

October 20, 2009

Actuarial Cost Estimate:  
The Commonwealth of  
Massachusetts House Bill  
3809

AN ACT RELATIVE TO INSURANCE  
COVERAGE FOR AUTISM

**OLIVER WYMAN**

Prepared By:

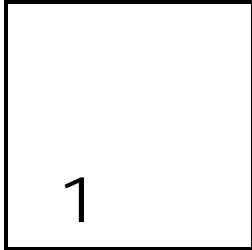
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## Background

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 of the benefits mandated by the Commonwealth of Massachusetts House Bill 3809 which provides coverage for the diagnosis and treatment of autism spectrum disorders. This report is a revision of our May 4, 2009 report. The reason that we have prepared this revised report is to address the potential cost impact of the Centers for Disease Control (CDC) increased overall ASD prevalence estimates that were preliminarily communicated earlier this month. We note that the CDC has not yet communicated any revised estimates in a formal report, and it is not clear what the detailed findings of the formal report will be, or how these could be expected to impact insurance cost estimates.

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 House Bill 3809 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.

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## 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 House Bill 3809 and the associated premium impact on the markets affected by House Bill 3809. 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 House Bill 3809.

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 estimating costs, though typically independent estimates show premium increases due to mandated autism benefits of less than 1%. A March 2009 report of The Council for Affordable Health Insurance states: “CAHI’s actuarial working team estimates that an autism mandate increases the cost of health insurance by about 1 percent.”<sup>1</sup> The reason for this variability is that the largest component of the increase in costs under the House Bill 3809 mandated ASD benefits is for behavioral therapy, including 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 further 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 uncertain. Insurance policies often cover some services for children diagnosed with an ASD, although the mandate could cause the insured costs for certain services to

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

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.

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## Description of Key House Bill 3809 Provisions and their Impact on Covered Benefits

### Insurance Markets Covered by the Mandate

The Bill amends Chapter 32A, Chapter 175, Chapter 176A, Chapter 176B, and Chapter 176G of the General Laws. House Bill 3809 appears to apply to the merged market (small group and post-July 2007 individual), large group (51+ employees), and government agency markets. It does not appear to apply to the individual closed block market.

### Covered Benefits

The Bill provides for the diagnosis and treatment of autism spectrum disorders, by stating that “*The commission shall provide...for the diagnosis and treatment of Autism Spectrum Disorder in individuals.*” Treatment of autism spectrum disorders “*will include the following care prescribed, provided, or ordered for an individual diagnosed with one of the autism spectrum disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary:*

- a. habilitative or rehabilitative care;*
- b. pharmacy care;*
- c. psychiatric care;*
- d. psychological care; and*
- e. therapeutic care.*

*... ‘Habilitative or rehabilitative care’ means professional, counseling, and guidance services and treatment programs, including applied behavior analysis supervised by a Board Certified Behavior Analyst, that are necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an individual.”*

The inclusion of applied behavior analysis (ABA), in the definition of “*habilitative or rehabilitative care*” is especially important. The coverage of behavioral therapies, including ABA, has the most significant impact on cost of any mandated service. For the purpose of this report, reference to ABA encompasses all behavioral therapies. We note ABA is the most widely accepted behavioral therapy and that we would expect other approved behavioral programs to have similar costs.

ABA programs are marked by intensive therapy that may include 30-40 hours of therapy a week under the most intensive programs, although many programs would not utilize that level of resources. Key assumptions underlying our ABA cost estimates are outlined in Section 5.

Annual Maximum Benefit for Applied Behavior Analysis

The Bill specifically states that “*Any such policy shall be deemed to be providing such benefits on a nondiscriminatory basis if the policy does not contain any annual or lifetime dollar or unit of service limitation on coverage for the diagnosis and treatment of said Autism Spectrum Disorders which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the diagnosis and treatment of physical conditions.*” Therefore, we have assumed that the Bill would not limit the annual benefits for ABA services that an insured may receive.

Maximum Age for Benefits

The Bill does not contain any language that limits the ages for which insureds may receive covered ASD services.

Medical Necessity and Treatment Review

The Bill does not contain any language related to utilization review. Therefore, we assume that ASD benefits under the Bill will be subject to utilization review procedures currently in place by insurers. This is important as insurers will develop protocols to review treatments and manage care which will limit unnecessary treatments if reviews are done appropriately.

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## Modeling Methodology

The following 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 6. Details of key assumptions are discussed in Section 5 and illustrated graphically in the exhibits shown in Appendix 1.

## 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 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 mandated ASD services and for parents of autistic children to aggressively seek diagnosis and treatment of their children's 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.

Acknowledging that short-term costs are also important to policymakers, in the sections outlining our cost estimates, we have included illustrative exhibits showing the possible progression of costs for mandated 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.

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 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 mandate might change after the first year.<sup>2</sup> 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 premium<sup>3</sup>), so the statistics provided indicate a mandate cost of less than 0.1% of premium.

## 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 current estimate of ASD prevalence in the United States.
2. Prevalence rates by diagnostic subtype (autistic disorder, PDD-NOS, Asperger's Syndrome) were estimated separately, since diagnosis patterns and service utilization could reasonably be expected to vary 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.<sup>4</sup>
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 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 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.

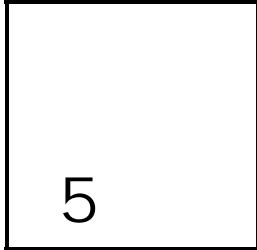
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<sup>2</sup> Associated Press. *Lawmaker: Oklahoma autism bill has momentum*. December 4, 2008. <http://newsok.com/article/3327594>. Accessed January 2009.

<sup>3</sup> NAIC Annual Statements for 2007.

<sup>4</sup> IAN database. <http://dashboard.ianexchange.org/StateStatsAdvanced.aspx?A1=VA&ADU=T>. Accessed January 2009.

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 Massachusetts, and Kaiser Family Foundation coverage data. These assumptions are further documented in Section 5.
11. 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 under a range of assumptions to develop “Low,” “Middle,” and “High” cost scenario estimates.



## Summary of Key Assumptions

Key assumptions underlying the cost estimates for the proposed mandated 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

Overall treated prevalence is based on the 2007 CDC<sup>5</sup> study estimating United States ASD prevalence of 1 in 150. Prevalence by diagnostic subtype was estimated based on an academic study published in the American Journal of Psychiatry.<sup>6</sup>

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 Massachusetts are shown below:

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

<sup>5</sup> Centers for Disease Control. Morbidity and Mortality Weekly Report. February 9, 2007.

<sup>6</sup> 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, and many others diagnosed with ASD, especially those in more rural areas, may have difficulty accessing a provider. For this reason, we have assumed that 40% to 66.7% (40% for “Low” scenario, 50% for “Middle” and 66.7% for “High”) of diagnosed children under age 6 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.

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 olds<sup>7</sup>, which is considerably 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 in their teenage years. Programs would be expected to terminate if a child has experienced sufficient progress whereby a program is no longer necessary or if the insurer or family sees no progress, as well as for other reasons.

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<sup>7</sup> 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.

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

<b>% of Diagnosed Children w/ ABA</b>	
Under 6	50.0%
6	37.5%
7	25.0%
8	16.7%
9	11.1%
10	7.4%
11	4.9%
12	3.3%
Ages 13 to 21	2.5%

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 benefits.<sup>8</sup> For three age bands we developed a distribution of expected hours that resulted in the annual averages shown in the table below:

<b>Average ABA Program Hours</b>	
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 Massachusetts, based on Bureau of Labor Statistics<sup>9</sup> health care wage data. The resulting average cost per hour of ABA therapy in Massachusetts is \$51.90 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.

<sup>8</sup> Autism Therapy Reference- Microsoft Corporation (administered by Premera Blue Cross).

<sup>9</sup> BLS wage data. <http://www.bls.gov/guide/geography/wages.htm> accessed January 2009.

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 as follows:

- “**Low**” cost scenario - assumes average ABA program cost is \$45,000 per year.
- “**Middle**” cost scenario - assumes average ABA program cost is \$55,000 per year.
- “**High**” cost scenario - based on the assumptions outlined in this section for the continuance of ABA programming, the number of annual hours for ABA programming, and an hourly rate of \$51.90, the calculated average annual cost for an ABA program for all ages is \$64,981.

Adjusted Treated Prevalence Rate for “High” Scenario

We note that the CDC has recently disseminated preliminary information that suggests that the ASD population prevalence rate may be closer to 1 in 100. This information has not yet been released in a formal report. While we believe that it is appropriate to reflect this emerging, though preliminary estimate in our analysis, it is unclear to what degree the increased population prevalence will impact the treated prevalence which would drive medical insurance costs. For this reason we believe assuming a 1 in 100 treated prevalence rate is conservative for cost estimation purposes, as there are multiple reasons that treated prevalence would be expected to be lower than population prevalence.

**Other (than ABA) Medical Costs**

Based on several studies<sup>10</sup>, 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 the mandate would mean that some services that an insurer could currently deny or exclude would now be covered. In our range of estimates, we assumed that the mandate would result in additional insured medical costs equal to 50% to 100% of the current level of estimated covered non-inpatient costs for services to children under 23 diagnosed with an ASD. We also noted that average medical costs for medical services associated with ASD typically decrease as individuals age, so we reduced costs for covered dependents ages 23 and over, which would also take into account that many children with an ASD can become independent adults and would cease to be covered by their parents’ insurance policies. 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 the mandate are shown for each scenario in the table below:

Scenario	Non-ABA Medical Costs under 23	Non-ABA Medical Costs 23 & over
Low	\$2,300	\$1,150
Middle	\$3,450	\$1,725
High	\$4,600	\$2,300

(Amounts in 2009 dollars)

<sup>10</sup> Mandell, Cao, Ittenbach, & Pinto-Martin, 2006. Croen, Najjar, Ray, Lotspeich, & Bernal, 2006. Liptak, Stuart, & Auinger, 2006.

## 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.

## Massachusetts 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 Massachusetts was available for 2006<sup>11</sup>, so we trended this based on average recent employer premium increases provided from the Kaiser Family Foundation HRET<sup>12</sup> 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 Plans,<sup>13</sup> which showed average premiums and members per policy by state.

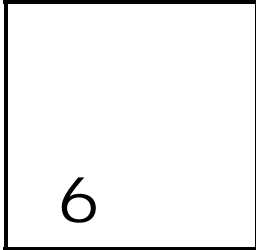
In developing our premium and membership estimates, we utilized 2006 experience, which was prior to the merging of the individual and small group markets in Massachusetts. To approximate the composition of the current market, we combined our individual and small group estimates to develop estimates for the merged market. In addition, we completed reasonableness tests by reviewing 2008 insurer annual statement filing information to ensure that the merged market and large group premium estimates were not unreasonable.

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<sup>11</sup> MEPS state survey data. [http://www.meps.ahrq.gov/mepsweb/data\\_stats/state\\_tables.jsp?regionid=-1&year=-1](http://www.meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp?regionid=-1&year=-1). Accessed January 2009.

<sup>12</sup> Kaiser Family Foundation and Health Research Educational Trust. Employer Health Benefits- 2008 Annual Survey.

<sup>13</sup> 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](http://www.ahipresearch.org/pdfs/Individual_Market_Survey_December_2007.pdf). Accessed January 2009.



## 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 for each market. Our “Middle” estimate is that in the long-term, the premium increase associated with the mandated benefits provided by House Bill 3809 would be about 0.60% of insured premiums, assuming that the merged and large group markets are covered by the Bill. However, we note that costs could be lower in the years immediately following the passage of the mandate due to the limited supply of ABA therapists.

The estimated cost increases for the merged and large group markets are shown in the table below. The annual claim cost per covered person estimate of \$23.30 and premium increase of \$27.40 are in 2009 dollars.

	Market		
	Merged Market	Large Group	All
Covered Persons	929,000	1,245,000	2,174,000
Average Premium per Person	\$5,300	\$4,000	\$4,549
Annual Mandate Claim Cost per Covered Person	\$23.30	\$23.30	\$23.30
Claim Cost as a Percentage of Premium	0.44%	0.58%	0.51%
Estimated Premium Increase with Admin @ 15%	\$27.40	\$27.40	\$27.40
Premium Increase as a Percentage of Premium	0.52%	0.69%	0.60%

### 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 House Bill 3809. 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	% Diagnosed Under Age 6 Starting ABA	Avg. Annual ABA Program Cost	Avg. Annual Under 23 non-ABA Cost	Annual Premium Increase per Person	Premium Increase (% of Premium)
Low	40.0%	\$45,000	\$2,300	\$18.10	0.40%
Middle	50.0%	\$55,000	\$3,450	\$27.40	0.60%
High	66.7%	\$64,981	\$4,600	\$60.30	1.33%

As noted, the “High” estimate also includes an increased ASD treated prevalence estimate of 1 in 100.

### 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 due to the limited supply of ABA therapists 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.

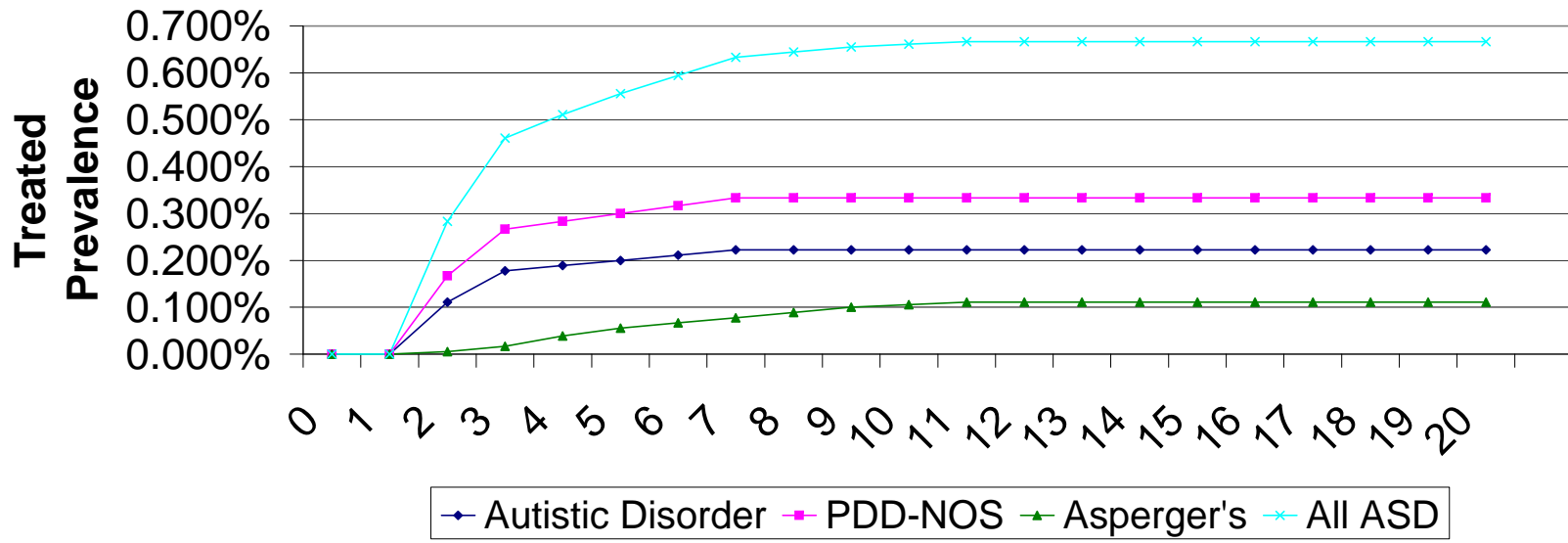
Estimated Increase in Premiums due to HB 3809 by Year						
Scenario	Year 1	Year 2	Year 3	Year 4	Year 5	Years 6 and Beyond
Low	0.13%	0.19%	0.24%	0.29%	0.35%	0.40%
Middle	0.30%	0.36%	0.42%	0.48%	0.54%	0.60%
High	0.88%	0.97%	1.06%	1.15%	1.24%	1.33%

Appendix 1

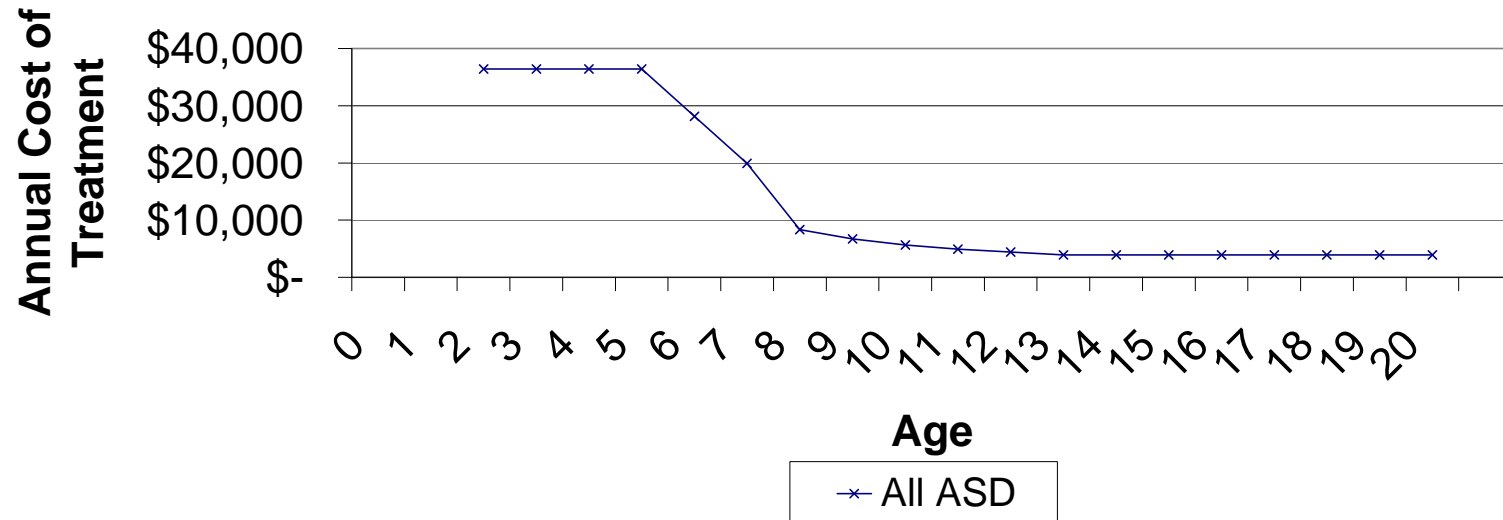
## Cost Assumptions – Illustrative Exhibits



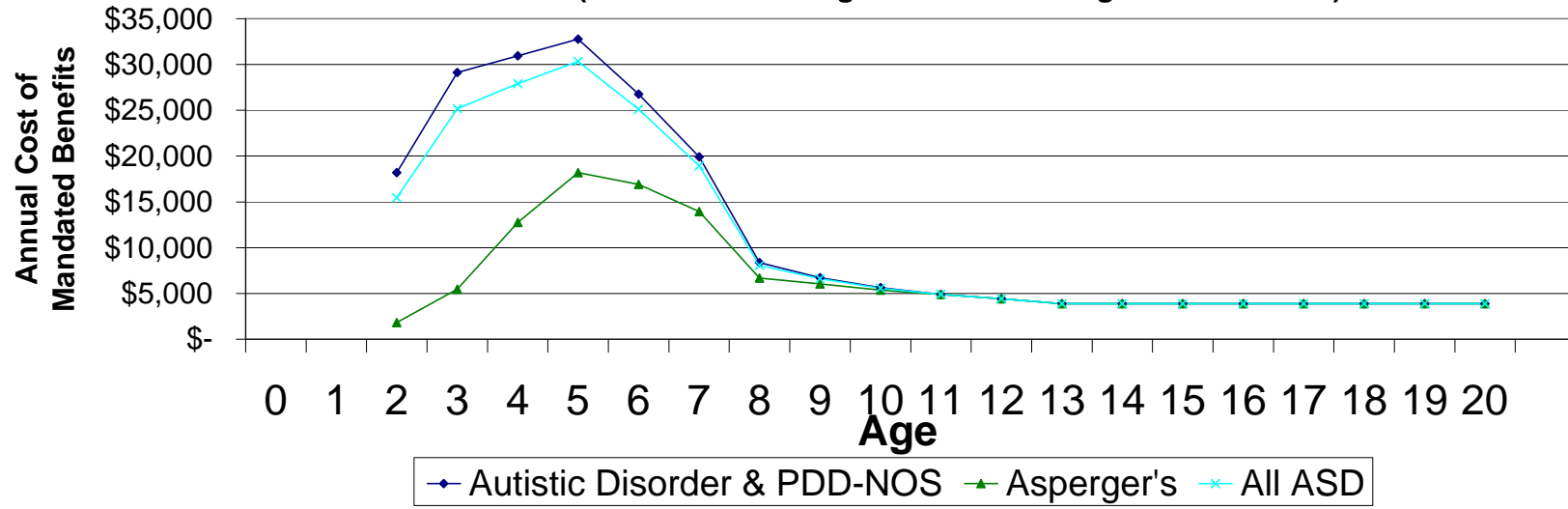
### Exhibit II - Treated Prevalence by Age



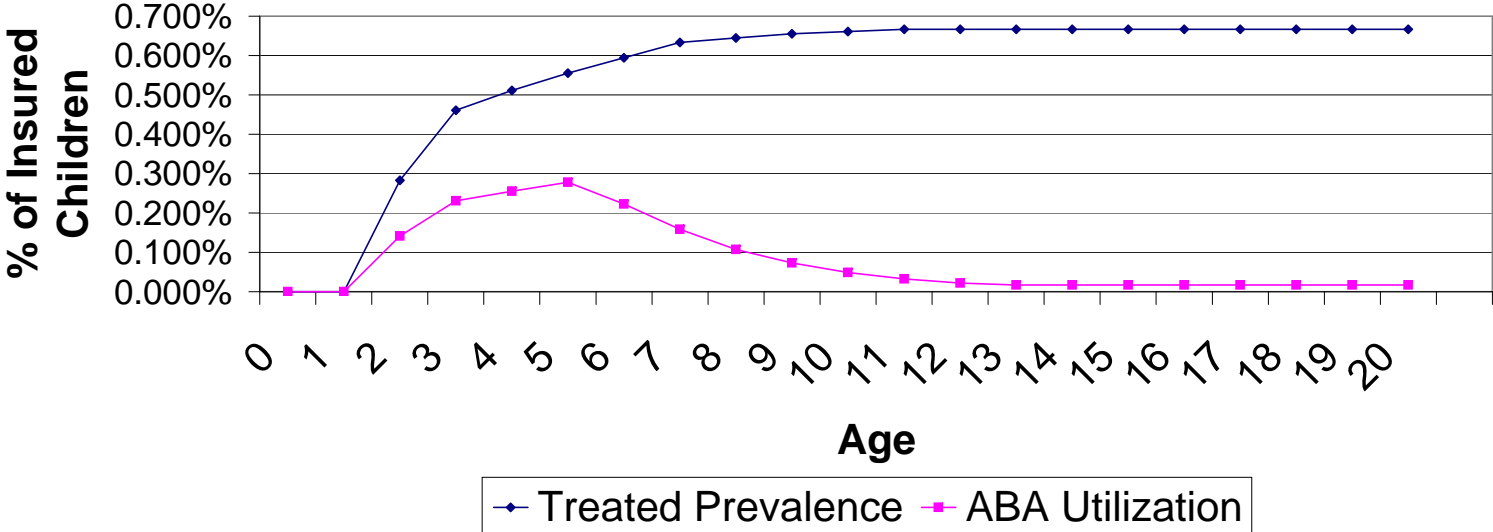
### Exhibit III - Annual Cost Per Diagnosed/Treated Child



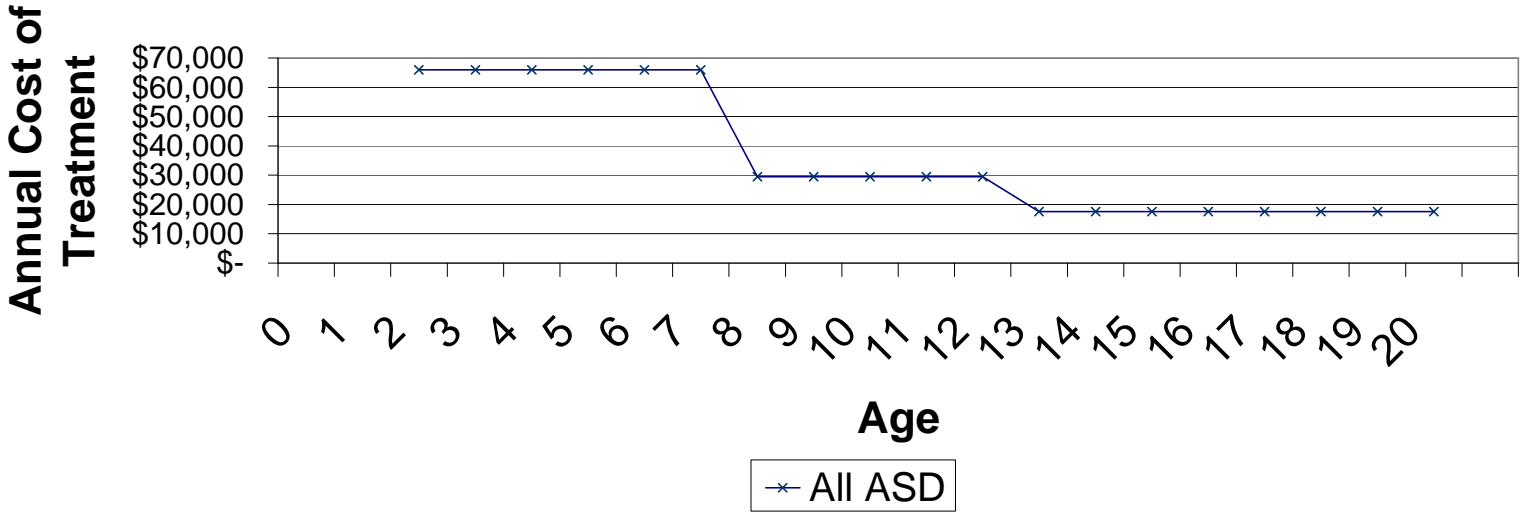
### Exhibit IV - Annual Cost Per Autistic Child (Includes both Diagnosed and Undiagnosed Children)



**Exhibit V - ABA Utilization vs. Treated Prevalence**



### Exhibit VI - Annual Cost per Child With ABA Program



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