MANDATED BENEFIT REVIEW OF HOUSE BILL 2116

AND SENATE BILL 1292

SUBMITTED TO THE 192ND GENERAL COURT:

AN ACT PROVIDING ACCESS TO FULL SPECTRUM ADDICTION TREATMENT SERVICES

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Prepared for Massachusetts Center for Health Information and Analysis

By Berry Dunn McNeil & Parker, LLC

Mandated Benefit Review of House Bill (H.B.) 2116 and Senate Bill (S.B.) 1292 Submitted to the 192nd General Court

An Act Providing Access to Full Spectrum Addiction Treatment Services

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1.0 Benefit Mandate Overview: H.B. 2116 and S.B. 1292; Both Entitled: An Act Providing Access to Full Spectrum Addiction Treatment Services

1.1 History of the Bill

The Massachusetts Legislature's Committee on Mental Health, Substance Use and Recovery referred House Bill (H.B.) 2116 and Senate Bill (S.B.) 1292, both entitled, "An Act Providing Access to Full Spectrum Addiction Treatment Services,"[1] to the Massachusetts Center for Health Information and Analysis (CHIA) for review.[i] 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. H.B. 2116 and S.B. 1292 are identical and will be collectively referenced as "the bill."

This report is not intended to determine whether the bill would constitute a health insurance 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, the bill amends current mandated benefits laws to require insurance carriers to add medically necessary transitional support services (TSS) to the already mandated coverage of acute treatment services (ATS) and medically necessary clinical stabilization services (CSS). The bill would require coverage of all three (TSS, ATS, CSS) for up to 30 consecutive days (an increase from the currently mandated 14 days for ATS and CSS), without prior authorization. The bill requires facilities to provide carriers with notification of admission and the initial treatment plan within 48 hours of admission. In addition, facilities must provide carriers with a projected discharge plan within a reasonable time.

The bill would extend the time before carriers would be permitted to begin utilization review procedures for any combination of the three levels of service (ATS, CSS, and TSS) from day 7 to day 14. Although the bill allows carriers to initiate utilization review procedures on day 14, carriers would be precluded from making utilization review decisions that impose restrictions or denials on future medically necessary ATS, CSS, or TSS, unless the patient has received at least 30 consecutive days of these services.

Upon receipt of notification by the admitting facility and receipt of the discharge plan, the bill permits carriers to provide outreach to the treating clinician and the patient to offer care management and support services. Under the bill, medical necessity is determined by the treating clinician in consultation with the patient. The bill defines "TSS" as follows:

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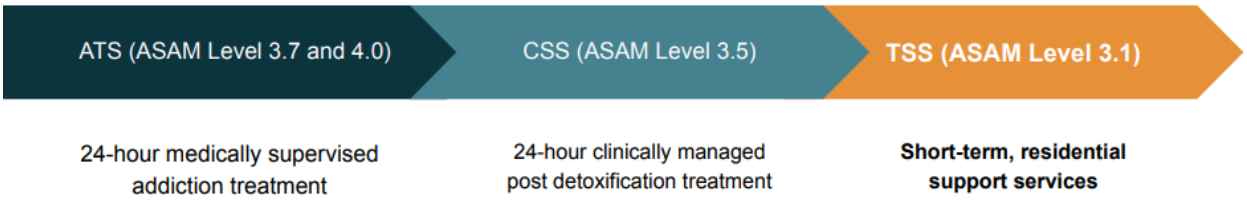
[i] The bills were refiled with the 193rd General Court; they are now H.B. 1146 and S.B. 662.

> *TSS refers to "short-term, residential support services, as defined by the department of public health, usually following clinical stabilization services, that provide a safe and structured environment to support adults or adolescents through the addiction recovery process and the transition to outpatient or other step-down addiction recovery care."*

TSS generally follows the American Society of Addiction Medicine (ASAM) level of addiction[ii] treatment as shown below:

Figure 1 ATS, CSS, and TSS ASAM Levels of Care



1.3 Medical Efficacy of the Bill

TSS are short-term residential rehabilitation programs that provide services for individuals who need a safe and structured environment to aid in their recovery process after detoxification. TSS are designed to help individuals who need services between acute treatment and residential rehabilitation, and to assist with their eventual transition to outpatient or other step-down addiction recovery treatment.[2] TSS falls under the ASAM 3.1 level of care referred to as "Clinically Managed Low-Intensity Residential Treatment Services."[3] The average length of stay (ALOS) for TSS is typically longer than the ALOS for ATS and CSS. Length of stay (LOS) in any level of care might vary substantially by individual, as ASAM Criteria emphasizes that LOS must be based on an individual's illness severity, and the individual's overall function.[4]

TSS utilization is greater for members who are insured by MassHealth than for members who are insured by commercial insurers. The Massachusetts Section 1115 MassHealth Demonstration (Waiver) enables coverage of Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services in the form of 24-hour TSS. MassHealth allows enrollment in ATS as a diversionary service that is intended to intervene and stabilize individuals experiencing crises to avoid the need for acute inpatient hospitalization and allows enrollment in CSS as a standalone treatment or following ATS for SUD.[5] For vulnerable populations who may be unhoused, or who may lack a supportive home environment, TSS offers an appropriate setting in which they can continue their recovery and plan for their eventual discharge to outpatient care.

[ii] The American Society of Addiction Medicine (ASAM) defines addiction as "a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment, and an individual's life experiences. People with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences." ASAM: American Society of Addiction Medicine. Definition of Addiction. Accessed 20 January 2023. **https://www.asam.org/quality-care/definition-of-addiction**.

There is evidence that shorter lengths of stay for SUD might increase the likelihood of readmission. Given the complexities involved in evaluating the ASAM dimensions of care,[iii] the bill may improve access to a longer duration of intensive services for some members in need —thus reducing the risk of readmission.

1.4 Current Coverage

BerryDunn surveyed nine insurance carriers in the Commonwealth, and six responded. None of the respondent carriers cover TSS services. All respondent carriers reported following the currently mandated 14-day period of coverage for ATS and CSS services before requiring authorization.

1.5 Cost of Implementing the Bill

Requiring coverage for medically necessary TSS, ATS and CSS for up to 30 consecutive days, without prior authorization, would increase the typical member's monthly health insurance premium by an estimated range of between **$0.00 and $0.22** per member per month (PMPM) on average over the first five years of enactment, or between **0.00% and 0.037%** of premium. The impact on premiums is driven by the requirement that carriers cover TSS and by increasing the required minimum coverage for combined LOS from 14 days (for ATS and CSS) to 30 days (for ATS, CSS, and TSS).

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:[6]

- 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, also amends Chapter 118E of the General Laws which regulates Medicaid (MassHealth) in the Commonwealth. However, estimating the bill's impact to MassHealth membership is outside the scope of this report.

[iii] The ASAM Criteria utilizes a six-dimensional assessment to identify the intensity of treatment services that best fit patient needs. Treatment plans for adults and adolescents are developed by applying a multidimensional patient assessment across five broad levels of treatment informed by the amount provided of direct medical management, structure, safety, and security, as well as the intensity of treatment services. **https://www.asam.org/asam-criteria/about-the-asam-criteria**.

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] H.B. 2116. An act providing access to full spectrum addiction treatment services. **https://malegislature.gov/Bills/192/H2116**. S.B. 1292. An act providing access to full spectrum addiction treatment services. Accessed December 23, 2022. **https://malegislature.gov/Bills/192/S1292**.

[2] Substance Addiction Services Descriptions. Mass.gov. Accessed November 23, 2022. **https://www.mass.gov/service-details/substance-addiction-services-descriptions**.

[3] About the ASAM Criteria. Accessed December 12, 2022. **https://www.asam.org/asam-criteria/about-the-asam-criteria**.

[4] D. M. Lee. The New ASAM Criteria for the Treatment of Addictive, Substance-Related and Co-Occurring Conditions - What's New and Why? 7/7/2014. Accessed December 14, 2022. **https://graduate.lclark.edu/live/files/17473-nwias-2014-meelee-plenary**.

[5] State Residential Treatment for Behavioral Health Conditions: Regulation and Policy Massachusetts. August 2021. Accessed December 28, 2022. **https://aspe.hhs.gov/sites/default/files/2021-08/StateBHCond-Massachusetts.pdf**.

2.0 Medical Efficacy Assessment

As submitted to the 192nd General Court, the bill amends current mandated benefits laws to require insurance carriers to add medically necessary transitional support services (TSS) to the already mandated coverage of acute treatment services (ATS) and clinical stabilization services (CSS). The bill would require coverage, without prior authorization, for all three services (ATS, CSS, and TSS) for up to 30 consecutive days (an increase from the currently mandated 14 days for ATS and CSS). The bill requires facilities providing services to provide carriers with notification of admission and the initial treatment plan within 48 hours of admission. In addition, facilities must provide carriers with a projected discharge plan within a reasonable time.

The bill would extend the time before carriers would be permitted to begin utilization review procedures for any combination of the three levels of service (ATS, CSS, and TSS) from day 7 to day 14. Although the bill allows carriers to initiate utilization review procedures on day 14, carriers would be precluded from making utilization review decisions that impose restrictions or denials on future medically necessary ATS, CSS, or TSS, unless the patient has received at least 30 consecutive days of these services.

Upon receipt of notification by the admitting facility and receipt of the discharge plan, the bill permits carriers to provide outreach to the treating clinician and the patient to offer care management and support services. Under the bill, medical necessity is determined by the treating clinician in consultation with the patient. The bill defines "TSS" as follows:

> *TSS refers to "short-term, residential support services, as defined by the department of public health, usually following clinical stabilization services, that provide a safe and structured environment to support adults or adolescents through the addiction recovery process and the transition to outpatient or other step-down addiction recovery care."*

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 includes the following sections:

2.1 SUD Prevalence and Treatment Utilization

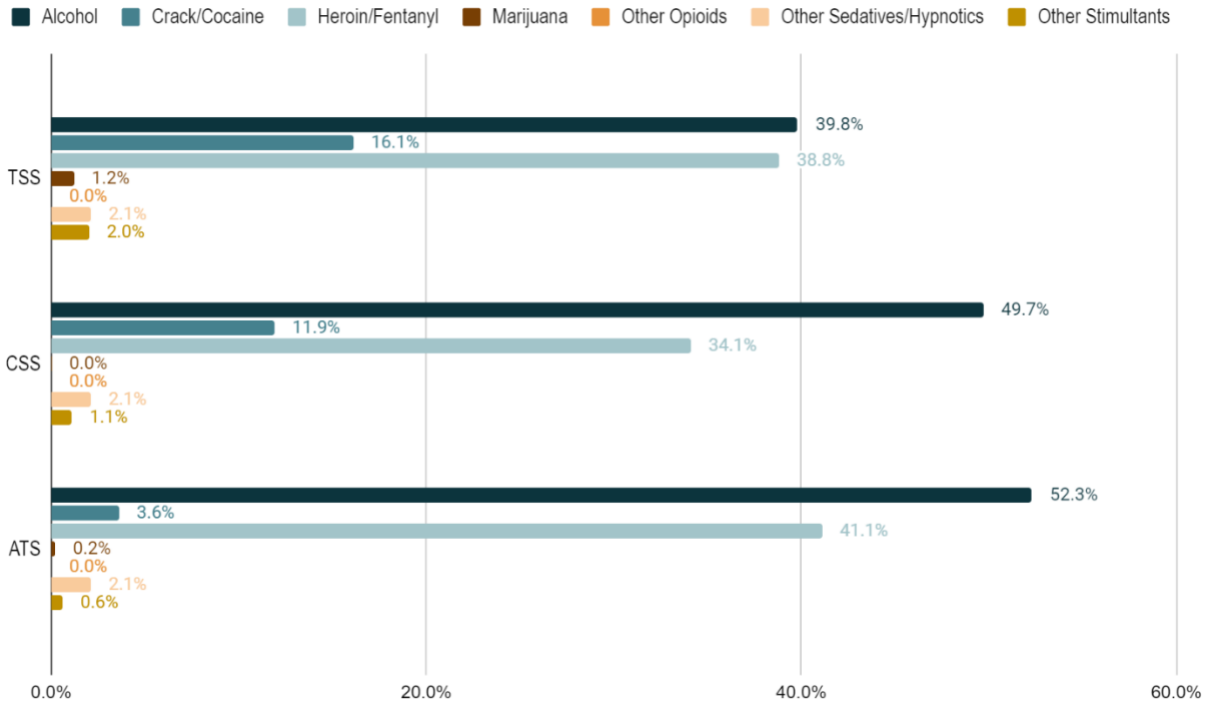
The bill would require coverage of TSS and an extended length of time for members with SUD to obtain services before carriers could require authorization for any combination of ATS, CSS, and TSS. SUD continues to be an important health issue in the United States, as well as in Massachusetts. The average annual prevalence of SUD among people aged 12 or older in Massachusetts from 2017 – 2019 was 516,000 individuals, or 8.7% of the population, which is equivalent to the regional average of 8.7%, but higher than the national average of 7.4%. Among individuals aged 12 or older in Massachusetts, the average annual prevalence of past-year illicit drug use disorder from 2017 – 2019 was 3.6%, or 213,000 individuals. This was close to the regional average of 3.4%, and slightly higher than the national average of 2.9%. In 2018 to 2019, 1.8% of adolescents and 6.5% of adults in Massachusetts self-reported experiencing alcohol use disorder (AUD), which based on the 2018 Massachusetts population equates to approximately 123,948 adolescents and 447,590 adults.[1,2]

Deaths due to opioid overdoses account for the majority (89.8%) of all drug overdose deaths in Massachusetts. Deaths due to drug overdoses of any substance have increased by approximately 20% from 28.0 per 100,000 in 2015 to 33.6 per 100,000 in 2020. In 2019, the age-adjusted opioid overdose death rate per 100,000 in Massachusetts was 28.9, close to double that of the national average of 15.5.[3] The MA Department of Public Health reports that the rate of opioid deaths increased by 8.8% in 2021 compared to 2020.[4] There were 2,290 confirmed and estimated opioid-related deaths in 2021—an estimated 185 more than the prior year.[5] Preliminary data from the first three months of 2022 indicate that there have been 4% fewer deaths than the same time last year.[6]

Based on data from the National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services in March 2019, for a single-day count, 66,912 people in Massachusetts were enrolled in treatment for SUD, a 47.3% increase from 2015 when 45,438 people were enrolled. Among those enrolled in SUD treatment, the majority (56.7%) were receiving treatment for only a drug issue, 14.6% were receiving treatment for only an alcohol issue, and 28.7% were receiving treatment for both drug and alcohol issues.

In Massachusetts from July 1, 2021, through June 30, 2022, according to data from the Bureau of Substance Addiction Services (BSAS), the most used primary drug among individuals with TSS, CSS, or ATS enrollments was alcohol (39.8% for TSS, 49.7% for CSS, and 52.3% for ATS, see Figure 2).[7] Across all three treatment settings, heroin/fentanyl was the second most commonly used primary drug (38.8% for TSS, 34.1% for CSS, and 41.1% for ATS, see Figure 2). Figure 2 utilizes statistics from data submitted to BSAS and includes all payers. However, all commercial data is not submitted to BSAS.

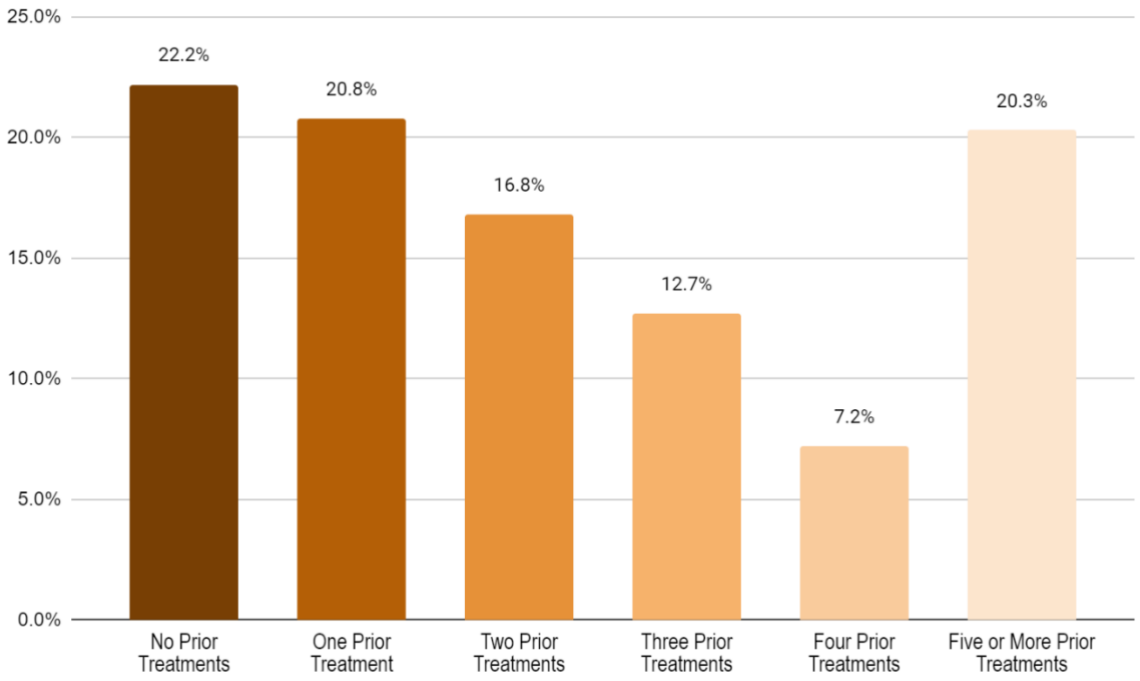
Figure 2 TSS, CSS, and ATS % of Enrollments by Primary Drug, Jul 01, 2021 – Jun 30, 2022, Data as of September 2, 2022*



*Note percentages may not sum to 100% due to multi-choice selection.

Most individuals TSS enrollments received prior residential treatment; 77.8% had prior residential treatment, of which 20.3% had five or more prior treatments, and 22.2% had no prior residential treatment (see Figure 3).[8]

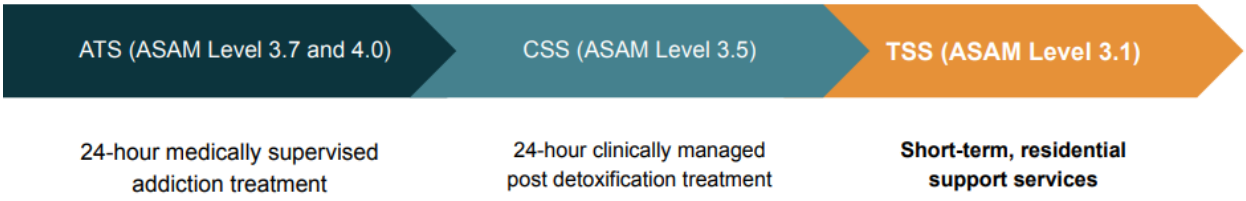
Figure 3 TSS Prior SUD Treatment History in Residential Treatment Setting, Jul 01, 2021 - Jun 30, 2022, Data as of September 2, 2022*[9]



2.2 TSS

TSS are short-term residential rehabilitation programs that provide services for individuals who need a safe and structured environment to aid in their recovery process after detoxification. TSS generally follow ATS and CSS as shown below:

Figure 2 ATS, CSS, and TSS Levels of Care



Level of intensity decisions utilize a six-dimensional assessment (ASAM Criteria) to identify the intensity of treatment services that best fit individual needs. Treatment plans for adults and adolescents are developed by applying a multidimensional patient assessment across five broad levels of treatment informed by the amount provided of direct medical management, structure, safety, and security, as well as the intensity of treatment services. ASAM's dimensions are as follows: [10]

- Dimension 1: "acute intoxication and/or withdrawal potential" – individuals' past and current experiences of substance use and withdrawal is explored
- Dimension 2: "biomedical conditions and complications" – individuals' health history and needs pertaining to physical health is explored
- Dimension 3: "emotional, behavioral, or cognitive conditions and complications" – individuals' mental health history, as well as cognitive and mental health needs is explored
- Dimension 4: "readiness to change" – individuals' motivation and interest in changing is explored
- Dimension 5: "relapse, continued use or continued problem potential" – individuals' personal needs that influence their potential for relapse or continued use is explored
- Dimension 6: "recovering/living arrangement" – individuals' recovery and/or living situation, and their network of people and places that could promote or block their recovery is explored [11]

TSS are designed to help individuals who need services that are between acute treatment and residential rehabilitation, and to assist with their eventual transition to outpatient or other step-down addiction recovery treatment.[12] TSS falls under the ASAM 3.1 level of care referred to as "Clinically Managed Low-Intensity Residential Treatment Services."[13] ASAM's Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions focuses on individualized, person-centered medicine, and does not prescribe a fixed LOS by treatment facility setting. The ASAM Criteria emphasizes that LOS must be based on an individual's illness severity, and the individual's overall function. Consideration must also be given to the individual's responsiveness to treatment, treatment progress, and clinical outcomes when determining LOS. However, ASAM also notes that research indicates a positive correlation between longer courses of treatment in the continuum of care and improved clinical outcomes.[14]

Research on TSS is not as extensive as research on other levels of care for treatment of SUD, such as ATS and CSS (see Appendix A for all ASAM levels of care). A complicating factor when evaluating the effectiveness of TSS is that it can be conflated with other terminology, including recovery residence and sober rehabilitation housing (or also historically "halfway houses" which is no longer in use due to the stigma associated with it), and isolating TSS from other residential treatment settings is not always possible when conducting analyses.[15,16]

As of 2021, there are several requirements for licensure for SUD facilities that provide TSS in Massachusetts (See Appendix B for facility locations):

1. A minimum of four hours of nursing services available daily.
2. Case management services.
3. Transportation services available a minimum of 12 hours daily, seven days a week.
4. Services for health monitoring, education, and crisis.
5. Referral and follow-up for SUD treatment services.[17]
6. Supervision of the nursing staff in TSS facilities is conducted by a registered nurse.[18]

2.3 ALOS for TSS, ATS, and CSS

The ALOS for TSS is longer than the ALOS for ATS and CSS. The Substance Abuse and Mental Health Services Administration's (SAMHSA) report on Admissions to and Discharges from Publicly Funded Substance Use Treatment Facilities using Treatment Episode Data Set (TEDS): 2020 found that among those who completed their course of treatment, the median LOS for short-term residential treatment, comparable to TSS, was 26 days. BSAS Closed Enrollments Disenrolled in Fiscal Year (FY) 2020 data reflected slightly different ALOS and median LOS than CHIA and SAMHSA reported previously; with an ALOS for ATS of 5.55 days (and median LOS of 5 days), an ALOS for CSS of 14.98 days (and median LOS of 14 days), and an ALOS for TSS of 30.26 days (and median LOS of 24 days). Using 2020 data from the Massachusetts All Payer Claims Database (APCD), the ALOS for ATS was 5.5 days, essentially matching the ALOS reflected in the BSAS data, and the ALOS for CSS was 7.4 days, shorter than the ALOS found in the BSAS data.

Currently noted to be eligible for TSS are those age 18 or older who are referred by a publicly funded ATS program, such as detoxification, a homeless shelter, or an outreach worker.[19] The availability of TSS allows individuals in recovery to progress from CSS to a less restrictive environment when they are currently experiencing homelessness, or their home situation is unsafe. TSS provides case management services to help ensure that individuals have a stable place to go to continue recovery. There are a small number of claims for commercial members in the MA APCD despite the eligibility criteria for referral (i.e., from a publicly funded ATS program, homeless shelter, or an outreach worker).

The ALOS for individuals with drug use comorbidity is higher than for individuals without drug use comorbidity. A 2019 study using data from the National Inpatient Sample (NIS), a part of the Healthcare Cost and Utilization Project (HCUP), found that individuals with drug use comorbidity had an ALOS of 5.5 days compared to an ALOS of 4.5 days ($p<0.001$) for individuals who do not have drug use comorbidity. Across insurance types, ALOS was higher for those with drug use comorbidity; for those privately insured with drug use comorbidity the ALOS was 5.25 days, compared to 3.83 days for those without drug use comorbidity; for those insured via Medicaid with drug use comorbidity, the ALOS was 5.80 days compared to 4.33 days for those without drug use comorbidity; and for individuals who were self-insured with drug use comorbidity, the ALOS was 4.29 days compared to 3.89 days for those without drug use comorbidity.[20]

The ALOS for individuals with AUD is slightly higher than the ALOS for individuals with other types of SUD. A 2022 retrospective analysis using National Hospital Ambulatory Medical Care Survey data (2014 to 2018) found that the ALOS for individuals with AUD and for individuals with other types of SUD differed by less than one day; for individuals with AUD the ALOS was 6.1 days (95% confidence interval: 5.0-7.1) and for individuals with other types of SUD the ALOS was 5.5 days (95% confidence interval: 4.6-6.4). Individuals with AUD who experienced hospitalizations were more likely to be privately insured (21.6%) than individuals with other types of SUD who experienced hospitalization (18.0%), and this difference was statistically significant ($p<0.001$).[21]

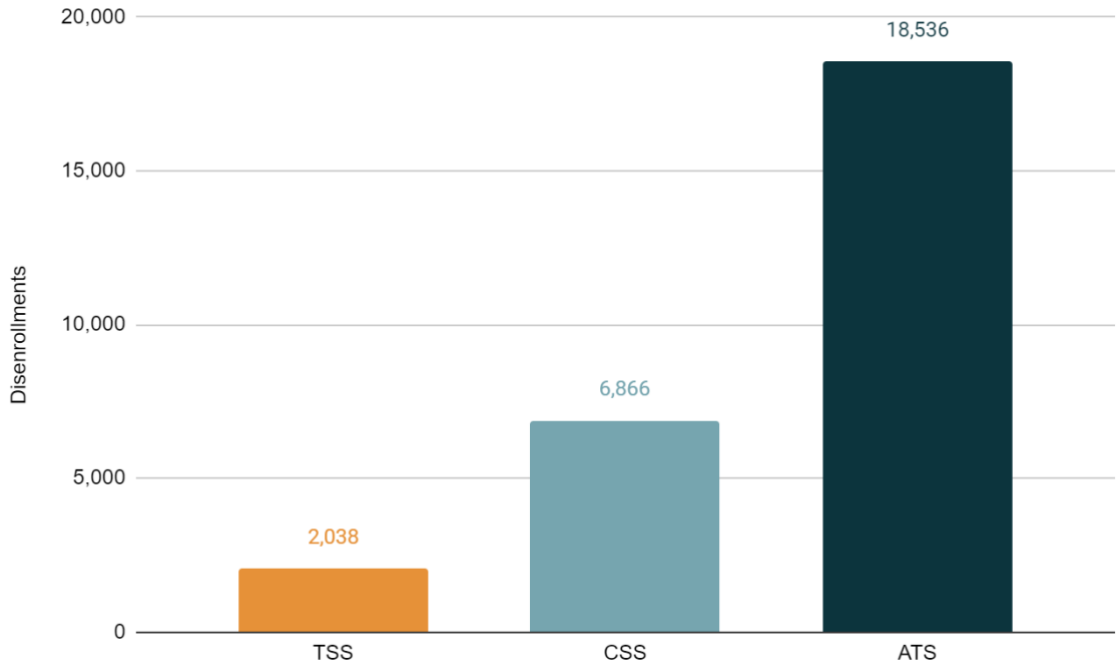
2.4 Services: Discharges, Referrals, and Readmissions

Based on the TEDS, nationally, the primary reason for discharge from short-term residential treatment facilities was due to completion of treatment (54.0%). Transfers from short-term residential treatment facilities to another level of care comprised 15.7% of reason for discharge, 21.4% of individuals dropped out of treatment, 4.6% of individuals

terminated treatment[iv], and 4.4% of individuals had "other" reasons for discharge. The treatment completion rate was higher for those in hospital residential treatment facilities, with 70.6% of individuals completing their course of treatment. In addition, the transfer rate was lower (11.2%), and the drop-out rate was lower (12.4%) compared to short-term residential rates.[22]

According to BSAS data, in Massachusetts there were 2,038 disenrollments (i.e., discharges) from TSS, 6,866 disenrollments from CSS, and 18,536 disenrollments from ATS (see Figure 5) in FY 2021.[23] In Massachusetts in 2020, SAMHSA data reflected that for short-term residential treatment discharges (among individuals 12 years and older), 69.8% completed their treatment, 6.1% transferred, 18.8% dropped out, 3.1% terminated treatment, and 2.2% had "other" reasons for discharge.[24]

Figure 5 FY 2021 TSS, CSS, and ATS Disenrollments[25]

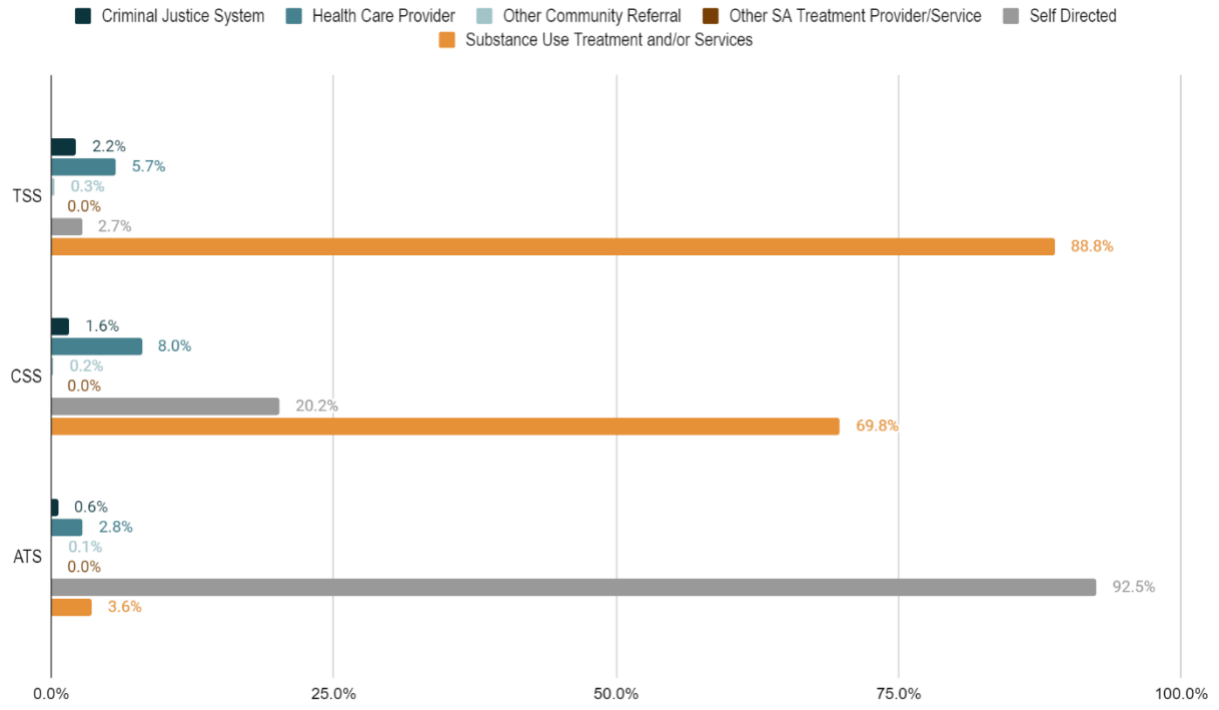


As of November 1, 2022, there were a total of seven BSAS-licensed adult TSS programs in Massachusetts; two in the northeast region of the state, two in the western region of the state, one in Boston, one in the central region of the state, and one in the southeast region of the state. There were 243 total licensed beds across these seven facilities: with 65 beds in the northeast region, 57 beds in the western region, 45 beds in Boston, 40 beds in the central region, and 36 beds in the southeast region (see Appendix B: Adult TSS Facilities in MA by ZIP code). There were 1,583 licensed beds for CSS (ASAM level 3.5), and 1,342 licensed beds for ATS (ASAM level 3.7 and 4).[26]

[iv] The difference between "termination" and "dropped out" is not defined by the source material.

Most referrals for TSS (88.8%) and for CSS (69.8%) originated from SUD treatment and/or services, while the majority of referrals for ATS (92.5%) originated from the individuals themselves (see Figure 6).[27]

Figure 6 TSS, CSS, and ATS % of Enrollments by Referral Source, Jul 01, 2021 - Jun 30, 2022, Data as of September 2, 2022[28]



*Note percentages may not sum to 100% due to multi-choice selection.

The 2016 Massachusetts Special Commission to Investigate and Study State Licensed Addiction Treatment Centers found that 36% of individuals enrolled in ATS did not complete their treatment, 32% of individuals enrolled in CSS did not complete their treatment, and 51% of individuals enrolled in TSS did not complete their treatment. Readmissions were also present across these treatment settings in BSAS-licensed facilities; 21% of individuals who received TSS were readmitted within 30 days of discharge, 20% of individuals who received CSS were readmitted within 30 days of discharge, and 17% of individuals who received ATS were readmitted within 14 days of discharge.[29]

The bill extends the amount of time members could receive services for ATS and CSS without carrier authorization. There is limited research on the impact of ATS and CSS ALOS on outcomes. However, a study of the impact of managed care on SUD treatment in Massachusetts found that when the length of inpatient treatment was reduced by two days, the likelihood of readmission increased by 18%.[30] Further, the study noted that a shorter stay created pressure on arranging the coordination of care at a time the patient's condition was more acute and resulted in a demand for more services as a result of an earlier discharge.[31] Another study found that receipt of outpatient services was associated with an increased risk of hospital readmission, which could seem contradictory to expectations.[32] Some possible explanations include that outpatient treatment may have been insufficient in meeting the patient's

needs, but residential treatment may not have been recommended by the discharge team, or may not have been readily available, or may not have been covered.[33] A number of studies have shown the importance of level of treatment matching to substance use outcomes.[34,35,36]

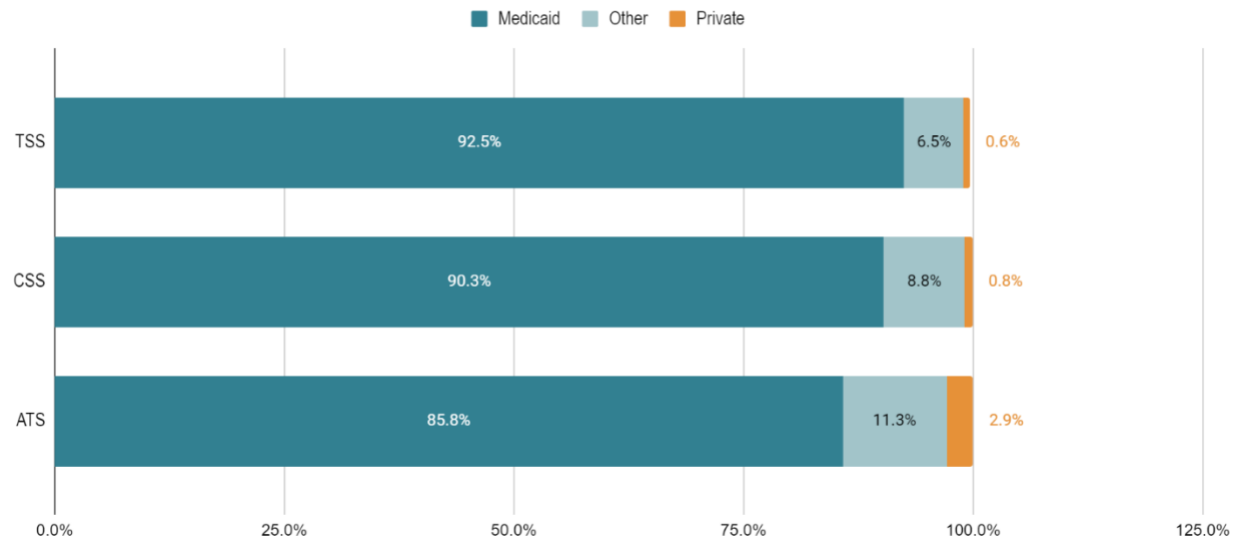
2.5 SUD Services Coverage

Nationally, as of 2020, most nonelderly adults with SUD diagnoses were privately insured (58%). Individuals enrolled in Medicaid comprised 21% of the population of those with SUD diagnoses, 14% were uninsured, and 7% had "other" insurance.[37]

In Massachusetts, among adults with any mental illness (AMI), including SUD, from 2018 to 2019, 62.4% were privately insured, compared to the national average of 59.6%. Adults with Medicaid coverage comprised 28.0% of the population of adults with AMI, compared to the national average of 21.6%. Medicaid covers the range of services on ASAM's continuum of care from inpatient detoxification, through intensive outpatient treatment for SUD and smoking/tobacco cessation counseling.[38]

Data from BSAS demonstrates that individuals insured through Medicaid comprise most enrollments for TSS, CSS, and ATS (see Figure 7).[39]

Figure 7 TSS, CSS, and ATS % of Enrollments by Medicaid, Other, or Private Jul 01, 2021 - Jun 30, 2022, Data as of September 2, 2022



*Note there were multiple possible selections for insurance type categorization. Other includes a roll-up of categories of HMO, Medicare, None, and Other.

3.0 Conclusion

The bill's requirements have potential implications on treatment access, as it adds medically necessary TSS to the already mandated coverage of medically necessary ATS and CSS, as well as on LOS, and it allows for up to 30 consecutive days (an increase from the currently mandated 14 days) of combined TSS, ATS, and CSS. Currently members with commercial insurance typically use alternative services to TSS, such as intensive outpatient (IOP) services or ongoing therapy after being discharged to their homes. Opponents of the bill cite a lack of evidenced-based support for TSS. There is a lack of academic literature pertaining to TSS specifically. The terminology "TSS" is not consistently used in the literature, and isolating TSS from other residential treatment settings is not always possible when conducting analyses.[40,41] However, evidenced-based treatment for individuals with SUD supports using the least restrictive environment possible, and for vulnerable populations who may be unhoused, or who may lack a supportive home environment, TSS offers an appropriate setting in which they can continue their recovery and plan for their eventual discharge.

There is evidence that shorter lengths of stay for SUD might increase the likelihood of readmission. Given the complexities involved in evaluating the ASAM dimensions of care, the treating provider may be in a in a better position to assess the patient's readiness to participate in discharge planning and ensure the patient is in in the appropriate level of care during more intensive services—thus reducing the risk of readmission. The bill would likely increase access to a longer duration of continued services for some members.

Endnotes

[1] Mental Health in Massachusetts. KFF. Accessed December 5, 2022. **https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/massachusetts/**.

[2] Quickfacts Massachusetts. U.S. Census Bureau. Accessed December 5, 2022. **https://www.census.gov/quickfacts/MA**.

[3] *Op. cit. Mental Health in Massachusetts. KFF.*

[4] Press Release. Massachusetts opioid-related overdose death rate up 1 percent in the first nine months of 2021. Mass.gov. Accessed 20 January 2023: **https://www.mass.gov/news/massachusetts-opioid-related-overdose-death-rate-up-1-percent-in-the-first-nine-months-of-2021**.

[5] *Ibid.*

[6] *Ibid.*

[7] BSAS Jul 01, 2021 - Jun 30, 2022 ATS, CSS, and TSS Statewide Reports. Prepared by: Massachusetts Department of Public Health, Bureau of Substance Addiction Services, Office of Statistics and Evaluation on Oct 27, 2022, Data received upon request. Accessed January 5, 2023.

[8] *Ibid.*

[9] *Ibid.*

[10] ASAM American Society of Addiction Medicine. About The ASAM Criteria. ASAM Criteria. What is The ASAM Criteria? Accessed 13 February 2023: **https://www.asam.org/asam-criteria/about-the-asam-criteria**.

[11] *Ibid.*

[12] Substance Addiction Services Descriptions. Mass.gov. Accessed November 23, 2022. **https://www.mass.gov/service-details/substance-addiction-services-descriptions**.

[13] About The ASAM Criteria. Accessed December 12, 2022. **https://www.asam.org/asam-criteria/about-the-asam-criteria**.

[14] D. M. Lee. The New ASAM Criteria for the Treatment of Addictive, Substance-Related and Co-Occurring Conditions - What's New and Why? 7/7/2014. Accessed December 14, 2022. **https://graduate.lclark.edu/live/files/17473-nwias-2014-meelee-plenary**.

[15] American Addiction Centers. National Rehabs. Accessed January 31, 2023. **https://rehabs.com/pro-talk/halfway-house-vs-recovery-residence-what-you-need-to-know/**.

[16] Heslin, K. C., Singzon, T., Aimiuwu, O., Sheridan, D., & Hamilton, A. (2012). From personal tragedy to personal challenge: responses to stigma among sober living home residents and operators. Sociology of health & illness, 34(3), 379–395. Accessed January 31, 2023. **https://doi.org/10.1111/j.1467-9566.2011.01376.**

[17] State Residential Treatment for Behavioral Health Conditions: Regulation and Policy MASSACHUSETTS. Accessed December 12,2022. **https://aspe.hhs.gov/sites/default/files/2021-08/StateBHCond-Massachusetts.pdf**.

[18] 105 CMR: DEPARTMENT OF PUBLIC HEALTH LICENSURE OF SUBSTANCE USE DISORDER TREATMENT PROGRAMS. Accessed December 12, 2022. **https://www.sec.state.ma.us/reg_pub/pdf/100/105164.pdf**.

[19] *Op. cit. Substance Addiction Services Descriptions. Mass.gov.*

[20] Ndanga, M., & Srinivasan, S. (2019). Analysis of Hospitalization Length of Stay and Total Charges for Patients with Drug Abuse Comorbidity. Cureus, 11(12), e6516. Accessed January 30, 2023. **https://doi.org/10.7759/cureus.6516**.

[21] Suen, L. W., Makam, A. N., Snyder, H. R., Repplinger, D., Kushel, M. B., Martin, M., & Nguyen, O. K. (2022). National Prevalence of Alcohol and Other Substance Use Disorders Among Emergency Department Visits and Hospitalizations: NHAMCS 2014-2018. Journal of general internal medicine, 37(10), 2420–2428. Accessed January 30, 2023. **https://doi.org/10.1007/s11606-021-07069-w**.

[22] *Op. cit. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality.*

[23] *Op. cit. BSAS Jul 01, 2021 - Jun 30, 2022 ATS, CSS, and TSS Statewide Reports.*

[24] *Op. cit. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality.*

[25] *Op. cit. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality.*

[26] BSAS. Program Services Bed Counts. November 1, 2022. Data received upon request. Accessed December 20, 2022.

[27] *Op. cit. BSAS Jul 01, 2021 - Jun 30, 2022 ATS, CSS, and TSS Statewide Reports.*

[28] *Ibid.*

[29] *Op. cit. Commonwealth of Massachusetts. Special Commission to Investigate and Study State Licensed Addiction Treatment Centers.*

[30] Shephard, Donald S, Daley Marilyn, Ritter Grant A, Hodgkin D, and Einecke Richard H. Managed Care and the Quality of Substance Abuse Treatment. The Journal of Mental Health Policy and Economics, 5:163-174 (2002). Accessed January 19, 2023. **https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=ba92ecfc55763d787636ca24dc53ad0532740281.**

[31] *Op. cit. Shephard, Donald S, Daley Marilyn, Ritter Grant A, Hodgkin D, and Einecke Richard H. Managed Care and the Quality of Substance Abuse Treatment.*

[32] Reif, Sharon; Acevedo, Andrea, PhD; Garnich Deborah W, ScD, Fullerton, Catherine A, MD MPH. Reducing Behavioral Health Inpatient Readmissions for People With Substance Use Disorders: Do Follow-Up Services Matter? Psychiatric Services (**psychiatryonline.org**)17 April 2017.Accessed January 19, 2023. **https://doi.org/10.1176/appi.ps.201600339**.

[33] *Ibid.*

[34] McLellan AT, Grissom GR, Zanis D, et al.: Problem-service "matching" in addiction treatment: a prospective study in 4 programs. Archives of General Psychiatry 54:730–735, 1997 Accessed January 19, 2023. **https://doi.org/10.1001/archpsyc.1997.01830200062008**.

[35] *Ibid.*

[36] Sharon E, Krebs C, Turner W, et al.: Predictive validity of the ASAM Patient Placement Criteria for hospital utilization. Journal of Addictive Diseases 22(suppl 1):79–93, 2003. Accessed January 19, 2023. **https://doi.org/10.1300/j069v22s01_06**.

[37] Demographics and Health Insurance Coverage of Nonelderly Adults With Mental Illness and Substance Use Disorders in 2020. KFF. Accessed December 12, 2022. **https://www.kff.org/medicaid/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/**.

[38] Mental Health in Massachusetts. KFF. Accessed December 12, 2022. **https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/massachusetts/#:~:text=Substance%20use%20disorder%20is%20using,substance%20use%20during%20the%20pandemic**.

[39] *Op. cit. BSAS Jul 01, 2021 - Jun 30, 2022 ATS, CSS, and TSS Statewide Reports.*

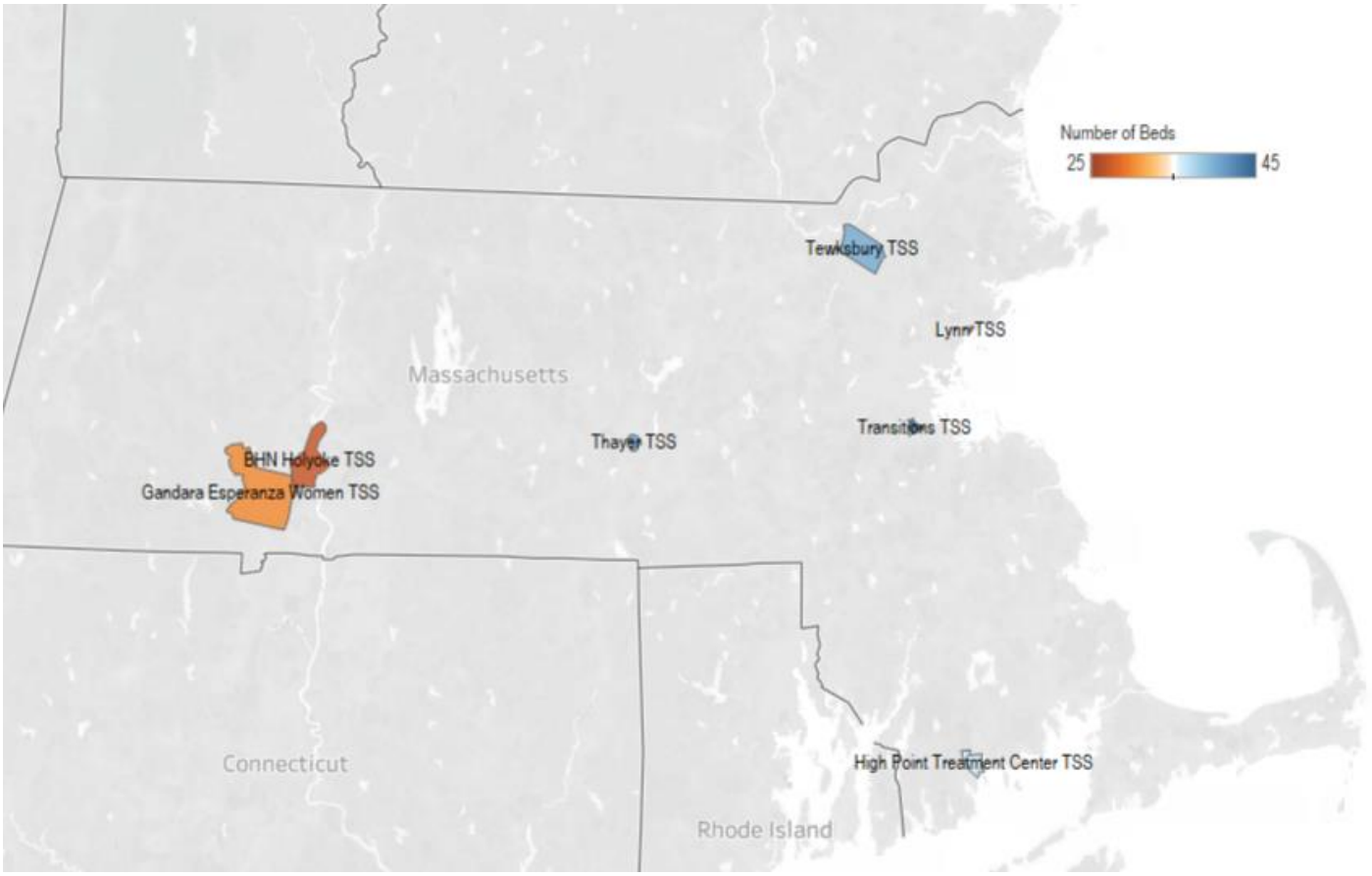
[40] American Addiction Centers. National Rehabs. Accessed January 31, 2023. **https://rehabs.com/pro-talk/halfway-house-vs-recovery-residence-what-you-need-to-know/**.

[41] Heslin, K. C., Singzon, T., Aimiuwu, O., Sheridan, D., & Hamilton, A. (2012). From personal tragedy to personal challenge: responses to stigma among sober living home residents and operators. Sociology of health & illness, 34(3), 379–395. Accessed January 31, 2023. **https://doi.org/10.1111/j.1467-9566.2011.01376**.

Appendix A: ASAM Levels of Care[v,vi]

[v] ASAM American Society of Addiction Medicine. About The ASAM Criteria. ASAM Criteria. What is The ASAM Criteria? Accessed 13 February 2023. https://www.asam.org/asam-criteria/about-the-asam-criteria.
[vi] The bill would add Level 3.1 to the list of already mandated SUD coverage (Levels 3.5, 3.7, and 4).

Appendix B: Adult TSS Facilities in MA by ZIP Code



*BSAS Program Services Data as of November 1, 2022.[1]

AN ACT PROVIDING ACCESS TO FULL SPECTRUM ADDICTION TREATMENT SERVICES

ACTUARIAL ASSESSMENT

1.0 Executive Summary

The Massachusetts Legislature's Committee on Mental Health, Substance Use and Recovery referred House Bill (H.B.) 2116 and Senate Bill (S.B.) 1292, both entitled, "An Act Providing Access to Full Spectrum Addiction Treatment Services,"[2] to the Massachusetts Center for Health Information and Analysis (CHIA) for review.[vii] 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. H.B. 2116 and S.B. 1292 are identical and will be collectively referenced as "the bill."

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. The intent of the actuarial estimate portion of this report is to estimate the bill's fiscal impact, including changes to premiums and administrative expenses.

1.1 Current Insurance Coverage

BerryDunn surveyed nine insurance carriers in the Commonwealth, and six responded. None of the respondent carriers cover TSS services. All respondent carriers reported following the currently mandated 14-day period of coverage for ATS and CSS services.

1.2 Analysis

The proposed legislation requires insurance carriers to provide coverage of:

1) Medically necessary transitional support services (TSS)--in addition to medically necessary acute treatment services (ATS), and medically necessary clinical stabilization services (CSS)
2) ATS, CSS, and TSS (any combination) for up to 30 consecutive days without prior authorization

Carriers do not currently cover TSS for members with commercial insurance. Members insured via MassHealth and individuals who are uninsured have historically been the greatest utilizers of these services. Members with commercial insurance have typically been referred to other services (e.g., intensive outpatient (IOP)) after CSS. Estimating the cost impact of TSS involves calculating the increase in utilization of services that might result from commercial coverage of these services.

The increased time of ATS, CSS, and TSS (any combination) before carriers are permitted to require authorization is the other provision of the bill that could impact cost. Current law already mandates a period of 14 days without prior carrier authorization. ALOS is typically 5 – 5.5 days for ATS, 7 – 7.7 days for CSS, and 18 – 28 days for TSS. Individuals in recovery may be admitted first to ATS and transferred to CSS or they may be admitted to CSS directly

[vii] The bills were refiled with the 193rd General Court; they are now H.B. 1146 and S.B. 662.

(and then infrequently to TSS). Estimating the marginal cost impact of the bill on premiums also requires estimating the increased ALOS that may result from a lengthened period without authorization requirements.

1.3 Summary Results

Table ES-1, on the following page, summarizes the estimated effect of the bill on premiums for fully insured plans over five years. This analysis estimates that the bill, if enacted as drafted for the General Court, would increase fully insured premiums by as much as 0.06% at the end of the five-year projection period; a more likely increase is around 0.03%, equivalent to an annual expenditure of $5.1 million at the end of the period 2024 – 2028.

Table ES-1: Summary Results

	2024	2025	2026	2027	2028	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
Members (000s)	2,242	2,262	2,266	2,269	2,271		
Medical Expense Low ($000s)	$21	$30	$31	$31	$32	$31	$145
Medical Expense Mid ($000s)	$502	$1,481	$2,352	$3,319	$4,391	$2,550	$12,045
Medical Expense High ($000s)	$984	$2,957	$4,721	$6,682	$8,852	$5,122	$24,196
Premium Low ($000s)	$24	$34	$36	$37	$38	$36	$169
Premium Mid ($000s)	$585	$1,725	$2,739	$3,866	$5,114	$2,970	$14,029
Premium High ($000s)	$1,146	$3,444	$5,499	$7,782	$10,310	$5,966	$28,181
PMPM Low	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
PMPM Mid	$0.03	$0.06	$0.10	$0.14	$0.19	$0.11	$0.11
PMPM High	$0.06	$0.13	$0.20	$0.29	$0.38	$0.22	$0.22
Estimated Monthly Premium	$562	$577	$593	$609	$625	$593	$593
Premium % Rise Low	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%
Premium % Rise Mid	0.005%	0.011%	0.017%	0.023%	0.030%	0.018%	0.018%
Premium % Rise High	0.011%	0.022%	0.034%	0.047%	0.060%	0.037%	0.037%

Endnotes

[1] Bureau of Substance Addiction Services. Program Services Bed Counts. November 1, 2022. Data upon request from BSAS via Jim Cremer.

[2] H.B. 2116. An act providing access to full spectrum addiction treatment services. **https://malegislature.gov/Bills/192/H2116**. S.B. 1292. An act providing access to full spectrum addiction treatment services. Accessed December 23, 2022. **https://malegislature.gov/Bills/192/S1292**.

2.0 Introduction

As submitted to the 192nd General Court, H.B. 2116 and S.B. 1292 (collectively, "the bill"[1]) amend current mandated benefits laws to require insurance carriers to add medically necessary transitional support services (TSS) to the already mandated coverage of acute treatment services (ATS) and clinical stabilization services (CSS) for up to 30 consecutive days (an increase from the currently mandated 14 days), without prior authorization. The bill requires facilities providing services to provide carriers with notification of admission and the initial treatment plan within 48 hours of admission. In addition, facilities must provide carriers with a projected discharge plan within a reasonable time. The bill would extend the time before carriers would be permitted to begin utilization review procedures for any combination of the three levels of services (ATS, CSS, and TSS) from day 7 to day 14. Although the bill allows carriers to initiate utilization review procedures on day 14, carriers would be precluded from making utilization review decisions that impose restrictions or denials on future medically necessary ATS, CSS, or TSS, unless the patient has received at least 30 consecutive days of these services. Upon receipt of notification by the admitting facility and receipt of the discharge plan, the bill permits carriers to provide outreach to the treating clinician and the patient to offer care management and support services. Under the bill, medical necessity is determined by the treating clinician in consultation with the patient. The bill defines "TSS" as follows:

> *TSS refers to "short-term, residential support services, as defined by the department of public health, usually following clinical stabilization services, that provide a safe and structured environment to support adults or adolescents through the addiction recovery process and the transition to outpatient or other step-down addiction recovery care."*

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 TSS and Increased Time Before Carrier Authorization Permitted

As submitted to the 192nd General Court of the Commonwealth of Massachusetts, the bill adds the following requirements that could impact the cost of the bill should it become law. The bill requires insurance carriers to provide coverage of:

1) Medically necessary TSS—in addition to medically necessary ATS, and medically necessary CSS

2) ATS, CSS, and TSS (any combination) for up to 30 consecutive days, without prior authorization.

Currently, Massachusetts carriers do not cover TSS services, and they conform to existing state law allowing 14 consecutive days before prior authorization for ATS and CSS services.

3.2 Plans Affected by the Proposed Mandate

The bill amends statutes that regulate commercial health care 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:[2]

- Chapter 32A – Plans Operated by the 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 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 also amends Chapter 118E, this analysis does not estimate the bill's impact to MassHealth.

3.3 Covered Services

BerryDunn surveyed nine insurance carriers in the Commonwealth, and six responded. None of the respondent carriers cover TSS services. All respondent carriers reported following the currently mandated 14-day period of coverage for ATS and CSS services.

3.4 Existing Laws Affecting the Cost of the Bill

State law currently requires coverage for substance use disorder (SUD) including medically necessary ATS and CSS for up to 14 consecutive days without prior authorization, provided the facility notifies the carrier of admission and provides the initial treatment plan within 48 hours of the admission.[3]

SUD services are considered one of the ACA's 10 essential health benefits (EHBs). The Massachusetts Benchmark Plan defines the EHBs to be included in small group and individual plans offered in the state, both inside and outside the Marketplace (i.e., the Health Connector). The Benchmark plan provides coverage for inpatient and intermediate treatments, described as acute residential treatment or partial hospital programs or intensive outpatient programs. The plan does not mention TSS services.

While there are no federal laws that require coverage of TSS, if the bill were to pass, carriers would be required to offer TSS in a manner that does not impose less favorable limitations on these services than medical/surgical benefits (i.e., in parity as required by the Mental Health Addiction and Equity Act [MHPAEA]).

4.0 Methodology

4.1 Overview

As submitted to the 192nd General Court, H.B. 2116 and S.B. 1292 (collectively, "the bill"[4]) amend current mandated benefits laws to require insurance carriers to cover medically necessary TSS, in addition to medically necessary ATS, and medically necessary CSS—for up to 30 consecutive days, without prior authorization. The bill requires facilities providing TSS to provide carriers with notification of admission and the initial treatment plan within 48 hours of admission. In addition, facilities must provide carriers with a projected discharge plan within a reasonable time. The bill allows carriers to initiate utilization review procedures on day 14; provided that carriers do not make utilization review decisions that impose restrictions or denials on future medically necessary ATS, CSS, or TSS, unless the patient has previously received at least 30 consecutive days total of any combination of these three services. Upon receipt of notification by the admitting facility and receipt of the discharge plan, the bill permits carriers to provide outreach to the treating clinician and the patient to offer care management and support services. Under the bill, medical necessity is determined by the treating clinician in consultation with the patient.

The incremental cost of increasing the required minimum coverage for combined LOS from 14 days (for ATS and CSS) to 30 days (for ATS, CSS, and TSS) is estimated using claims data from the Massachusetts APCD to determine per day unit costs for ATS and CSS. The APCD is used to calculate the current number of admissions, and the ALOS. BerryDunn used an analysis from the Chapter 208 study[5,6],of the impact of Chapter 258, on the ALOS to estimate the increase in the ALOS. The incremental cost of requiring coverage for TSS is estimated using data from the BSAS to determine per day unit costs for TSS. BSAS data is used to calculate the current number of admissions, the ALOS, and the service capacity for services. The number of incremental bed days, accounting for bed day capacity, is multiplied by the cost per day to calculate the incremental claims cost. Accounting for carrier retention results in a baseline estimate of the proposed mandate's incremental effect on premiums, which is projected over the five years following the assumed January 1, 2024, implementation date of the proposed law.

4.2 Data Sources

The primary data sources used in the analysis are as follows:

- Survey of legislative sponsors, providing information about the intended effect of the bill
- Survey of commercial carriers in the Commonwealth, gathering descriptions of current coverage
- Survey of BSAS, including data collection and gathering information about licensed ATS, CSS, and TSS bed counts and other TSS utilization data
- Massachusetts APCD
- Published scholarly literature, reports, and population data, cited as appropriate

4.3 Steps in the Analysis

This section summarizes the analytic steps to estimate the impact of the bill on premiums.

1. **Estimate the increase in ALOS for ATS and CSS due to increased length of time before carrier may require authorization -- from 14 days (for ATS and CSS) to 30 days (for ATS, CSS, and TSS).**

To estimate the impact of the longer LOS for ATS and CSS, BerryDunn:

- **A.** Used claims data from the APCD determine the historical number of ATS and CSS admissions to measure the total paid claims cost, the number of days, and the number of admissions for commercially fully insured patients
- **B.** Divided the total paid claims cost by the total number of days and calculated the cost per day
- **C.** Calculated the cost per day over the projection period using projected increases in facility costs
- **D.** Divided the total number of days by the total number of admissions and calculated the ALOS
- **E.** Estimated the percent increase in the ALOS and in the number of bed days based on relevant experience from Chapter 258, and the APCD
- **F.** Multiplied the estimated percent increase in bed days by the total number of days and calculated the additional or incremental number of days
- **G.** Multiplied the additional number of days by the cost per day to determine the incremental cost
- **H.** Divided the incremental cost from Step G above by corresponding member months to calculate incremental per member per month (PMPM) cost

2. Estimate the impact of requiring coverage for TSS and its impact on the marginal cost to insurers

To estimate the impact of requiring coverage for TSS and its impact on marginal cost to insurers, BerryDunn:

- **A.** Obtained the current licensed bed capacity for TSS treatment units
- **B.** Used data from BSAS to estimate the number of commercial admissions
- **C.** Used data from the APCD to estimate the portion of commercial admission for fully insured members
- **D.** Used data from BSAS to calculate the ALOS for commercially insured patients
- **E.** Calculated the incremental number of bed days
- **F.** Obtained from BSAS the TSS per day unit cost. Estimated fully insured commercial per day costs for each year in the projection period
- **G.** Multiplied the cost per day by the estimated bed days to calculate incremental claim cost
- **H.** Divided the incremental cost from Step G above by corresponding member months to calculate incremental PMPM

3. Calculate the impact of the projected claim costs on insurance premiums.

- **A.** Added the incremental cost from ATS and CSS calculated in Step 1 to the incremental cost of TSS in Step 2
- **B.** Estimated the fully insured Commonwealth population under age 65, projected for the next five years (2024 – 2028)
- **C.** Multiplied the PMPM incremental net cost of the mandate by the projected population estimate, to calculate the total estimated marginal claims cost of the bill
- **D.** Estimated insurer retention (administrative costs, taxes, and profit) and applied the estimate to the final incremental claims cost calculated in Step C

4.4 Limitations

The incremental cost of the bill stems from an increase in the ALOS. This cost was estimated using the impact of Chapter 258 taken from APCD claims. Currently ATS and CSS providers are not operating at full licensure capacity because of the labor shortage. During the public health emergency (PHE), facilities operated at reduced capacity to allow for social distancing. The ability of providers to fully staff all beds, and the resulting potential additional bed day capacity is uncertain. Assumptions are varied to account for this uncertainty.

In addition, the incremental cost of the bill also stems from the requirement that carriers must cover TSS. Carriers currently do not provide coverage for TSS, and as such, the unit cost per day for TSS coverage for commercial carriers is uncertain. There are several reasons that it is difficult to estimate of the impact of TSS coverage, should the bill become law:

- TSS is not currently covered by commercial carriers, and therefore there are minimal claims in the APCD – the actual number of these claims is challenging to calculate due to difficulty isolating TSS from other levels of residential care claims
- BSAS currently funds TSS for commercial members, so it is difficult to predict how/whether referral patterns would change
- TSS more appropriately meets the needs of individuals experiencing unstable home situations, and there might be little demand for services in the commercial population

These assumptions are addressed in greater detail in the next section of this report.

The PHE 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 the PHE and economic trends will have on employment, and therefore ESI, in the 2023 – 2028 projection period is uncertain. Appendix A addresses these limitations further.

5.0 Analysis

This section describes the calculations outlined in the previous section in more detail. The analysis includes a best-estimate middle-cost scenario, a low-cost scenario, and a high-cost scenario using more conservative assumptions.

The analysis section will proceed as follows:

- Section 5.1 describes the impact on the ALOS.
- Section 5.2 describes the steps used to calculate the fully insured commercial TSS admission rates.
- Section 5.3 describes the steps to calculate the TSS ALOS and bed stays.
- Section 5.4 describes the steps to calculate the TSS unit cost and marginal cost.
- Section 5.5 aggregates the marginal PMPM costs.
- Section 5.6 projects the fully insured population age 0 to 64 in the Commonwealth over the years 2024 to 2028.
- Section 5.7 calculates the total estimated marginal cost of the bill.
- Section 5.8 adjusts these projections for carrier retention to arrive at an estimate of the bill's effect on premiums for fully insured plans.

5.1 Effect of Minimum Coverage on Length of Stay

The proposed legislation increases the required combined minimum coverage from 14 days for ATS and CSS under Chapter 258 to a combined 30 days for ATS, CSS, and TSS. To determine whether the increase in days of combined minimum coverage will increase cost by increasing ATS, CSS, or TSS bed days for commercial fully insured members, BerryDunn interviewed BSAS representatives about bed capacity.[7] Due to the labor shortages, facilities are operating with only a percentage of their beds and utilization is "constrained by projected bed capacity." The currently available beds are full. It is uncertain if ATS and CSS beds will remain at capacity throughout the projection period. If the labor shortage continues through the period, any increase in ALOS would be offset by fewer patients being served. That is, when all available beds are utilized, an increase in ALOS will necessarily result in fewer patients being served, with no increase in total bed days provided or covered, and therefore no increase in cost of the proposed mandate over Chapter 258.

ALOS increases in a system at capacity will only increase cost if capacity increases. BerryDunn calculates the incremental cost component by determining what the increase in ALOS would likely be for the admissions that would be occurring if capacity were available, and then estimates the cost of meeting the additional bed days generated with that new capacity.

BerryDunn developed a historical service profile using the 2020 Massachusetts APCD and calculated paid claim amounts, the number of admissions, and the number of days for services (ATS and CSS). BerryDunn divided the paid claim cost by the number of days to measure the average cost per day for commercially fully insured members. Results are displayed in Table 1.

Table 1: ATS and CSS Cost Per Day

	PAID CLAIM COST	NUMBER OF DAYS	COST PER DAY
ATS	$20,238,771	26,620	$760.28
CSS	$6,916,608	11,670	$592.68

Next, BerryDunn used the APCD to measure the total number of days and the number of admissions for these services. BerryDunn divided the total number of days by the number of admissions and calculated the ALOS. Results are displayed in Table 2.

Table 2: ATS and CSS Average Length of Stay (ALOS)

	NUMBER OF DAYS	ADMISSIONS	ALOS
ATS	26,620	4,806	5.5 Days
CSS	11,670	1,583	7.4 Days

BerryDunn also studied the impact to the ALOS under Chapter 258, which made similar changes by partially transferring the determination of medical necessity from the carrier to the provider for SUD treatment. Shortly after Chapter 258 passed, bed capacity in the Commonwealth was greatly expanded due to new providers entering the market. The new providers entering the market had both a higher cost per day and a higher ALOS (as seen in the APCD data). Under the current bill, it is unlikely a similar effect will be seen given the current workforce shortage. As such, BerryDunn excluded any impact due to new providers entering the market when using the results from the prior study and increased the ALOS by approximately 15% to estimate the impact of the increase in minimum coverage from 14 to 30 days.

The Massachusetts Health and Hospital Association estimated in fall 2022 that there were approximately 19,000 full-time job vacancies across Massachusetts hospitals.[8] During the February 8, 2023, Massachusetts Health Policy Commission (HPC) Meeting of the Advisory Council, HPC Executive Director David Seltz announced that one of HPC's priorities for this year (2023) is to "Address Health Care Workforce Challenges and Identify Solutions." This will be done by issuing a new HPC report titled *Workforce Challenges and Policy Recommendations in Massachusetts* and holding events that convene key collaborators to discuss workforce challenges and highlight solutions. Additionally, HPC will continue to support and advance innovative care models that highlight leveraging recovery coaches, and community health workers, among other non-traditional healthcare workers.[9]

The low-cost scenario assumes the current labor shortage will continue and that there will be no incremental bed days. In this scenario, the analysis assumes that any increase in the ALOS will be offset by lower admissions resulting in the same number of bed days. The high-cost scenario assumes a 15.0% increase in the ALOS, resulting in an increase of 0.9 days for ATS and 1.1 days for CSS. The mid-range scenario assumes that the ALOS will increase 7.5%, or 0.51 days for ATS and CSS. It is expected to take time for resolution to the labor shortage issues, and this analysis assumes that will occur by the end of the projection period. As a result, BerryDunn estimates that the impact of the increased LOS on bed days will grow gradually throughout the projection period. Table 3 displays the assumed increase in the ALOS.

Table 3: Estimated Increase in ALOS

	CURRENT	% INCREASE	ADDITIONAL DAYS
ATS Low	5.5 Days	0.0%	0.0 Days
ATS Mid	5.5 Days	7.5%	0.5 Days
ATS High	5.5 Days	15.0%	0.9 Days
CSS Low	7.4 Days	0.0%	0.0 Days
CSS Mid	7.4 Days	7.5%	0.5 Days
CSS High	7.4 Days	15.0%	1.1 Days

The bed days attributable to the anticipated increase in the ALOS are incremental to the bill. BerryDunn used 2020 as the most recent available cost per day data to determine unit cost. When compared to 2020, the ATS number of bed days per member was slightly higher in 2019, the year before COVID-19. BerryDunn adjusted the number of 2020 days by the higher number of bed days per member in 2019 to get 27,654 ATS bed days and 11,696 CSS bed days. These adjusted 2020 bed days reflect pre-COVID-19 levels. BerryDunn multiplied the estimated increase in the ALOS from Table 3 by the adjusted total number of days and calculated the additional number of bed days that are incremental due to the bill. As discussed above, this analysis assumes that the impact of the increased LOS on the number of bed days will increase gradually throughout the projection period. The additional days are shown in Table 4.

Table 4: ATS and CSS Incremental Bed Days

	2024	2025	2026	2027	2028
ATS Low	0	0	0	0	0
ATS Mid	415	830	1,244	1,659	2,074
ATS High	830	1,659	2,489	3,318	4,148
CSS Low	0	0	0	0	0
CSS Mid	175	351	526	702	877
CSS High	351	702	1,053	1,404	1,754

The incremental cost of the longer ALOS proposed in the bill is based on a projected cost per day and the additional days. BerryDunn projected the cost per day using the long-term average national projection for cost increases to hospital care expenditures of 5.9% over the study period.[10] BerryDunn multiplied the projection factor by the cost per day calculated in Table 1. Results are shown in Table 5.

Table 5 Projected ATS and CSS Cost Per Day

	2024	2025	2026	2027	2028
ATS	$955.62	$1,011.85	$1,071.38	$1,134.41	$1,201.15
CSS	$744.96	$788.79	$835.20	$884.33	$936.36

BerryDunn multiplied the estimated number of bed days for ATS and CSS for fully insured commercial members (from Table 4) by the estimated cost per day rates (from Table 5) to calculate the marginal claim cost of the longer LOS. Results are shown in Table 6.

Table 6: Estimated Marginal Claims Cost Due to Longer ALOS

	2024	2025	2026	2027	2028
ATS Low	$0	$0	$0	$0	$0
ATS Mid	$396,395	$839,433	$1,333,229	$1,882,223	$2,491,200
ATS High	$792,790	$1,678,865	$2,666,457	$3,764,445	$4,982,400
CSS Low	$0	$0	$0	$0	$0
CSS Mid	$130,699	$276,777	$439,591	$620,605	$821,397
CSS High	$261,398	$553,554	$879,182	$1,241,210	$1,642,793

BerryDunn divided the estimated annual costs by corresponding commercial member months, yielding the marginal PMPM medical expense. Appendix A describes the sources of the commercial member months for 2024 through 2028. Table 7 displays the results over the projection period.

Table 7: Estimated Marginal PMPM Claims Cost Due to Longer ALOS

	2024	2025	2026	2027	2028
ATS Low	$0.00	$0.00	$0.00	$0.00	$0.00
ATS Mid	$0.02	$0.04	$0.06	$0.09	$0.12
ATS High	$0.04	$0.08	$0.12	$0.18	$0.23
CSS Low	$0.00	$0.00	$0.00	$0.00	$0.00
CSS Mid	$0.01	$0.01	$0.02	$0.03	$0.04
CSS High	$0.01	$0.03	$0.04	$0.06	$0.08

In the following sections BerryDunn calculates the cost of adding TSS services to commercial fully insured coverage.

5.2 TSS Commercial Admission Rates

BSAS currently funds TSS, collects utilization data on all of their licensed facilities, and collects data on insurance coverage for each patient. BSAS provided BerryDunn utilization reports of disenrollment (discharge) counts for patients by their type of insurance. This analysis assumes that disenrollments are a proxy for admissions.

BSAS reported data for commercially insured individuals, both fully insured and self-insured. To adjust total commercial disenrollments to reflect only the fully insured commercial population, BerryDunn used the membership projection data to estimate that fully insured commercial membership is approximately 42% of total commercial membership. Multiplying this percentage by the total commercial disenrollments yields an estimate of TSS disenrollments for fully insured commercial members. Results are shown in Table 8.

Table 8: TSS Admissions

	TOTAL	COMMERCIAL	% FI	FULLY INSURED
2013	3,811	131	42.0%	55
2014	4,767	195	42.0%	82
2015	4,357	191	42.0%	80
2016	4,141	121	42.0%	51
2017	4,314	70	42.0%	29
2018	4,506	65	42.0%	27
2019	4,450	20	42.0%	8
2020	3,268	22	42.0%	9
2021	3,011	21	42.0%	9

TSS admissions for patients covered by commercial insurance have declined steadily from 55 in 2014, to 9 in 2021 and the reason for this reduction is not clear. It is likely caused by a combination of factors including a lower service capacity and a shift during the PHE to other types of service. Under the mandate, it is likely that admissions will increase relative to current levels. This analysis assumes that in the high scenario the number of admissions will increase each year in the projection period returning to the 2014 levels by the end of the projection period. The analysis assumes in the low scenario that the number of admissions will remain level with the current number, and in the mid or most likely scenario the number of admissions will increase each year until the end of the projection period and reach half of the 10-year high observed in 2014. The projected number of TSS admission are shown in Table 9.

Table 9: Projected Fully Insured TSS Admissions

	2024	2025	2026	2027	2028
Low	8	8	8	8	8
Mid	8	16	25	33	41
High	9	27	46	64	82

5.3 TSS ALOS and Bed Days

The TSS ALOS for patients covered by commercial carriers is lower than the overall average ALOS for all payers (21 days vs. 27 days, respectively). Furthermore, commercial carriers would not be required to cover more than 30 days of ATS, CSS, and TSS combined. In the mid-cost scenario the ALOS was assumed to be the current and long-term average of 21 days for commercially insured members. In the high-cost scenario commercial members are assumed to have a 24-day ALOS, and in the low-cost scenario the commercial members are assumed to have an ALOS of 18

days. These ALOS estimates are multiplied by the fully insured commercial admissions in Table 9 to calculate fully insured commercial bed days. These bed days are displayed in Table 10.[8]

Table 10: TSS Bed Days

	2024	2025	2026	2027	2028
Low Scenario	144	144	144	144	144
Mid Scenario	171	348	524	701	877
High Scenario	222	673	1,124	1,575	2,025

5.4 TSS Unit Cost and Marginal Cost

According to BSAS, their current rate is $185.21 per day for TSS. This rate includes a 10% temporary increase that was provided during the public health emergency (PHE), and, as such, this increase will eventually be removed. In general, public-payer rates, particularly Medicaid rates, are typically significantly lower than those paid by commercial insurers, suggesting there may be some upward pressure on unit cost in 2024 as providers seek to contract with commercial payers at a higher rate. Assuming that the current per diem rate of $185 is at or near the cost of TSS, this analysis assumes an increase in unit cost for commercial carriers more modest than would be expected when comparing commercial and Medicaid rates more generally.

In the mid-cost scenario, BerryDunn estimates the commercial TSS unit cost will maintain the 10% issued during the PHE in 2024. The low-cost scenario estimates fees will increase 5% in 2024 relative to the current rate, excluding the additional 10% granted during the PHE. BerryDunn assumes in the high-cost scenario that the unit cost is anticipated to increase by 20% in 2024 relative to the rates excluding the additional 10%. In subsequent years (2025 to 2028), BerryDunn applied a 3.2% medical inflation rate, which is based on the average annual unit cost increase for TSS between 2015 and 2023. Table 11 displays the TSS cost per day for the 2023 base period and over the projection period. The 2023 base period rate excludes the additional 10% provided during the PHE.

Table 11: Projected TSS Cost Per Day

	2023	2024	2025	2026	2027	2028
Low	$168.37	$176.79	$182.45	$188.29	$194.31	$200.53
Mid	$168.37	$185.21	$191.14	$197.25	$203.57	$210.08
High	$168.37	$193.63	$199.82	$206.22	$212.82	$219.63

BerryDunn multiplied the estimated number of bed days for TSS for fully insured commercial members (from Table 10) by the estimated unit cost rates (from Table 11) to calculate the marginal claim cost for TSS coverage. Results are shown in Table 12.

[8] In practice, to the extent the length of stay for a combined episode of care of the three services exceeds 30 days, costs of the "excess" TSS days would not be incremental costs of the proposed mandate. However, due to data limitations, BerryDunn did not model the magnitude of this effect and has therefore taken the conservatively high position of assuming the commercial carrier will pay all TSS days calculated here.

Table 12: Estimated Marginal TSS Coverage Claims Cost

	2024	2025	2026	2027	2028
Low Scenario	$28,640	$29,557	$30,503	$31,479	$32,486
Mid Scenario	$35,005	$68,236	$103,558	$141,071	$180,878
High Scenario	$41,824	$130,685	$225,191	$325,612	$432,229

BerryDunn divided the estimated annual costs by corresponding commercial member months, yielding the marginal PMPM medical expense. Table 13 displays the results over the projection period.

Table 13: Estimated Marginal PMPM Cost of TSS Coverage

	2024	2025	2026	2027	2028
Low Scenario	$0.00	$0.00	$0.00	$0.00	$0.00
Mid Scenario	$0.00	$0.00	$0.00	$0.01	$0.01
High Scenario	$0.00	$0.00	$0.01	$0.01	$0.02

5.5 Combined Marginal Cost PMPM

Adding the estimated PMPM costs associated with ATS and CSS to the cost associated with TSS (from Tables 7 and 13) yields the total PMPM marginal claims cost, shown in Table 14.

Table 14: Estimated Total Marginal PMPM Cost of Mandate

	2024	2025	2026	2027	2028
Low Scenario	$0.00	$0.00	$0.00	$0.00	$0.00
Mid Scenario	$0.03	$0.05	$0.09	$0.12	$0.16
High Scenario	$0.05	$0.11	$0.17	$0.25	$0.32

5.6 Projected Fully Insured Population in the Commonwealth

Table 15 shows the fully insured population in the Commonwealth ages 0 to 64 projected for the next five years. Appendix A describes the sources of these values.

Table 15: Projected Fully Insured Population in the Commonwealth, Ages 0 – 64

YEAR	TOTAL (0-64)
2024	2,241,736
2025	2,262,201
2026	2,265,778
2027	2,268,960
2028	2,270,746

5.7 Total Marginal Medical Expense

Multiplying the total estimated PMPM cost by the projected fully insured membership over the analysis period results in the total cost (medical expense) associated with the proposed requirement, shown on in Table 16. This analysis assumes the bill, if enacted, would be effective January 1, 2024.[9]

Table 16: Estimated Marginal Claims Cost

	2024	2025	2026	2027	2028
Low Scenario	$20,650	$29,557	$30,503	$31,479	$32,486
Mid Scenario	$502,026	$1,481,404	$2,351,570	$3,319,221	$4,390,604
High Scenario	$983,730	$2,957,021	$4,721,216	$6,681,913	$8,851,681

5.8 Carrier Retention and Increase in Premium

Assuming an average retention rate of 14.1%—based on CHIA's analysis of administrative costs and profit in the Commonwealth[11]—the increase in medical expense was adjusted upward to approximate the total impact on premiums. Table 17 displays the result.

Table 17: Estimate of Increase in Carrier Premiums

	2024	2025	2026	2027	2028
Low Scenario	$24,051	$34,425	$35,526	$36,663	$37,836
Mid Scenario	$584,711	$1,725,395	$2,738,880	$3,865,905	$5,113,748
High Scenario	$1,145,752	$3,444,050	$5,498,813	$7,782,441	$10,309,576

6.0 Results

The estimated impact of the proposed requirement on medical expense and premiums appears below. The analysis includes development of a best-estimate "mid-level" scenario, as well as a low-level scenario, and a high-level scenario using more conservative assumptions.

The impact on premiums is driven by the provisions of the bill that require commercial carriers to cover TSS and increase the required minimum coverage for combined LOS from 14 days (for ATS and CSS) to 30 days (for ATS, CSS, and TSS).

[9] The analysis assumes the mandate would be effective for policies issued and renewed on or after January 1, 2024. Based on an assumed renewal distribution by month, by market segment, and by the Commonwealth market segment composition, 72.1% of the member months exposed in 2024 will have the proposed mandate coverage in effect during calendar year 2024. The annual dollar impact of the mandate in 2024 was estimated using the estimated PMPM and applying it to 72.1% of the member months exposed.

6.1 Five-Year Estimated Impact

For each year in the five-year analysis period, Table 18 (on the following page) displays the projected net impact of the bill's proposed language on medical expense and premiums using a projection of Commonwealth fully insured membership. Note that the relevant provisions of the bill are assumed effective January 1, 2024.[12]

The low scenario impact is $38 thousand in the final year of the projection period, based on an assumption that the unit cost of TSS will increase by 5% over the current rates and an assumption of no additional service capacity. The high scenario impact is $10.3 million in the final year of the projection period, based on an assumption that the unit cost of TSS will increase by 20% over the current rates and an assumption of full ATS and CSS service capacity by the end of the projection period. The middle assumes the unit cost of TSS will increase by 10% over the current rates and an assumption of additional service capacity resulting in annual costs of $5.1 million, or 0.03% of premium in the final year of the projection period.

Finally, the impact of the proposed law on any one individual, employer group, or carrier may vary from the overall results, depending on the current level of benefits each receives or provides, and on how the benefits will change under the proposed language.

Table 18: Summary Results

	2024	2025	2026	2026	2028	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
Members (000s)	2,242	2,262	2,266	2,269	2,271		
Medical Expense Low ($000s)	$21	$30	$31	$31	$32	$31	$145
Medical Expense Mid ($000s)	$502	$1,481	$2,352	$3,319	$4,391	$2,550	$12,045
Medical Expense High ($000s)	$984	$2,957	$4,721	$6,682	$8,852	$5,122	$24,196
Premium Low ($000s)	$24	$34	$36	$37	$38	$36	$169
Premium Mid ($000s)	$585	$1,725	$2,739	$3,866	$5,114	$2,970	$14,029
Premium High ($000s)	$1,146	$3,444	$5,499	$7,782	$10,310	$5,966	$28,181
PMPM Low	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
PMPM Mid	$0.03	$0.06	$0.10	$0.14	$0.19	$0.11	$0.11
PMPM High	$0.06	$0.13	$0.20	$0.29	$0.38	$0.22	$0.22
Estimated Monthly Premium	$562	$577	$593	$609	$625	$593	$593
Premium % Rise Low	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%	0.000%
Premium % Rise Mid	0.005%	0.011%	0.017%	0.023%	0.030%	0.018%	0.018%
Premium % Rise High	0.011%	0.022%	0.034%	0.047%	0.060%	0.037%	0.037%

The proposed mandate would apply to self-insured plans operated for state and local employees by the GIC. The benefit offerings of GIC plans are like most other commercial plans in Massachusetts, and the next section describes the results for the GIC.

6.2 Impact on GIC

Findings from BerryDunn's carrier survey indicate that GIC benefit offerings and other commercial plans in the Commonwealth are similar. For this reason, the cost of the bill for GIC will likely be similar to the cost for other fully insured plans in the Commonwealth.

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, 2024. Because of the July effective date, the results in 2024 are approximately one-half of an annual value. Table 19 breaks out the GIC's self-insured membership, as well as the corresponding incremental medical expense.

Table 19: GIC Summary Results

	2024	2025	2026	2026	2028	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
GIC Self-Insured							
Members (000s)	312	312	311	311	310		
Medical Expense Low ($000s)	$2	$4	$4	$4	$4	$4	$19
Medical Expense Mid ($000s)	$49	$204	$323	$454	$599	$362	$1,630
Medical Expense High ($000s)	$95	$408	$648	$915	$1,209	$728	$3,274

Endnotes

[1] H.B. 2116. An act providing access to full spectrum addiction treatment services. https://malegislature.gov/Bills/192/H2116. S.B. 1292. An act providing access to full spectrum addiction treatment services. Accessed December 23, 2022. https://malegislature.gov/Bills/192/S1292.

[2] 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.

[3] Chapter 258. Association for Behavioral Healthcare. Accessed January 5, 2023. https://www.abhmass.org/publications-reports/chapter-258.html.

[4] H.B. 2116. An act providing access to full spectrum addiction treatment services. https://malegislature.gov/Bills/192/H2116. S.B. 1292. An act providing access to full spectrum addiction treatment services. https://malegislature.gov/Bills/192/S1292.

[5] Acts of 2018 Chapter 208. Accessed January 5, 2023. https://malegislature.gov/Laws/SessionLaws/Acts/2018/Chapter208.

[6] An Act for Prevention and Access to Appropriate Care and Treatment of Addiction (H4742). Accessed January 5, 2023. https://www.chiamass.gov/assets/docs/r/pubs/19/H4742-Appropriate-Care-and-Treatment-of-Addiction.pdf.

[7] Interview via videocall with BSAS representatives, February 8, 2023.

[8] Massachusetts Health & Hospital Association. New Data Reveals Vast Workforce Shortages at Massachusetts Hospitals. October 31, 2022. Accessed February 14, 2023. https://www.mhalink.org/MHA/MyMHA/Communications/PressReleases/Content/2022/2022_MHA_Workforce_Report.aspx.

[9] Massachusetts Health Policy Commission. Presentation - Advisory Council - February 8, 2023. Accessed February 14, 2023. https://www.mass.gov/doc/presentation-advisory-council-february-8-2023/download.

[10] U.S. Centers for Medicare & Medicaid Services (CMS), Office of the Actuary. National Health Expenditure Projections. Table 6, Hospital Care Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2020-2028; Private Insurance. Accessed 10 February 2023. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.

[11] *Op. cit. Massachusetts Center for Health Information and Analysis. Annual Report on the Massachusetts Health Care System.*

[12] With an assumed start date of January 1, 2024, dollars were estimated at 72.1% of the annual cost, based upon an assumed renewal distribution by month (Jan through Dec) by market segment and the Massachusetts market segment composition.

Appendix A: Membership Affected by the Proposed Language

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

The unprecedented economic circumstances due to COVID-19 add challenges to estimation of health plan membership. 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. Given the uncertainty, BerryDunn took a simplified approach to the membership projections. These membership projections are not intended for any purpose other 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, based on published membership reports available from CHIA and the Massachusetts Division of Insurance (DOI).

CHIA publishes monthly enrollment summaries in addition to its biannual enrollment trends report and supporting databook (enrollment-trends-Data Through September 2021 databook[1] and Monthly Enrollment Summary – June 2021[2]), which provide enrollment data for Commonwealth residents by insurance carrier for most carriers, excluding some small carriers. CHIA uses supplemental information beyond the data in the Massachusetts APCD to develop its enrollment trends report and adjust the resident totals from the Massachusetts APCD.

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 small carriers not in the Massachusetts APCD.

In 2021, commercial, fully insured membership was 5.6% less than in 2019, with a shift to both uninsured and MassHealth coverage. As part of the PHE, members were not disenrolled from MassHealth coverage, even when they no longer passed eligibility criteria. When the PHE ends, redetermination efforts will begin at which time these individuals will no longer be eligible for MassHealth coverage. It is anticipated that a portion of individuals losing coverage will be eligible for coverage in individual ACA plans. Although the impact of COVID-19 on the fully insured market over the five-year projected period (2024 – 2028) is uncertain, BerryDunn has made the following assumptions to estimate membership:

- The federal PHE will end in 2023
- Redetermination will occur over 12 months for MassHealth members [5]
- MassHealth members will be eligible for commercially insured plans

BerryDunn assumes 80% of the commercial membership reductions that occurred during the PHE will return to the commercial market by the end of 2023. BerryDunn further assumes that the remainder of this membership will return to the commercial market by the end of the projection period in December of 2027.

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.[6] Membership was projected from 2022 – 2028 using Massachusetts Department of Transportation population growth rate estimates by age and gender.[7]

Projections for the GIC self-insured lives were developed using the GIC base data for 2018 and 2019, which 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 A: Endnotes

[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] Ibid.

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

[5] Blue Cross Blue Shield of Massachusetts Foundation, The End of the Federal Continuous Coverage Requirement in MassHealth. Accessed September 22, 2022. **https://www.bluecrossmafoundation.org/publication/end-federal-continuous-coverage-requirement-masshealth-key-strategies-reducing-coverage.**

[6] 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.**

[7] 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.**