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Actuarial Cost Estimate: Nebraska Legislative Bill 1129

AN ACT relating to insurance; to provide requirements for coverage of autism spectrum disorders; to define terms; and to provide duties for the Director of Insurance

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Executive Summary

Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) has been engaged by Autism Speaks to develop a cost model in order to analyze and estimate the impact of insurance benefits for autism spectrum disorders (ASDs) under Nebraska Legislative Bill 1129 that will be referred to as LB 1129 throughout this report.

The most significant class of treatments covered under LB 1129 is behavioral health treatments, which is referred to as applied behavioral analysis, or “ABA”, throughout this document, since ABA is one of the most common behavioral health treatments and the general approach and costs for ABA are assumed to be similar to those of other behavioral health treatments. The key provisions of LB 1129 are explained further in Section 4 of this report.

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

Our analysis included scenario testing to develop cost estimates under a range of assumptions. Our “Middle” estimate is that, in the long-term, costs would increase by about 0.38% of premiums and premiums would increase by about 0.44% should LB 1129 be enacted. Our estimated range of long-term premium increases is 0.28% to 0.65% based on our “Low” and “High” estimates.

We expect that premium increases would be lower in the years immediately following the passage of a law consistent with the provisions of LB 1129, with first year premium increases in the range of 0.09% to 0.43%. Our expectation of lower first year costs is based on experiences in other states that have seen low initial costs when ASD benefits are first

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

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

Long-Term Cost Estimates - “Middle” Scenario

	Market			
	Individual	Small Group	Large Group	All
Covered Persons	132,000	126,000	129,000	387,000
Average Premium per Person	\$3,100	\$4,100	\$4,400	\$3,859
Annual Claim Cost per Covered Person	\$14.50	\$14.50	\$14.50	\$14.50
Claim Cost as a Percentage of Premium	0.47%	0.35%	0.33%	0.38%
Estimated Premium Increase with Admin @ 15%	\$17.10	\$17.10	\$17.10	\$17.10
Premium Increase as a Percentage of Premium	0.55%	0.42%	0.39%	0.44%

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

Scenario Testing

Scenario	% Autistic Disorder Diagnosed Under Age 8 Starting ABA	Program Cost - Autistic Disorder Under Age 8	Avg. Annual non-ABA Cost	Premium Increase per Covered	Premium Increase (% of Premium)
Low	50.0%	\$40,000	\$1,950	\$15.60	0.28%
Middle	65.0%	\$50,000	\$2,925	\$17.10	0.44%
High	80.0%	\$62,759	\$3,900	\$24.90	0.65%

While this analysis focused primarily on estimating the insured costs of covered medical benefits associated with LB 1129, in Section 8 we summarize information related to the lifetime costs of ASD, which include the costs associated with medical services, education, custodial care and the lost productivity and wages of individuals affected by ASD, as well as their family caregivers.

Section 8 also references several studies that would suggest that the costs of ABA treatments covered under LB 1129 could be recovered through reductions in educational and medical expenditures alone. Benefits associated with successful treatments would be expected to reduce future costs of caring for individuals with ASD, and improve both the productivity and the quality of life for individuals with ASD, as well as their family caregivers.

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Background

Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) has been engaged by Autism Speaks to develop a cost model in order to analyze and estimate the impact of legislation providing for additional insurance benefits for autism spectrum disorders (ASDs) on insurance premiums. As part of this work, Oliver Wyman has developed a range of independent estimates of the impact of LB 1129 on insurance premiums, which provides coverage for the diagnosis and treatment of ASDs.

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

This report, along with its supporting analysis, was developed by Marc Lambright, a Principal and consulting actuary in Oliver Wyman's Philadelphia office. Marc is a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries and is professionally qualified to analyze the cost impact of LB 1129 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 incremental insured costs of the ASD benefits provided for in LB 1129 and the associated premium impact on the individual, small group, and large group markets affected by the passage of LB 1129. This analysis also identifies and partially quantifies identified offsetting cost savings associated with successful ASD treatment.

We note that cost estimates associated with autism coverage legislation have varied widely state to state based on state specific differences in legislation and the methods and assumptions used in estimating costs, though typically independent estimates show premium increases due to legislation covering additional autism benefits of less than 1%. A March 2009 report by The Council for Affordable Health Insurance (CAHI) states: “CAHI’s actuarial working team estimates that an autism mandate increases the cost of health insurance by about 1 percent.”¹ The reason for this variability is that the largest component of the increase in costs under LB 1129 is the coverage of behavioral therapies, including applied behavioral analysis (ABA), which historically has generally been excluded from health coverage, and therefore very little mature insured data exists for use in developing credible utilization and unit cost estimates for ABA. Emerging cost data does however suggest that the initial costs associated with autism insurance costs covered by laws similar to LB 1129 have been low. This emerging experience is discussed in Section 5.

While the ultimate cost of covering ABA benefits is uncertain, this analysis reflects the likely behavior of consumers, providers and insurers of ABA services in developing the assumptions underlying the cost estimates. Likewise, the additional costs for medical services other than ABA are uncertain. Insurance policies often cover some services for children diagnosed with an ASD, although the legislation could cause the insured costs for certain services to increase because ASD exclusions or limitations are common. Certain services that may have been initially denied or terminated following utilization review or benefit limitations might be covered with the passage of legislation consistent with LB 1129.

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

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Description of Key LB 1129 Provisions and Their Impact on Covered Benefits

Insurance Markets Covered by LB 1129

The Bill States: “*any individual or group sickness and accident insurance policy or subscriber contract delivered, issued for delivery, or renewed in this state and any hospital, medical, or surgical expense-incurred policy, except for policies that provide coverage for a specified disease or other limited-benefit coverage, and (b) any self-funded employee benefit plan to the extent not preempted by federal law, including any such plan provided for employees of the State of Nebraska, shall provide coverage for the screening, diagnosis, and treatment of an autism spectrum disorder in an individual under twenty-one years of age..*”

In our modeling we are assuming that this means that LB 1129 applies to all comprehensive health insurance contracts in the individual, small group, and large group markets.

Covered Benefits

LB 1129 provides for the screening, diagnosis and treatment of autism spectrum disorders, specifically:

Diagnosis means a medically necessary assessment, evaluation, or test to diagnose if an individual has an autism spectrum disorder;

Treatment means evidence-based care, including related equipment, that is prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary, including:

- (i) Behavioral health treatment;
- (ii) Pharmacy care;
- (iii) Psychiatric care;
- (iv) Psychological care; and
- (v) Therapeutic care.

The inclusion of "**Behavioral health treatment**" which is defined as “ *counseling and treatment programs, including applied behavior analysis, that are: (i) Necessary to develop, maintain, and restore, to the maximum extent practicable, the functioning of an individual; and (ii) provided or supervised by a behavior analyst or a licensed psychologist if the services performed are within the boundaries of the psychologist's competency*” is especially important. The coverage of these types of programs has the most significant impact on the cost of benefits under LB 1129.

ABA may include 30-40 hours of therapy a week, though many programs would not utilize that level of resources. Also, LB 1129 limits benefits for ABA by including the following: “*applied behavior analysis and other evidence-based care, shall be subject to a maximum benefit of seventy thousand dollars per year for an insured nine years of age or younger and twenty thousand dollars per year for an insured over nine years of age..*” Our analysis considers these limits in our estimates.

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

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Modeling Methodology

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

Modeling Perspective

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

In spite of these real limitations that will likely limit short-term costs associated with autism benefits covered under LB 1129, we feel that it is appropriate from a public policy perspective to look at the costs over a longer term and assume that both awareness of ASDs will increase and that supply and demand for ASD services would eventually be in balance. We have developed our estimates with this in mind.

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

Emerging Cost Experience for Autism Coverage

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

South Carolina Employee State Health Plan

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

The Ohio State University³

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

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

Aetna Texas

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

Other State Employee Health Plans

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

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

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

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

⁵ NAIC Annual Statements for 2007.

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

Table 1. Year One Costs

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

Table 2. Year Two Costs

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

Table 3. Projected versus Actual Costs

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

General Modeling Process

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

1. A treated prevalence estimate for Nebraska was developed based on the Center for Disease Control and Prevention's (CDC) Mortality and Morbidity Weekly Report (MMWR) on autism prevalence dated December 18, 2009.
2. Prevalence rates by diagnostic subtype (Autistic Disorder, PDD-NOS, and Asperger's Syndrome) were estimated separately, since diagnosis patterns and service utilization could reasonably be expected to vary by how severely affected an individual with ASD is and by diagnostic subtype.
3. The percentage of children diagnosed by age for each diagnostic subtype was estimated so that the average ages of diagnosis implicit in the modeling are consistent with publicly available age at diagnosis statistics.⁶
4. The percentage of diagnosed children who could be expected to have an ABA program was estimated for each age based on assumptions regarding the percentage of children that would start a program and typical program continuance.
5. A distribution of the number of annual hours for ABA by age was developed based on ABA provider input and an assumption that utilization review by insurers would impact utilization to some degree.
6. Based on the assumed treatment prevalence, likelihood of having an ABA program, assumed distribution of ABA program hours, and estimated ABA program cost per hour of therapy, ABA cost estimates by age were developed.
7. Non-ABA costs were estimated based upon studies of medical costs for children diagnosed with ASD, and the potential increase in costs that could be expected due to LB 1129 benefits.
8. Based on Census demographic data and the cost estimates associated with LB 1129's coverage of ASD services by age as outlined in 1-7 above, an annual cost per covered person was developed.
9. The cost of services was increased to reflect administrative and other insurer costs or profit charges.
10. The estimated size of the covered market was developed based on Census, Medical Expenditure Panel Survey (MEPS) enrollment and premium information for Nebraska, and Kaiser Family Foundation coverage data. These assumptions are further explained and documented in Section 6.
11. The incremental costs of the ASD services per covered person and as a percentage of premiums were calculated based on the model cost estimates and market data under a range of assumptions to develop "Low," "Middle," and "High" cost scenario estimates.

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

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Summary of Key Assumptions

Key assumptions underlying the cost estimates for the proposed LB 1129 covered benefits are summarized in this section. In order to better illustrate the sensitivity of costs to various assumptions, we developed assumptions for “Low,” “Middle,” and “High” cost scenarios. Appendix 1 further illustrates these assumptions for the “Middle” scenario.

Treated Prevalence and Age at Diagnosis

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

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

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

⁸ Ibid, p. 1.

⁹ Ibid, p. 7.

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

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

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

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

¹⁰ Ibid, p. 7.

¹¹ Ibid, p. 9.

¹² Ibid, p.7.

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

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

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

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

ABA Program Utilization and Cost

ABA Program Utilization by Age

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

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

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

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

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

20% of diagnosed three to six year olds¹⁵, which is lower than assumed in each of the scenarios in our modeling. While our range of assumptions for ABA utilization may appear conservative, and likely is conservative in the near-term, we feel that the range is reasonable since insurers will likely have some conservatism in their cost estimates and premium rates. Private insurance utilization will also likely be higher than under the public/private programs in Minnesota, and utilization could increase over time due to increased awareness of ASD, and potentially, an increased supply of ABA providers.

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

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

% of Diagnosed Children with Autistic Disorder with ABA	
Under 6	65.0%
6	48.8%
7	32.5%
8	21.7%
9	14.4%
10	9.6%
11	6.4%
12	4.3%
13 to 20	3.3%

ABA Program Annual Number of Hours

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

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

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

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

Ages Under 8	1,500
Ages 8 to 12	671
Ages 13 to 20	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 Nebraska, based on Bureau of Labor Statistics¹⁷ health care wage data. The resulting average cost per hour of ABA therapy in Nebraska is about \$43 for a program based on the assumption that staffing will be in line with what best practices might recommend. This is the cost underlying our “High” assumption, though we note that costs would vary based on the mix of professionals and technicians providing the services, and likely would be lower if less experienced ABA practitioners need to be employed to meet the increasing demands for services. Costs will vary, as well, depending upon the degree of care management employed by a given payer.

Range of Annual ABA Program Costs for Scenario Estimates

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

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

“Middle” cost scenario - assumes average ABA program cost for a child under 8 is \$50,000 per year.

“High” cost scenario - based on the assumptions outlined in this section for the continuance of ABA programming, 1,500 annual hours for ABA programming for a child under 8, an hourly rate of about \$43, and an annual ABA benefit limit of \$70,000, the calculated average annual cost for an ABA program for a child under 8 is \$62,759.

Cost estimates are lower for older children due to the assumptions that program hours will be lower, and the \$20,000 annual benefit cap above age 9. After developing cost estimates for ABA for children diagnosed with Autistic Disorder, we assumed that for children diagnosed with PDD-NOS or Asperger’s, ABA costs would be one-third of the Autistic Disorder costs. The basis for this adjustment is that children with these two diagnoses can be expected to utilize ABA programs at a significantly lower rate than those with Autistic Disorder, and

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

have less intensive programs (i.e., programs with fewer weekly and annual therapy hours). The one-third factor applied to overall costs reflects the combination of lower utilization and fewer therapy hours.

Other (than ABA) Medical Costs

Based on several studies¹⁸, we estimated that children with ASDs had costs covered by insurers of approximately three times the average for non-inpatient medical services under current benefit programs. It is also clear that under LB 1129 some services that an insurer could currently deny or exclude would now be covered. In our range of estimates, we assumed that this additional coverage would result in increased insured medical costs of 50% to 100% of the current level of estimated covered non-inpatient costs for services to all children diagnosed with an ASD, which we assumed are currently three times higher than the population costs in the absence of the benefits under LB 1129 for children/dependents up to age 20 diagnosed with an ASD.

The estimated annual cost for additional non-ABA services (note many non-ABA medical services are already provided to individuals with ASD) that would be covered as a result of LB 1129 are shown for each scenario in the table below:

Scenario	Non-ABA Costs
Low	\$1,950
Middle	\$2,925
High	\$3,900

(Amounts in 2012 dollars)

Administrative Costs

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

Nebraska 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 Nebraska was available for 2010¹⁹, so we trended this data based on average recent employer premium increases provided in the Kaiser Family Foundation HRET²⁰ survey to estimate the 2012 average annual premium per member necessary to compute the cost of LB 1129 benefits as a percentage of annual premiums.

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

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

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

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

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

7

Cost Estimates

Long-Term Cost Estimates - “Middle” Cost Scenario

The table below summarizes our “Middle” scenario average annual cost estimates and premium increases on a per covered person basis, and as a percentage of the annual premiums. Our “Middle” estimate is that, in the long-term, the premium increase associated with the additional benefits provided by LB 1129 would be about 0.44% of insured premiums across all markets. However, we expect that costs would be lower in the years immediately following the passage of LB 1129 based on experiences in other states that have passed legislation providing for the coverage of additional ASD benefits, lags typically seen in accessing new benefits, and the limited supply of ABA providers.

The estimated cost increases by market are shown in the table below. The annual claim cost per covered person estimate of \$14.50 and premium increase estimate of \$17.10 are in 2012 dollars.

	Market			
	Individual	Small Group	Large Group	All
Covered Persons	132,000	126,000	129,000	387,000
Average Premium per Person	\$3,100	\$4,100	\$4,400	\$3,859
Annual Claim Cost per Covered Person	\$14.50	\$14.50	\$14.50	\$14.50
Claim Cost as a Percentage of Premium	0.47%	0.35%	0.33%	0.38%
Estimated Premium Increase with Admin @ 15%	\$17.10	\$17.10	\$17.10	\$17.10
Premium Increase as a Percentage of Premium	0.55%	0.42%	0.39%	0.44%

Scenario Estimates

As discussed in Section 3, limited insurance data exists that can be used to directly estimate the costs of ABA benefits under LB 1129. This causes uncertainty in developing actuarial assumptions and cost estimates. Due to this uncertainty, it is useful to develop cost estimates for scenarios using optimistic and pessimistic assumptions.

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

Scenario	% Autistic Disorder Diagnosed Under Age 8 Starting ABA	Program Cost - Autistic Disorder Under Age 8	Avg. Annual non-ABA Cost	Premium Increase per Covered	Premium Increase (% of Premium)
Low	50.0%	\$40,000	\$1,950	\$15.60	0.28%
Middle	65.0%	\$50,000	\$2,925	\$17.10	0.44%
High	80.0%	\$62,759	\$3,900	\$24.90	0.65%

Short-Term Cost Estimates by Scenario

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

Estimated Increase in Premiums due to Nebraska LB 1129						
Scenario	Year 1	Year 2	Year 3	Year 4	Year 5	Years 6 and Beyond
Low	0.09%	0.13%	0.17%	0.21%	0.24%	0.28%
Middle	0.22%	0.27%	0.31%	0.35%	0.40%	0.44%
High	0.43%	0.47%	0.52%	0.56%	0.60%	0.65%

Individual Market Comment

Completing an assessment of the potential for anti-selection to increase premium rates in the individual market under LB 1129 is complicated for several reasons. Notably, the recent passage of Federal health care reform legislation has guaranteed issue provisions that would impact the coverage of individuals with ASDs in the individual market. Therefore, a detailed analysis of the individual market is complicated by several matters, and is beyond the scope of this review.

8

Cost – Benefit Analysis for ASD Treatments

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

Societal Costs of Autism- Ganz Report

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

Direct Medical

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

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

Direct Nonmedical

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

Indirect

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

Cost Savings to State and Local Governments

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

Virginia's independent Joint Legislative Audit and Review Commission (JLARC) issued a report in August 2009: *Report of the Joint Legislative Audit and Review Commission To the Governor and The General Assembly of Virginia - Assessment of Services For Virginians With Autism Spectrum Disorders*. As part of this report, JLARC reviewed several studies related to the efficacy of EIBI, and potential cost savings to State and Local governments associated with effective EIBI treatments. The JLARC report outlines their assessment of the cost savings associated with EIBI as follows²²:

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

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

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

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

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

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

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

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

While a complete cost-benefit analysis is beyond the scope of this review, under the assumption that the costs of ASD services and efficacy of EIBI are in line with those indicated in the studies noted, the costs of ABA treatments covered under LB 1129 could be recovered through reductions in educational and medical expenditures, alone.

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

Appendix

Cost Assumptions – Illustrative Exhibits

EXHIBIT I - SUMMARY OF LB 1129 "MIDDLE" SCENARIO ASSUMPTIONS AND COSTS

<u>State</u>	Nebraska				<u>Key Assumptions:</u>	<u>United States Treated Prevalence</u>		<u>% of Diagnosed Children with Autistic Disorder with ABA</u>	
						<u>Diagnostic Subtype</u>	<u>Ultimate Prevalence</u>	<u>Average Age of Diagnosis</u>	
						Autistic Disorder	1 in 450	3	Under 6 65.0%
						PDD-NOS	1 in 300	3	6 48.8%
						Asperger's	1 in 900	6	7 32.5%
						All ASD	1 in 150		8 21.7%
									9 14.4%
									10 9.6%
									11 6.4%
									12 4.3%
									13 to 20 3.3%
<u>Age Limits for Autism Benefits</u>						<u>Nebraska Treated Prevalence</u>			
Minimum	0					<u>Diagnostic Subtype</u>	<u>Ultimate Prevalence</u>	<u>Average Age of Diagnosis</u>	
Maximum	20					Autistic Disorder	1 in 450	3	
						PDD-NOS	1 in 300	3	
						Asperger's	1 in 900	6	
						All ASD	1 in 150		
<u>Additional Annual Medical Costs for Non ABA Services</u>									<u>Average Annual ABA Program Hours for a Child with Autistic Disorder</u>
Up to age 20 \$	2,925	per person w/ ASD							Ages Under 8 1,500
									Ages 8 to 12 671
									Ages 13 to 20 401
<u>Annual Limits by Covered Service</u>									
	<u>Hours Limit</u>	<u>Max Hours</u>	<u>Dollar Limit</u>	<u>Max \$s</u>					
ABA (Ages 0-9)	No	-	Yes	\$70,000					
ABA (Ages 10-20)	No	-	Yes	\$20,000					
									<u>Average cost of ABA Program (0-6 Year Olds):</u> \$50,000
									<u>Average cost of ABA Program (10 Year Olds):</u> \$17,844

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	132,000	\$3,100	\$409,200,000	\$1,914,000	0.47%	\$14.50	\$2,252,000	0.55%	\$17.10
Small Group	126,000	\$4,100	\$516,600,000	\$1,827,000	0.35%	\$14.50	\$2,149,000	0.42%	\$17.10
Large Group	129,000	\$4,400	\$567,600,000	\$1,870,500	0.33%	\$14.50	\$2,201,000	0.39%	\$17.10
Total	387,000	\$3,859	\$1,493,490,000	\$5,611,500	0.38%	\$14.50	\$6,602,000	0.44%	\$17.10

Exhibit II - Treated Prevalence by Age

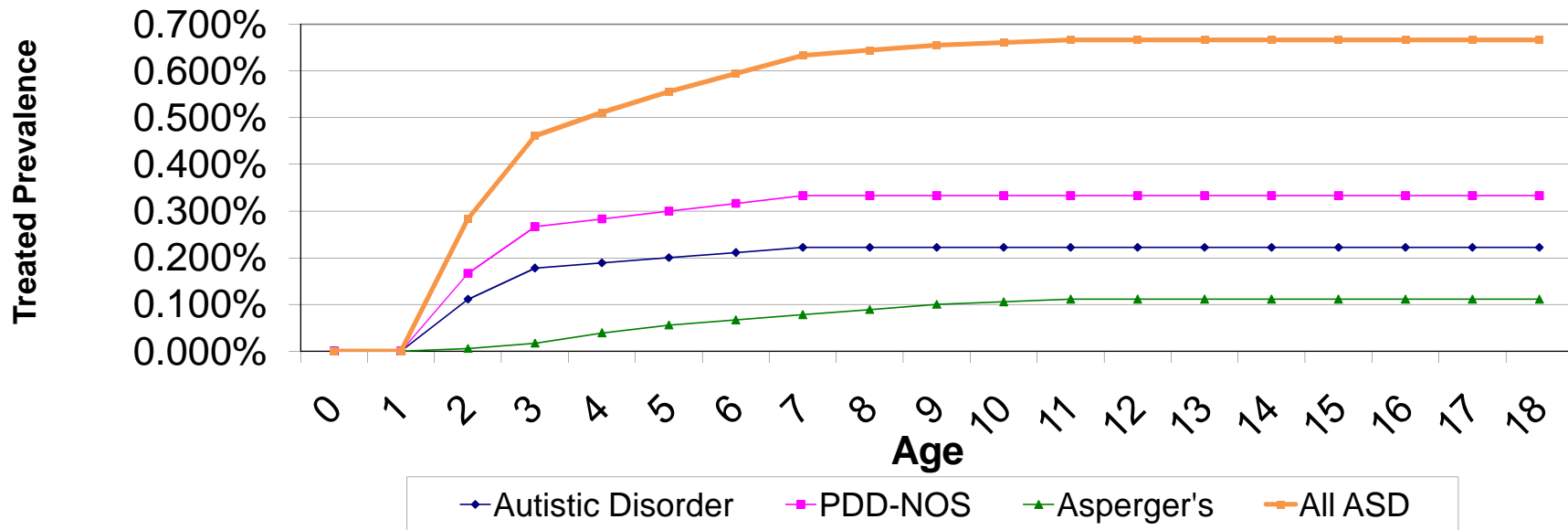


Exhibit III - Annual Cost Per Diagnosed/Treated Child

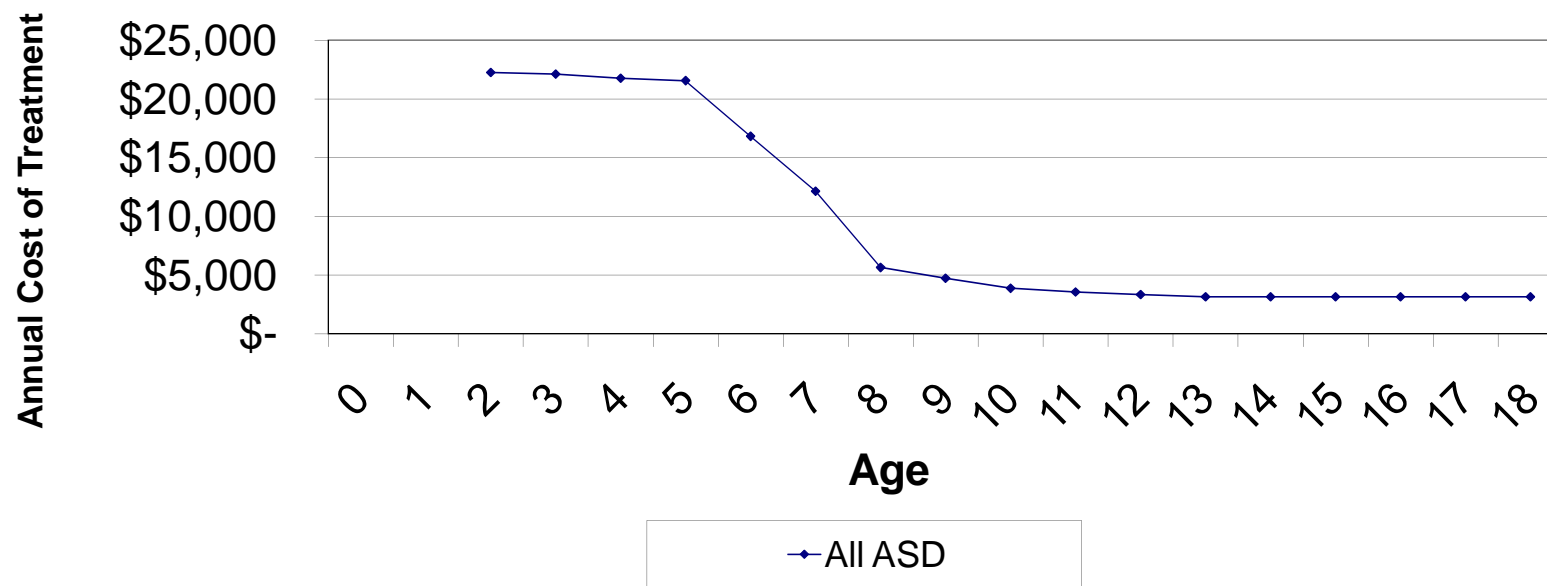


Exhibit IV - Annual Cost Per Autistic Child

(Includes both Diagnosed and Undiagnosed Children)

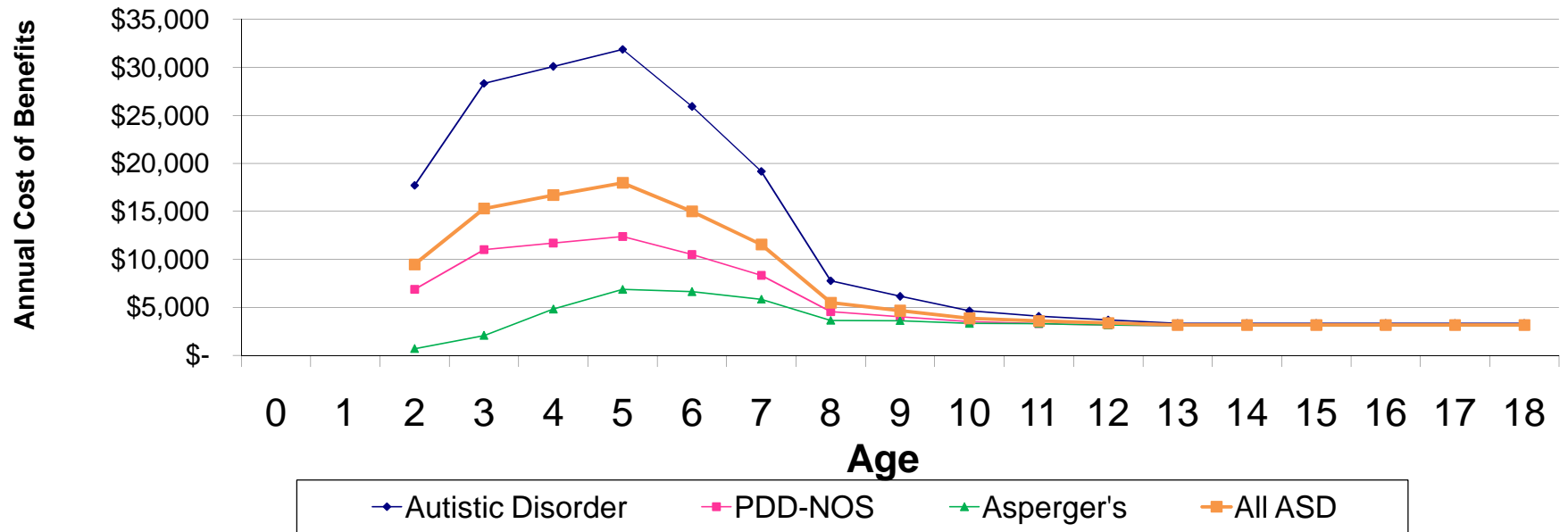


Exhibit V - ABA Utilization vs. Treated Prevalence

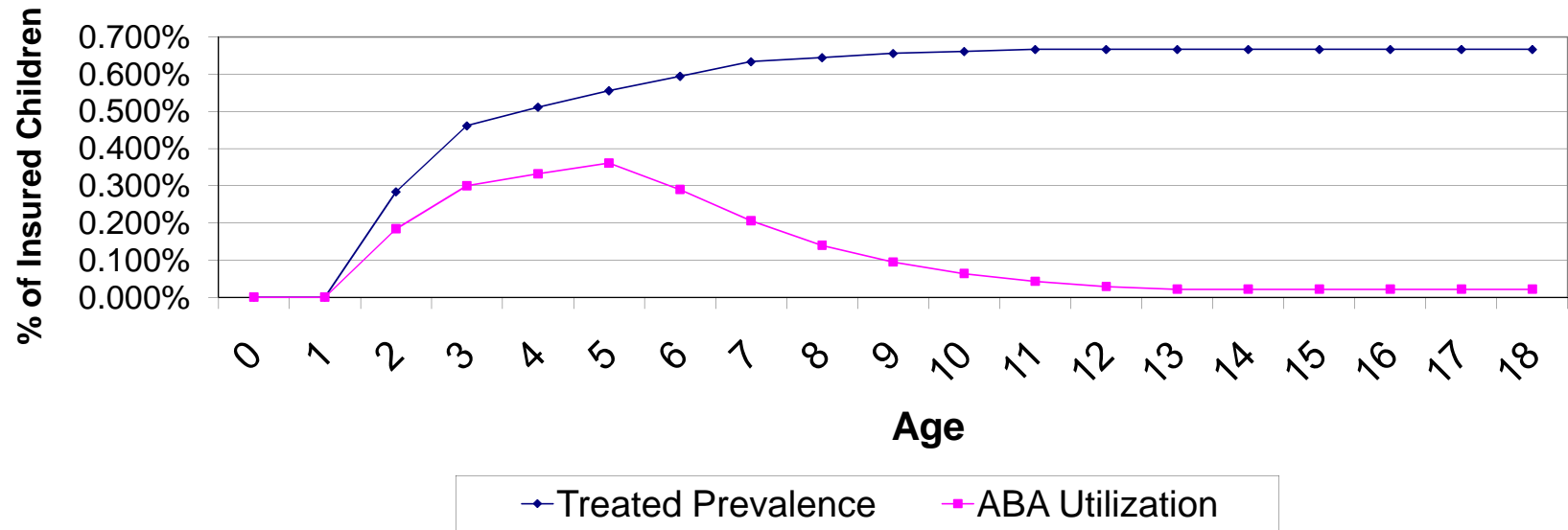
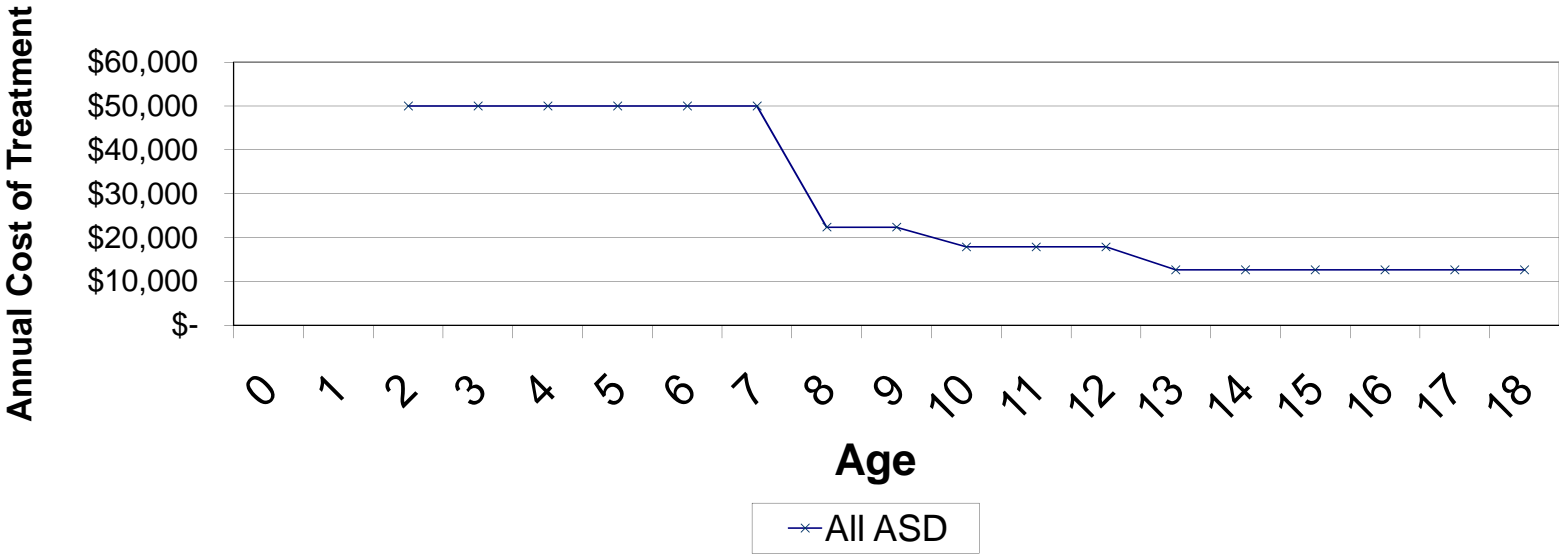


Exhibit VI - Annual Cost of ABA Program per Child with Autistic Disorder



Autism Speaks' Analysis of The Fiscal Impact of Autism Insurance Reform

The Fiscal Impact of Autism Insurance Reform

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

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

Interpretive Summary

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

Table 1. Year One Costs

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

Table 2. Year Two Costs

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

Table 3. Projected versus Actual Costs

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

Appendix 1. Terms of Coverage

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

Appendix 2. Claims Data

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

* monetary cap applies only to Applied Behavior Analysis

LB 1129 Text

LEGISLATURE OF NEBRASKA

ONE HUNDRED SECOND LEGISLATURE

SECOND SESSION

LEGISLATIVE BILL 1129

Introduced by Coash, 27.

Read first time January 19, 2012

Committee: Banking, Commerce and Insurance

A BILL

- 1 FOR AN ACT relating to insurance; to provide requirements for
- 2 coverage of autism spectrum disorders; to define terms;
- 3 and to provide duties for the Director of Insurance.
- 4 Be it enacted by the people of the State of Nebraska,

1 Section 1. (1) For purposes of this section:

2 (a) Applied behavior analysis means the design,
3 implementation, and evaluation of environmental modifications, using
4 behavioral stimuli and consequences, to produce socially significant
5 improvement in human behavior, including the use of direct
6 observation, measurement, and functional analysis of the relationship
7 between environment and behavior;

8 (b) Autism services provider means any licensed
9 physician, psychiatrist, or psychologist that provides treatment of
10 autism spectrum disorders;

11 (c) Autism spectrum disorder means any of the pervasive
12 developmental disorders as defined by the most recent edition of the
13 Diagnostic and Statistical Manual of Mental Disorders, including
14 Autistic Disorder, Asperger's Disorder, and Pervasive Developmental
15 Disorder Not Otherwise Specified;

16 (d) Behavioral health treatment means counseling and
17 treatment programs, including applied behavior analysis, that are:
18 (i) Necessary to develop, maintain, and restore, to the maximum
19 extent practicable, the functioning of an individual; and (ii)
20 provided or supervised by a behavior analyst or a licensed
21 psychologist if the services performed are within the boundaries of
22 the psychologist's competency;

23 (e) Diagnosis means a medically necessary assessment,
24 evaluation, or test to diagnose if an individual has an autism
25 spectrum disorder;

1 (f) Pharmacy care means a medication that is prescribed
2 by a licensed physician and any health-related service deemed
3 medically necessary to determine the need or effectiveness of the
4 medication;

5 (g) Psychiatric care means a direct or consultative
6 service provided by a psychiatrist licensed in the state in which he
7 or she practices;

8 (h) Psychological care means a direct or consultative
9 service provided by a psychologist licensed in the state in which he
10 or she practices;

11 (i) Therapeutic care means a service provided by a
12 licensed speech-language pathologist, occupational therapist, or
13 physical therapist; and

14 (j) Treatment means evidence-based care, including
15 related equipment, that is prescribed or ordered for an individual
16 diagnosed with an autism spectrum disorder by a licensed physician or
17 a licensed psychologist who determines the care to be medically
18 necessary, including:

19 (i) Behavioral health treatment;

20 (ii) Pharmacy care;

21 (iii) Psychiatric care;

22 (iv) Psychological care; and

23 (v) Therapeutic care.

24 (2) Notwithstanding section 44-3,131, (a) any individual
25 or group sickness and accident insurance policy or subscriber

1 contract delivered, issued for delivery, or renewed in this state and
2 any hospital, medical, or surgical expense-incurred policy, except
3 for policies that provide coverage for a specified disease or other
4 limited-benefit coverage, and (b) any self-funded employee benefit
5 plan to the extent not preempted by federal law, including any such
6 plan provided for employees of the State of Nebraska, shall provide
7 coverage for the screening, diagnosis, and treatment of an autism
8 spectrum disorder in an individual under twenty-one years of age. To
9 the extent that the screening, diagnosis, and treatment of autism
10 spectrum disorder are not already covered by such policy or contract,
11 coverage under this section shall be included in such policies or
12 contracts that are delivered, issued for delivery, amended, or
13 renewed in this state or outside this state if the policy or contract
14 insures a resident of Nebraska on or after January 1, 2013. No
15 insurer shall terminate coverage or refuse to deliver, issue for
16 delivery, amend, or renew coverage of the insured as a result of an
17 autism spectrum disorder diagnosis or treatment.

18 (3) Except as provided in subsection (4) of this section,
19 coverage for an autism spectrum disorder shall not be subject to any
20 limits on the number of visits an individual may make for treatment
21 of an autism spectrum disorder, nor shall such coverage be subject to
22 dollar limits, deductibles, copayments, or coinsurance provisions
23 that are less favorable to an insured than the equivalent provisions
24 that apply to a general physical illness under the policy.

25 (4) Coverage for behavioral health treatment, including

1 applied behavior analysis and other evidence-based care, shall be
2 subject to a maximum benefit of seventy thousand dollars per year for
3 an insured nine years of age or younger and twenty thousand dollars
4 per year for an insured over nine years of age. On or after January
5 1, 2014, the Director of Insurance shall, on an annual basis, adjust
6 the maximum benefit for inflation by using the medical care component
7 of the United States Department of Labor, Bureau of Labor Statistics,
8 Consumer Price Index for All Urban Consumers. The director shall
9 submit the adjusted maximum benefit for publication annually no later
10 than X of each calendar year, and the published adjusted maximum
11 benefit will be applicable in the following calendar year to policies
12 and contracts subject to this section. Payments made by an insurer on
13 behalf of a covered individual for treatment other than behavioral
14 health treatment, including applied behavior analysis and other
15 evidence-based care shall not be applied to any maximum benefit
16 established under this section.

17 (5) Except in the case of inpatient service, if an
18 individual is receiving treatment for an autism spectrum disorder, an
19 insurer shall have the right to request a review of that treatment
20 not more than once every twelve months unless the insurer and the
21 individual's licensed physician or licensed psychologist execute an
22 agreement that a more frequent review is necessary. Any such
23 agreement regarding the right to review a treatment plan more
24 frequently shall apply only to a particular individual being treated
25 for an autism spectrum disorder and shall not apply to all

1 individuals being treated for autism spectrum disorder by a licensed
2 physician or licensed psychologist. The cost of obtaining a review
3 under this subsection shall be borne by the insurer.

4 (6) This section shall not be construed as limiting any
5 benefit that is otherwise available to an individual under a
6 hospital, surgical, or medical expense-incurred policy or health
7 maintenance organization contract. This section shall not be
8 construed as affecting any obligation to provide services to an
9 individual under an individualized family service plan,
10 individualized education program, or individualized service plan.

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