2nd App. No. B232338

IN THE COURT OF APPEAL FOR THE STATE OF CALIFORNIA
SECOND APPELLATE DISTRICT
DIVISION THREE

CONSUMER WATCHDOG, et al.,

Plaintiff/Appellant/Cross-Respondents,

v.

CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE, et al.,

Defendants/Respondents/Cross-Appellants

Appeal from the Superior Court for the County of Los Angeles

Honorable Robert H. O'Brien, Hon. James C. Chalfant

(Superior Court Case No. BS121397)

BRIEF OF AMICI CURIAE AUTISM SPEAKS and AUTISM DESERVES EQUAL COVERAGE

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I. INTRODUCTION

Autism Speaks and Autism Deserves Equal Coverage (collectively "Autism Speaks") jointly submit this amicus brief in response to the Court's letter of April 22, 2013, and its Order of May 29, 2013, inviting interested parties to submit briefs pertinent to the issues raised on appeal.

The Department of Managed Health Care ("DMHC") agrees that applied behavior analysis ("ABA") prescribed for children with autism must be covered as a medically necessary healthcare service under California law. DMHC insists, however, that Section 2052 of the California Business and Professions Code *prohibits* it from requiring health plans to cover this service when provided and supervised by *behavior analysts who are nationally board certified* but are *not licensed under state law*. DMHC asserts that requiring this coverage would constitute a crime. DMHC's position is incorrect as a matter of law, and wrongly deprives children with autism from medically necessary and life-changing care.

DMHC maintains its position even though individuals with private insurance routinely get ABA services provided or supervised by nationally board-certified analysts ("BCBAs"). In the vast majority of states, BCBAs are currently delivering applied behavior analysis and being reimbursed by health insurance even though, like California, those states have not established a license for practitioners of applied behavior analysis. Nor does any other licensed profession in California provide for expertise in ABA as part of its licensure criteria.

If sustained, DMHC's position would result in the indefensible situation that autistic children and adults covered by state-approved private insurers can access necessary applied behavior analysis treatment provided and supervised by BCBAs, but autism sufferers subject to CalPERS state-sponsored insurance are prohibited from treatment by these same qualified therapists, on penalty of

criminal prosecution. This Court should put right this legally indefensible inequity.

The Knox Keene Act recognizes that qualified unlicensed providers may, in circumstances like this, deliver healthcare services where licensure is not required by law. In SB946, the legislature manifested its intent that national board certification was an appropriate credential for delivering insurance-reimbursed applied behavior analysis ABA in California. This Court should so hold.

II. INTERESTS OF THE AMICI

Autism Speaks is the nation's leading autism science and advocacy organization. It is dedicated to funding research into autism's causes, prevention, treatments and a cure for autism; increasing awareness of autism spectrum disorders; and advocating for the needs of individuals with autism and their families.

Autism Speaks has spearheaded the passage of autism insurance reform in over 30 states and has assisted stakeholders in implementation of these laws. Autism Speaks worked closely with the California Legislature on passage of SB946, and continues to work within California and nationally to ensure access to applied behavior analysis nationally as a necessary healthcare treatment for autism.

Autism Deserves Equal Coverage is a California organization whose mission is to ensure individuals with autism receive comprehensive coverage through health insurance for the diagnosis and treatment of autism spectrum disorders. Autism Deserves Equal Coverage also worked closely with the legislature and other advocates on passage of SB946 and continues to advocate for access to ABA as a necessary healthcare treatment for autism.

DMHC's imposition of a non-existent licensing requirement has prevented families represented by Autism Deserves Equal Coverage from receiving applied behavior analysis and reimbursement for the therapy from DMHC-regulated health plans.

III. BACKGROUND

A. Autism and Applied Behavior Analysis

Autism is a complex neurodevelopmental disorder that occurs through no fault of the affected individual or her or his family. Autism is characterized symptomatically by developmental abnormality in three areas: deficits in reciprocal social interaction skills; deficits in communication skills; and the presence of stereotyped behavior, interests, and activities.

Typically manifesting by age three, the current prevalence rate for autism is approximately 1 in 88 children -- a staggering increase from prevalence estimates of approximately 1 in 5000 a few decades ago.[1] An estimated 1 out of 54 boys and 1 in 253 girls are diagnosed with autism in the United States.[2] Prevalence

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[1] L. Wing and J. Gould, *Severe impairments of social interaction and associated abnormalities in children*, J. Autism Dev. Disord. 1979, 9:11-29; US Centers for Disease Control and Prevention (CDC), *Prevalence of Autism Spectrum Disorders — Autism and Developmental Disabilities Monitoring Network, 14 Sites, United States, 2008*, Morbidity and Mortality Weekly Report (MMWR). 2012; 61(SS03);1-19.

The 1 in 88 estimate (11.3 per 1,000) represents a 23% increase since 2009. *See New Data on Autism Spectrum Disorders,* Ctrs. for Disease Control & Prevention (Mar. 29, 2012), available at http://www.cdc.gov/Features/CountingAutism/.

[2] US Centers for Disease Control and Prevention (CDC), *Prevalence of Autism Spectrum Disorders — Autism and Developmental Disabilities Monitoring Network, 14 Sites, United States, 2008*, Morbidity and Mortality Weekly Report (MMWR) 61(SS03) 1-19 (2012).

(continued...)

rates have increased 10 to 17 percent annually in recent years.[3] While some of this statistical rise has been attributed to improved diagnoses, the best available evidence indicates that the substantial increase is actually greater incidence of the disorder.[4] More children are diagnosed with autism each year than with juvenile diabetes, AIDS, and cancer, combined.[5]

Autism affects over two million individuals in the United States, and occurs in all racial, ethnic, and socioeconomic categories. On average, medical expenditures for individuals with autism are four to six times greater than for individuals without autism. Nevertheless, due to difficulties in accessing or affording care, children with autism are more likely than other special needs children to delay or forego care entirely.

The families of autistic children have greater out-of-pocket costs, diminished work hours, more lost income, and more negative health plan

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3 *Id.*

4 Summary of information from Autism Speaks/CDC Workshop, *U.S. Data to Evaluate Changes in the Prevalence of Autism Spectrum Disorders*, (February 1, 2011) available at http://blog.autismspeaks.org/2011/02/03/s-evaluating-change/.

5 *2009/10 National Survey of Children with Special Health Care Needs*, available at http://childhealthdata.org/search?k=prevalence.

experiences.[6] Families with autistic children face "unique stresses," including depression, anxiety and decreased family cohesion.[7]

Scientists do not know what causes autism. Just as there are different levels of severity and combinations of symptoms in autism, there are probably multiple causes. The best scientific evidence available points toward a potential for various combinations of factors causing autism – multiple genetic components that may cause autism on their own, or possibly when combined with exposure to as yet undetermined environmental factors. Timing of exposure during the child's development (before, during or after birth) may also play a role in the development or final presentation of the disorder. There is a growing interest among researchers about the role of the functions and regulation of the immune system in autism – both within the body and the brain.

Since an unknown cause cannot be the target of treatment, the focus of interventions has been on therapies designed to alleviate the debilitating nature of the symptoms, as tailored for the unique diagnosis of every individual. Manifest signs and symptoms of autism may often be observed by 2 to 3 years of age or earlier. There is overwhelming consensus within the scientific community that treatment should begin as soon as possible after diagnosis and that with intensive treatment, the symptoms of autism can be made less disabling.

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6 Data Resource Center for Child & Adolescent Health, *National Profile of Children with Special Health Care Needs and Autism Spectrum Disorders: Key Findings from the 2009/10 NS-CSHCN & 2007 NSCH*, available at http://www.childhealthdata.org.

7 Laura A. Schieve et al., *The Relationship between Autism and Parenting Stress*, 119 Pediatrics S114, S115, S121 (2007).

In particular, over the last several decades, a therapy known as applied behavior analysis has emerged as the most widely-prescribed and most thoroughly validated in scientific literature.

Behavior Analysis is a scientific approach to understanding behavior and how it is affected by the environment. Applied Behavior Analysis ("ABA") is the application of this approach to address socially important problems and to bring about meaningful changes in behavior. In lay terms, ABA builds on principles about how behavior works, such as the understanding that when a behavior is followed by something an individual finds rewarding, the behavior is more likely to be repeated.

ABA uses techniques such as positive reinforcement and scientific observation and data collection and analysis mechanisms to bring about meaningful and positive changes in an individual's behavior. Individual changes are then generalized and built upon in a comprehensive and systematic fashion. ABA therapy relies on reinforced practice of various skills, with the goal of getting the individual as close to typical development and functioning as possible.

Studies have shown that, if ABA therapy is administered intensively and by properly-trained therapists, approximately half of the treated individuals will "overcome" their autistic characteristics to such an extent that they can enter school indistinguishable from their peers. And the other half make significant gains, too, such that they need less support for the rest of their lives.

In a landmark study published in 1987, Dr. Ivar Lovaas of UCLA reported that 47% of the children who received intensive ABA therapy by properly-trained therapists achieved normal intellectual functioning and, as a result, were placed in mainstream general educational environments with no additional supports. A

further 42 percent of children made substantial gains that significantly reduced their special education and supports needs.[8] Lovaas's 1987 study was followed in 1993 by another study of these same 38 subjects confirming that these results were maintained over time.[9]

Numerous peer reviewed studies and meta-analysis have confirmed that ABA is widely recognized as a safe and effective treatment for autism.[10] The National Institute of Mental Health,[11] the Centers for Disease Control and

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[8] O. Ivar Lovaas, *Behavioral Treatment and Normal Educational and Intellectual Functioning in Young Autistic Children*, 55 J. Consult. Clin. Psychol. 3 (1987); H. Cohen, M. Amerine-Dickens, and T. Smith, *Early intensive behavioral treatment: replication of the UCLA model in a community setting*, J. Dev. Behav. Pediatr. S145–S155 (2006).

[9] John McEachin, Tristram Smith, & O. Ivar Lovaas, *Long-Term Outcome for Children with Autism who Received Early Intensive Behavioral Treatment*, 97 Am. J. Ment. Retard. 359 (1993).

[10] *See, e.g.*, J.M. Campbell, *Efficacy of behavioral interventions for reducing problem behavior in persons with autism: A quantitative synthesis of single-subject research,* Research in Developmental Disabilities 24, 120-138 (2003); S. Eldevik, R.P. Hastings, J.C. Hughes, E. Jahr, S. Eikeseth, S. Cross, *Meta-analysis of early intensive behavioral intervention for children with autism*, Journal of Clinical Child and Adolescent Psychology 38, 439-450 (2009); S. Eldevik, R.P. Hastings, E. Jahr, S. Eikeseth, S. Cross, *Using participant data to extend the evidence for intensive behavioral intervention for children with autism*, American Journal on Intellectual and Developmental Disabilities 115, 381-405 (2010); S.J. Rogers & L.A. Vismara, *Evidence-based Comprehensive Treatments for Early Autism,* Journal of Clinical Child and Adolescent Psychology 37, 8-38 (2008); W.J. Barbaresi, S.K. Katusic, & R.G. Voigt, *Autism: A Review of the State of the Science for Pediatric Primary Health Care Clinicians,* Archives of Pediatric and Adolescent Medicine 160, 1167,1175 (2006).

[11] *A Parent's Guide to Autism Spectrum Disorder: How Is Autism Treated?*, Nat'l Inst. of Mental Health (Oct. 26, 2011), available at http://www.nimh.nih.gov/healthl publications/a-parents-guide-to-autism-spectrum-disorderlhow-is-autism-treated.shtml.

Prevention,[12] and the American Academy of Pediatrics[13] have all concluded that ABA is effective and supported by research. The U.S. Surgeon General has found that "30 years of research demonstrated the efficacy of applied behavior methods in reducing inappropriate behavior and increasing communication, learning and appropriate behavior."[14]

Although ABA is highly effective, because of the intensity of hours required, it is typically quite costly. As a result, for many years, ABA was excluded from coverage by insurance companies even when prescribed by a child's treating physician. A typical comprehensive ABA program may involve 40 hours per week of therapy—far beyond the ability of most parents to afford out-of-pocket.

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12 *Autism Spectrum Disorders*, Ctrs. for Disease Control & Prevention (May 24, 2012), available at http://www.cdc.gov/ncbdddlautism/treatment.html.

13 Scott M. Myers et al., *Management of Children with Autism Spectrum Disorders*, 120 Pediatrics 1162, 1164 (2007), available at http://pediatrics.aappublications.org/contentl120/5/1162.full.pdf+h ("The effectiveness of ABA-based intervention in AUTISMs has been well documented through 5 decades of research by using single-subject methodology and in controlled studies of comprehensive early intensive behavioral intervention programs in university and community settings.") This publication was reaffirmed in September 2010. *See* Am. Acad. of Pediatrics, *AAP Publications Retired and Reaffirmed*, 126 Pediatrics 1622, 1622 (2010), available at http://pediatrics.aappublications.org/contentl126/6/eI622.full. pdf+html.

14 U.S. Dep't of Health & Human Servs. et al., *Mental Health: A Report of the Surgeon General* 163-64 (1999), available at http://profiles.nlm.nih.gov/ps/retrievelResourceMetadatalNNBBHS.

B. ABA and Insurance Coverage in Other States

At least 33 states have passed autism insurance reform statutes requiring coverage of ABA treatment.[15] Autism Speaks has been directly involved in the passage of almost all of these statutes.

The development and acceptance of national board certification for behavior analysts under the auspices of the national Behavior Analyst Certification Board ("BACB") predated these statutory reforms. Most states still have generally not established state-specific licenses for behavioral analysts. Because of the cost barriers to state licensing and maintaining a licensing board, the BACB certification has become the universally accepted credential at the state level. BACB certification allows insurers and consumers access to a network of

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[15] Alaska Stat. Ann. § 21.42.397 (West); Ariz. Rev. Stat. Ann. §§ 20-826.04, 20-1057.11, 20-1402.03, 20-1404.03 (West); Ark. Code Ann. § 23-99-418(a)-(c) (West); Cal. Health & Safety Code § 1374.72 (West); Colo. Rev. Stat. Ann. § 10-16-1 04(1.4) (XIII) (b) (1) (West); Conn. Gen. Stat. Ann. § 38a-514b (West); Del. Code Ann. tit. 18, § 3366 (West); Fla. Stat. Ann. § 627.6686 (West); 215 Ill. Compo Stat. Ann. 5/356z.14 (West); Ind. Code Ann. §§ 27-8-14.2-4(a), 27-13-7-14.7 (West); 460 Ind. Admin. Code 6-3-5.1 (West); Iowa Code Ann. § 514C.28 (1) (West); Kan. Stat. Ann. § 75-6524 (West); Ky. Rev. Stat. Ann. §§ 304.17A-142, 143 (West); La. Rev. Stat. Ann. §§ 22:1050(A) (1), (G) (6) (West); Me. Rev. Stat. tit. 24-A, §§ 2768(2), 2847-T, 4259 (West); Mass. Gen. Laws Ann. ch. 32A, § 25 (West); Mich. Compo. Laws Ann. § 550.1461e (West); Mo. Ann. Stat. § 376.1224 (West); Mont. Code Ann. § 33-22-515(1) (West); Nev. Rev. Stat. Ann. § 689A.0435 (West); N.H. Rev. Stat. Ann. § 417-E: 2 (West); N.J. Stat. Ann. §§ 17:48-6ii, 17:48A-7ff, 17:48E-35.33, 17B:26-2.1cc, 17B:27-46.1ii, 17B:27A-7.16, 17B:27 A -19.20, 26:2J-4.34, § 52:14-17.29p, 52:14-17.46.1 (West); N.M. Stat. Ann. § 59A-22-49(A) (l)-(2) (West); N.Y. Ins. Law § 3216 (West); 40 Pa. Cons. Stat. Ann. § 764h (West); R.I. Gen. Laws Ann. §§ 27-20.11-1, -3 (West); S.C. Code Ann. § 38-71-280 (West); Tex. Ins. Code Ann. § 1355.015 (West); Vt. Stat. Ann. tit. 8, § 4088i (West); Va. Code Ann. § 38.2-3418.17 (West); W.Va. Code §§ 5-16B-6e, 33-16-3v, 33-24-7k, 33-25A-8j (West); Wis. Stat. Ann. § 632.895(12m). Minnesota's legislation (HF.1233) was signed into law on May 23, 2013. *See* http://mn.gov/governor/images/2013_budget_better_mn_healthcare.pdf.

qualified providers of ABA services able to provide these services in fulfillment of autism insurance mandates.

Board-certified Behavior Analysts are subject to rigorous training, examination, and practice requirements including continuing education obligations, adherence to the BACB code of ethics and disciplinary oversight by the BACB.[16] In addition, the BACB is continually developing new requirements, standards and guidelines in keeping with peer-reviewed research and best practices.

The BACB has also issued Guidelines for Health Plan Coverage of Applied Behavior Analysis Treatment for Autism Spectrum Disorder.[17] The guidelines were developed to provide guidance to health plans, consumers, and providers so that individuals diagnosed with autism spectrum disorder receive applied behavior analysis (ABA) treatment consistent with the best available scientific evidence and expert clinical opinion.

The BACB guidelines describe the tiered delivery methodology which is standard clinical practice for providing ABA. The Board-certified Behavior Analyst is the clinical supervisor and designs, directs, and as necessary modifies the treatment. Under the direction of the Board-certified Behavior Analyst, trained

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16 *BACB Certification Eligibility Standards*, available at http://www.bacb.com/index.php?page=53. For example, in addition to holding at least a Masters degree from an appropriately-accredited institution of higher education in behavior analysis, BCBA candidates must have at least 225 classroom hours of graduate level behavior analysis coursework in specified content areas and ethics, and 1,500 hours of Supervised Independent Fieldwork in behavior analysis prior to being allowed to sit for the BCBA exam.

17 BACB Guidelines, *Health Plan Coverage of Applied Behavior Analysis Treatment for Autism Spectrum Disorder*, available at http://www.bacb.com/Downloadfiles/ABA_Guidelines_for_Autism.pdf.

Behavior Technicians, and in some cases Board Certified Assistant Behavior Analysts, deliver the bulk of the treatment hours.

According to the BACB, "tiered service delivery models which rely upon the use of Behavioral Technicians have been the primary mechanism for achieving many of the significant improvements in cognitive, language, social, behavioral, and adaptive domains that have been documented in the peer-reviewed literature." In addition, national certification permits the maintenance of adequate networks of qualified providers and permits ABA to be delivered in a cost-effective manner.[18]

In keeping with their specialized knowledge, training and experience, BCBAs practice as a distinct profession in delivering ABA treatment in states across the country. Of the thirty-three states that have adopted insurance mandates requiring coverage for medically necessary treatments like ABA, only nine states have created their own state-specific license for Behavior Analysts. On June 13, 2013, New York passed a Behavior Analyst licensure statute.[19] In all of the remaining mandate states, BCBAs provide and supervise ABA services on the basis of their BACB certification alone, and are reimbursed by insurance. In *none* of those jurisdictions has the state's business and professions law or its equivalent been held to prevent this practice.

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18 BACB Guidelines at 24-27.

19 *See* A.6963, available at http://www.assembly.state.ny.us/leg/?sh=printbill&bn=S04862&term=2013. Although the New York mandate contains essentially the same language as SB946 recognizing BCBAs as qualified providers of ABA, the New York Department of Financial Services promulgated temporary regulations limiting the scope of BCBAs' reimbursable activities, which in turn stalled implementation of the insurance mandate. Autism Speaks and others entered into a tolling agreement with DFS on litigation to enforce the statute. It now appears that the recently passed licensure bill will resolve the issue by allowing for immediate licensure of behavior analysts based on their national BACB credential.

While the majority of these states' insurance mandates specifically recognize national board certification, and/or the BACB credential specifically, several states, including Indiana, New Jersey, and South Carolina, do not. For example, the New Jersey mandate requires coverage of ABA but does not address the qualifications of providers. Similar to California, New Jersey has not adopted a license for behavior analysts. To avoid credentialing issues in implementing insurers' responsibility to deliver ABA, the New Jersey Department of Banking and Insurance issued guidance identifying BACB certification as the appropriate credential to be used.[20] New Jersey's licensure statute governing the practice of medicine or surgery, which like California's Section 2052 encompasses "any method of treatment of human ailment, disease, pain, injury, deformity, mental or physical condition,"[21] was not an impediment to this.

Licensure can be an evolutionary process. Similar to the experience of occupational therapists in California detailed in Appellants' prior briefing,[22] BCBAs in other states have practiced and received insurance reimbursement both before and after licensure.

For example, Massachusetts passed its autism insurance reform statute in 2010, and subsequently unlicensed BCBAs provided and supervised mandated

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20 New Jersey Department of Banking and Insurance, Bulletin No. 10-02, available at http://www.state.nj.us/dobi/bulletin10.html.

21 *See* N.J. Stat. Ann. § 45:9-5.1. Section 2052 of the California Business and Professions Code similarly refers to anyone who "diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person."

22 *See, e.g.*, Appellants' Opening Brief. pp. 40-43 (discussing required coverage of unlicensed occupational therapy as basic health care service prior to legislature's adoption of license for OTs, and intermediate regulation of OTs on the basis of their national certification).

ABA services. A licensure bill was signed into law on January 10, 2013 and now, through January 1, 2014, BCBAs may apply for and be granted Massachusetts licensure as Applied Behavior Analysts on the basis of their BACB certification.[23]

Similarly, Louisiana's autism insurance mandate was enacted in 2008, and amended to broaden coverage by increasing age limits in 2012.[24] Throughout this period, insurance-reimbursed ABA services have been delivered by Louisiana BCBAs on the basis of their national board certification. Recently, a Behavior Analyst licensure bill was passed by the Louisiana legislature and signed into law by the Governor on June 17, 2013 with an effective date of August 1, 2013.[25]

In sum, of the states without a state-specific ABA license that have adopted autism insurance reform to provide ABA coverage, an overwhelming majority permit and rely on unlicensed BCBAs to provide and supervise insurance reimbursed ABA, notwithstanding the provisions of their respective business and profession codes.

The Federal Employee Health Benefits Program has also determined that ABA is a medical service which may be covered by its health plans, including plans in California.[26] Under these plans, which like CalPERS plans are not subject

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23 *See* Mass. Ann. Laws ch. 112, §165.

24 *See* La. Rev. Stat. Ann. § 22:1050.

25 The text and history of SB 134 is available at http://www.legis.la.gov/legis/BillInfo.aspx?s=13RS&b=SB134&sbi=y

26 U.S. Office of Personnel Management, *Healthcare and Insurance, FEHB Program Carrier Letter, April 19, 2012, Letter No. 2012-12(c)*, available at http://www.opm.gov/healthcare-insurance/healthcare/carriers/2012/2012-12a2.pdf.

to SB946, ABA may be furnished by either a BCBA or a qualified licensed provider.[27]

C. ABA in California

In addition to ABA provided pursuant to plans subject to SB 946 and FEHB plans, ABA healthcare has long been provided by unlicensed BCBAs in California. Section 2052 has never been deemed to prevent these services. Indeed, California has a long history of using the same tiered delivery model used in other states and described by the BACB Guidelines.

For many years, California's Regional Centers have contracted with BCBAs to deliver ABA therapy to children with autism disorders.[28] Behavior Management Consultants ("BMC") and Behavior Analysts ("BA") serve as clinical supervisors, with a clinical license or BCBA, respectively. Assistant Behavior Analysts, Associate Behavior Analysts and Behavior Management Technicians (paraprofessionals) provide ABA under the supervision of the BMCs and B,As and are neither licensed nor certified.[29] Confirming the ABA provided by California's Regional Centers is the same as that provided by the health plans,

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[27] *See, e.g.*, 2013 Anthem Blue Cross – Select HMO (FEHB), p.55; available at http://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2013/brochures/73-877.pdf#page=15

[28] *See* Cal. Gov't Code § 95021 (standards for ABA providers who contract with Regional Centers] and 17 Cal. Code Regs. §§ 54342(8) & (11) (adopting certification by BACB as the qualification for payment).

[29] 17 Cal. Code Regs §§ 54342 (8), (11) and (12).

treatment of ABA for regional center clients was transitioned from regional centers to insurance companies after the full implementation of SB 946.[30]

Major self-insured companies in California such as Wells Fargo also use BCBAs to provide or supervise ABA under their health plans.[31] More than 20 self-funded health plans provide ABA using this model. These include Intel, starting in 2006, Cisco Systems in 2007, Yahoo! in 2009, and Google in 2010, among others.[32]

DMHC itself has authorized the use of BCBAs to provide ABA in settlement agreements with insurers.[33]

IV. ARGUMENT

There is no dispute that ABA treatment for individuals with autism is a necessary health care service that must be covered pursuant to the Knox Keene Act. The only issue is who can provide that treatment. BCBAs, by their numbers, knowledge, training and experience (as required and reflected by their national

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30 Regional Centers are required to seek reimbursement for ABA from any available health care plan. Cal. Welf. & Inst. Code § 4659. Further underscoring the healthcare nature of these services are prohibitions against providing any nonmedical service including educational services. *Id.* at §§ 4648.5(a)(3) & (4).

31 *See* Wells Fargo Summary Plan Description, Anthem Blue Cross Blue Shield PPO Plan, January 1, 2011, p. 58 (stating ABA clinicians "must be licensed or be a board certified behavior analyst."). *See also* Jacobson Decl., Vol. 9, Joint. Appx., Tab 31, p. 2321-32 (identifying self-insurers such as Yahoo and various health plans including Magellan, Aetna, Cigna, Optum/United providing for ABA services to be furnished by BCBAs prior to SB946).

32 *See id.*

33 *See* Appellants' Request for Judicial Notice, dated Dec. 23, 2011 at Exhibit 4 at 4-5 (Blue Shield settlement) and Exhibit 5 at 5 (Anthem Blue Cross settlement).

board certification), are appropriate and necessary providers to deliver these critical healthcare services.

DMHC's contention that Business and Professions Code Section 2052 prohibits requiring, or even allowing, insurers to use BCBAs to deliver these services is belied by the plain terms of the relevant statutes, the historic practice of BCBAs in the state, and by DMHC's own conduct.

DMHC does not contend that its prohibition on BCBAs is grounded in its exercise of sound discretion. As reflected by SB946, the Legislature has concluded that BCBAs are appropriate and necessary providers to meet these healthcare needs. The number of providers licensed in other professions who have adequate training and experience in ABA is far too small to address the need -- even if such persons could be identified, vetted and assembled into networks. DMHC has provided no evidence that it could meet the need for these critical healthcare services solely through the use of such providers.

Given the immediate availability of strong networks of BCBAs currently delivering services under the majority of insurance plans in California, it would be arbitrary, capricious, and fundamentally irrational to forego use of these trained and qualified professionals, and to instead require the exclusive use of otherwise-licensed providers who are rarely available, less qualified by credential, and likely to be more expensive.

A. Business and Professions Code Section 2052 Does Not Prohibit Delivery of ABA by BCBAs.

DMHC's sole basis for its position that it cannot be compelled to require insurers to cover prescribed ABA services provided or supervised by a BCBA is that section 2052 of the Business and Professions Code would make this a felony. The Superior Court correctly rejected this argument. *Decision on Writ of Mandate*

at 4 ("Section 2052 does not prohibit non-licensed ABA specialists from practicing.").

Section 2052 deals with physicians and surgeons. It does not apply to the services of applied behavior analysts. Chapter 5, which includes section 2052, is entitled the "Medical Practice Act." It expressly restricts those who do not possess a physician's or surgeon's license from practicing medicine.

Various other healthcare professions have their own licensure requirements and boards that are dealt with elsewhere in the Code. *See, e.g.*, Cal. Bus. & Prof. Code §2570.3(a) (physical therapy license). Many other healthcare professionals have not as yet been accorded a license and therefore practice within the category of "unlicensed allied health professionals." The relevant provisions of the Health and Safety Code specifically contemplate the use of unlicensed allied health professionals. *See* Cal. Health & Saf. Code §1367(f).

As indicated by the experience of Occupational Therapists -- whose services have been deemed reimbursable health care both before and after a state license was established -- the fact that the Legislature has not adopted a license for a particular group of health care providers does not preclude either their practice or their reimbursement by insurance.[34] Licensure typically follows in the wake of developments in medical practice and involves a variety of practical and administrative decisions, including the costs of maintaining a licensing board. *See* Board Meeting Minutes, May 18-19, 2011, Board of Behavioral Services (discussing bill to license the "profession of applied behavior analysis" and noting that the "Business and Professions Code does not apply any requirements to the

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[34] The history of the regulation of occupational therapists starting with no regulation at all and including the intermediate step of regulatory recognition similar to the recognition of BCBAs in the Regional Center system is detailed in Appellants' Opening Brief at pp. 40-43.

practice of ABA" which is "commonly used to treat autism spectrum disorders" but raising concerns about administrative costs of implementing a licensing program based on budget and staffing constraints).[35]

The Knox Keene Act makes licensure a prerequisite only where required by law. *See* Cal. Health & Saf. Code § 1367(b) ("Personnel shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.") It is not for DMHC to impose a licensure requirement where none exists.

The agency actually charged with enforcement authority over the Business and Professions Code -- the Department of Consumer Affairs -- has never taken the position that the provision of ABA by BCBAs constitutes a felony as DMHC contends. To the contrary, as set forth above, BCBAs have been delivering ABA healthcare treatment to individuals with autism for years under contract with the Regional Centers, under self-insured health plans and through private pay Contracts, all of which would constitute continuing crimes under DMHC's current view of Section 2052.

The Department of Consumer Affairs is well aware of the ongoing practice of ABA by BCBAs in California as evidenced by prior unsuccessful bills to license behavior analysts in California. Further, DMHC estimates that there are now 3,693 persons with autism insured under CalPERS.[36]

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35 Board of Behavior Services, Board Meeting Minutes, May 18-19, 2011, p.28, available at http://www.bbs.ca.gov/pdf/board_minutes/2011/0511_bd_minutes.pdf.

36 *See* http://regs.cqstatetrack.com/info/kwic?action_id=462921&profile_id=3735&text_hits=physician%2C+provider%2C+provider's%2C+providers%2C+willing

Moreover, if DMHC's "illegality" theory was correct, its own settlement agreements with insurers, which provide for the delivery of ABA by BCBAs and other trained but unlicensed and uncertified individuals supervised by BCBA or licensed professionals, would violate the law.[37]

DMHC's novel reading of Section 2052 DMHC also violates its own admonition in statements made outside this litigation that statutes "must be given a reasonable and common sense interpretation consistent with the apparent purpose and intent of the lawmakers, practical rather than technical in nature which upon application will result in wise policy rather than mischief or absurdity."[38]

DMHC's view of Section 2052 also cannot be reconciled with Knox Keene's recognition of the use of allied health professionals for whom no license has been established to deliver medically necessary care. DMHC's approach would also render it essentially impossible to provide the medically necessary ABA required by Knox Keene.

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37 *See* Appellants' Request for Judicial Notice dated Dec. 23, 2011 at Exhibits 4 (Blue Shield settlement) and 5 (Anthem Blue Cross settlement) of Appellants' Request for Judicial Notice, dated Dec. 23, 2011. If the provision of ABA services by unlicensed individuals were in fact illegal, then DMHC's agreement that licensed personnel can "supervise" unlicensed BCBAs, or unlicensed, uncertified para-professionals working under them, would be aiding and abetting a crime.

38 DMHC Adoption of Emergency Regulations at10 (quoting *People v. Zambia*, 51 Cal. 4th 965, 972 (2011)). Moreover, the legislative history of SB 946 cited by Consumer Watchdog provides strong evidence that the intent of Legislature in enacting SB946 was to confirm and enforce its understanding of what Knox Keene already required -- the use of BCBAs to provide services. This follows because no specific exemption to the Business and Professions Code was included in SB946 and Senator Steinberg repeatedly expressed his opinion that licensure of BCBAs was not required. *See* Appellant's Opening Brief, at pp. 52-53.

Due to the large number of hours of therapy per week, often 30 to 40 hours, the therapy is generally provided by unlicensed line therapists working under the supervision and direction of board certified behavior analysts. Even assuming DMHC could locate a qualified licensed provider willing and able to provide all components of the ABA program, including day to day line therapy, it would be cost prohibitive and impossible for the provider to serve more than a handful of clients.

DMHC's alternative argument is that BCBAs are not delivering a "necessary health service." This argument is equally without merit, for several reasons. First, the panoply of health care services required under Knox Keene is broader than services provided by physicians and surgeons, and expressly includes services by providers for whom no California-specific state license or certificate has been established.

Second, it is axiomatic that whether something is a health care service depends not on the licensing status of a provider but the nature, methods and objectives of the treatment. OT was OT before and after a license for it was established. ABA is ABA whether it is delivered to the child of a federal worker, a company-insured Silicon Valley professional, the employee of a business with insurance covered by SB946, or a firefighter covered by CalPERS. A child's need for ABA treatment and a doctor's prescription of it as medically necessary do not vary depending on whether provider is state licensed or nationally board certified. ABA as a prescribed treatment for autism does not change its essential nature depending on whether it is being delivered under a plan covered by SB946 or when prescribed for a state employee's child under CalPERS. Certainly nothing in the Knox Keene Act dictates otherwise.

Third, by specifying in SB946 that, when prescribed as a treatment for autism, ABA can be provided either by a BCBA or a licensed provider with

sufficient qualifications and experience, the Legislature made clear that whether ABA availability does not vary based only on the licensing status of the provider.

B. DMHC Must Require All Plans under Its Jurisdiction to Cover ABA Furnished by BCBAs

The Superior Court ruled that DMHC was *not prohibited* by the Business and Professions Code from requiring plans to cover the services of BCBAs, but that it *could in its discretion* limit coverage to licensed providers based on concerns of consumer protection. *Decision on Writ of Mandate* at 6. With the subsequent passage of SB946 specifically recognizing BCBAs as appropriate providers of ABA health treatment to children with autism, the Superior Court's ruling cannot stand.

Indeed, DMHC no longer argues that its refusal to require plans to cover BCBAs is a matter of discretion. Rather it asserts it is required to do so. If, for the reasons explained above, there is no such prohibition, any discretionary determination to refuse to cover these providers would be arbitrary, capricious and fundamentally irrational. This must follow because BCBAs deliver the exact same ABA services to the majority of plans administered by DMHC, have been recognized by the Legislature as qualified and appropriate to provide ABA services, and, as a practical matter, are essential to maintain an adequate network of coverage for the service called out for by the Legislature.

Contrary to what the Superior Court concluded, this case does not merely present an issue of licensed versus unlicensed providers. Strictly speaking, there are no licensed providers of ABA in California. No behavior analyst license has been established by the State and none of the existing healthcare professional licenses in California require any training, experience or examination in applied behavior analysis. Thus, simply requiring licensed personnel does not enhance consumer protection. By contrast the BACB credential *does* require extensive

education, training and examination in ABA. Thus DMHCs analogies in its most recent filing to personal trainers versus physical therapists and to unlicensed speech therapists are singularly inapposite.[39]

Consumers are actually injured by reducing access to critical ABA services from the one significant pool of qualified providers available -- BCBAs. Although there are a handful of providers who hold licenses in other fields but have knowledge of ABA, there is no evidence that there is anywhere near to a sufficient and available number of such qualified practitioners to serve the need for ABA services. Requiring all providers of ABA to be licensed further diminishes consumer protection by preventing access to ABA.

A key component of Knox Keene is that there be an adequate network of providers. *See* 28 Cal. Code Regs. §1300 67.2.2 (Timely Access to Non-Emergency Health Care Services). Yet, as reflected in DMHCs own settlement agreements specifically allowing the use of BCBAs, it is effectively impossible to maintain an adequate network of ABA providers without BCBAs.

In light of SB 946, the lower court's ruling upholding DMHC's licensure requirement as a permissible exercise of discretion cannot be sustained, and DMHC does not appear to argue otherwise. The Legislature has accepted that BCBAs may provide and supervise ABA prescribed as a healthcare treatment for autism. The California Department of Insurance acknowledges this too. Even DMHC accepts it for purposes of the SB946 plans it administers which constitute the vast majority of plans it regulates. Under these circumstances, there can be no non-arbitrary basis to single out CalPERS plans and preclude BCBAs or their supervisees from delivering ABA services.

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[39] DMHC Letter brief, May 31, 2013, p. 4; Declaration of Chad Bartlett, May 31, 2013, Exhibit G.

C. The Ongoing Harm to Children and Families Struggling with Autism

Outside of this litigation, DMHC has recognized that "interruptions or delays in securing medically necessary [Behavioral Health Therapy], including ABA, can result in stunted and permanent impaired developmental outcomes and can cause irreparable disability to children with [Pervasive Developmental Disorder] and autism."[40] Yet, in its most recent filing, DMHC chooses to analogize ABA to "horse therapy" and "yoga sessions."[41]

DMHC's position will cause devastating harm to families who desperately need these essential health treatments. Every day a child goes without medically necessary ABA treatments is a day that can never be recovered. As indicated in the landmark UCLA study by Lovaas, autistic children who do not receive timely and intensive treatment are unlikely to ever overcome their condition. Studies have estimated that an untreated child will ultimately cost society $3.2 million dollars over his or her lifetime.[42]

Applied behavior analysis is a basic health care service that must be provided when prescribed for a child with autism, regardless of what plan is involved. Families with CalPERS coverage and similar plans are entitled to the same quality care and the same accessibility to care as those under private plans.

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40 DMHC Adoption of Emergency Regulations, p.7 Available at http://regs.cqstatetrack.com/info/kwic?action_id=462921&profile_id=3735&text_hits=physician%2C+provider%2C+provider's%2C+providers%2C+willing

41 DMHC, Letter brief, May 31, 2013, at p. 4.

42 Michael L. Ganz, *The Lifetime Distribution of the Incremental Societal Costs of Autism*, Arch. Pediatr. Adolesc Med.161:343-349 (2007).

Nothing in the law prevents this. This Court should so hold enabling all families to have access to the crucial care they need.

CONCLUSION

For the reasons set forth above, the Court should reverse the Superior Court's decision and order the entry of the writ of mandamus sought by the Plaintiffs.

Dated: June 28, 2013

Respectfully submitted,

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AUTISM SPEAKS and
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CERTIFICATION

I certify that, pursuant to Cal. App. R. 8.204(c), this brief is proportionately spaced, has a 13-point typeface, and consists of 6,305 words, including footnotes, as determined by a word processor word count function.

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PROOF OF SERVICE

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am employed in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within action. My business address is 1999 Avenue of the Stars, Suite 1700, Los Angeles, California 90067.

On June 28, 2013, I served the documents described as:

BRIEF OF AMICI CURIAE AUTISM SPEAKS AND AUTISM DESERVES EQUAL COVERAGE

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Executed on June 28, 2013, at Los Angeles, California.

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