements in various areas should lead to lesser need for non-health-related services, in particular special education, in the longer term. Providing a precise estimate of such savings is impossible; the most useful studies are randomized controlled studies and the results speak to impact on measures, not specific expenditures that likely would be reduced due to changes in those measures. As noted, long-term randomized controlled longitudinal studies would be necessary to examine the demand and cost of services and the results of the intervention.

Given the cost of special education and mental health services, minor improvements for a small portion of the ABS population served will result in savings that will almost certainly more than offset the increased insurance cost for State and local governments. Therefore, one would expect the bills to lead to an indeterminate but positive fiscal impact for State and local governments. A more definitive fiscal impact statement would have to be based on a well-designed long-term peer-reviewed randomized controlled longitudinal study.

Senate Bill 981

Senate Bill 981 will create some new costs for the Department of Licensing and Regulatory Affairs related to the development and administration of the autism coverage incentive program. Administrative costs may include processing applications for the program, administering payments, and likely other operational

expenses. The bill also establishes the Autism Coverage Fund, which will be funded by a legislative appropriation made at a later date. The bill specifies that not more than 1% of the annual appropriation made to the Fund may be spent on administering the autism coverage incentive program. It is not known at this time how much money will be appropriated to the Fund, how much (up to 1%) of that will be used for administration, or if 1% of the appropriation will be sufficient to administer the program. Any administrative costs in excess of 1% of the Fund's annual appropriation will be borne by existing LARA resources.

The cost of Senate Bill 981 will equal the amount of public money deposited in the Fund. The bill does not specify the amount as it will be subject to annual appropriations, so the cost of the Fund will be determined by the Legislature through the budgetary process.

Fiscal Analyst: Steve Angelotti
Josh Sefton

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.