Proposed law raises the age for mandated health insurance coverage of autism spectrum disorders from 17 to 21, eliminates the lifetime maximum benefit of $144,000, provides relative to supervision of treatment and repeals R.S. 22:1050(H)(1.), which were provisions that limit this mandate not be applied to small businesses with fewer than 50 individuals. Proposed law provides that to the extent that the provisions of this bill require benefits that exceed the essential health benefits specified under Section 1302(b) of the Patient Protection and Affordable Care Act, the specific benefits that exceed the specified essential health shall not be required of a health benefit plan when the plan is offered by a health care insurer in this state. Proposed law changes the implementation date of plans delivered, renewed, or issued for delivery on or after January 1, 2014.

The OGB estimates are based upon the following assumptions:
1.) That in 2011 OGB paid $773,304 for 299 claims for the current autism treatment; the medical loss ratio of costs is 85;
2.) That the average claim in 2011 is $2,586 ($773,304/299 = $2,586);
3.) That a low medical inflation of costs is 7% and a high medical inflation of costs is 12%;
4.) That there are 219,317 members within the PPO and HMO plans currently;
5.) That approximately 0.14% of the eligible population will get treated for coverage (299 claims/219,317=0.14%);
6.) That the following child members by age in 2012 are as follows: 12 years old - 2,492, 13 years old - 2,475, 14 years old - 2,763, 18 years old - 2,930, 19 years old - 3,051;
7.) That the calculated low and high incidence rates are based upon 0.14% of the current number of children and those incidence rates range from 15.89 children to 20.01 children being treated annually.

NOTE: A State General Fund appropriation shall be required to cover the state portion, 66.7%, of the increased premium cost (approximately $0.02 to $0.04 per member per month premium increase). The OGB estimates are based upon the following assumptions:
1.) That in 2011 OGB paid $773,304 for 299 claims for the current autism treatment; the medical loss ratio of costs is 85;
2.) That the average claim in 2011 is $2,586 ($773,304/299 = $2,586);
3.) That a low medical inflation of costs is 7% and a high medical inflation of costs is 12%;
4.) That there are 219,317 members within the PPO and HMO plans currently;
5.) That approximately 0.14% of the eligible population will get treated for coverage (299 claims/219,317=0.14%);

The OGB estimates are based upon the following assumptions:
1.) That in 2011 OGB paid $773,304 for 299 claims for the current autism treatment; the medical loss ratio of costs is 85;
2.) That the average claim in 2011 is $2,586 ($773,304/299 = $2,586);
3.) That a low medical inflation of costs is 7% and a high medical inflation of costs is 12%;
4.) That there are 219,317 members within the PPO and HMO plans currently;
5.) That approximately 0.14% of the eligible population will get treated for coverage (299 claims/219,317=0.14%);
6.) That the following child members by age in 2012 are as follows: 12 years old - 2,492, 13 years old - 2,475, 14 years old - 2,763, 18 years old - 2,930, 19 years old - 3,051;
7.) That the calculated low and high incidence rates are based upon 0.14% of the current number of children and those incidence rates range from 15.89 children to 20.01 children being treated annually.

NOTE: A State General Fund appropriation shall be required to cover the state portion, 66.7%, of the increased premium cost to add the additional benefit pursuant to proposed legislation (estimated to be $32,277 to $46,783 in FY 14 and increasing to $70,139 to $77,097 in FY 17).

The expenditures of OGB will increase as a result of this measure.

The revenues for OGB will increase as a result of this measure.
NOTE: Due to the provisions of the federal Affordable Care Act, any changes to existing health insurance mandates or if any new health insurance mandates are enacted after December 2011, the state would be required to pay for those costs outside the essential health benefits. However, the House Insurance Committee adopted an amendment that appears to eliminate the state’s expenditure exposure associated with this health insurance mandate expansion.

According to DHH, the state will have to choose a “benchmark plan,” which will be identified as Louisiana’s essential health benefits. Although the federal Affordable Care Act appears to give states some discretion for health benefits offered in the health insurance exchange beyond the “essential benefit,” DHH/DON will not know the specifics of the essential health benefit until the federal rules are released on June 20, 2012.