



NEIL ABERCROMBIE
GOVERNOR

SHAN S. TSUTSUI
LT. GOVERNOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
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KEALI'I S. LOPEZ
DIRECTOR

JO ANN M. UCHIDA TAKEUCHI
DEPUTY DIRECTOR

TO THE HOUSE COMMITTEE ON CONSUMER PROTECTION & COMMERCE
TWENTY-SEVENTH LEGISLATURE
Regular Session of 2013
Monday, March 11, 2013
2 p.m.

WRITTEN TESTIMONY ONLY

TESTIMONY ON SENATE BILL NO. 668, S.D. 2 – RELATING TO HEALTH.

TO THE HONORABLE ANGUS L.K. MCKELVEY, CHAIR, AND MEMBERS OF THE COMMITTEES:

My name is Gordon Ito, State Insurance Commissioner ("Commissioner"), testifying on behalf of the Department of Commerce and Consumer Affairs ("Department"). The Department takes no position on this bill and offers the following comments.

The purpose of this bill is to add a new mandated health insurance benefit requiring health insurers, mutual benefit societies, and health maintenance organizations to provide coverage for the treatment of autism spectrum disorders.

The bill establishes a \$50,000 maximum benefit for coverage for behavioral health treatment per year and a maximum lifetime benefit of \$300,000, but shall not be subject to any limits on the number of visits to an autism service provider. After December 31, 2015, this bill requires the Commissioner, on an annual basis, to adjust the maximum benefit for inflation using the medical care component of the U.S. Department of Labor Consumer Price Index ("CPI") for all urban consumers. In addition, the Commissioner would be responsible for publishing the adjusted maximum benefit annually.

While the Department does not oppose making adjustments to the maximum benefit if warranted, the Department has concerns about requiring the Commissioner to publish and automatically adjust the maximum benefit on an annual basis relying solely on the CPI and without any opportunity for public input on the matter. Since the maximum benefit will be established in the Hawaii Revised Statutes, any changes to the maximum benefit should be made by amending the appropriate statutory provisions.

The addition of a new mandated coverage may trigger section 1311(d)(3) of federal Patient Protection and Affordable Care Act, which requires states to defray the additional cost of any benefits in excess of the essential health benefits of the State's qualified health plan.

We thank the Committee for the opportunity to present testimony on this matter.

**TESTIMONY BY KALBERT K. YOUNG
DIRECTOR, DEPARTMENT OF BUDGET AND FINANCE
STATE OF HAWAII
TO THE HOUSE COMMITTEE ON CONSUMER PROTECTION AND COMMERCE
ON
SENATE BILL NO. 668, S.D. 2**

MARCH 11, 2013

RELATING TO HEALTH INSURANCE

Senate Bill No. (SB) 668, Senate Draft (S.D.) 2, proposes to require all health insurers, mutual benefit societies and health maintenance organizations to provide health care coverage and benefits for the diagnosis and treatment of autism spectrum disorders up to age 26. Maximum benefits for behavioral health treatment provided may be limited to \$50,000 per year, or \$300,000 during the lifetime of the individual, but shall not be subject to any limits on the number of visits an individual may make for treatment of autism spectrum disorder.

The Department of Budget and Finance provides the following comments in regards to SB 668, SD2.

We are concerned that SB 668, SD2 will: 1) limit a carrier's ability to control both the appropriateness of care and costs by mandating coverage for specific types of disorders 2) increase the cost of health insurance leading to higher premiums for employees and employers; and 3) duplicate coverage that is already available from the Department of Health and the Department of Education.

Active State employees are currently paying 50% of their health insurance and some employees are finding it increasingly difficult to afford health insurance coverage for themselves and their dependents. The State is struggling to find a way to fund health care for its employees and retirees. While SB 668, S.D. 2, may benefit a certain

insured group, any increase to the cost of health insurance premiums impacts all of the insured and their employers.

A study was performed by the legislative auditor in 2009 regarding mandatory health insurance for autism spectrum disorders. The auditor concluded that: 1) the Department of Education was providing educational services; 2) health plans were already providing coverage for diagnosis and medical treatment although not to the extent being proposed; and 3) the cost of the mandate was high and would get higher over time resulting in increases to the cost of premiums which would be passed on to all health insurance consumers. In a similar study performed by the Legislative Reference Bureau (2013), the bureau recommended obtaining an independent actuarial analysis of an autism spectrum disorder benefits mandate that would apply statistical modeling to provide information specific to the autism spectrum population and prevalence rate, provider networks and health care market in Hawaii.

We defer to the Insurance Commissioner in regards to the impact of SB668, SD2 upon Article 10A of the State of Hawaii Insurance Code.



STATE OF HAWAII
DEPARTMENT OF HEALTH
P.O. Box 3378
HONOLULU, HAWAII 96801-3378

In reply, please refer to:
File:

Committee on Consumer Protection and Commerce

S.B. 668, SD2, Relating to Health

**Testimony of Loretta J. Fuddy, A.C.S.W., M.P.H.
Director of Health**

March 11, 2013

WRITTEN TESTIMONY ONLY

1 **Department's Position:** The Department of Health appreciates the intent of S.B. 668, SD2 to improve
2 the access of individuals with autism spectrum disorders (ASD) to appropriate services.

3 **Fiscal Implications:** The Department of Health defers to the Department of Commerce and Consumer
4 Affairs.

5 **Purpose and Justification:**

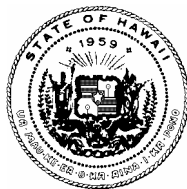
6 S.B. 668, SD2 amends Chapter 431, Hawaii Revised Statutes to provide coverage for the
7 screening, diagnosis and treatment of ASD to the policyholder and individuals under twenty-six years of
8 age, and allows a maximum benefit of \$50,000 per year for Autism related services. The measure is not
9 to be construed as limiting benefits otherwise available to an individual under a health insurance
10 company. Also, benefits cannot exceed the essential health benefits specified under section 1302b of the
11 Patient Protection and Affordable Care Act (PPACA) as of January 1, 2016. Among other benefits, this
12 bill would allow families of individuals with ASD to obtain services, including evidence-based
13 behavioral health treatments.

1 The Department appreciates the amendment that will clarify that behavioral health treatments are
2 provided or supervised by a Board-Certified Behavior Analyst or a licensed psychologist with
3 appropriate training. The proposed amendments to the bill will allow best practice, evidence-based
4 treatments such as Applied Behavioral Analysis (ABA) that has been shown to improve socialization
5 and language of people, especially children with ASD. Treatment of ASD at an early age using ABA
6 and/or other treatments will increase the opportunity for children and teens to develop the skills and
7 functioning needed for adult life. Improved outcomes may lessen the need for long-term supports when
8 children with autism become adults.

9 According to the U.S. Centers for Disease Control and Prevention, about 1 in 88 children has
10 been identified with ASD. Research shows that early treatment services can greatly improve a child's
11 development. Increasing the access of individuals to appropriate services, including through private
12 health insurance, will contribute to improved outcomes for individuals with ASD.

13 Thank you for this opportunity to testify.

NEIL ABERCROMBIE
GOVERNOR



PATRICIA McMANAMAN
DIRECTOR

BARBARA YAMASHITA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809

March 11, 2013

TO: The Honorable Angus McKelvey, Chair
House Committee on Consumer Protection and Commerce

FROM: Patricia McManaman, Director

SUBJECT: **S.B. 668, S.D.2 – RELATING TO HEALTH**
Hearing: Monday, March 11, 2013; 2:00 p.m.
Conference Room 325, State Capitol

PURPOSE: The purpose of this bill is require health insurers, mutual benefit societies, and health maintenance organizations to provide health care coverage and benefits for autism spectrum disorders beginning December 31, 2013.

DEPARTMENT'S POSITION: The Department of Human Services (DHS) respectfully opposes this bill because it does not include an appropriation in general funds needed for DHS to pay for these new services.

This measure would have the effect of requiring health plans contracted with the DHS to provide applied behavioral analysis (ABA), a service not currently covered by the Hawaii Medicaid program. Assuming that DHS provides medical assistance to approximately 150,000 children, the prevalence of autism is 1/88 or approximately 1,700 Medicaid children and youth. If ABA is covered it is estimated that it would cost \$1,000 per week per child or \$52,000 per year at a total cost of \$88.4 million to cover the new service. In addition, under early prevention, screening, diagnosis, and treatment (EPSDT), if covered, DHS could not place any limits on ABA for children.

Thank you for the opportunity to provide testimony on this bill.

AN EQUAL OPPORTUNITY AGENCY



STATE OF HAWAII
STATE COUNCIL
ON DEVELOPMENTAL DISABILITIES
919 ALA MOANA BOULEVARD, ROOM 113
HONOLULU, HAWAII 96814
TELEPHONE: (808) 586-8100 FAX: (808) 586-7543
March 11, 2013

The Honorable Angus L.K. McKelvey, Chair
House Committee on Consumer Protection and Commerce
Twenty-Seventh Legislature
State Capitol
State of Hawaii
Honolulu, Hawaii 96813

Dear Representative McKelvey and Members of the Committee:

SUBJECT: SB 668 SD2 - RELATING TO HEALTH

The State Council on Developmental Disabilities **SUPPORTS THE INTENT OF SB 668 SD2**. The bill requires health insurers, mutual benefit societies, and health maintenance organizations to provide health care coverage and benefits for autism spectrum disorders (ASD) beginning after December 31, 2013.

According to the U.S. Centers for Disease Control and Prevention, about 1 in 88 children have been identified with ASD. That rate is anticipated to significantly increase in the next decade. With this alarming rate, it is imperative that children with ASD are provided with early diagnosis and treatment. Evidence-based practice shows that early identification and treatment results in overall improved outcomes for children with ASD. Moreover, services provided early on may decrease or minimize long-term services and supports needed as the child becomes an adult and through the individual's lifetime.

HCR 177 HD2 SD1 (2012) requested the Legislative Reference Bureau (LRB) to conduct a study on requiring insurance coverage for the diagnosis and treatment of ASDs. The report has been submitted to the Twenty-Seventh Legislature, 2013 (Report No. 2, 2013). The report contained recommendations that address an actuarial analysis, applied behavioral analysis provider network, board certification and licensing of behavior analysts, and criminal background checks.

The Council considers the recommendations in LRB's report to have merit for consideration for action. We support the recommendations that address: 1) the actuarial analysis, 2) access to behavioral health treatments including applied behavioral analysis (ABA) on the Neighbor Islands, 3) board certification of behavioral analysts, 4) criminal background check, and 5) consideration of individuals with other medical conditions who may also benefit from behavioral health treatments and ABA.


The Honorable Angus L.K. McKelvey
Page 2
March 11, 2013

In addition to the above, we respectfully ask for your consideration of the recommendations offered by the Special Education Advisory Council that included adding the following provisions:

1. Screening for ASDs, including well-baby and well-child screening to ensure that services are offered as early as possible.
2. Family counseling and training as one of the components of care in the treatment for ASDs.
3. Language under the definition of "behavioral health treatment" that ensures that treatments are evidenced-based.

Thank you for the opportunity to submit comments **supporting the intent of SB 668 SD2.**

Sincerely,


Waynette K.Y. Cabral, MSW
Executive Administrator


J. Curtis Tyler III
Chair



S E A C
Special Education Advisory Council
919 Ala Moana Blvd., Room 101
Honolulu, HI 96814
Phone: 586-8126 Fax: 586-8129
email: spin@doh.hawaii.gov

March 11, 2013

**Special Education
Advisory Council**

Ms. Ivalee Sinclair, *Chair*
Ms. Martha Guinan, *Vice
Chair*

Ms. Brendelyn Ancheta
Ms. Cassandra Bennett
Dr. Tammy Bopp
Ms. Jyo Bridgewater
Dr. Robert Campbell
Ms. Deborah Cheeseman
Ms. Annette Cooper
Ms. Phyllis DeKok
Ms. Shari Dela Cuadra-Larsen,
liaison to the Superintendent
Ms. Gabriele Finn
Ms. Tami Ho
Ms. Barbara Ioli
Ms. Deborah Kobayakawa
Ms. Bernadette Lane
Ms. Shanelle Lum
Ms. Eleanor MacDonald
Ms. Rachel Matsunobu
Ms. Dale Matsuura
Ms. Stacey Oshio
Ms. Zaidarene Place
Ms. Barbara Pretty
Ms. Kau'i Rezentes
Ms. Melissa Rosen
Dr. Patricia Sheehey
Mr. Tom Smith
Mr. Mike Tamahaha
Dr. Daniel Ulrich
Ms. Cari White

Jan Tateishi, Staff
Susan Rocco, Staff

Representative Angus L.K. McKelvey, Chair
Committee on Consumer Protection & Commerce
State Capitol
Honolulu, HI 96813

RE: SB 668, SD 2 - RELATING TO HEALTH

Dear Chair McKelvey and Members of the Committee,

The Special Education Advisory Council (SEAC), Hawaii's State Advisory Panel under the Individuals with Disabilities Education Act (IDEA), **supports** SB 668 SD 2 that proposes to mandate health insurance coverage for the diagnosis and treatment of autism spectrum disorders (ASD).

SEAC has been active over the last number of years in advising the Department of Education on appropriate educational supports for students who are on the Autism spectrum. We are very aware that the early identification and amelioration of the complex communication, social and behavioral needs of these children has a significantly positive impact on academic and behavioral goals.

SEAC recognizes that SB 668, SD 2 does not relieve the Department of Education of its responsibility to provide individualized special education and related services to students with ASD; however the bill provides for critically needed diagnostic and *medically necessary* treatments for children and young adults up to age twenty-six. This legislation also clearly defines the diagnoses included in the coverage and the components of treatment.

SEAC offers the following recommendations regarding SB 668, SD 1:

- include screening for autism spectrum disorders, including well-baby and well-child screening to ensure that services are offered as early as possible;
- include family counseling and training as one of the components of care in the treatment for autism spectrum disorders; and
- add language under the definition of "behavioral health treatment" that ensures that treatments are evidence-based.



Testimony on SB 668, SD 2
March 11, 2013
Page 2

SEAC agrees with the Med-Quest Division (as cited in Chapter 8 of the 2013 Legislative Reference Bureau's report on "Autism Spectrum Disorders and Mandated Benefits Coverage in Hawaii") that behavioral health treatments, including Applied Behavioral Analysis, may benefit children and youth with health conditions other than ASD. Therefore, the committee may wish to consider opening up these behavioral health treatments to individuals with similar developmental disabilities as research validates the efficacy of applying these treatments to other diagnoses.

Thank you for the opportunity to provide comments on this important legislation. If you have any questions, I will be happy to answer them.

Respectfully,

Ivalee Sinclair, Chair

HMSA



An Independent Licensee of the Blue Cross and Blue Shield Association

March 11, 2013

The Honorable Angus L. K. McKelvey, Chair
The Honorable Derek S. K. Kawakami, Vice Chair
House Committee on Consumer Protection and Commerce

Re: SB 668, SD2 – Relating to Health

Dear Chair McKelvey, Vice Chair Kawakami and Members of the Committee:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on SB 668, SD2, which would require health plans to provide coverage for services for autism spectrum disorders (ASD). HMSA certainly is empathetic to the intent of this Bill. However, we are concerned that the Legislature and the community need more and clearer information about the consequences of such a mandate.

The 2012 Legislature, in fact, did attempt to gain that knowledge by adopting HCR 177, HD2, SD1, directing the Legislative Reference Bureau (LRB) study of the impacts of mandating insurance coverage for the diagnosis and treatment of ASD. The LRB submitted that report, "Autism Spectrum Disorders and Mandated Benefits Coverage in Hawaii," to the 2013 Legislature

Unfortunately, the LRB report is inconclusive with regard to many of its findings, including the financial impact and the impact of the Affordable Care Act on such a mandate. The LRB instead offers recommendations including:

- Should the Legislature want more certainty with respect to the cost of a mandate, it may consider commissioning an independent actuarial analysis.
- Should the Legislature want more accurate information concerning the costs of the mandate to the Med-QUEST and EUTF systems, it may require the agencies to commission studies of their own.
- The Legislature needs to ensure Applied Behavioral Analysis network adequacy, especially for ASD patients on the Neighbor Islands.

While providing services for persons with ASD is important, clarifying the impact of a coverage mandate for those services on the community and the health care system also is imperative. Consequently, the Legislature may wish to consider pursuing some or all of the additional studies recommended by the LRB.

Thank you for the opportunity to offer our comments on SB 668, SD2.

Sincerely,

A handwritten signature in black ink, appearing to read 'JD' followed by a flourish.

Jennifer Diesman
Vice President, Government Relations

Testimony of Phyllis Dendle

Before:

House Committee on Consumer Protection and Commerce
The Honorable Angus L. K. McKelvey., Chair
The Honorable Derek S.K. Kawakami, Vice Chair

March 11, 2013
2:00 pm
Conference Room 325

SB 668 SD2 RELATING TO HEALTH

Chair McKelvey and committee members, thank you for this opportunity to provide testimony on SB 668 SD2 which would mandate expanded insurance coverage for people with autism spectrum disorders.

Kaiser Permanente Hawaii opposes this bill based on how it is written.

Our first concern is that this bill reflects none of the recommendations of either the Legislative Auditor or the Legislative Reference Bureau. Both studies were done as requested by the legislature and the auditor's study recommended against passing this mandate and the LRB made specific recommendations about what would need to be included.

We also want to explain our concerns about specific language in this bill.

Age-This bill sets the upper limit of coverage at 26 years of age. This is far above what other states cover for autism related services. No state is above age 21 and many are set younger than that. Several states focus their resources on young children who, research indicates, may benefit from services described in the bill. Testimony on this bill supports the concept of early intervention. If the legislature feels it must pass this legislation we recommend that it be focused on the group that is most likely to benefit and limit this coverage to children up to their 6th birthday.

Screening and diagnosis-Screening and diagnosis are already covered services under existing law. At Kaiser Permanente we follow the guidelines of the American

Academy of Pediatrics on identification and evaluation of children to diagnose those with autism spectrum disorders. When these children are identified they are linked to the State Department of Health early intervention services and as the child grows they are linked to the Department of Education both of whom currently provide services to children with autism as well as children with other developmental issues.

Maximum dollar limits-We appreciate the intention of the drafters of this bill to create some financial certainty to health plans by placing a dollar limit per year and per lifetime. However, this is not consistent with federal law. Federal mental health parity laws require that there be no coverage limits on mental health services which are not also on other health services. The federal Patient Protection and Accountable Care Act (ACA) prohibits any lifetime limit. We are concerned that this bill might pass with the limits listed but would be superseded by federal law which would require coverage with no limits.

Also, this dollar limit is only for "behavioral health treatment" and the bill specifically says this must be in addition to any coverage for other care, treatment, intervention, or service. The actual cost of care could easily exceed the proposed dollar figures.

Review of treatment- The bill would permit a health plan to review the treatment of a covered individual not more than once every twelve months. This is not in the best interest of the patient. All other medical treatments are subject to regular review to determine if the treatment is beneficial. It is essential for all medical care, including what is being required in this bill, to be based on what is medically necessary. If the individual is not improving it may be the wrong treatment or it may be the wrong provider. Under the circumstances described in the bill an individual could languish for a year making no improvement before the health plan would be able to evaluate the patient's progress. There is no requirement for the prescribing provider to have oversight to this care once prescribed. There is also no requirement that services provided be in line with evidence-based research and be provided to consistent standards.

Coordination of care- This bill does not clearly delineate the responsibilities between health plans and providers and the Departments of Health and Education. The schools are required to provide a range of services to students under federal disability and special education laws. This bill could set up circumstance where individuals are shuffled back and forth because

it is not clear who is responsible for what services. This is similar to what was experienced before the Felix consent decree.

Who's covered- As written, this bill sets up two different levels of care based on whether the plan is gotten through the health insurance exchange or outside of the exchange. Those in the exchange will not be covered for this mandate. Will Medicaid be required to pay for all of the same services to the same degree as commercial insurance? What will be the impact be on the EUTF?

Who pays- This bill shifts the cost of the services it requires directly to businesses through increased premiums paid for purchasing coverage for their employees and to the individuals purchasing their own coverage. At least part of the cost is shifted from the schools who receive federal funds to provide appropriate educational service to students with disabilities. As with all mandates it is anticipated that there will be increased demand for the services described in this bill.

Federal- The federal Accountable Care Act and its related regulations will have an impact on state mandates. In particular, mandates not already in effect will not be part of the federal essential health benefits which may shift the cost of providing these later mandates to the state rather than the purchaser of health coverage. This is just one of the peculiarities of ACA. Health providers and plans continue to work toward implementing the vast array of requirements of ACA and its ever-evolving regulations--in a short time frame.

Implementation- The implementation date of January 1, 2014 gives plans, providers and businesses only six months to prepare for the additional treatment and expenses generated by this bill. It is not clear that there are even sufficient qualified providers available to provide these services, particularly on the neighbor islands. When considered in the context of the changes being implemented by the federal government a more realistic date would be at least January 1, 2015.

Providers- The definition of Autism Service provider--places no professional requirements on who may provide services. There is no certification or licensure requirement. There is no requirement that these individuals pass a criminal history record check. The individuals who receive the treatment described in this bill are among the most vulnerable and the treatment is frequently one on one. The state should require at minimum that service providers meet the same requirements the Department of Human Services requires of providers of services for participants in Med-QUEST.

These are serious matters that need to be addressed and corrected before this bill becomes law. We urge the committee to hold this bill which is more about shifting costs than providing effective care for children with autism. It is possible to create a law that would provide services that could improve the lives of children with autism and their families. The providers and staff of Kaiser Permanente Hawaii would welcome the opportunity to work on drafting such a law.

Thank you for your consideration.



HAWAII MEDICAL ASSOCIATION

1360 S. Beretania Street, Suite 200, Honolulu, Hawaii 96814
Phone (808) 536-7702 Fax (808) 528-2376 www.hmaonline.net

DATE: Monday, March 11, 2013
TIME: 2:00 p.m.
PLACE: Conference Room 325

TO:
COMMITTEE ON CONSUMER PROTECTION & COMMERCE
Rep. Angus L.K. McKelvey, Chair
Rep. Derek S.K. Kawakami, Vice Chair

From: Hawaii Medical Association
Dr. Steven Kemble, MD, President
Dr. Linda Rasmussen, MD, Legislative Co-Chair
Dr. Joseph Zobian, MD, Legislative Co-Chair
Dr. Christopher Flanders, DO, Executive Director
Lauren Zirbel, Community and Government Relations

Re: SB 668 RELATING TO HEALTH

Position: Strongly Support

The Hawaii Medical Association is submitting testimony in strong support of SB 668.

There is an abundance of evidence that early diagnosis and treatment of ASD results not only in improved outcomes for children with ASD, but also significant savings in health care coverage and the need for additional services of the lifetime of the individual.

Mahalo for the opportunity to submit testimony on this important issue.

OFFICERS

PRESIDENT - STEPHEN KEMBLE, MD PRESIDENT-ELECT –WALTON SHIM, MD
SECRETARY - THOMAS KOSASA, MD IMMEDIATE PAST PRESIDENT – ROGER KIMURA, MD
TREASURER – BRANDON LEE, MD EXECUTIVE DIRECTOR – CHRISTOPHER FLANDERS, DO



Eric Gill, Financial Secretary-Treasurer

Hernando Ramos Tan, President

Godfrey Maeshiro, Senior Vice-President

March 10, 2013

Sen. Angus McKelvey, Chair
Sen. Derek Kawakami, Vice Chair

Members of the Committee on Consumer Protection and Commerce
State of Hawaii House of Representatives

Re: Testimony in support of re: SB 668, SD2

Chair McKelvey and Members of the Committee on Consumer Protection and Commerce:

UNITE HERE, Local 5 represents over 10,000 workers in the hotel, restaurant and health care industries in Hawai'i. Over 1,900 of our members work at Kaiser Permanente, where they strive to provide good, quality patient care for our community. We firmly believe that providing insurance coverage of autism spectrum disorders is vital to the health of our community. For that reason, we appreciate the committee's consideration of this bill and we strongly support the passage of SB 668.

As society's awareness of these disorders has increased, our knowledge of how to effectively treat them has grown. It would be an understatement to say that autism makes life more difficult for those who have it and their families - words cannot do justice to what they must go through. The cost of raising children is already high, but the cost of raising autistic children is tremendous, in terms of time, effort, stress and money. If we fail to address this, many people with autism may go without appropriate treatment - this comes at an even greater cost, both to families and to society as a whole. Families have shouldered the significant additional burden of paying out of pocket for autism treatment for far too long.

Hawai'i is at a crossroads. If we continue on our current path, we will be allowing large corporations, developers and big banks to make massive profits from everything our state has to offer, while working people struggle more and more to stay healthy, pay bills, afford a home, and get a decent education. There is another option - we can break from that path and instead commit to building a healthy, sustainable community where the needs of the people come before corporate profits. You have before you today the opportunity to help change our course by providing much needed health care coverage for those that need it most.

One in 88 children is now diagnosed with an autism spectrum disorder. These are our 'ohana. Treatment can make a real difference in their lives. No one should have to choose between putting food on the table and providing the health care their children need to become functioning members of society. Please pass SB668.

Sincerely,

A handwritten signature in black ink, appearing to read "Benjamin Sadoski".

Benjamin Sadoski
UNITE HERE, Local 5



March 11, 2013

The Honorable Angus L.K. McKelvey, Chair
The Honorable Derek S. K. Kawakami, Vice Chair

House Committee on Consumer Protection & Commerce

Re: SB 668 SD2 – Relating to Health

Dear Chair McKelvey, Vice Chair Kawakami, and Members of the Committee:

My name is Rick Jackson and I am Chairperson of the Hawaii Association of Health Plans (“HAHP”) Public Policy Committee. HAHP is a non-profit organization consisting of nine (9) member organizations:

AlohaCare	MDX Hawai’i
Hawaii Medical Assurance Association	‘Ohana Health Plan
HMSA	University Health Alliance
Hawaii-Western Management Group, Inc.	UnitedHealthcare
Kaiser Permanente	

Our mission is to promote initiatives aimed at improving the overall health of Hawaii. We are also active participants in the legislative process. Before providing any testimony at a Legislative hearing, all HAHP member organizations must be in unanimous agreement of the statement or position.

HAHP appreciates the opportunity to provide testimony in opposition to SB 668 SD2 which would require health plans to provide coverage for autism and related services. HAHP recognizes that legislative health mandates are often driven by the desire for improved health care services to the community; as health plans, our member organizations are committed to the same ideal.

Intended Cost Shift for Autism Treatment

This bill’s intent is to cause a “cost shift” for all of the treatment responsibility and cost for autism spectral disorder to licensed health plans, including all of HAHP’s member organizations. Currently, a broad range of organizations and support groups assist in dealing with this set of developmental disorders: Department of Education (DOE), Department of Health – Developmental Disabilities Division, the Department of Human Services through Medicaid and other community-based organizations. As we understand the bill, treatment “prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician, psychologist, or registered nurse practitioner if the care is determined to be medically necessary: (1) Psychiatric care; (2) Psychological care; (3) Behavioral health treatment; (4) Therapeutic care; and (5) Pharmacy care” will be mandated to be covered by health plans.

Cost of the Bill

We reasonably expect that virtually every child who has been diagnosed with autism, the most severe diagnosis in autism spectral disorder, would receive these new mandated benefits to the full extent of the proposed annual cap of \$50,000. Last year, the Department of Education reported that there were

approximately 1,000 children in the DOE system with autism; so, we are looking at a minimum cost shift and increase to local employers of \$50,000,000 annually. Adding the additional cost of those children with less severe symptoms will surely add significantly to this minimum estimate.

Who Will Bear the Cost of This Bill

The Accountable Care Act contains a provision that requires any new State mandated health benefits enacted after 2012 that are not part of a basic benefit package be paid for by the State which enacts them. Hawaii authorities have chosen the HMSA preferred provider plan benefits currently in place to be the Hawaii standard. Treatment protocols called for in this bill will not be considered “essential health benefits” because they are not listed in the HMSA PPP coverage. Therefore, the government of the State of Hawaii will be responsible to pay for the costs of this bill, if enacted, and not the State’s health plans or employers.

We believe that the state should not pass any additional mandated benefits, especially this costly proposal. Therefore we would respectfully request that the Committee see fit to hold this measure today.

Thank you for the opportunity to provide testimony.

Sincerely,

A handwritten signature in black ink, appearing to read "Rick Jackson". The signature is fluid and cursive, with a long horizontal stroke at the end.

Rick Jackson
Chair, Public Policy Committee



March 11, 2013

Representative Angus L.K. McKelvey
Chair, House Committee on Consumer Protection & Commerce
State Capitol
415 South Beretania St
Honolulu, HI 96813

Re: In support of SB 668 SD 2; Relating to Health. Mandatory Health Coverage; Autism Spectrum Disorders

Dear Chair McKelvey and Members of the Committee,

I am Mike Wasmer, Associate Director for State Government Affairs at Autism Speaks and the parent of a child with autism. Autism Speaks is the world's leading autism science and advocacy organization, dedicated to funding research into the causes, prevention, treatments and a cure for autism; increasing awareness of autism spectrum disorders; and advocating for the needs of individuals with autism and their families. Our state government affairs team has played a leading role in most of the now 32 states that have enacted autism insurance reform laws and I am happy to speak today in strong support of SB 668 SD 2.

Thank you for your support last month when HB 721 was passed out of this committee and for honoring Luke Pinnow's brave testimony by amending the bill to be named after him. I hope that you will consider a similar amendment today. If enacted SB 668 SD 2 would provide Luke and many other Hawaii children with autism access to desperately needed treatment and the opportunity to become self sufficient tax paying citizens.

SB 668 SD 2 versus HB 721 HD1

Based on our experience in other states, Autism Speaks proposed amendments in the hearing on HB 721 that would strengthen the bill and minimize problems with implementation if it were to be enacted. Most of these were addressed in the committee report and reflected in HB 721 HD1. However several important amendments were omitted e.g., clarifying that proposed benefits apply to individual as well as group plans; addressing issues of network adequacy of ABA providers that have arisen in other states; and correcting the definition of autism spectrum disorder relative to the forthcoming edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Other amendments that did not appear in HB 721 HD1 were recommended in order to make the terms of coverage consistent between the section pertaining to mutual benefit societies, and the section pertaining to accident and health or sickness insurance contracts. Others were technical corrections.

I have submitted an addendum to my testimony that details the concerns we have regarding HB 721 HD 1. All of these issues have been resolved in SB 668 SD 2 which is the version of the bill that we ask that you please advance from this committee.



RESPONSE TO OPPOSITION TESTIMONY

In addition to SB 668, similar legislation is active in 7 other states (i.e., GA, MN, KS, NE, NC, OR, and TN) . Historical arguments against such legislation including questions about the efficacy and medical necessity of applied behavior analysis (ABA) have largely been dismissed as the research in support of its use in individuals with autism is overwhelming. In fact, at a hearing on Nebraska's autism insurance reform bill last month, all 3 major insurers in the State testified as neutral on the bill - going on record that they were not opposed to the proposed benefits.

Cost

At issue in most states is the question of cost. Opponents of SB 668 have suggested an actuarial analysis be performed to estimate the cost of proposed coverage. In fact, an independent actuarial analysis was performed on Hawaii SB 2631 SD1 last year and was submitted during testimony. SB 2631 SD 1 proposed identical terms of coverage to the bill you are considering today. The actuarial firm of Oliver Wyman estimated the long term impact on premiums as a result of such coverage to be less than 0.6% (see attached)¹.

More compelling is the fact that we now have available actual claims data from States which were among the first to enact such legislation showing the average cost of coverage is 31 cents per member per month. This includes claims data recently reported by the Missouri Department of Insurance which also demonstrated that the actual cost of Missouri's autism benefit represented less than 0.2% of their overall health claims costs. Based on this observation the Missouri report concluded that "it is very unlikely that such costs will have an appreciable impact on insurance premiums."²

Duplicating services provided by Hawaii Department of Education

Opponents of SB 668 have asserted that proposed coverage duplicates services already provided by the Hawaii Department of Education (HIDOE). The 2013 Legislative Reference Bureau (LRB) report on autism clarifies that under IDEA the HIDOE is required to provide a free and appropriate education to students eligible to receive special education services, including students with autism. Students must also be placed in the least restrictive environment.³ Benefits proposed by SB 668 SD 2 are medical services provided for a medical condition. IDEA does not require treatment of a medical condition.

Implications of the Patient Protection and Affordable Care Act

Opponents have also questioned the consequences of enacting this legislation relative to the Patient Protection and Affordable Care Act (PPACA) and whether the State would be obligated to defray the cost of benefits that exceed the essential health benefits package. Under the PPACA, this obligation only applies to plans sold inside State Exchanges. SB 668 SD 2 specifies that benefits that exceed the

¹ Lambright, Marc. "Actuarial Cost Estimate: Hawaii Senate Bill 2631 S.D.1: Act to ensure the provision of quality health care procedures for all Hawaii residents by requiring coverage of and treatment for autism spectrum disorders" (Oliver Wyman) March 2, 2012.

² "Insurance Coverage for Autism Treatment and Applied Behavior Analysis" (Annual Report to the Missouri Legislature), Missouri Department of Insurance Financial Institutions & Professional Registration, February 1, 2013.

³ Coke, Matthew and Kaneshige, Velma. "Autism spectrum disorders and mandated benefits coverage in Hawaii." Honolulu, HI: Legislative Reference Bureau, January 2013.



essential health benefits will not be required of a qualified health plan when the plan is offered through the Hawaii health insurance exchange. The 2013 LRB report concluded that “[by] excluding these health plans from the mandate, the State would be relieved of its responsibility under the PPACA to defray the cost of those mandated ASD benefits that fall outside Hawaii’s EHB benchmark.”

Age Cap

One insurer has testified that the age cap of 26 in SB 668 is “far above what other states cover for autism related services” and that “no state is above age 21.” These statements are not accurate. In fact, three states (i.e., CA, IN and NY) impose no age cap on covered services. One State (i.e., NM) extends coverage until age 23 and two States (i.e., NV and NH) extend coverage until age 22. Of the 29 states with an age cap, the average cap is 18 years of age. The age cap proposed by SB 668 SD 2 is consistent with the fact that under the PPACA, young adults are allowed to remain on their parent’s health insurance up to age 26.

Licensure of ABA providers

Opponents have also expressed concern that SB 668 does not require licensure of ABA providers. As indicated in the 2013 LRB report, licensure of ABA providers is not a prerequisite for enacting autism insurance reform laws. Nor is licensure a prerequisite for reimbursement of ABA providers by insurers.

Of the 32 states that require coverage for ABA for autism only 8 require licensure of ABA providers. Similar to that proposed by SB 668 SD 2, the majority of States allow for reimbursement of ABA providers if they are credentialed by the national Behavior Analyst Certification Board or if they are an appropriately trained licensed psychologist. While Autism Speaks does not have a position on licensure of ABA providers, factors for States to consider in this discussion include the cost of licensure and the need to ensure that licensure does not delay or restrict access to services.

The prevalence of autism as reported by the Centers for Disease Control and Prevention (CDC) is now 1:88. This represents a 1000 fold increase in the past forty years. Autism is an epidemic and a public health crisis. The time to act is now. Thank you for your consideration of my comments in support of SB 668 SD 2.

Sincerely,

Michael L. Wasmer, DVM, DACVIM
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Autism Speaks

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Addendum to Wasmer Testimony on SB 668 SD 2

All of the following proposed amendments to HB 721 HD 1 have been accurately incorporated into SB 668 SD 2:

1. **page 1, line 12**; Insert “individual and” after “each” to read:

“...of section 431:10A-102.5 each individual and employer group accident and health...”

The provisions of this section are to apply to individual as well as group plans.

2. **page 2, line 12**; Strike “2016” and replace with “2015”

The adjustment for inflation is to occur annually beginning one year (not 2 years) after enactment.

3. **page 4, line 1**; Strike “2016” and replace with “2014”

The section of the Patient Protection and Affordable Care Act referenced in subsection (i) becomes effective January 1, 2014 (not 2016).

4. **page 4, line 11**; Insert new subsection (j) and reassign subsequent subsections appropriately

(j) Insurers must include at least as many Board Certified Behavior Analysts in their provider network as there are qualified licensed psychologists in their network of approved providers of applied behavior analysis.

Similar to SB 668, California law allows for both BCBAAs and licensed psychologists to provide ABA for autism. However some California insurers are only networking licensed psychologists which has limited access to care. The proposed amendment is in response to this concern.

(k) If an individual has been diagnosed...

Reassigns existing subsection (j) as subsection (k)

(l) As used in this section, unless ...

Reassigns existing subsection (k) as subsection (l)

5. **page 5, lines 9-11**; Insert “or autism spectrum disorders” after “developmental disorders” in line 10 to read:

"Autism spectrum disorders" means any of the pervasive developmental disorders or autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

Addendum to Wasmer Testimony on SB 668 SD 2

The recommended edit reflects the changes to the definition of “autism spectrum disorders” in the forthcoming edition of the DSM. The DSM IV uses the umbrella term “pervasive developmental disorders” but the DSM V will not. Rather, the DSM V will use the umbrella term “autism spectrum disorder.”

6. **page 6, line 4**; Strike lines 4-6, definition of “health insurance policy”

7. **page 6, line 19**; Strike the word “provided”

The word “provided” should be deleted because the listed professionals are the ones who serve as gatekeepers at the “prescribing” or “ordering” phase, which is what is at issue in this clause. The appropriate professionals to “provide” the treatments are discussed elsewhere in the bill.

8. **page 7, line 18**; Insert “screening” after “for the” to read:

“...for the screening, diagnosis and treatment of autism spectrum...”

Screening tests are to be a covered service and is consistent with coverage detailed in Section 3 of the bill.

9. **page 8, line 9**; Strike “2016” and replace with “2015”

The adjustment for inflation is to occur annually beginning one year (not 2 years) after enactment.

10. **page 8, line 18**; Strike lines 18-20 and replace with:

“...intervention, or service other than behavioral health treatment shall not be applied...”

This edit maintains consistency with the intent of subsection (c), i.e., the maximum benefit is applicable only to behavioral health treatment. This is also consistent with provisions in Section 3 of the bill.

11. **page 9, line 1**; Strike “shall” and replace with “may”

12. **page 9, lines 2-3**; Strike “a health insurance policy” and replace with:

“...an individual or group hospital or medical service plan, policy, contract, or agreement...”

This edit maintains consistency with the type of plan addressed in Section 4, i.e. mutual benefit societies.

Addendum to Wasmer Testimony on SB 668 SD 2

13. **page 9, lines 7-8**; Strike “a health insurance policy.” and replace with:

“...an individual or group hospital or medical service plan, policy, contract, or agreement.”

This edit maintains consistency with the type of plan addressed in Section 4, i.e. mutual benefit societies.

14. **page 9, line 9**; Insert new subsections (f) through (j), and reassign existing subsection (f) as new subsection (k)

- (f) Coverage for treatment under this section shall not be denied on the basis that the treatment is habilitative or non-restorative in nature.
- (g) Except for inpatient services, if an individual is receiving treatment for autism spectrum disorders, an insurer may request a review of that treatment not more than once every twelve months. The cost of obtaining any review shall be borne by the insurer.
- (h) This section shall not be construed as reducing any obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan.
- (i) As of January 1, 2014, to the extent that this section requires benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), the specific benefits that exceed the specified essential health benefits shall not be required of a qualified health plan when the plan is offered in this State through the Hawaii health insurance exchange by a health carrier. Nothing in this subsection shall nullify the application of this section to plans offered outside the exchange.
- (j) Insurers must include at least as many Board Certified Behavior Analysts in their provider network as there are qualified licensed psychologists in their network of approved providers of applied behavior analysis.
- (k) If an individual has been diagnosed...

15. **page 9, line 18**; reassign existing subsection (g) as new subsection (l)

Addendum to Wasmer Testimony on SB 668 SD 2

16. **page 10, lines 6-11**; Insert “or autism spectrum disorders” after “developmental disorders” in line 7, and strike lines 9-11 to read:

"Autism spectrum disorders" means any of the pervasive developmental disorders or autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

The recommended edit reflects the changes to the definition of “autism spectrum disorders” in the forthcoming edition of the DSM. The DSM IV uses the umbrella term “pervasive developmental disorders” but the DSM V will not. Rather, the DSM V will use the umbrella term “autism spectrum disorder” which will subsume the diagnoses of autistic disorder, Asperger’s disorder, pervasive developmental disorder not otherwise specified, Rett’s disorder, and childhood disintegrative disorder.

17. **page 10, line 12**; Strike lines 12-16 and insert:

“Behavioral health treatment” means counseling and treatment programs, including applied behavior analysis, that are:

- (1) necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and
- (2) provided or supervised by a Board Certified Behavior Analyst or by a licensed psychologist so long as the services performed are commensurate with the psychologist’s formal university training and supervised experience.

This amendment clarifies that both direct services provided by a Board Certified Behavior Analyst (BCBA) or an appropriately trained licensed psychologist, and services provided by the therapists working under their supervision are covered services.

18. **page 10, line 20**; Strike lines 20-22, definition of “health insurance policy”
19. **page 11, line 13**; Strike the word “provided”. See explanation in #7 above
20. **page 12, line 15**; Change “...issued in this State by a health maintenance..” to “...issued or renewed in this State by a health maintenance...”

This amendment is consistent with the requirements of accident and health or sickness insurance contracts in Section 3, and mutual benefit societies in Section 4 of the bill.

21. **page 12, line 19**; Strike “July 1, 2112” and replace with “upon its approval.”

March 2, 2012

Actuarial Cost Estimate: Hawaii Senate Bill 2631 S.D.1

Act to ensure the provision of quality health care procedures for all Hawaii residents by requiring coverage of and treatment for autism spectrum disorders.

OLIVER WYMAN

Prepared By:

Marc Lambright, FSA, MAAA

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Executive Summary

Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) has been engaged by Autism Speaks to develop a cost model in order to analyze and estimate the impact of insurance benefits for autism spectrum disorders (ASDs) under Hawaii Senate Bill 2631 S.D.1. The Bill will be referred to as SB 2631 S.D.1 throughout this report.

The most significant class of treatments covered under SB 2631 S.D.1 is behavioral health treatments, which is referred to as applied behavioral analysis, or “ABA,” throughout this document, since ABA is one of the most common behavioral health treatments and the general approach and costs for ABA are assumed to be similar to those of other behavioral health treatments. The key provisions of SB 2631 S.D.1 are explained further in Section 4 of this report.

Our analysis involved developing a robust model that reflects the likely behavior of consumers, providers and insurers of ABA services, and includes Hawaii demographic and insurance market information. Key assumptions, including the treated prevalence of ASD, the age of diagnosis, ABA program utilization by age, ABA annual costs by age, and additional other (i.e., not ABA) medical costs, as well as the modeling methodology are explained in detail in Sections 5 and 6 of this report and summarized through graphs in the Appendix.

Our analysis included scenario testing to develop cost estimates under a range of assumptions. Our “Middle” estimate is that, in the long-term, costs would increase by about 0.32% of premiums and premiums would increase by about 0.38% should SB 2631 S.D.1 be enacted. Our estimated range of long-term premium increases is 0.26% to 0.53% based on our “Low” and “High” estimates.

We expect that premium increases would be lower in the years immediately following the passage of a law consistent with the provisions of SB 2631 S.D.1, with first year premium increases in the range of 0.09% to 0.35%. Our expectation of lower first year costs is based on experiences in other states that have seen low initial costs when ASD benefits are first

covered. These lower costs can be expected due to the lags typically seen in accessing new benefits and the limited supply of ABA providers.

The estimated long-term cost increases for our “Middle” scenario, along with some statistics for the individual, small, and large group markets, are shown in the table below.

Long-Term Cost Estimates - “Middle” Scenario

	Market			
	Individual	Small Group	Large Group	All
Covered Persons	51,000	137,000	290,000	478,000
Average Premium per Person	\$3,000	\$4,400	\$3,900	\$3,947
Annual Claim Cost per Covered Person	\$12.70	\$12.70	\$12.70	\$12.70
Claim Cost as a Percentage of Premium	0.42%	0.29%	0.33%	0.32%
Estimated Premium Increase with Admin @ 15%	\$14.90	\$14.90	\$14.90	\$14.90
Premium Increase as a Percentage of Premium	0.50%	0.34%	0.38%	0.38%

For our scenario testing we varied the assumptions that drive cost estimates. The assumptions under the “Low,” “Middle,” and “High” scenarios and premium increase estimates are summarized in the table below.

Scenario Testing

Scenario	% Autistic Disorder Diagnosed Under Age 8 Starting ABA	Program Cost - Autistic Disorder Under Age 8	Avg. Annual non-ABA Cost	Premium Increase per Covered	Premium Increase (% of Premium)
Low	50.0%	\$40,000	\$2,000	\$10.10	0.26%
Middle	65.0%	\$45,000	\$3,000	\$14.90	0.38%
High	80.0%	\$49,829	\$4,000	\$20.90	0.53%

While this analysis focused primarily on estimating the insured costs of covered medical benefits associated with SB 2631 S.D.1, in Section 8 we summarize information related to the lifetime costs of ASD, which include the costs associated with medical services, education, custodial care and the lost productivity and wages of individuals affected by ASD, as well as their family caregivers.

Section 8 also references several studies that would suggest that the costs of ABA treatments covered under SB 2631 S.D.1 could be recovered through reductions in educational and medical expenditures alone. Benefits associated with successful treatments would be expected to reduce future costs of caring for individuals with ASD, and improve both the productivity and the quality of life for individuals with ASD, as well as their family caregivers.

2

Background

Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) has been engaged by Autism Speaks to develop a cost model in order to analyze and estimate the impact of legislation providing for additional insurance benefits for autism spectrum disorders (ASDs) on insurance premiums. As part of this work, Oliver Wyman has developed a range of independent estimates of the impact of SB 2631 S.D.1 on insurance premiums, which provides coverage for the diagnosis and treatment of ASDs.

Oliver Wyman is a part of the Marsh & McLennan family of companies. With over 60 members of the American Academy of Actuaries, Oliver Wyman is one of the largest actuarial practices in North America. Oliver Wyman’s health practice, which has fourteen credentialed actuaries, advises insurers, regulators, governments, interest groups, and others.

This report, along with its supporting analysis, was developed by Marc Lambright, a Principal and consulting actuary in Oliver Wyman’s Philadelphia office. Marc is a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries and is professionally qualified to analyze the cost impact of SB 2631 S.D.1 and provide the estimates shown in this report. As part of Oliver Wyman’s quality assurance process, the underlying analysis and this report were independently peer reviewed by another credentialed Oliver Wyman actuary.

3

Scope and Limitations

The intent of this analysis is to provide a reasonable range of estimates for the incremental insured costs of the ASD benefits provided for in SB 2631 S.D.1 and the associated premium impact on the individual, small group, and large group markets affected by the passage of SB 2631 S.D.1. This analysis also identifies and partially quantifies identified offsetting cost savings associated with successful ASD treatment.

We note that cost estimates associated with autism coverage legislation have varied widely state to state based on state specific differences in legislation and the methods and assumptions used in estimating costs, though typically independent estimates show premium increases due to legislation covering additional autism benefits of less than 1%. A March 2009 report by The Council for Affordable Health Insurance (CAHI) states: “CAHI’s actuarial working team estimates that an autism mandate increases the cost of health insurance by about 1 percent.”¹ The reason for this variability is that the largest component of the increase in costs under SB 2631 S.D.1 is the coverage of behavioral therapies, including applied behavioral analysis (ABA), which historically has generally been excluded from health coverage, and therefore very little mature insured data exists for use in developing credible utilization and unit cost estimates for ABA. Emerging cost data does however suggest that the initial costs associated with autism insurance costs covered by laws similar to SB 2631 S.D.1 have been low. This emerging experience is discussed in Section 5.

While the ultimate cost of covering ABA benefits is uncertain, this analysis reflects the likely behavior of consumers, providers and insurers of ABA services in developing the assumptions underlying the cost estimates. Likewise, the additional costs for medical services other than ABA are uncertain. Insurance policies often cover some services for children diagnosed with an ASD, although the legislation could cause the insured costs for certain services to increase because ASD exclusions or limitations are common. Certain services that may have been initially denied or terminated following utilization review or benefit limitations might be covered with the passage of legislation consistent with SB 2631 S.D.1.

¹ The Council for Affordable Health Insurance. “The Growing Trend Towards Autism Coverage.” March 2009.

4

Description of Key SB 2631 S.D.1 Provisions and Their Impact on Covered Benefits

Insurance Markets Covered by SB 2631 S.D.1

SB 2631 S.D.1 states: *“Any other law to the contrary notwithstanding, all accident and health or sickness insurance policies issued or renewed in this State after December 31, 2012, shall provide to the policyholder and individuals under twenty-six years of age covered under the policy, coverage for the well-baby and well-child screening and the diagnosis and treatment of autism spectrum disorders.”*

In our modeling we are assuming that this means that SB 2631 S.D.1 applies to all comprehensive health insurance contracts in the individual, small group, and large group markets.

Covered Benefits

SB 2631 S.D.1 provides for the treatment of autism spectrum disorders, specifically:

“Treatment for autism spectrum disorders” includes the following care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, or registered nurse practitioner if the care is determined to be medically necessary:

- (1) Behavioral health treatment;*
- (2) Pharmacy care;*
- (3) Psychiatric care;*
- (4) Psychological care; and*
- (5) Therapeutic care.”*

The inclusion of *“Behavioral health treatment”* which is defined as *“professional counseling and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual”* is

especially important. The coverage of these types of behavioral health treatment programs has the most significant impact on the cost of benefits under SB 2631 S.D.1. Note, one of the most common behavioral health treatments is Applied Behavioral Analysis, or “ABA”, which is defined as *“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”* in the Bill. For simplicity, we refer to behavioral health treatments as “ABA” throughout this report, under the assumption that other behavioral health treatments will have costs and characteristics similar to ABA.

ABA may include 30-40 hours of therapy a week, though many programs would not utilize that level of resources. Also, SB 2631 S.D.1 limits benefits for ABA by including the following: *“Minimum benefits for behavioral health treatment provided under this section may be limited to \$50,000 per year, or \$300,000 during the lifetime of the individual, but shall not be subject to any limits on the number of visits an individual may make for treatment of autism spectrum disorder. After December 31, 2015, the insurance commissioner, on an annual basis, shall adjust the maximum benefit for inflation using the medical care component of the United States Department of Labor Consumer Price Index for all urban consumers.”* Our analysis considers this coverage amount, and we assume that insurers will limit ABA benefits to \$50,000 per year in our estimates. Our estimates reflect one year cost estimates, and do not take into consideration the \$300,000 lifetime cap. The lifetime cap could have a small impact on overall costs several years into the future, because we would expect that it would only affect a relatively small number of insureds who will have had intensive programs for many years as of that future point in time.

Key assumptions underlying our ABA cost estimates which also consider costs of other intensive programs are outlined in Section 6.

5

Modeling Methodology

The following discussion outlines the general modeling methodology used to develop our cost estimates. Estimates were developed both on a per covered person per year basis and as a percentage of average annual premiums, as shown in Section 7. Details of key assumptions are discussed in Section 6 and illustrated graphically in the exhibits shown in the Appendix.

Modeling Perspective

Our model was developed to produce costs under a range of assumptions, but generally assumes that a sufficient supply of providers would be available to meet the demand for autism services, especially with regard to ABA services. It also assumes that there would be sufficient awareness of autism and motivation (primarily by parents) to seek treatment so that the diagnosis and treatment of ASDs would be more in line with CDC diagnosed prevalence estimates. We would expect that it would take a minimum of several years for both the supply of providers to meet the demand for ASD services and for parents of autistic children to aggressively seek treatment of their children’s disorders.

In spite of these real limitations that will likely limit short-term costs associated with autism benefits covered under SB 2631 S.D.1, we feel that it is appropriate from a public policy perspective to look at the costs over a longer term and assume that both awareness of ASDs will increase and that supply and demand for ASD services would eventually be in balance. We have developed our estimates with this in mind.

Acknowledging that short-term costs are also important to policymakers, in the following discussion outlining our cost estimates, we have included illustrative exhibits showing the possible progression of costs for additional covered benefits by assuming that initial costs would be roughly one-half of the long-term estimates. We also assumed that it would take five years for costs to reach their ultimate levels, although these assumptions varied by cost scenario.

Emerging Cost Experience for Autism Coverage

While actual cost experience is limited, there have been some examples of emerging experience reported in various forums that are indicative of the costs of autism insurance laws being modest. These examples of emerging experience are not inconsistent with the cost estimates in this report.

South Carolina Employee State Health Plan

Calendar year 2010 and June 30, 2011 year-to-date annualized costs were approximately \$2 million for about 400,000 members. This reflects an increase of approximately 0.1% to 0.2% in medical costs for the plan due to coverage of autism services.²

The Ohio State University³

Percentage of claim cost experienced by the Ohio State University (OSU) Managed Health Care Systems Inc. (MHCS) for Autism Treatment:

2006	0.15%
2007	0.15%
2008	0.12%
2010	0.09%

Aetna Texas

Comments to press indicated increased costs equal to approximately 0.1% of premium in the year after the Texas autism law was enacted. Aetna noted in December 2008 that it had tracked the cost of the autism coverage legislation in Texas for its first year of existence and found that it increased costs for policyholders who filed autism-related claims by \$379 a month. A total of 235 policyholders had filed autism claims in the state as of the time the data was released. At that time, the company had not decided whether to pass those costs on to the policyholders because the cost of the legislation might change after the first year.⁴ While this is only first year experience for a single insurer, it illustrates that initial costs after the passage of autism insurance legislation are likely low. Aetna's Texas block of business is quite large (approximately \$1.5 - 2.0 billion in premium⁵), so the statistics provided indicate a cost of less than 0.1% of premium.

Other State Employee Health Plans

Autism Speaks has obtained information from administrators associated with state employee health plans related to the initial costs of autism insurance laws for these plans. This data is summarized below in the following three tables, and the Autism Speaks analysis is included in its entirety as an appendix to this report. While we have not fully analyzed the analysis or its underlying data, the analysis does indicate that initial costs for these state plans associated

² APS Healthcare letter dated August 21, 2011 with South Carolina state employees' plan experience.

³ Robert Meier Ohio legislature testimony submitted July 25, 2011.

⁴ Associated Press. *Lawmaker: Oklahoma autism bill has momentum*. December 4, 2008. <http://newsok.com/article/3327594>. Accessed January 2009.

⁵ NAIC Annual Statements for 2007.

with insurance laws requiring autism coverage have been low, and generally have been much lower than projected in the fiscal notes developed when similar bills were being vetted.

Table 1. Year One Costs

	Year of coverage	Number of Covered Lives	Total Claims	PMPM cost
Texas	1	460,510	\$295,379	\$0.05
South Carolina	1	371,384	\$856,369	\$0.19
Illinois	1	171,979	\$187,684	\$0.09
Florida	1	382,083	\$390,724	\$0.09
Arizona	1	130,000	\$473,818	\$0.30
Kentucky	1	240,000	\$278,922	\$0.10
	Average first year cost			\$0.14

Table 2. Year Two Costs

	Year of coverage	Number of Covered Lives	Total Claims	PMPM cost
Texas	2	499,993	\$405,762	\$0.07
South Carolina	2	397,757	\$2,042,394	\$0.43
Illinois	2	170,790	\$197,290	\$0.10
Louisiana	2	149,477	\$722,828	\$0.40
Florida	2	386,203	\$1,748,849	\$0.38
Arizona	2	130,000	\$388,662	\$0.25
	Average second year cost			\$0.27

Table 3. Projected versus Actual Costs

	Year of coverage	Total Claims	Fiscal Note from State Legislature	Difference in projected versus actual cost
Texas	2	\$405,762	\$888,676	219%
South Carolina	1	\$856,369	\$10,590,000	1,237%
	2	\$2,042,394	\$10,590,000	519%
Louisiana	2	\$722,828	\$2,118,307	293%
	2	\$722,828	\$2,686,796	372%
Arizona	1	\$473,818	\$2,500,000	528%
	1	\$473,818	\$4,900,000	1,034%
	2	\$388,662	\$2,500,000	643%
	2	\$388,662	\$4,900,000	1,261%

General Modeling Process

The modeling process employed to develop our cost estimates was as follows:

1. A treated prevalence estimate for Hawaii was developed based on the Center for Disease Control and Prevention’s (CDC) Mortality and Morbidity Weekly Report (MMWR) on autism prevalence dated December 18, 2009.
2. Prevalence rates by diagnostic subtype (Autistic Disorder, PDD-NOS, and Asperger’s Syndrome) were estimated separately, since diagnosis patterns and service utilization could reasonably be expected to vary by how severely affected an individual with ASD is and by diagnostic subtype.
3. The percentage of children diagnosed by age for each diagnostic subtype was estimated so that the average ages of diagnosis implicit in the modeling are consistent with publicly available age at diagnosis statistics.⁶
4. The percentage of diagnosed children who could be expected to have an ABA program was estimated for each age based on assumptions regarding the percentage of children that would start a program and typical program continuance.
5. A distribution of the number of annual hours for ABA by age was developed based on ABA provider input and an assumption that utilization review by insurers would impact utilization to some degree.
6. Based on the assumed treatment prevalence, likelihood of having an ABA program, assumed distribution of ABA program hours, and estimated ABA program cost per hour of therapy, ABA cost estimates by age were developed.
7. Non-ABA costs were estimated based upon studies of medical costs for children diagnosed with ASD, and the potential increase in costs that could be expected due to SB 2631 S.D.1 benefits.
8. Based on Census demographic data and the cost estimates associated with SB 2631 S.D.1’s coverage of ASD services by age as outlined in 1-7 above, an annual cost per covered person was developed.
9. The cost of services was increased to reflect administrative and other insurer costs or profit charges.
10. The estimated size of the covered market was developed based on Census, Medical Expenditure Panel Survey (MEPS) enrollment and premium information for Hawaii, and Kaiser Family Foundation coverage data. These assumptions are further explained and documented in Section 6.
11. The incremental costs of the ASD services per covered person and as a percentage of premiums were calculated based on the model cost estimates and market data under a range of assumptions to develop “Low,” “Middle,” and “High” cost scenario estimates.

⁶ IAN database. <http://dashboard.ianexchange.org/StateStatsAdvanced.aspx?A1=NE&ADU=T>. Accessed February 2012.

6

Summary of Key Assumptions

Key assumptions underlying the cost estimates for the proposed SB 2631 S.D.1 covered benefits are summarized in this section. In order to better illustrate the sensitivity of costs to various assumptions, we developed assumptions for “Low,” “Middle,” and “High” cost scenarios. Appendix 1 further illustrates these assumptions for the “Middle” scenario.

Treated Prevalence and Age at Diagnosis

The December 18, 2009 CDC MMWR⁷ report included the following information related to the prevalence of ASD:

- 1. Children aged 8 years with a notation of an ASD or descriptions consistent with an ASD were identified through screening and abstraction of existing health and education records containing professional assessments of the child’s developmental progress at health-care or education facilities. Children aged 8 years whose parent(s) or legal guardian(s) resided in the respective areas in 2006 met the case definition for an ASD if their records documented behaviors consistent with the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, text revision (DSM-IV-TR) criteria for autistic disorder, pervasive developmental disorder–not otherwise specified (PDD NOS), or Asperger disorder. Presence of an identified ASD was determined through a review of data abstracted from developmental evaluation records by trained clinician reviewers.⁸*
- 2. In 2006, the overall identified ASD prevalence per 1,000 children aged 8 years varied across ADDM sites ... The average across all 11 sites was 9.0 (CI = 8.6–9.3) per 1,000 children.⁹ A prevalence rate of 9 per 1,000 is approximately 1 in 110.*

⁷ Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report. December 18, 2009. <http://www.cdc.gov/mmwr/PDF/ss/ss5810.pdf>. Accessed February 2011.

⁸ Ibid, p. 1.

⁹ Ibid, p. 7.

3. *In general, estimated ASD prevalence was lower in ADDM sites that relied solely on health sources to identify cases (mean: 7.5 per 1,000 population; CI = 7.0 – 7.9) compared with sites that also had access to education sources.¹⁰*
4. *Among all children meeting the ADDM ASD surveillance case definition, approximately 77% had a documented ASD classification in their records.¹¹*
5. *All children initially identified for screening were first stratified by two factors highly associated with final case status: information source (education only, health only, or both types of sources) and the presence or absence of either an ASD ICD-9 code (299.0 or 299.8) or an autism special education eligibility. The potential number of cases missed because of missing records, and the impact on prevalence, was estimated on the assumption that within each of the strata, the proportion of children with missing records who ultimately would be confirmed as having ASD cases would have been similar to that of children for whom no records were missing.¹²*

In estimating treated prevalence, which drives medical services utilization and costs, we used the population prevalence as a starting point, and then made adjustments based on details in the MMWR study which would indicate that treated prevalence could be expected to be lower than population prevalence. Treated prevalence rates would be expected to be lower than population prevalence rates for several reasons:

1. As noted in 4. above, approximately 77% of children meeting the ADDM ASD surveillance case definition had documented ASD classification in their records. Without a documented ASD diagnosis, it is not likely that someone would receive treatments for ASD covered by insurance. Note 77% of the 9.0/1,000 population prevalence means a documented diagnosis prevalence rate of approximately 1 in 144.
2. There is a reasonable expectation that covered medical ASD services would be supported by documentation in health records. Based on a review of health records only, the population prevalence of ASD is approximately 7.5/1,000, or 1 in 133.
3. The CDC methodology assumed that where records and information were missing, the proportion of children with missing records who ultimately would be confirmed as having ASD would have been similar to that of children for whom no records were missing. There is a reasonable likelihood that records would be less likely to be missing for children with documented ASD diagnoses who would seek treatment.
4. With ASD, as with any other disease or disorder, there will be some subset of the diagnosed population that will not seek treatment for any number of reasons.

Based on our analysis of the CDC report, including the key items from the report noted above, a reasonable assumption for the treated prevalence of ASDs is 1 in 150.

¹⁰ Ibid, p. 7.

¹¹ Ibid, p. 9.

¹² Ibid, p.7.

Prevalence by diagnostic subtype was estimated based on an academic study published in the American Journal of Psychiatry.¹³ As noted in the previous section, the percentage of children diagnosed by age for each diagnostic subtype was estimated so that the average age of diagnosis implicit in the modeling is consistent with publicly available age at diagnosis statistics.

The treated prevalence and age at diagnosis assumptions for Hawaii are shown below:

<u>Hawaii Treated Prevalence</u>		
<u>Diagnostic Subtype</u>	<u>Ultimate Prevalence</u>	<u>Average Age of Diagnosis</u>
Autistic Disorder	1 in 450	3
PDD-NOS	1 in 300	3
Asperger's	1 in 900	6
All ASD	1 in 150	

The average age of diagnosis stated in the 2009 CDC MMWR report is 53 months,¹⁴ which is higher than the average age used in our cost modeling of about 42 months. We believe that this difference is reasonable and explainable in that we are using parent reported data that is likely provided by the same parents who would most likely utilize insured benefits. Note, a lower age of diagnosis results in higher cost estimates, all other things being equal.

ABA Program Utilization and Cost

ABA Program Utilization by Age

ABA programs require a significant commitment from affected children, as well as their families. It is likely that a significant number of ASD children will not have an ABA program regardless of the availability of a provider, and many others diagnosed with an ASD may have difficulty accessing a provider. We also note that the most severely affected children with the diagnostic subtype of Autistic Disorder will be more likely to have behavioral programs than those with PDD-NOS or Asperger’s and will also, on the whole, have more intensive programs.

For this reason, we have assumed that 50% to 80% of children with Autistic Disorder (50% for “Low” scenario, 65% for “Middle” and 80% for “High”) diagnosed under age six will begin an ABA program. Based on discussions with ABA providers and researchers, actual utilization of ABA programs has been lower in many cases due to the lack of providers, the lack of coverage, and to some extent the limited understanding of ABA programs and their efficacy. As noted later, we make an adjustment to reflect lower cost estimates for PDD-NOS and Asperger’s. Implicit in that adjustment is an expectation of lower ABA utilization for these two diagnostic subtypes.

In Minnesota, a state that is widely regarded as having some of the most extensive ABA coverage and services in the nation, provider data indicates ABA utilization of approximately

¹³ Fombonne, E. and S. Chakrabarti. American Journal of Psychiatry. June 2005.

¹⁴ Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report. December 18, 2009. p. 9.

20% of diagnosed three to six year olds,¹⁵ which is lower than assumed in each of the scenarios in our modeling. While our range of assumptions for ABA utilization may appear conservative, and likely is conservative in the near-term, we feel that the range is reasonable since insurers will likely have some conservatism in their cost estimates and premium rates. Private insurance utilization will also likely be higher than under the public/private programs in Minnesota, and utilization could increase over time due to increased awareness of ASD, and potentially, an increased supply of ABA providers.

In addition to the likelihood of starting a program, program continuance assumptions have a very significant impact on overall ABA utilization and cost estimates. ABA programs are generally geared towards addressing deficits in younger children and are not intended to be continued indefinitely. For this reason, we have assumed that no programs would terminate prior to school age, that a large percentage of ABA programs would terminate at ages six and seven, when an autistic child could be expected to enter elementary school, and annually thereafter a large percentage of remaining programs would terminate until only a very small percentage of children have ABA programs by the time they reach their teenage years. Programs would be expected to terminate if a child has experienced sufficient progress such that a program is no longer necessary or if the insurer or family sees no progress, as well as for other reasons.

The assumed percentage of children diagnosed with Autistic Disorder that have an ABA program by age for our “Middle” scenario is shown in the table below:

% of Diagnosed Children with Autistic Disorder with ABA	
Under 6	65.0%
6	48.8%
7	32.5%
8	21.7%
9	14.4%
10	9.6%
11	6.4%
12	4.3%
13 to 21	3.3%

ABA Program Annual Number of Hours

In developing the assumed annual ABA program hours, we discussed typical ABA programming with ABA providers, and reviewed benefit materials from one of the large self-insured employer who offers ABA benefits.¹⁶ We developed a distribution of expected hours for a child with Autistic Disorder that resulted in the annual averages shown in the following table:

¹⁵ Discussion with Dr. Eric Larsson Executive Director, Clinical Services, The Lovaas Institute for Early Intervention. Midwest Headquarters regarding ABA utilization research in Minnesota. February 2009.

¹⁶ Autism Therapy Reference - Microsoft Corporation (administered by Premera Blue Cross).

**Average Annual ABA Program Hours for
a Child with Autistic Disorder**

Ages Under 8	1,500
Ages 8 to 12	671
Ages 13 to 21	401

The general assumption is that pre-school aged children will have programs for 20 to 40 hours a week, averaging about 30 hours a week. This time will be reduced by over half by age eight, when children would be expected to be in school and the school system would be required to provide services during the school day. It would then again be reduced significantly at age 13, as the child ages and ABA programs would be expected to be less time consuming and address a smaller number of behavioral deficits.

Cost per Hour of ABA Service

In developing the costs per hour, we reviewed ABA program staffing information and ABA provider wage and overhead cost assumptions. We developed an average cost for the entire United States and then adjusted this for Hawaii, based on Bureau of Labor Statistics¹⁷ health care wage data. The resulting average cost per hour of ABA therapy in Hawaii is about \$56 for a program based on the assumption that staffing will be in line with what best practices might recommend. This is the cost underlying our “High” assumption, though we note that costs would vary based on the mix of professionals and technicians providing the services, and likely would be lower if less experienced ABA practitioners need to be employed to meet the increasing demands for services. Costs will vary, as well, depending upon the degree of care management employed by a given payer.

Range of Annual ABA Program Costs for Scenario Estimates

Given the actual cost of an ABA program could vary significantly for many reasons, we have assumed annual average program costs by scenario for a young child with Autistic Disorder being treated with an intensive ABA program as follows:

“Low” cost scenario - assumes average ABA program cost for a child under 8 is \$40,000 per year.

“Middle” cost scenario - assumes average ABA program cost for a child under 8 is \$45,000 per year.

“High” cost scenario - based on the assumptions outlined in this section for the continuance of ABA programming, 1,500 annual hours for ABA programming for a child under 8, an hourly rate of about \$56, and an annual ABA benefit limit of \$50,000, the calculated average annual cost for an ABA program for a child under 8 is \$49,829, which is close to the expected annual cap of \$50,000.

After developing cost estimates for ABA for children diagnosed with Autistic Disorder, we assumed that for children diagnosed with PDD-NOS or Asperger’s, ABA costs would be one-third of the Autistic Disorder costs. The basis for this adjustment is that children with these two diagnoses can be expected to utilize ABA programs at a significantly lower rate than those with Autistic Disorder, and have less intensive programs (i.e., programs with

¹⁷ BLS wage data. <http://www.bls.gov/guide/geography/wages.htm>. Accessed February 2012.

fewer weekly and annual therapy hours). The one-third factor applied to overall costs reflects the combination of lower utilization and fewer therapy hours.

Other (than ABA) Medical Costs

Based on several studies,¹⁸ we estimated that children with ASDs had costs covered by insurers of approximately three times the average for non-inpatient medical services under current benefit programs. It is also clear that under SB 2631 S.D.1 some services that an insurer could currently deny or exclude would now be covered. In our range of estimates, we assumed that this additional coverage would result in increased insured medical costs of 50% to 100% of the current level of estimated covered non-inpatient costs for services to all children diagnosed with an ASD, which we assumed are currently three times higher than the population costs in the absence of the benefits under SB 2631 S.D.1 for children/dependents up to age 21 diagnosed with an ASD.

The estimated annual cost for additional non-ABA services (note many non-ABA medical services are already provided to individuals with ASD) that would be covered as a result of SB 2631 S.D.1 are shown for each scenario in the table below:

Scenario	Non-ABA Costs
Low	\$2,000
Middle	\$3,000
High	\$4,000

(Amounts in 2012 dollars)

Administrative Costs

Typically, medical claim costs could be expected to be 80% to 90% of premiums, meaning 10% to 20% of premiums are available for administration, profit, or other costs, often collectively referred to as “retention.” We have estimated the incremental retention charge to be 15% of premium.

Hawaii Market Data

The MEPS survey provides average premiums, enrollees, offer rates, take-up rates, and self-insured percentages by employer size for healthcare coverage sponsored by privately insured employers. From this data we can estimate the size of the privately insured small group, insured large group, and self-insured markets. State-specific premium data for Hawaii was available for 2010,¹⁹ so we trended this data based on average recent employer premium increases provided in the Kaiser Family Foundation HRET²⁰ survey to estimate the 2012 average annual premium per member necessary to compute the cost of SB 2631 S.D.1 benefits as a percentage of annual premiums.

¹⁸ Mandell, Cao, Ittenbach, & Pinto-Martin, 2006. Croen, Najjar, Ray, Lotspeich, & Bernal, 2006. Liptak, Stuart, & Auinger, 2006.

¹⁹ MEPS state survey data. http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp?regionid=-1&year=2010. Accessed February 2012.

²⁰ Kaiser Family Foundation and Health Research Educational Trust. Employer Health Benefits- 2011 Annual Survey.

To estimate average premiums for the individual market, we reviewed the 2010 individual premium and membership experience found in the regulatory filings for health insurers in Hawaii. We calculated the average individual premium for 2010 based on these filings, and trended this amount to estimate 2012 premiums.

As part of our development of premiums and membership estimates, we completed reasonableness tests by reviewing Hawaii insurer regulatory filings to ensure that the premium estimates were not unreasonable.



Cost Estimates

Long-Term Cost Estimates - “Middle” Cost Scenario

The table below summarizes our “Middle” scenario average annual cost estimates and premium increases on a per covered person basis, and as a percentage of the annual premiums. Our “Middle” estimate is that, in the long-term, the premium increase associated with the additional benefits provided by SB 2631 S.D.1 would be about 0.38% of insured premiums across all markets. However, we expect that costs would be lower in the years immediately following the passage of SB 2631 S.D.1 based on experiences in other states that have passed legislation providing for the coverage of additional ASD benefits, lags typically seen in accessing new benefits, and the limited supply of ABA providers.

The estimated cost increases by market are shown in the table below. The annual claim cost per covered person estimate of \$12.70 and premium increase estimate of \$14.90 are in 2012 dollars.

	Market			
	Individual	Small Group	Large Group	All
Covered Persons	51,000	137,000	290,000	478,000
Average Premium per Person	\$3,000	\$4,400	\$3,900	\$3,947
Annual Claim Cost per Covered Person	\$12.70	\$12.70	\$12.70	\$12.70
Claim Cost as a Percentage of Premium	0.42%	0.29%	0.33%	0.32%
Estimated Premium Increase with Admin @ 15%	\$14.90	\$14.90	\$14.90	\$14.90
Premium Increase as a Percentage of Premium	0.50%	0.34%	0.38%	0.38%

Scenario Estimates

As discussed in Section 3, limited insurance data exists that can be used to directly estimate the costs of ABA benefits under SB 2631 S.D.1. This causes uncertainty in developing actuarial assumptions and cost estimates. Due to this uncertainty, it is useful to develop cost estimates for scenarios using optimistic and pessimistic assumptions.

Cost estimates are very sensitive to various assumptions, especially those related to ABA utilization and costs. Therefore, we varied our assumptions to develop estimated costs for ASD services under “Low,” “Middle,” and “High” cost scenarios, as shown in the table below:

Scenario	% Autistic Disorder Diagnosed Under Age 8 Starting ABA	Program Cost - Autistic Disorder Under Age 8	Avg. Annual non-ABA Cost	Premium Increase per Covered	Premium Increase (% of Premium)
Low	50.0%	\$40,000	\$2,000	\$10.10	0.26%
Middle	65.0%	\$45,000	\$3,000	\$14.90	0.38%
High	80.0%	\$49,829	\$4,000	\$20.90	0.53%

Short-Term Cost Estimates by Scenario

In addition to the uncertainty associated with long-term cost estimates, how quickly costs could reach their ultimate level is also uncertain. We have provided the table below to illustrate the potential short-term increases in premiums, and how they could grade into the long-term estimates over time.

Estimated Increase in Premiums due to Hawaii SB 2631 S.D.1						
Scenario	Year 1	Year 2	Year 3	Year 4	Year 5	Years 6 and Beyond
Low	0.09%	0.12%	0.15%	0.19%	0.22%	0.26%
Middle	0.19%	0.23%	0.26%	0.30%	0.34%	0.38%
High	0.35%	0.39%	0.42%	0.46%	0.50%	0.53%

Individual Market Comment

Completing an assessment of the potential for anti-selection to increase premium rates in the individual market under SB 2631 S.D.1 is complicated for several reasons. Notably, the recent passage of Federal health care reform legislation has guaranteed issue provisions that would impact the coverage of individuals with ASDs in the individual market. Therefore, a detailed analysis of the individual market is complicated by several matters, and is beyond the scope of this review.

8

Cost – Benefit Analysis for ASD Treatments

There have been several studies related to the efficacy of ABA treatment programs, and the costs associated with ASD treatments, care, and supports. In this section, we summarize some of these studies.

Societal Costs of Autism- Ganz Report

One of the most often cited reports explaining the financial costs of ASD is *The Lifetime Distribution of the Incremental Societal Costs of Autism* by Michael Ganz, MS, PhD which was published in 2007. This report summarized the modeled costs of a hypothetical cohort of children born in 2000 and diagnosed with autism in 2003. A study result is that the incremental societal cost of autism is \$3.2 million per capita in 2003 dollars.²¹ The report is very helpful in identifying specific costs of ASD, and in providing a framework for quantifying these costs, as well as providing actual cost estimates.

Direct Medical

- Physician and Dental
- Drugs
- Complementary and Alternative Therapies
- Behavioral Therapies
- Emergency and Hospital
- Home Health Care
- Travel

²¹ Ganz, Michael L. *The Lifetime Distribution of the Incremental Societal Costs of Autism*. Archives of Pediatrics & Adolescent Medicine. April 2007. Volume 161.

Direct Nonmedical

- Child Care
- Adult Care
- Respite Care
- Home Improvements
- Special Education
- Supported Work
- Other

Indirect

- Own Indirect- lost productivity and lower wages
- Not Own Indirect - lost productivity and lower wages of others (typically family)

Cost Savings to State and Local Governments

The Ganz study is probably the most comprehensive in terms of assessing the breadth of the financial costs associated with caring for individuals with ASD. Several other studies have attempted more limited quantifications of costs and savings to governments associated with providing early intensive behavioral interventions (EIBI) or ABA programs for young children. In summary, the studies quantify the costs of EIBI, assume success rates associated with EIBI based on efficacy studies, and then assume cost savings to educational and other government financed programs, like Medicaid, associated with these treatments.

Virginia's independent Joint Legislative Audit and Review Commission (JLARC) issued a report in August 2009: *Report of the Joint Legislative Audit and Review Commission To the Governor and The General Assembly of Virginia - Assessment of Services For Virginians With Autism Spectrum Disorders*. As part of this report, JLARC reviewed several studies related to the efficacy of EIBI, and potential cost savings to State and Local governments associated with effective EIBI treatments. The JLARC report outlines their assessment of the cost savings associated with EIBI as follows:²²

“A study published in a national journal found that Pennsylvania could save an average of \$187,000 to \$203,000 on each child who received three years of EIBI relative to one who received special education services until age 22. The Pennsylvania study also suggested that cost savings would likely continue to accrue after children exit the school system. The study found that the state could save from \$656,000 to \$1.1 million per child if expenditures up to age 55 are included. Another study published in a national journal found that Texas could save an average of \$208,500 in education costs for each student who received three years of EIBI relative to a student who received 18 years of special education from ages four to 22. Applied to the estimated 10,000 children with ASDs in Texas, it was estimated that the state could save almost \$2.1 billion by implementing intensive treatment programs.

By applying the methodology used in the Pennsylvania and Texas studies to Virginia-related data, JLARC staff estimate that the Commonwealth could save approximately \$137,400 in special education costs per student with an ASD if EIBI was consistently provided. In fact, the analysis

²² Report of the Joint Legislative Audit and Review Commission To the Governor and The General Assembly of Virginia - Assessment of Services For Virginians With Autism Spectrum Disorders, p. 15. <http://jlarc.virginia.gov/reports/Rpt388.pdf>. Accessed December 2009.

indicates that Virginia could realize savings as long as at least 42 percent of students with ASDs who received EIBI make moderate improvements (require less intensive services and fewer supports), which is a substantially more conservative outcome than the outcomes reported in the research literature.”

The actual success rates of EIBI treatments will drive the benefits derived from these treatments. Also, as noted in the JLARC report, moderate improvements in functioning could also lead to significant financial savings. The JLARC report also discusses various studies of the efficacy of EIBI, and Table 3 on page 15 of the report summarizes the findings on the efficacy of EIBI from three research studies. This table is reproduced below:

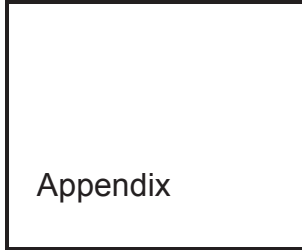
Table 3: Multiple Studies Demonstrate Children Who Receive Intensive Treatment Fare Better Than Those Who Receive Less Intensive Services

Group	Outcomes	
	Average Change in IQ Points	Educational Placement
<i>EIBI compared to less intensive public school special education (2006 study)</i>		
Treatment	+25	<ul style="list-style-type: none"> ▪ 29% in general class without supports ▪ 52% in general class with supports
Comparison	+14	<ul style="list-style-type: none"> ▪ 5% in general class
<i>EIBI compared to less intensive parent-training model (2000 study)</i>		
Treatment	+16	<ul style="list-style-type: none"> ▪ 27% in general class without supports
Comparison	-1	<ul style="list-style-type: none"> ▪ No children in general class without supports
<i>EIBI compared to less intensive treatment (1987 study)</i>		
Treatment	<ul style="list-style-type: none"> ▪ 47% achieved IQ in normal range (94-120) 	<ul style="list-style-type: none"> ▪ 47% in general class without supports ▪ 42% in less intensive special education class for language delayed ▪ 11% in intensive special education class for children with autism or intellectual disability (ID)
Comparison	<ul style="list-style-type: none"> ▪ 2% achieved IQ in normal range 	<ul style="list-style-type: none"> ▪ 2% in general class without supports ▪ 45% in less intensive special education class for language delayed ▪ 53% in intensive special education class for children with autism or ID

Note: A more detailed table on the results of these studies can be found in Appendix C.

While a complete cost-benefit analysis is beyond the scope of this review, under the assumption that the costs of ASD services and efficacy of EIBI are in line with those indicated in the studies noted, the costs of ABA treatments covered under SB 2631 S.D.1 could be recovered through reductions in educational and medical expenditures, alone.

There would also be expected benefits associated with successful treatments in the areas noted in the beginning of this section through reducing other costs of care and improving the productivity of individuals with ASD and their caregivers, in addition to non-economic or quality of life benefits.



Cost Assumptions – Illustrative Exhibits

Exhibit II - Treated Prevalence by Age

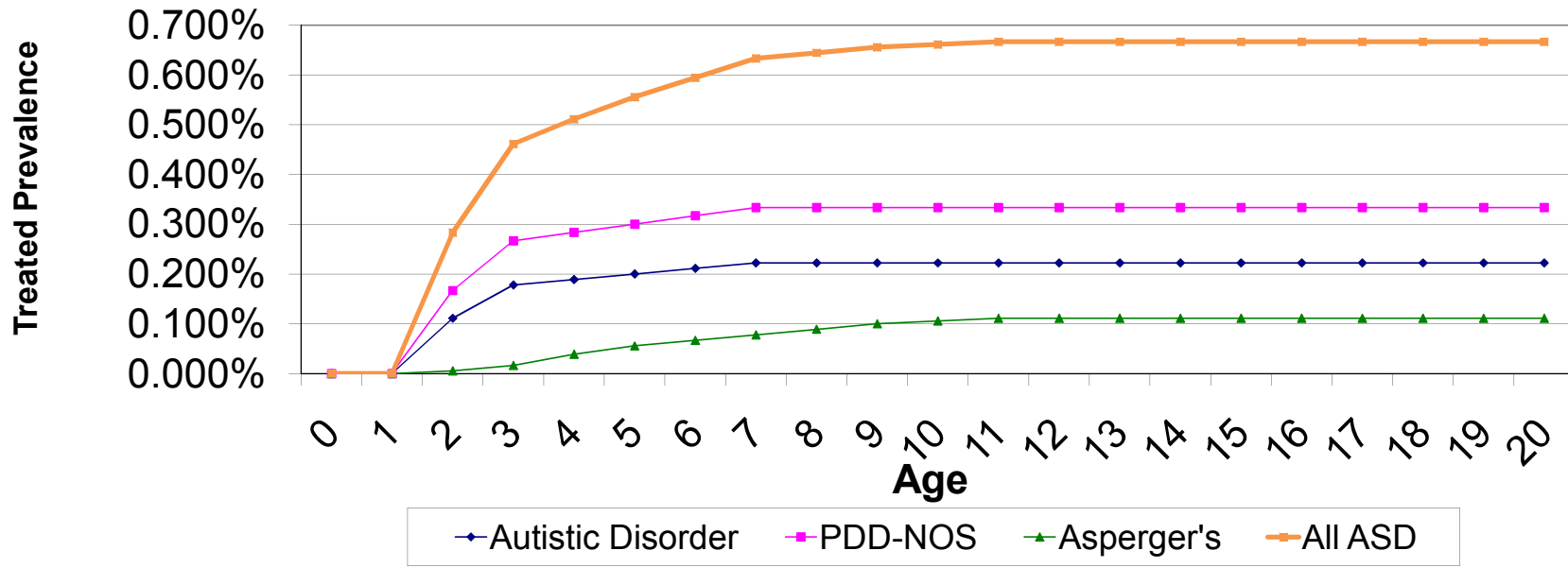


Exhibit III - Annual Cost Per Diagnosed/Treated Child

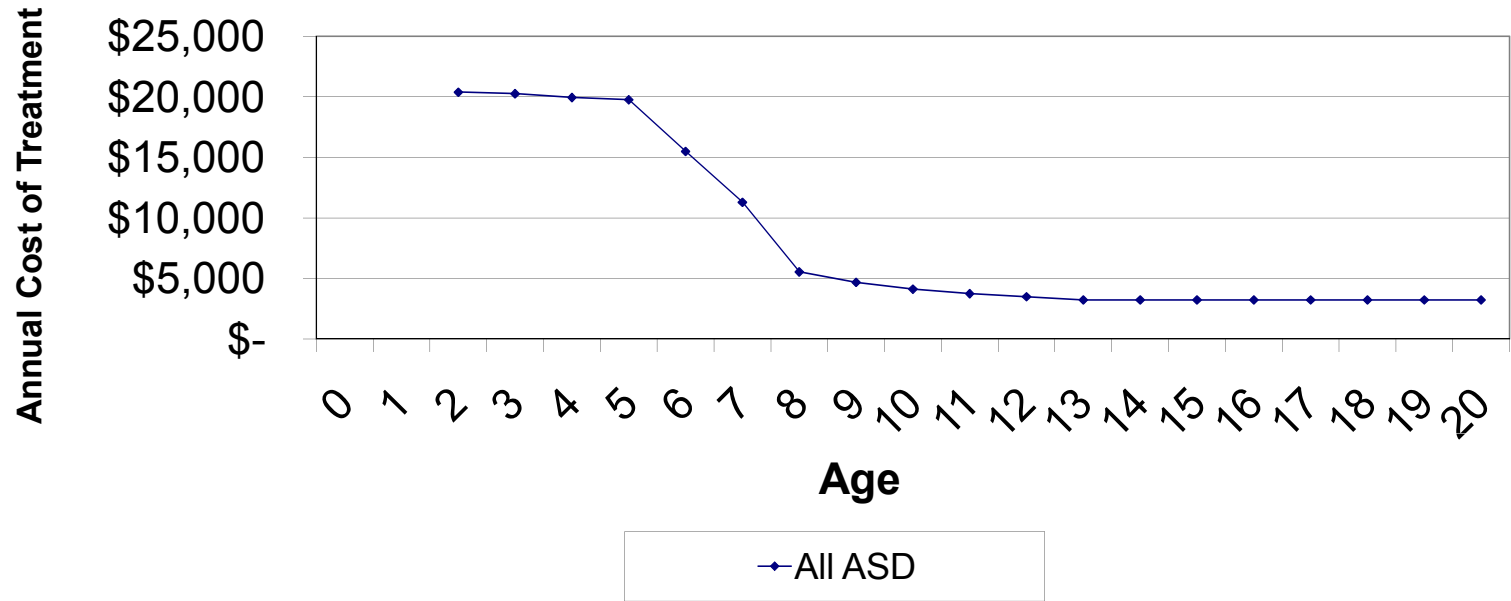


Exhibit IV - Annual Cost Per Autistic Child (Includes both Diagnosed and Undiagnosed Children)

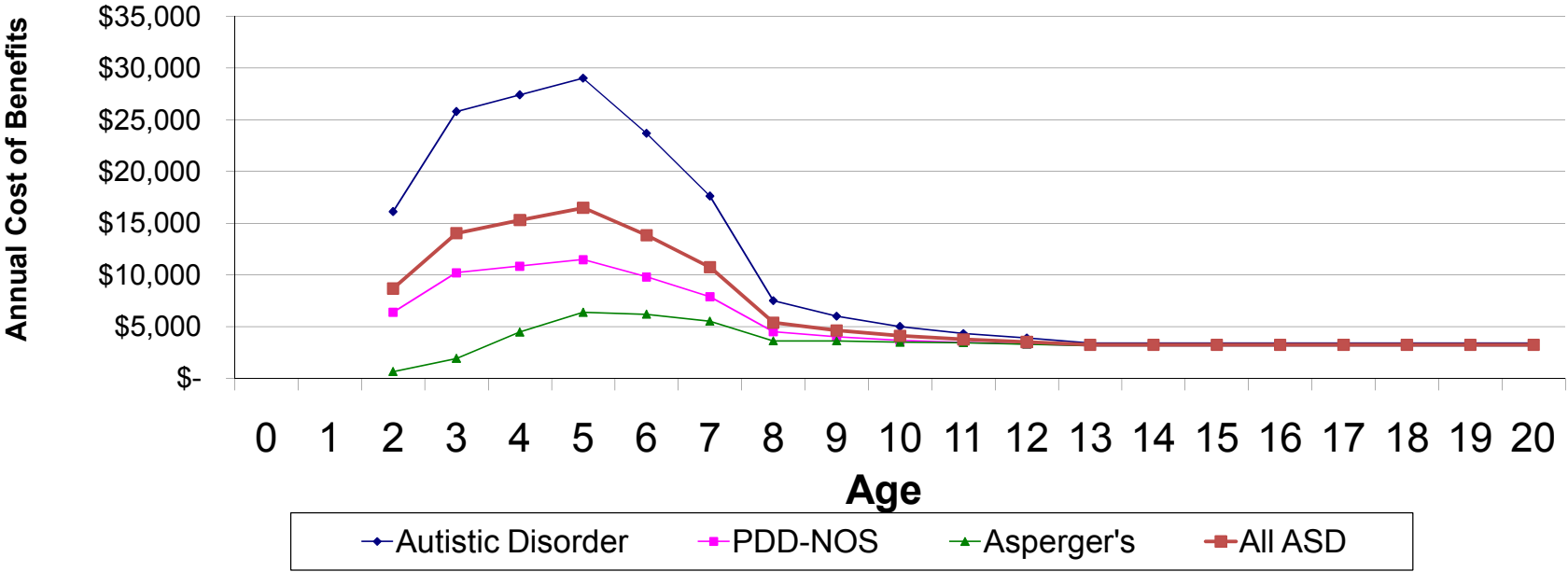


Exhibit V - ABA Utilization vs. Treated Prevalence

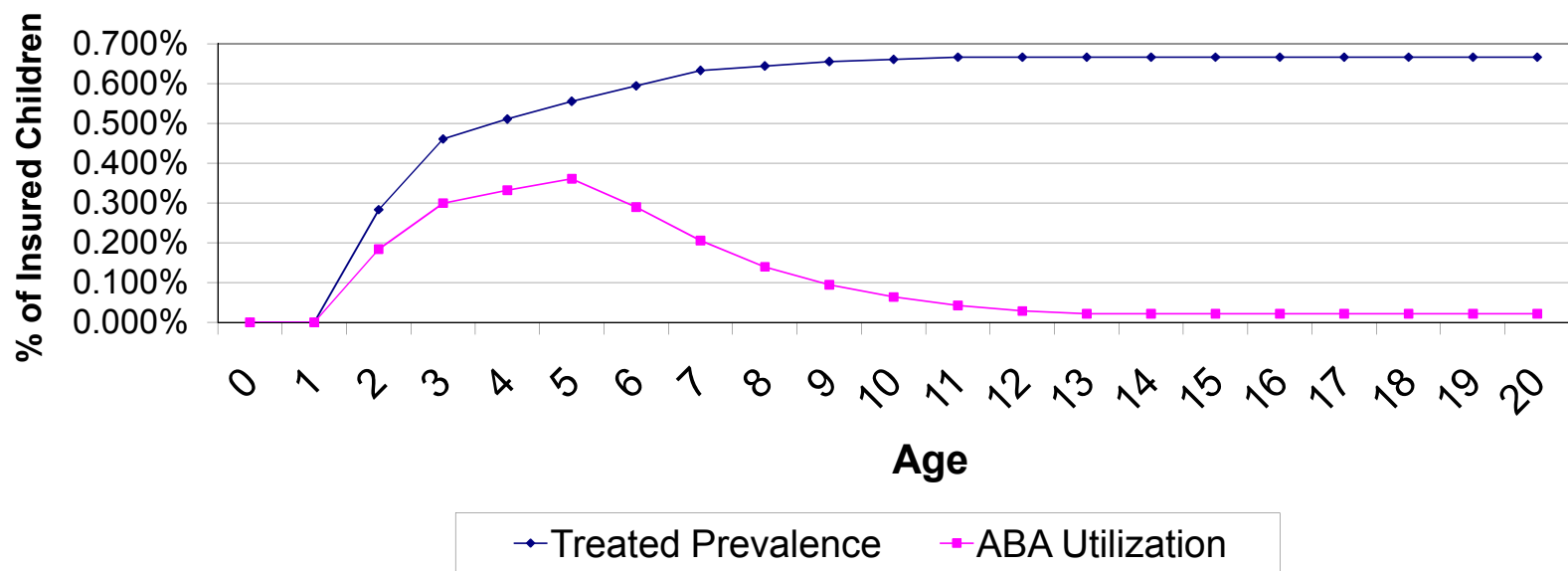
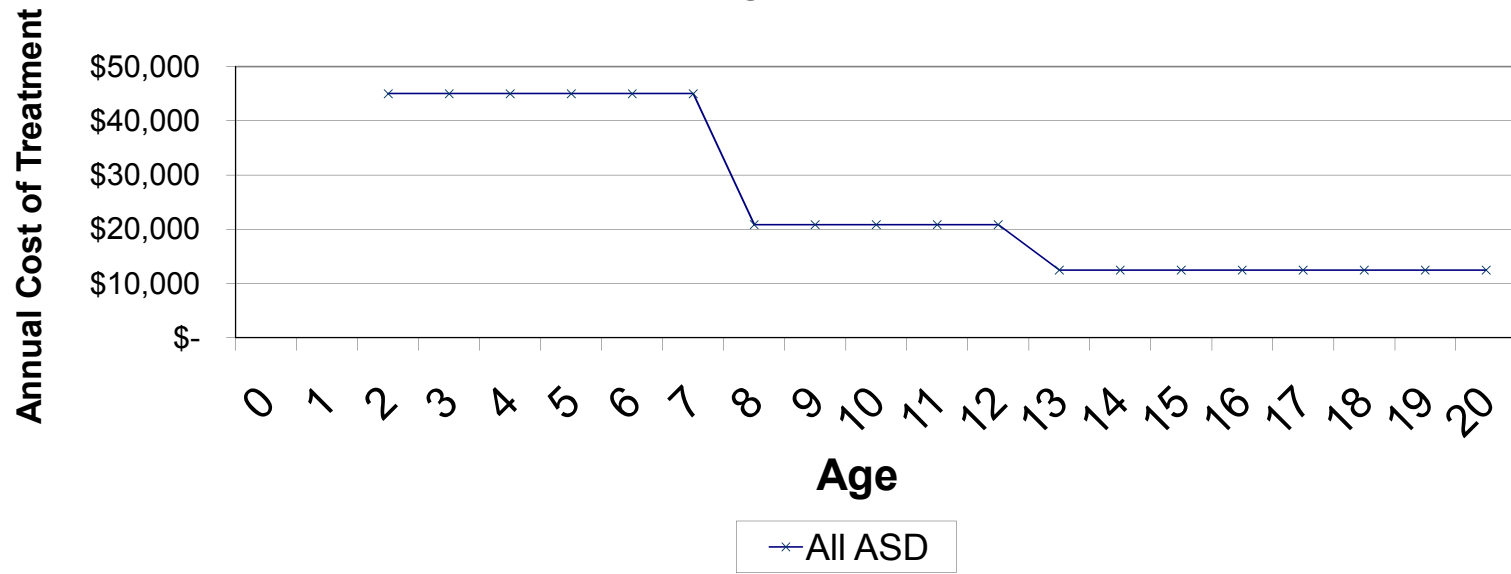


Exhibit VI - Annual Cost of ABA Program per Child with Autistic Disorder



Analysis of the Fiscal Impact of Autism Insurance Reform

The Fiscal Impact of Autism Insurance Reform

Recognizing the importance of early intervention for Autism Spectrum Disorders (ASD), 29 states have enacted autism insurance reform laws. Each of these states require that health insurance cover medically necessary treatment for ASD including behavioral health treatments such as Applied Behavior Analysis (ABA).

In order to determine the fiscal impact of autism insurance reform, Autism Speaks is collecting claims data from states where such laws apply to members of the state employee health plan and have been in effect for at least one year.

Interpretive Summary

1. Autism insurance reform laws have been in effect for at least one year in 15 states. Thirteen of these states require coverage for members of their state employee health plan. The terms of coverage vary and are detailed in Appendix 1.
2. Claims data has been requested from all 13 states. Data has been received from 7 states and is presented in Appendix 2.
3. Claims data is available from the first year of implementation in 6 states (i.e., TX, SC, IL, FL, AZ and KY). The first year costs of coverage range from \$0.05 per member per month (PMPM) to \$0.30 PMPM. The average first year cost of coverage is \$0.14 PMPM. (Table 1)
4. Claims data is available from the second year of implementation in 6 states (i.e., TX, SC, IL, LA, FL and AZ). The second year costs of coverage range from \$0.07 PMPM to \$0.43 PMPM. The average second year cost of coverage is \$0.27 PMPM. (Table 2)
5. Texas is the only state where third year claims data is available. The third year cost of coverage was \$0.06 PMPM. It is important to note that the third year total claims cost as well as PMPM cost are less than those in the second year of coverage. Claims costs would be expected to plateau as a newly implemented benefit matures.
6. Minnesota has not enacted autism insurance reform. However as a result of a settlement of litigation against Blue Cross and Blue Shield of Minnesota, they have been required to cover unlimited treatment for ASD since 2001. After 6 years, the premium impact on the commercial market resulting from unlimited coverage for ASD was \$0.83 PMPM. (BCBS Minnesota)
7. Fiscal notes were prepared for the legislatures in 6 of the states where we have been able to obtain claims data. These cost projections were prepared for fiscal or calendar years that correspond to available claims data in 4 states. Fiscal projections overestimated the actual cost of autism insurance reform by 219% to 1,261%. (Table 3)

Table 1. Year One Costs

	Year of coverage	Number of Covered Lives	Total Claims	PMPM cost
Texas	1	460,510	\$295,379	\$0.05
South Carolina	1	371,384	\$856,369	\$0.19
Illinois	1	171,979	\$187,684	\$0.09
Florida	1	382,083	\$390,724	\$0.09
Arizona	1	130,000	\$473,818	\$0.30
Kentucky	1	240,000	\$278,922	\$0.10
Average first year cost				\$0.14

Table 2. Year Two Costs

	Year of coverage	Number of Covered Lives	Total Claims	PMPM cost
Texas	2	499,993	\$405,762	\$0.07
South Carolina	2	397,757	\$2,042,394	\$0.43
Illinois	2	170,790	\$197,290	\$0.10
Louisiana	2	149,477	\$722,828	\$0.40
Florida	2	386,203	\$1,748,849	\$0.38
Arizona	2	130,000	\$388,662	\$0.25
Average second year cost				\$0.27

Table 3. Projected versus Actual Costs

	Year of coverage	Total Claims	Fiscal Note from State Legislature	Difference in projected versus actual cost
Texas	2	\$405,762	\$888,676	219%
South Carolina	1	\$856,369	\$10,590,000	1,237%
	2	\$2,042,394	\$10,590,000	519%
Louisiana	2	\$722,828	\$2,118,307	293%
	2	\$722,828	\$2,686,796	372%
Arizona	1	\$473,818	\$2,500,000	528%
	1	\$473,818	\$4,900,000	1,034%
	2	\$388,662	\$2,500,000	643%
	2	\$388,662	\$4,900,000	1,261%

Appendix 1. Terms of Coverage

	Bill Number	Statute	Date Enacted	Date Implemented	Terms of Coverage	Applicable to SEHP?
Indiana	HB 1122	Indiana Code 27-8-14.2	5/3/01	5/3/01	unlimited	YES
Texas	HB 1919		6/15/07	1/1/08	unlimited age 0-6	YES
	HB 451		6/19/09	1/1/10	unlimited age 0-10	YES
South Carolina	S 20		6/7/07	7/1/08	\$50,000* age 0-16	YES
Illinois	SB 934	Public Law 095-1005	12/13/08	12/12/08	\$36,000/yr age 0-21	YES
Louisiana	HB 958	Act 648	7/2/08	1/1/09	\$36,000/yr age 0-17	YES
Florida	SB 2654	Florida Statute s. 627.6686	5/2/08	4/1/09	\$36,000/yr age 0-19	YES
New Mexico	SB 39		4/2/09	6/19/09	\$36,000/yr age 0-21	NO
Arizona	SB 1263	A.R.S. § 20-181 A.R.S. § 20-182	3/21/08	7/1/09	\$50,000/yr* age 0-8 \$25,000/yr* age 9-16	YES
Pennsylvania	HB 1150		7/9/08	7/1/09	\$36,000/yr age 0-21	YES
Wisconsin	AB 75	sec. 3197 w. on page 596 of Act 28	10/19/09	11/1/09	\$50,000 for 4 yrs; \$25,000 thereafter	YES
Connecticut	SB 301	Public Act 09-115	6/9/09	1/1/10	\$50,000/yr* age 0-9 \$35,000/yr* age 9-12 \$25,000/yr* age 13-14	YES
Montana	SB 234		5/5/09	1/1/10	\$50,000/yr age 0-8 \$20,000/yr age 9-18	YES
New Jersey	S 1651		8/13/09	2/9/10	\$36,000/yr* age 0-21	YES
Kentucky	HB 159		4/14/10	5/14/10	\$50,000/yr age 0-7 \$1,000/mo age 7-21	YES
Colorado	SB 09-244	C.R.S. 10-16-104	6/2/09	7/1/10	\$34,000/yr* age 0-8 \$12,000/yr* age 9-19	NO

Appendix 2. Claims Data

	Date Implemented	Terms of Coverage	Date of Claims Data	Year	Number of Covered Lives	Total Claimants with ASD Diagnosis	Total Claims	PMPM cost	Source	Fiscal Note from State Legislature
Texas	1/1/08	unlimited age 0-10	Sep 08-Aug 09	1	460,510	350	\$295,379	\$0.05	Employee Retirement System of Texas	\$888,676 (FY 09) Texas Legislative Budget Board
			Sep 09-Aug 10	2	499,993	396	\$405,762	\$0.07		
			Sep 10-Aug 11	3	504,639	419	\$350,736	\$0.06		
South Carolina	7/1/08	\$50,000* age 0-16	CY 2009	1	371,384	60	\$856,369	\$0.19	APS Healthcare	\$10,590,000 per year South Carolina Budget and Control Board
			CY 2010	2	397,757	80	\$2,042,394	\$0.43		
Illinois	12/12/08	\$36,000/yr age 0-21	CY 2009	1	171,979	2,420 (?)	\$187,684	\$0.09	Illinois Department of Healthcare and Family Services	NA
			CY 2010	2	170,790	3,314 (?)	\$197,290	\$0.10		
Louisiana	1/1/09	\$36,000/yr age 0-17	CY 2009	1	NA	NA	NA	NA	Louisiana Office of Group Benefits	\$2,118,307 - \$2,686,796 (FY 10-11) Louisiana Legislative Fiscal Office
			CY 2010	2	149,477	386	\$722,828	\$0.40		
Florida	4/1/09	\$36,000/yr age 0-19	07/01/2009 - 06/30/2010	1	382,083	372	\$390,724	\$0.09	Florida Department of Management Services	"difficult to assess" The Professional Staff of the Florida Banking and Insurance Committee
			07/01/2010 - 06/30/2011	2	386,203	511	\$1,748,849	\$0.38		
Arizona	7/1/09	\$50,000/yr* age 0-8	07/01/2009 - 06/30/2010	1	130,000	257	\$473,818	\$0.30	Arizona Department of Administration	\$2.5 - \$4.9 million (FY 2010) Jorgensen/Zylla for Arizona Legislature
		\$25,000/yr* age 9-16	07/01/2010 - 06/30/2011	2	130,000	187	\$388,662	\$0.25		
Kentucky	5/14/10	\$50,000/yr age 0-7 \$1,000/mo age 7-21	May 2010 - April 2011	1	240,000	NA	\$278,922	\$0.10	Kentucky Department of Employee Insurance	\$4,000,000 (FY 2012) Kentucky Legislative Research Commission

* monetary cap applies only to Applied Behavior Analysis

Senate Bill 2631 S.D.1 Text

THE SENATE
TWENTY-SIXTH LEGISLATURE, 2012
STATE OF HAWAII

S.B. NO. 2631
S.D. 1

A BILL FOR AN ACT

RELATING TO HEALTH INSURANCE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The purpose of this Act is to ensure the provision of quality health care procedures for all Hawaii residents by requiring coverage of and treatment for autism spectrum disorders by all accident and health or sickness insurers, mutual benefit societies, and health maintenance organizations.

SECTION 2. Chapter 431, Hawaii Revised Statutes, is amended by adding a new section to article 10A to be appropriately designated and to read as follows:

"§431:10A- Autism spectrum disorders benefits and coverage; notice; definitions. (a) Any other law to the contrary notwithstanding, all accident and health or sickness insurance policies issued or renewed in this State after December 31, 2012, shall provide to the policyholder and individuals under twenty-six years of age covered under the policy, coverage for the well-baby and well-child screening and the diagnosis and treatment of autism spectrum disorders.

(b) Every accident and health or sickness insurer shall provide written notice to its members regarding the coverage required by this section. The notice shall be in writing and prominently positioned in any literature or correspondence sent to members and shall be

transmitted to members within calendar year 2013 when annual information is made available to members or in any other mailing to members, but in no case later than December 31, 2013.

(c) Minimum benefits for behavioral health treatment provided under this section may be limited to \$50,000 per year, or \$300,000 during the lifetime of the individual, but shall not be subject to any limits on the number of visits an individual may make for treatment of autism spectrum disorder. After December 31, 2015, the insurance commissioner, on an annual basis, shall adjust the maximum benefit for inflation using the medical care component of the United States Department of Labor Consumer Price Index for all urban consumers. The commissioner shall publish the adjusted maximum benefit annually no later than April 1 of each calendar year, which shall apply during the following calendar year to health insurance policies subject to this section. Payments made by an insurer on behalf of a covered individual for any care, treatment, intervention, or service other than behavioral health treatment shall not be applied toward any minimum benefit established under this subsection.

(d) Coverage under this section may be subject to copayment, deductible, and coinsurance provisions of an accident and health or sickness insurance policy that are no less favorable than the copayment, deductible, and coinsurance provisions for other medical services covered by the policy.

(e) This section shall not be construed as limiting benefits that are otherwise available to an individual under an accident and health or sickness insurance policy.

(f) Coverage for treatment under this section shall not be denied on the basis that the treatment is habilitative or non-

restorative in nature.

(g) Except for inpatient services, if an individual is receiving treatment for autism spectrum disorders, an insurer may request a review of that treatment not more than once every twelve months. The cost of obtaining any review shall be borne by the insurer.

(h) Coverage is required for applied behavior analysis services only when provided or supervised by a board-certified behavior analyst or by a licensed psychologist, so long as the services performed are commensurate with the psychologist's formal university training and supervised experience. Reimbursement to the board-certified behavior analyst or licensed psychologist for applied behavior analysis services shall include reimbursement for the therapists working under the supervision of the board-certified behavior analyst or licensed psychologist.

(i) This section shall not be construed as reducing any obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan.

(j) As of January 1, 2014, to the extent that this section requires benefits that exceed the essential health benefits specified under section 1302(b) of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), the specific benefits that exceed the specified essential health benefits shall not be required of a qualified health plan when the plan is offered in this State through the Hawaii health connector by a health carrier. Nothing in this subsection shall nullify the application of this section to plans offered outside the Hawaii health connector.

(k) For the purposes of this section, unless the context clearly requires otherwise:

"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.

"Autism spectrum disorders" means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder, pervasive developmental disorder not otherwise specified, Rett's disorder, and childhood disintegrative disorder.

"Behavioral health treatment" means professional counseling and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

"Diagnosis of autism spectrum disorders" means medically necessary assessments, evaluations, or tests conducted to diagnose whether an individual has an autism spectrum disorder.

"Pharmacy care" means medications prescribed by a licensed physician or registered nurse practitioner and any health-related services that are deemed medically necessary to determine the need or effectiveness of the medications.

"Psychiatric care" means direct or consultative services provided by a licensed psychiatrist.

"Psychological care" means direct or consultative services

provided by a licensed psychologist.

"Therapeutic care" means services provided by licensed speech pathologists, registered occupational therapists, or licensed physical therapists.

"Treatment for autism spectrum disorders" includes the following care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, or registered nurse practitioner if the care is determined to be medically necessary:

- (1) Behavioral health treatment;
- (2) Pharmacy care;
- (3) Psychiatric care;
- (4) Psychological care; and
- (5) Therapeutic care."

SECTION 3. Chapter 432, Hawaii Revised Statutes, is amended by adding a new section to article I to be appropriately designated and to read as follows:

"§432:1- Autism spectrum disorders benefits and coverage; notice; definitions. (a) Any other law to the contrary notwithstanding, each individual and group hospital or medical service plan, policy, contract, or agreement issued or renewed in this State after December 31, 2012, shall provide to the member and individuals under twenty-six years of age covered under the service plan, policy, contract, or agreement, coverage for the well-baby and well-child screening and the diagnosis and treatment of autism spectrum disorders.

(b) Every individual and group hospital or medical service plan, policy, contract, or agreement shall provide written notice to

its members regarding the coverage required by this section. The notice shall be in writing and prominently positioned in any literature or correspondence sent to members and shall be transmitted to members within calendar year 2013 when annual information is made available to members or in any other mailing to members, but in no case later than December 31, 2013.

(c) Minimum benefits for behavioral health treatment provided under this section may be limited to \$50,000 per year, or \$300,000 during the lifetime of an individual, but shall not be subject to any limits on the number of visits an individual may make for treatment of autism spectrum disorder. After December 31, 2015, the insurance commissioner, on an annual basis, shall adjust the maximum benefit for inflation, using the medical care component of the United States Department of Labor Consumer Price Index for all urban consumers. The commissioner shall publish the adjusted maximum benefit annually no later than April 1 of each calendar year, which shall apply during the following calendar year to health insurance policies subject to this section. Payments made by an individual and group hospital or medical service plan, policy, contract, or agreement on behalf of a covered individual for any care, treatment, intervention, service, or item other than behavioral health treatment shall not be applied toward any minimum benefit established under this subsection.

(d) Coverage under this section shall be subject to copayment, deductible, and coinsurance provisions of an individual or group hospital or medical service plan, policy, contract, or agreement to the extent that other medical services covered by the plan, policy, contract, or agreement are subject to these provisions.

(e) This section shall not be construed as limiting benefits

that are otherwise available to an individual under an individual or group hospital or medical service plan, policy, contract, or agreement health insurance policy.

(f) Coverage for treatment under this section shall not be denied on the basis that the treatment is habilitative or non-restorative in nature.

(g) Except for inpatient services, if an individual is receiving treatment for an autism spectrum disorder, an insurer may request a review of that treatment not more than once every twelve months. The cost of obtaining any review shall be borne by the insurer.

(h) Coverage is required for applied behavior analysis services only when provided or supervised by a board-certified behavior analyst or by a licensed psychologist so long as the services performed are commensurate with the psychologist's formal university training and supervised experience. Reimbursement to the board-certified behavior analyst or licensed psychologist for applied behavior analysis services must include reimbursement for the therapists working under the supervision of the board-certified behavior analyst or licensed psychologist.

(i) This section shall not be construed as reducing any obligation to provide services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan.

(j) For the purposes of this section, unless the context clearly requires otherwise:

"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 relations between environment and behavior.

"Autism spectrum disorders" means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder, pervasive developmental disorder not otherwise specified, Rett's disorder, and childhood disintegrative disorder.

"Behavioral health treatment" means professional counseling and treatment programs, including applied behavior analysis, that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

"Diagnosis of autism spectrum disorders" means medically necessary assessments, evaluations, or tests conducted to diagnose whether an individual has an autism spectrum disorder.

"Pharmacy care" means medications prescribed by a licensed physician or registered nurse practitioner and any health-related services that are deemed medically necessary to determine the need or effectiveness of the medications.

"Psychiatric care" means direct or consultative services provided by a licensed psychiatrist.

"Psychological care" means direct or consultative services provided by a licensed psychologist.

"Therapeutic care" means services provided by licensed speech pathologists, registered occupational therapists, or licensed physical therapists.

"Treatment for autism spectrum disorders" includes the following care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, or registered nurse practitioner if the care is determined to be medically necessary:

- (1) Behavioral health treatment;
- (2) Pharmacy care;
- (3) Psychiatric care;
- (4) Psychological care; and
- (5) Therapeutic care."

SECTION 4. Section 432D-23, Hawaii Revised Statutes, is amended to read as follows:

"§432D-23 Required provisions and benefits. Notwithstanding any provision of law to the contrary, each policy, contract, plan, or agreement issued in the State after January 1, 1995, by health maintenance organizations pursuant to this chapter, shall include benefits provided in sections 431:10-212, 431:10A-115, 431:10A-115.5, 431:10A-116, 431:10A-116.5, 431:10A-116.6, 431:10A-119, 431:10A-120, 431:10A-121, 431:10A-125, 431:10A-126, [~~and~~] 431:10A-122, and 431:10A-____, and chapter 431M."

SECTION 5. The coverage and benefits to be provided by a health maintenance organization under section 4 of this Act shall begin for all policies, contracts, plans, or agreements issued in this State by a health maintenance organization after December 31, 2012.

SECTION 6. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 7. This Act shall take effect upon its approval.

Report Title:

Mandatory Health Coverage; Autism Spectrum Disorders; Behavioral Health

Description:

Requires all accident and health or sickness insurers, mutual benefit societies, and health maintenance organizations to provide health care coverage and benefits for well-baby and well-child screening and diagnosis and treatment of autism spectrum disorders beginning after 12/31/2012. (SD1)

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.

OLIVER WYMAN

Two Logan Square, 22nd Floor
Philadelphia, PA 19103-2797
1 215 246 1000



COMMUNITY CHILDREN'S COUNCIL OF HAWAII
1177 Alakea Street • B-100 • Honolulu • HI • 96813
TEL: (808) 586-5363 • TOLL FREE: 1-800-437-8641 • FAX: (808) 586-5366

March 8, 2013

Representative McKelvey
Chair of the Commerce Consumer Protection and Commerce – State Capitol

RE: SB 668 SD2 – RELATING TO HEALTH
Mandatory Health Coverage; Autism Spectrum Disorders

Dear Chair McKelvey, Vice-Chair Kawakami and Members of the Committee,

The Community Children's Councils (CCC's) **strongly supports** the testimony of The Autism Society of Hawaii (ASH) and the Special Education Advisory Council (SEAC) in regards to SB 668 SD2, which proposes coverage for the diagnosis and treatment of autism spectrum disorders for individuals under the age of twenty-six years and treatment of an autism spectrum disorder through speech therapy, occupational therapy, and physical therapy, and applied behavior analysis.

The CCC's **strongly suggests** the inclusion of:

- 1) Mandated developmental screenings for all children at their well-baby and well-child check-ups
- 2) The 17 CCCs recommend the licensure or accreditation of ABA providers and licensed "clinical psychologist" be considered in the implementing rule, bill or the act, as presently there are no licensure procedures in the state.
- 3) The inclusion of specific "evidenced based treatments" should also be included.

The CCCs have maintained that *all* children benefit from early intervention and this is especially true in the case with children who have been touched with autism. Research has repeatedly shown that with early intervention the rates of children who are able to mainstream into Kindergarten are much higher than those who did not receive services. The Academy of Pediatric recommends diagnostic tools that can be used to diagnose children early to receive early intervention.

The 17 CCCs are community-based bodies comprised of parents, professionals in both public and private agencies and other interested persons who are concerned with specialized services provided to Hawaii's students. Membership is diverse, voluntary and advisory in nature. The CCCs are in rural and urban communities organized around the Complexes in the Department of Education.

Should you have any questions or need additional information, please contact the Community Children's Council Office (CCCO) at 586-5363.

Thank you for considering our testimony,
Tom Smith, Co-Chair

Jessica Wong-Sumida, Co-Chair

(Original signatures are on file with the CCCO)

HAWAII DISABILITY RIGHTS CENTER

1132 Bishop Street, Suite 2102, Honolulu, Hawaii 96813

Phone/TTY: (808) 949-2922 Toll Free: 1-800-882-1057 Fax: (808) 949-2928

E-mail: info@hawaiidisabilityrights.org Website: www.hawaiidisabilityrights.org

THE HOUSE OF REPRESENTATIVES THE TWENTY-SEVENTH LEGISLATURE REGULAR SESSION OF 2013

Committee on Consumer Protection and Commerce Testimony in Support of S.B. 668, SD2 Relating to Health

**Monday, March 11, 2013, 2:00 P.M.
Conference Room 325**

Chair McKelvey and Members of the Committee:

The Hawaii Disability Rights Center, testifies in strong support of this bill.

The purpose of the bill is to require health insurance plans to provide coverage for autism spectrum disorders. This is a very important bill and this coverage is very appropriate for insurance policies. The whole point of insurance is to spread risk and cost among an entire population, so that disproportionate, catastrophic expenses are not heaped upon specific individuals or groups.

With that in mind, we need to realize that autism is occurring among children in epidemic proportions. According to current statistics, **one out of 110 children (1 out of 85 boys) are born with autism**. That is a staggering, alarming figure, as is the cost to those families and to society to care for these individuals over the course of their lives. **It is estimated that the cost of caring for a single individual with autism for a lifetime is \$3 million.** Evidence suggests that techniques such as applied behavioral analysis have been effective in mitigating or reducing or eliminating the effects of autism if used at an early age. While the treatments may seem costly in the short run, hundreds of thousands of dollars, if not millions, are saved over the course of a lifetime by the early utilization of treatments.

Further, while some services are supposed to be provided via the DOE under the Individuals With Disabilities Education Act, in reality, the DOE has done a very poor job



of either educating or providing needed services to children with autism. Therefore, other means of providing coverage and services need to be addressed. Inasmuch as autism is unfortunately becoming common and the costs are so high, insurance coverage is appropriate as a mechanism to spread the risk and cost amongst all of us. We note that **approximately half the states in the country currently mandate some insurance coverage for autism**. Therefore, this would seem to be an approach to addressing this problem which has received broad support.

Thank you for the opportunity to testify in support of this measure.



**Testimony to the House Committee on Consumer Protection and Commerce
Monday, March 11, 2013 at 2:00 P.M.
Conference Room 325, State Capitol**

RE: SB 668, SD2 – Relating to Health

Chair McKelvey, Vice Chair Kawakami, and Members of the Committee:

The Chamber of Commerce of Hawaii ("The Chamber") **does not support** SB 668, SD2 – Relating to Health in mandating these benefits at this time. We believe further study is required.

The Chamber is the largest business organization in Hawaii, representing over 1000 businesses. Approximately 80% of our members are small businesses with less than 20 employees. As the "Voice of Business" in Hawaii, the organization works on behalf of members and the entire business community to improve the state's economic climate and to foster positive action on issues of common concern.

We appreciate the intent of the bill to address autism spectrum disorders. However, the Chamber has several concerns with the bill.

- The findings of the 2009 Auditor's report on similar legislation stated concerns on the enactment of a mandated benefit.
- Presently these services are already being offered by the Departments of Education and Health.
- The projected cost could be at least \$70 million per year if not more for private sector companies.

We strongly urge this committee to implement the recommendations of the Legislative Reference Bureau study requested by HCR 177, HD2, SD1 in 2012; specifically, the recommendation to commission an independent actuarial analysis which will help project the cost of this mandated benefit. Also, we suggest that the affected agencies conduct an analysis as to what would be the additional cost per this mandate. Based on testimony from government agencies it could cost the state and county governments at least an additional \$80 million per year.

Ninety percent of the cost of an employee's health care premium is paid for by the employer. Adding another mandate could lead to exponential increases to a level that is unsustainable for some businesses. Please keep in mind that this will be in addition to the already annual increase in health care premiums of 7-10% each year. Most employers would be unable to pass this new cost onto the consumer.

Therefore, while we appreciate and understand the intent of this bill, we respectfully ask that the Legislature further study this issue to determine the overall impact this mandate will have on cost and other factors. Thank you for the opportunity to testify.

TESTIMONY FOR SB668

Dr. William Bolman, M.D., Child Psychiatrist, Professor of Child Psychiatry UH
(retired)

I am testifying on the basis of my experience with treating children with autism for the past 25 years.

1) 20-25 years ago, before this autism epidemic, I saw 2 preschool children with autism. One was fortunate and got ABA treatment, the kind SB668 describes. The other lived in Hauula and was unable to get these services. NOW, 25 years later the child who got treatment is a young adult who graduated high school and college, has a job, and pays taxes. The other never even finished the 6th grade and he lives in a residential center where he will cost the state support for the next 50 years.

2) In preparation for these SB668 hearings i counted the number of children with autism I have seen. The number is 568. Some of these children got good services because their parents could afford treatment despite lack of insurance coverage. However the majority have gotten little or none, and will impose a huge care burden on the State of Hawaii. SB 668 is the first step the legislature can take to reduce these costs.

Thank You.

Jerry Bump
3248 Lamaloa Place
Honolulu, HI 96816

March 8, 2013

House Committee on Consumer Protection and Commerce

Hearing: March 11, 2013, 2:00 p.m., Conference Room 325

Re: Testimony in Strong Support of SB 668, SD2 – Relating to Health

Dear Chair McKelvey, Vice Chair Kawakami and Members of the Committee,

Aloha and thank you for the opportunity to submit testimony in favor of SB 668, SD2.

I am writing to you as a parent who is raising a child with an Autism Spectrum Disorder (ASD). We cannot afford to provide him the necessary treatment he needs. If SB 668, SD2 is passed, it will greatly improve my sons' chance at an independent and productive life.

Currently, a majority of states specifically require insurers to provide coverage for the treatment of autism. Year after year, study after study, the Hawaii Legislature passes on making real change in our keiki's lives. Let this be the year Hawaii stops the discrimination and requires health insurers' to provide the necessary treatment.

Please do the right thing for my child and the rest of Hawaii's keiki and pass SB 668, SD2.

Mahalo,
Jerry Bump

Senate Committee on Health and Committee on Commerce and Consumer Protection

SB 668 Relating to Health

Chair Green and Members of the Committee and Chair Baker and Members of the Committee:

Thank you for the opportunity to testify on SB 668. My name is Brandon Letoto and I am in strong support of this measure.

My wife Lori and I are the proud parents of five year old twin boys, Luke and Troy. Our son Luke was diagnosed with Autism Spectrum Disorder PDD-NOS around the age of 2. Since then, we have been to many Doctors visits and therapy sessions. Many of which are not covered by medical insurance.

Our son Luke is considered nonverbal and we send him to weekly speech therapy services at O'ahu Speech Therapy. Our families out of pocket cost for this is \$100 an hour. Additionally, Luke takes daily supplements which add another \$100 to our monthly bills. We also have our son on a special gluten free, casein free diet. The cost of this special diet is another cost that many families with autistic children face.

We are in the process of seeking Biomedical Treatment from other physicians here locally. These services include prescription drugs and other treatments that could possibly help our son. Biomedical Physicians are very expensive and will put another financial burden on our family.

I believe that passing this bill will increase Luke's chances of thriving by allowing him to receive more therapy and treatments that could help him to "recover" from his autism diagnosis. Like every parent, they have dreams for their child. My dream for Luke is that one day he will not only be able to function independently but also be a contributing member of society. There are thousands of children who have been diagnosed with autism in Hawai'i and the statistics are showing that this number is on the rise. With your help these children can be given the opportunities that they deserve.

Having a child with autism is very challenging and the cost of medical care and therapies is just one of the many hurdles that families must overcome. Currently 32 other states have Autism Reform for Health care and Hawai'i and its effected children are long overdue for some relief. By passing this bill, you will help ease some of the very real financial struggles that these children and their families face.

Thank you for your time and consideration,
Brandon M. Letoto
45-501 Apapane St.
Kaneohe, HI 96744

kawakami2 - Rise

From: mailinglist@capitol.hawaii.gov
Sent: Friday, March 08, 2013 7:43 PM
To: CPCtestimony
Cc: mariono@hawaii.edu
Subject: Submitted testimony for SB668 on Mar 11, 2013 14:00PM

SB668

Submitted on: 3/8/2013

Testimony for CPC on Mar 11, 2013 14:00PM in Conference Room 325

Submitted By	Organization	Testifier Position	Present at Hearing
Mari Ono	Individual	Comments Only	No

Comments: So that families may have the greatest access to the highest number of qualified and experienced professionals I respectfully submit that licensed clinical social workers (LCSWs) be included in the list of licensed professionals able to prescribe, provide or order treatment for autism spectrum disorders (page 6, lines 18-22). In Hawai'i and across the nation, LCSWs are equally recognized and competent to provide assessment, diagnosis and treatment of disorders listed in the Diagnostic and Statistical Manual of Mental Disorders. Parents deserve the right to choose from the widest array of licensed, experienced and qualified professionals. Autism is a complex multi-faceted disorder and requires a trans-disciplinary multi-faceted treatment approach. I am concerned about the limited scope of providers of "behavioral health treatment" and the exclusion of LCSWs (page 5 line 15 – page 6 line 3). Licensed clinical social workers are already recognized in the state as providers of such treatment- and bring a unique broad lens to the community along with proven evidenced based clinical skills. Including LCSWs ensures that families have the right to choose from the broadest array of qualified, experienced and licensed professionals in the state. Mari Ono, MSW, LSW 2450A Naai St. Honolulu, HI 96819

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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kawakami2 - Rise

From: mailinglist@capitol.hawaii.gov
Sent: Saturday, March 09, 2013 10:48 AM
To: CPCtestimony
Cc: pattyspecial@gmail.com
Subject: Submitted testimony for SB668 on Mar 11, 2013 14:00PM

SB668

Submitted on: 3/9/2013

Testimony for CPC on Mar 11, 2013 14:00PM in Conference Room 325

Submitted By	Organization	Testifier Position	Present at Hearing
Patricia Adams	Individual	Support	No

Comments: This legislation is extremely important for Hawaii's families; having the safety net of Insurance coverage for ASD will provide a consistency of care from the earliest possible diagnosis to a continuous system of intervention and standards based quality of care for our children. Thank you for giving your time and attention to this vitally important "life line" for Hawaii's families.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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COMMITTEE ON CONSUMER PROTECTION AND COMMERCE

REP. ANGUS L.K. MCKELVEY, CHAIR
REP. DEREK S.K. KAWAKAMI, VICE CHAIR

Jeffrey D. Stern, Ph.D.
Licensed Clinical Psychologist
1833 Kalakaua Ave. Suite 908
Honolulu, HI 96815

Saturday, March 9, 2013

In regards to **SB668, SD2 (SSCR 808)** that requires health insurers, mutual benefit societies, and health maintenance organizations to provide health care coverage and benefits for autism spectrum disorders beginning after 12/31/13, I am in support of the bill as it addresses a serious need for coverage that private insurers should bear, while capping costs at \$50,000 per year.

I am a psychologist who was raised here in Honolulu and I am the Past President of the Hawaii Psychological Association, though the view expressed in this email is not necessarily the view of the organization I serve. I was fortunate to have received special training and internship experience to work with children on the Autism Spectrum and have provided expert witness testimony at Due Process hearings involving families seeking services from the Department of Education for their neurodevelopmentally disabled youth, including children on the Autism spectrum.

While I support this legislation, I would like to offer the following changes and the rationale for said changes.

Under section (l), on pages 5 and 11, in the subsection on “behavioral health treatment,” I would like to see the following revisions (omissions in italics, additions in bold):

“Behavioral health treatment” means [counseling and treatment programs, including] applied behavior analysis, that [are] is:

- (2) Provided [or supervised] by a board-certified behavior analyst or **provided or supervised by** a licensed psychologist so long as the services performed are commensurate with the psychologist’s formal university training and supervised experience.”

The reasons that I feel these changes are necessary are that **BCBAs may not be qualified to provide or supervise counseling or other kinds of treatment for ASD, as their training, to my knowledge, is limited to applied behavior analysis.** Many children and adolescent with ASD have additional mental health problems, such as anxiety, depression, and/or ADHD. Other treatments for ASD that have “good” or “best” support and that come under the “counseling and treatment programs” umbrella include but are not limited to parent management training, peer pairing, and social/occupational/physical therapy (see “Evidence Based Psychosocial Interventions” published by the American Academy of Pediatrics). BCBAs should not be permitted to provide counseling and other non-ABA treatments if they are not formally trained to do so. On this point, of course, I humbly defer to the DCCA.

As for the supervision component of the legislation, appropriately trained psychologists have the training to provide such supervision, but it is unclear whether or not BCBAs have the same or adequate training. According to the BACB website (www.bacb.com), a supervisor training curriculum for behavioral analyst certification has only recently been outlined, and is not

required for certification until 2015. I am also concerned that, “the cumulative duration of training must be at least 8 hours....” Given that BCBAs are not licensed and therefore not as accountable, it seems irresponsible to allow them to supervise when their own supervision training requirements may be limited and don’t even take effect until 2015. How will they be held accountable? Again, I defer to the DCCA.

As I have stated in previous testimony, I am a strong supporter of the work of BCBAs with children and adolescents with ASD, particularly as ABA is an empirically supported treatment for ASD symptoms (with “best” support), the cost of which will be reduced if said services are being provided by BCBAs rather than by psychologists and/or psychiatrists, but their scope of practice MUST BE RESTRICTED to treatments for which they have received ample training. I would prefer they go through the process of licensure as a means of providing accountability and assuring an adequate level of competence and it is my understanding that the focus of training is Applied Behavior Analysis, only. I am very uncomfortable with the idea of BCBAs providing or supervising counseling services as the current language in the legislation permits, and uneasy endorsing BCBAs supervising other BCBAs and BCBA trainees prior to 2015.

Thank you for the opportunity to provide my mana’o.

Respectfully,

Jeffrey D. Stern, Ph.D.
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March 10, 2013

Honorable Angus L.K. McKelvey, Chair
Honorable Derek S.K. Kawakami, Vice Chair
House Committee on Consumer Protection & Commerce

RE: SB 668-SD2 Mandatory Health Coverage; Autism Spectrum Disorders
SUPPORT WITH REVISIONS

Chairman McKelvey, Vice Chair Kawakami and Members of the Committee on Consumer Protection & Commerce:

With revisions I look forward to supporting SB 668–SD2. Mandated insurance coverage for autism treatment in Hawai'i is crucial. Equally crucial is that the legislation ensures access to the widest array evidenced based treatments and qualified professionals with expertise in Autism Spectrum Disorders.

As a provider with over ten years of experience treating individuals with autism I have seen families lose precious time searching and waiting for a professional with expertise to provide a thorough assessment, diagnosis, recommendations and treatment for their child. This is especially true on neighbor islands where experienced professionals are few. So that families may have the greatest access to the highest number of qualified and experienced professionals I respectfully submit that **licensed clinical social workers (LCSWs) be included in the list of licensed professionals able to prescribe, provide or order treatment for autism spectrum disorders**, and be amended to read:

"Treatment for autism spectrum disorders includes the following care prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician, psychiatrist, psychologist, **licensed clinical social worker**, or registered nurse practitioner if the care is determined to be medically necessary...
(page 6, lines 18 - 22)

In Hawai'i and across the nation, LCSWs are equally recognized and competent to provide assessment, diagnosis and treatment of disorders listed in the Diagnostic and Statistical Manual of Mental Disorders. Parents deserve the right to choose from the widest array of licensed, experienced and qualified professionals.

I am continually humbled by how uniquely autism impacts individuals and families. There is no one size fits all. Autism is a complex multi-faceted disorder and requires a trans-disciplinary multi-faceted treatment approach. I am concerned about the limited scope of providers of "behavioral health treatment" and the exclusion of LCSWs (page 5 line 15 – page 6 line 3).

Licensed clinical social workers are already recognized in the state as providers of such treatment- and bring a unique lens to the community along with proven evidenced based clinical skills. **I respectfully submit that licensed clinical social workers be included as providers and supervisors of behavioral health treatment** (page 5, line 21 – page 5 line 3). Including LCSWs ensures that families have the ability to choose from the broadest array of qualified, experienced and licensed professionals in the state.



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In the same spirit of widening access to qualified licensed professionals, I further submit that LCSWs also be included providers of psychological care (page 6, lines 13-14 and where else defined). Psychological care might more appropriately be labeled 'mental health care' to encompass what is being treated rather than the profession providing the treatment; ***allowing families the greatest amount of freedom to secure experienced, licensed professionals.*** We might also consider amending the definition of "therapeutic care" to read:

"Therapeutic care" means services provided by licensed speech pathologists, registered occupational therapists, **social workers,** or licensed physical therapists.

The spirit of this bill is evident: to increase access to services and the quality of life for individuals with autism. I firmly believe by respecting uniqueness of individuals and the clinical judgment of professionals to make treatment decisions in collaboration with families and expanding the array of licensed professionals to include LCSWs, this legislation has the power to do just that. With a widened scope, I look forward to providing my support and celebrating its passage with the families I serve.

Respectfully,
Lauren Wilson, MSW
Autism Service Provider

kawakami2 - Rise

From: mailinglist@capitol.hawaii.gov
Sent: Sunday, March 10, 2013 12:04 PM
To: CPCtestimony
Cc: keikicare@hawaii.rr.com
Subject: Submitted testimony for SB668 on Mar 11, 2013 14:00PM

SB668

Submitted on: 3/10/2013

Testimony for CPC on Mar 11, 2013 14:00PM in Conference Room 325

Submitted By	Organization	Testifier Position	Present at Hearing
Vera Marie Asato	Individual	Support	No

Comments: My name is Vera Marie Asato. I'm writing to ask the committee to please pass SSB668. I'm a mother of a 21 year old son on the spectrum and this bill will help us and other families with children of autism. The financial hardship we have to go through to get services for our child. Having insurance help pay for cost will be such a great relief. The overall picture of getting help early will really help these young children be much successful in their adult life. The cost saving to society will be less if you give them help early in their years.

Please note that testimony submitted less than 24 hours prior to the hearing, improperly identified, or directed to the incorrect office, may not be posted online or distributed to the committee prior to the convening of the public hearing.

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Our family is writing in support SB668. As parents we can speak firsthand to the positive results of therapy on our son's development and our families quality of life. At age 3 ½ my wife and I were constantly translating what our son was saying due to significant articulation delays. We understood most of what he said, but other people did not. It significantly impacted our son's social experiences and development, making it difficult to have a positive preschool experience or play with other children. We felt isolated and confused since our son had very good language (vocabulary, grammar, ability to express ideas and understand others). We sought an evaluation through the DOE, and our son was initially denied speech services by the school. Thankfully, we sought a second opinion from the UH Speech Clinic, who evaluated his articulation to be at the 7% and in contrast to the DOE, recommended our son start speech therapy as soon as possible. We began seeing a private speech therapist in October. Her evaluation was helpful in understanding what was going on and we began speech therapy immediately. Now, about a year and a half later after receiving private speech services twice a week and with lots of hard work on our families part (doing daily exercises recommended and monitored by our SLP) our circumstances have improved. Many people, even children, understand much of what he says. We have had to use our retirement funds to pay for most of the therapy. His grandparents have diverted the funds they were saving for our son's college education to help us pay for speech. We know there are many families who simply cannot afford therapy and we feel for them, knowing the very real impact therapy can have on a child's self-esteem, social development and quality of life. It impacts the entire family.

Since our son is very articulate and high functioning, we thought we would ask for his input:

What has speech done for you?

"When I started speech I couldn't talk good. Most kids couldn't understand me. Now lots of kids can understand me."

How does that make you feel?

"Good."

My son used to be afraid to talk to others because he would be teased and bullied by other children and adults would just smile and stare at him.

Passing this bill would be good for the children and families of Hawaii.