Autism Health Insurance Reform: SB1568

Testimony by Paul Terdal to
Senate Health Care, Human Services and Rural Health Policy Committee
February 10, 2012

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SB1568: Autism Health Insurance Reform

Background

- Autism is a medical and behavioral health condition that now affects 1 in 110 children nationally, with even higher rates in Oregon – incidence has risen dramatically
- Most insurers deny coverage for medically necessary, evidence-based treatments that can dramatically improve outcomes for individuals with autism – patients are referred to government programs that provide minimal treatment at taxpayer expense
- 29 other states have already enacted similar legislation

SB1568: Based on 2011 SB555

- Reinforces and clarifies existing laws requiring health benefit plans to cover the diagnosis and treatment of autism spectrum disorders, including:
  - Behavioral health treatment, including applied behavior analysis (ABA)
  - Psychiatric and Psychological care
  - Speech, occupational, and physical therapy
  - Other medically necessary care
- Establishes credentials for ABA providers to ensure high quality, cost effective care
  - Recognizes national Board Certified Behavior Analyst credentials
  - Sets training and supervision standards for paraprofessionals
  - Requires registration with and oversight by Department of Human Services
- Prohibits arbitrary limits on number or frequency of visits or duration of treatment; coverage may be limited to medically necessary, evidence-based treatment

Why Act Now?

- 600 new children are diagnosed with autism every year in Oregon
  - With effective treatment, half of these children – 300 – can enter school without need for special education; another third will make substantial gains and need fewer services
  - Each year's delay irrevocably denies hundreds of children the opportunity for recovery
- The State of Oregon is currently spending $200 million or more per biennium on special education and community services for children and adults with autism
  - Cost to the state would be greatly reduced if insurance was covering cost of treatment
- Legal precedent (court rulings, administrative appeals) confirms that ABA is already required for coverage under existing policies – but enforcement is difficult

Paul Terdal February 10, 2012
paul@AutismInsuranceOR.org (503)984-2950

Key Changes from 2011 SB555

The proposed Autism Health Insurance Reform legislation for 2012 was based on the SB555A approved by the Senate Healthcare Committee in 2011, with some key changes to reflect stakeholder input:

- Credentialing Requirements for ABA providers:
  - Sets specific credentialing requirements for Certified Behavior Analysts and Autism Line Therapists, based on standards used by Tricare
  - Provides for registration with DHS through an existing Behavior Consultant program or another board or agency determined by administrative rule
  - Credentialing approach is similar to that used by most other states, and by several prominent Oregon insurers
- Behavioral Health Treatment:
  - Replaces original definition of "Habilitative or Rehabilitative Care," which was too broad
  - New definition based on recent legislation in New York and California
  - Improves compatibility with the 2010 Patient Protection and Affordable Care Act, which includes "behavioral health treatment" as an essential benefit
- Definition "medically necessary":
  - Insurers may use their own definition of "medically necessary"
- Utilization Controls and Utilization Review:
  - Insurers may impose controls that are "reasonable in the context of individual determinations of medical necessity"
  - Insurers may review medical necessity and the treatment plan, provided that the review frequency is not unreasonably excessive
  - Removes fixed, arbitrary age and hour limits on ABA
- Technical Corrections:
  - Numerous small technical corrections were made to many definitions to bring them into alignment with Oregon law
  - Preserved original language of ORS 743A.190 (section 4 in this draft), but removed autism from the scope – this protects other developmental disabilities

Amendments to Oregon SB1568, Autism Health Insurance Reform

Executive Summary

This document describes the -1 Amendments to the Autism Health Insurance Reform bill, Oregon Senate Bill 1568. These amendments are intended to address concerns raised in the January 18, 2012 Senate Health Care, Human Services and Rural Health Policy Committee hearing, as well as technical issues.

Requests from Senate Health Care, Human Services and Rural Health Policy Committee:

- Allow insurance companies to restrict reimbursement to family members
- Credentialing for Certified Behavior Analysis and Autism Line Therapists
  - The Department of Human Services has agreed to accept responsibility for this task
  - Text has been clarified to show DHS responsibility for administrative rulemaking and credentialing instead of a generic, unspecified "board or agency of the state"
  - Added authority for DHS to charge registration fees for Certified Behavior Analysts and Autism Line Therapists

Request from Jean Rystrom, Kaiser Permanente:

- Clarify that there isn't an "any willing provider mandate" – insurers may regulate networks of providers for autism services just as they would for other conditions

Technical Fixes:

- Change the definition name "Board-certified behavior analyst" to "Certified behavior analyst" to address trademark infringement concerns with the Behavior Analyst Certification Board
  - All actual requirements remain the same – only the statutory title changes
- Delete the word "intensive" from "... other intensive behavioral programs" in the definition of "Behavioral Health Treatment"
  - Applied Behavior Analysis and other Behavioral Health Treatment programs aren't necessarily "intensive", particularly for older children

Senate Bill 1568 with -1 Amendments

Sponsored by Senators HASS, BATES; Senators ATKINSON, BOQUIST, BURDICK, COURTNEY, MONROE, PROZANSKI, ROSENBAUM, SHIELDS, STEINER HAYWARD, VERGER, Representatives DEMBROW, FREDERICK, KENY-GUYER, PARRISH, READ, SCHAUFLER (Presession filed.)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Establishes requirements for health insurance coverage of autism spectrum disorders. Declares emergency, effective on passage.

A BILL FOR AN ACT

Relating to health insurance coverage of autism spectrum disorders; creating new provisions; amending ORS 743A.190; and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. Sections 2 and 3 of this 2012 Act are added to and made a part of the Insurance Code.

SECTION 2. As used in this section and section 3 of this 2012 Act:

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

(2) "Autism line therapist" means an individual who:

(a) Has completed:

(A) A minimum of 12 semester hours, or the equivalent of 12 semester hours, of college coursework and is currently enrolled in a course of study leading to an associate's or bachelor's degree in psychology, education, social work, behavioral science, human development or related fields; or

(B) A minimum of 48 semester hours, or the equivalent of 48 semester hours, of college coursework in any field;

(b) Has completed 40 hours of training by a ~~board-certified~~certified behavior analyst or licensed health care professional, that covers the following topics:

(A) Introduction to autism spectrum disorder, applied behavior analysis, intensive behavioral programs and typical child development;

(B) Principles and application of applied behavior analysis or other intensive behavioral programs;

(C) Legal, ethical and safety issues in working with families and vulnerable populations;

(D) Professional standards and ethics; and

(E) Additional topics as may be required under rules adopted by ~~a board or agency of this state;~~the Department of Human Services;

(c) Has completed 40 hours of work in the field supervised by a ~~board-certified~~certified behavior analyst or licensed health care professional during a period of 12 weeks or less;

(d) Has passed a criminal background check;

(e) Receives ongoing, scheduled oversight by a ~~board-certified~~certified behavior analyst or licensed health care professional;

(f) Has paid fees and been been approved by the Department ~~of Human Services~~ pursuant to administrative rules adopted by the department or by entering into a provider agreement with the department; and

(g) Meets additional registration, supervision or credentialing requirements as may be required by rules adopted by ~~a board or agency of this state~~the department.

(3) "Autism spectrum disorder" means a neurobiological condition that includes autistic disorder, Asperger's disorder, childhood disintegrative disorder and pervasive developmental disorder not otherwise specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(4) "Behavioral health treatment" means counseling and treatment programs or applied behavior analysis and other ~~intensive~~ behavioral programs that are necessary to develop, improve, maintain or restore the functioning of an individual to the maximum extent possible and are provided by:

(a) A licensed health care professional;

(b) A ~~board-certified~~certified behavior analyst; or

(c) An autism line therapist supervised by a ~~board-certified~~certified behavior analyst or licensed health care professional.

(5) "~~Board-certified~~Certified behavior analyst" means an individual who:

(a) Has been certified by the Behavior Analyst Certification Board, Incorporated, as a "Board Certified Behavior Analyst" or a "Board Certified Assistant Behavior Analyst";

(b) Has passed a criminal background check;

(c) Has been approved by the Department ~~of Human Services~~ pursuant to administrative rules adopted by the department or by entering into a provider agreement with the department; and

(d) Has paid required fees and Meets additional registration, supervision or credentialing requirements as may be required by rules adopted by ~~a board or agency of this state~~the department.

(6) "Coordination of care" means a service that:

(a) Facilitates linking patients with appropriate services and resources in a coordinated effort to ensure that patient needs are met and services are not duplicated by organizations involved in providing care;

(b) Assists patients and families to more effectively navigate and use the health care system; or

(c) Maximizes the value of services delivered to patients by facilitating beneficial, efficient, safe and high-quality patient experiences and improved health care outcomes.

(7) "Diagnosis" means medically necessary assessment, evaluations or tests.

(8) "Medical accommodations for usual care" means medical accommodations and services that are medically necessary in order for an individual with an autism spectrum disorder to receive the same medical or dental care that an individual without an autism spectrum disorder would receive, including but not limited to sedation.

(9) "Medically necessary" means in accordance with the definition of medical necessity that is specified in the policy, certificate or contract for the health benefit plan and that applies uniformly to all covered services under the plan.

(10) "Pharmacy care" means medications prescribed by a licensed physician or other health care professional licensed to prescribe medications, and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

(11) "Psychiatric care" means direct or consultative services provided by a licensed psychiatrist or psychiatric mental health nurse practitioner.

(12) "Psychological care" means direct or consultative services provided by a licensed psychologist, clinical social worker or professional counselor.

(13) "Rehabilitative care" means services provided by a licensed speech-language pathologist, occupational therapist, physical therapist, speech-language pathology assistant, occupational therapy assistant or physical therapist assistant.

(14) "Treatment for autism spectrum disorders" includes, but is not limited to, the following care prescribed, provided or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed physician or licensed psychologist who determines the care to be medically necessary:

(a) Behavioral health treatment;

(b) Pharmacy care to the same extent that pharmacy care is covered by the health benefit plan for other medical conditions;

(c) Psychiatric care;

(d) Psychological care;

(e) Rehabilitative care;

(f) Augmentative communication devices and other assistive technology devices to the same extent that medical devices are covered by the health benefit plan for other medical conditions;

(g) Medical accommodations for usual care;

(h) Coordination of care; and

(i) Any other medical services that are medically necessary and are otherwise covered by the health benefit plan.

SECTION 3. (1) A health benefit plan, as defined in ORS 743.730, that provides coverage for hospital, surgical or medical care shall provide coverage for the screening for, diagnosis of and treatment for autism spectrum disorders. An insurer may not terminate coverage or refuse to issue or renew coverage for an individual solely because the individual is diagnosed with one of the autism spectrum disorders or has received treatment for an autism spectrum disorder.

~~**(2) Coverage under this section may be subject to utilization controls that are reasonable in the context of individual determinations of medical necessity.**~~

~~**(3) Coverage under this section may not be subject to dollar limits, deductibles,**~~**(2) Coverage under this section may:**

(a) Be subject to utilization controls that are reasonable in the context of individual determinations of medical necessity;

(b) Not be subject to dollar limits, deductibles, copayments or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, copayments or coinsurance provisions that apply to physical illness generally under the health benefit plan; and

(c) Be subject to requirements and limitations that apply to out-of-network providers of physical health care under the terms of the health benefit plan.

(~~4~~3) This section does not limit coverage that is otherwise available to an individual under a health benefit plan or reduce benefits required under ORS 743A.168.

(~~5~~4) A claim for services described in this section may not be denied on the basis that the service is habilitative or rehabilitative and does not fully restore function.

(~~6~~5) Coverage required by this section includes medically necessary treatment provided in the home and in the community, except that health benefit plans may impose limits on coverage for specialized education and related services provided by schools as required by federal or state law and services provided by family or household members.

(~~7~~6) Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder, an insurer may request a review of the determination that the treatment is medically necessary in a manner consistent with the insurer's review process for other

conditions, provided that the frequency of review is not unreasonably burdensome on the insured. The insurer may require the treatment plan to include the diagnosis, the proposed treatment by type and frequency, the anticipated duration of treatment, the anticipated outcomes stated as goals and the reasons the treatment is medically necessary.

(~~8~~7) Subsections (1) to (~~7~~6) of this section apply to health benefit plans and to self-insurance programs offered by the Public Employees' Benefit Board and the Oregon Educators Benefit Board.

(~~9~~8) ORS 743A.001 does not apply to this section.

(~~10~~9) The Department of Consumer and Business Services, after notice, hearing and consultation with a panel of experts with expertise in diagnosing and treating autism spectrum disorders, may adopt rules necessary to carry out the provisions of this section.

SECTION 4. ORS 743A.190 is amended to read:

743A.190. (1) A health benefit plan, as defined in ORS 743.730, must cover for a child enrolled in the plan who is under 18 years of age and who has been diagnosed with a pervasive developmental disorder all medical services, including rehabilitation services, that are medically necessary and are otherwise covered under the plan.

(2) The coverage required under subsection (1) of this section, including rehabilitation services, may be made subject to other provisions of the health benefit plan that apply to covered services, including but not limited to:

(a) Deductibles, copayments or coinsurance;

(b) Prior authorization or utilization review requirements; or

(c) Treatment limitations regarding the number of visits or the duration of treatment.

(3) As used in this section:

(a) "Medically necessary" means in accordance with the definition of medical necessity that is specified in the policy, certificate or contract for the health benefit plan and that applies uniformly to all covered services under the health benefit plan.

(b)**(A)** "Pervasive developmental disorder" means a neurological condition that includes

[*Asperger's syndrome, autism,*] developmental delay, developmental disability or mental retardation.

(B) "Pervasive developmental disorder" does not include autism spectrum disorders as defined in section 2 of this 2012 Act.

(c) "Rehabilitation services" means physical therapy, occupational therapy or speech therapy services to restore or improve function.

(4) The provisions of ORS 743A.001 do not apply to this section.

(5) The definition of "pervasive developmental disorder" is not intended to apply to coverage required under ORS 743A.168.

SECTION 5. Sections 2 and 3 of this 2012 Act and the amendments to ORS 743A.190 by section 4 of this 2012 Act apply to policies or certificates issued or renewed on or after the effective date of this 2012 Act.

SECTION 6. This 2012 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2012 Act takes effect on its passage.

Autism Health Insurance Reform: SB1568 Cost Benefit Analysis

Executive Summary

This report reviews the fiscal impact to the State of Oregon of implementing Autism Health Insurance Reform (SB1568), and the potential benefit through reduced cost of Applied Behavior Analysis (ABA) for PEBB and OEBB, reduced special education costs, and reduced societal impact of autism.

Existing Law Already Requires Coverage of ABA as Outpatient Mental Health care

- Courts in Oregon and Washington have ordered ABA coverage under Mental Health Parity
  - McHenry v PacificSource ordered PacificSource to pay for ABA
    - PacificSource now pays for ABA with licensed providers at $96 / hour for all patients in its' group plans
  - D.F. et al v Washington State Health Care Authority and Public Employees Benefits Board (PEBB): "HCA is required by the Act [Mental Health Parity] to cover medically necessary ABA therapy ... by licensed therapists."
- External Review decisions by IROs selected by Oregon Insurance Division have overturned Kaiser Permanente denials of ABA in four separate cases in December 2011 and January 2012
  - Kaiser is now negotiating a provider agreement with a local ABA therapist

Reduced Cost of ABA for PEBB and OEBB

- SB1568 enables use of certified behavior analysts (BCBAs) and paraprofessionals (Autism Line Therapists) to provide ABA at a lower cost ($4,686,833 per biennium for PEBB and OEBB)
  - *Savings* with SB1568 is $8,546,578 per biennium, relative to cost of ABA with licensed mental health providers as required by existing law

Special Education Cost Savings

- Oregon spends over $204M per biennium in special education costs for individuals with autism
- Over the first decade after implementation, as early intensive treatment of autism becomes standard, we could see long-term savings of $136M per biennium in special education costs

Reduced Societal Impact of Autism

- The lifetime per capita incremental societal cost of autism has been estimated at $3.2 million; with intensive intervention, this cost can be cut in half

Conclusion

- *Existing law already requires coverage of Applied Behavior Analysis as a form of Outpatient Mental Health care when provided by licensed mental health providers– it isn't a new mandate*
- *SB1568 reduces cost of ABA for PEBB and OEBB by $8,546,578 per biennium immediately*
- *Long-term savings in special education costs may reach $136M per biennium*

Paul Terdal, MBA
paul@AutismInsuranceOR.org (503)984-2950

Existing Law Already Requires Coverage of Applied Behavior Analysis (ABA) as Outpatient Mental Health care

Existing state and federal laws, taken together, already require coverage of Applied Behavior Analysis (ABA) as a treatment for autism. Recent legal precedents, and administrative appeals facilitated by the Oregon Insurance Division, have confirmed that these laws can be enforced to require coverage for ABA. This section reviews the applicable laws and legal precedent.

State and Federal Laws Requiring coverage of ABA

There are three critical state and federal laws that do require coverage for medically necessary autism treatment. Taken together, these laws mandate coverage for Applied Behavior Analysis as a treatment for autism:

- ORS 743A.168: Mental Health Parity
- ORS 743A.190: Children with pervasive developmental disorder
- Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

ORS 743A.168: Mental Health Parity:

- Applies to group health insurance plans. It applies to OEBB, but not to PEBB, which is self-funded.

ORS 743A.168 states:

> "ORS 743A.168 Treatment of chemical dependency, including alcoholism, and mental or nervous conditions; rules. A group health insurance policy providing coverage for hospital or medical expenses shall provide coverage for expenses arising from treatment ... for mental or nervous conditions at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions...."

OAR 836-053-1404, the administrative rules for implementation of ORS 743A.168, defines "mental or nervous conditions" as "All disorders listed in the 'Diagnostic and Statistical Manual of Mental Disorders, DSM-IV-TR, Fourth Edition'". Autism is thus in scope for this statute as a "mental or nervous condition."

ORS 743A.168 therefore requires coverage for expenses arising from treatment of autism at the same level as, and subject to limitations no more restrictive than, those imposed on coverage or reimbursement of expenses arising from treatment for other medical conditions.

743A.190 Children with pervasive developmental disorder

- Applies to Health Benefit Plans. It applies to OEBB, but not to PEBB, which is self-funded.

ORS 743A.190 states:

> "743A.190 Children with pervasive developmental disorder. (1) A health benefit plan, as defined in ORS 743.730, must cover for a child enrolled in the plan who is under 18 years of age and who

has been diagnosed with a pervasive developmental disorder all medical services, including rehabilitation services, that are medically necessary and are otherwise covered under the plan."

This statute requires coverage of "all medical services ... that are medically necessary and are otherwise covered under the plan."

Applied Behavior Analysis is a form of behavioral health treatment or outpatient mental health care. Any health benefit plan that covers outpatient mental health care for other conditions must therefore cover outpatient mental healthcare – including ABA – for autism.

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

- Applies to: plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully insured arrangements. Applies to both PEBB and OEBB.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (H. R. 1424, Subtitle B, Section 512 (a) (1) (A)) states:

> "(A) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that—
>
> (i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and
>
> (ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits."

Autism is a mental health condition, which is covered by both PEBB and OEBB. Therefore, MHPAEA requires the plans to ensure that "the treatment limitations applicable to such mental health ... benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan."

The federal departments of Treasury (IRS), Labor, and Health and Human Services have issued an Interim Final Rule (75 FR 5410) governing implementation of this act. The Interim Final Rule requires non-quantitative treatment limitations – including "Medical management standards limiting or excluding benefits based on medical necessity or appropriateness" and "Exclusions or limitations on particular therapies or treatments" – to be in parity.

This means that under MHPAEA, an insurer can't exclude or limit a particular therapy or treatment for a mental health condition (such as autism) unless it can demonstrate that it is using an exclusion or limitation standard that is no more restrictive than the standard it would use for the predominant medical / surgical conditions.

As an IRO appointed by the Oregon Insurance Division wrote in a recent External Review decision:[1]

> "ABA is the current standard for treatment of behavioral issues in children with autistic spectrum disorders. The research papers about ABA show it to be the most medically effective treatment currently available."

Therefore, under MHPAEA, an insurer can't exclude or limit ABA as a treatment for autism unless it can demonstrate that it is equally arbitrary in excluding or limiting the most medically effective treatments for the predominant medical / surgical conditions.

Legal Precedent Requiring ABA Coverage

McHenry v PacificSource, Federal District Court for the District of Oregon

- Case 3:08-cv-562-ST, January 12, 2011

Ordered PacificSource to pay for ABA as a treatment for autism. Key findings:

- ABA is medically necessary for McHenry's son
- "ABA therapy is firmly supported by decades of research and application and is a well-established treatment modality of autism and other PDDs. It is not an experimental or investigational procedure" (page 19)
- "McHenry is entitled to reimbursement for ABA therapy...."
- PacificSource was ordered to reimburse $211,942.50 in plaintiff's legal fees

Under this order, PacificSource is now covering Applied Behavior Analysis (ABA) as a treatment for autism for all patients on all group plans, with no age, visit, hour, or monetary limits, through licensed mental health providers at a reimbursement rate of $96 / hour.

D.F. et al v Washington State Health Care Authority; Public Employees Benefits Board (PEBB), Superior Court of Washington for King County

- Case 10-2-29400-7 SEA, June 8, 2011

Ordered the Health Care Authority (HCA) and Public Employees Benefits Board (PEBB) to cover medically necessary ABA therapy. Key findings:

- "The court concludes as a matter of law that HCA is not in compliance with the Mental Health Parity Act insofar as it imposes a blanket exclusion of ABA therapy, even when provided by licensed therapists. HCA is required by the Act to cover medically necessary ABA therapy (as determined on an individualized basis) that is provided by licensed therapists."

[1] IPRO, External Review Determination –Case ER11105, December 2, 2011

Administrative Appeals Ordering ABA Coverage in Oregon

In the last few months, a number of families have filed Administrative Appeals with Kaiser Permanente requesting reimbursement for Applied Behavior Analysis (ABA). Although it vigorously resisted, Kaiser was unable to find a contractual or legal basis to deny coverage for ABA, and argued instead that ABA wasn't "medically necessary" for treatment of autism. Under ORS 743.857, the families requested External Reviews with Independent Review Organizations (IRO) selected by the Insurance Division.

In four out of five cases decided in 2011 and 2012, the IROs overturned Kaiser's denial, and ordered coverage of ABA on grounds that ABA was medically necessary. As one IRO wrote:

> "Of all the myriad therapeutic interventions used in the treatment of autism, ABA is the best established as safe and effective in accordance with principles of evidence-based best practice; it comprises the current standard of care for this condition. *Any* young child, including this enrollee, who is diagnosed with Autistic Disorder (299.0), should be referred for ABA as a matter of course since this is the most effective treatment available at this time." (Emphasis original)

Under ORS 743.863 and the provisions of its' health benefit plans, Kaiser is obligated to comply with External Review decisions or pay "a civil penalty of not less than $100,000 and not more than $1 million." These decisions have involved children on many different types of plans, including:

- Individual and Family Plan
- Large Group Plan
- Self-Funded Plan (Kaiser employee, City of Portland employee)

Kaiser is now negotiating a provider agreement with an ABA therapist who can serve these children with autism.

Providence has also been reimbursing ABA for another child with autism since 2007, after a similar IRO decision. Numerous other families have initiated Administrative Appeals with Kaiser and other insurers, including PEBB, requesting coverage for ABA.

Conclusion:

- *Courts in Oregon and Washington have ordered ABA coverage under Mental Health Parity*
    - *McHenry v PacificSource ordered PacificSource to pay for ABA under ORS743A.168, Mental Health Parity (Case 3:08-cv-562-ST, 8/30/11)*
        - *PacificSource now pays for ABA with licensed providers at $96 / hour*
    - *D.F. et al v Washington State Health Care Authority concludes "HCA is required by the Act [Mental Health Parity] to cover medically necessary ABA therapy ... that is provided by licensed therapists." (NO. 10-2-29400-7 SEA, 6/8/2011)*
- *External Review decisions by IROs selected by Oregon Insurance Division have overturned Kaiser denials of ABA in four separate cases in December 2011 and January 2012*
    - *Kaiser is now negotiating a provider agreement with an ABA therapist*

Estimated Fiscal Impact to PEBB and OEBB

This section estimates the cost to PEBB and OEBB of providing ABA through licensed mental health providers, as required by existing law, and through Certified Behavior Analysts and Autism Line Therapists as enabled by SB1568.

Assumptions:

Autism Prevalence:

- Total prevalence for all forms of Autism Spectrum Disorder (ASD) is 1 in 110
- ASD Breakdown by subtype[2]:
    - Autistic Disorder: 33.3%
    - PDD-NOS: 50.0%
    - Asperger's: 16.7%
    - Childhood Disintegrative Disorder: effectively 0% (prevalence is 1 in 100,000)
- Treatment begins immediately upon diagnosis
    - Individuals with Autistic Disorder and PDD-NOS are typically diagnosed at age 3[3]
    - Individuals with Asperger's are typically diagnosed at age 6

Applied Behavior Analysis Provider Reimbursement Rates:

- Licensed Mental Health Providers, as per existing law (ORS743A.168, ORS743A.190, Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA))
    - Licensed Professional Counselor or equivalent: $96 / hour[4]
    - For intensive program, assume 30 hours of line therapy / week = $2,880 / week
- Certified Behavior Analysts and Autism Line Therapists, as per SB1568:
    - Autism Line Therapists: $30 / hour[5]
    - Board Certified Behavior Analyst (BCBA): $120 / hour[6]
    - For intensive program, assume 30 hours of line therapy / week + 1 BCBA hour / week = $1,020 / week, or blended cost of $34 / hour

[2] Fombonne, E. and S. Chakrabarti. "Pervasive Developmental Disorders in Preschool Children: Confirmation of High Prevalence," American Journal of Psychiatry; 2005; 162:1133–1141

[3] Centers for Disease Control and Prevention. "Prevalence of Autism Spectrum Disorders — Autism and Developmental Disabilities Monitoring Network, United States, 2006." Morbidity and Mortality Weekly Report. December 18, 2009.

[4] Actual reimbursement rate for ABA in Oregon by LPCs or LCSWs by PacificSource

[5] Quoted rate for Autism Line Therapists by Play Connections Autism Intervention Center in Beaverton, Oregon. Market rates for Autism Line Therapists in Oregon range from $15 / hour to $30 / hour.

[6] Quoted rate for BCBAs by Play Connections Autism Intervention Center in Beaverton, Oregon. National market rates for BCBAs vary from $120 to $125 / hour.

Applied Behavior Analysis Consumption Rates:

- Utilization of ABA programs varies by age and ASD subtype[7]
  - A large majority of children with Autistic Disorder under age 6 will use ABA (65%) if available
  - From ages 6 and up, utilization declines as children improve, or utilization review determines that further treatment would not yield significant gains
  - Over age 21: ABA programs are less common in adults
- Utilization rates for children with Asperger's and PDD-NOS are estimated to be 1/3 of those with Autistic Disorder[8]
  - This correction factor addresses both the fact that fewer patients with these forms will use ABA, and that those who use it will require less-intensive programs

Table 1: ABA Program Utilization by Age and Autism Spectrum Subtype:

Age:	Autistic Disorder:	PDD-NOS:	Asperger's:
Under 6	65.0%	21.7%	21.7%
6	48.8%	16.3%	16.3%
7	32.5%	10.8%	10.8%
8	21.7%	7.2%	7.2%
9	14.4%	4.8%	4.8%
10	9.6%	3.2%	3.2%
11	6.4%	2.1%	2.1%
12	4.3%	1.4%	1.4%
13 to 21	3.3%	1.1%	1.1%
Over 21	0%	0%	0%

- For those individuals who use ABA, intensity varies by age[9]
  - Under age 8: 30 hours / week, or 1,500 hours per year
    - This is conservative; OHSU recommends 20 to 25 hours per week
  - Ages 8 to 12: need for intensive ABA declines after first few years of therapy
  - Ages 13 to 21: ABA programs address a smaller number of behavioral deficits and are less time consuming
  - Over age 21: ABA programs are uncommon in adults

Table 2: Average ABA Program Hours and Cost for Patients with Autistic Disorder

Age:	Hours / Year:	Hours / Week:	Annual Cost (Licensed Providers):	Annual Cost (BCBA + Line Therapist):
Under 8	1,500	30	$144,000	$51,000
Ages 8 to 12	671	13	$64,416	$22,814
Ages 13 to 21	401	8	$38,496	$13,634
Over 21	0	0	$0	$0

[7] M. Lambright, "Actuarial Cost Estimate: Oregon House Bill 2214 and Senate Bill 555," Oliver Wyman, February 24, 2011. Pp. 12-13.
[8] ibid. P.14.
[9] ibid. Pp. 13-14.

PEBB and OEBB Enrollment:

- PEBB Members: 129,343
  - 50,730 employees
  - 78,613 dependents[10], including 45,596 children (children estimated at 58% of dependents from analysis of PEBB PPO + Choice data)[11]
- OEBB Members: 130,566
  - 60,090 employees
  - 70,476 dependents[12], including 40,876 children (children estimated at 58% of dependents as per PEBB, above)

Implementation Rate:

- Analysis assumes that individuals with autism immediately access all available autism coverage, and that there are no delays in finding providers available to meet the demand
- Actual experience in other states indicates long ramp-up time as providers become available
- Fiscal Notes from other State Legislatures have historically overstated PEBB costs by from 293% (Louisiana) to 1,261% (Arizona), due to failure to account for ramp-up times[13]

[10] PEBB Operations Summary, Wendy Edwards, PEBB Operations Subcommittee Meeting, Jul. 11, 2011

[11] Oregon Public Employees Benefits Board Self-Insurance Medical Plans Dashboard, June 30, 2011 Quarterly Report, Nov. 14, 2011. Children estimated from demographics data on slide 4.

[12] Attachment 3a – Enrollment Statistics Summary 2008-09 through 2011-12, OEBB Board Meeting, Nov. 10, 2011

[13] Wasmer M., "The Fiscal Impact of Autism Insurance Reform," Autism Speaks, December 6, 2011.

paul@AutismInsuranceOR.org (503)984-2950

PEBB ABA Cost:

Table 3: PEBB Population, Autism Prevalence, and ABA Consumption

Population by Age:		Autism Diagnoses:			ABA Consumers:		
Age:	PEBB Children:	Autistic Disorder:	PDD-NOS:	Asperger's:	Autistic Disorder:	PDD-NOS:	Asperger's:
Birth to 2	6,218	-	-	-	-	-	-
3	2,073	6.28	-	-	4.08	-	-
4	2,073	6.28	-	-	4.08	-	-
5	2,073	6.28	-	-	4.08	-	-
6	2,073	6.28	9.42	3.14	3.06	1.53	0.51
7	2,073	6.28	9.42	3.14	2.04	1.02	0.34
8	2,073	6.28	9.42	3.14	1.36	0.68	0.23
9	2,073	6.28	9.42	3.14	0.90	0.45	0.15
10	2,073	6.28	9.42	3.14	0.60	0.30	0.10
11	2,073	6.28	9.42	3.14	0.40	0.20	0.07
12	2,073	6.28	9.42	3.14	0.27	0.14	0.05
13 to 21	18,653	56.52	84.79	28.26	1.87	0.93	0.31
	45,596	119	151	50	23	5	2

Table 4: PEBB ABA Cost by Age, ASD Subtype, and Provider Type

	ABA Cost (BCBAs + Line Therapists)			ABA Cost (Licensed Providers)		
Age:	Autistic Disorder:	PDD-NOS:	Asperger's:	Autistic Disorder:	PDD-NOS:	Asperger's:
Birth to 2	-	-		$-	$-	$-
3	$208,195	$-	$-	$587,843	$-	$-
4	$208,195	$-	$-	$587,843	$-	$-
5	$208,195	$-	$-	$587,843	$-	$-
6	$156,306	$78,153	$26,051	$441,335	$220,667	$73,556
7	$104,097	$52,049	$17,350	$293,922	$146,961	$48,987
8	$31,092	$15,546	$5,182	$87,789	$43,894	$14,631
9	$20,632	$10,316	$3,439	$58,256	$29,128	$9,709
10	$13,755	$6,877	$2,292	$38,837	$19,419	$6,473
11	$9,170	$4,585	$1,528	$25,892	$12,946	$4,315
12	$6,161	$3,081	$1,027	$17,396	$8,698	$2,899
13 to 21	$25,431	$12,716	$4,239	$71,806	$35,903	$11,968
	$991,228	$183,322	$61,107	$2,798,762	$517,616	$172,539

Table 5: PEBB Total ABA Cost by Provider Type

	BCBAs + Line Therapists	Licensed Providers
Annual	$1,235,658	$3,488,916
Biennial	$2,471,316	$6,977,833

OEBB ABA Cost:

Table 6: OEBB Population, Autism Prevalence, and ABA Consumption

Population by Age:		Autism Diagnoses:			ABA Consumers:		
Age:	OEBB Children:	Autistic Disorder:	PDD-NOS:	Asperger's:	Autistic Disorder:	PDD-NOS:	Asperger's:
Birth to 2	5,574	-	-	-	-	-	-
3	1,858	5.63	-	-	3.66	-	-
4	1,858	5.63	-	-	3.66	-	-
5	1,858	5.63	-	-	3.66	-	-
6	1,858	5.63	8.45	2.82	2.75	1.37	0.46
7	1,858	5.63	8.45	2.82	1.83	0.91	0.30
8	1,858	5.63	8.45	2.82	1.22	0.61	0.20
9	1,858	5.63	8.45	2.82	0.81	0.41	0.14
10	1,858	5.63	8.45	2.82	0.54	0.27	0.09
11	1,858	5.63	8.45	2.82	0.36	0.18	0.06
12	1,858	5.63	8.45	2.82	0.24	0.12	0.04
13 to 21	16,722	50.67	76.01	25.34	1.67	0.84	0.28
	40,876	107	135	45	20	5	2

Table 7: OEBB ABA Cost by Age, ASD Subtype, and Provider Type

	ABA Cost (BCBAs + Line Therapists)			ABA Cost (Licensed Providers)		
Age:	Autistic Disorder:	PDD-NOS:	Asperger's:	Autistic Disorder:	PDD-NOS:	Asperger's:
Birth to 2	-	-		$-	$-	$-
3	$186,645	$-	$-	$526,997	$-	$-
4	$186,645	$-	$-	$526,997	$-	$-
5	$186,645	$-	$-	$526,997	$-	$-
6	$140,127	$70,064	$23,355	$395,653	$197,827	$65,942
7	$93,322	$46,661	$15,554	$263,499	$131,749	$43,916
8	$27,874	$13,937	$4,646	$78,702	$39,351	$13,117
9	$18,497	$9,248	$3,083	$52,226	$26,113	$8,704
10	$12,331	$6,166	$2,055	$34,818	$17,409	$5,803
11	$8,221	$4,110	$1,370	$23,212	$11,606	$3,869
12	$5,523	$2,762	$921	$15,595	$7,798	$2,599
13to21	$22,799	$11,399	$3,800	$64,373	$32,187	$10,729
	$888,629	$164,347	$54,782	$2,509,070	$464,039	$154,680

Table 8: OEBB Total ABA Cost by Provider Type

	BCBAs + Line Therapists	Licensed Providers
Annual	$1,107,759	$3,127,789
Biennial	$2,215,517	$6,255,578

paul@AutismInsuranceOR.org (503)984-2950

Conclusion:

Table 9: Summary of Biennial ABA Costs for PEBB and OEBB by Provider Type

	BCBAs / Line Therapists	Licensed Providers	Savings with BCBAs / Line Therapists
PEBB	$2,471,316	$6,977,833	$4,506,517
OEBB	$2,215,517	$6,255,578	$4,040,061
	$4,686,833	$13,233,411	$8,546,578

- *Existing law requires coverage of ABA as an Outpatient Mental Health care service with licensed mental health providers*
    - *Existing obligation for PEBB and OEBB (combined) to cover ABA with licensed mental health providers is $13,233,411 per biennium*
- *SB1568 would enable use of certified behavior analysts (BCBAs) and paraprofessionals (Autism Line Therapists) at a lower cost*
    - *Estimated cost to PEBB and OEBB (combined) is $4,686,833 per biennium with BCBAs and Line Therapists*
- *Savings to PEBB and OEBB with SB1568 is $8,546,578 per biennium*

paul@AutismInsuranceOR.org (503)984-2950

Special Education Cost Savings

It is conservatively estimated that Oregon spends over $204M per biennium in special education costs for individuals with autism. Over the first decade after implementation, Oregon's schools will realize substantial savings in special education costs, as many (but not all) individuals with autism who receive intensive intervention will be able to either leave special education altogether or substantially reduce the amount of support that they require.

Assumptions:

- A 2004 GAO report[14], using 1999-2000 data, estimated the incremental cost of educating an individual with Autism at $12,234 per student with autism per year; typical costs include:
  - Special education classes (classes designed specifically for students with disabilities, taught by special education teachers)
  - Resource specialists (special education teachers who either pull students with disabilities out of regular education classes or go into regular education classrooms to work with students with disabilities)
  - Related services (Speech, Occupational, and Physical Therapy; social workers; school nurses; school psychologists)
  - Other special education services (community based training, extended time services, summer school)
- Oregon schools had 8,338 students with autism as of the Dec. 1, 2010[15], not including children under the age of 3 in Early Intervention programs
- A very conservative estimate – assuming no increase in autism education costs in the last 12 years – is that Oregon spends $102,007,092 on incremental special education costs alone for children with autism every year ($204,014,184 per biennium)
  - Total Special Education funding in Oregon: $702 M in the 2009-2011[16] biennium
- Expected recovery rate with ABA[17]:
  - 47% recover "typical" function (no special support required; $0 incremental cost)
  - 40% make significant improvement (minimal supports required; 50% incremental cost)
  - 13% make little progress (full supports required; 100% of incremental cost)

[14] Education of Children with Autism, GAO-05-220 Special Education, Dec. 13, 2004
[15] Report of Children with Disabilities Receiving Special Education on 12-01-2010
[16] Castillo, State of Oregon 2010-11 Application for IDEA State Maintenance of Financial Support Waiver, March 8, 2011
[17] Bouder, James and Hockenyos. "Benefit-Cost Analysis of Michigan Autism Insurance Coverage." Presented to the Michigan House of Representatives Health Policy Committee. (2009).

Analysis:

Table 10: Special Education Cost Savings by Outcome Group (Annual)

Outcome Group	% of Total	Students with Autism (2010)	Untreated Incremental Special Education Cost		Treated Incremental Special Education Cost		Annual Savings with Treatment
			Per Pupil	Total	Per Pupil	Total	
Recover "Typical" Function	47%	3,919	$12,234	$47,943,333	$0	$0	$47,943,333
Significant Improvement	40%	3,335	$12,234	$40,802,837	$6,117	$20,401,418	$20,401,418
Little Progress	13%	1,084	$12,234	$13,260,922	$12,234	$13,260,922	$0
Total	100%	8,338		$102,007,092		$33,662,340	$68,344,752
Total per Biennium				$204,014,184		$67,324,681	$136,689,503

Conclusion:

Over the first decade after implementation, as intensive treatment becomes the norm for individuals with autism in Oregon, we could see a savings of $136 million in special education costs per biennium.

Reduced Societal Impact of Autism

Dr. Michael Ganz, of the Harvard School of Public Health, has estimated the lifetime per capita incremental societal cost of autism at $3.2 million.[18] The largest components of cost are in lost productivity and adult care – which can be substantially mitigated through early intensive intervention.

Assumptions:

- Incremental societal cost of autism is $3,160,384 per capita (Ganz)
  - Direct Medical (Physician, Therapies, Rx, Dental, Travel): $305,956
  - Direct Non-Medical (Child/Adult care, Respite, Special Education, Supported Employment): $978,761
  - Indirect (Own and parental lost productivity): $1,875,667
- Expected recovery rate with intervention[19]:
  - 47% recover "typical" function; lifetime cost = $516K
  - 40% make significant improvement; lifetime cost = $1.6M
  - 13% make little progress; lifetime cost = $3.2M

Analysis:

Table 11: Variation in Lifetime Costs with Intervention by Recovery Cohort[20]

	Recover Typical Function	Significant Improvement	Little Progress with Intervention	Intensive Intervention Not Attempted
Incidence	47%	40%	13%	
Lifetime Costs (2003$)	$515,722	$1,646,682	$3,160,384	$2,939,110
Weighted Lifetime Cost	$242,389	$658,673	$410,850	$1,311,912
			Net Gain	$1,627,198

Note: figures are in 2003$ for consistency with Ganz; Hockenyos' original calculations were in 2008$

Conclusion:

The lifetime per capita incremental societal cost of autism has been estimated at $3.2 million; with intensive intervention, this cost can be cut in half

[18] The Lifetime Distribution of Incremental Societal Costs of Autism, Michael L. Ganz, Ph.D., Archives of Pediatric Adolescent Medicine 2007;161:343-349

[19] Chasson, Gregory S., Harris, Gerald E., & Neely, Wendy J. (2007). "Cost Comparison of Early Intensive Behavioral Intervention and Special Education for Children with Autism." Journal of Child and Family Studies. Vol 16, pp. 401-413.

[20] Benefit-Cost Analysis of Appropriate Intervention to Treat Autism, Jon Hockenyos, Nov. 2009

paul@AutismInsuranceOR.org (503)984-2950

Jeremiah W. (Jay) Nixon
Governor
State of Missouri

Department of Insurance
Financial Institutions
and Professional Registration
John M. Huff, Director

Feb. 1, 2012

The Honorable Jeremiah W. (Jay) Nixon, Governor
State Capital Building
Room 216
Jefferson City, Missouri 65101

Re. Report to General Assembly pursuant to 376.1224 RSMo, regarding the impact of Autism / ABA coverage mandates on the insurance marketplace

Dear Governor Nixon:

The Department of Insurance, Financial Institutions & Professional Registration (DIFP) has completed a report assessing the impact on the insurance marketplace of recent requirements that health insurers provide coverage for the treatment of autism, including applied behavior analysis (ABA). Pursuant to 376.1224, the DIFP issued a data call from all insurers providing comprehensive health insurance subject to the mandate for claims experience during 2011. Among the findings:

- Insurers incurred claims equal to $4.3 million for the treatment of autism, of which $1.1 million was directed to ABA therapies. These amounts represent 0.1 percent and 0.02 percent of total claim costs incurred by health insurers during 2011, and are consistent with initial DIFP projections.

- Nearly 4,000 individuals diagnosed with autism received treatment covered by their insurer, a figure that amounts to 1 in every 350 insureds.

- For each individual diagnosed with an ASD that received treatment during 2011, the average monthly cost was $143, of which $35 consisted of ABA therapies.

- By year-end, all individuals insured through the small and large group markets had the mandated coverage. Only one-third of persons insured in the individual market had such coverage. In total, nearly 1.6 million individuals either have the coverage or have the option of purchasing it as an endorsement for an additional premium.

- The mandate was effective for all policies issued or renewed after January 1, 2011. By year-end, the infrastructure necessary to deliver services for autism was still growing. One example is the licensure of behavior analysts. The first licenses were issued in Missouri in December, 2010. By the end of June, 85 licenses had been issued, increasing to 120 by mid-January, 2012. An additional 24 persons obtained assistant behavior analyst licenses mid-January.

Now that medical delivery systems are more fully developed, it is expected that the benefits of the mandate will be more fully realized over the course of the new year. While costs are expected to increase somewhat as a result, no credible evidence suggests that they will exceed 0.2 – 0.5 percent of claim costs, and a smaller percentage of premiums. Given the low costs of autism treatment as a percent of all claims costs, the autism mandate is expected to have minimal impact of health insurance premiums. However, because the DIFP has no authority over health insurance rates and does not receive rate filings, a more exact assessment of the rate impact cannot be provided.

The DIFP continues to monitor insurance carriers to ensure full compliance with relevant statutes, and will continue to monitor market trends in response to the autism mandate. Additional detail can be found in the full report.

Sincerely,

John M. Huff

Annual Report
to the
Missouri Legislature

Insurance Coverage for Autism Treatment & Applied Behavior Analysis

Statistics Section
Jan. 31, 2012

DIFP

Jeremiah W. (Jay) Nixon
Governor

Department of Insurance,
Financial Institutions &
Professional Registration

John M. Huff
Director

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The efficacy of behavioral interventions for the treatment of Autism Spectrum Disorders (ASDs) has been well established in the scientific literature. Over the past several decades, intensive early behavioral therapy has been shown to increase IQ, language skills, academic performance and sociality. In turn, improved cognitive and social functioning resulting from such treatment has been shown to reduce long-term medical and other costs. However, while Missouri's mental health parity statute (§376.1550 RSMo.) has been in effect since 2005, many behavioral therapies proven to effectively treat ASDs have in the past been routinely excluded from health insurance coverage.

House Bill 1311, signed into law by Governor Jay Nixon on June 10, 2010, mandated health insurance coverage for medically efficacious treatments for ASDs. All group policies issued or renewed after January 1, 2011 were required to cover medically necessary treatments for autism. All policies issued in the individual market were required to offer such coverage as an optional benefit. In addition, the law requires coverage for applied behavior analysis (ABA) for individuals up to 18 years of age. Required coverage for ABA was initially capped at $40,000 per year, to be adjusted for inflation each year thereafter. The cap currently stands at $41,263.

To assess the impact of the mandate on the health insurance market, the Department of Insurance, Financial Institutions & Professional Registration (DIFP) obtained data from all insurers that had comprehensive health insurance in force subject to the autism mandate. These data indicate that the mandate has succeeded in broadly extending coverage to autistic individuals during its first year, and is expected to expand access to medically efficacious treatments to Missouri's autistic population in the future.

Summary of Key Findings

The data reflect the fact that 2011 was a transitional year during which much of the infrastructure necessary to deliver the mandated benefits was developed. By the second half of the year clinics had acquired the staff and other capacities to begin treatments pursuant to the mandate, insurance coverage became effective, and patients began to receive treatment.

1. **Coverage** By year-end, all insureds in the small and large group market were covered for the mandated benefits, including ABA therapy. A much lower proportion, about one-third, received similar coverage in the individual market, including individually-underwritten association coverage. A few large providers of individual insurance extended autism coverage to all of their insureds. However, Missouri statute only requires autism benefits as an optional coverage in the individual market, and most insurers do not provide it as a standard benefit.

2. **Number impacted** Nearly 4,000 individuals received treatment covered by insurance for an ASD at some point during 2011. This amounts to 1 in every 350 insureds, a figure in line with estimates in the scientific literature of treatment rates.[1]

3. **Licensure** The first licenses for applied behavior analysis were issued in Missouri in December, 2010. As of January 20, 2012, 120 individuals held an applied behavior analyst license, and an additional 24 persons obtained assistant behavior analyst licenses.

4. **Claim payments** Claims costs incurred for autism services during 2011 amounted to $4.3 million, of which nearly $1.1 million was directed to ABA services. These amounts represent 0.1 percent and 0.02 percent of total claims incurred during this period, consistent with initial projections produced by the DIFP.[2] For each member month of autism coverage, total autism-related claims amounted to $0.25, while the cost of ABA treatment amounted $0.06.

5. **Average Monthly Cost of Treatment** – For each individual diagnosed with an ASD that received treatment at some point during 2011, the average ***monthly*** cost of treatment across all market segments was $143, of which $35 consisted of ABA therapies. The average, of course, includes individuals with minimal treatment as well as individuals whose treatments very likely cost much more.

6. **Medical infrastructure** Anecdotal evidence indicates that fully operational ABA programs were not widely available during the first half of 2011. Among the many requisites for such a program are the negotiation of contracts and reimbursement rates, the development of billing systems, and the hiring of trained and licensed staff. Correspondence with several clinics indicates that ABA operations began in full between July and September.

7. **Impact on premiums** While claims costs are expected to grow somewhat in the future, it seems very unlikely that costs for autism treatment will have an appreciable impact on insurance premiums. However, because the DIFP has no authority over health insurance rates and does not receive rate filings, a more exact assessment of the impact of the mandate on rates cannot be provided.

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[1] While the CDC estimates that the prevalence of autism is between 1/100 and 1/150, autism presents with a high degree of variability. Not all such individuals will benefit from, or seek, treatment specifically targeted at the ASD.

[2] The DIFP estimated that the mandate would produce additional treatment costs of between 0.2 percent and 0.8 percent. The analytical assumptions associated with the lower-end of the estimate range appear to be validated by the claims data presented in this report.

Background

The term Autism Spectrum Disorder (ASD) encompasses a variety of related neurobiological developmental disorders that can present with varying degrees of impairment. Beyond classic autism, the term ASD includes Asperger's Syndrome, Rett's Syndrome, Childhood Disintegrative Disorder, and Pervasive Developmental Disorder. Generally, autism and related conditions are associated with deficits in communicative skills and capacity for social interaction and reciprocity, restricted repetitive behavioral patterns and sometimes severe cognitive and perceptual dysfunction.

The etiology of ASDs is not currently well understood, although studies have associated the disorder with anomalies in the structures of the brain related to facial recognition and emotional response (Mosconi, et. al., 2009) and with abnormalities associated with neurotransmitters and synapses (Wittenmayer, et. al., 2009). Left untreated, severe cases may require life-long care.

While there is no cure, the success of behavioral therapies in improving cognitive, linguistic and social functioning has been convincingly demonstrated in controlled studies. Behavioral interventions have led to robust improvements in IQ, behavioral adaptation, and a reduction in other symptoms associated with ASDs. Remington et. al. (2007) found that early intensive behavioral intervention led to dramatic increases in intelligence, language, daily living skills and positive social behavior compared to a control group that received "treatment as usual." Similar results were obtained by Cohen, Amerine-Dickens and Smith (2006), who found that a community-based behavioral treatment program resulted in significantly higher IQ scores and adaptive behavior scores. Nearly one-third of the children receiving behavioral treatment were able to transition into a regular educational setting without additional assistance, and 11 others did so with assistance, compared to only 1 in the control group.

There appears to be a strong consensus within the literature regarding the efficacy of behavioral treatments for autism in a variety of settings (see also Eikeseth, Smith, Jahr and Eldevik, 2002 and 2006; Howard, et. al. 2005; Sallows and Graupner, 2005). A good overview of clinical practice related to behavioral interventions can be found in Scott and Johnson (2007). Summarizing the large body of research, the Surgeon General reported as early as 1999 that "Among the many methods available for treatment and education of people with autism, applied behavior analysis (ABA) has become widely accepted as an effective treatment. Thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and increasing communication, learning, and appropriate social behavior" (US Department of Health and Human Services, 1999).

History of HB 1311 and the ABA mandate

Prior to the passage of HB 1311 in 2010, Missouri enacted a mental health parity statute that became effective in 2005 (§376.1550). The purpose of this statute was to ensure that health insurers offered mental health benefits in a manner consistent with the provision of services for physical health: "A health benefit plan shall provide coverage for treatment of a mental health condition and shall not establish any rate, term, or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition" (§376.1550.1(2)). Under the terms of the statute, the term *mental health condition* is defined broadly to include all of the disorders recognized in the Diagnostic and Statistical Manual.

By this definition, insurers were required to cover treatment of ASDs even prior to the passage of HB 1311. However, the prior statute granted a broad exemption for treatments that were considered primarily for familial, educational or training purposes, that were custodial in nature, that were not clinically appropriate or that were experimental (§376.1550.5). Many, and perhaps most health insurance contracts issued in Missouri prior to HB 1311 included broad exclusionary language. For example, a typical exclusion was "...no Benefits will be provided for any of the following services, supplies, equipment or care; or for any complications, related to, or received in connection with, such services, supplies, equipment or care that are:

Not Medically Necessary.

Not specifically covered under this Agreement.

Any Health Care Service that is determined by the Company, in its discretion and subject to the right to submit a Grievance as set forth in Section 12 of this Agreement, to be Experimental or Investigational for the treatment of a specific patient's disease and clinical circumstance..." was excluded from coverage.

Autism treatments such as ABA were commonly excluded via the rationale that they are experimental in nature. Prior analysis by the DIFP indicated that even under the most generous set of assumptions, insurance carriers did not offer benefits of a level or kind that could have been expected to have any significant impact on individuals diagnosed an ASD. This analysis was consistent with the academic literature, which has documented that treatment for ASDs are either generally paid out-of-pocket by parents and relatives, are provided via public services such as special education programs, or, as was more likely, left largely untreated (Peele, Lave and Kelleher, 2002). Further, insurer-compensated treatment was not targeted to young individuals for whom treatments are known to be most effective and most likely to achieve an enduring and dramatic improvement in symptoms.

The paucity of insurance benefits for effective treatments of ASDs very likely contributed to lasting functional impairment of individuals with autistic and related disorders. To the extent that

such care cannot be funded by parents, nor provided publicly, individuals are likely to endure life-long cognitive and social deficits with enormous direct and indirect social costs (see Ganz, 2007).

To address the inadequate coverage for the treatment of ASDs in the private insurance market, and to ensure broader access to treatments that were known to be efficacious, HB 1311 established broad coverage requirements for ASD treatments. Applied behavior analysis (ABA) was specifically mandated for individuals 18 and under, for an amount up to $40,000 per year (adjusted for inflation in each subsequent year). All group plans were required to offer blanket coverage for all insureds. Individual plans, and individually-underwritten association plans, were required to extend an offer to cover the mandated benefits, though the offer can be refused by the policy-holder. In addition, HB1311 established a system of licensure for behavioral analysts to ensure the delivery of high-quality care.

HB1311 became effective for all health insurance plans issued or renewed in Missouri after January 1, 2011. Earlier this year, the DIFP issued a data call to assess the impact of the new law through June 30th, and to serve as a trial run to assess the kinds and quality of information that could be provided by insurers. A follow-up data call was issued at year-end. The experience during the first half of 2011 revealed that significant lags were associated with the implementation of the new law: mandated coverage was not extended until the renewal date of a health insurance policy; individuals required training and credentialing to practice ABA; medical providers faced the task of developing the infrastructure to secure compensation for services that were previously excluded by most health insurance plans; and insureds faced a learning curve with respect to the scope of the newly available benefits. Data below indicate that as the medical delivery infrastructure was put into place, significant benefits delivered through health plans were steadily increasing by the second half of 2011.

Coverage

All group plans issued or renewed after January 1, 2011, are required to extend the mandated benefits for the treatment of ASDs, including ABA, to all insureds. An offer of such coverage must accompany any insurance purchased in the individual market, including individually-underwritten association plans.[3] As such, many insureds will not have received ASD coverage until well after the January 1 effective date, since renewal dates will not coincide with the calendar year.

[3] Association health coverage, such as insurance sold through the AARP and a broad variety of other groups, is considered group coverage for some purposes. However, because it is individually-underwritten in a fashion similar to the true individual market, it is often treated as individual coverage. Under HB1311, such association coverage is considered individual coverage and therefore must only offer the mandated benefits.

By year-end, all insureds in the group market, and about one-third of insureds in the individual market were covered for the mandated ASD and ABA benefits. Over 90 percent of "member-months" over the course of the entire year in the group market were covered for the benefit, indicating the relative rapidity with which coverage went into effect after the effective date of the mandate.[4] The percentage of annual member months with such coverage in the individual market is considerably lower at 32.2 percent, which is virtually unchanged since the first half of the year.

Percent of Member Months With Coverage for Mandated ASD Benefits
By Market Segment
2011

Market Segment	Total Member Months	Member Months of Policies with Autism Coverage	% With Coverage
Individual	3,272,121	1,053,043	32.2%
Small Group	5,524,721	5,034,574	91.1%
Large Group	11,871,686	11,245,146	94.7%
Total	**20,668,528**	**17,332,763**	**83.9%**

It is less likely that coverage will be broadly extended in the individual market due to the distribution of costs in this market. For group coverage, costs associated with the mandate are borne by the entire group in the same manner as any other illness. Since only the offer of coverage is required in the individual market, there will be a strong tendency of "adverse selection" with respect to autism benefits. Namely, the vast majority of individuals accepting ASD coverage will already have a dependent with an autism-related diagnosis. Since the coverage is usually provided as a rider at an additional premium, the entire costs of the mandated benefits will therefore be concentrated among such policyholders. The resulting premiums will likely make such coverage unaffordable for many. The DIFP is aware that the cost for an autism endorsement in the individual market can range from $500 to several thousand dollars per month.

[4] That is, most member months without ABA coverage occurred during the beginning of the year. Implementation of coverage occurred as plans were renewed over the course of the year.

For those individual plans for which coverage is optional, the take-up rate for ASD benefits is nearly zero. As noted earlier, a few large insurers have extended ABA coverage to all of their policy-holders in the individual market, though they are only required to extend it as an optional coverage that can be purchased for additional premium. The remaining insurers offering individual coverage comprise 69 percent of the market. For these carriers, less than 1/10th of 1 percent of member months had such coverage in effect for 2011.

Coverage in the Individual Market – *Excluding* Insurers That Offer ABA Coverage to All Policyholders

Member Months	% of Individual Market	Member Months With Autism Coverage	% Member Months With Autism Coverage
2,251,456	68.8%	1,353	0.1%

Treatment Rates

The DIFP attempted to assess the prevalence of individuals diagnosed with an ASD with coverage under a licensed health insurer. Unfortunately, insurers are only able to identify such individuals via information available from submitted claims, such that an individual with an ASD diagnosis must have sought a treatment for conditions specific to the ASD during the period under examination to appear in our data.[5] Thus, the estimates that follow should not be considered as even a proxy for all ASD-diagnosed individuals with health insurance coverage, but rather a subset of that group that received some form of ASD-related treatment during 2011. The overall prevalence of ASD-diagnosed insureds is quite likely to be significantly larger.

Lastly, the DIFP sought to estimate the number of individuals diagnosed with an ASD that *lacked* coverage under the autism mandate. However, because such individuals would be far less

[5] That is, individuals that did not seek treatment directly associated with the ASD would not normally be identified on a typical claims form. The DIFP requested that insurers count anyone who sought an ASD-related treatment during the preceding 12 months as part of their autistic population.

likely to seek treatment than their covered counterparts, and would be less likely to submit the claim when treatment was sought, these estimates are considered unreliable and not presented here.

During the last year, over 1.3 million Missourians obtained comprehensive coverage through a licensed insurer[6] in the individual, small group or large group markets. Of this number, nearly 4,000 individuals sought treatment during the reporting period for which the primary diagnosis was an ASD. The majority of these individuals, or 3,123, were 18 and under and therefore eligible for coverage under the ABA mandate. Across all market segments, 1 insured in 350 sought treatment for an ASD-related condition. Treatment rates are considerably lower than the prevalence rate of ASDs in the general population, which the Centers for Disease Control has estimated to be between 1/100 and 1/150. Autism can present with a high degree of variability. Many autistic individuals will neither seek, nor benefit from, extensive treatment.

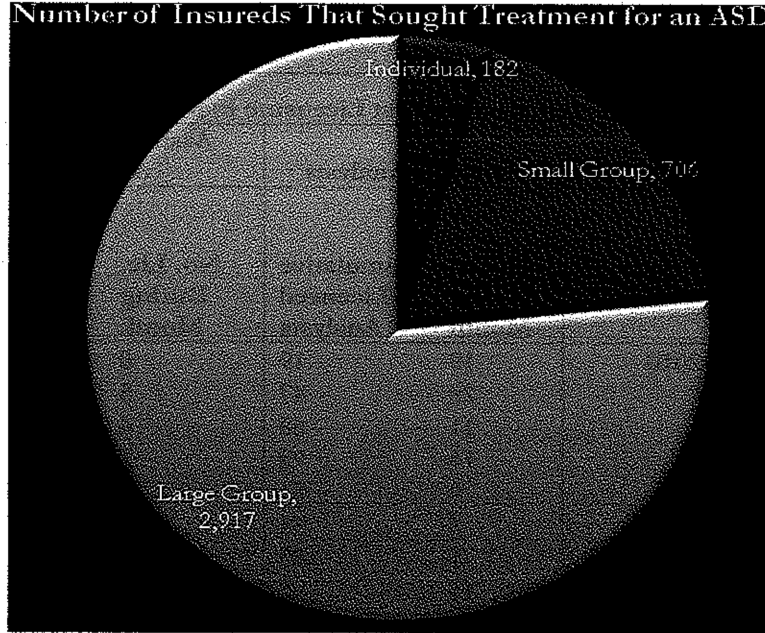
Prevalence of ASD Covered Treatment[7]

Market Segment	Insureds	Insureds With an ASD, Covered Under Mandate	1 Covered ASD Diagnosed Individual Per X Insureds	Insureds Under 18 With an ASD
Individual	249,188	182	1,369	153
Small Group	379,767	706	538	585
Large Group	702,218	2,917	241	2,385
Total	**1,331,173**	**3,805**	**350**	**3,123**

As expected, the percent of insureds with a covered ASD was nearly twice as high in the group market compared to the individual market. Only 182 individuals sought treatment for an ASD covered in the individual market, representing only 4.8 percent of all such individuals across all market segments.

[6] These figures exclude the non-licensed market and employers that self-insure under federal ERISA statutes. Self-insurers comprise a significant portion of the group market. Prior estimates by the DIFP suggest that self-insureds represent as much as 2/3 of the group market. Also excluded from these figures are all forms of public coverage.

[7] Figures are based solely on initial survey responses of licensed insurers for fully-insured plans related to the data period 2011. Some entities that are known to offer autism-related benefits, such as the Missouri Consolidated Health Care Plan (MCHCP) and some self-insured employer plans, are not included in the data.



Licensure

House Bill 1311 requires that each behavior analyst and assistant behavior analyst pass an examination and obtain board certification to be eligible for a license to practice in Missouri. The first licenses were issued in December, 2010. By mid-January of 2012, licenses were issued to 120 behavior analysts. In addition, 24 assistant behavior analysis licenses were issued. Assistants must practice under the supervision of a behavior analyst. In addition to licensed behavior therapists, licensed psychologists may also provide ABA therapy.

These figures indicate that Missouri is well on the way to developing the necessary medical infrastructure and expertise to deliver ABA services to a broad population. Correspondence with medical providers specializing in ASD treatment reinforce this impression, but also illustrate the considerable time and effort necessary to make ABA treatment more widely available as coverage for such treatment is extended. Coding methodology and claim transmittal protocols must be developed. Rates for the provision of previously excluded services must be negotiated. Appropriately trained and licensed personnel must be added to existing staff. One clinic indicated that they were not fully operational to deliver ABA services until July 1. A second began providing ABA treatments as of September 1.

Applied Behavior Analyst Licensure in Missouri				
	Behavior Analysts		Assistant Behavior Analysts	
Month License Issued	No. Lic. Issued During Month	Cumulative Licensed Analysts	No. Lic. During Month	Cumulative Licensed Analysts
December, 2010	19	19	0	0
January	28	47	5	5
February	11	58	4	9
March	14	72	2	11
April	9	81	2	13
May	3	84	0	13
June	1	85	1	14
July	11	96	3	17
August	0	96	4	21
September	2	98	0	21
October	3	101	1	22
November	6	107	1	23
December	6	113	1	24
January, 2012 (partial)	7	120	0	24
Total	**120**		**24**	

Claim Payments

During 2011, comprehensive health plans incurred a total of $4.3 billion in total claim costs. Only a small fraction of this amount resulted from autism-related treatments, which amounted to $4.6 million or 0.1 percent of total claims. Costs incurred for ABA therapies were only 0.02 percent of total claims, or $1,050,764.

The DIFP has previously estimated that the ABA mandate would produce claim costs of between 0.2 percent and 0.8 percent of total premium. Amounts incurred thus far are well below this estimate, but for reasons already discussed are expected to grow as the benefits of the mandate are more fully realized.

Autism-Related Claim Costs			
Line of Business	**Total Incurred Losses**	**All Autism-Related Incurred Losses**	**Losses Incurred, ABA**
Individual	$484,064,498	$543,916	$36,252
Small Group	$975,765,332	$1,027,953	$205,499
Large Group	$2,889,525,540	$2,737,959	$809,013
Total	**$4,349,355,370**	**$4,309,828**	**$1,050,764**

Autism Treatment as Percent of Incurred Losses		
Line of Business	**All Autism-Related Incurred Losses**	**ABA-Related Incurred Losses**
Individual	0.11%	0.01%
Small Group	0.11%	0.02%
Large Group	0.09%	0.03%
Total	**0.10%**	**0.02%**

Another method of expressing the costs of the mandate is the ratio of autism-related treatment costs to the total member months during which autism coverage was in effect. Across all market segments, the average autism-related claim costs for each month of autism coverage was $0.25, and $0.06 for the costs of ABA treatments.

Claim Costs for Autism Per Member Per Month for Policies with Autism Coverage					
Market Segment	**Member Months of Policies With Autism Coverage**	**All Autism Related Claims**	**ABA Claims**	**All Autism-Related Claims, PMPM**	**ABA-Related Claims, PMPM**
Individual	1,053,043	$543,916	$36,252	$0.52	$0.03
Small Group	5,034,574	$1,027,953	$205,499	$0.20	$0.04
Large Group	11,245,146	$2,737,959	$809,013	$0.24	$0.07
Total	**17,332,763**	**$4,309,828**	**$1,050,764**	**$0.25**	**$0.06**

For each individual receiving any form of treatment directly associated with an ASD, the average monthly claims cost during 2011 was $143, ranging from $293 in the individual market to $142 in the large group market. With respect to the population 18 years of age and younger, the costs of ABA treatments ranged from $15 in the individual market to $58 in the large group market.

Average Monthly Claim Cost Per Individual Treated for Autism				
	All Ages		**Age 18 and Under**	
Market Segment	**All Autism-Related Treatment**	**ABA**	**All Autism-Related Treatment**	**ABA**
Individual	$293	$19	$314	$15
Small Group	$115	$23	$122	$29
Large Group	$142	$42	$161	$58
Total	**$143**	**$35**	**$160**	**$47**

Other DIFP Activities Related to Autism

The DIFP worked on numerous fronts to successfully implement the autism mandate during 2011. Following the passage of the law, staff engaged stakeholders representing a wide variety of perspectives and needs – from insurance companies to providers to parents and advocates. This outreach was designed to anticipate and address any potential problems. Additionally, the Department was able to provide education and resources to parents and providers as they began navigating through the process of obtaining insurance coverage for autism benefits for the first time.

Complaints

The DIFP monitors the number of complaints and inquiries received that are related to the autism mandate. Over the course of 2011, DIFP staff responded to 109 consumer contacts by insureds with questions about autism coverage. Only six of these contacts resulted in formal complaints against an insurer. Subject matter ranged from the lack of medical providers, the lack of coverage in self-funded plans under federal jurisdiction, to concerns about costs and requests for clarification of various aspects of the new law.

Impact on Small Business

Initial concerns about the potential costs of the mandate resulted in an opt-out provision for small employers. Any small employer may petition the director for a waiver of the mandate if providing the coverage causes premiums to increase by 2.5 percent or more over any 12 month period. The earliest such a waiver request could have been made is therefore January 1, 2012. To date, the DIPF has received no requests for a waiver.

National recognition for online education

Before the law took effect on Jan. 1, 2011, the Department launched new educational content online for parents, health care providers and insurers on its website. The online resources include explanations of the new law's various provisions, frequently asked questions, instructions for filing consumer complaints, a Parent Resource Center and content specifically designed for health care providers. The Department's efforts in creating this comprehensive online guide were heralded by Autism Speaks, the nation's largest advocacy group for autism. At its Autism Law Summit in October 2011, the group recognized the DIFP for outstanding efforts on behalf of individuals with autism.

Outreach

The Department assembled an autism working group meeting in Jefferson City during November, 2010, which was attended by parents, advocates, medical providers and representatives of major insurance companies in the Missouri market. At the meeting, stakeholders discussed concerns and how the Department could best facilitate consumer and provider education about the new law as well as facilitate an open exchange of information between the insurance industry and the provider community.

In response to many of the issues identified through the working group, the DIFP issued a bulletin to all health insurance companies on January 3, 2011, outlining Department plans for enforcing the new law. This bulletin:

- Encourages the insurance industry to accept HCPCS codes
- Asks any companies that are not able to utilize these codes make information readily available to providers both in- and out-of-network.
- Reminds that the department will closely monitor the delivery of autism related services and ensure no unnecessary barriers to treatment are imposed
- Encourages companies to exercise flexibility in accommodating children already enrolled in ABA treatment, so as not to interrupt their ongoing therapy.

- Extends a one year "safe harbor" from any enforcement or disciplinary action related to temporary modifications or deviations to practices or procedures in order to accommodate those currently enrolled in ABA treatment.

Following the passage of HB 1311, Director Huff and other members of the DIFP team appeared throughout the state at more than 10 public events for consumers, industry and stakeholders.

Most recently, the Department hosted the Autism Provider Summit in December of 2011. The summit served as a one-day training program to educate autism treatment providers about insurance billing, navigating the insurance world, and ensuring that their staffs are properly credentialed and licensed. Close to 80 providers and interested parties attended the summit.

Conclusion

Applied behavior therapies have been shown to dramatically reduce long-term costs for a significant proportion of individuals diagnosed with an ASD, and to significantly improve their quality of life. The costs associated with the autism and ABA coverage mandate has thus far been minimal, even as the mandate has led to dramatically expanded coverage and the delivery of medically beneficial services. The law has achieved its purposes in an unqualified way for every measureable metric.

Bibliography

American Psychiatric Association. 2000. Pervasive development disorders. In **Diagnostic and Statistical Manual of Mental Disorders.** Fourth edition. Washington, D.C: American Psychiatric Association: 69-70.

Cohen, Howard, Mila Amerine-Dickens, and Tristram Smith. 2006. Early intensive behavioral treatment: Replication of the UCLA model in a community setting.

Eikeseth, S., T. Smith, E. Jahr, and S. Eldevik. 2002. Intensive behavioral treatment at school for 4- to 7-year-old children with autism: a 1year comparison controlled study. **Behavioral Modification.** 26: 49-68.

Ganz, Michael. 2007. The lifetime distribution of the incremental societal costs of autism. **Archive of Pediatric and Adolescent Medicine.** 161: 343 – 349.

Howard, J.S. et. al. 2005. A comparison of intensive behavior analytic and eclectic treatments for young children with autism. **Research in Developmental Disabilities.** 26: 359-383.

Mosconie, Matthew W., et. al. 2009. Longitudinal study of Amygdala volume and joint attention in 2- to 4-year-old children with autism. **Archive of General Psychiatry.** 66 (5): 509.

Peele, Pamela B., Judith R. Lave, and Kelly J. Kelleher. 2002. Exclusions and limitations in children's behavioral health care coverage. **Psychiatric Services.** 53(5): 591-594.

Remington, B., et. al. 2007. Early intensive behavioral intervention: outcomes for children with autism and their parents after two years. **American Journal on Mental Retardation.** 112; 418-38.

Sallows, G. O. and T. D. Graupner. 2005. Intensive behavioral treatment for children with autism: four-year outcome and predictors. **American Journal on Mental Retardation.** 110: 417-438.

U.S Department of Health and Human Services. 1999. **Mental Health: A Report of the Surgeon General—Executive Summary.** Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

Wittenmayer, N, et. al. 2009. Postsynaptic neuroligin-1 regulates presynaptic maturation. **Proceedings of the National Academy of Sciences.** 106(32): 13564-13569.

__________. 2006. Effects of low-intensity behavioral treatment for children with autism and mental retardation. **Journal of Autism and Developmental Disorders.** 36: 211-224.

Insurance Consumer Hotline

Contact DIFP's Insurance Consumer Hotline
if you have questions about your insurance policy
or to file a complaint against an
insurance company or agent:

difp.mo.gov

800-726-7390

DIFP

Department of Insurance,
Financial Institutions &
Professional Registration

Harry S Truman Building, Room 530
301 W. High St.
PO Box 690
Jefferson City, MO 65102

JANUARY 2012

HON. SUSAN J. CRAIGHEAD
Noted for Hearing: June 8, 2011
Without Oral Argument

IN THE SUPERIOR COURT OF WASHINGTON
FOR KING COUNTY

D.F. and S.F., by and through their parents, A.F. and R.F.; S.M.-O., by and through his parents, S.M. and D.O.; on their own behalf and on behalf of all similarly situated individuals,

Plaintiffs,

v.

WASHINGTON STATE HEALTH CARE AUTHORITY; PUBLIC EMPLOYEES BENEFITS BOARD; DOUG PORTER, Administrator of the Washington State Health Care Authority and Chairman of the Public Employees Benefits Board, in his official capacity;

Defendants.

NO. 10-2-29400-7 SEA

~~[PROPOSED]~~
ORDER:

(1) GRANTING, IN PART, PLAINTIFFS' MOTION FOR PARTIAL SUMMARY JUDGMENT AND

(2) DENYING DEFENDANTS' SUMMARY JUDGMENT MOTION

THIS MATTER came before the Court upon plaintiffs' Motion for Partial Summary Judgment and Permanent Injunction and defendants' Cross-Motion for Summary Judgment. The Court heard oral argument on February 4, 2011. Plaintiffs D.F., S.F. and S.M.-O., by and through their parents, were represented by Eleanor Hamburger and Richard E. Spoonemore, SIRIANNI YOUTZ SPOONEMORE. Defendants Washington State Health Care Authority, Public Employees Benefits Board and Doug Porter, in his official capacity as Administrator of the Washington State Health Care Authority and Chairman of the Public Employees Benefits Board (collectively

SIRIANNI YOUTZ SPOONEMORE
999 THIRD AVENUE, SUITE 3650
SEATTLE, WASHINGTON 98104
TEL. (206) 223-0303 FAX (206) 223-0246

"defendants"), were represented by Melissa A. Burke-Cain and Kristen K. Culbert, OFFICE OF THE ATTORNEY GENERAL.

In their motion, defendants seek an order declaring that the Washington State Health Care Authority's health care coverage, which lists Applied Behavior Analysis therapy as a specific exclusion, complies with Washington's Mental Health Parity Act, RCW 41.05.600. Defendants also seek summary judgment on plaintiffs' claims for the failure to exhaust their administrative remedies. Plaintiffs, in their motion, seek partial summary judgment and an injunction declaring that defendants are required to cover Applied Behavior Analysis when the service is medically necessary, and that defendants' exclusion of Applied Behavior Analysis is illegal under the Mental Health Parity Act.

Along with oral argument, the Court reviewed and considered the pleadings and record herein, including:

- Plaintiffs' Motion for Partial Summary Judgment and Permanent Injunction;
- the Declaration of Lynda Gable and any exhibits attached thereto;
- the Declaration of Jeffrey D. Mills and any exhibits attached thereto;
- the Declaration of Richard E. Spoonemore and any exhibits attached thereto;
- the Declaration of A.F., mother of D.F. and S.F. and any exhibits attached thereto;
- Defendants' Cross-Motion for Summary Judgment and any exhibits attached thereto;
- the Declaration of Joleen McMahon and any exhibits attached thereto;
- the Declaration of Melissa Burke-Cain and any exhibits attached thereto;
- the Declaration of Nicole Oishi and any exhibits attached thereto;

SIRIANNI YOUTZ SPOONEMORE
999 THIRD AVENUE, SUITE 3650
SEATTLE, WASHINGTON 98104
TEL. (206) 223-0303 FAX (206) 223-0246

- Plaintiffs' Response to Defendants' Cross-Motion for Summary Judgment;
- the Second Declaration of Richard E. Spoonemore and any exhibits attached thereto;
- the Declaration of J.M. and any exhibits attached thereto;
- the Second Declaration of A.F. and any exhibits attached thereto;
- Defendants' Opposition to Plaintiffs' Motion for Partial Summary Judgment and Injunctive Relief re: Mental Health Parity Act;
- the Declaration of Melissa Burke-Cain in Support of Defendants' Opposition to Plaintiffs' Partial Summary Judgment Motion and any exhibits attached thereto;
- the Declaration and Amended Declaration of Eliana Gall and any exhibits attached thereto;
- Defendants' Reply Brief in Support of Defendants' Cross-Motion for Summary Judgment;
- Plaintiffs' Reply in Support of Their Motion for Partial Summary Judgment and Injunctive Relief re: Violation of the Mental Health Parity Act;
- the Third Declaration of A.F. and any exhibits attached thereto;
- the Declaration of Allison Lowy Apple and any exhibits attached thereto;
- the Third Declaration of Richard E. Spoonemore and any exhibits attached thereto;
- the Declaration of Michael A. Fabrizio, M.A. and any exhibits attached thereto; and
- the Declaration of Stacey Shook, Ph.D., B.C.B.A.-D., C.M.H.C. and any exhibits attached thereto.

Based upon the foregoing, the Court hereby GRANTS, in part, plaintiffs' Motion for Partial Summary Judgment and DENIES, in total, defendants' Motion for Summary Judgment.

SIRIANNI YOUTZ SPOONEMORE
999 THIRD AVENUE, SUITE 3650
SEATTLE, WASHINGTON 98104
TEL. (206) 223-0303 FAX (206) 223-0246

As set forth in a letter ruling dated May 23, 2011, which is incorporated herein at *Exhibit A*, the Court concludes that, as a matter of law, plaintiffs are entitled to a declaration that specific exclusions contained in health benefit plans administered by the defendants that exclude coverage of Applied Behavior Analysis therapy, even when medically necessary and performed by licensed health providers, do not comply with Washington's Mental Health Parity Act, RCW 41.05.600. The Court further declares that under the Mental Health Parity Act defendants are required to cover medically necessary Applied Behavior Analysis therapy, as determined on an individualized basis, when provided by licensed providers.

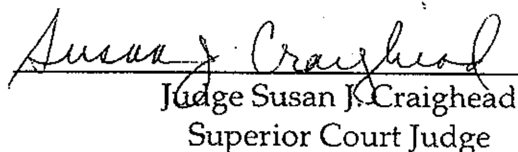
The Court reserves ruling, at this time, whether defendants are required to cover Applied Behavior Analysis therapy when provided by certified or registered—as opposed to licensed—health providers.

The Court denies, without prejudice, plaintiffs' request for injunctive relief at this time. The Court anticipates that an evidentiary hearing may need to be conducted after a ruling on class certification to determine whether an injunction should issue against defendants as to the individual plaintiffs or a class of plaintiffs.

The Court denies defendants' motion for summary judgment because (1) defendants have not complied with the Mental Health Parity Act (as set forth above and in the Court's May 24, 2011 letter ruling), and (2) defendants' exhaustion defense fails with respect to plaintiffs on summary judgment. The Court also concludes that there is no need for other putative class members exhaust administrative remedies, as set forth in the Court's May 24, 2011 letter ruling.

IT IS SO ORDERED.

DATED this 7th day of June, 2011.

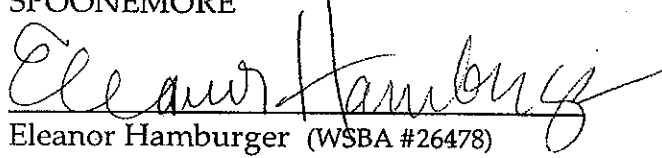


Judge Susan J. Craighead
Superior Court Judge

SIRIANNI YOUTZ SPOONEMORE
999 THIRD AVENUE, SUITE 3650
SEATTLE, WASHINGTON 98104
TEL. (206) 223-0303 FAX (206) 223-0246

1 Presented by:

2 SIRIANNI YOUTZ
3 SPOONEMORE

4 

5 Eleanor Hamburger (WSBA #26478)
6 Richard E. Spoonemore (WSBA #21833)
Attorneys for Plaintiffs

7

8 Approved as to Form by:

9

ROBERT M. McKENNA
10 Attorney General

11

12

13 Melissa A. Burke-Cain (WSBA #12895)
Kristen K. Culbert (WSBA #32930)
14 Attorneys for Defendants

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SIRIANNI YOUTZ SPOONEMORE
999 THIRD AVENUE, SUITE 3650
SEATTLE, WASHINGTON 98104
TEL. (206) 223-0303 FAX (206) 223-0246

Exhibit A

Superior Court for the State of Washington in and for the County of King

SUSAN J. CRAIGHEAD
Judge

King County Courthouse
Seattle, Washington 98104-2312
E-mail: Susan.Craighead@kingcounty.gov

May 23, 2011

Mr. Richard E. Spoonemore
Ms. Eleanor Hamburger
Sirianni Youtz Meier & Spoonemore
999 3rd Ave. Ste 3650
Seattle, WA 98104-4038

Ms. Melissa A. Burke-Cain
Ms. Kristen K. Culbert
Office of the Attorney General
Agriculture & Health Division
7141 Cleanwater Drive SW
P.O. Box 40109
Olympia, WA 98504

<u>S.F., et al v. Washington State Health Care Authority</u>, No. 10-2-29400-7 SEA
Cross-Motions for Summary Judgment

Counsel,

Before the Court are cross-motions for summary judgment. The Washington Health Care Authority (HCA) seeks an order declaring that its coverage under its Uniform Medical Plan (UMP) complies with the mental health parity law, RCW 41.05.600; HCA also seeks summary judgment dismissing the action because plaintiffs failed to exhaust their administrative remedies. For the reasons set forth below, HCA's motion for summary judgment is denied.

Plaintiffs seek partial summary judgment in the form of an injunction requiring HCA to cover Applied Behavioral Analysis (ABA) for children with autism for whom the service is medically necessary. For the reasons set forth below, this motion is granted in part.

Plaintiffs are a putative class of children who have Autism Spectrum Disorder (ASD) whose families are insured through HCA; the named plaintiffs under UMP and Aetna. There is no dispute about the diagnosis. ABA therapy is an intensive, one-on-one intervention that has shown success with some children with ASD , assisting them changing behaviors that make it difficult for them to interact with others. Children spend between 25-40 hours per week undergoing therapy, at a cost of as much as $50,000 per year. Plaintiffs contend that ABA therapy can enable children with ASD to attend school, even in mainstream classrooms, or avoid institutionalization. HCA contends that there is no scientific evidence establishing statistically significant improvement in children who have undergone ABA therapy. Both Aetna and UMP, in accordance with HCA's policy, flatly exclude ABA therapy from coverage.

S.F. and his family first enrolled in the Aetna Public Employees Plan in January 2009. His family had previously been insured through Premera Blue Cross. Premera provided limited coverage for ABA

therapy. S.F. and his brother, D.F., received ABA therapy through a program prescribed and monitored by Dr. Stephen Glass, a well-known pediatric neurologist. The program was implemented by Allison Apple, Ph.D., who is a licensed mental health provider. The boys' parents were initially told that this therapy would be covered by Aetna under a "transition of Care" benefit, but later Aetna declined coverage for a consulting appointment with Dr. Glass and all other therapy related to ABA on the grounds that ABA is not covered under the plan. The parents appealed the denial; HCA denied the appeal on the grounds that the treatment was not "medically necessary." At that point, the parents requested an independent review of the dispute; this review found that ABA therapy is the standard medical care for children with autism and concluded that ABA therapy was medically necessary. After this review, Aetna paid for S.F.'s ABA therapy, which was provided by a master's level therapist who was a certified mental health counselor. However, as it had told S.F.'s parents it would, Aetna subsequently amended its certificate of coverage to specifically exclude ABA therapy, even if it was medically necessary.

HCA argues that it does not cover ABA therapy because it is provided by unlicensed practitioners. HCA contends that it only provides coverage for care performed by licensed health care providers, whether the care is for medical or mental health conditions. Plaintiffs acknowledge that many ABA therapists are not licensed by the State of Washington (although there is a voluntary national certification for ABA practioners), but contend that HCA denied coverage in this case for care that would have been performed by licensed mental health providers. The crux of the plaintiffs' argument is that ABA is excluded from coverage by HCA regardless of who provides it and regardless of whether it is medically necessary for an individual child; in contrast, there is no similar blanket exclusion for any category of medical care. While HCA argues in this litigation that its concern is the licensure of the practitioners, it did not cite this basis as grounds for denying coverage to the named plaintiffs before the litigation began.

Both parties rely on language in the mental health parity law, RCW 41.05.600, to support their arguments. Plaintiffs cite RCW 41.05.600(1), which defines "mental health services" as "medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders..." and then lists certain categories of treatment that are expressly not included in the definition of "mental health services." Plaintiffs argue that this provision means that all other mental services are to be covered, without limitation. This, they argue, was the legislature's way of remedying past discrimination against mental health care.

HCA points to RCW 41.05.600(2)(c), which provides in part that "[t]reatment limitations or any other financial requirements on coverage for mental health services are only allowed if the same limitations or requirements are imposed on coverage for medical and surgical services. " HCA argues that this provision allows it to restrict coverage to licensed mental health care providers, since only medical and surgical services performed by licensed providers are covered. HCA also notes RCW 41.05.600(4), which provides that a health plan may require that "mental health services be medically necessary...if a comparable requirement is applicable to medical and surgical services."

The court is not persuaded that the statute's definition of mental health services evidences a legislative intent that all services that purport to remedy mental health problems must be covered by HCA, regardless of medical necessity. Similarly, the court is not persuaded that the legislature intended to require HCA to cover services no matter the qualifications of the provider. It appears from the language cited by HCA above, that the legislature anticipated that restrictions could be placed on coverage for mental health services as long as they were the same type of restrictions placed on coverage for medical and surgical services.

Although both parties attempt to persuade the court of their respective positions on the medical necessity of ABA therapy, or lack thereof, that is not an issue that needs to be resolved to rule on the plaintiffs' motion. From the evidence presented to the court, it is apparent that ABA therapy may provide benefit to some individuals. The plaintiffs are seeking the opportunity to establish medical necessity on a case by case basis.

The court concludes as a matter of law that HCA is not in compliance with the Mental Health Parity Act insofar as it imposes a blanket exclusion of ABA therapy, even when provided by licensed therapists. HCA is required by the Act to cover medically necessary ABA therapy (as determined on an individualized basis) that is provided by licensed therapists. The court cannot determine as a matter of law that HCA is required to cover ABA therapy provided by certified or registered providers because on this record it is not clear whether HCA covers mental health services provided by counselors or therapists who hold certifications or registrations, but not licenses. Neither is it clear whether a national certification as is held by some ABA providers is equivalent to any certification for providers of other mental health services currently covered by HCA.

Exhaustion: HCA contends that plaintiffs have failed to exhaust their administrative and/or contractual remedies and, therefore, their claims should be dismissed. It does not appear that the Administrative Procedure Act applies to this dispute; the relationship among the parties is contractual, governed by the Certificates of Coverage. S.F. has exhausted his contractual remedies under the Certificate of Coverage, inasmuch as he appealed the denial of coverage for ABA services, prevailed before the IRO, only to have Aetna change the Certificate of Coverage to thwart the result of his appeal. There is no need for other putative class members to go through a similar exercise when is plain that the result will be the same. HCA's exhaustion defense fails on summary judgment.

Request for a Permanent Injunction: The court has struggled with the plaintiffs' request for a permanent or, in the alternative, preliminary, injunction. The extent to which the court may resort to injunctive relief in the context of summary judgment is unclear; under CR 56, the court is not supposed to weigh facts, but the court must make findings of fact and conclusions of law to support entry of injunctive relief. The plaintiffs seek an injunction that would apply not only to them, but to other children with autism, yet this court has not yet been asked to certify this action as a class action. The parties advised the court at oral argument that the question of whether ABA therapy qualified as a neurodevelopmental therapy has yet to be litigated. While HCA has not presented any information contradicting plaintiffs' assertions that ABA therapy is medically necessary for them, plaintiffs have not

presented declarations from experts establishing medical necessity or the likelihood of irreparable harm, other than the fact that the IRO concluded that ABA therapy was medically necessary for S.F. It is certainly the opinion of the plaintiffs' parents that the lack of ABA therapy has caused and will continue to cause irreparable injury to them, but the court is not certain that this opinion alone can justify findings to support entry of injunctive relief. For these reasons, the court denies the request for injunctive relief without prejudice. The court anticipates that some type of evidentiary hearing could be conducted following a ruling on class certification to determine whether a preliminary injunction should issue, either as to these plaintiffs or as to a class of plaintiffs. The court welcomes suggestions from counsel regarding this procedure.

Counsel for plaintiffs is directed to present proposed orders to the court that include a list of all of the documents this court reviewed in connection with these cross-motions.

The court apologizes for the length of time it took this matter under advisement. I hope the parties can see the degree of care the court devoted to this very important case.

Sincerely,

Susan J. Craighead
Judge

Oregon
John A. Kitzhaber, MD, Governor

Department of Consumer and Business Services
Insurance Division
350 Winter St. NE
P.O. Box 14480
Salem, OR 97309-0405
503-947-7980
Fax: 503-378-4351
www.insurance.oregon.gov

December 22, 2011 Sent via email

Ronald Lagergren
Kaiser Foundation Health Plans of the Northwest
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Ronald.L.Lagergren@kp.org

RE: IPRO External Reviewers Findings ER 11105 –

Dear Mr. Lagergren:

I have received a copy of an email sent from you to Melanie Shaw, MA, BCBA at Play Connections Autism Services. In your email you stated "unfortunately, we cannot provide an authorization to another clinician. The appeal overturn was specifically for Don. We need to provide the authorization for services directly to Don". I assume this was in reference to the external review by IPRO reference # ER11105.

Please refer to the reviewers findings on page three of the external review. The reviewer states that:

"The documents provided support the diagnosis of Autistic Disorder as well as the need for ABA interventions. It appears that the insurer is denying the ABA based on 1) lack of evidence that ABA is effective treatment, 2) ABA not meeting medical necessity, and 3) the provider not being on the policy's approved panel.

However:

1. ABA is the current standard for treatment of behavioral issues in children with autistic spectrum disorders. The research papers about ABA show it to be the most medically effective treatment currently available.
2. Use of ABA will most likely reduce or ameliorate the child's behavioral disability, thereby meeting the definition of medical necessity.
3. Given 1 and 2 (above), **an out-of-network provider is medically necessary if a preferred provider for ABA is not available on the insurer's panel.**

Based on the above the denial is reversed."

Point 3 specifically refers to an out-of-network provider if a preferred provider for ABA is not available on the insurer's panel. This external review was for medical necessity not who the provider would be that ultimately provides treatment. Please refer to OAR 836-053-1330 a referral for external review may not be made solely based on providers it must be either medical necessity, experimental or investigational, or continuity of care.

Does Kaiser have a network preferred provider who can deliver the ABA therapy? If not then please work with Mr. [redacted] to find an out of network provider who can provide the required services. Donald Shaw did not agreed to be bound by the results of this review nor does he have any contract with Kaiser. Donald Shaw is not part of this agreement. Please refer to ORS 743.863 Civil penalty for failure to comply by an insurer that agreed to be bound by a decision.

If you think the issue at hand is not medical necessity please let me know. Please provide me status updates on your handling of this matter.

Please contact me if you have any questions.

Sincerely,

John Hardiman, CLU, ChFC, AIE
Market Analyst, Oregon Insurance Division
Market Conduct, (503) 947-7250, E-mail: John.Hardiman@state.or.us

February 3, 2012

To Health Care Committee Members:

My apologies. I was unable to rearrange my clinical schedule so that I could testify in person today. I would be very pleased to respond to any questions in writing and appear in person at subsequent hearings. I am testifying today as a clinician although I wear several other hats: Professor of Pediatrics at OHSU, member of the Governor's Commission on Autism Spectrum Disorder and chair of its health care committee, and medical consultant to the Oregon Center for Children and Youth with Special Health Needs at OHSU.

I have worked as a Developmental Pediatrician in Oregon for nearly 32 years. During that time, the apparent prevalence of autism spectrum disorders (ASD) in children has increased dramatically. Currently about 1 in 110 children will develop an ASD. The diagnosis is made at earlier ages and there is a great body of empirical research documenting effective interventions. And yet, current treatment services for children and in particular young children remain strikingly inadequate. Insurance plans provide very limited and at times no coverage for therapies for children with ASD and publically funded programs are markedly underfunded to meet the need. For example, a 2 year old with a new diagnosis of an ASD may receive Early Intervention (EI) services one hour per week through a center-based toddler group in addition to every other week home visits. In contrast, the Institute of Medicine of the National Academy of Sciences has recommended a minimum of 20-25 hours of structured intervention per week.

About 30% of young children with autism appear to be developing typically until regressing in their skills at 18-20 months of age. I ask you to picture yourselves in my shoes as I counsel the parents of a 2 year old who has just experienced such a regression; a child who was smiling, talking and singing nursery rhymes but now uses no words, has little eye contact and shows no joy. I work with the parents to see how we might put together a treatment program. I refer them to their local EI program knowing the limitation in funding for EI, I mention websites for further information, and I ask them to review their insurance plan knowing that many will have no treatment coverage for ASD services and coverage of limited services from other plans may require repeated appeals.

It is time we did better. I strongly support SB 1568. Families should be able to expect routine and consistent coverage across health plans for medically necessary treatments for ASD including behavioral health treatments. Early and intensive behavioral health interventions based on Applied Behavioral Analysis (ABA) principles are a critical part of the treatment of children with ASD. There is a rich body of research demonstrating the effectiveness of a variety of behavioral interventions based on ABA. These studies were recently reviewed by the National Autism Center and their National Standards Project (www.nationalautismcenter.org). We owe children with ASD access to appropriate treatments. Dollars spent now on their health care will result in lower costs not only for K through 12 education but for future adult services.

Robert E Nickel, MD
Developmental Pediatrician
Professor of Pediatrics
Child Development and Rehabilitation Center
Oregon Health & Science University

KAISER PERMANENTE

AUTHORIZATION FOR MEDICAL CARE

Referral Center Location and Phone:
500 NE Multnomah, Suite 100
Portland, Oregon 97232-2099
(503) 813-4560

IMPORTANT: This authorization expires at the completion of the number of visits or dates of service whichever comes first. All inpatient admissions must be preauthorized by calling the referral center listed above. Unless preauthorized, all diagnostic studies need to be performed at KPNW.

January 31, 2012

Patient Name and Address

PORTLAND OR

Group #: 802-002 KPIF PLAT RX 19-64 P1 (79180)
MRN: **DOB:** **GENDER:** male

Home Phone
Work Phone
Mobile

Subscriber:

PORTLAND OR

Referred to Provider:
Play Connections Autism Services, LLC
15100 SW Koll Pkwy, Suite A
Beaverton, OR 97006

Referred by:
Maureen A. Veatch NPI:NPI Unknown
Kaiser Permanente Building
500 Ne Multnomah St., Suite 100
Portland, OR 97232-9807

Send Bill to:
Kaiser Permanente - Claims Department
500 N.E. Multnomah, Suite 100
Portland, Oregon 97232-2099
When billing Kaiser Permanente please include: Authorization number, patient's complete name, medical record number and date of birth.

AUTHORIZATION:
Number:
Start: 01/30/2012 End: 07/30/2012
Visits / Days: 50

Diagnoses:
299.00 (ICD-9-CM) - AUTISM DISORDER

Reason for Referral: Outpatient Services
I am referring this to begin treatment with Play Connections Autism Services for an initial diagnosis of 299.00. Authorized CPT codes: Fifty (50) total G0176 codes. This authorization is valid for six (6) months from 1/30/2012.
Provider please note: any CPT codes not listed above, or those in excess of the authorized quatity, or outside of the valid time frame will be administratively denied. Reimbursement may not be sought from member.

Processed by: She/M

1. Provider agrees that in no event, including, but limited to nonpayment by Kaiser Permanente or Kaiser Permanente's insolvency, shall provider bill, charge, collect a deposit from, seek compensation, payment or reimbursement from or have any recourse against the member for services authorized pursuant to the Referral. This shall not prohibit collection from the member for deductibles, cost shares, coinsurance and/or non covered services.

2. If Provider is not a party to a written contract with Kaiser Permanente, Provider agrees that it will accept usual, customary and reasonable charges as determined by Kaiser Permanente as payment in full for services rendered to members who are not eligible for Medicare that would be paid by Medicare or Medicaid (whichever is applicable to the member) for services. Providers who do not have written a contract with Kaiser Permanente are prohibited from collecting any more than the Medicare and/or Medicaid allowable from either Kaiser Permanente or the member.

3. Unless specified on this form, please call the referring physician if hospitalization, surgery or referral to another physician or provider is contemplated in order to confirm authorization. Kaiser Permanente will pay for preauthorized services only. An additional authorization is required if care is extended beyond what is specified on the form.

4. A report of consultation is required. Please include the patient's Kaiser Permanente health record number on your medical report and mail this information to: Kaiser Permanente Medical Records, 10220 S.E. Sunnyside Road, Clackamas, Oregon 97015. If records are not received, or additional records are needed:
During regular business hours please call: 503 571 5051
Evenings, weekends and holidays, please call: 503 571 5815

5. Kaiser Permanente benefits only extend through the time the member is actively enrolled in Kaiser Permanente. Current eligibility may be verified by contacting Kaiser Permanente membership services at 800-813-2000

Medical and Scientific Evidence for Applied Behavior Analysis (ABA)

Peer-reviewed literature

Article:	Content / Findings:
Dawson G., "Behavioral interventions in children and adolescents with autism spectrum disorder: a review of recent findings." *Current Opinion in Pediatrics*, 2011; Vol 23: pp 616–620	• Reviews and summarizes 27 studies published in peer-reviewed literature since January, 2010 on behavioral interventions for children and adolescents with autism spectrum disorder (ASD) • Key findings: behavioral interventions are effective for improving language, cognitive abilities, adaptive behavior, and social skills, and reducing anxiety and aggression.
McEachin J, et al. "Long-Term Outcome for Children With Autism Who Receive Early Intensive Behavioral Treatment." *American Journal on Mental Retardation*, 1993; Vol. 97, No. 4: pp 359-372	• Follow-up to 1987 Lovaas study (below), assessing long-term progress of the same 38 children at a mean age of 11.5 years • Results showed that the experimental group (who received intensive behavioral intervention) preserved its' gains over the control group
Lovaas O. "Behavioral Treatment and Normal Educational and Intellectual Functioning in Young Autistic Children." *Journal of Consulting and Clinical Psychology*, 1987; Vol. 55, No. 1: pp3-9	• Examines the impact of intensive behavioral intervention (Applied Behavior Analysis, or ABA) • Compared an experimental group of 19 children who received 40 hours of ABA per week for two years to comparison groups • 9 out of 19 children in the ABA group attained average cognitive functioning, and were able to perform in school with minimal supports, compared to only 1 of 40 children in the control group
Cohen, H., Amerine-Dickens, M. and Smith, T. "Early Intensive Behavioral Treatment: Replication of the UCLA Model in a Community Setting." *Journal of Developmental Pediatrics*, 2006; Vol. 27, No. 2: pp145-155	• Replicated 1987 Lovaas study (above). Compared 21 children who received 35 to 40 hours of ABA per week to a control group of 21 age- and IQ-matched children in public school special education classes • ABA group obtained significantly higher IQ and adaptive behavior scores than control group • 6 of 21 ABA children were fully included in regular education without assistance at year 3, and 11 others were included with support (for 17 out of 21 placed in regular education), compared to only 1 of 21 comparison children included in regular education

Article:	Content / Findings:
Dawson, G. et al, "Randomized, Controlled Trial of an Intervention for Toddlers With Autism: The Early Start Denver Model." *Pediatrics*, 2010; Vol. 125, No. 1: pp17-23 http://pediatrics.aappublications.org/content/125/1/e17.full.pdf+html	• Randomized controlled trial of Early Start Denver Model (ESDM), a developmental behavioral intervention based on developmental and ABA principles • 48 children with autism between 18 and 30 months of age were assigned to either intensive ESDM by trained therapists, or referred to community providers • Compared with children who received community intervention, children who received ESDM showed significant improvements in IQ, adaptive behavior, and autism diagnosis

Studies or research conducted by a federal government agency or a nationally recognized federal research institute

Agency:	Report:	Finding:
Federal Agency for Healthcare Research and Quality	Comparative Effectiveness Review # 26: Therapies for Children With Autism Spectrum Disorders, Agency for Healthcare Research and Quality, AHRQ Publication No. 11-EHC029-EF, April 2011 http://www.effectivehealthcare.ahrq.gov/ehc/products/106/656/CER26_Autism_Report_04-14-2011.pdf	• "Evidence supports early intensive behavioral and developmental intervention, including the University of California, Los Angeles (UCLA)/Lovaas model and Early Start Denver Model (ESDM) for improving cognitive performance, language skills, and adaptive behavior in some groups of children." (p. vi) • "Within this category, studies of UCLA/Lovaas-based interventions report greater improvements in cognitive performance, language skills, and adaptive behavior skills than broadly defined eclectic treatments available in the community. However, strength of evidence is currently low." (page ES-7)
National Institute of Mental Health	Autism Spectrum Disorders Pervasive Developmental Disorders, NIH Publication No. 08-5511, 2008 http://www.nimh.nih.gov/health/publications/autism/nimhautismspectrum.pdf	• "Among the many methods available for treatment and education of people with autism, applied behavior analysis (ABA) has become widely accepted as an effective treatment." (p. 19)

Agency:	Report:	Finding:
National Academy of Sciences	Educating Children with Autism, Committee on Educational Interventions for Children with Autism, National Research Council, ISBN: 0-309-51278-6, 2001 http://www.nap.edu/catalog/10017.html	• "Forty years of single-subject-design research testifies to the efficacy of time-limited, focused applied behavior analysis methods in reducing or eliminating specific problem behaviors and in teaching new skills to children and adults with autism or other developmental disorders." (p.120)
Center for Medicaid and Medicare Services	IMPAQ International, LLC, Final Report on Environmental Scan, Autism Spectrum Disorders (ASDs) Services Project, March 9, 2010 http://www.impaqint.com/files/4-content/1-6-publications/1-6-2-project-reports/finalasdreport.pdf	• Identified 15 ABA, Developmental, and other behavioral interventions as "Established"

Clinical practice guidelines that meet Institute of Medicine criteria

Organization:	Clinical Practice Guideline:	Finding:
American Academy of Pediatrics	Scott M. Myers, MD, Management of Children With Autism Spectrum Disorders, Pediatrics, 2007 http://pediatrics.aappublications.org/cgi/reprint/120/5/1162	• "The effectiveness of ABA-based intervention in ASDs 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. Children who receive early intensive behavioral treatment have been shown to make substantial, sustained gains in IQ, language, academic performance, and adaptive behavior as well as some measures of social behavior, and their outcomes have been significantly better than those of children in control groups." [Emphasis added]
American Psychological Association	Autism Treatment Options, American Psychological Association website http://www.apa.org/topics/autism/treatment.aspx	• "Medication and behavioral interventions can help children cope with autism. Since medications on their own rarely improve behavior, behavioral interventions are crucial." [Emphasis added]

Organization:	Clinical Practice Guideline:	Finding:
New York State Department of Health	Clinical Practice Guideline Report of the Guideline Recommendations Autism / Pervasive Developmental Disorders Assessment and Intervention for Young Children (Age 0-3 Years), New York State Department of Health Early Intervention Program, 1999 http://www.nyhealth.gov/community/infants_children/early_intervention/disorders/autism/ http://www.nyhealth.gov/publications/4216.pdf	• "It is recommended that principles of applied behavior analysis (ABA) and behavior intervention strategies be included as an important element of any intervention program for young children with autism. [A]" • "It is recommended that intensive behavioral programs include as a minimum approximately 20 hours per week of individualized behavioral intervention using applied behavioral analysis techniques (not including time spent by parents). [A]"
American Society of Child and Adolescent Psychiatry	American Academy of Child and Adolescent Psychiatry, "Practice Parameters For The Assessment And Treatment Of Children, Adolescents, And Adults With Autism And Other Pervasive Developmental Disorders," 1999. P. 37. http://www.aacap.org/galleries/PracticeParameters/Autism.pdf	• "Early and sustained intervention appears to be particularly important, regardless of the particular philosophy of the program, so long as a high degree of structure is provided. Such programs have typically incorporated behavior modification procedures and applied behavior analysis. These methods build on a large body of research on the application of learning principles to the education of children with autism and related conditions. Procedures that strengthen desired behaviors and/or decrease undesired maladaptive behaviors are utilized in the context of a careful and individualized plan of intervention based on observation of the individual. It is clear that behavioral interventions can significantly facilitate acquisition of language, social, and other skills and that behavioral improvement is helpful in reducing levels of parental stress." [Emphasis added]

Organization:	Clinical Practice Guideline:	Finding:
United States Surgeon General, U.S. Department of Health and Human Services	Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Mental Health, 1999. http://www.surgeongeneral.gov/library/mentalhealth/chapter3/sec6.html#autism	• "Thirty years of research demonstrated the efficacy of applied behavioral methods in reducing inappropriate behavior and in increasing communication, learning, and appropriate social behavior."

OREGON HEALTH & SCIENCE UNIVERSITY

Child Development and Rehabilitation Center

Autism Program

Mail code: CDRC
707 S.W. Gaines Street
Portland, OR 97239-3098
tel 503 494-2749
fax 503 494-6868
www.ohsu.edu/outreach/cdrc/

Darryn M. Sikora, Ph.D.
Associate Professor
Department of Pediatrics
Licensed Psychologist
sikorad@ohsu.edu

Robin McCoy, M.D.
Assistant Professor
Department of Pediatrics
Developmental Pediatrician
mccoyr@ohsu.edu

February 3, 2012

Written Testimony for Senate Senate Health Care, Human Services and Rural Health Policy Committee – SB 1568 – Autism Health Insurance Reform

Thank you for the opportunity to provide this testimony to you. We are both professionals working every day with children with autism and their families. We diagnose about 150 children each year with autism and provide ongoing management services for another 100-150 children annually. Over time, we have worked with thousands of children with autism. We have had the opportunity to witness the positive impact of autism-specific interventions, particularly when provided consistently to children shortly after diagnosis. During annual follow-up visits, we have seen firsthand the progress each child makes. Invariably, those children that make the greatest progress are those children that receive intensive, empirically-supported interventions on a consistent basis over an extended period of time. Growing evidence suggests that a number of autism-specific intervention services have empirical support (see www.nationalautismcenter.org for more information), and those of us working daily with children with autism can bear witness to treatment efficacy. In addition, there is a positive relationship between the number of hours a child receives of services and the amount of progress he or she makes. The amount of community-based intervention each child receives varies drastically. That variability is caused, in part, by health insurance coverage.

When we think of health insurance coverage in Oregon today and juxtapose that with what we know about the importance of empirically-supported, autism-specific intervention, several concerns come to mind. First, many of the children we serve have health insurance that does not cover autism-specific intervention. In other words, if a child carries a diagnosis of autism, his or her insurance company will not cover any intervention services. Second, for those children that do have insurance coverage for autism intervention, their insurance chooses not to cover services within the broad ABA classification, which is problematic, because many of the empirically-supported interventions are based on ABA principles. Third, many insurance companies do to allow for regularly scheduled, consistent treatment. They limit the number of treatment sessions or the number of hours of services a child can receive. Some children are provided with as few as 20 treatment hours per year by their insurance company. In contrast, the Institute of Medicine of the National Academy of Sciences has recommended a minimum of 20-25 hours of structured intervention per week.

The passage of SB 1568 would go a long way toward drastically improving the amount of intervention each child with autism in Oregon would receive, by mandating insurance coverage of empirically-supported intervention by qualified professionals. SB 1568 reduces the financial barrier to appropriate intervention services that so many of our families face. We believe that early, intensive intervention services for children with autism result in cost savings, not only to insurance companies, but also to the state and federal government over a child's life time. Research conducted by the advocacy group Autism Speaks indicates that for every dollar spent on early intervention services, about $50 dollars are saved on services provided in adulthood. Coverage for autism interventions should save everyone money, not to mention improve the quality of life for thousands of Oregonians with autism.

February 3, 2012

To Health Care Committee Members:

My apologies. I was unable to rearrange my clinical schedule so that I could testify in person today. I would be very pleased to respond to any questions in writing and appear in person at subsequent hearings. I am testifying today as a clinician although I wear several other hats: Professor of Pediatrics at OHSU, member of the Governor's Commission on Autism Spectrum Disorder and chair of its health care committee, and medical consultant to the Oregon Center for Children and Youth with Special Health Needs at OHSU.

I have worked as a Developmental Pediatrician in Oregon for nearly 32 years. During that time, the apparent prevalence of autism spectrum disorders (ASD) in children has increased dramatically. Currently about 1 in 110 children will develop an ASD. The diagnosis is made at earlier ages and there is a great body of empirical research documenting effective interventions. And yet, current treatment services for children and in particular young children remain strikingly inadequate. Insurance plans provide very limited and at times no coverage for therapies for children with ASD and publically funded programs are markedly underfunded to meet the need. For example, a 2 year old with a new diagnosis of an ASD may receive Early Intervention (EI) services one hour per week through a center-based toddler group in addition to every other week home visits. In contrast, the Institute of Medicine of the National Academy of Sciences has recommended a minimum of 20-25 hours of structured intervention per week.

About 30% of young children with autism appear to be developing typically until regressing in their skills at 18-20 months of age. I ask you to picture yourselves in my shoes as I counsel the parents of a 2 year old who has just experienced such a regression; a child who was smiling, talking and singing nursery rhymes but now uses no words, has little eye contact and shows no joy. I work with the parents to see how we might put together a treatment program. I refer them to their local EI program knowing the limitation in funding for EI, I mention websites for further information, and I ask them to review their insurance plan knowing that many will have no treatment coverage for ASD services and coverage of limited services from other plans may require repeated appeals.

It is time we did better. I strongly support SB 1568. Families should be able to expect routine and consistent coverage across health plans for medically necessary treatments for ASD including behavioral health treatments. Early and intensive behavioral health interventions based on Applied Behavioral Analysis (ABA) principles are a critical part of the treatment of children with ASD. There is a rich body of research demonstrating the effectiveness of a variety of behavioral interventions based on ABA. These studies were recently reviewed by the National Autism Center and their National Standards Project (www.nationalautismcenter.org). We owe children with ASD access to appropriate treatments. Dollars spent now on their health care will result in lower costs not only for K through 12 education but for future adult services.

Robert E Nickel, MD
Developmental Pediatrician
Professor of Pediatrics
Child Development and Rehabilitation Center
Oregon Health & Science University

We urge you to seriously consider the positive impact that SB 1568 will have on children with autism and their families. In addition, we believe that SB 1568 will ultimately result in positive impact for insurance providers and the State of Oregon. Oregon has often been a national leader in progressive reform that improves the lives of its citizens. Almost 30 other states have already enacted legislation that provides insurance coverage for autism-specific intervention. We believe it is time for Oregon to do the same.

Respectfully submitted,

Robin McCoy, MD
Developmental Pediatrician
Oregon Health & Science University

Darryn Sikora, PhD
Psychologist
Oregon Health & Science University

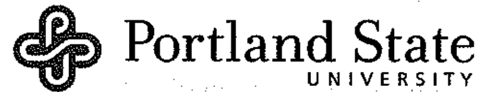
Concerning SB 1568

I am a Developmental Pediatrician who co-founded the Developmental Assessment Clinic at Kaiser Permanente in 1978. When we started the clinic, we saw children with the diagnosis of Autism approximately 1 to 2 times a month. Now the majority of children seen have this diagnosis. In fact, we have changed the structure of the clinic so that 2 clinics a month are for children with this concern only. In my experience, there is no question that the number of children affected is increasing rapidly. Also it is my experience which is backed up by good medical and educational research that children diagnosed early and treated intensively have a chance at recovery. Children who would have required special education in school and possibly lifelong care and supervision can lead a normal life. In order to achieve this goal, these children need to be diagnosed as early as possible and they need to receive direct therapy and parent training also. Unfortunately this is too often not available in Oregon. Recently I was aware of a child diagnosed at age 2 who could not receive direct speech therapy through his insurance carrier for 10 months. This is missing critical time period when neural connections are still forming in the brain. That critical time period lost may not be recoverable.

Please support our most vulnerable children with Autism Spectrum disorder to receive the therapy they need to give them a chance for a normal life

Sincerely

Mary Lynn O'Brien MD
Developmental Pediatrician



College of Liberal Arts & Sciences
Department of Speech & Hearing Sciences

Post Office Box 751
Portland, Oregon 97207-0751

503-725-3533tel
503-725-9171fax
www.sphr.pdx.edu

2/8/12

Dear Members of the Senate Health Care Committee,

I am Amy Donaldson and I writing as a teacher, researcher, speech-language pathologist, and Oregon voter and resident to express my strong support for SB 1568.

At Portland State University my research and teaching focuses on autism and child language disorders, particularly related to treatment efficacy. In addition, I have been serving children with communication challenges as a speech-language pathologist for nearly 17 years. For the past 12 years, my clinical research has focused specifically on early intervention and the social communication skills of children with autism spectrum disorders (ASD) and I have served on a number of state and regional boards and committees related to autism (e.g., subcommittees of the Oregon Commission on Autism Spectrum Disorders). Over the course of my career, I have served hundreds of children with ASD who demonstrate a variety of challenges and strengths related to cognition, communication, social interaction, play and adaptive skills.

Evidence for interventions focused on supporting individuals with ASD has grown significantly in the past several decades. Currently, best available evidence provides strong support for interventions based on the principles of Applied Behavior Analysis (ABA), as well as those interventions that incorporate principles of ABA. One such intervention that incorporates principles of ABA within a developmental, social-interaction focused treatment is the Early Start Denver Model (ESDM). The ESDM follows the National Research Council (2001) recommendations of early, intensive, individualized intervention – the NRC recommends 25 hours of individualized intervention for children with autism, starting at 24 months of age. A recent randomized control trial (RCT) investigated the efficacy of ESDM for toddlers with ASD (Dawson et al, 2010). Following two years of intervention, children with autism in the ESDM group demonstrated significant improvements in cognitive, communication and language skills, as compared to a control group of toddlers with ASD receiving community-based services. This study was the first RCT of early intensive developmental behavioral intervention for toddlers with ASD. At this time, the UC-Davis MIND Institute, University of Washington, and University of Michigan are further investigating the efficacy of ESDM within a multi-site clinical trial.

The June 2010 of the Agency for Healthcare Research and Quality (AHRQ) in the U.S. Department of Health and Human Services reviewed interventions for children with ASD. The report indicates evidence to support ABA-based interventions including the UCLA model (Discrete Trial Training) and ESDM. In addition, the report indicated growing support for other

interventions, including the use of parent training and cognitive behavioral interventions for supporting the social communication and language skills of children with ASD.

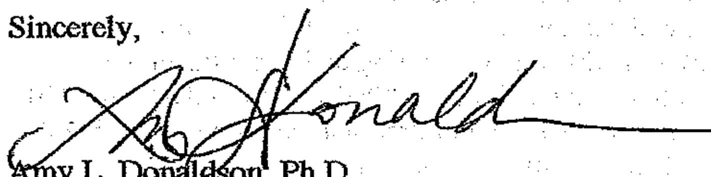
Given the evidence of benefit for early intervention services for children with ASD, one must consider the resources required to support evidence-based intervention. Research by Autism Speaks indicates that for every dollar spent on early intervention, $50 may be saved in adult-based services. However, as ASD is a lifelong, neurodevelopmental disorder impacting individuals across a spectrum of profiles. Individuals with ASD beyond the early intervention stage and into adulthood continue to require evidence-based services to support ongoing communicative, social and adaptive skill growth. Our knowledge base regarding interventions across the lifespan for individuals with ASD is growing. We must ensure that resources are available to support evidence-based practices for individuals and families affected by ASD at this same rate of growth.

I strongly support SB1568 to provide needed insurance coverage for children and adults with ASD. In my experience, families with individuals with ASD experience significant challenges related to financing intervention services – often they may not have insurance coverage specific to ASD, or the insurance benefits they do have limit the services provided and/or eliminate services at an arbitrary age. Overall, improved outcomes for individuals with ASD provide long-term positive impacts for the State of Oregon.

Finally, it is my understanding that the Oregon Speech-Language Hearing Association (OSHA) is not in support of this bill. As a member of OSHA and two-time invited guest speaker to their annual convention (on the topics of autism and progress monitoring), I am extremely disappointed in their position. As a speech-language pathologist and scientist, I fully support this bill.

Thank you for the opportunity to submit my testimony on this important issue today. Should you have any questions, please feel free to contact me at adonald@pdx.edu or 503-725-3224.

Sincerely,



Amy L. Donaldson, Ph.D.
Assistant Professor

February 5, 2012

To Health Care Committee Members:

My name is Anna Dvortcsak. I am a speech language pathologist that provides services to children with autism throughout the Portland Metro Area. In addition to providing treatment to children with autism I have conducted research on the efficacy of treatment approaches for children with autism and train other individuals throughout the United States to provide treatment to children with autism. I have attached my CV which outlines my credentials. I am writing a letter to support SB1568. Please feel free to contact me should you have additional questions.

Recent studies have revealed that the rate of Autism is 10 times more prevalent today than in 1980 (Yeargin-Allsopp, et all, 2003.). Children with Autism Spectrum Disorders (ASD) have impairments in the areas of verbal and nonverbal communication, social interaction, and creative play. In addition, children with ASD have difficulty maintaining skills learned in treatment and generalizing these skills to new environments. While there is no cure for autism many children with the disorder can learn with intervention, reducing the cost of life long care. Experts agree that intervention can improve children with autisms communication skills, lessen disruptive behaviors, and improve independence. The Autism Society of America reports that the earlier the treatment is initiated the better chance the child will reach normal functioning. Furthermore, research has shown that without effective intervention, most individuals with autism and other pervasive developmental disorders (PDD) require lifelong specialized educational family, and adult services that at a total cost that is estimated upwards of $ 4 million in some states (*Behavioral Interventions*, 1998). Research clearly indicates the need and positive effects of early intervention for children with autism.

In terms of guidelines for interventions to be effective it is reported that treatment must be comprehensive, individualized, and intensive. In addition, it is often reported that in order for children with ASD to make progress they must be enrolled in 25- 40 hours of therapy per week (Smith, Groen, & Wynn, 2000) (25 hours a week, NRC, 2001). Some of the intervention is educational and can take place in the schools should they have enough funding. However, some of the intervention is medically necessary and should take place at home. Examples of some treatment goals that should be covered by insurance polices include:1) behavioral and sensory challenges that interfere with a child's ability to receive adequate nutrition; 2)behavioral and communication challenges that interfere with a child's ability to communicate when they are hurt or sick. Delay in acknowledgment of these symptoms of illness can lead to increased severity of illness and medical costs 3) communication, sensory, and behavioral challenges that interfere with the child's ability to follow a daily routine. (e.g. go to the doctor, dentist, school) 4)behavioral and communication challenges that lead to poor hygiene and difficulty toilet training which can lead to and/or cause medical illness and 5) communication challenges that make it difficult for a child to communicate their basic needs; 6)motor speech difficulties that cause the child's speech to be unintelligible. This list is by no means inclusive of all goals that are medically necessary for a child with autism.

It does, however, highlight some of the goals that should fall under "medically necessary" rather than educational school based interventions.

I have worked with children with autism for 15 years. I have seen first hand the positive effects that early and intensive intervention has on children with autism. I have also conducted and reviewed research that demonstrates the positive effects of intervention for children with autism. Unfortunately, I have also met families who did not have access to services whose children were 10-11. Most of these children were unable to communicate or follow simple daily routines. This is not acceptable. Autism is a disorder that affects children's ability to communicate and interact with others. It is a spectrum of disorders that can vary in severity of symptoms. However, one consistent is that children with autism can improve with early intervention and intensity of services.

It is extremely important that we pass legislation that enables all families to receive consistent coverage across health plans for medically necessary treatments for ASD including behavioral health treatments.

Thank you,

Anna Dvortcsak, MS CCC-SLP
818 SW 3rd #68
Portland, OR 97204

Anna K. Dvortcsak

Dvortcsak Speech & Language Services, Inc
4110 SE Hawthorne Blvd. #420
Portland, OR 97214
Phone: 503-887-1130; Email: anna@dslsi.com

EDUCATION

M.S. in Communicative Disorders- *University of Redlands, Redlands, CA* (1997)
B.A. in Communicative Disorders- *University of Redlands, Redlands, CA* (1995)

CURRENT POSITION

Speech Language Pathologist – *Private Practice, Portland, OR* (August 2005-Present)

LICENSURE & CERTIFICATION

Speech-Language Pathology License-State of Oregon-License #12296 (March 2002-Present)
American Speech-Language-Hearing Association-Certified Member-Account # 12008583 (April 1998-Present)
Speech Language Pathology License-State of California-License #10713 (April1998- December 2002)

PUBLICATIONS & PRESENTATIONS

Refereed Publications

Ingersoll, B. & Dvortcsak, A (2006). Including parent training in the early childhood special education curriculum for children with autism spectrum disorders. *Journal of Positive Behavior Interventions, 8,* 79-87.

Ingersoll, B., Dvortcsak, A., Whalen, C., & Sikora, D. (2005). The effects of a developmental, social-pragmatic language intervention on rate of expressive language production in young children with autistic spectrum disorders. *Focus on Autism and Other Developmental Disabilities, 20,* 213-222.

Book Chapters

Dvortcsak, A. (2008). Comparison of Educational Interventions used to treat language deficits in autism spectrum disorder. In G. R. Buckendorf (Ed.), *Autism.* Eau Claire: WI: Thinking Publications.

Ingersoll, B & Dvortcsak, A. (2009) Increasing Generalization by Training Teachers to Provide Parent Training for Young Children with Autism Spectrum Disorders. In Christina Whalen. Real life, Real Progress for children with Autism Spectrum Disorders. Chelsea, Michigan. Brookes Publishing Company.

Books:

Ingersoll, B. & Dvortcsak, A. (2010). *Teaching Social Communication Skills to Children with Autism*. NY: NY: Guilford Publications

Presentations at Professional Meetings

Dvortcsak, A (2008, April). *Parent-Mediated Intervention: Teaching Parents strategies to promote their child's communication development*. Presentation at the Early Intervention Conference for Oregon, Medford, OR.

Dvortcsak, A & Buckendorf, G (2007, October). *Clinical Decision Making and the Continuum of treatment approaches for children with autism*. Presentation at the Oregon Speech-Hearing Association, Eugene, OR.

Dvortcsak, A (2005, October). *Parent-Mediated Intervention: Teaching Parents strategies to promote their child's communication development*. Presentation at the Occupational Therapy Association of Oregon, Portland, OR.

Dvortscak, A & Ingersoll, B. (2004, November). *Parent-mediated intervention: Teaching parents strategies to promote their child's communication development.* Presentation at the Oregon Speech-Hearing Association, Portland, OR.

Dvortcsak, A., Ingersoll, B. & Buckendorf, B. (2003, November). *Developmental and naturalistic behavioral approaches: Theory and practice.* Paper presented at the annual meeting of the American Speech-Language Hearing Association, Chicago, IL.

Ingersoll, B., Dvortcsak, A., Sikora, D., & Buckendorf, B. (2003, November). *Efficacy of Floor Time as an intervention strategy for children with autism.* Poster session presented at the annual meeting of the American Speech-Language Hearing Association, Chicago, IL.

Dvortcsak, A. (2003, March). *Understanding and Promoting Children's Communication Development.* Presentation at the Providers Helping Providers Conference, Portland, OR.

CLINICAL EXPERIENCE

Speech Language Pathology Private Practice –*Portland, OR.* Established a private practice in August of 2005. Responsibilities include development and implementation of clinical services, training to professionals (speech language pathologists, occupational therapists, and early intervention teachers) working with children with autism, and consultations with schools. Clinical services include individualized parent training, individualized speech and language services, and inclusion support.
(August 2005-present)

Director, Autism Treatment & Research Program – *Hearing & Speech Institute, Portland, OR.* Development of intervention services for children with autism and their families. Responsibilities included development and implementation of clinical services, hiring, training, and supervision of

program staff, supervision of Clinical fellows, grant writing, and budget development. Clinical services included individualized parent training program, individualized speech and language services, parent education and support group, and sibling social-language group.
(January 2003-July 2005)

Speech-Language Pathologist: Autism Specialist- *Hearing and Speech Institute, Portland, OR.*
Collaborated with a multidisciplinary team to determine community needs for development of an autism program at the Hearing and Speech Institute. Responsibilities included reviewing current services available, reviewing research on treatments for children with autism, participating in hiring of necessary staff to develop an autism program, hiring, training, and supervising speech language pathologists to work in the autism program. Clinical services included administering and interpreting standardized assessments for children with autism, consultations with families and schools to implement recommendations, individual parent training, individualized speech and language treatment, and social skills classes.
(March 2002-January 2003)

Speech Language Pathologist: Marin County Special Education Department: *Kentfield Elementary, Kentfield, CA.*
Conducted assessments and developed individualized treatment plans for children age 5-11 referred for developmental concerns including apraxia, articulation, autism, down syndrome, fluency, and language delay, as part of a multidisciplinary diagnostic team. Responsibilities included: administering and interpreting standardized assessments, writing reports, and reviewing results with a multidisciplinary team including family members; consultations with teachers and families to implement recommendations; and leading IEP meetings
(September 2001-January 2002)

Speech Language Pathologist: Palo Alto Unified School District:

Full Inclusion Specialist, Escondido Elementary: Conducted assessments and developed individualized treatment plans for children with autism spectrum disorders and language disorders as part of a multidisciplinary team. Responsibilities included: administering and interpreting standardized assessments, writing reports, and reviewing results with the team including the family members; training teachers and classroom aides to implement strategies within the classroom; devising and implementing behavior plans, picture schedules, and communication systems for children as indicated; and leading monthly team meetings to review progress and modify programs as necessary.
(September 2000-June 2001)

Preschool Assessments, PAUSD: Conducted assessments and developed individualized treatment plans for children age 3-5 referred for developmental concerns including apraxia, autism, down syndrome, fluency, language delay, and speech intelligibility as part of a multidisciplinary diagnostic team. Responsibilities included: administering and interpreting standardized assessments, writing reports, and reviewing results with the team including the family members; working with families and professionals to implement recommendations; coordinating the intake process; and development of assessment procedures and protocols.
(September 1999-June 2001)

Elementary School, Escondido Elementary; Addison Elementary: Conducted assessments and developed individualized treatment plans for children age 5-11 referred for developmental concerns including apraxia, articulation, autism, down syndrome, fluency, and language delay, as part of a multidisciplinary team. Responsibilities included: administering and interpreting standardized assessments, writing a report, and reviewing results with the team including the family members; consultations with teachers and families to implement recommendations; and leading SST and IEP meetings
(September 1998-June 2001)

Speech Language Pathologist: Sundance Rehabilitation:
Conducted speech, language and swallowing assessments and developed treatment plans for adults with Right and Left CVA, Traumatic Head Injury, Aphasia, Dysarthria, Dysphagia, and Dementia as part of a multidisciplinary diagnostic team. Responsibilities included administering and interpreting standardized assessments, conducting team meetings, discharge meetings, and family meetings. Supervisor: Marcy Finos, MS CCC-SLP (June 1997- August 1998)

PROFESSIONAL TRAININGS & WORKSHOP PRESENTATIONS

Dvortcsak, A (2011, November). *How to teach parents strategies to promote their child's social communication* In-service training for St Charles Hospital, Bend, Oregon
Dvortcsak, A (2010, October). *How to teach parents strategies to promote their child's social communication* In-service training for Easter Seals Little Rock, Arkansas
Dvortcsak, A (2010, October). *How to teach parents strategies to promote their child's social communication* In-service training for Humboldt County Office of Education, Eureka, CA
Dvortcsak, A (2009, December). *How to teach parents strategies to promote their child's social communication* In-service training for Pasco Education Service District, Pendleton, OR.
Dvortcsak, A (2009, November). *How to teach parents strategies to promote their child's social communication* In-service training for Pasco Education Service District, Pasco, WA.
Dvortcsak, A. (2008, May). *How to teach parents strategies to promote their child's social communication* In-service training for Lincoln County Education Service District, Lincoln City, OR.
Dvortcsak, A. (2008, May). *How to teach parents strategies to promote their child's social communication* In-service training for Willamette Education Service District, Salem, OR.
Dvortcsak, A. (2008, April). *How to teach parents strategies to promote their child's social communication* In-service training for Willamette Education Service District, Salem, OR.
Dvortcsak, A. (2008, April). *How to teach parents strategies to promote their child's social communication* In-service training for Lincoln County Education Service District, Lincoln City, OR.
Dvortcsak, A. (2008, March). *How to teach parents strategies to promote their child's social communication* In-service training for Oregon Health and Science University, Portland, OR.
Dvortcsak, A. (2008, February). *How to teach parents strategies to promote their child's social communication* In-service training for Oregon Health and Science University, Portland, OR.
Dvortcsak, A. (2008, February). *How to promote children's expressive language and social communication skills* In-service training for Charles F. Tigard Elementary, Tigard, OR.
Dvortcsak, A. (2008, January). *How to teach parents strategies to promote their child's social communication* In-service training for Oregon Health and Science University, Portland, OR.

Dvortcsak, A. & Meyer, C (2007, September). *How to teach parents strategies to promote their child's social communication* In-service training for Lane County Service District, Eugene, OR.

Dvortcsak, A. (2007, July). *How to teach parents strategies to promote their child's social communication* In-service training for Oregon Health and Science University, Portland, OR.

Ingersoll, B. & Dvortcsak, A. (2007, March). *How to teach parents strategies to promote their child's social communication* In-service training for Willamette Education Service District, Salem, OR.

Ingersoll, B. & Dvortcsak, A. (2006, October). *How to teach parents strategies to promote their child's social communication.* In-service training for High Multnomah County Education Service District, Portland, OR.

Ingersoll, B. & Dvortcsak, A. (2006, September). *How to teach parents strategies to promote their child's social communication.* In-service training for High Desert Service District, Bend, OR.

Ingersoll, B. & Dvortcsak, A. (2006, March). *How to teach parents strategies to promote their child's social communication.* In-service training for Willamette Education Service District, Salem, OR.

Ingersoll, B. & Dvortcsak, A. (2006, January). *How to teach parents strategies to promote their child's social communication.* In-service training for Linn-Benton-Lincoln Education Service District, Corvallis, OR.

Ingersoll, B. & Dvortcsak A. (2005, September-November; 2004, September-November; 2005, March-May). *Strategies for promoting your child's social-communication.* Parent training series for families at Northwest Regional Education Service District, Hillsboro, OR.

Dvortcsak, A. (2005, June). Overview of the Indirect Techniques used in the Social Communication intervention for Children with Autism and Related Disorders: A Parent Implemented Approach In-service training for Hearing and Speech Institute, Portland, OR

Dvortcsak, A. (2005, October).Overview of Direct Techniques used in the Social Communication intervention for Children with Autism and Related Disorders: A Parent Implemented Approach Hearing and Speech Institute, Portland OR

Dvortcsak A. & Ingersoll, B. (2004, April). *Naturalistic therapy approaches for children with autism and related disorders.* In-service training for Bend-La Pine School District, Bend, OR.

Ingersoll, B. & Dvortcsak, A. (2004, March). *Training parents to teach their children with autism.* In-service training for Northwest Regional Education Service District, Hillsboro, OR.

Dvortcsak, A. (2003, October).*Developing Goals.* Portland Pediatric Treatment Study Group, Portland OR

Carol B. Markovics, Ph.D.
Clinical and Developmental Psychologist
Play2Grow Developmental Therapy Services
18959 SW 84th Ave
Tualatin, OR 97062
Phone:503-563-5280
Dr.Carol@me.com

February 6, 2012

Dear Members of the Senate Health Care, Human Services and Rural Health Policy Committee:

I urge you to support SB1568, the Autism Health Insurance Reform bill introduced by Sen. Hass and Sen. Bates, with the -1 Amendments. This bill would require insurance companies to pay for medically necessary, evidence-based treatment for patients with autism. I have been an active participant in drafting this bill, serving on the Autism Commission's subcommittee for insurance reform, the steering committee for the bill presented in 2011 and the current steering committee for this particular bill. As a clinical and developmental psychologist with more than 35 years of experience working with children and families as well as teens and adults, I am well aware of the value both economically and socially of appropriately treating mental health problems. During the past 15 years, my major professional focus has been on intervention with those on the autism spectrum. The research findings on autism treatment decisively support the medical necessity of intensive, efficacious treatment, starting at a very young age and continuing throughout development. From my direct work in collaboration with families and trusted colleagues, I have witnessed the gains that can be accomplished with even the most severely effected individuals. Dedicated families struggle to provide the best possible treatments for their children, often at great personal and economic sacrifice. Because of the efforts of the mental health community and federal and state legislators, the services of mental health professionals are typically covered to treat some of the symptoms common to those with autism spectrum disorder including anxiety and social and behavioral issues. However, psychological and psychiatric therapies are not adequate to address the broad spectrum of challenges facing those with autism and it is

critical to provide additional therapies through the direct work of speech pathologists and occupational therapists. It is critical that therapy for individuals with ASD not be subject to arbitrary limits but set by the standard of medical necessity which will differ for each case. Too many families must ration their speech and OT visits to allow them to last until year-end rather than basing visits primarily on the needs of the child or teen. Further, for some children and teens, the importance of even greater intensity has been shown to be most effective in addressing the acquisition of cognitive, social, emotional and life skills. For these neurologically impaired individuals, several hours each day may be necessary to effect positive change and this direct service is most efficiently provided by well-qualified, well-trained and closely supervised para-professionals working within developmental and behavioral treatment programs.

I urge you, Senators, to pass this bill that will improve the future for so many with this complex neurological condition.

Sincerely,

Carol B. Markovics, Ph.D.

February 6, 2012

SB1568 Senate Health Care Committee Hearing

Dear Members of the Senate Health Care Committee:

The Oregon Association for Behavior Analysis Board of Directors would like to offer its strongest possible endorsement of SB 1568.

Applied Behavior Analysis, including early intensive behavioral intervention for young children and other behavior analytic interventions for older children and adults, has been demonstrated to be the most effective treatment for individuals with autism. These treatments not only improve the lives of individuals with autism and their families, they produce significant long-term cost savings in terms of both private and public resources.

SB 1568 includes substantial provisions for consumer protection, including a state-regulated registration system for behavior analysts and direct care staff. This registration, paired with the Behavior Analyst Certification Board's rigorous certification requirements and oversight, will ensure that the interests of individuals with autism are protected while their treatment needs are met. Families in Oregon will finally receive the assistance that they need to access necessary care, and a system will be in place that will regulate the quality of care.

Please follow the 29 other states that have acted to enact autism insurance reform. We urge you to schedule a vote on SB 1568 in the Senate Health Care Committee, and vote "yes" for autism insurance reform.

Thank you for your time.

Sincerely,

The Oregon Association for Behavior Analysis Board of Directors
Jenny Fischer, Interim President
Robbin Sobotka-Soles, Secretary
Analise Herrera, Treasurer

/.advbehavioralconcepts.com P.O. Box 55902 Portland, Oregon 97238 phone: (971) 344-9440

February 2, 2012

RE: Testimony for SB 1568

Dear Health Care Committee Representatives,

I am writing to provide written testimony in support of SB 1568. I am a Board Certified Behavior Analyst and Licensed Professional Counselor who provides ABA services to children and adults in Portland and surrounding areas. I was on the Executive Board of the Indiana Association for Behavior Analysis and past President of the Oregon Association for Behavior Analysis. I have witnessed not only the extreme financial strain that funding these programs has on families but the incredible progress made by the individuals receiving the treatment. Families across the state have utilized any means possible to find resources to provide this evidence based treatment including refinancing their homes multiple times, accessing retirement funds, selling their homes and other personal property.

I have had the opportunity to practice in other states including Indiana, Wisconsin, Illinois, and Texas all of which have Autism coverage for their families. Upon relocating to Oregon, I was surprised that a state known to be progressive in so many ways failed to recognize the families that needed support the most. I have been in Oregon for almost 3 years and during that time I have seen three families relocate to New Jersey, North Carolina, and Wisconsin so that they could obtain the necessary coverage for their children with Autism. Within weeks of relocating they were in the process of obtaining ABA treatment with the support of insurance and/or educational funding.

Providers of ABA services must demonstrate competency in the implementation of behavior analysis for treatment to be effective and consistent with evidence based practices. This is best done by recognizing the credential of Board Certified Behavior Analyst. I am credentialed both as a Licensed Professional Counselor and Board Certified Behavior Analyst. The education and experience requirements set forth by states for licensure do not guarantee competency in behavior analysis. Many of the families that I work with receive some coverage of services if the provider has a state license regardless of the fact that exposure to behavior analysis by most licensed professionals is absent.

I would like to share a specific story about Sam, a client that I have worked with for just over a year. Sam is an 8 year-old little boy diagnosed with Autism. He is the middle of three children and Sam's younger brother is also diagnosed with Autism. Prior to the implementation of an intensive in-home ABA program Sam was in school. He was non verbal and unable to sit in a learning environment for longer than 5 seconds. Sam had no pre-academic academic skills and demonstrated extreme tantrum behaviors multiple times a day ranging from 10 to 45 minutes in duration. His program was established in October of 2009 immediately after his parents removed him from school due to lack of progress. Sam worked with his in-home therapist 40 hours a week first on merely establishing learner readiness skills (e.g., sitting and attending, waiting, accepting no, etc..) then on language and pre academic skills. Currently, Sam is able to sit and attend in a learning environment for up to 20 minutes. He has over 200 functional words

and is able to get his needs met throughout the day. Sam can request items, activities, and attention from people in his environment. He is able to read, write, and type. Sam's tantrums have decreased to less than 3 times a month lasting only 45 seconds or less. Sam's family has recently had to let their in-home therapist go because they can no longer afford the program they have been privately funding. Sam's parents have literally exhausted all of their financial resources. The guilt experienced by the family is heartbreaking. Here is a program that has taught their son skills in just over one year that the school wasn't able to teach in two. They were faced with a decision to jeopardize Sam's progress for the well being and survival of their family. This is a decision that no family should ever have to face.

Research clearly demonstrates the efficacy of ABA treatment across age groups for individuals with Autism. The case law established by the McHenry Case in September 2010 was ground breaking since it solidified the fact that ABA not experimental. I would be happy to provide resources for locating research on the efficacy of ABA upon request. In addition, colleagues and I have numerous single case examples like Sam demonstrating the impact ABA programming has on the lives of those receiving the treatment and their families. We would be happy to provide additional examples upon request.

Oregon has the opportunity to pass SB 1568 and assist families in obtaining evidence based ABA treatment for their loved ones with Autism. Effective treatment should be available to all families. Progress for individuals with Autism does not have to cease once a child reaches a certain age or when savings accounts are drained. Oregon needs to take this opportunity to head in the same direction as the rest of the county when it comes to providing services to individuals with Autism.

Sincerely,

Sarah L. Schaefer

Sarah L. Schaefer, LPC, BCBA
Behavior Analyst