

February 19, 2009

Actuarial Cost Estimate:
Kansas Senate Bill 12 – An
Act Concerning Insurance;
Providing Coverage for
Autism Spectrum Disorder

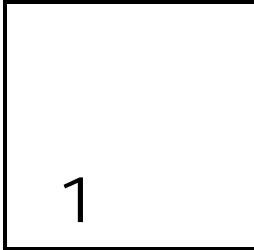
OLIVER WYMAN

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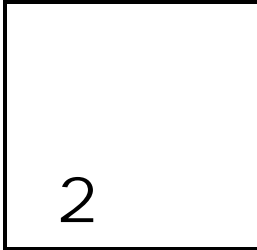


Background

Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman or We) has been engaged by Autism Speaks to develop a cost model in order to analyze and estimate the impact of mandated insurance benefits for Autism Spectrum Disorders (ASD) on insurance premiums. As part of this work, Oliver Wyman has developed a range of independent estimates of the impact on insurance premiums for the benefits mandated by Kansas Senate Bill 12 (SB 12) which provides coverage for the diagnosis and treatment of autism spectrum disorder in individuals under the age of 21.

Oliver Wyman is a part of the Marsh & McLennan (MMC) 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 twelve 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 health 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 12 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.

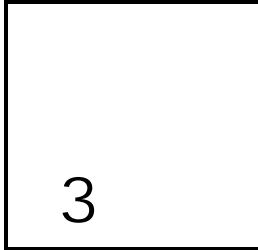


Scope and Limitations

The intent of this analysis is to provide a reasonable range of estimates for the insured costs of the mandated ASD benefits provided for in SB 12 and the associated premium impact on the markets affected by SB 12. This analysis makes no attempt to quantify potential offsetting cost savings associated with successful ASD treatment, nor does it include any estimate of the potential reduction in other government expenditures associated with providing ASD services that might overlap with the benefits provided by this mandate. Therefore, the reader is cautioned that this report should only be considered a cost analysis, and not be misconstrued as a cost-benefit analysis when assessing the merit of SB 12.

We note that cost estimates for autism mandates have varied widely state to state, based on differences in the state specific mandates and the methods and assumptions used in the estimating costs, though typically independent estimates show premium increases due to mandated autism benefits of less than 1%. The reason for this variability is that the largest component of the increase in costs under the SB 12 mandated ASD benefits is for Applied Behavior Analysis (“ABA”), which is almost universally excluded from health coverage, and therefore essentially no insured data exists for use in developing credible utilization and unit cost estimates for ABA.

The reader is cautioned that the ultimate cost of covering ABA benefits is uncertain; however, this analysis attempts to reflect the likely behavior of consumers, providers and insurers of ABA services in developing the assumptions underlying the cost estimates. Likewise, the additional costs for mandated medical services other than ABA are difficult to quantify. Insurance policies often cover some services for children diagnosed with an ASD, although the mandate could cause the costs for certain services to increase because ASD exclusions are common, and certain services that may have been denied or terminated following utilization review might be covered due to the mandate.



Description of Key SB 12 Provisions and their Impact on Covered Benefits

Insurance Markets Covered by Mandate

New Section 1. (a) (1) states: *Any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for accident and health services and which is delivered, issued for delivery, amended or renewed on or after July 1, 2009, shall provide coverage for the diagnosis and treatment of autism spectrum disorders in any covered individual.*

New Section 1 goes on to state in (e) (1) *Any employer that has 50 or fewer employees shall have the option to exclude the coverage required by this section from any health benefit plan, as such term is defined in K.S.A. 40-2209d, and amendments thereto, offered to such employees., and in (e) (2) Any individual with an individually underwritten health insurance policy shall have the option to exclude the coverage required by this section from such policy.*

The bill, as written, mandates coverage of ASD services for the large group (51+ employees) market, as well as requires insurers to offer coverage of ASD services as a benefit option in the small group (2-50 employees) and Individual markets. Autism Speaks has asked us to model the following scenarios:

1. Mandated coverage applies to large group market, only.
2. Mandated coverage applies to large and small group markets.
3. Mandated coverage applies to the large group, small group, and individual markets.
4. Mandated coverage applies to the large group market, and a mandate to offer coverage applies to the small group market.

Covered Benefits

Treatment includes: (A) *Habilitative or rehabilitative care*; (B) *pharmacy care*; (C) *psychiatric care*; (D) *psychological care*; and (E) *therapeutic care*.

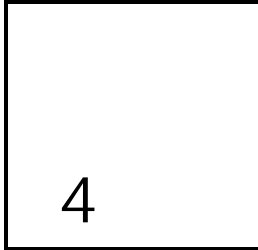
The inclusion of applied behavioral analysis (ABA) in the definition of *Habilitative or rehabilitative care* is especially important. The coverage of ABA has the most significant impact on cost of any mandated service. ABA programs are marked by intensive therapy that may include 30-40 hours of therapy a week under the most intensive programs, though many programs would not utilize that level of resources. Key assumptions underlying our ABA cost estimates are outlined in Section 5.

Annual ABA Maximum Benefit of \$75,000 through Age 21

The annual coverage maximum is important as it has the effect of capping costs for the heaviest users of ASD services. From a practical standpoint, this would generally apply to young children whose therapy includes an intensive ABA program.

Medical Necessity and Treatment Review

The bill does allow for utilization review by specifically stating: *an insurer will have the right to request a review of that treatment not more than once every 12 months unless the insurer and the individual's licensed physician or licensed psychologist agrees that a more frequent review is necessary*. This is important as insurers will develop protocols to review treatments and manage care which will limit unnecessary treatments if reviews are done appropriately.



Modeling Methodology

The following outlines the general modeling methodology used to develop the cost estimates. Estimates were developed both on a per member per month (PMPM) basis, and as a percentage of average annual premiums as shown in Section 6. Details of key assumptions are discussed in Section 5 and illustrated graphically in the exhibits shown in Appendix 1.

Modeling Perspective

In general, the model was developed to produce costs under the assumption that sufficient 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 prevalence estimates. We would expect that it would take at a minimum several years for both the supply of providers to meet the demand for mandated ASD services and for parents of autistic children to aggressively seek diagnosis and treatment of their childrens' disorders.

In spite of these real limitations that will likely limit short-term costs associated with mandated autism benefits, we feel that it is appropriate from a public policy perspective to look at the costs from a longer term perspective 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.

In the near term we would note that the supply of ABA service providers, specifically credentialed Board Certified Behavior Analysts (BCBAs) and Board Certified Associated Behavior Analysts (BCaBAs) would not be sufficient to meet the demand for ABA programs if ABA benefits are mandated. There are currently about 35¹ certified BCBAs and BCaBAs in Kansas, which translates to approximately one therapist per 117 children

¹ BACB Certificant Registry: http://www.bacb.com/cues/frame_about.html, accessed January 2009.

treated for ASD in Kansas based on the prevalence and age at diagnosis assumptions outlined in this report. While it is true that not all autistic children will have an ABA program, it is also true that behavioral analysts provide services to individuals other than autistic children. It is reasonable to conclude that demand for ABA services, at least initially, would far exceed supply should health care coverage similar to that mandated by SB 12 become typical. Therefore, the long-term estimates shown in this report should not be used as a basis for trying to determine the near-term cost impact of the mandated benefits.

In trying to ascertain the near-term impact of SB 12, it is also instructive to look at some of the limited evidence available related to actual costs of ABA mandated benefits in other states. Aetna noted in December 2008 that it had tracked the cost of the autism mandate 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 policy holders 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 mandate might change after the first year.² While this is only first year experience for a single insurer, it illustrates that initial mandate costs are likely low. Aetna's Texas block of business is quite large (approximately \$1.5 - 2.0 billion in premium³), so the statistics provided indicate a mandate cost of less than 0.1% of premium. This experience is likely not atypical of experiences in other states.

General Modeling Process

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

1. Assumed treated prevalence for the United States is 1 in 150 based on the CDC's estimate of ASD prevalence in the United States. For Kansas, we decreased this prevalence rate by 15% based the fact that the percentage of children reported with autism in Individuals with Disabilities Education Act (IDEA) Part B child count⁴ data is approximately 30-40% (depending upon ages considered) lower in Kansas than in the United States. These child counts should be a reasonable indicator of the relative likelihood of children receiving medical treatment for ASD in different states.
2. Prevalence rates by diagnostic subtype (autistic disorder, PDD-NOS, Asperger's Syndrome) were estimated separately as diagnosis patterns and service utilization could reasonably be expected to vary by diagnostic subtype.

² Lawmaker: Oklahoma autism bill has momentum. Associated Press. December 4, 2008. <http://newsok.com/article/3327594> accessed January 2009.

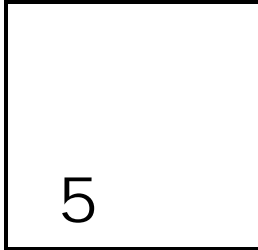
³ NAIC Annual Statements for 2007.

⁴ IDEA Part B database. <http://www.ideadata.org/PartBChildCount.asp>. Accessed January 2009.

3. 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 statistics⁵.
4. The percentage of diagnosed children who could be expected to have an ABA program was estimated for each age based on assumptions regarding how many children would start a program and typical program continuance.
5. A distribution of the number of annual hours for an ABA program 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 and adjusted to reflect the impact of the annual \$75,000 cap.
7. Non-ABA costs were estimated based upon studies of medical costs for ASD children and judgment regarding the increase in costs that could be expected due to the mandated benefits.
8. Based on Census demographic data and the cost estimates for mandated ASD services by age as outlined in 1-7 above, an annual cost per covered individual 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 Kansas, and Kaiser Family Foundation coverage data. These assumptions are further documented in the following section.
11. In order to understand how regulations for rating affect the rates that can be charged to individuals in Kansas, we reviewed the rating requirements in the Kansas Insurance Department Administrative Regulations (Agency 40, Article 4- Accident and Health Insurers).⁶ This review is discussed further in section 6 of this report.
12. The cost of the mandated services per covered person and as a percentage of premiums were calculated based on the model cost estimates and market data.

⁵ IAN database. <http://dashboard.ianexchange.org/StateStatsAdvanced.aspx?A1=VA&ADU=T>. Accessed January 2009.

⁶ Kansas Administrative Regulations. http://www.ksinsurance.org/legal/regs_list.htm. Accessed February 2009.



Summary of Key Assumptions

Key assumptions underlying the cost estimates for the mandated benefits are summarized in this section. Appendix 1 further illustrates these assumptions.

Treated Prevalence and Age at Diagnosis

Overall treated prevalence is based on the 2007 CDC⁷ study estimating United States' ASD prevalence of 1 in 150 adjusted downward by 15% due to reported autism rates per IDEA Part B child count data being significantly lower in Kansas than for the country as a whole. Prevalence by diagnostic subtype estimated based on an academic study published in the American Journal of Psychiatry⁸.

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 base model treated prevalence and age at diagnosis assumptions for Kansas are shown below:

<u>Kansas Prevalence</u>		
<u>Diagnostic Subtype</u>	<u>Ultimate Prevalence</u>	<u>Average Age of Diagnosis</u>
Autistic Disorder	1 in 529	3
PDD-NOS	1 in 353	3
Asperger's	1 in 1059	6
All ASD	1 in 176	

⁷ Centers for Disease Control. Morbidity and Mortality Weekly Report. February 9, 2007.

⁸ Fombonne, E. and S. Chakrabarti. American Journal of Psychiatry. June 2005.

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. For this reason, we have assumed that two-thirds of diagnosed children will begin an ABA program. Based on discussions with ABA providers and researchers, actual utilization of ABA programs has been significantly lower. 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 20% of diagnosed three to six year olds⁹, which is considerably lower than the 66.7% assumption employed in cost modeling shown in this report. While this (66.7% of diagnosed children under age six will have ABA program) higher assumption is likely conservative at least in the near-term, it is probably reasonable since insurers will likely have some conservatism in their cost estimates and premium rates, private insurance utilization will likely be higher than under the public/private programs in Minnesota, and utilization will likely increase over time due to increased awareness of ASD and potentially increased supply in ABA providers.

ABA programs are generally geared towards addressing deficits in younger children and are generally 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 thereafter a large percentage of programs would terminate annually until only a very small percentage of children have ABA programs in their teenage years. Programs would be expected to terminate if a child has experienced sufficient progress so 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 ASD that have an ABA program is shown in the table below:

% of Diagnosed Children w/ ABA	
Under 6	66.7%
6	50.0%
7	33.3%
8	22.2%
9	14.8%
10	9.9%
11	6.6%
12	4.4%
13 to 21	3.3%

⁹ 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.

ABA Program Annual Number of Hours

In developing the assumed annual ABA program hours, we discussed typical ABA programming with ABA providers, and reviewed some benefit materials from one of the few large self-insured employers who offer ABA benefits¹⁰. For three age bands, we developed a distribution of expected hours that resulted in the annual averages shown in the table below.

Average ABA Program Hours	
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, and then again would 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 Kansas, based on Bureau of Labor Statistics¹¹ health care wage data. The resulting average cost per hour of ABA therapy in Kansas is \$41.34.

Other (than ABA) Medical Costs

Based on several studies¹², we estimated that children with ASDs had costs approximately three times the average for non-inpatient medical services under current benefit programs. It is also likely that the mandate would mean that some services that an insurer could currently deny or exclude would now be covered. In our base estimate, we assumed that the mandate would result in additional insured medical costs equal to the current level of covered non-inpatient costs for services to children diagnosed with an ASD.

Administrative Costs

Typically, group medical claims 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,

¹⁰ Autism Therapy Reference- Microsoft Corporation (administered by Premera Blue Cross).

¹¹ BLS wage data. <http://www.bls.gov/guide/geography/wages.htm> accessed January 2009.

¹² Mandell, Cao, Ittenbach, & Pinto-Martin, 2006. Croen, Najjar, Ray, Lotspeich, & Bernal, 2006. Liptak, Stuart, & Auinger, 2006.

often collectively referred to as “retention.” We have estimated the incremental retention charge to be 15% of premium under our base assumptions.

Kansas 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 Kansas was available for 2006¹³, so we trended this based on average recent employer premium increases provided from the Kaiser Family Foundation HRET¹⁴ survey to estimate the 2009 average annual premium per member necessary to compute the cost of mandated benefits as a percentage of annual premiums.

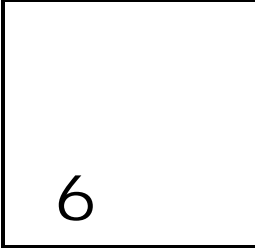
To estimate average premiums for the individual market, we reviewed survey results developed by America’s Health Insurance Plans¹⁵ that showed premiums and average members by contract type and state.

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

¹³ MEPS state survey data. http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp?regionid=-1&year=-1. Accessed January 2009.

¹⁴ Kaiser Family Foundation and Health Research Educational Trust. Employer Health Benefits- 2008 Annual Survey.

¹⁵ AHIP Individual Health Insurance 2006 - 2007: A Comprehensive Survey of Premiums, Availability, and Benefits. http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf. Accessed January 2009.



Cost Estimates

Base Cost Estimates

As we noted in Section 3, we developed cost estimates assuming various markets would be affected by the mandate, as follows:

1. Mandated coverage applies to large group market, only.
2. Mandated coverage applies to large and small group markets.
3. Mandated coverage applies to the large group, small group, and individual markets.
4. Mandated coverage applies to the large group market, and a mandate to offer coverage applies to the small group market.

Large and Small Group Mandated ASD Coverage

The table below summarizes the mandate costs and impact on small and large group premiums under the base assumptions outlined in Section 5. The base estimate is that the long-term cost of the mandated benefits provided by SB 12 would be about 0.73% of insured premiums, though this cost would likely initially be much lower in the years immediately following the passage of the mandate due to the limited supply of ABA therapy providers. If only the large group market were to be covered, our base estimate indicates a 0.76% of premium increase.

	Market		
	Small Group	Large Group	All
Covered Persons	230,000	272,000	502,000
Average Premium per Person	\$3,800	\$3,500	\$3,637
Annual Mandate Claim Cost per Covered Person	\$22.60	\$22.60	\$22.60
Claim Cost as a Percentage of Premium	0.59%	0.65%	0.62%
Estimated Premium Increase with Admin @ 15%	\$26.60	\$26.60	\$26.60
Premium Increase as a Percentage of Premium	0.70%	0.76%	0.73%

Large Group, Small Group, and Individual Mandated Benefits

The large and small group estimates are the same as those shown on the previous page.

Individual Market

In developing the individual market cost estimates we reviewed SB 12 and Kansas rating regulations, and noted the following:

- SB 12 includes the following language: *No individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society or health maintenance organization which provides coverage for accident and health services and which provides coverage with respect to an autism spectrum disorder shall: ... (2) deny or refuse to issue coverage on, refuse to contract with, or refuse to renew, refuse to reissue or otherwise terminate or restrict coverage on an individual solely because the individual is diagnosed with an autism spectrum disorder;*
- Kansas Insurance Department Administrative Regulations (Agency 40, Article 4-Accident and Health Insurers) do not include any rating restrictions based on health status.

Mandating coverage or allowing an individual the option of covering ASD services could potentially have similar impacts on premium rates in the individual market. In either case the coverage would be expensive since insurers would likely price individual coverage assuming that the insured would have a much higher likelihood of utilizing ASD services when purchasing optional ASD coverage, or having a dependent with ASD. Carrier pricing strategies and the manner in which the insurance department would regulate rates for ASD coverage is difficult to ascertain at this time, however, it is reasonable to assume that insurers would price it conservatively to mitigate the financial risk associated with covering individuals with high expected medical costs.

We have assumed that the average amounts would be based on the same cost assumptions outlined in the prior sections of this report. We estimate an average increase of 1.07% assuming a 15% average retention percentage for all markets as shown in the table below:

	Market
	Individual
Covered Persons	175,000
Average Premium per Person	\$2,200
Annual Mandate Claim Cost per Covered Person	\$20.00
Claim Cost as a Percentage of Premium	0.91%
Estimated Premium Increase with Admin @ 15%	\$23.50
Premium Increase as a Percentage of Premium	1.07%

We note that the premium increases in the individual market would be borne primarily by the purchasers of policies who have dependents with ASD. Policyholders that would not be at risk for ASD claims would likely see little or no premium increase, with actual premium increase amounts being dependent upon carrier pricing strategies which will vary.

If the mandate covers the large group, small group and individual markets, we estimate that the overall premium increase for affected policyholders will be approximately 0.79%.

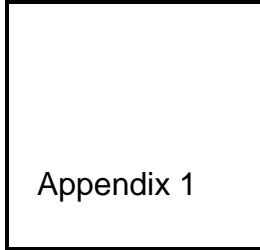
Large Group Mandated and Small Group Optional ASD Coverage

The large group premium increase under the Base Scenario would still be the same, 0.76%. Pricing the optional small group coverage will be a little bit difficult in that the carrier will have to make some assumptions regarding the likelihood of groups electing coverage and the morbidity of the groups electing coverage. For optional ASD coverage, a carrier will likely charge some amount, perhaps 2-3 times the 0.70% premium increase estimated for mandated coverage since a carrier would likely assume that those groups electing coverage will have higher claims. The carrier also could potentially include a small contingency charge for all policyholders to account for the additional risk of offering a new benefit that is difficult to price. Overall, premiums for policyholders electing optional ASD coverage would likely see premium increase of 1-3%, and policyholders not electing coverage could potentially see a small risk charge. An upper bound on the average increase in premiums for optional small group coverage is the 0.70% estimate assuming mandated coverage for all small groups, though the average increase would likely be less than that amount as certain groups would not purchase optional coverage.

Scenario Estimates

As discussed in Section 1, very little insurance data exists that can be used to directly estimate the costs of ABA benefits mandated by SB 12. This causes uncertainty in developing actuarial assumptions and cost estimates. Due to this uncertainty, it is useful to develop cost estimates for additional scenarios using more optimistic and pessimistic assumptions. Ranges of the long-term premium increases associated with mandated benefits under SB 12 are that premiums would increase as follows assuming the mandate covers various markets:

1. Mandated coverage applies to large group market, only- premium increase of 0.57% to 0.95%.
2. Mandated coverage applies to large and small group markets- premium increase of 0.55% to 0.91%.
3. Mandated coverage applies to the large group, small group, and individual markets- premium increase of 0.59% to 0.99%.
4. Mandated coverage applies to the large group market, and a mandate to offer coverage applies to the small group market- Average increase will likely be similar to Estimate 2 above - 0.55% to 0.91%.



Cost Assumptions – Illustrative Exhibits

EXHIBIT I - SUMMARY OF SENATE BILL 12 ASSUMPTIONS AND COSTS

State	Kansas	Key Assumptions:		
Mandate Market		United States Prevalence	Average Age of Diagnosis	% of Diagnosed Children w/ ABA
Individual	No	Diagnostic Subtype	Ultimate Prevalence	Under 6
Small Group	Yes	Autistic Disorder	1 in 450	6
Large Group	Yes	PDD-NOS	1 in 300	7
Self-Insured (ERISA)	No	Asperger's	1 in 900	8
State and Local Govt	No	All ASD	1 in 150	9
				10
				11
				12
				13 to 21
Age Limits for Autism Benefits		Kansas Prevalence Adjustment:	0.85	66.7%
Minimum	0			50.0%
Maximum	21			33.3%
		Kansas Prevalence	Average Age of Diagnosis	Average ABA Program Hours
Additional Annual Medical Costs for Non ABA Services		Diagnostic Subtype	Ultimate Prevalence	Ages Under 8
All Ages \$	3,700	Autistic Disorder	1 in 529	1,500
		PDD-NOS	1 in 353	671
		Asperger's	1 in 1059	401
		All ASD	1 in 176	
Annual Limits by Covered Service				Cost per ABA Hour:
ABA	Hours Limit No	Max Hours -	Dollar Limit Yes	Max \$s \$75,000
				\$41.34

Market
Individual
Small Group
Large Group
Self-Insured (ERISA)
State, Local and Federal
Total

Coverage Estimates		
Number of Persons Covered	Premium (Per Person)	Total Premium
230,000	3,800	874,000,000
272,000	3,500	952,000,000
502,000	\$ 3,637	\$ 1,826,000,000

Costs Excluding Administrative Expense			Premium Increase including Admin @ 15%		
Costs	Costs (% of Premium)	Cost (Per Covered Person)	Incremental Premium	Premium Increase %	Annual Increase per Covered Person
5,198,000	0.59%	22.60	6,115,000	0.70%	26.60
6,147,200	0.65%	22.60	7,232,000	0.76%	26.60
\$ 11,345,200	0.62%	\$ 22.60	\$ 13,347,000	0.73%	\$ 26.60

Exhibit II - Treated Prevalence by Age

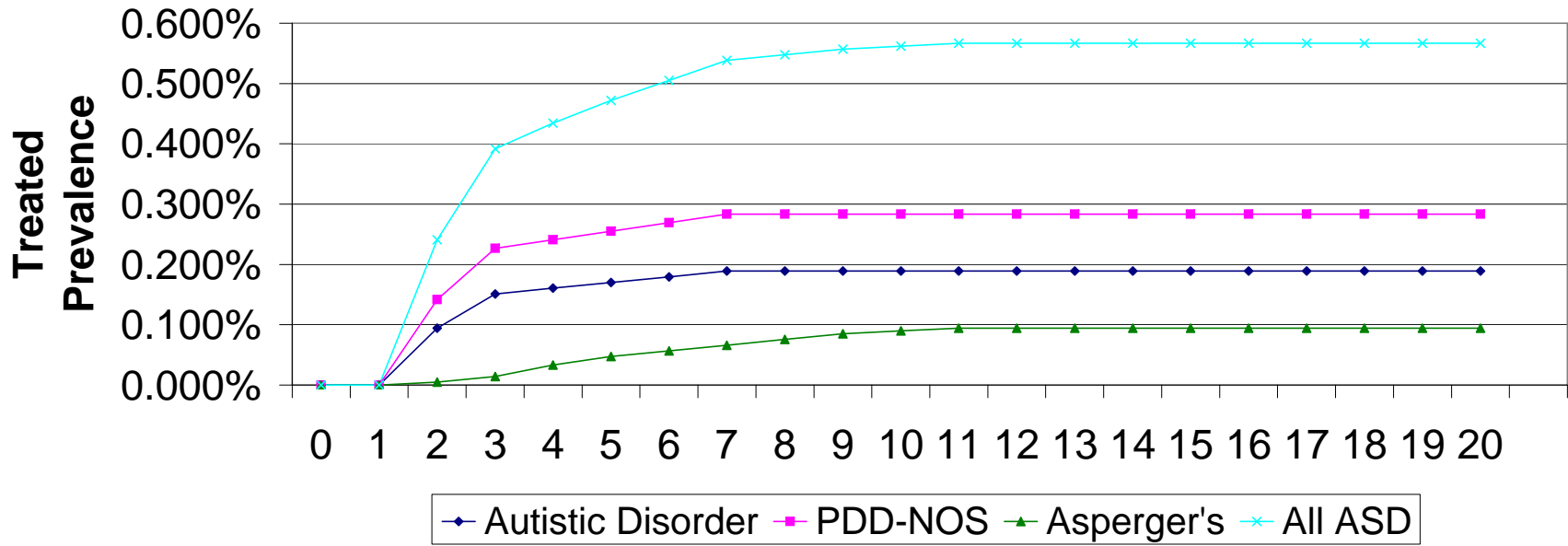


Exhibit III - Annual Cost Per Diagnosed/Treated Child

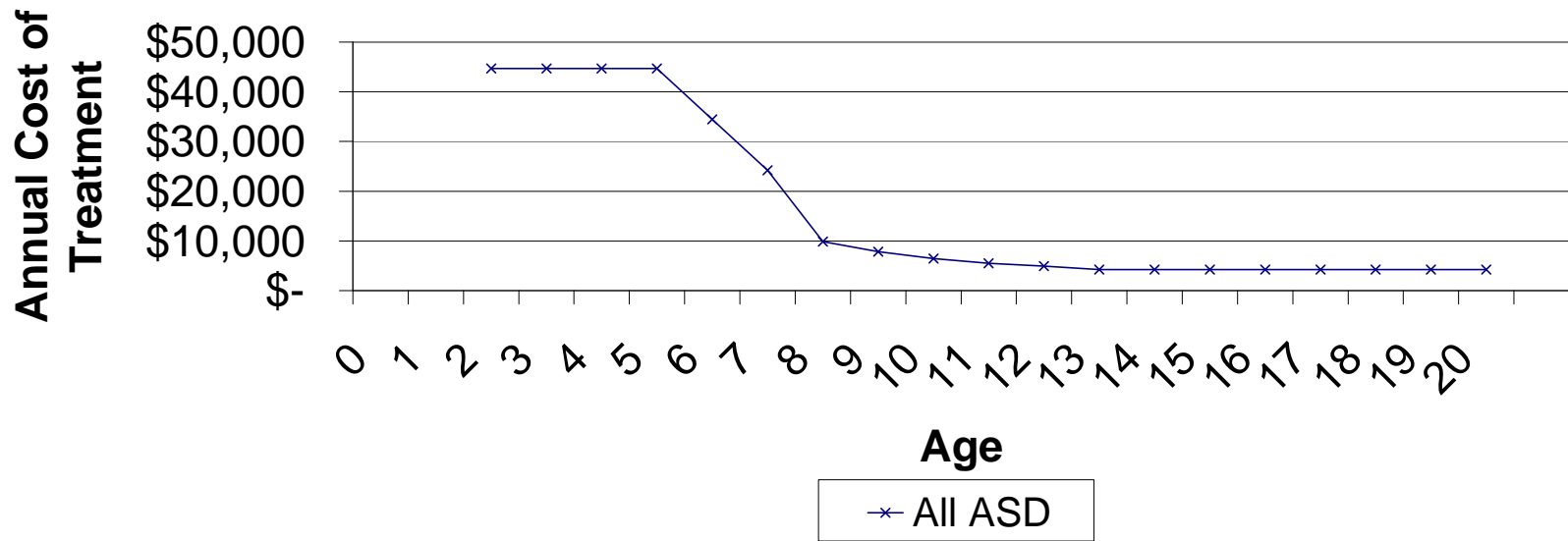


Exhibit IV - Annual Cost Per Autistic Child (Includes both Diagnosed and Undiagnosed Children)

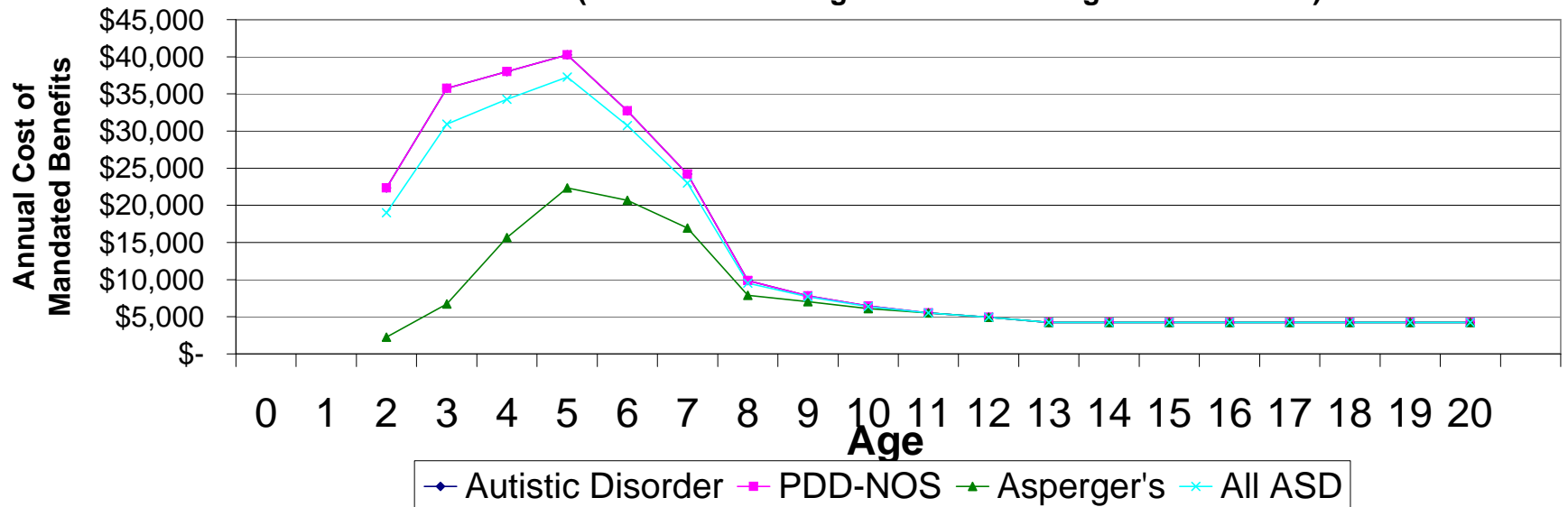


Exhibit V - ABA Utilization vs. Treated Prevalence

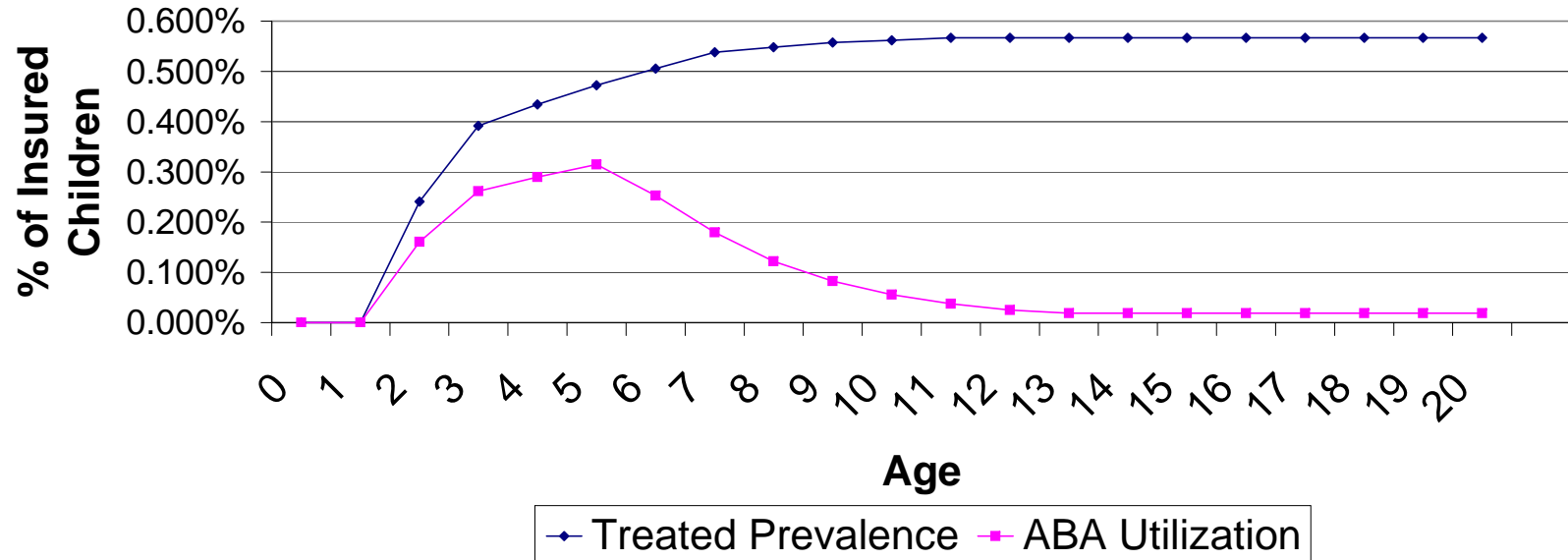
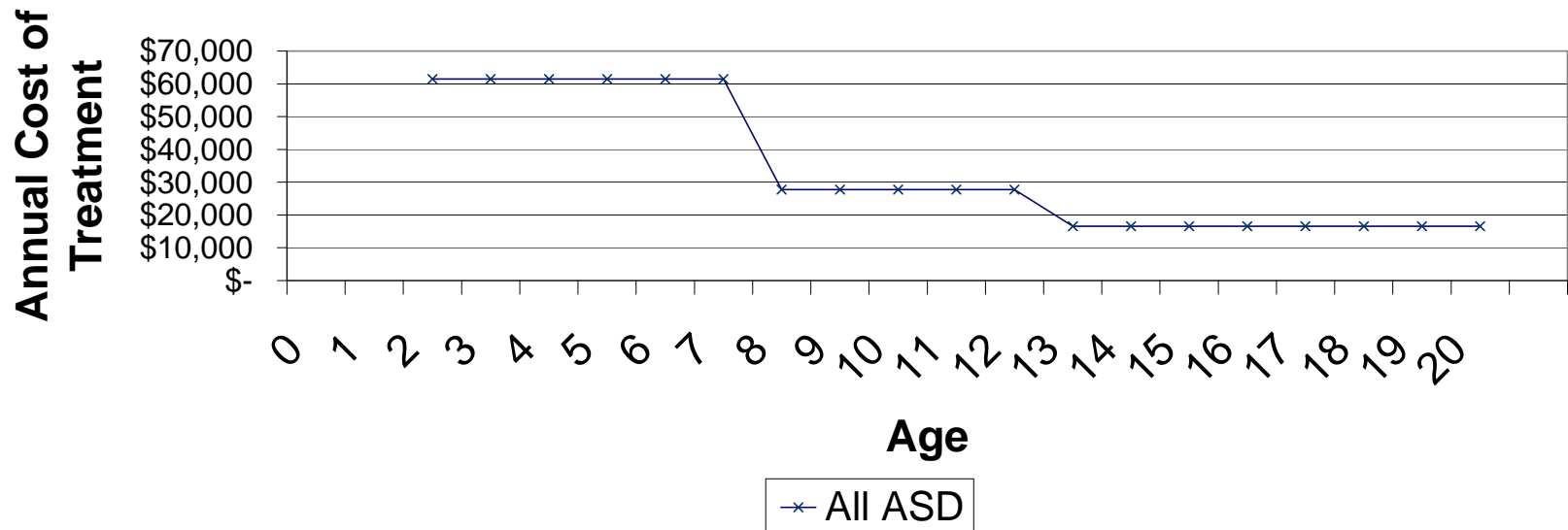


Exhibit VI - Annual Cost per Child With ABA Program



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