

Simpler Than Possible: Insurance Mandates for Autism Spectrum Disorders

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The diagnosis and management of autism spectrum disorder (ASD) and co-occurring medical and behavioral health conditions strain both health and educational resources in the United States. State mandates for insurance coverage for ASD-related health care were intended to improve access to indicated services, with inclusion of board-certified behavior analysts (BCBAs) as a newly licensed group of professionals to provide one approach to evidence-based intervention. McBain et al¹ examined the association of the state by state passage of legislation on one indicator of access to services: number of providers who serve this population. Mandated insurance coverage, especially more-generous coverage, was associated with a greater growth in the workforce of BCBAs, a small increase in the number of child psychiatrists, and no change in the number of pediatricians.

The authors acknowledged the associational nature of their study and their inability to explore use or distribution of services. However, when interpreting the impact of insurance mandates that focus primarily on reimbursement for applied behavioral analysis (ABA) as an intervention, there are additional implications that must be considered when examining actual health care provided for individuals with ASD. The insurance mandate did little to improve serious deficits in access to diagnostic services or to address the training needs of existing and available pediatric care providers.²

Augmenting workforce capacity includes current efforts to enhance pediatricians' ability to contribute to timely ASD diagnosis, thereby promoting earlier entrance to intervention.^{3,4} Most interventions provided for children and youth with ASD have not been impacted by the wave of insurance legislation over the past decade but are provided through the legal mandate of the Individuals with Disabilities Education Act through the educational system. Consistent with patterns in specialty behavioral health care, special education and community services are not equitably distributed across a representative population (eg, based on race, ethnicity, age, income, language, and geographic region).⁵

Increases in provider numbers resultant from insurance mandate legislation may imply false equivalence with evidence-based practice. Although behavior analytic services are efficacious for some,⁶ there is an increasing evidence base for interventions (eg, naturalistic developmental behavioral interventions⁷) that are not covered by insurance mandates. There is insufficient evidence to assume a single approach is effective for all individuals with ASD. Factors such as child characteristics and family choice become increasingly important drivers of treatment selection as predictors of success and outcome measurement are studied in greater depth. However, insurance legislation that is directly tied to funding ABA and advocated in

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Opinions expressed in these commentaries are those of the authors and not necessarily those of the American Academy of Pediatrics or its Committees.

DOI: <https://doi.org/10.1542/peds.2020-020396>

Accepted for publication Jul 28, 2020

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PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

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FINANCIAL DISCLOSURE: The authors have indicated they have no financial relationships relevant to this article to disclose.

FUNDING: No external funding.

POTENTIAL CONFLICT OF INTEREST: The authors have indicated they have no potential conflicts of interest to disclose.

COMPANION PAPER: A companion to this article can be found online at www.pediatrics.org/cgi/doi/10.1542/2020-0836.

To cite: Hyman SL and Iadarola S. Simpler Than Possible: Insurance Mandates for Autism Spectrum Disorders. *Pediatrics*. 2020;146(4):e2020020396

parallel to licensure for BCBAs⁸ sends a message that ABA is the only effective intervention. This may come at the cost of awareness of and reimbursement for other possibly efficacious interventions, as well as development of comprehensive care plans including both the educational and medical systems.

An additional erroneous assumption is that an increase in number of BCBAs and child psychiatrists leads to increased access to care. Indeed, families who are generally under-represented in service systems on the basis of race, ethnicity, and income level are especially likely to report unmet service needs.⁵ Such disparities are exacerbated by Medicaid restrictions for insurance mandates, which may disproportionately affect populations that are already underserved. Second, service quality remains independent from access. Community-based early intervention services, for instance, are delivered with highly variable fidelity, which may affect child outcomes. In addition, despite the general conviction in the field that more intensive intervention yields more positive results, conventions around the minimum recommended number of hours of ABA are not rooted in evidence.⁹

Recommendations to steer families toward readily available services should not supplant individualized, evidence-based determinations for intervention selection based on child and family variables and preferences.

McBain et al¹ add support to the evidence that the overall supply of child behavioral health services in the

United States is inadequate to address the existing needs of not only children but people with ASD across the life span. We echo the recommendation that policies do need to address the existing behavioral and medical health needs but also suggest the following: (1) in addition to increasing the numbers of psychiatrists and BCBAs, the existing interprofessional workforce needs education and supports to improve quality of care; (2) care coordination must be recognized and funded as a method to improve efficiencies and access across health and educational systems; (3) providers and service systems must prioritize equitable access to services for all families; and (4) innovative research in this area will include the development and evaluation of cost-efficient and effective interventions for all people with ASD. Per Albert Einstein, “Everything should be made as simple as possible, but not simpler.” Full consideration of these numerous system complexities is necessary to adequately address the needs of individuals with ASD and their families.

ABBREVIATIONS

ABA: applied behavioral analysis
ASD: autism spectrum disorder
BCBA: board-certified behavior analyst

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Pediatrics 2020;146;

DOI: 10.1542/peds.2020-020396 originally published online September 8, 2020;

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DOI: 10.1542/peds.2020-020396 originally published online September 8, 2020;

The online version of this article, along with updated information and services, is located on the World Wide Web at:

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