Autism, Insurance, and Discrimination: The Effect of an Autism Diagnosis on Behavior-Analytic Services

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Abstract

This paper discusses variables contributing to behavior analysis's growth within the autism community and the effect of an autism diagnosis on behavior-analytic services and access to those services. Recent insurance reforms in 47 states, the District of Columbia, and the U.S. Virgin Islands require insurance companies to offer, or cover, behavior-analytic services to individuals diagnosed with autism spectrum disorder. However, despite many benefits associated with increased coverage for individuals with autism, potential limitations exist, such as age and disability discrimination. Furthermore, this paper examines factors influencing the growing number of behavior analysts practicing in the area of autism and steps to ensure the field's growth beyond autism.

Keywords Advocacy · Autism · Behavior analysis · Insurance · Legislation

Lerman, Iwata, and Hanley (2013) described two distinct features setting applied behavior analysis (ABA) apart from other applied psychology areas. First, the authors stated ABA's foundation is rooted in alignment between both theoretical and experimental behavior-analytic principles. Second, the authors noted, unlike other fields, “distinguished by their emphasis on a particular clientele, problem, or setting, ABA is constrained only by its principles and methods” (Lerman et al., 2013, p. 81). However, colloquially, ABA has become synonymous with autism spectrum disorder (ASD) treatment (Poling, 2010), despite nothing inherent concerning behavior-analytic interventions specifically relating to a diagnosis of ASD, or any developmental disability diagnosis for that matter (Axelrod, McElrath, & Wine, 2012). In fact, nothing explicitly classifies ABA as a treatment; rather, ABA is a set of principles used to inform treatment across many different disciplines, as well as different socially significant behaviors, regardless of disability.

Although not comprehensive, behavior analysis's breadth can be illustrated by the Association for Behavior Analysis International's (ABAI) numerous special interest groups (SIGs). These SIGs represent the field's versatility across populations, behaviors, and settings. Currently, ABAI has 36 SIGs, including Applied Animal Behavior; Behavior Analysis and the Arts; Behavior Analysis for Sustainable Societies; Behavioral Gerontology; Behavioral Medicine; Crime, Delinquency, and Forensic Behavior Analysis; Health, Sport, and Fitness; Organizational Behavior Management; and Sexual Behavior: Research and Practice (Association for Behavior Analysis International, 2018a, b). Each SIG focuses on research, education, and practice within its specific area of interest. For example, the Behavior Analysis for Sustainable Societies SIG focuses on advancing “applications of behavior analysis to environmental issues that contribute to the development of solutions to climate change, pollution, overconsumption of resources, and imbalances in environmental sustainability” (ABAI, 2018a, 2.1). An additional SIG, Behavioral Gerontology, promotes using behavior-analytic principles and technologies to address socially valid behaviors of adults later in life (i.e., 65 and older). Specific topics include “self-management for health promotion and disease prevention, functional assessments of and interventions for behavioral changes commonly associated with neurocognitive disorders (e.g., Alzheimer's disease), effective participation in inter- or multidisciplinary teams, or aging with a disability” (ABAI, 2018b, 2.1).

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Furthermore, because ABA is only constrained by its principles and methods (Lerman et al., 2013), its utility across populations, settings, and behaviors is also exemplified through empirical evidence ranging from the effect of behavior-analytic techniques to support organizational behavior management (OBM) to the mitigation of safety concerns involving medically fragile infants (Roane, Ringdahl, & Falcomata, 2015). Ludwig (2015) described OBM as the application of behavior-analytic assessments and interventions to organizational problems in the workplace. Researchers evaluating behavior-analytic techniques within an OBM context have addressed behaviors resulting in cash register shortages (Rohn, Austin, & Lutrey, 2002), behaviors associated with increased pet store sales (Milligan & Hantula, 2005), lifeguards' cleaning behaviors (Rose & Ludwig, 2009), nurses' glove-wearing compliance (DeVries, Burnette, & Redirion, 1991), and closing-task completion in restaurant settings (Austin, Weatherly, & Gravina, 2005). Research also supports the effectiveness of behavior-analytic assessments and interventions to address socially valid behaviors regardless of age or ability. For example, studies indicate behavior-analytic interventions improve medically fragile infants' feeding behaviors (Piazza, Milnes, & Shalev, 2015), as well as behaviors related to aging such as depression and anxiety, health maintenance, independent ambulation, self-care, and specific behaviors related to dementia (LeBlanc, Raetz, & Feliciano, 2013).

Considering behavior analysis's success and utility across various populations, problems, and settings, its exponential growth within the autism community warrants an examination of potential variables contributing to its popularity within a specific population. The purpose of this paper is to examine variables influencing the relationship between ABA and the autism community. Furthermore, the authors discuss whether a diagnosis of ASD, or the absence of an ASD diagnosis, affects behavior-analytic treatment and/or access to treatment. Therefore, when referring to the autism community and/or culture, the authors use the term *autism*, but when referring to a diagnosis, the authors use the term *ASD*. Finally, the authors examine factors influencing the growing number of behavior analysts practicing in the field of autism and steps to ensure the field's growth beyond autism.

Establishing the Relationship between ASD and ABA

Research

ABA's popularity in the autism community can be attributed to three main variables: research, advocacy, and legislation. Lovaas's (1987) landmark study indicating promising results for individuals with ASD following ABA-based interventions

provided groundwork to establish positive implications of behavior-analytic interventions on socially significant dependent variables. Specifically, Lovaas evaluated the effect of procedures based on behavior-analytic principles on the academic and language skills of young children with ASD. Lovaas's study, combined with numerous subsequent studies, provided compelling evidence supporting the positive effects of ABA-based treatment approaches on academic, communication, and social skills (e.g., Bouxsein, Tiger, & Fisher, 2008; Hagopian, Kuhn, & Strother, 2009) for individuals with ASD. However, research also demonstrates ABA's utility in the population with ASD extending beyond language and social improvements, including improved adaptive behavior (Volkert & Vaz, 2010), safety skills (e.g., Gunby, Carr, & LeBlanc, 2010), and reduced rates of dangerous problem behaviors (e.g., Rhine & Tarbox, 2009) following behavior-analytic interventions.

Advocacy

Although Lovaas's (1987) study indicated positive results for individuals with ASD, ABA's popularity also began to grow within the autism community when parents began sharing their personal narratives. Maurice's (1993) book, *Let Me Hear Your Voice: A Family's Triumph Over Autism*, recounted a family's perspective on the effect of behavioral interventions on the lives of individuals with ASD and their family members. By providing her perspective in lay terms, Maurice made ABA more accessible to a wider audience, including parents searching for answers. However, individual advocates such as Maurice were not alone; in fact, Maurice's book echoed the efforts of sizable advocacy groups, such as the Autism Society. In fact, Bernard Rimland, founder of the National Society for Autistic Children (later renamed the Autism Society of America), wrote Maurice's foreword and attributed behavior modification's limited popularity at the time to parents receiving misinformation regarding autism's etiology (e.g., "refrigerator mothers" behaving indifferently toward their children).

To address misinformation and advocate for appropriate education and care for individuals with ASD, Rimland founded the Autism Society in 1965. The organization began with 60 people, primarily composed of parents of individuals with ASD. In addition to advocating for appropriate education and care, the organization championed issues such as appropriate legislative changes and adequate research and funding, as well as increased publicity. For example, the organization petitioned Congress for increased funding for autism research and disseminating information regarding both early signs of autism and appropriate and effective interventions. In fact, in the 1970s, the Autism Society led a nationwide awareness campaign that was later adopted by Congress in 1984 (Autism Society, 2011).

The Autism Society worked in combination with Autism Speaks and similar advocacy groups to collectively campaign for autism awareness (e.g., early signs of autism and autism prevalence). As a result, communities organized fund-raisers and walks, including “autism awareness” nights at sporting events (e.g., Eason, 2018). Additionally, autism awareness efforts included campaigns for World Autism Awareness Day, which the United Nations (UN) formally adopted on December 18, 2007 (UN General Assembly, 2008). The UN resolution described ASD and its effect regardless of gender, race, or socioeconomic status. In addition, the UN resolution expressed deep concern regarding high prevalence rates and the consequent challenges to government organizations, families, communities, and individuals with ASD (UN General Assembly, 2008).

Legislation

Previously mentioned advocacy efforts, combined with research supporting ABA’s effectiveness, led to legislative changes. These changes influenced ABA’s popularity within the autism community. Similar to any therapy requiring trained (and often licensed or credentialed) professionals, ABA services can be costly. Chasson, Harris, and Neely (2007) estimated an average year of ABA therapy (5–7 h per day of early intensive behavioral intervention, EIBI) costs \$40,000 per child, ranging from \$20,000 to \$60,000 a year, and the cost of parent-directed ABA programs was approximately \$25,000 a year. In addition to expenses associated with ABA therapy, families raising individuals with ASD can also expect to pay six times the medical costs of families without children with ASD (Centers for Disease Control and Prevention [CDC], 2013). In fact, Buescher, Cidav, Knapp, and Mandell (2014) discovered the cost of raising a child with ASD in the United States is approximately \$1.43 million, and the cost for raising an individual with ASD and intellectual disability is \$2.44 million. The authors attributed much of the cost to special education services, residential accommodations, medical care, and productivity losses in adulthood. Additional reports, such as (Chasson et al., 2007), hypothesized across 18 years, the state of Texas would save over two billion dollars in costs associated with special education services by investing in EIBI for all students with ASD.

In addition, the CDC estimates ASD affects 1 in 59 children (CDC, 2018a), which suggests a large number of families paying above-average medical costs, as well as high costs associated with special education services. In response to the substantial number of children diagnosed with ASD and the associated elevated medical costs, as well as the positive effects associated with ABA services, states began requiring insurance plans to cover ASD treatments (Baller et al., 2016). Previously, health insurance companies designated “autism as a diagnostic exclusion” (Unumb, 2015, p. 74).

Furthermore, Unumb (2015) explained that some insurance companies covering ASD treatments did not always cover the most effective interventions such as ABA.

Due to the growing prevalence rates, positive outcomes, and cost associated with ABA therapy compared to long-term savings associated with raising an individual with ASD, insurance-reform efforts, spearheaded by groups like Autism Speaks, successfully advocated for legislative changes requiring insurance companies to cover ASD. As of May 2018, 47 states, the District of Columbia, and the U.S. Virgin Islands passed laws requiring health insurance coverage for individuals with ASD (Autism Speaks, 2018). In 2014, the Centers for Medicare and Medicaid Services (CMS) also added ABA to its list of covered treatments (CMS, 2014), therefore allowing physicians to prescribe ABA as a medical necessity and allowing health care providers to bill Medicaid for ABA services.

Challenges

Autism Diagnosis Drives Access

Insurance As a result of this insurance reform, an ASD diagnosis might affect access to behavior-analytic treatment and might also affect the supply of service providers (Douglas, Benevides, & Carretta, 2017). Douglas et al. (2017) attributed variation among insurance coverage to the largely unregulated private health insurance market. For instance, some states require insurance plans to cover ASD treatment (e.g., Florida, Pennsylvania, and South Carolina), whereas other states require insurance plans to simply offer ASD treatment coverage (e.g., Alabama). In other words, states mandating insurance coverage require insurance companies to cover ASD treatment in all plans, but states requiring insurance companies to offer coverage allow the employer and individuals to decide whether to include ASD treatment coverage.

Service Providers An additional factor affecting treatment access is whether or not an ASD diagnosis affects the supply of, and access to, service providers. Deochand and Fuqua (2016) analyzed the Behavior Analyst Certification Board’s (BACB) certification data by state to evaluate overall growth patterns, geographic variations, and the influence of autism insurance-reform laws. Although the authors discovered high correlations between state populations and the number of BACB certificants found within those states, they noted some states displayed disproportionately higher BACB certificants than indicated by the state population. Upon further investigation, Deochand and Fuqua discovered higher growth rates among states that adopted insurance-reform policies, whereas states with the lowest BACB certificants per capita were those that rejected insurance reform (e.g., Idaho and Wyoming).

Because current insurance reform is directly related to an ASD diagnosis, and insurance reform influences the number of certificants per state, it is certainly possible that an ASD diagnosis also influences access to services based on the number of available service providers. Therefore, states adopting insurance-reform laws, specifically laws mandating coverage for individuals diagnosed with ASD, might also offer more service providers, which increases accessibility.

Equity Despite the positive influence of insurance reform mandating coverage for scientifically based treatments such as ABA, some individuals may face discrimination based on state-imposed age limits. For instance, the passing of Utah's SB57 (Autism Services Amendments, 2018) in 2014 made Utah the 35th state to pass legislation providing insurance coverage for ASD treatment. Though it provides insurance coverage for numerous families, SB57, similar to other insurance-reform laws, is still controversial. Primary concerns regarding SB57, and similar health insurance laws, include limited age-range coverage, as well as only requiring insurance coverage for individuals diagnosed with ASD. This bill officially went into effect for state-regulated health policies issued on or after January 1, 2016. However, SB57 applies to children between the ages of 2 and 9 with an ASD diagnosis from a licensed physician or psychologist. After receiving a formal diagnosis, the child is eligible to access insurance coverage for treatment programs, including those based in behavior analysis, counseling services, and therapeutic services (e.g., speech, occupational, and physical therapy).

Utah's SB57, and similar state laws mandating insurance coverage, might inadvertently discriminate against Black and Hispanic families. Despite no difference in prevalence rates, the CDC (2018b) reported that White children were more likely to be diagnosed with ASD than Black or Hispanic children. Furthermore, Black and Hispanic children were also more likely to receive an ASD diagnosis later than their White peers. Consequently, Black and Hispanic children are less likely to receive services due to identification disparities. Moreover, because Black and Hispanic children receive a formal diagnosis later than White children, age caps associated with insurance coverage will limit their access to services.

In addition to racial disparities, insurance reform might also discriminate against other disabilities, such as attention deficit hyperactive disorder and acquired brain injuries (ABI). These conditions' sometimes-associated behavioral excesses and deficits are often amenable to behavior-analytic treatment (Heinicke & Carr, 2014; LaRue, Sloman, Dashow, & Isenhour, 2015). For example, Heinicke and Carr's (2014) ABI meta-analysis showed behavioral interventions resulted in "large effect sizes across a wide variety of behavioral excesses and deficits experienced by 219 individuals with brain injury" (p. 103). Although insurance may cover medically necessary interventions, failure to provide patients with

clinically proven behavior-analytic treatments when those treatments are available to others with similar needs but different diagnoses is discriminatory. This is discrimination based on disability, not based on patient need.

Autism Diagnosis Should Not Be a Prerequisite for Treatment

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) classifies ASD as a combination of communication and social skill deficits with restrictive and repetitive interests and behaviors (APA, 2013). Similarly, the CDC (2017) also classifies ASD as a social communication disorder and provides specific examples of hallmark behaviors displayed by individuals with ASD. For example, the CDC states individuals with ASD might experience difficulties during transitions, display limited expressive language, and engage in repetitive behaviors. Due to most of the ASD classifications referring to behaviors (the presence of communication and social skill deficits combined with repetitive, restrictive behaviors), proponents suggesting ABA-based therapy treats ASD raise valid arguments. The effect of ABA-based treatment on individuals with ASD is evidenced by numerous studies demonstrating the effect of ABA services on behaviors directly associated with ASD, such as improved communication, social skills, and other behavioral outcomes following behavior-analytic treatment (Matson et al., 2012). Therefore, because ABA-based treatments directly target behaviors associated with an ASD diagnosis, technically ABA treats ASD.

In contrast to an ASD diagnosis, other formal psychiatric diagnoses might not increase access to ABA services covered by health insurance. However, the description associated with a psychiatric diagnosis provides little to no use to behavior analysts. For example, when observing two children with ASD engage in the same repetitive behavior such as rocking, the psychiatric approach might attribute body rocking to their ASD diagnosis. The topographies listed in the DSM-5 neither provide information regarding contextual variables nor provide information regarding a potential maintaining function, which are essential to designing effective ABA treatment.

Function-Based Diagnosis

In contrast, Cipani and Schock (2011) countered the psychiatric diagnosis with a behavior-analytic, function-based diagnostic classification system. The authors stated the function-based system "does not presume that the exhibition of the behavior is driven by characteristics inherent in the client or child" (Cipani & Schock, 2011, p. 81). Instead, the function-based system presumes behavior is driven by environmental characteristics. In the aforementioned example, the function-

based diagnosis system examines contextual variables and might discover that Child 1 begins rocking each time the teacher places a demand, which is often followed by the teacher temporarily suspending the demand or completely removing the demand, whereas Child 2 begins rocking each time his or her teacher removes a favorite toy, which is frequently followed by the teacher quickly returning the item.

Despite both children engaging in the same response (i.e., body rocking), each child's behavior involves different contingencies and, as a result, different maintaining functions. Child 1 seems to engage in body rocking to escape demands, but Child 2 engages in body rocking to access a favorite toy. The function-based diagnostic classification system might diagnose Child 1's rocking behavior as escape maintained and Child 2's rocking behavior as access maintained. Though both children received a psychiatric diagnosis of ASD, a function-based diagnosis provides valuable contextual information and directly leads to differential prescriptive treatments following assessment procedures (Cipani & Schock, 2011). In other words, behavior analysts use the function-based diagnosis to develop differential treatment plans based on individual client needs, rather than implementing generic interventions for all consumers with ASD.

Again, as Lerman et al. (2013) stated, ABA is not constrained by specific clientele, problems, or settings. Correspondingly, ABA is not a science exclusively applied to individuals with ASD, nor are behavior-analytic effects limited to individuals with ASD. Numerous studies also indicate positive effects from ABA with individuals with Down syndrome (e.g., Dalton, Rubino, & Hislop, 1973; Farb & Throne, 1978; Fritz, Iwata, Hammond, & Bloom, 2013) and individuals diagnosed with intellectual disability (e.g., Fisher, Burke, & Griffin, 2013). Furthermore, similar to an ASD diagnosis, any formal psychiatric diagnosis serves no place in behavior-analytic treatment decisions, and Cipani and Schock's (2011) function-based diagnostic criteria can be applied across populations, settings, and behaviors.

Behavior Analysis and Autism Practice Distribution

Despite many areas of interest existing beyond ASD, a large percentage of behavior-analytic professionals practice within the area of autism. The BACB obtained data from 7,107 participants regarding their areas of practice, and 67.65% of the respondents indicated they practiced within the area of autism (BACB, n.d.). The staggering percentage of professionals who reported practicing within the area of autism was followed by only 12.24% indicating practicing within education, 8.33% within developmental disabilities, 2.12% in other areas, 2.08% in behavioral medicine, 2% in university teaching, and 1.6% in caregiver training. The remaining 3.98% of

respondents indicated practicing within the areas of dissemination, behavioral pediatrics, brain injury rehabilitation, OBM, professional supervision, child welfare, behavioral gerontology, sports and fitness, public policy and advocacy, corrections and delinquency, or nonuniversity research (range 0.93%–0.03%).

Jim Carr, CEO of the BACB, described factors contributing to the field's growth and distribution and explained that neither ABAI, the BACB, nor any one organization can manage or control the field's growth or its distribution (Cicoria, 2017). Rather, behavior analysis's growth and distribution, similar to any field's growth and distribution, is influenced by factors affecting market demand. The current market demands large numbers of behavior analysts to meet the needs of a population covered by insurance providers. This is likely one factor contributing to 67.65% of the field's practitioners reporting working within the area of autism. The need for behavior analysts practicing within the area of autism also influences training programs specifically preparing practitioners to practice within the area of autism. Moreover, per the BACB's *Professional and Ethical Compliance Code for Behavior Analysts*, addressing responsible conduct of behavior analysts, behavior analysts are required to provide services within the boundaries of their competency, which includes education and experience (BACB, 2017). Consequently, large demands for behavior analysts to provide services for individuals with ASD lead to universities preparing students to specifically work with this population, subsequently limiting their scope of practice, and essentially pigeonholing future behavior analysts to practice within the area of autism, unless they seek additional education, training, or supervised experiences.

Furthermore, although many share the sentiment that behavior analysts should practice beyond autism (e.g., Poling, 2010), the field also believes, and has demonstrated, behaviors to be environmentally selected (Moore, 2008). Accordingly, the environment (i.e., the market) has selected the field's practice distribution (i.e., 67.65% practicing within the area of autism). If the field is to expand into different areas, it will be environmentally selected rather than a result of an individual organization or individual behavior analysts' advice to expand beyond autism. For example, Carr (Cicoria, 2017) stated that the field might also experience the same exponential growth within additional areas, such as gerontology or child welfare, when ABA's demonstrated utility within these areas is disseminated to larger audiences.

Expanding Beyond Autism

If behavior analysts wish the field to expand beyond autism, we must recognize factors contributing to the current market and their impact on the field's expansion and distribution. The aforementioned factors contributing to behavior-analytic

growth and popularity within the autism community might serve as a navigation tool to expand into other areas of interest. For example, perhaps more meta-analyses similar to Lovaas's (1987) are needed to demonstrate ABA's effect within different areas. Or perhaps behavior analysts should take note of and adopt similar advocacy techniques demonstrated by the autism community to increase awareness and create legislative change. Furthermore, if behavior analysts want to expand their consumer base, they might also heed LeBlanc, Heinicke, and Baker's (2012) advice to meet the needs of consumers in the twenty-first century.

LeBlanc et al. (2012) described strategies for behavior analysts to diversify their consumer base by developing competence and creating employment opportunities. To increase competency, the authors urged practitioners to contact both the behavior-analytic literature and literature outside of behavior-analytic journals that relate to specific areas of interest. Second, the authors recommended participating in the target group's professional organizations and conferences. Third, behavior analysts should identify mentors to obtain appropriate training and supervision opportunities, which LeBlanc et al. (2012) suggested might be possible by interacting with ABAI's SIGs. Last, behavior analysts should identify professional credentials that might be needed to access funding or elevate their standing within an organization.

When describing ways to identify employment opportunities, LeBlanc et al. (2012) suggested developing effective communication skills, a sentiment shared by other behavior analysts (e.g., Critchfield, 2014). Specifically, the authors noted developing skills to translate behavior analysis to lay audiences. Critchfield (2014) stated that because dissemination is a skill, similar to other skills, it can be improved upon with practice. To help facilitate appropriate and effective communication techniques, perhaps university programs could devote time to preparing their students to disseminate behavior analysis across various disciplines. For example, the University of Georgia offers a course titled "Communicating Science and Scholarship," which is taught by faculty from the theater department. This course prepares students to communicate their science to nonspecialist audiences by specifically focusing on developing skills related to interdisciplinary and community communication, education, and outreach, as well as connecting research to policy (University of Georgia, n.d.). One of the course's activities requires students to develop a short talk regarding their area of research. Once prepared, students are randomly assigned a fictitious audience and must communicate their research to this audience (e.g., a room of kindergarten students, someone they recently met at a wedding, a barista). This activity, and many of the other activities, follows the format of behavioral skills training, which includes (a) providing instructions, (b) modeling, (c) role-play, and (d) feedback (Gianoumis, Seiverling, & Sturmey, 2012; Sarokoff & Sturmey, 2004).

Additionally, LeBlanc et al. (2012) indicated that learning how to effectively communicate behavior analysis across disciplines should also be combined with recognizing target behaviors that are socially valid to the providers and consumers. Lovaas's (1987) study exemplifies the effect of studying socially valid behaviors such as communication. Following EIBI, children who were previously considered noncommunicative by society's standards began communicating. As previously mentioned, the effect of interventions based in behavior-analytic principles on powerful dependent variables is not an anomaly to autism. If the field desires to expand beyond autism, dissemination might involve developing skills to effectively communicate about the science and additional inquiry regarding socially valid behaviors across disciplines.

Conclusion

Lerman et al. (2013) described the following two critical features of ABA: (a) behavior-analytic practices are rooted in theoretical and experimental principles, and (b) ABA's utility is only constrained by its principles and methods. These features are ingrained in behavior-analytic coursework, as well as the BACB's *Professional and Ethical Compliance Code for Behavior Analysts* (BACB, 2017). Despite numerous conference presentations and papers devoted to extending and promoting ABA's application beyond autism, a large percentage of professionals practice within the area of autism. However, the market, rather than any one organization's efforts, selects our field's distribution. Therefore, extending beyond autism might require a behavior-analytic revival focused on evaluating and addressing market demand and factors influencing growth distribution within other areas. Furthermore, behavior analysts are required to rely on behavior-analytic principles to guide treatment decisions rather than on those approved by insurance companies and should explicitly note that ABA is not constrained to a specific population based on insurance coverage.

An article written by Walsh (2011) exemplifies the recent focus on behavior-analytic interventions for individuals with ASD. In her article, Walsh (2011), a parent of a child diagnosed with ASD, listed 10 reasons she believed people with ASD deserve behavior-analytic interventions. A majority of Walsh's list falls into two categories: (a) individuals with ASD have the ability and right to learn, and (b) ABA can help individuals with ASD learn functional skills. Though Walsh's sentiment suggesting individuals with ASD have the ability and right to learn is accurate and well intentioned, the ability and right to learn is not limited to individuals with a diagnosis of ASD. Arguably, everyone, regardless of diagnosis, has the ability and right to learn. In fact, interventions derived from ABA have proven to help individuals of all ages and abilities learn functional skills. Perhaps behavior analysts could extend the reach of Walsh's sentiment and identify 10

reasons everyone deserves behavior-analytic services. After all, the science of predicting and influencing socially significant behavior (i.e., ABA) does not belong to the autism community. Rather, the science of ABA belongs to everyone, regardless of whether they have an ASD diagnosis or insurance coverage.

Compliance with Ethical Standards

Conflict of Interest Cary E. Trump declares that she has no conflict of interest. Kevin M. Ayres declares that he has no conflict of interest.

Ethical Approval This article does not contain any studies with human participants performed by any of the authors.

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