

February 19, 2009

Actuarial Cost Estimate:  
Washington Senate Bill 5203  
An Act Relating to Insurance  
Coverage for Autism  
Spectrum Disorders

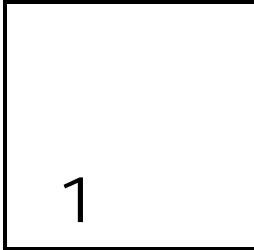
**OLIVER WYMAN**

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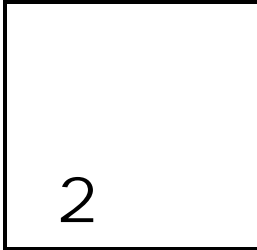


## Background

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 Washington Senate Bill 5203 (SB 5203) 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 5203 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.

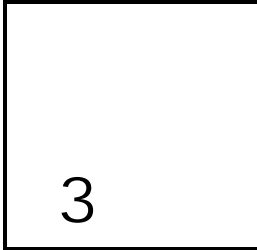


## Scope and Limitations

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 5203 and the associated premium impact on the markets affected by SB 5203. 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 5203.

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 5203 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 5203 Provisions and their Impact on Covered Benefits

### Insurance Markets Covered by Mandate

New Section Sec. 2 states: *(2) Each health plan offered to the public under chapter 48.21, 48.44, or 48.46 RCW must include coverage for the diagnosis of autism spectrum disorders and treatment of autism spectrum disorders in individuals less than twenty-one years of age.*

The sections of the Revised Code of Washington (RCW) referenced in the bill include both individual and group insurers. Therefore, the bill mandates coverage of ASD services for the large group (51+ employees), small group (2-50 employees), and individual markets.

### Covered Benefits

Treatment includes:

- (i) Applied behavior analysis and other structured behavior programs;*
- (ii) Pharmacy care;*
- (iii) Psychiatric care;*
- (iv) Psychological care;*
- (v) Therapeutic care;*
- (vi) Any care for individuals with autism spectrum disorders that is determined by the state health department, based upon its review of best practices or evidence-based research, may be medically necessary and that is published in the Washington State Register. Any such care, treatment, intervention, service, or item that was not previously covered will be included in any health insurance policy delivered, executed, issued, amended, adjusted, or renewed on or after sixty days following the date of its publication in the Washington State Register.*

The inclusion of applied behavior analysis (ABA) 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.

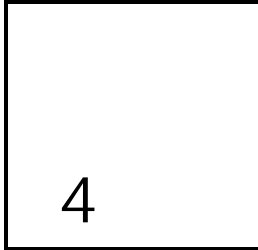
Annual ABA Maximum Benefit of \$50,000 for individuals less than 21

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: *Except for inpatient services, if an individual is receiving treatment for autism spectrum disorders, an insurer will have the right to request a review of that treatment not more than once every six 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 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.

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 68<sup>1</sup> certified BCBAs and BCaBAs in Washington, which translates to approximately one therapist per 145

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<sup>1</sup> BACB Certificant Registry: [http://www.bacb.com/cues/frame\\_about.html](http://www.bacb.com/cues/frame_about.html), accessed January 2009.

children treated for ASD in Washington 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 5203 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 5203, 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.<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. 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.
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.
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 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 an ABA program was developed based on ABA provider input and an assumption that utilization review by insurers would impact utilization to some degree.

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

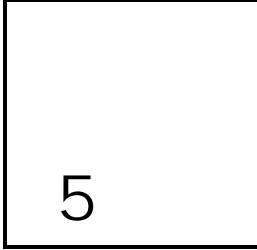
<sup>3</sup> NAIC Annual Statements for 2007.

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

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 \$50,000 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 Washington, 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 Washington, we reviewed the rating requirements in RCW Chapters 48.43 and 48.44<sup>5</sup>. These Washington individual market rating regulations are 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.

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<sup>5</sup> Revised Code of Washington- Title 48 Insurance. <http://apps.leg.wa.gov/RCW/default.aspx?Cite=48>. 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 CDC<sup>6</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>7</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 base model treated prevalence and age at diagnosis assumptions for Washington are shown below:

<b><u>Washington 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>6</sup> Centers for Disease Control. Morbidity and Mortality Weekly Report. February 9, 2007.

<sup>7</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. 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 olds<sup>8</sup>, 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 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:

<b>% of Diagnosed Children w/ ABA</b>	
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%
Ages 13 to 20	3.3%

<sup>8</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.

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>9</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, 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 Washington, based on Bureau of Labor Statistics<sup>10</sup> health care wage data. The resulting average cost per hour of ABA therapy in Washington is \$50.37.

**Other (than ABA) Medical Costs**

Based on several studies<sup>11</sup>, 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, 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, often

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<sup>9</sup> Autism Therapy Reference- Microsoft Corporation (administered by Premera Blue Cross).

<sup>10</sup> BLS wage data. <http://www.bls.gov/guide/geography/wages.htm> accessed January 2009.

<sup>11</sup> Mandell, Cao, Ittenbach, & Pinto-Martin, 2006. Croen, Najjar, Ray, Lotspeich, & Bernal, 2006. Liptak, Stuart, & Auinger, 2006.

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

## Washington 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 estimated the size of the privately insured small group, insured large group, and self-insured markets. State specific premium data for Washington was available for 2006<sup>12</sup>, so we trended this based on average recent employer premium increases provided from the Kaiser Family Foundation HRET<sup>13</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>14</sup> that showed premiums and average members by contract type and state.

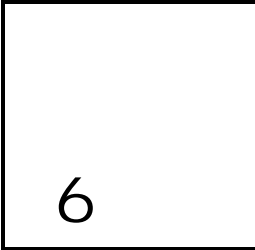
As part of our development of premiums and membership estimates, we completed reasonableness tests by reviewing insurer annual statement filings to ensure that the individual and group premium estimates were not unreasonable.

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<sup>12</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>13</sup> Kaiser Family Foundation and Health Research Educational Trust. Employer Health Benefits- 2008 Annual Survey.

<sup>14</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

### Base Cost Estimates

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

The table below summarizes our estimates of the mandate costs and impact on small and large group premiums under the base assumptions outlined in Section 5. The base estimate is that in the long-term cost the mandated benefits provided by SB 5203 would result in an increase of about 0.73% of insured premiums assuming the individual, small group, and large group private insurance markets are covered by the bill, 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 therapists. The estimated premium increases for the individual, small group, and large group markets are shown in the table below.

	Market			
	Individual	Small Group	Large Group	All
Covered Persons	326,000	439,000	452,000	1,217,000
Average Premium per Person	\$2,200	\$3,700	\$3,800	\$3,335
Annual Mandate Claim Cost per Covered Person	\$20.70	\$20.70	\$20.70	\$20.70
Claim Cost as a Percentage of Premium	0.94%	0.56%	0.54%	0.62%
Estimated Premium Increase with Admin @ 15%	\$24.40	\$24.40	\$24.40	\$24.40
Premium Increase as a Percentage of Premium	1.11%	0.66%	0.64%	0.73%

In developing the impact on the individual market, we assumed that the current mechanism of underwriting individual insureds based on a health questionnaire would remain in place, and that the mix of risks written by private insurers in the individual market would not change. This is based on our understanding that applicants currently would be guaranteed coverage by an individual insurer or, if rejected, by the Washington State Health Insurance Pool, so the bill would not necessarily affect the mix of the risks written by private insurers in the individual market. Should the bill and any subsequent

administrative actions actually change the way that individuals with ASD are underwritten; our estimate of the impact on the individual market could be revisited.

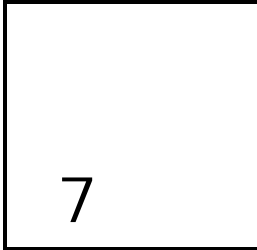
## Scenario Estimates

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 5203. 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 5203 are that premiums would increase as follows assuming the mandate covers various markets:

Small and Large Group Markets - premium increase of 0.50% to 0.80%.

Individual Market- premium increase of 0.80% to 1.40%.

Small Group, Large Group, and Individual Markets- premium increase of 0.55% to 0.90%.



## Comments on SB 5203 Fiscal Note

### Data, Information, and Assumptions

Per “HCA Fiscal Note”

- *We expect the highest cost group to be the age zero through seven and have assumed, the costs will be \$50,000 per child per year. The \$50,000 cost estimate is increased at a rate of 3.5 percent per year.*
- *HCA assumes an incidence rate of 1 per 150 children under the age of twenty one consistent with published literature. We assume the number of members who would receive autism related services would be 497 each year. We assume 151 children are age zero through seven. We assume 346 children are age eight through twenty.*
- *The \$50,000 annual limit increases by 3.5 percent each year and pertains to the children age zero through seven. For children age eight through twenty, we assume an increased annual cost of \$8,000 with medical trend increases of 7 percent.*

### Suggested Revisions to Fiscal Note Assumptions

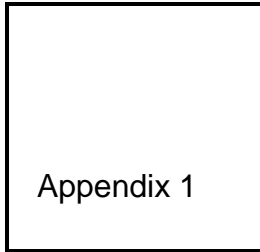
Based on the number of ASD individuals under 21 estimated at 497, the 1/150 prevalence estimate, and our estimate that approximately 30% of the members covered by the state plan are under 21, we would estimate that the fiscal note estimates costs for approximately 250,000 covered individuals.

The cost estimates discussed in this report indicate a per member per year cost of about \$20.70 for group insurance products. We would expect a similar cost for the coverage of state employees. This translates into a total cost of about \$5.2 million for calendar year 2009. Trending at the 7% rate in the HCA analysis and adding about 10% for administrative costs (which is conservative), we would estimate a fiscal impact of no more than \$3 million for the six months ending June 30, 2010. Note that this \$3 million is a conservative estimate since it assumes there are sufficient ABA therapists to meet the

demand, and is not adjusted to reflect the real shortage of therapists that currently exists. Our \$3 million estimate compares to an HCA estimate of \$5,384,265. We would expect that our estimates would also be 50-60% of HCA's estimates in the other projection years.

It would be appropriate to adjust the SB 5203 fiscal note assumptions for the following reasons:

- 1 in 150 prevalence is the CDC population prevalence estimate for eight year-olds, it is not a prevalence statistic for all ages. The average age of diagnosis is generally accepted to be between three and four years old, this is not accounted for in the fiscal note estimate. If the fiscal note took into consideration that undiagnosed children could not receive treatment, the treated number of children under 8 would be reduced by approximately 40%, as would the costs for these children. This would translate into an FY2010 reduction of about \$1.7 million. HCA should incorporate an assumption for the age of diagnosis when developing estimates for all projection years.
- It is not plausible that all children diagnosed with ASD will have an ABA program and use the maximum annual benefit \$50,000 in FY 2010 when there is a shortage of ABA providers. In Minnesota, a state with a significant ABA provider network, data showing that 20% of 3 to 6 year olds diagnosed with ASD recently had an ABA program is supportive of this statement.



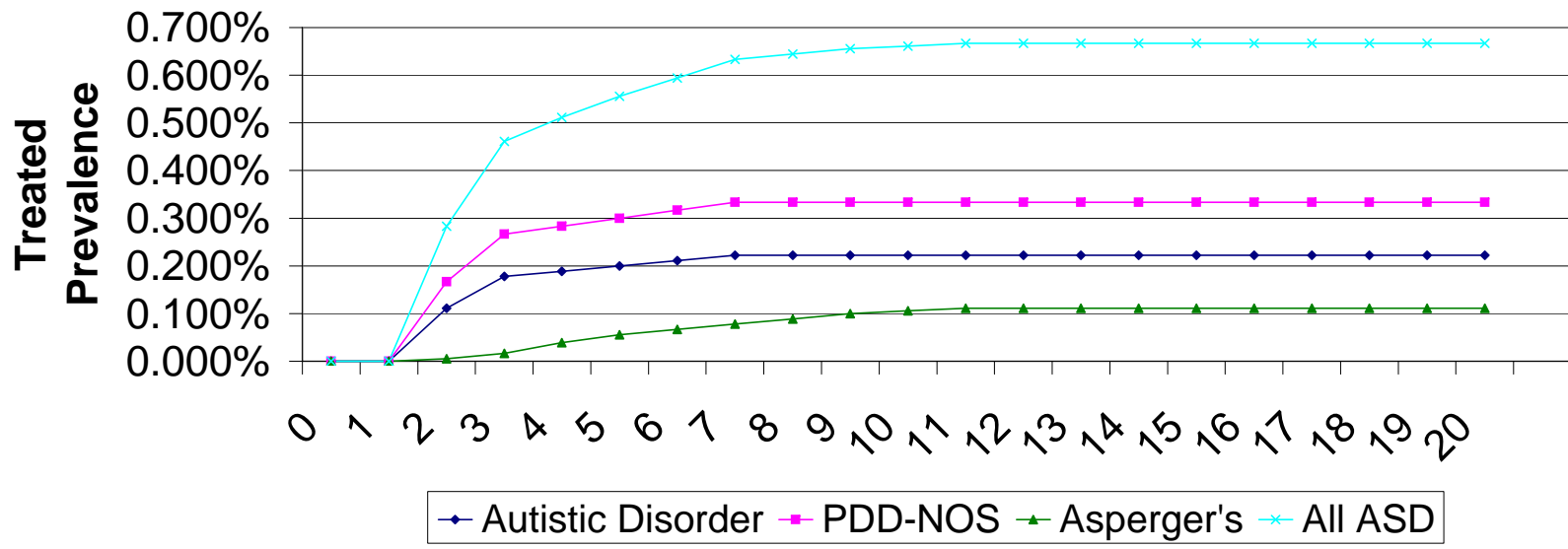
## Cost Assumptions – Illustrative Exhibits

## EXHIBIT I - SUMMARY OF SENATE BILL 5203 ASSUMPTIONS AND COSTS

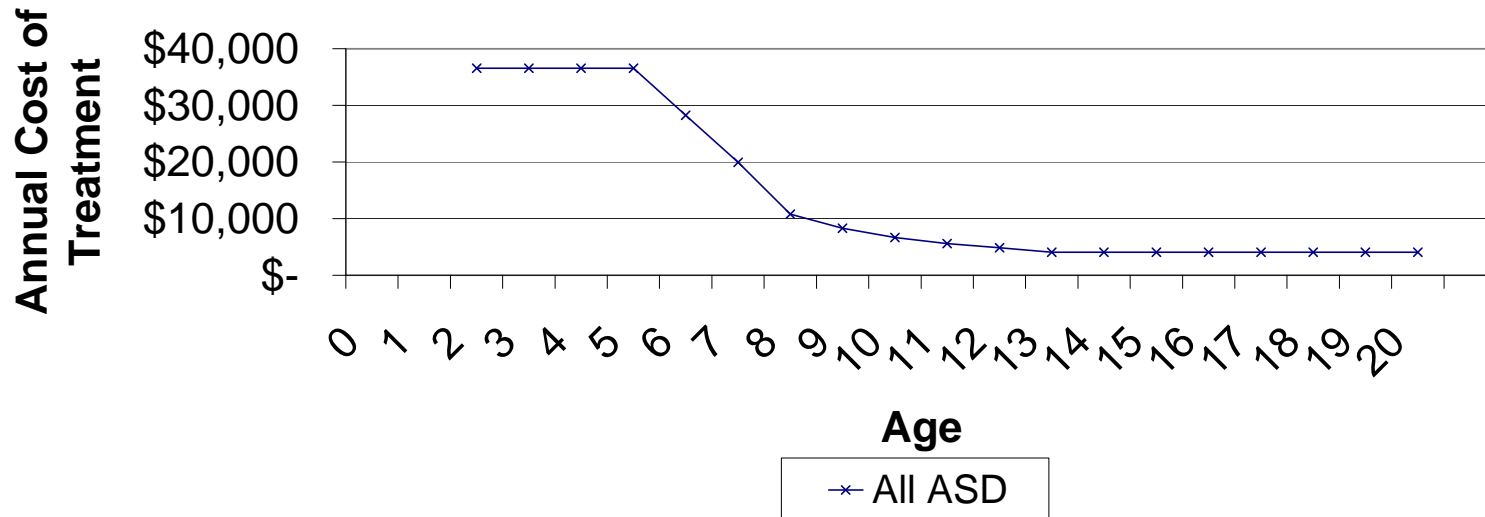
<b>State</b>	Washington	<b>Key Assumptions:</b>		
		<b>United States Prevalence</b>		<b>% of Diagnosed Children w/ ABA</b>
<b>Mandate Market</b>		<b>Diagnostic Subtype</b>	<b>Ultimate Prevalence</b>	<b>Average Age of Diagnosis</b>
Individual	Yes	Autistic Disorder	1 in 450	0
Small Group	Yes	PDD-NOS	1 in 300	0
Large Group	Yes	Asperger's	1 in 900	0
Self-Insured (ERISA)	No	<b>All ASD</b>	<b>1 in 150</b>	
State and Local Govt	No			
				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%
				Ages 13 to 20      3.3%
<b>Age Limits for Autism Benefits</b>		Washington Prevalence Adjustment:	1.00	
Minimum	0			
Maximum	20			
		<b>Washington Prevalence</b>		
		<b>Diagnostic Subtype</b>	<b>Ultimate Prevalence</b>	<b>Average Age of Diagnosis</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>	
				<b>Average ABA Program Hours</b>
				Ages Under 8      1,500
				Ages 8 to 12      671
				Ages 13 to 20      401
<b>Additional Annual Medical Costs for Non ABA Services</b>				
All Ages	\$ 3,400			
<b>Annual Limits by Covered Service</b>				
	<b>Hours Limit</b>	<b>Max Hours</b>	<b>Dollar Limit</b>	<b>Max \$s</b>
ABA	No	-	Yes	\$50,000
				<b>Cost per ABA Hour:</b> \$50.37

Market	Coverage Estimates			Costs Excluding Administrative Expense			Premium Increase including Admin @ 15%		
	Number of Persons Covered	Premium (Per Person)	Total Premium	Costs	Costs (% of Premium)	Cost (Per Covered Person)	Incremental Premium	Premium Increase %	Annual Increase per Covered Person
Individual	326,000	\$ 2,200	\$ 717,200,000	\$ 6,748,200	0.94%	\$ 20.70	\$ 7,939,000	1.11%	\$ 24.40
Small Group	439,000	3,700	1,624,300,000	9,087,300	0.56%	20.70	10,691,000	0.66%	24.40
Large Group	452,000	3,800	1,717,600,000	9,356,400	0.54%	20.70	11,008,000	0.64%	24.40
Self-Insured (ERISA)									
State, Local and Federal									
<b>Total</b>	1,217,000	\$ 3,335	\$ 4,059,100,000	\$ 25,191,900	0.62%	\$ 20.70	\$ 29,638,000	0.73%	\$ 24.40

### Exhibit II - Treated Prevalence by Age

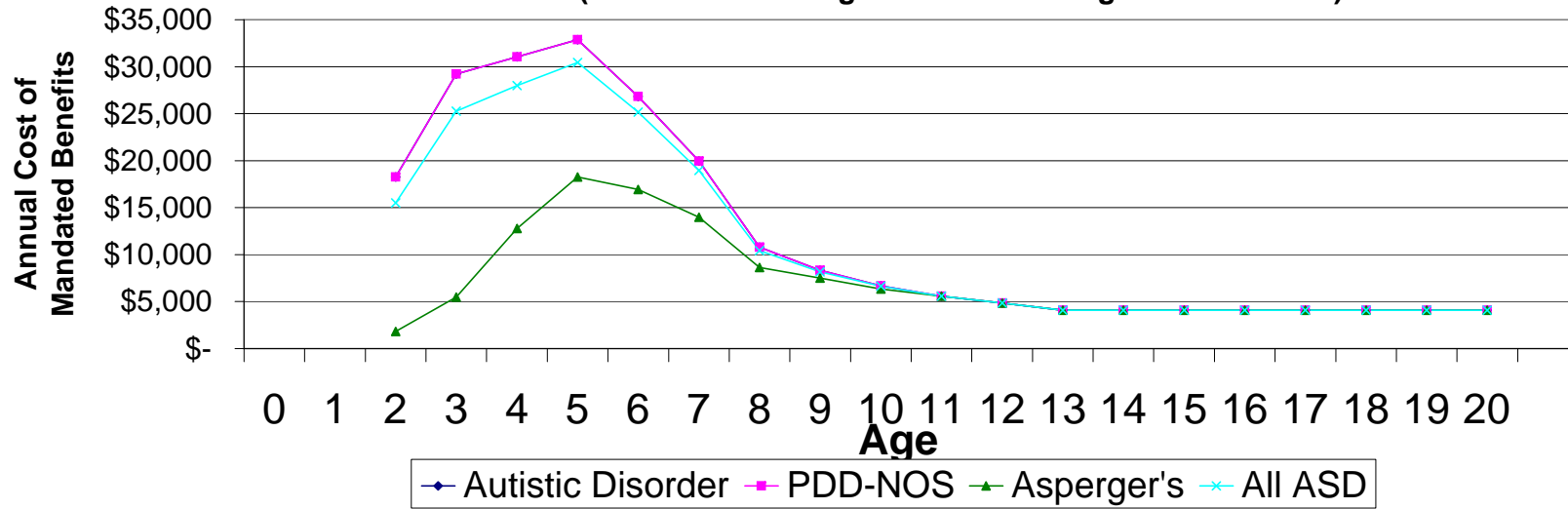


### Exhibit III - Annual Cost Per Diagnosed/Treated Child

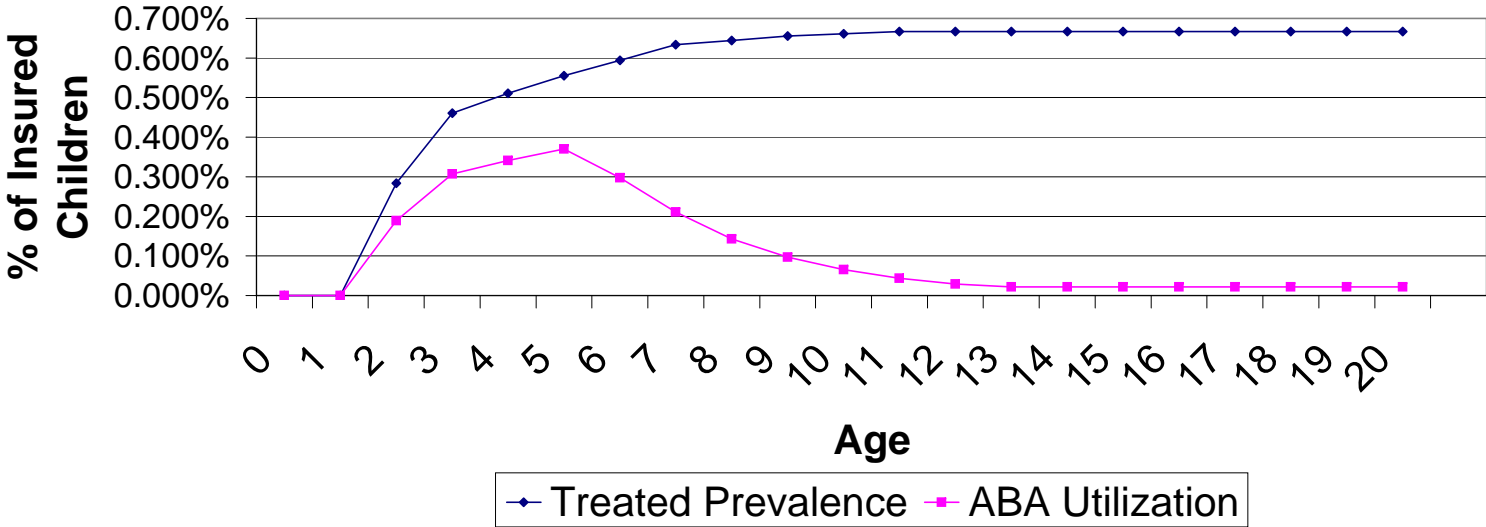


## Exhibit IV - Annual Cost Per Autistic Child

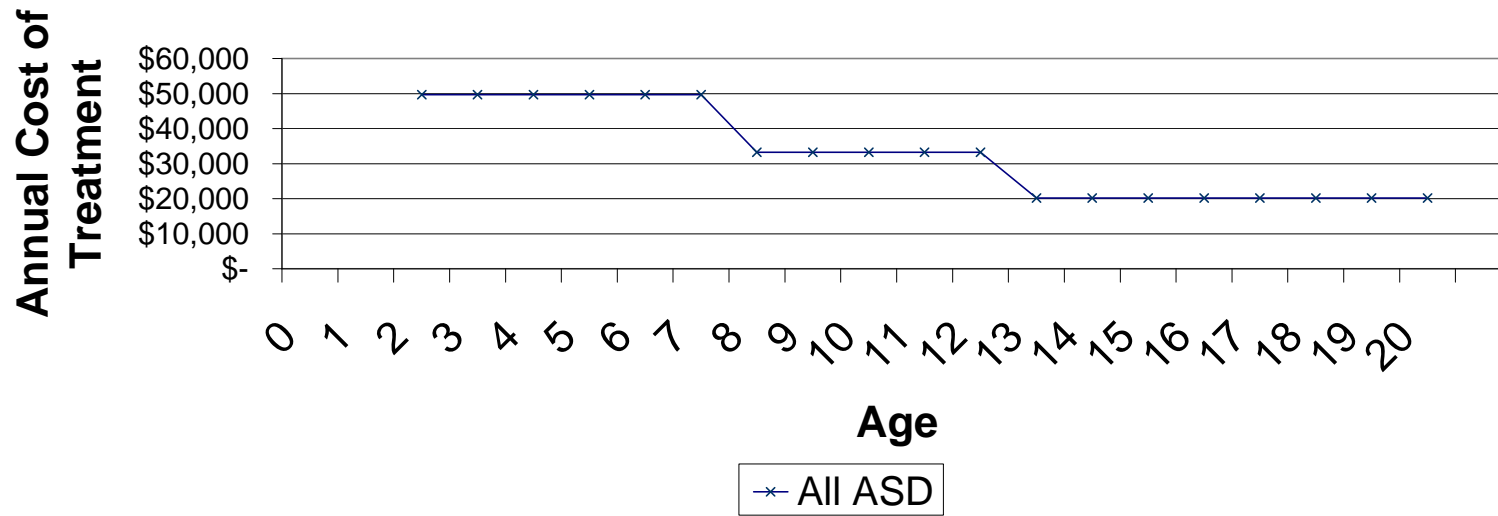
(Includes both Diagnosed and Undiagnosed Children)



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



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



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