MANDATED BENEFIT REVIEW OF
SENATE BILL 769
SUBMITTED TO THE 192ND GENERAL COURT:

AN ACT RELATIVE TO COLLABORATIVE CARE

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Prepared for Massachusetts Center for Health information and Analysis
by Berry Dunn McNeil & Parker, LLC

BerryDunn

CHIA.

Mandated Benefit Review of Senate Bill (S.B.) Submitted to the 192nd General Court

An Act relative to collaborative care.

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1.0 Benefit Mandate Overview: S.B. 769: An Act relative to collaborative care

1.1 History of the Bill

The Massachusetts Legislature's Joint Committee on Health Care Financing referred Senate Bill (S.B.) 769 entitled, "An Act relative to collaborative care,"[1] to the Massachusetts Center for Health Information and Analysis (CHIA) for review. Massachusetts General Law (MGL) Chapter 3 §38C requires CHIA to review the medical efficacy of treatments or services included in each mandated benefit bill referred to the agency by a legislative committee, should it become law. CHIA must also estimate each bill's fiscal impact, including changes to premiums and administrative expenses.

This report is not intended to determine whether the bill would constitute a health insurance benefit mandate for purposes of Commonwealth of Massachusetts (Commonwealth) defrayal under the Affordable Care Act (ACA), nor is it intended to assist with Commonwealth defrayal calculations if it is determined to be a health insurance mandate requiring Commonwealth defrayal.

1.2 What Does the Bill Propose?

As submitted to the 192nd General Court of the Commonwealth, the bill requires insurers to cover mental health or substance use disorder treatment services that are delivered via the Psychiatric Collaborative Care Model (CoCM). This includes reimbursement of three current procedural terminology (CPT) billing codes established by the American Medical Association: (1) 99492; (2) 99493; and (3) 99494. CHIA and its consultants clarified with the legislative sponsor that the bill's intent is to include CPT code G2214,[2] as well as other CPT codes yet to be created for CoCM. Accordingly, the bill stipulates that "the commissioner of insurance shall update this list of codes through the promulgation of regulations if there are any alterations or additions to the billing codes for the psychiatric collaborative care model."[3]

1.3 Medical Efficacy of the Bill

CoCM is an evidence-based, patient-centered treatment model that integrates behavioral health with primary care. CoCM care teams provide population-based patient care, led by primary care providers (PCPs), and include a behavioral health care manager (BHCM) and consulting psychiatrist. The care team uses a registry to track patient progress, monitor improvement, and amend patient treatment plans accordingly. Each patient receives an individual treatment plan with tailored personal goals and associated clinical outcomes that are measured through evidence-based tools. Treatment plans are based on an individual's specific diagnosis. Providers who practice within the CoCM model are accountable for measurable outcomes and paid for services based on quality of care and clinical outcomes.

The most common uses for CoCM include the treatment of depression, anxiety, and alcohol or substance use disorders (SUD). The need for mental health treatment and SUD services is high nationwide. The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) reports that close to one in five adults aged 18 or older in the United States lives with a mental illness.[4] Among those diagnosed with any mental illness (AMI), 24.3 million

(46.2% of 52.9 million) received mental health treatment in the measurement year 2020.[5] Among those diagnosed with a serious mental illness (SMI), 9.1 million (64.5% of 14.2 million) received mental health treatment.[6]

The effectiveness and efficiency of CoCM has been demonstrated in over ninety randomized control trials. These studies indicate that CoCM is more effective than usual care[i] for patients with behavioral health diagnoses such as anxiety and depression. CoCM has also been shown to improve outcomes for patients with comorbid mental and physical health conditions.

1.4 Current Coverage

The Commonwealth does not currently require coverage of CoCM. Mental health services are considered one of the 10 essential health benefits (EHBs) under the Affordable Care Act (ACA). Benefits are defined for Massachusetts according to its benchmark plan (the Blue Cross and Blue Shield of Massachusetts [BCBSMA] HMO Blue® plan).[7] The benchmark plan description does not specifically mention CoCM.

Massachusetts law specifically mandates that fully-insured plans, employer-sponsored plans, individual plans, and state employee plans provide behavioral health treatment services on a non-discriminatory basis for select diagnoses. These conditions include: schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, substance abuse disorders, and autism.[8] The law requires that annual limits, lifetime limits, and quantitative treatment limits for these aforementioned conditions are equal to those for other medical conditions. Coverage of treatment for patients with conditions not on the specified list is also required in the form of a minimum-60-day inpatient treatment, and 24 outpatient visits if the treatment is deemed medically necessary. Insurance plans must also provide coverage for children under age 19 without the specified conditions who cannot attend school because of their condition, are hospitalized due to their condition, or possess behavior that could endanger themselves or others.

Under the federal Mental Health Parity and Addiction Equity Act of 2008 (MPHAEA), group health plans and health insurance issuers that offer mental health benefits or substance use disorder benefits may not impose more stringent benefit limits on those benefits than on medical/surgical benefits. Depending on an MPHAEA analysis of a health plan's benefit exclusions (i.e. comparison of the factors used to exclude certain medical/surgical benefits versus the factors used to exclude certain mental health/substance use disorder benefits), the findings might support CoCM coverage from a compliance standpoint.

BerryDunn surveyed nine insurance carriers in the Commonwealth, and seven carriers responded. The responding carriers represent approximately 97% of the membership of the carriers surveyed. One of the respondent insurance carriers indicated it does not provide benefits for the CoCM. The two carriers that did not respond had per member per month (PMPM) claims costs that were higher than average when compared to the respondent carriers that indicated they do cover the CoCM. For this analysis, BerryDunn has assumed that both of the carriers that did not respond cover CoCM.

[i] "Usual care" refers to the traditional model of treating individuals' physical and behavioral health separately—at separate appointments, with different providers (i.e., a behavioral health provider prescribes medication at a patient care visit, separate from primary care visits).

1.5 Cost of Implementing the Bill

All but one of the respondent insurance carriers cover CoCM, and the membership of the carrier that does not cover CoCM is only about 3.0% of the total fully-insured membership. Therefore, the impact of requiring coverage for CoCM, on the average commercial fully-insured medical expense and premiums, is less than $0.005 PMPM. This analysis therefore concludes that the incremental impact over the 2023 to 2027 projection period is estimated to be immaterial and assumed to be zero.

1.6 Plans Affected by the Proposed Benefit Mandate

The bill amends statutes that regulate healthcare carriers in the Commonwealth. It includes the following sections, each of which addresses statutes regarding a particular type of health insurance policy when issued or renewed in the Commonwealth:[9]

- Chapter 32A – Plans Operated by the Group Insurance Commission (GIC) for the Benefit of Public Employees
- Chapter 175 – Commercial Health Insurance Companies
- Chapter 176A – Hospital Service Corporations
- Chapter 176B – Medical Service Corporations
- Chapter 176G – Health Maintenance Organizations (HMOs)

The bill, as written, amends Chapter 118E of the General Laws. However, estimating the bill's impact to MassHealth membership is outside the scope of this report.

1.7 Plans Not Affected by the Proposed Benefit Mandate

Self-insured plans (i.e. where the employer or policyholder retains the risk for medical expenses and uses a third-party administrator or insurer to provide only administrative functions), except for those provided by the GIC, are not subject to state-level health insurance mandates. State mandates do not apply to Medicare and Medicare Advantage plans or other federally-funded plans, including TRICARE (covering military personnel and dependents), the Veterans Administration, and the Federal Employees Health Benefit Plan, the benefits for which are determined by, or under the rules set by, the federal government.

Endnotes

[1] The 192nd General Court of the Commonwealth of Massachusetts Senate Bill 769, "An Act relative to collaborative care." Accessed February 2, 2022: **https://malegislature.gov/Bills/192/S769.** House Bill 1057 is identical to Senate Bill 769. Accessed February 2, 2022: **https://https://malegislature.gov/Bills/192/S769malegislature.gov/Bills/192/H1057.**

[2] CPT G2214 was introduced in 2021 for Medicare reimbursement.

[3] The 192nd General Court of the Commonwealth of Massachusetts Senate Bill 769, "An Act relative to collaborative care." Accessed February 2, 2022: **https://malegislature.gov/Bills/192/S769.** House Bill 1057 is identical to Senate Bill 769. Accessed February 2, 2022: **https://malegislature.gov/Bills/192/H1057.**

[4] Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health. Accessed February January 26, 2022. **https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.**

[5] Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health. Accessed February January 26, 2022. **https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.**

[6] Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health. Accessed February January 26, 2022. **https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf.**

[7] Essential Health Benefit Benchmark Plan. Accessed February 2, 2022: **https://www.mass.gov/service-details/essential-health-benefit-benchmark-plan.**

[8] Mass. General Laws c.175 § 47B. Accessed February 2, 2022. **https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter175/Section47B.**

[9] Although Chapter 176A is not included in the bill's current language, the sponsor confirmed the bill's intent is to include it. Chapter 118E (MassHealth) is included in the bill, but estimating the bill's impact for MassHealth is not within the scope of this report.

2.0 Medical Efficacy Assessment

As submitted to the 192nd General Court of the Commonwealth, the bill requires insurers to cover mental health or substance use disorder treatment services that are delivered via the Psychiatric Collaborative Care Model (CoCM), including reimbursement of three current procedural terminology (CPT) billing codes established by the American Medical Association: (1) 99492; (2) 99493; and (3) 99494. [1] CHIA and its consultants clarified with the legislative sponsor that the bill's intent is to include CPT code G2214, [2] as well as other CPT codes yet to be created for CoCM. Accordingly, the bill stipulates that "the commissioner of insurance shall update this list of codes through the promulgation of regulations if there are any alterations or additions to the billing codes for the psychiatric collaborative care model."[3]

The bill indicates CoCM is an evidence-based, integrated, behavioral health service delivery method as described in 81 FR 80230 below:

> *The Psychiatric Collaborative Care Model (CoCM) [is] an evidence-based approach to behavioral health integration that enhances "usual" primary care by adding care management support and regular psychiatric inter-specialty consultation.*

MGL Chapter 3 §38C charges CHIA with reviewing the medical efficacy of proposed mandated health insurance benefits. Medical efficacy reviews summarize current literature on the effectiveness and use of the treatment or service, and describe the potential impact of a mandated benefit on the quality of patient care and health status of the population.

This report proceeds in the following sections:

2.0 Medical Efficacy Assessment

- Section 2.1: CoCM Overview
- Section 2.2: Mental Illness Service Capacity and Treatment Needs
- Section 2.3: CoCM Efficacy Studies

3.0 Conclusion

2.1 CoCM Overview

CoCM is an integrated care model in which behavioral health and general medical care providers collaborate to meet their patients' mental health needs.[4]

The American Psychiatric Association defines five key elements of Psychiatric Collaborative Care:

1. Patient Centered Team Care: Primary care providers and behavioral health providers use care plans with patient-specific goals. This setting provides familiarity and comfort for patients, while also eliminating potential duplicate assessments.

2. Population-Based Care: Patients are entered into a registry that is shared with the care team. Primary care practices track patients, and contact those who show no signs of improvement.
3. Measurement-Based Treatment: Patients receive a tailored plan with personal goals, and clinical outcomes that are measured through evidence-based tools. Treatments are amended if patients do not show improvement as expected.
4. Evidence-Based Care: Treatment for patients is targeted for their specific condition(s), and is based on the CoCM that has substantial evidence for its effectiveness.
5. Accountable Care: Providers within this model are accountable and reimbursed for care quality and clinical outcomes.[5]

Each member of the care team within CoCM holds distinct roles and responsibilities:

- The billing provider, typically the primary care provider:
  - Directs the behavioral care manager and the clinical staff.
  - Oversees patient care, including prescribing medications, providing treatment, and making referrals when appropriate.
  - Maintains continuous oversight of the management, collaboration, and reassessment of patient cases.
  - In some cases, might directly deliver all of a patient's behavioral health services.
- The behavioral health care manager (BHCM):
  - Completes assessments and manages care.
  - Administers validated rating scales, such as GAD-7 for anxiety and PHQ-9 for depression, for behavioral health care planning.
  - Revises care plans accordingly if patients are not progressing, or if their health status changes.
  - Maintains the patient registry.
  - Collaborates with the billing provider while in continuous communication with the psychiatric consultant.
  - Delivers services to patients, including brief counseling and coordinating treatment, and engages with them outside of clinic hours as needed.
  - Is not required to be an independently licensed professional; however, clerical and administrative staff are not eligible to fill this role.
- The psychiatric consultant:
  - Conducts regular reviews of patient clinical status, and advises the billing provider and BHCM about patient diagnoses.
  - Adjusts treatment for patients who show no signs of progress, or who are not tolerating treatment.

- Manages negative interactions between patients' behavioral health and medical treatments.
- May provide services remotely, and are not expected to have direct interaction with patients, prescribe medications, or deliver patient care.
- Is required for Medicare reimbursement of CoCM.
- May not be an independently licensed professional who is qualified to bill independently (as PCP is the billing provider). This role may not be filled by clerical and administrative staff.[6]

2.2 Mental Illness Service Capacity and Treatment Needs

Behavioral workforce shortages may limit the provision of needed services to persons with mental health and substance use disorders (SUD)—highly prevalent conditions causing substantial disability in the United States. CoCM is designed to extend the capacity of mental health providers to care for patients in need. CoCM offers one approach to address the shortage of mental health service providers relative to need within the population.

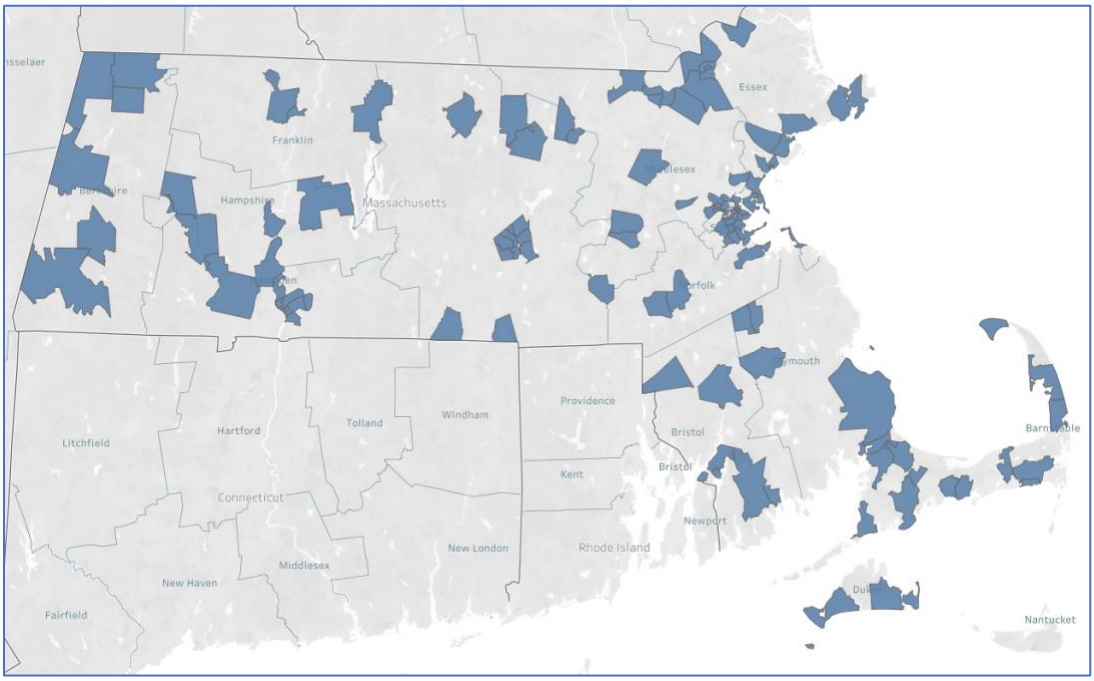
If CoCM helps effectively use the existing behavioral workforce, its implementation may increase access to care and better meet the needs of those with mental health disorders and SUD. A study of behavioral health service delivery models reports several potential workforce efficiencies[7]:

- using staff with lower levels of training and credentials to augment service provision
- permitting staff to perform all functions within their scope of practice
- directing consumers to the appropriate staff or level of care
- using technology to extend provider reach
- increasing capacity for non-mental health or SUD providers to treat people with mental health and SUD conditions

Many studies report substantial shortages of psychiatrists and other mental health providers, with shortfalls particularly noted in under-resourced urban and rural areas, and in community mental health centers that often treat the most severe mental illnesses.[8,9,10]

Precise estimates of current shortages are lacking, given widely-varying assumptions, differences in data collection, and questions about the validity, reliability, and comparability of workforce data across states.[11,12] National modeling, performed by the U.S. Department of Health and Human Services in 2018, suggests that Massachusetts has a sufficient supply of mental health professionals. Yet, concurrently, Massachusetts has 57 federally designated Health Professional Shortage Areas (HPSAs) for mental health care.[13] These HPSAs include 50 facilities, six underserved populations, and one geographic area. Nearly every county in Massachusetts includes a mental health HPSA.[14] This reflects only those areas that have actively sought such designation for the purposes of participating in various federal programs. It is likely that other areas are also experiencing shortages in capacity to deliver needed mental health services.

Figure 1: Massachusetts zip codes with federal designation as Health Professional Shortage Areas (HPSA) for mental health services



A report released in February 2022 by the Association for Behavioral Healthcare (ABH) points to a significant shortage in the mental health workforce in Massachusetts, resulting in longer waits for outpatient treatment and fewer people getting care.[15]The ABH reports that the average wait time in Massachusetts for an initial mental health assessment by a licensed clinician is longer than two months. The report attributes long waits and limited service capacity to a diminishing workforce, with more licensed clinicians leaving positions than being hired.

The ABH report's findings were based on surveys of 37 agencies that represent 124 outpatient clinic sites across Massachusetts. Nearly all the clinics reported increased wait times with almost 14,000 people on wait lists. The average wait for an assessment or therapy for children and youth was three weeks longer than waits for adults. The clinics also reported that the COVID-19 pandemic increased the demand for mental health services. Yet, with staffing vacancies and workforce shortages, the reporting clinics served 11% fewer people in 2021 than before the pandemic began.

Primary care providers report that behavioral health care is the most difficult subspecialty medical service to obtain.[16] The 2019 Milliman Report on Addiction and Mental Health versus Physical Health conducted using 2017 data found clear disparities in behavioral health treatment accessibility. Massachusetts demonstrated higher out of-of-network utilization disparity levels across treatment settings than the all-states average. In Massachusetts, the out-of-network utilization disparity level for PPO plans for medical/surgical treatment was 2.0%, compared to 21.3% for behavioral health treatment. This translates to a 10.49x higher proportion of behavioral treatment out-of-network use than medical/surgical out-of-network use, and is approximately 2x the all-states proportion of behavioral out-of-network use at 5.24x. The outpatient facility out-of-network utilization disparity level in Massachusetts for medical/surgical was

3.3%, compared to 25.1% for behavioral, resulting in a 7.64x higher proportion of behavioral out-of-network use compared to the all-states proportion of 5.72x. The office visit out-of-network utilization disparity level in Massachusetts for medical/surgical was 3.2%, compared to 17.3% for behavioral, resulting in a 5.48x higher proportion of behavioral out-of-network use, slightly higher than the all-states proportion of 5.41x behavioral out-of-network use.

The America's Mental Health 2018 survey of 5,000 American adults, conducted by the Cohen Veterans Network, found that an unprecedented number of Americans are seeking mental health treatment (56%).[17] Among those surveyed, 76% viewed mental health as equally important as physical health, yet almost the same majority (74%) consider services for mental health out of reach. Cost and inadequate insurance coverage were ranked as top barriers for access to mental health services for 42% of those surveyed. A proportion (17%) of those surveyed stated they have had to decide between seeking treatment for a physical health issue and a mental health issue due to the stipulations of their health insurance policy. Among those who have sought treatment for mental health, 64% assert that the U.S. government should do more to improve mental health treatment.[18]

During the recent and ongoing COVID-19 public health emergency, Massachusetts residents have demonstrated an increased need for mental health services. The Blue Cross Blue Shield of Massachusetts Foundation survey, which covered approximately the first year of the COVID-19 pandemic (January 2020 through March 2021), found that 35% of Massachusetts adults over age 19 reported requiring behavioral health care for themselves or for a close relative. Additionally, 27% of Massachusetts adults reported needing mental health services to care for themselves, with a disproportionate level of need among adults age 19-39 who identify as a race or ethnicity other than non-Hispanic white and among adults who have lower family incomes. Among those who reported requiring behavioral health care, 26% report not receiving the support they needed, and 31% received some care but were not always able to schedule appointments for services when needed. Reported obstacles to obtaining necessary behavioral health care treatment included affordability, accessibility, and stigma/confidentiality.[19]

Mental illnesses include different conditions that vary in severity and are broken into two categories: "any mental illness" (AMI) and "serious mental illness" (SMI).[20] AMI is defined as a mental, behavioral, or emotional disorder that can vary in severity ranging from no impairment to mild, moderate, and severe impairment. SMI is defined as a mental, behavioral, or emotional disorder that results in serious functional impairment that restricts one or more life activities.[21] The 2020 National Survey on Drug Use and Health (NSDUH), conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), reports the following data for the United States:

- Almost 1 in 5 adults aged 18 or older have AMI (52.9 million, 21.0%).
- AMI is higher among females (25.8%) than males (15.8%).
- Prevalence varies by age: 30.6% of adults aged 18-25 have AMI diagnoses, 25.3% of adults aged 26-49 have AMI diagnoses, and 14.5% of adults aged 50 or older have AMI diagnoses.

Prevalence also varies by race: 35.8% of adults who reported two or more races have AMI diagnoses, 22.6% of white adults have AMI diagnoses, and 13.9% of Asian adults have AMI diagnoses. Prevalence of SMI was lower than that of AMI; 14.2 million adults aged 18 or older had an SMI diagnosis, representing 5.6% of all U.S. adults. As with AMI, SMI was more prevalent in females (7.0%) than males (4.2%). Prevalence varied by age: 9.7% of adults aged

18-25 had an SMI diagnosis, 6.9% of adults aged 26-49 had an SMI diagnosis, and 3.4% of adults aged 50 or older had an SMI diagnosis. Prevalence also varied by race: 9.9% of adults who reported two or more races had an SMI diagnosis, 6.6% of American Indian/Alaskan Native (AI/AN) adults had an SMI diagnosis, and 1.2% of Native Hawaiian/Other Pacific Islander (NH/OPI) adults had an SMI diagnosis.

The Massachusetts Department of Mental Health (DMH) uses these SAMHSA estimates, combined with federal population census data from the American Community Survey, to develop prevalence estimates of SMI specific to the Commonwealth, as follows:

Table 1: Massachusetts (MA) Prevalence Estimates (2018-19) of Serious Mental Illness (SMI)/Serious Emotional Disturbance

DMH AREA	AGES ≤ 17	AGES 18-25	AGES 26-65	AGES ≥ 65
Metro Boston	15,777	6,801	13,876	2,959
Central MA	54,549	13,720	37,313	11,122
Northeast	59,044	16,318	43,450	13,094
Southeast	51,104	14,155	38,875	14,026
Western MA	27,330	9,740	19,450	6,855
Total MA	207,803	60,734	152,964	48,056

During 2020, the Massachusetts Department of Public Health (DPH) conducted a COVID-19 Community Impact Survey (CCIS), with over 33,000 adult respondents in the final sample. The sample of respondents represented a wide cross-section of the Commonwealth's residents, including those identifying as African American, Alaska Native/Native American, Hispanic, Asian, LGBTQ, deaf and hard of hearing, and those who speak languages other than English.

Findings specific to mental health needs include the following:

- Reports of poor mental health among survey respondents was 3x times higher than in 2019 (2019 BRFSS), with a third of adults currently reporting poor mental health (15+ days in the last 30 days).
- People experiencing persistent poor mental health were 2-3x more likely to experience significant barriers to accessing care, including appointment delays or cancellations, concerns about contracting COVID-19, not having a private place for a telehealth appointment, cost/insurance coverage, and lack of safe transportation.
- All demographic groups show an increase in people reporting poor mental health.
- Some populations were significantly more likely to report poor mental health: American Indian/Alaska Natives; the Hispanic/Latino community; people who identify as multi-racial; people between the ages of 25-44; people with lower income; caregivers of adults with special needs; people with disabilities; transgender people; non-binary people and those questioning their gender identity; and the LGBTQ+ community.

The prevalence of AMI and SMI in a community determines the need for treatment and use of mental health services. NSDUH considers the following as mental health treatment: inpatient treatment/counseling, outpatient treatment/counseling, and use of prescription medication to address emotional, neurological, or mental health issues.[22]

Among the 52.9 million adults in the US with AMI diagnoses in 2020, 24.3 million (46.2%) received mental health treatment during the prior year, with females (51.2%) receiving more mental health services than males (37.4%). Mental health treatment varied by age: 42.1% of adults aged 18-25 years received treatment, 46.6% adults aged 26-49 received treatment, and 48.0% adults aged 50 or older received treatment. Service use also varied by race for AMI: 51.8% of white adults received treatment, 37.1% of Black or African American adults received treatment, 20.8% of Asian adults received treatment, and 35.1% of Hispanic or Latino adults received treatment.[23] A higher percentage of adults with SMI received treatment in the prior year (64.5%), with females receiving more services (69.9%) than males (54.9%). As with AMI, mental health treatment for SMI varied by age: 57.6% of adults aged 18-25 years received treatment, 63.0% adults aged 26-49 received treatment, and 72.9% adults aged 50 or older received treatment.[24] Treatment also varied by race for SMI: 69.9% of White adults received treatment and 48.7% of Hispanic or Latino adults received treatment.[25]

2.3 CoCM Efficacy Studies

The Collaborative Care model has over 90 randomized control trials that indicate both its effectiveness and efficiency. Research has demonstrated that CoCM is more cost effective than treatment as usual, saving an average of $6.50 for every $1 spent on treatment for depression in the United States.[26] A seminal study on CoCM conducted in 2002 examined its effectiveness for treatment of late-life depression.[27] The results found that at 12 months of implementation of CoCM, 45% of intervention patients had a 50% or larger reduction in depressive symptoms compared to 19% of the usual care patients.[28]

Evidence from a review of 79 randomized controlled trials that compared Psychiatric Collaborative Care with the usual treatment for depression and anxiety report CoCM as superior to routine treatment in the improvement of depression for up to two years. This same level of improvement, lasting up to two years, was found in studies investigating the impact of CoCM on anxiety. Implementation of CoCM led to an increase in the number of patients using applicable medication for their diagnoses. Patients with depression and anxiety who received CoCM treatment also reported more satisfaction with their course of care.[29]

CoCM has also demonstrated effectiveness in the treatment of comorbid depression and chronic illnesses.[30] A 2010 study conducted by Katon et al. randomly assigned usual care or an intervention (CoCM treatment) to a group of 214 participants, who all had poorly controlled diabetes and/or coronary heart disease, and coexisting depression. Patients in the intervention group demonstrated greater overall improvement in their chronic illness metrics, including decreases in glycated hemoglobin, LDL cholesterol, and systolic blood pressure, as well as decreases in their depressive symptoms, according to their Symptom Checklist-20 (SCL-20) scores. Compared to patients in the usual care group, patients assigned to the intervention group also reported better quality of life, along with greater satisfaction with the treatment they received for their physical illness(es) and depression.

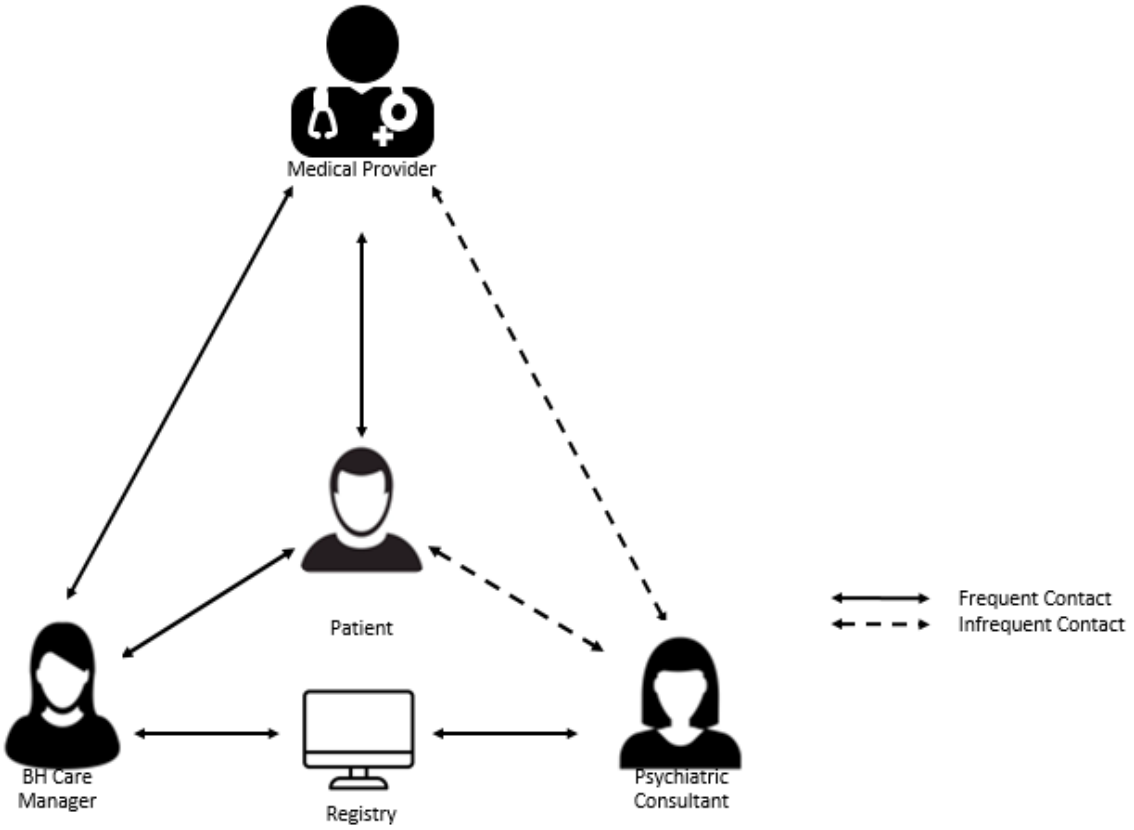
Evidence also suggests that CoCM can provide enduring improvements across race and ethnicity. One CoCM study involving minority veterans with untreated depression reports higher response rates from CoCM treatment than white veterans. The inclusion of cultural components within CoCM could augment the benefit of CoCM for minority adults. These components could include multilingual educational materials for prospective and current patients, and training staff in culturally-adapted interview techniques. One study tested a cultural component that included targeted messages focused on patient beliefs and attitudes toward treatment. Here, a black adult patient population benefited from CoCM regardless of whether they received the cultural component in their intervention.[31]

CoCM, backed by this research, has gained endorsement as a readily implementable and significantly more effective treatment than usual care for patients with depression in primary care settings.

3.0 Conclusion

Comprehensive research supports CoCM as a medically effective treatment for a range of mental health illnesses. One in five U.S. adults live with some form of mental illness, with current capacity for treatment limited. CoCM offers a viable, cost-effective, accessible treatment pathway for those with mental health illnesses, and shows effectiveness with diverse patient populations. Patients can seek services within the familiarity of their primary care practice, and be supported by a multi-faceted care team that provides evidence-based treatment for their specific condition.

Appendix A: Psychiatric Collaborative Care Model



Based on: University of Washington AIMS Center diagram: https://aims.uw.edu/collaborative-care/team-structure[32]

Endnotes

[1] The 192nd General Court of the Commonwealth of Massachusetts Senate Bill 769, "An Act relative to collaborative care." Accessed February 2, 2022: **https://malegislature.gov/Bills/192/S769.** House Bill 1057 is identical to Senate Bill 769. Accessed February 2, 2022: **https://malegislature.gov/Bills/192/H1057.**

[2] CMS/Medicare additional codes: 99484 (Care management services, minimum 20 minutes-General Behavioral Health Integration (BHI) Services); FQHC and RHC Medicare codes G0511 and G0512. CPT G2214 was introduced in 2021 for Medicare reimbursement.

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[5] Model Legislation for Private Insurance Coverage of the Psychiatric Collaborative Care Model (COCM) Codes." Model Collaborative Care Legislation. Accessed January 26, 2022.
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AN ACT RELATIVE TO COLLABORATIVE CARE

ACTUARIAL ASSESSMENT

1.0 Executive Summary

The Massachusetts Legislature's Joint Committee on Health Care Financing referred Senate Bill (S.B.) 769, entitled, "An Act relative to collaborative care,"[1] to the Massachusetts Center for Health Information and Analysis (CHIA) for review. Massachusetts General Law (MGL) Chapter 3 §38C requires CHIA to review the medical efficacy of treatments or services included in each mandated benefit bill referred to the agency by a legislative committee, should it become law. CHIA must also estimate each bill's fiscal impact, including changes to premiums and administrative expenses.

This report is not intended to determine whether the bill would constitute a health insurance benefit mandate for purposes of Commonwealth of Massachusetts (Commonwealth) defrayal under the Affordable Care Act (ACA), nor is it intended to assist with Commonwealth defrayal calculations if determined to be a health insurance mandate requiring Commonwealth defrayal.

1.1 Current Insurance Coverage

The Commonwealth does not currently require coverage of the Psychiatric Collaborative Care Model (CoCM). Mental health services are considered one of the 10 essential health benefits (EHBs) under the Affordable Care Act (ACA). Benefits are defined for Massachusetts according to its benchmark plan (the Blue Cross and Blue Shield of Massachusetts [BCBSMA] HMO Blue® plan.[2]) The benchmark plan description does not specifically mention CoCM.

Massachusetts law specifically mandates that fully-insured plans, employer-sponsored plans, individual plans, and state employee plans provide behavioral health treatment services on a non-discriminatory basis for select diagnoses. These conditions include: schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, substance abuse disorders, and autism.[3] The law requires that annual limits, lifetime limits, and quantitative treatment limits for these aforementioned conditions are equal to those for other medical conditions. Coverage of treatment for patients with conditions not on the specified list is also required in the form of a minimum of 60 days of inpatient treatment, and 24 outpatient visits if the treatment is deemed medically necessary. Insurance plans must also provide coverage for children under age 19 without the specified conditions who cannot attend school because of their condition, are hospitalized due to their condition, or possess behavior that could endanger themselves or others.

Under the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), group health plans and health insurance issuers that offer mental health benefits or substance use disorder benefits may not impose more stringent benefit limits on those benefits than on medical/surgical benefits. Depending on an MPHAEA analysis of a health plan's benefit exclusions (i.e. comparison of the factors used to exclude certain medical/surgical benefits versus the factors used to exclude certain mental health/substance use disorder benefits), the findings might support CoCM coverage from a compliance standpoint.

BerryDunn surveyed nine insurance carriers in the Commonwealth, and seven responded. The responding carriers represent about 97% of the membership of the carriers surveyed. One of the respondent insurance carriers indicated it does not provide CoCM benefits. A review of 2020 claims data in the Massachusetts All-Payer Claims Database

(APCD) supports that the remaining carriers cover psychiatric CoCM. The two carriers that did not respond had per member per month (PMPM) claims costs that were at or higher than the average for the carriers that cover CoCM. For this analysis, BerryDunn has assumed the nonresponding carriers cover CoCM.

1.2 Analysis

The proposed legislation mandates that carriers provide reimbursement of mental health or substance disorder benefits delivered via the CoCM using the CPT codes 99493, 99493, 99494, and other billing codes promulgated through regulations by the commissioner of insurance. Current law and the bill do not restrict rates carriers may pay to providers for these services. Estimating the marginal cost impact of the bill on premiums requires calculating the PMPM cost for carriers that do cover CoCM. Using 2020 claims data from the APCD, BerryDunn estimated the claims cost of CoCM for 2020 was $0.04 PMPM. The projected cost for carriers that cover CoCM at the end of the 2023 to 2027 projection period ranged between $0.07 PMPM and $0.10 PMPM.

1.3 Summary Results

Projected CoCM PMPMs were used to estimate the bill's cost related to the one surveyed carrier that reported it does not cover CoCM, representing approximately 3.0% of the total fully-insured membership. The bill's marginal PMPM cost is based on the estimated cost for the carrier that does not cover CoCM spread across all fully-insured membership. BerryDunn added carrier retention to estimate the bill's incremental effect on premiums for the five years, assuming an implementation date of January 1, 2023. At the high end of the range, and the end of the projection period, the incremental effect of the bill on average for commercial fully-insured premiums was estimated to less than $0.005 PMPM. Therefore, this analysis concludes that the incremental impact of the bill over the 2023 to 2027 projection period is immaterial and assumed to be zero.

Endnotes

[1] The 192nd General Court of the Commonwealth of Massachusetts Senate Bill 769, "An Act relative to collaborative care." Accessed February 2, 2022: **https://malegislature.gov/Bills/192/S769.** House Bill 1057 is identical to Senate Bill 769. Accessed February 2, 2022: **https://malegislature.gov/Bills/192/H1057.**

[2] Essential Health Benefit Benchmark Plan. Accessed February 2, 2022: **https://www.mass.gov/service-details/essential-health-benefit-benchmark-plan.**

[3] Mass. General Laws c.175 § 47B Accessed February 2, 2022: **https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter175/Section47B.**

2.0 Introduction

As submitted to the 192nd General Court of the Commonwealth, the bill requires insurers to cover mental health or substance use disorder treatment services that are delivered via the Psychiatric Collaborative Care Model (CoCM).[1] This includes reimbursement of three current procedural terminology (CPT) billing codes established by the American Medical Association: (1) 99492; (2) 99493; and (3) 99494. CHIA and its consultants clarified with the legislative sponsor that the bill's intent is to include CPT code G2214, [2] as well as other CPT codes yet to be created for CoCM. Accordingly, the bill stipulates that "the commissioner of insurance shall update this list of codes through the promulgation of regulations if there are any alterations or additions to the billing codes for the psychiatric collaborative care model."[3]

The bill indicates CoCM is an evidence-based, integrated behavioral health service delivery method as described in 81 FR 80230 (below).

> *The Psychiatric Collaborative Care Model (CoCM) [is] an evidence-based approach to behavioral health integration that enhances "usual" primary care by adding care management support and regular psychiatric inter-specialty consultation.*

Section 3.0 of this analysis outlines the provisions and interpretations of the bill. Section 4.0 summarizes the methodology used for the estimate. Section 5.0 discusses important considerations in translating the bill's language into estimates of its incremental impact on healthcare costs, and steps through the calculations. Section 6.0 discusses results.

3.0 Interpretation of the Bill

3.1 Reimbursement for CoCM

As submitted to the 192nd General Court of the Commonwealth, the bill requires commercial health plans to provide reimbursement of mental health or substance disorder benefits delivered via the CoCM using the CPT codes 99493, 99493, 99494, and other billing codes promulgated through regulations by the commissioner of insurance. The sponsor of the bill confirmed that the intent of the bill is to require coverage of G2214,[4] as well as other CPT codes yet to be created for the psychiatric CoCM.

3.2 Plans Affected by the Proposed Mandate

The bill amends statutes that regulate commercial healthcare carriers in the Commonwealth. It includes the following sections, each of which addresses statutes dealing with a particular type of health insurance policy when issued or renewed in the Commonwealth:[5]

- Chapter 32A – Plans Operated by the Group Insurance Commission (GIC) for the Benefit of Public Employees
- Chapter 175 – Commercial Health Insurance Companies
- Chapter 176A – Hospital Service Corporations

- Chapter 176B – Medical Service Corporations
- Chapter 176G – Health Maintenance Organizations (HMOs)

Self-insured plans, except for those managed by the Group Insurance Commission (GIC), are not subject to state-level health insurance benefit mandates. State mandates do not apply to Medicare or Medicare Advantage plans, the benefits of which are qualified by Medicare. This analysis excludes members over 64 years of age who have fully-insured commercial plans, and this analysis does not address any potential effect on Medicare supplement plans, even to the extent they are regulated by state law. Although the bill includes Chapter 118, this analysis does not estimate the bill's impact to MassHealth.

3.3 Covered Services

BerryDunn surveyed nine insurance carriers in the Commonwealth, and seven responded. Based on membership data in the APCD, the responding carriers represent about 97% of the membership of the carriers surveyed. Nearly all of the respondent carriers reported covering the CPT codes associated with psychiatric CoCM. One of the respondent insurance carriers indicated it does not provide benefits for the CoCM. The two carriers that did not respond had per member per month (PMPM) claims costs that were at or higher than the average for the carriers that cover CoCM. For this analysis, BerryDunn has assumed that both carriers that did not respond cover CoCM.

3.4 Existing Laws Affecting the Cost of the Bill

The Commonwealth does not currently require reimbursement of psychiatric CoCM. However, several federal and state laws support carriers' decisions to provide CoCM coverage.

Mental health services are considered one of the ACA's 10 essential health benefits (EHBs). Benefits are defined for Massachusetts according to its benchmark health plan (the Blue Cross and Blue Shield of Massachusetts HMO Blue® plan), which does not provide specific language regarding "psychiatric CoCM."

Massachusetts requires fully-insured plans to provide behavioral health treatment coverage on a non-discriminatory basis for certain mental health conditions. The law mandates that annual limits, lifetime limits, and quantitative treatment limits for the following conditions are equal to those for other medical conditions:

- Schizophrenia
- Schizoaffective disorder
- Major depressive disorder
- Bipolar disorder
- Paranoia and other psychotic disorders
- Obsessive-compulsive disorder
- Panic disorder
- Delirium and dementia
- Affective disorders
- Eating disorders
- Post-traumatic stress disorder
- Substance abuse disorders
- Autism

Coverage is also required for treatment for children under age 19 who do not have the above conditions, but who cannot attend school due to their mental health diagnosis, are hospitalized due to their condition, or possess

behavior that could endanger themselves or others. The law states that treatment can occur in the least-restrictive clinically-appropriate setting ranging from inpatient to outpatient. Coverage for the treatment of autism is required to be covered under Massachusetts law.[6]

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), group health plans and health insurance issuers that offer insured mental health benefits or substance use disorder benefits may not impose more stringent benefit limits on those benefits than on medical/surgical benefits. Depending on an MHPAEA analysis of a health plan's benefit exclusions (i.e., comparison of the factors used to exclude medical/surgical benefits versus the factors used to exclude mental health/substance use disorder benefits), the findings might support CoCM coverage from a compliance standpoint.

4.0 Methodology

4.1 Overview

The proposed legislation mandates that carriers reimburse mental health or substance disorder benefits delivered via the CoCM using CPT codes 99493, 99493, 99494, and other billing codes promulgated through regulations by the commissioner of insurance. BerryDunn conducted a survey of Massachusetts' nine largest commercial health insurance carriers to determine their current practices in covering these CPT codes. BerryDunn also reviewed 2020 claims data in the Massachusetts All-Payer Claim Database (APCD) to identify whether carriers paid claims for these CPT codes.

All but one of the responding carriers indicate this coverage is already in place for all of their policies. A review of 2020 claims data in the APCD supports that the carriers cover psychiatric CoCM. CoCM claims by carriers that did not respond to the survey were found in the APCD, supporting that these carriers also cover CoCM. Note that the current law and the proposed mandate do not restrict rates carriers may pay to providers for these services.

Estimating the marginal cost impact of the bill on premiums requires calculating the PMPM cost for the carriers that cover CoCM. This PMPM is used as an estimated cost for the carrier that does not cover CoCM. The overall marginal PMPM cost is based on the estimated cost for the carrier that excludes coverage, spread across all fully-insured membership. BerryDunn added carrier retention to calculate a baseline estimate of the proposed mandate's incremental effect on premiums, which is projected over the five years following the assumed January 1, 2023, implementation date of the proposed law.

4.2 Data Sources

The primary data sources used in the analysis are:

- Information about the intended effect of the bill, gathered from the legislative sponsor
- Information, including descriptions of current coverage, from responses to a survey of commercial health insurance carriers in the Commonwealth
- The Massachusetts APCD
- Academic literature, published reports, and population data, cited as appropriate

4.3 Steps in the Analysis

BerryDunn performed the analytic steps summarized in this section to estimate the impact of the bill on premiums.

1. **Estimate the incremental cost to insurers to cover CoCM.**
   In order to estimate the cost of covering CoCM services, BerryDunn:

   A. Used claims data from the APCD to determine total claims cost of CoCM for carriers that cover CoCM.[ii]

   B. Divided the total claims cost by the corresponding membership to determine PMPM cost of CoCM.

   C. Projected the growth rates in the use of CoCM over the five-year analysis period.

   D. Used publicly-available information and projected the growth rate in the unit cost over the five-year analysis period.

   E. Used projected growth rates to estimate PMPM costs of CoCM over the five-year analysis period for carriers that cover CoCM.

   F. Used membership data from the APCD to determine a weighted average impact of adding coverage for the carrier that does not cover CoCM to determine the incremental PMPM.

2. **Calculated the impact of the projected claim costs on insurance premiums.**
   To calculate the impact on premiums, BerryDunn:

   A. Estimated the fully insured Commonwealth population under age 65, projected for the next five years (2023 – 2027).

   B. Multiplied the estimated incremental PMPM cost of the mandate by the projected population estimate, to calculate the total estimated marginal claims cost of the bill.

   C. Estimated insurer retention (administrative costs, taxes, and profit) and applied the estimate to the final incremental claims cost calculated in Step B.

4.4 Limitations

With one exception, respondent carriers in Massachusetts indicated they currently provide coverage for CoCM. The incremental cost of the bill stems from the one carrier that does not cover CoCM. This cost was estimated using the APCD claims for the carriers that cover the services as a baseline. Impacting the marginal cost estimate is the increase in the use of these services over the projection period, which is uncertain. CoCM is relatively new, and there is not enough data to predict the rate of growth. Research reviewing post-COVID-19-era psychiatry trends projects that psychiatric disorders will increase, along with the associated need for mental health services, and offers CoCM as a potential solution.[7] However, growth in CoCM might be slow due to factors including lack of resources and difficultly in implementing the new procedure codes.[8] BerryDunn conservatively assumed a range of growth rates in calculating the marginal cost estimate.

It is also possible that the carrier that does not cover CoCM will voluntarily decide to do so in the future, as the research supports its efficacy and cost effectiveness with over 90 randomized control trials. Furthermore, studies

[ii] See Appendix A for information about distribution of claims across carriers.

have demonstrated that CoCM is more cost effective than treatment as usual, saving an average of $6.50 for every $1 spend on treatment for depression in the United States.[9]

COVID-19 has impacted the number of commercial fully-insured members in 2020. Fully-insured membership declined due to decreased enrollment in employer-sponsored insurance (ESI). The impact that COVID-19 will have on unemployment, and therefore ESI, in the 2023 – 2027 projection period is uncertain.

BerryDunn addresses these limitations further in Appendix A.

5.0 Results

5.1 Five-Year Estimated Impact

The proposed legislation mandates that carriers provide reimbursement of mental health or substance disorder benefits delivered via the CoCM using CPT codes 99493, 99493, 99494, and other billing codes promulgated through regulations by the commissioner of insurance.

Estimating the marginal cost impact of the bill on premiums requires calculating the PMPM cost for the carriers that cover CoCM. Using 2020 claims data from the APCD, BerryDunn calculated a range of PMPM claims cost between $0.01 and $0.06. The effective dates of the coverage impacted the 2020 PMPMs observed. Some carriers also indicated that they took steps, such as adding provider incentives, to increase the use of CoCM. Some of these steps occurred in the latter half of 2020. Figure 1 shows the number of members with CoCM claims and the corresponding portion of each carrier's fully-insured membership. Conservatively, BerryDunn calculated the PMPM cost using only the four carriers with more mature CoCM claims experience. For the carriers with a more mature CoCM program, the 2020 claims cost was $0.04 PMPM. BerryDunn used $0.04 as a baseline cost. To estimate costs over the projection period, the long-term national average projection for cost increases to physician services (4.8%)[10] was used to project cost increases. The increase in utilization is uncertain. BerryDunn assumed that utilization will increase between 2.5% and 7.5% per year over the projection period. The projected cost for carriers that cover CoCM at the end of the projection period ranged between $0.07 PMPM and $0.10 PMPM.

The projected PMPMs are used as estimated costs for the carrier that does not cover CoCM. The marginal PMPM cost is based on the estimated cost for the carrier that excludes coverage, spread across all fully-insured membership. BerryDunn added carrier retention which results in the bill's incremental effect on premiums, which was projected over the five years following the assumed January 1, 2023, implementation date of the proposed law. The membership of the carrier that does not cover CoCM is only about 3.0% of the total fully-insured membership. Even at the high end of the range, the incremental effect of the bill on average commercial fully-insured medical expense and premiums is less than $0.005 PMPM. This analysis therefore concludes that the incremental impact over the 2023 to 2027 projection period is immaterial and assumed to be zero.

The proposed mandate would apply to self-insured plans operated for state and local employees by the Group Insurance Commission (GIC). The benefit offerings of GIC plans are similar to most other commercial plans in Massachusetts, and the one carrier that does not cover CoCM does offer GIC health benefit plans. However, the

carrier's portion of the GIC membership is different than their portion of the fully insured membership, so the estimated marginal cost is not the same. The next section describes the results for the GIC.

5.2 Impact on GIC

Findings from BerryDunn's carrier survey indicate that benefit offerings for GIC and other commercial plans in the Commonwealth are similar. For this reason, the cost of CoCM is assumed to be similar to other fully insured plans in the Commonwealth. However, the carrier that does not cover CoCM represents a greater portion of the GIC membership, or a little more than twice the portion that they represent in the fully insured market. As a result, marginal cost for the GIC is estimated to be about 2.445 times the cost for the fully insured market. Over the projection period BerryDunn estimates that the incremental cost for the GIC is between $0.004 and $0.008.

BerryDunn assumed the proposed legislative change will apply to self-insured plans that the GIC operates for state and local employees, with an effective date of July 1, 2023. Because of the July effective date, the results in 2022 are approximately one-half of an annual value. Table 1 breaks out the GIC's self-insured membership, as well as the corresponding incremental medical expense.

Table 1: GIC Summary Results

	2023	2024	2025	2026	2027	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
GIC Self-Insured							
Members (000s)	313	312	312	311	311		
Medical Expense Low ($000s)	$8	$17	$18	$19	$20	$18	$82
Medical Expense Mid ($000s)	$8	$18	$20	$22	$24	$21	$93
Medical Expense High ($000s)	$9	$20	$23	$25	$29	$23	$106

Appendix A: Distribution of Claims

Figure 1: Percent of Members with CoCM Claims 2020. Data is unique by payer and member.[iii]

	MEMBERS WITH CLAIMS	TOTAL FULLY INSURED MEMBERS	PERCENT OF MEMBERS WITH CLAIMS
Payer			
Carrier 11	92	18,100	0.5083%
Carrier 10	54	32,987	0.1637%
Carrier 9	363	485,702	0.0747%
Carrier 8	817	2,340,285	0.0349%
Carrier 7	448	2,257,135	0.0198%
Carrier 6	17	107,461	0.0158%
Carrier 5	280	2,223,418	0.0126%
Carrier 4	37	537,317	0.0069%
Carrier 3	652	9,663,342	0.0067%
Carrier 2	13	735,316	0.0018%
Carrier1	12	994,782	0.0012%

[iii] Carriers with fewer than 10 members with claims are excluded from this figure.

Figure 2: Number of CoCM Claims by Payer 2020. Data is unique by claim[iv]

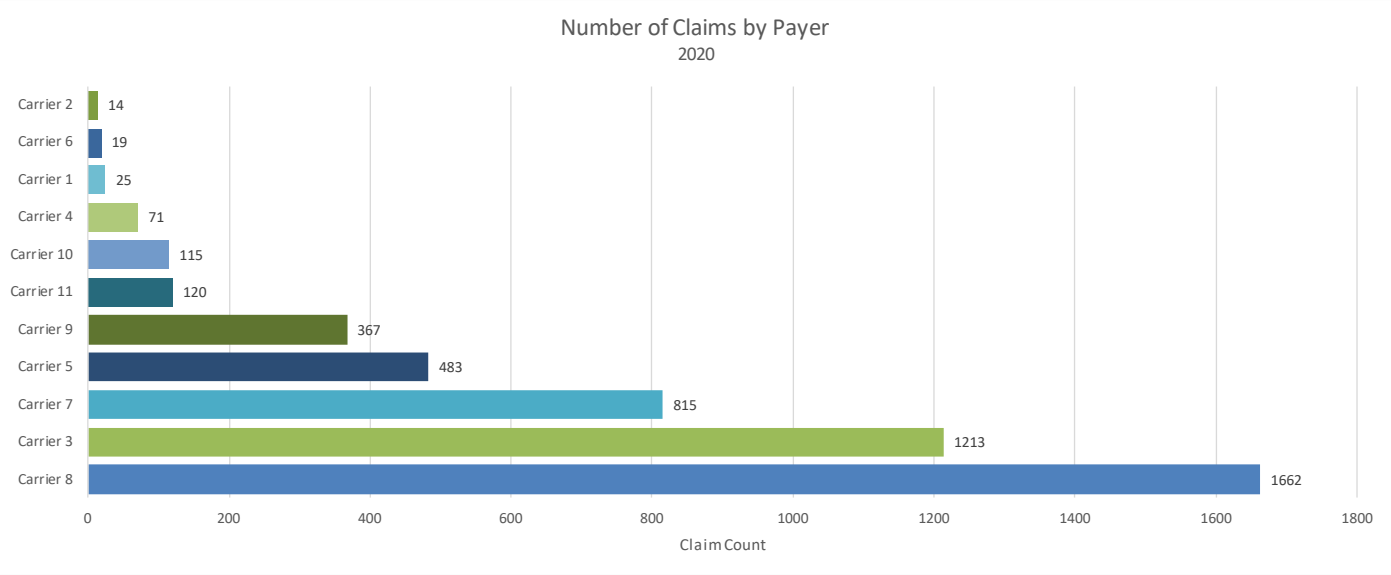
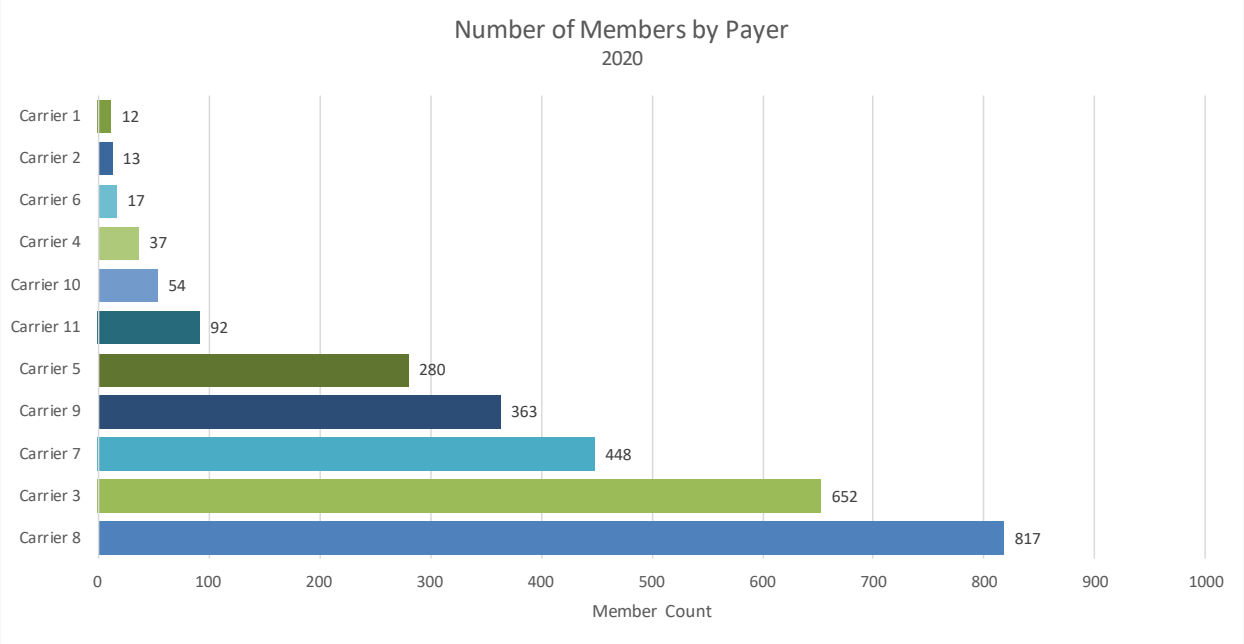


Figure 3: Number of Members Receiving Care under the CoCM by Payer 2020. Data is unique by payer and member.[v]



Endnotes

[1] The 192nd General Court of the Commonwealth of Massachusetts Senate Bill 769, "An Act relative to collaborative care." Accessed February 2, 2022: **https://malegislature.gov/Bills/192/S769.** House Bill 1057 is identical to Senate Bill 769. Accessed February 2, 2022: **https://malegislature.gov/Bills/192/H1057.**

[2] CMS/Medicare additional codes: 99484 (Care management services, minimum 20 minutes-General Behavioral Health Integration (BHI) Services); FQHC and RHC Medicare codes G0511 and G0512.

[2] CPT G2214 was introduced in 2021 for Medicare reimbursement.

[3]The 192nd General Court of the Commonwealth of Massachusetts Senate Bill 769, "An Act relative to collaborative care." Accessed February 2, 2022: **https://malegislature.gov/Bills/192/S769.** House Bill 1057 is identical to Senate Bill 769. Accessed February 2, 2022: **https://malegislature.gov/Bills/192/H1057.**

[4] CPT G2214 was introduced in 2021 for Medicare reimbursement.

[5] The bill, as currently written, does not include Chapter 176A. However, it was confirmed with the Sponsors that the bill's intent is to include Chapter 176A.

[6] Mass. General Laws c.175 § 47B Accessed February 2, 2022:
https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter175/Section47B.

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https://www.psychiatry.org/psychiatrists/advocacy/state-affairs/model-cocm-legislation.

[10] U.S. Centers for Medicare and Medicaid Services (CMS), Office of the Actuary. National Health Expenditure Projections. Table 7, Physician and Clinical Services Expenditures; Aggregate and per Capita Amounts, Calendar Years 2019-2028; Private Insurance. Accessed March 3, 2022.

[iv] Carriers with fewer than 10 members with claims are excluded from this figure. Carrier number is the same number used in Figure 1 (e.g., Carrier 1 is the same in Figures 1-3).

[v] Carriers with fewer than 10 members with claims are excluded from this figure. Carrier number is the same number used in Figure 1 (e.g., Carrier 1 is the same in Figures 1-3).

Appendix B: Membership Affected by the Proposed Language[6]

Membership potentially affected by proposed mandated change criteria includes Commonwealth residents with fully insured, employer-sponsored health insurance issued by a Commonwealth-licensed company (including through the GIC); nonresidents with fully insured, employer-sponsored insurance issued in the Commonwealth; Commonwealth residents with individual (direct) health insurance coverage; and lives covered by GIC self-insured coverage.

Please note these are unprecedented economic circumstances due to COVID-19, which makes the estimation of membership extremely challenging. The membership projections are used to determine the total dollar impact of the proposed mandate in question; however, variations in the membership forecast will not affect the general magnitude of the dollar estimates. As such, given the uncertainty, BerryDunn took a simplified approach to the membership projections as described below. These membership projections are not intended to be used for any other purpose than producing the total dollar range in this study. Further, to assess how recent volatility in commercial enrollment levels might affect these cost estimates, please note that the PMPM and percentage of premium estimates are unaffected because they are per-person estimates, and the total dollar estimates will vary by the same percentage as any percentage change in enrollment levels.

The 2018 Massachusetts APCD formed the base for the projections. The Massachusetts APCD provided fully insured membership by insurance carrier. The Massachusetts APCD was also used to estimate the number of nonresidents covered by a Commonwealth policy. These are typically cases in which a nonresident works for a Commonwealth employer that offers employer-sponsored coverage. Adjustments were made to the data for membership not in the Massachusetts APCD, on published membership reports available from CHIA and the Massachusetts Department of Insurance (DOI).

CHIA publishes monthly enrollment summaries in addition to its biannual enrollment trends report and supporting databook (enrollment-trends-March-2020-databook[1] and Monthly Enrollment Summary – August 2020[2]), which provides enrollment data for Commonwealth residents by insurance carrier for most carriers. (Some small carriers are excluded.) CHIA uses supplemental information beyond the data in the Massachusetts APCD to develop its enrollment trends report. The supplemental data was used to adjust the resident totals from the Massachusetts APCD. In 2020, commercial, fully insured membership is 2.6% less than in 2019 with a shift to both uninsured and MassHealth coverage. The impact of COVID-19 on fully insured employers over the five-year projected period is uncertain. BerryDunn took a high-level conservative approach and assumed that membership would revert to 2019 levels by January 1, 2022.

The DOI published reports titled Quarterly Report of HMO Membership in Closed Network Health Plans as of December 31, 2018[3] and Massachusetts Division of Insurance Annual Report Membership in MEDICAL Insured Preferred Provider Plans by County as of December 31, 2018.[4] These reports provide fully insured covered members for licensed Commonwealth insurers where the member's primary residence is in the Commonwealth. The DOI reporting includes all insurance carriers and was used to supplement the Massachusetts APCD membership for

[6] Last updated November 15, 2020.

small carriers not in the Massachusetts APCD.

The distribution of members by age and gender was estimated using Massachusetts APCD population distribution ratios and was checked for reasonableness and validated against U.S. Census Bureau data.[5] Membership was projected from 2019 – 2027 using Massachusetts Department of Transportation population growth rate estimates by age and gender.[6]

Projections for the GIC self-insured lives were developed using the GIC base data for 2018 and 2019, that BerryDunn received directly from the GIC, as well as the same projected growth rates from the Census Bureau that were used for the Commonwealth population. Breakdowns of the GIC self-insured lives by gender and age were based on the Census Bureau distributions.

Appendix B: Endnote

[1] Center for Health Information and Analysis. Estimates of fully insured and self-insured membership by insurance carrier. Accessed November 15, 2020: **https://www.chiamass.gov/enrollment-in-health-insurance/.**

[2] Center for Health Information and Analysis. Estimates of fully insured and self-insured membership by insurance carrier. Accessed November 15, 2020: **https://www.chiamass.gov/enrollment-in-health-insurance/.**

[3] Massachusetts Department of Insurance. HMO Group Membership and HMO Individual Membership Accessed November 12, 2020: **https://www.mass.gov/doc/group-members/download; https://www.mass.gov/doc/individual-members/download.**

[4] Massachusetts Department of Insurance. Membership 2018. Accessed November 12, 2020: **https://www.mass.gov/doc/2018-ippp-medical-plans/download.**

[5] U.S. Census Bureau. Annual Estimates of the Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2018. Accessed November 12, 2020: **https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk.**

[6] Massachusetts Department of Transportation. Socio-Economic Projections for 2020 Regional Transportation Plans. Accessed November 12, 2020: **https://www.mass.gov/lists/socio-economic-projections-for-2020-regional-transportation-plans.**