

**CENTER FOR HEALTH
INFORMATION AND ANALYSIS**

**BENEFIT MANDATE REVIEW:
H.B. 916: AN ACT TO PROVIDE EARLY AND PERIODIC
SCREENING, DIAGNOSIS AND TREATMENT TO PRIVATELY
INSURED CHILDREN UNDER THE AGE OF 21**

MARCH 2015





Benefit Mandate Review: H.B. 916: An Act to provide early and periodic screening, diagnosis and treatment to privately insured children under the age of 21

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Benefit Mandate Overview: H.B. 916: EPSDT for Privately Insured Children

HISTORY OF THE BILL

The Joint Committee on Financial Services referred House Bill (H.B.) 916, “An Act to provide early and periodic screening, diagnosis and treatment to privately insured children under the age of 21,” sponsored by Rep. Garballey of Arlington, to the Center for Health Information and Analysis (CHIA) for review. Massachusetts General Laws, chapter 3, section 38C requires CHIA to review and evaluate the potential fiscal impact of each mandated benefit bill referred to the agency by a legislative committee.

WHAT DOES THE BILL PROPOSE?

H.B. 916 requires health insurance plans to “cover early and periodic screening, diagnosis and treatment (EPSDT) services for children and adolescents under age 21 in a manner equal to the amount, duration and scope of those services provided to Medicaid children and adolescents” as required under federal law.¹

COMPARING EPSDT TO CURRENT COMMERCIAL COVERAGE

EPSDT is a federally-defined comprehensive program of health care benefits for children, adolescents, and young adults under age 21 enrolled in Medicaid. The program defines a rich set of benefits for children, including preventive, diagnostic, and treatment services for medical, vision, dental, hearing, behavioral, developmental, and other care for all types of acute and chronic conditions. By requiring commercial insurers to provide EPSDT-defined coverage to children, H.B. 916 would significantly expand certain categories of covered services for children. Changes in coverage for medical screening and diagnostic testing would be modest, but the bill would significantly expand the breadth and depth of commercial coverage for treatment services. It would:

- Require coverage for pediatric services to age 21, three years beyond the currently typical cutoff of 18
- Require coverage for all services that could be approved under the Medicaid State Plan, including, but not limited to: coverage for certain categories of treatment services, including eyewear, dental services, and transportation services (to medical appointments, if necessary), and significantly expanded coverage for services for chronic or long-term physical, behavioral, and developmental health issues
- Remove many policy limitations and exclusions
- Affect utilization review and determinations of medical necessity

¹The 188th General Court of the Commonwealth of Massachusetts. Bill H. 916: An Act to provide early and periodic screening, diagnosis and treatment to privately insured children under the age of 21. Accessed 10 April 2014: <https://malegislature.gov/Bills/188/House/H916>. Specifically, the mandate cites: 42 U.S.C. §§ 1396a(a)(10); 1396a(a)(43); 1396d(a)(4)(B); 1396d(r). Details can be found at 42 U.S.C. 1396A - STATE PLANS FOR MEDICAL ASSISTANCE. Accessed 6 May 2014: <http://www.gpo.gov/fdsys/search/pagedetails.action?st=citation%3A42+USC+60&granuleId=USCODE-2010-title42-chap7-subchapXIX-sec1396a&packageId=USCODE-2010-title42&bread=true>.

MEDICAL EFFICACY OF H.B. 916

Enactment of H.B. 916 would increase the set of benefits available to children under commercial insurance by adding currently-excluded benefits, removing limits on benefits, and changing the extent to which insurers may deny services as medically unnecessary. The question of the medical efficacy of H.B. 916 therefore turns on whether expanding commercial plans improves the overall health of covered children. CHIA's analysis uncovered no studies directly addressing this question. However, while the impact of these proposed changes on the general child population is not tested, it is likely expanded coverage will result in increased service utilization by at least some of these children. Commercially-insured children with special health care needs, who are less likely than other children to be able to obtain services that fully meet their needs, will have expanded access to services currently absent from, or limited in, commercial plans.

COST OF IMPLEMENTING THE BILL

If enacted, H.B. 916 would be effective December 31, 2016. Requiring coverage for this benefit by fully-insured health plans would result in an average annual increase to the average monthly health insurance premium of between \$5.40 (0.91%) and \$12.45 (2.10%) per year for the first three years of the mandate's effective period (2017 to 2019). It is possible, in setting premiums, insurers will spread the cost of the bill primarily among family (as opposed to individual) plans, such that premiums for family plans might increase by a greater percentage (and individual plans by a lower one) than indicated above.

As the actuarial estimate of the cost of the bill describesⁱⁱ, the most-likely premium increase totals \$220 million per year across all affected plans. In addition, because many plans have deductibles and other cost-sharing provisions, members and families who benefit from this increased coverage would likely pay, as a group, approximately \$36 million out-of-pocket. The net impact on a given household's expenditures would depend on the extent to which it is currently paying for these services without the aid of insurance.

PLANS AFFECTED BY THE PROPOSED BENEFIT MANDATE

Individual and group accident and sickness insurance policies, corporate group insurance policies, and HMO policies issued pursuant to Massachusetts General Laws, as well as plans, self- and fully-insured, provided by the Group Insurance Commission (GIC) for public employees and their dependents, would be subject to this proposed mandate. The proposed benefit mandate would apply to members covered under the relevant plans, regardless of whether they reside within the Commonwealth or merely have their principal place of employment in the Commonwealth.

ⁱⁱ H.B. 916 as drafted defines the mandated services by referencing the federal EPSDT statutes, but without further specification. This analysis, based on an understanding of the sponsor's intent gathered through interviews, and on available scholarly writings and legal cases interpreting the federal statutes governing EPSDT, assumes insurers will be required to cover the full set of services in the federal statutes including services they generally do not cover currently such as private duty nursing and community-supported living arrangement services, as well as services they currently cover. As noted, this analysis also assumes that, because case law includes in EPSDT all Medicaid services provided to children, the treatment standard for all children's services must approximate the federal EPSDT standard. This analysis might include in the Medicaid/MassHealth base some services not in the scope of the mandated services. If H.B. 916 were to be enacted, the Massachusetts insurance regulation process would refine the set of services insurers must cover and/or the care standard they must apply; however, using the MassHealth service and care standards as a starting point enables the analysis to reach a reasonable estimate based on a known standard.

PLANS NOT AFFECTED BY THE PROPOSED BENEFIT MANDATE

Self-insured plans (i.e., where the employer policyholder retains the risk for medical expenses and uses an insurer to provide administrative functions), except for those managed under the GIC, are not subject to state-level health insurance benefit mandates. State health benefit mandates do not apply to Medicare and Medicare Advantage plans whose benefits are qualified by Medicare; consequently this analysis excludes members of commercial fully-insured plans over 64 years of age. These mandates also do not apply to federally-funded plans including TRICARE (covering military personnel and dependents), the Veterans Administration, and the Federal Employee's Health Benefit Plan. Finally, this bill does not apply to Medicaid/MassHealth.

PRELIMINARY ESTIMATE OF POTENTIAL MASSACHUSETTS LIABILITY UNDER THE ACA

Analysis of the cost associated with proposed state benefit mandates is important in light of new requirements introduced by the Affordable Care Act (ACA). In accordance with the ACA, all states must set an Essential Health Benefits (EHB) benchmark that all qualified health plans (QHPs), and those plans sold in the individual and small-group markets must cover at a minimum. Section 1311(d)(3)(B) of the ACA, as codified in 45 C.F.R. § 155.170, explicitly permits a state to require QHPs to offer benefits in addition to EHB, provided that the state is liable to defray the cost of additional mandated benefits by making payments to or on behalf of individuals enrolled in QHPs. The requirement to make such payments applies to QHPs sold both on and off the Exchange, but not to non-QHP plans. The state is not financially responsible for the costs of state-required benefits that are considered part of the EHB benchmark plan. In Massachusetts, the Benchmark Plan is the Blue Cross and Blue Shield HMO Blue \$2000 Deductible (HMO Blue). State-required benefits enacted on or before December 31, 2011 (even if effective after that date) are not considered "in addition" to EHB and therefore will not be the financial obligation of the state, if such additional benefits are *not* already covered benefits under the State's EHB Benchmark Plan, HMO Blue. This ACA requirement is effective as of January 1, 2014 and is intended to apply for at least plan years 2014 and 2015.

CHIA's *preliminary* estimate of the proposed health benefit mandate is not intended to determine whether or not this mandate is subject to state liability under the ACA.ⁱⁱⁱ CHIA generated this estimate to provide neutral, reliable information to stakeholders who make decisions that impact health care access and costs in the Commonwealth.

If enacted, H.B. 916 would be effective December 31, 2016. Therefore it will add nothing to the Commonwealth's obligation to defray mandate costs in 2015. The federal government may remove or modify the obligation after 2015, but for reference, if it remains the same, CHIA estimated the 2017 cost – the first year after the effective date – by applying the mid-range PMPM (per-member per-month) actuarial projection for 2017 cost (\$8.45) to an estimated maximum of 800,000 potential QHP members.^{iv} This results in an estimated maximum potential incremental premium increase to QHPs of \$6.76 million per month or \$81.1 million per year. This preliminary estimate is based on the incremental effect of requiring insurers to cover all EPSDT services; final state liability under the ACA might be less because the ACA requires states to defray the cost of only selected types of benefits. An estimate and eventually a final determination of the Commonwealth's liability will require a detailed analysis by the appropriate state agencies, including an assessment of whether this mandate is subject to state liability under the ACA and the actual number of QHP enrollees.

ⁱⁱⁱ The Health Connector, in consultation with the Massachusetts Division of Insurance, will need to be consulted to provide an analysis of estimated state liability associated with a given proposed mandated benefit bill.

^{iv} Estimated maximum QHP membership provided by the Massachusetts Division of Insurance.

Medical Efficacy Assessment: H.B. 916: EPSDT for Privately Insured Children

Massachusetts House Bill (H.B.) 916 requires health insurance plans to pay for early and periodic screening, diagnosis, and treatment (EPSDT) services for children “in a manner equal to the amount, duration and scope of those services provided to Medicaid children and adolescents” as required under federal law.¹ M.G.L. c. 3 § 38C charges the Massachusetts Center for Health Information and Analysis (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 mandated treatment or service, and describe the potential impact of a mandated benefit on the quality of patient care and the health status of the population.

DEFINITION OF EPSDT

EPSDT is a federally-defined comprehensive program of health care benefits for children, adolescents, and young adults under age 21 enrolled in Medicaid. The U.S. Centers for Medicare and Medicaid Services (CMS), which administers Medicaid at the federal level, summarizes the program as follows (Appendix A provides more detail):²

Early:	Assessing and identifying problems early
Periodic:	Checking children’s health at periodic, age-appropriate intervals
Screening:	Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
Diagnostic:	Performing diagnostic tests to follow up when a risk is identified
Treatment:	Control, correct or reduce health problems found.

The program includes preventive, diagnostic, and treatment services including medical, vision, dental, hearing, behavioral, developmental, and other specialty services for all types of acute and chronic conditions. Services must be medical in nature, delivered by a qualified health care provider, and identified as medically necessary.³

EPSDT defines a rich set of benefits for children. Screening and diagnostic services are intended to identify behavioral health, developmental, and physical conditions early, so that the child can receive treatment “to correct or ameliorate defects and chronic conditions found.”⁴ While some overlap exists between EPSDT benefits and benefits typically covered by private insurance, the EPSDT program was designed using a “pediatric standard of care,” and is a more comprehensive benefit, especially in treatment services.⁵ According to CMS, “[n]ecessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.”⁶ EPSDT “...expanded Medicaid’s role beyond treatment of illness to include promoting childhood growth and development.”⁷ All services covered by federal Medicaid, regardless of restrictions that apply to adult beneficiaries, must be covered for enrolled children when medically necessary; this includes federally-defined mandatory services, as well as services defined at the federal level but provided at the option of the states.⁸ In other words, even if a state does not include a given optional

service in its adult benefit program, this service must still be covered for children if medically necessary. More information on Medicaid benefits appears in Appendix B. In contrast, in general commercial insurers limit treatments and services for their covered populations, applying eligibility and benefit limits, referral and authorization requirements, and utilization management guidelines in addition to applying medical necessity criteria they define, rather than criteria defined by the federal government, as in the EPSDT program.⁹

EPSDT AND MEDICAL NECESSITY

One key difference between Medicaid EPSDT benefits and commercial insurance lies in their respective definitions of medical necessity.¹⁰ In the commercial sector, according to the American College of Medical Quality, “[m]edical necessity is defined as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.”¹¹ Services are generally intended to restore an individual to a level of functioning present prior to an acute episode, illness, or injury.

In contrast, medical need under EPSDT is tied to a child’s development; services are intended to help a child avoid functional deterioration and to promote development regardless of condition or disability.¹² The U.S. statutes cited by H.B. 916 include the federal medical necessity guidelines applied to the EPSDT program; therefore, if the bill is enacted, this standard would apply to commercial insurance coverage for children. EPSDT focuses specifically on early detection and identification to reduce the impact of any identified condition, with the goal of “early identification and treatment of health conditions that can impede children’s natural growth and development,” in contrast to treatment in response to an acute illness or disorder.¹³ Needs identified in children must be treated, regardless of whether the service is specifically included in the state’s Medicaid plan.^{14,15,16} One review describes EPSDT’s scope in the following way:

In its current form, the EPSDT benefit is uncommonly sweeping, not only in its primary preventive coverage (comprehensive health examinations, assessment of developmental health, and comprehensive vision, dental, and hearing care) but also in the degree to which its terms encompass all medically necessary treatments and services falling within any of Medicaid’s dozens of enumerated benefit classes, regardless of whether coverage would be available under a state Medicaid plan in the case of individuals aged ≥ 21 . Moreover, because EPSDT’s purpose is early and preventive, courts have interpreted its provisions to encompass not only treatments that improve health, but also treatments that enable children with disabilities to attain and maintain maximum developmental health. As a result, the EPSDT benefit bars limitations and exclusions used by commercial insurers to exclude otherwise-covered treatments that promote the health of children with chronic and serious physical and mental health conditions that delay development.¹⁷

COMPARING ACCESS AND CARE BY INSURANCE STATUS

EPSDT offers a wide range of services, many of which are covered by commercial insurance plans, especially preventive services and acute care services such as short-term hospitalization for injury or illness. Therefore, the question of the medical efficacy of H.B. 916 turns on whether expanding commercial plans – to include services currently limited or not offered – improves the overall health of covered children. A fully-credible estimate of the bill’s effect on the health of commercially-insured

children would require comparative longitudinal studies of the health of a commercially-insured child population and of children with EPSDT benefits, controlling for the relative baseline health of the two populations. This analysis uncovered no studies directly addressing this question.¹⁸

To the extent commercially-insured children might currently receive medically necessary services within the EPSDT scope, but funded by other sources including self-payment and possibly school systems, H.B. 916 might shift funding for these services to commercial payers, but would not necessarily result in higher volume or more effective utilization of services in a way that improves children’s health. On the other hand, requiring coverage of such EPSDT-related services by commercial payers will likely result in at least some increase in utilization of some services not currently covered. A reasonable inference would be that some of this increased utilization might improve the health of the commercially-insured population for those children who currently lack coverage for certain medically necessary services.

While not definitive, some studies of related questions suggest the potential impact these additional EPSDT benefits might have if they were available to commercially-insured children. Studies measuring the health status of children covered by EPSDT often compare them to children without insurance; for example, an early study of the implementation of EPSDT found that children in the program had 30 percent “fewer abnormalities requiring care” than their peers without these benefits.¹⁹ Other studies found that, for some children, expanded Medicaid eligibility resulted in reduced acute health conditions and functional limitations²⁰ as well as significant reductions in childhood mortality.²¹ More narrow studies on dental care have found that dental disparities among U.S. children decreased after the enactment and expansion of Medicaid.²² These studies have generally shown that children who have insurance coverage are healthier than uninsured children; however, these are not health status-controlled studies comparing children eligible for Medicaid EPSDT services to children covered by commercial plans.

IMPACT OF EPSDT ON CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Even if, as noted above, studies of the efficacy of shifting coverage for the general population of children from commercial to Medicaid are limited, it is clear that H.B. 916 will especially affect children with special health care needs (CSHCN).²³ Given the limitations on coverage and medical necessity under commercial insurers, CSHCN, who by definition require health and related services “of a type or amount beyond that required by children generally,”²⁴ are sometimes unable, or less able than other children, to obtain services that fully meet their needs.²⁵

Lack of access to commercial insurance or limitations imposed within commercial policies leads some to seek the broader coverage available under Medicaid. In Massachusetts, nearly 40 percent of CSHCN are covered at least in part by public insurance.^{26,27} Of this group, H.B. 916 would directly affect the portion dually-eligible for both public and private insurance (under plans subject to the bill), as the services they currently receive under public insurance would be fully covered under their commercial policies, shifting the expense to commercial insurers. Further, if H.B. 916 is enacted, those CSHCN currently covered only by commercial insurance (again, under plans subject to the bill) will also be eligible for the full range of EPSDT services and benefits, and no longer subject to limitations currently set by their commercial plans.

A study by the U.S. General Accounting Office (now the Government Accountability Office) on the role of Medicaid for CSHCN found that benefits for privately-insured CSHCN are limited when compared to Medicaid.²⁸ Medicaid was found to cover a broader array of services specifically designed to address chronic and long-term needs.²⁹ Moreover, as some states have specifically-designed Medicaid programs for CSHCN, Medicaid may be able to provide better coordination and continuity of care than typical private coverage, and may be able “to more comprehensively address their extensive and complex needs than private health insurance plans that serve few persons with such needs.”³⁰

As noted, CSHCN, whose health issues include a range of conditions from learning disorders to severe disabilities, face more problems accessing care than do other children, regardless of insurance status.³¹ While studies have found that Medicaid and commercial insurance provide similar access to primary and preventive services for CSHCN,³² Medicaid programs for CSHCN have been found to shift the overall financial burden of care away from families when compared to private insurance programs.³³

In summary, evidence exists that providing the EPSDT benefit to the previously-uninsured improves outcomes and functional performance. This review did not identify any studies that examined whether expanding benefits from those in a typical commercial package to the richer and less-restricted EPSDT benefit affects the health of the general population of commercially-insured children. However, research has shown that the federally-defined EPSDT benefit package includes services that children covered only by commercial carriers may be unable to access due to insurance limitations, or may only access by paying out-of-pocket or by obtaining secondary public insurance as dually-eligible recipients.

Appendix A: Description of EPSDT Services³⁴

SCREENING SERVICES

- Comprehensive health and developmental history
- Comprehensive unclothed physical exam
- Appropriate immunizations (according to the Advisory Committee on Immunization Practices)
- Laboratory tests (including lead toxicity screening)
- Health Education (anticipatory guidance including child development, healthy lifestyles, and accident and disease prevention)

VISION SERVICES

Includes, at a minimum, diagnosis and treatment for defects in vision, including eyeglasses. Vision services must be provided according to a distinct periodicity schedule developed by the state and at other intervals as medically necessary.

DENTAL SERVICES

At a minimum, dental services include relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services may not be limited to emergency services. Each state is required to develop a dental periodicity schedule in consultation with recognized dental organizations involved in child health.

HEARING SERVICES

At a minimum, hearing services include diagnosis and treatment for defects in hearing, including hearing aids.

OTHER NECESSARY HEALTH CARE SERVICES

States are required to provide any additional health care services that are coverable under the Federal Medicaid program and found to be medically necessary to treat, correct or reduce illnesses and conditions discovered regardless of whether the service is covered in a state's Medicaid plan. It is the responsibility of states to determine medical necessity on a case-by-case basis.

DIAGNOSTIC SERVICES

When a screening examination indicates the need for further evaluation of an individual's health, diagnostic services must be provided. Necessary referrals should be made without delay and there should be follow-up to ensure the enrollee receives a complete diagnostic evaluation. States should develop quality assurance procedures to assure comprehensive care is provided.

TREATMENT

Necessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.

Appendix B: Medicaid Benefits³⁵

States establish and administer their own Medicaid programs and determine the type, amount, duration, and scope of services within broad federal guidelines. States are required to cover certain “mandatory benefits,” and can choose to provide other “optional benefits” to adults 21 and over through the Medicaid program. Note that all “optional benefits” must be provided to children under age 21 under the EPSDT program.

MANDATORY BENEFITS

- Inpatient hospital services
- Outpatient hospital services
- EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services
- Nursing Facility Services
- Home health services
- Physician services
- Federally qualified health center services
- Laboratory and X-ray services
- Family planning services
- Nurse Midwife services
- Certified Pediatric and Family Nurse Practitioner services
- Freestanding Birth Center services (when licensed or otherwise recognized by the state)
- Transportation to medical care

OPTIONAL BENEFITS

- Prescription Drugs
- Clinic services
- Physical therapy
- Occupational therapy
- Speech, hearing and language disorder services
- Respiratory care services
- Other diagnostic, screening, preventive and rehabilitative services
- Podiatry services
- Optometry services
- Dental services
- Dentures
- Prosthetics
- Eyeglasses
- Chiropractic services
- Other practitioner services
- Private duty nursing services
- Personal Care
- Hospice
- Case management
- Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)
- Services in an intermediate care facility for the mentally retarded
- State Plan Home and Community Based Services-1915(i)
- Self-Directed Personal Assistance Services-1915(j)
- Community First Choice Option-1915(k)
- TB Related Services
- Inpatient psychiatric services for individuals under age 21
- Other services approved by the Secretary*

*This includes services furnished in a religious nonmedical health care institution, emergency hospital services by a non-Medicare certified hospital, and critical access hospital (CAH).



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Endnotes

¹ The 188th General Court of the Commonwealth of Massachusetts. House Bill 916: An Act to provide early and periodic screening, diagnosis and treatment to privately insured children under the age of 21. Accessed 10 April 2014: <https://malegislature.gov/Bills/188/House/H916>. Specifically, the mandate cites: 42 U.S.C. §§ 1396a(a)(10); 1396a(a)(43); 1396d(a)(4)(B); 1396d(r). Details can be found at 42 U.S.C. 1396A - STATE PLANS FOR MEDICAL ASSISTANCE. Accessed 6 May 2014: <http://www.gpo.gov/fdsys/search/pagedetails.action?st=citation%3A42+USC+60&granuleId=USCODE-2010-title42-chap7-subchapXIX-sec1396a&packageId=USCODE-2010-title42&bread=true>.

² Medicaid.gov: Early and Periodic Screening, Diagnostic and Treatment. Accessed 11 April 2014: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>.

³ National Academy for State Health Care Policy. Public Insurance Programs and Children with Special Health Care Needs: A Tutorial on the Basics of Medicaid and The Children's Health Insurance Program (CHIP). February 2012; accessed 16 June 2014: http://www.nashp.org/sites/default/files/Medicaid_101_tutorial.pdf.

⁴ 42 C.F.R. § 441.50 Subpart B—Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21: Basis and purpose. Accessed 6 May 2014: <http://www.ecfr.gov/cgi-bin/text-idx?rgn=div6&node=42:4.0.1.1.10.2>.

⁵ Goldstein MM, Rosenbaum S. From EPSDT to EHBS: the future of pediatric coverage design under government financed health insurance. *Pediatrics*. 2013 Apr;131 Suppl 2:S142-8. doi: 10.1542/peds.2013-0252e. Accessed 6 May 2014: http://pediatrics.aappublications.org/content/131/Supplement_2/S142.full.

⁶ *Op. cit.* Medicaid.gov: Early and Periodic Screening, Diagnostic and Treatment.

⁷ Peters CP. EPSDT: Medicaid's Critical But Controversial Benefits Program for Children. National Health Policy Forum Issue Brief No. 819, November 20, 2006. Accessed 28 April 2014: http://www.nhpf.org/library/issue-briefs/IB819_EPSDT_11-20-06.pdf.

⁸ *Ibid.*

⁹ Examples:

Medical necessity: The determination of whether care is required and appropriate given an individual's medical condition and general opinions of experts practicing in the field of medicine. Accessed 16 June 2014: https://www.bluecrossma.com/staticcontent/glossary_content.html?iphl=necessity:medical:medical.

Medically necessary health care: Health care services or products intended to prevent, diagnose, stabilize, or treat an illness, injury, or disease (or its symptoms) in a manner that is: consistent with generally accepted standards of medical practice; clinically appropriate in terms of type, frequency, extent, site and duration; demonstrated through scientific evidence to be effective in improving health outcomes; representative of "best practices" in the medical profession; not primarily for the convenience of the enrollee or physician or other health practitioner. Accessed 16 June 2014: https://www.harvardpilgrim.org/pls/portal/docs/PAGE/PROVIDERS/MANUALS/PROVIDER/A%20CLINICAL%20DECISIONS_011514.PDF.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the Plan service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations... The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic. Accessed 16 June 2014: http://www.tuftshealthplan.com/providers/pdf/mng/autism_aba_ri.pdf.

¹⁰ EPSDT applies the concept of medical necessity broadly:

While there is no federal definition of preventive medical necessity, federal amount, duration and scope rules require that coverage limits must be sufficient to ensure that the purpose of a benefit can be reasonably achieved... Since the purpose of EPSDT is to prevent the onset of [sic] worsening of disability and illness and children, the standard of coverage is necessarily broad... [T]he standard of medical necessity used by a state must be one that ensures a sufficient level of coverage to not merely treat an already-existing illness or injury but also, to prevent the development or worsening of conditions, illnesses, and disabilities.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health (USDHHS-HRSA-MCH): EPSDT Overview, Medical Necessity under EPSDT. Accessed 6 May 2014: <http://mchb.hrsa.gov/epsdt/mednecessity.html>.

- ¹¹ American College of Medical Quality (ACMQ): POLICY 8, Definition and Application of Medical Necessity. Accessed 6 May 2014: <http://www.acmq.org/policies/policy8.pdf>.
- ¹² *Op. cit.* Peters CP. EPSDT: Medicaid's Critical But Controversial Benefits Program for Children.
- ¹³ Kaiser Commission on Medicaid Facts: Early and Periodic Screening, Diagnostic, and Treatment Services. Fact Sheet October 2005; accessed 6 May 2014: <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/early-and-periodic-screening-diagnostic-and-treatment-services-fact-sheet.pdf>.
- ¹⁴ *Op. cit.* National Academy for State Health Care Policy. Public Insurance Programs and Children with Special Health Care Needs: A Tutorial on the Basics of Medicaid and The Children's Health Insurance Program (CHIP).
- ¹⁵ Ireys HT, Wehr E, Cooke RE. 1999. Defining Medical Necessity: Strategies for Promoting Access to Quality Care for Persons with Developmental Disabilities, Mental Retardation, and Other Special Health Care Needs. Arlington, VA: National Center for Education in Maternal and Child Health. Accessed 5 May 2014: <http://www.jhsph.edu/research/centers-and-institutes/womens-and-childrens-health-policy-center/publications/cshcn-MedicalNecessity.pdf>.
- ¹⁶ O'Connell M, Watson S, Butler B, et. al. Introduction to Medicaid: Eligibility, Federal Mandates, Hearings and Litigation. Southern Disability Law Center. Published 24 March 2004; accessed 6 May 2014: <http://209.203.251.64/conf2004/medicaid-intro.htm>.
- ¹⁷ *Op. cit.* Goldstein MM, Rosenbaum S. From EPSDT to EHBs: the future of pediatric coverage design under government financed health insurance.
- ¹⁸ This review has found only limited studies comparing outcomes between Medicaid and private insurance for children, in part because of the difficulty in controlling for differences in baseline economic and health status between the two covered populations. Medicaid for children primarily covers those who are low-income, disabled, eligible for institutional levels of care, or in out-of-home placements. [*Op. cit.* National Academy for State Health Care Policy. Public Insurance Programs and Children with Special Health Care Needs: A Tutorial on the Basics of Medicaid and The Children's Health Insurance Program (CHIP).] Studies comparing the two populations often do not control for medical or socioeconomic status, and so determining whether outcomes are due solely to differences between the insurance programs, or are influenced by underlying differences in the populations served, is difficult. [Dubay L, Kenney GM. Health care access and use among low-income children: who fares best? *Health Aff (Millwood)*. 2001 Jan-Feb;20(1):112-21. Accessed 12 June 2014: <http://content.healthaffairs.org/content/20/1/112.full>.]
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²⁸ U.S. General Accounting Office (U.S. GAO). Children with Disabilities: Medicaid Can Offer Important Benefits and Services. T-HEHS-00-152; Published: Jul 12, 2000; accessed 16 June 2014: <http://www.gao.gov/products/GAO/T-HEHS-00-152>.

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³⁰ *Op. cit.* U.S. General Accounting Office (U.S. GAO). Children with Disabilities: Medicaid Can Offer Important Benefits and Services.

³¹ *Op. cit.* Tu HT, Cunningham PJ. Public coverage provides vital safety net for children with special health care needs.

³² *Ibid.*

³³ *Op. cit.* Davidoff AJ, Yemane A, Hill I. Public insurance eligibility and enrollment for special health care needs children.

³⁴ *Op. cit.* Medicaid.gov: Early and Periodic Screening, Diagnostic and Treatment.

³⁵ Medicaid.gov: Medicaid Benefits. Accessed 6 May 2014: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html>.

**Actuarial Assessment of House Bill 916:
“An act to provide early and periodic screening,
diagnosis and treatment to privately insured children
under the age of 21”**

Prepared for
Commonwealth of Massachusetts
Center for Health Information and Analysis

March 2015

Prepared by
Compass Health Analytics, Inc.



**Actuarial Assessment of House Bill 916:
 “An act to provide early and periodic screening, diagnosis and
 treatment to privately insured children under the age of 21”**

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Actuarial Assessment of House Bill 916: “An act to provide early and periodic screening, diagnosis and treatment to privately insured children under the age of 21”

Executive Summary

Massachusetts House Bill 916 (H.B. 916) requires health insurance plans to pay for early and periodic screening, diagnosis and treatment (EPSDT) services for children “in a manner equal to the amount, duration and scope of those services provided to Medicaid children and adolescents” as required under federal law.¹ Massachusetts General Laws (M.G.L.) c.3 §38C charges the Massachusetts Center for Health Information and Analysis (CHIA) with, among other duties, reviewing the potential impact of proposed mandated health care insurance benefits on the premiums paid by businesses and consumers. CHIA has engaged Compass Health Analytics, Inc. to provide an actuarial estimate of the effect enactment of the bill would have on the cost of health insurance in Massachusetts.

EPSDT

H.B. 916 requires insurers to cover “early and periodic screening, diagnosis and treatment (EPSDT) services for children and adolescents under age 21 in a manner equal to the amount, duration and scope of those services provided to Medicaid children and adolescents as required by 42 USC §1396(a)10A, §1396(a)(a)(43), §1396d(a)(4)(B) and §1396d(r).” EPSDT is a federally-defined comprehensive program of health care benefits for children, adolescents, and young adults under age 21 enrolled in Medicaid. The U.S. Centers for Medicare and Medicaid Services (CMS) summarizes the program as follows:²

Early:	Assessing and identifying problems early
Periodic:	Checking children's health at periodic, age-appropriate intervals
Screening:	Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
Diagnostic:	Performing diagnostic tests to follow up when a risk is identified
Treatment:	Control, correct or reduce health problems found.

The program comprises preventive, diagnostic, and treatment services including medical, vision, dental, hearing, behavioral, developmental, and other specialty care for all types of acute and chronic conditions. Services must be medical in nature, delivered by a qualified health care provider, and identified as medically necessary.³

EPSDT defines a rich set of benefits for children. Screening and diagnostic services are intended to identify behavioral health, developmental, and physical conditions early so that the child can receive treatment “to correct or ameliorate defects and chronic conditions found.”⁴ While some overlap exists between EPSDT benefits and benefits typically covered by private insurance, the EPSDT program was designed using a “pediatric standard of care,” and is a more comprehensive

benefit, especially for treatment services.⁵ EPSDT “...expanded Medicaid’s role beyond treatment of illness to include promoting childhood growth and development.”⁶

One key difference between Medicaid EPSDT benefits and commercial insurance lies in their respective definitions of medical necessity.⁷ In the commercial sector, services are generally intended to restore an individual to a level of functioning present prior to an acute episode, illness, or injury. In contrast, medical need under EPSDT is tied to a child’s development; services are intended to help children avoid functional deterioration and to promote development regardless of condition or disability.⁸ EPSDT focuses specifically on early detection and identification to reduce the impact of any identified condition, with the goal of “early identification and treatment of health conditions that can impede children’s natural growth and development.”⁹ The definition of medical necessity is governed by Medicaid standards, which, compared to commercial insurance standards, give relatively more weight to the provider than to the payer in applying that definition.^{10,11}

As one summary stated:

[B]ecause EPSDT’s purpose is early and preventive, courts have interpreted its provisions to encompass not only treatments that [address acute concerns to] improve health, but also treatments that enable children with disabilities to attain and maintain maximum developmental health. As a result, the EPSDT benefit bars limitations and exclusions used by commercial insurers to exclude otherwise-covered treatments that promote the [developmental] health of children with chronic and serious physical and mental health conditions that delay development.¹²

Comparison to current coverage

In response to a survey of eight of the largest insurance carriers in Massachusetts, most reported that coverage for pediatric medical screening and most diagnostic testing services would not change significantly under the proposed mandate, as all follow the federal Affordable Care Act¹³ provisions requiring coverage for many preventative services.¹⁴ However, vision, dental, and non-newborn hearing screenings that would be required under the proposed mandate are currently not covered by all carriers.

Distinctions between EPSDT and current commercial coverage begin to broaden when the focus turns beyond screening to treatment services. H.B. 916 would require coverage for certain categories of EPSDT services currently not covered by commercial insurers, including, for example, eyewear, dental, and transportation services. Furthermore, within categories of service that carriers typically do cover, current commercial benefit plans “typically include cost sharing, limitations and exclusions... [and] cover certain services only on a short term basis.”¹⁵ Most also require pre-authorization and/or utilization review for certain services, and all vary in their definitions of medical necessity. H.B. 916 would remove most if not all of the service quantity limits insurers could impose and limit their ability to deny services as medically unnecessary. Many carriers specifically stated that services for chronic or long-term physical and behavioral health issues would be significantly expanded under the proposed mandate.

In summary, requiring fully-insured commercial policies to cover the EPSDT benefit would make the following changes to existing commercial health insurance coverage for children:

- Expand coverage to include all services (both required and state-optional services) allowed under federal Medicaid guidelines, which includes services designed to enhance and promote development and long-term services for chronic physical and behavioral issues
- Eliminate caps and limits on utilization of all services
- Incorporate the Medicaid EPSDT standards for medical necessity, reducing carriers' discretion in setting and applying them

These requirements represent a substantial increase in the number and type of services that must be covered for children in fully-insured commercial policies. The proposed mandate does not, however, prohibit carriers from applying cost sharing to these services.

Analysis

Because of the scope of the definition of EPSDT under federal law, H.B. 916 makes available to commercially-insured children the entire Medicaid benefit package, significantly broadening benefits available to the commercial population. Given the broad nature of the EPSDT benefit, separately estimating the cost of expanding coverage for each relevant service category – home care, various therapies, habilitative services, etc. – would be impractical in the timeframe for conducting this mandate analysis. Instead, this analysis employs a “top-down” approach, comparing the total per-child medical expense for children covered by commercial carriers to the medical expense for children covered under Medicaid.

The fundamental approach of this analysis is to assume commercial coverage for children after implementation of the bill would approximate the current Medicaid spending under the EPSDT benefit; therefore, the incremental cost of the mandate is calculated by subtracting the current per-child cost of children in commercial coverage from the per-child medical expense MassHealth incurs in providing the rich set of EPSDT benefits. However, producing a valid estimate of the incremental cost of the bill requires adjusting for four important differences in the two populations and benefit sets:

1. *Average morbidity level:* Given the demographic characteristics of the Medicaid-eligible population, children with Medicaid coverage present, on average, more, and more severe, illnesses and conditions than do commercially-insured children. To adjust for this difference, the analysis reduces the estimated per-child Medicaid cost, thus reducing the incremental impact of the bill.
2. *Difference in provider reimbursement rates:* On average, commercial insurers pay higher reimbursement rates than does MassHealth. This requires adjusting the Medicaid per-child cost, and the incremental impact of the bill, upward.
3. *Difference in patient cost sharing:* If H.B. 916 requires commercial insurers to cover more services, the insurers will not bear the full expense because they have cost-sharing

arrangements in many of their benefit plans; such cost sharing is not required of Medicaid recipients. This reduces the incremental cost of the bill that would be reflected in premiums. In addition, the presence of cost sharing will dampen utilization in the commercial population, further reducing the incremental cost of the bill.

4. *Impact of ACA on required services in commercial insurance:* The incremental cost of the bill must not include the cost of services already required by other state or federal mandates. The period from which the analysis draws medical expense data does not reflect the full effect of the federal ACA, but the projection period for the analysis is after the ACA implementation. A calculation is made for the impact of vision and dental benefits to avoid attributing ACA-required benefit expansions to the bill.

After making these adjustments to MassHealth spending, the resulting per-child spending amount is an estimate of commercial EPSDT per-child spending. The analysis then subtracts the current per-child spending under commercial insurance from the estimated commercial EPSDT per-child spending to estimate the incremental impact of H.B. 916 on insurer medical expense. The main body of this analysis describes the adjustments in detail, the amount of uncertainty present in each, and their effect on the final estimate of H.B. 916's effect on premiums.

H.B. 916 as drafted defines the mandated services by referencing the federal EPSDT statutes, but without further specification. This analysis assumes insurers will be required to cover the full set of services in the federal statutes, including services they do not cover currently and ones they do. As noted, this analysis also assumes that, because case law includes in EPSDT all Medicaid services provided to children, the treatment standard for all children's services must approximate the federal EPSDT standard. This analysis might include in the Medicaid/MassHealth base some services ultimately not in the scope of the mandated services. If H.B. 916 were to be enacted, the insurance regulation process would refine the set of services insurers must cover and/or the care standard they must apply; however, using the MassHealth service and care standards as a starting point enables the analysis to reach a reasonable estimate based on a known standard.

Summary results

Despite sources of uncertainty, the estimated costs of expanding commercial coverage for children to meet EPSDT standards, even under the analysis's low-range assumptions, are substantial. Table ES-1 summarizes the effect of H.B. 916 on premiums for fully-insured plans. Note that if enacted, H.B. 916 would be effective December 31, 2016. This analysis estimates that, if enacted, the bill would increase fully-insured premiums by as much as 2.1 percent on average over the three years following implementation; a more likely increase is in the range of 1.5 percent.

The impact of the bill 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 mandate. In particular, it is possible that in setting premiums, insurers will spread the cost of the bill only across family (as opposed to individual) plans, and in that case premiums in those plans would likely increase by a greater percentage (with individual plans' premiums increasing less).

The most-likely premium increase totals \$220 million per year across all affected plans. In addition, because many plans have deductibles and other cost-sharing provisions, members and families who benefit from this increased coverage would likely pay, as a group, approximately \$36 million out-of-pocket. The net impact on household expenditures would depend on the extent to which they are currently paying for these services without the aid of insurance.

**Table ES-1:
Summary Results**

	2015	2016	2017	2018	2019	3-yr Average	3-Yr Total
Members (000s)	2,144	2,121	2,096	2,071	2,045		
Medical Expense Low (\$000s)	\$0	\$0	\$114,543	\$118,630	\$122,941	\$118,705	\$356,114
Medical Expense Mid (\$000s)	\$0	\$0	\$188,093	\$194,805	\$201,884	\$194,927	\$584,782
Medical Expense High (\$000s)	\$0	\$0	\$264,311	\$273,742	\$283,690	\$273,914	\$821,743
Premium Low (\$000s)	\$0	\$0	\$129,427	\$134,045	\$138,916	\$134,129	\$402,388
Premium Mid (\$000s)	\$0	\$0	\$212,535	\$220,119	\$228,118	\$220,257	\$660,771
Premium High (\$000s)	\$0	\$0	\$298,656	\$309,313	\$320,554	\$309,508	\$928,523
PMPM Low	\$0.00	\$0.00	\$5.15	\$5.39	\$5.66	\$5.40	\$5.40
PMPM Mid	\$0.00	\$0.00	\$8.45	\$8.86	\$9.29	\$8.86	\$8.86
PMPM High	\$0.00	\$0.00	\$11.87	\$12.45	\$13.06	\$12.45	\$12.45
Estimated Monthly Premium	\$512	\$537	\$564	\$592	\$622	\$566	\$566
Premium % Rise Low	0.00%	0.00%	0.91%	0.91%	0.91%	0.91%	0.91%
Premium % Rise Mid	0.00%	0.00%	1.50%	1.50%	1.49%	1.50%	1.50%
Premium % Rise High	0.00%	0.00%	2.10%	2.10%	2.10%	2.10%	2.10%

Executive Summary Endnotes

¹ The 188th General Court of the Commonwealth of Massachusetts. Bill H. 916: An Act to provide early and periodic screening, diagnosis and treatment to privately insured children under the age of 21. Accessed 10 April 2014: <https://malegislature.gov/Bills/188/House/H916>. Specifically, the mandate cites: 42 U.S.C. §§ 1396a(a)(10); 1396a(a)(43); 1396d(a)(4)(B); 1396d(r). Details can be found at 42 U.S.C. 1396A - STATE PLANS FOR MEDICAL ASSISTANCE. Accessed 6 May 2014:

<http://www.gpo.gov/fdsys/search/pagedetails.action?st=citation%3A42+USC+60&granuleId=USCODE-2010-title42-chap7-subchapXIX-sec1396a&packageId=USCODE-2010-title42&bread=true>.

² Medicaid.gov: Early and Periodic Screening, Diagnostic and Treatment. Accessed 11 April 2014: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>.

³ National Academy for State Health Care Policy. Public Insurance Programs and Children with Special Health Care Needs: A Tutorial on the Basics of Medicaid and The Children's Health Insurance Program (CHIP). February 2012; accessed 16 June 2014: http://www.nashp.org/sites/default/files/Medicaid_101_tutorial.pdf.

⁴ 42 C.F.R. § 441.50 Subpart B—Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21: Basis and purpose. Accessed 6 May 2014: <http://www.ecfr.gov/cgi-bin/text-idx?rgn=div6&node=42:4.0.1.1.10.2>.

⁵ Goldstein MM, Rosenbaum S. From EPSDT to EHBs: the future of pediatric coverage design under government financed health insurance. *Pediatrics*. 2013 Apr;131 Suppl 2:S142-8. doi: 10.1542/peds.2013-0252e. Accessed 6 May 2014: http://pediatrics.aappublications.org/content/131/Supplement_2/S142.full.

⁶ Peters CP. EPSDT: Medicaid's Critical But Controversial Benefits Program for Children. National Health Policy Forum Issue Brief No. 819, November 20, 2006. Accessed 28 April 2014: http://www.nhpf.org/library/issue-briefs/IB819_EPSDT_11-20-06.pdf.

⁷ EPSDT applies the concept of medical necessity broadly:

While there is no federal definition of preventive medical necessity, federal amount, duration and scope rules require that coverage limits must be sufficient to ensure that the purpose of a benefit can be reasonably achieved.... Since the purpose of EPSDT is to prevent the onset of [sic] worsening of disability and illness and children, the standard of coverage is necessarily broad... [T]he standard of medical necessity used by a state must be one that ensures a sufficient level of coverage to not merely treat an already-existing illness or injury but also, to prevent the development or worsening of conditions, illnesses, and disabilities.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health (USDHHS-HRSA-MCH): EPSDT Overview, Medical Necessity under EPSDT. Accessed 6 May 2014: <http://mchb.hrsa.gov/epsdt/mednecessity.html>.

⁸ *Op. cit.* Peters CP. EPSDT: Medicaid's Critical But Controversial Benefits Program for Children.

⁹ Kaiser Commission on Medicaid Facts: Early and Periodic Screening, Diagnostic, and Treatment Services. Fact Sheet October 2005; accessed 6 May 2014: <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/early-and-periodic-screening-diagnostic-and-treatment-services-fact-sheet.pdf>.

¹⁰ Ireys HT, Wehr E, Cooke RE. 1999. Defining Medical Necessity: Strategies for Promoting Access to Quality Care for Persons with Developmental Disabilities, Mental Retardation, and Other Special Health Care Needs. Arlington, VA: National Center for Education in Maternal and Child Health. Accessed 5 May 2014: <http://www.jhsph.edu/research/centers-and-institutes/womens-and-childrens-health-policy-center/publications/cshcn-MedicalNecessity.pdf>.

¹¹ O'Connell M, Watson S, Butler B, et. al. Introduction to Medicaid: Eligibility, Federal Mandates, Hearings and Litigation. Southern Disability Law Center. Published 24 March 2004; accessed 6 May 2014: <http://209.203.251.64/conf2004/medicaid-intro.htm>.

¹² *Op. cit.* Goldstein MM, Rosenbaum S. From EPSDT to EHBs: the future of pediatric coverage design under government financed health insurance.

¹³ Affordable Care Act: “The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.” U.S. Centers for Medicare & Medicaid Services (CMS): Healthcare.gov glossary. Accessed 10 March 2014: <https://www.healthcare.gov/glossary/affordable-care-act/>.

¹⁴ Patient Protection and Affordable Care Act, 42 U.S.C. § 1001 §2713. Accessed 11 March 2014: <http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>.

¹⁵ Responses taken from survey of Massachusetts health insurance carriers issues March 25, 2014.

Actuarial Assessment of House Bill 916: “An act to provide early and periodic screening, diagnosis and treatment to privately insured children under the age of 21”

1. Introduction

Massachusetts House Bill 916 requires health insurance plans to cover “early and periodic screening, diagnosis and treatment (EPSDT) services for children and adolescents under age 21 in a manner equal to the amount, duration and scope of those services provided to Medicaid children and adolescents as required by 42 USC §1396(a)10A, §1396(a)(a)(43), §1396d(a)(4)(B) and §1396d(r).”¹ Massachusetts General Laws (M.G.L.) c.3 §38C charges the Massachusetts Center for Health Information and Analysis (CHIA) with, among other duties, reviewing the potential impact of proposed mandated health care insurance benefits on the premiums paid by businesses and consumers. CHIA has engaged Compass Health Analytics, Inc. (Compass) to estimate the effect enactment of the bill would have on the cost of health care insurance in Massachusetts.

Assessing the impact of this bill entails analyzing the incremental effect of the bill on spending by insurance plans. This in turn requires comparing spending under the provisions of the proposed law to spending under current statutes and current benefit plans for the relevant services.

Section 2 of this analysis outlines the provisions of the bill. Section 3 summarizes the methodology used for the estimate. Section 4 discusses important considerations in translating the bill’s language into estimates of its incremental impact on health care costs. Section 5 describes the calculation of the estimate.

2. Interpretation of H.B. 916

The following subsections describe the provisions of H.B. 916, as drafted for the 188th General Court.

2.1. Plans affected by the proposed mandate

The bill amends the statutes that regulate insurers providing health insurance in Massachusetts. It includes the following sections, each addressing statutes dealing with a type of health insurance policy:

- Section 1: Insurance for persons in service of the Commonwealth (creating M.G.L. c. 32A, § 17K)
- Section 2: Accident and sickness insurance policies (creating M.G.L. c. 175, § 47CC)
- Section 3: Contracts with non-profit hospital service corporations (creating M.G.L. c. 176A, § 8FF)

- Section 4: Certificates under medical service agreements (creating M.G.L. c. 176B, §4FF)
- Section 5: Health maintenance contracts (creating M.G.L. 176G, § 4X)
- Section 6: Preferred provider contracts (creating M.G.L. 176I, § 13)²

The bill requires coverage for members under the relevant plans, regardless of whether they reside within the Commonwealth or merely have their principal place of employment in the Commonwealth.

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, and this analysis assumes this proposed mandate does not affect Medicare extension/supplement plans even to the extent they are regulated by state law.

The bill, if enacted, would be effective December 31, 2016.

2.2. Scope of EPSDT services and current coverage

H.B. 916 requires insurers to cover “early and periodic screening, diagnosis and treatment (EPSDT) services for children and adolescents under age 21 in a manner equal to the amount, duration and scope of those services provided to Medicaid children and adolescents as required by 42 USC §1396(a)10A, §1396(a)(a)(43), §1396d(a)(4)(B) and §1396d(r).” To understand the effect of this language on fully-insured health policies, it is important to describe the special nature of the EPSDT benefit in the Medicaid program.

EPSDT services

EPSDT is a federally-defined comprehensive program of health care benefits for children, adolescents, and young adults under age 21 enrolled in Medicaid. The U.S. Centers for Medicare and Medicaid Services (CMS) summarizes the program as follows:³

Early:	Assessing and identifying problems early
Periodic:	Checking children's health at periodic, age-appropriate intervals
Screening:	Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
Diagnostic:	Performing diagnostic tests to follow up when a risk is identified
Treatment:	Control, correct or reduce health problems found.

The program comprises preventive, diagnostic, and treatment services including medical, vision, dental, hearing, behavioral, developmental, and other specialty care for all types of acute and chronic conditions. Services must be medical in nature, delivered by a qualified health care provider, and identified as medically necessary.⁴

EPSDT defines a rich set of benefits for children. Screening and diagnostic services are intended to identify behavioral health, developmental, and physical conditions early, so that the child can receive treatment “to correct or ameliorate defects and chronic conditions found.”⁵ While some overlap exists between EPSDT benefits and benefits typically covered by private insurance, the

EPSDT program was designed using a “pediatric standard of care,” and is a more comprehensive benefit, especially in treatment services.⁶ According to CMS, “[n]ecessary health care services must be made available for treatment of all physical and mental illnesses or conditions discovered by any screening and diagnostic procedures.”⁷ EPSDT “...expanded Medicaid’s role beyond treatment of illness to include promoting childhood growth and development.”⁸

All services covered by Medicaid, regardless of restrictions that apply to adult beneficiaries, must be covered for enrolled children when medically necessary; this includes federally-defined mandatory services, as well as services provided at the option of the states.⁹ In other words, even if a state does not include a given optional service in its adult benefit program, this service must still be covered for children if medically necessary.

Additional services may be provided to MassHealth recipients that are not required under federal EPSDT service guidelines, such as the state’s Pediatric Asthma Pilot Program. Coverage for these additional services would not be required under the proposed mandate for commercial insurance beneficiaries.¹⁰

EPSDT and medical necessity

One key difference between Medicaid EPSDT benefits and commercial insurance lies in their respective definitions of medical necessity.¹¹ In the commercial sector, according to the American College of Medical Quality, “[m]edical necessity is defined as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.”¹² Services are generally intended to restore an individual to a level of functioning present prior to an acute episode, illness, or injury. In general, commercial insurers apply medical necessity criteria they define, rather than criteria defined by the federal government as in the EPSDT program.¹³

In contrast, medical need under EPSDT is tied to a child’s development; services are intended to help a child avoid functional deterioration and to promote development regardless of condition or disability.¹⁴ The U.S. statutes cited by H.B. 916 include the federal medical necessity guidelines applied to the EPSDT program; therefore, if the bill is enacted, this standard would apply to commercial insurance coverage for children. Understanding the standard in some detail is therefore necessary to assessing the impact of the bill on commercial insurance.

EPSDT focuses specifically on early detection and identification to reduce the impact of any identified condition, with the goal of “early identification and treatment of health conditions that can impede children’s natural growth and development,” in contrast to treatment in response to an acute illness or disorder.¹⁵ Needs identified in children must be treated, regardless of whether the service is specifically included in the state’s Medicaid plan.¹⁶ The definition of medical necessity is governed by Medicaid standards, which, compared to commercial insurance standards, give relatively more weight to the provider than to the payer in applying that definition.^{17,18} One review describes EPSDT’s scope as:

[U]ncommonly sweeping, not only in its primary preventive coverage ... but also in the degree to which its terms encompass all medically necessary treatments and services falling within any of

Medicaid's dozens of enumerated benefit classes, regardless of whether coverage would be available under a state Medicaid plan in the case of individuals aged ≥ 21 . Moreover, because EPSDT's purpose is early and preventive, courts have interpreted its provisions to encompass not only treatments that improve health, but also treatments that enable children with disabilities to attain and maintain maximum developmental health. As a result, the EPSDT benefit bars limitations and exclusions used by commercial insurers to exclude otherwise-covered treatments that promote the health of children with chronic and serious physical and mental health conditions that delay development.¹⁹

Current coverage

In responses to a survey of eight of the largest insurance carriers in Massachusetts, most carriers reported that coverage for pediatric medical screening and most diagnostic testing services would not change significantly under the proposed mandate, as all follow the federal Affordable Care Act (ACA)²⁰ provisions requiring coverage for certain preventive services receiving an "A" or "B" grade recommendation by the U.S. Preventive Services Task Force (USPSTF).²¹ However, vision, dental, and non-newborn hearing screenings are currently not covered by all carriers but would be required under the proposed mandate.

Distinctions between EPSDT and current commercial coverage begin to broaden when the focus turns beyond screening to treatment services. Some insurers end coverage for pediatric services at age 18; this mandate requires coverage until age 21. H.B. 916 would require coverage for certain categories of EPSDT services currently not covered by commercial insurers, including, for example, eyewear, dental, and transportation services. Many carriers specifically stated that services for chronic or long-term physical and behavioral health issues would be significantly expanded under the proposed mandate.

As noted above, the U.S. statutes cited by H.B. 916 encompass the medical necessity guidelines applied to the EPSDT program. Therefore, if the bill is enacted, carriers would need to modify not only the services they currently cover and remove many current limits, but also modify medical necessity/utilization review standards to meet the EPSDT criteria.

Furthermore, within categories of service that carriers typically do cover, current commercial benefit plans "typically include cost sharing, limitations and exclusions... [and] cover certain services only on a short term basis."²² Most also require pre-authorization and/or utilization review for certain services. The federal statutes cited in H.B. 916 do not address cost-sharing requirements, nor does any other part of the bill. Therefore this analysis assumes that while the bill addresses the services that commercial insurers must cover, and the medical necessity criteria that apply, it does not alter the cost-sharing arrangements in commercial policies or require commercial insurers to replicate Medicaid's (typically minimal) cost sharing. Thus, H.B. 916 would remove most if not all of the service quantity limits insurers could impose and limit their ability to deny services as medically unnecessary, but continue to allow them to impose cost sharing.

2.3. Existing laws affecting the net cost of H.B. 916

The services for which H.B. 916 mandates coverage overlap to some degree with services already required under state or federal law. Massachusetts has in place mandates requiring insurers to cover a diverse set of services. Many (approximately 25) of these require coverage for services that

may pertain to children and adolescents, and may thus overlap with the proposed EPSDT mandate. Appendix B lists these mandates.

The ACA requires coverage for certain preventive health services, with no cost sharing, by all health insurance plans.^{23,24} Plans must cover, at a minimum, evidence-based preventive health services or items with an “A” or “B” rating in the recommendations of the United States Preventive Services Task Force (USPSTF) with no deductible, copayment, or coinsurance payments by the beneficiary. The USPSTF currently lists 18 screening, counseling and/or preventive medication guidelines for children and adolescents with an “A” or “B” rating.²⁵ Appendix C summarizes these services. The ACA also requires that individual and small group health plans sold both on and off the ACA-created marketplace (exchange) cover Essential Health Benefits (EHB’s) including pediatric dental and pediatric vision services.

2.4. Summary of interpretation of H.B. 916

Requiring fully-insured commercial policies to cover the EPSDT benefit would make the following changes to existing commercial health insurance coverage for children:

- Expand coverage significantly to include all services allowed under federal Medicaid guidelines, both required and state-optional services (though not those added by the Commonwealth for which federal matching is not available), which includes services designed to enhance and promote development, as well as long-term services for chronic physical and behavioral issues
- Eliminate caps and limits on utilization of all services
- Incorporate the Medicaid EPSDT standards for medical necessity, thereby reducing carriers’ discretion in setting and applying such standards

These requirements represent a substantial increase in coverage for children in fully-insured commercial policies. The proposed mandate does not, however, prohibit carriers from applying cost sharing to these services.

H.B. 916 would require coverage for services that overlap to some degree with those required under existing Massachusetts mandates and/or federal law, particularly the ACA. The ACA requires coverage for certain preventive health services by all health insurance plans and requires individual and small group health plans to cover pediatric dental and vision services.

H.B. 916 as drafted defines the mandated services by referencing the federal EPSDT statutes, but without further specification. This analysis, based on an understanding of the sponsor’s intent gathered through interviews, and on available scholarly writings and legal cases interpreting the federal statutes governing EPSDT, assumes insurers will be required to cover the full set of services in the federal statutes, including services they generally do not cover currently such as private duty nursing and community-supported living arrangement services, as well as services they currently cover. As noted, this analysis also assumes that, because case law includes in EPSDT all Medicaid services provided to children, the treatment standard for all children’s services must approximate the federal EPSDT standard. This analysis might include in the Medicaid/MassHealth base some

services ultimately not in the scope of the mandated services. If H.B. 916 were to be enacted, the Massachusetts insurance regulation process would refine the set of services insurers must cover and/or the care standard they must apply; however, using the MassHealth service and care standards as a starting point enables the analysis to reach a reasonable estimate based on a known standard.

3. Methodology

3.1. Overview

As described above, H.B. 916 requires commercial payers to expand their coverage of services for children to match the rich benefit set of the EPSDT program. Given the broad nature of the EPSDT benefit, separately estimating the cost of expanding coverage for each relevant service category – home care, various therapies, habilitative services, etc. – would be impractical in the timeframe for conducting this mandate analysis. Instead, this analysis employs a “top-down” approach, comparing the total per-child medical expense for children covered by commercial carriers to the medical expense for children covered under Medicaid.

A top-down approach is possible because of the comprehensive nature of the EPSDT benefit. EPSDT requires state Medicaid programs to cover care for the full set of a child’s health needs, providing all benefits required in the federal statutes and applying the medical necessity criteria described above;²⁶ essentially, all benefits that Medicaid provides for children are part of that EPSDT requirement. H.B. 916 therefore makes available to commercially-insured children the entire Medicaid benefit package, significantly broadening benefits available to the commercial population.

To estimate the cost of expanding commercial coverage to meet the EPSDT standard, the fundamental approach of this analysis is to assume commercial coverage for children after implementation of the bill would approximate the current Medicaid spending under the EPSDT benefit. Therefore the incremental cost of the mandate is calculated by subtracting the current per-child cost of children in commercial coverage from the per-child medical expense MassHealth incurs in providing the rich set of EPSDT benefits. However, for that subtraction to produce a valid estimate of the incremental cost of the bill, this analysis adjusts for four important differences in the two populations and benefit sets, described in further detail in Section 4:

1. *Average morbidity level:* Given the demographic characteristics of the Medicaid-eligible population, children with Medicaid coverage present, on average, more, and more severe, illnesses and conditions than do commercially-insured children. (This is often expressed as saying the commercial population has a lower “morbidity” or lower “risk”.) This analysis cannot assume commercially-insured children will consume services at the same rate as children under Medicaid, and therefore it adjusts the per-child Medicaid cost, and consequently the incremental impact of the bill, downward by a risk adjustment factor.

2. *Difference in provider reimbursement rates:* On average, commercial insurers pay higher reimbursement rates than does MassHealth. This requires adjusting the Medicaid per-child cost, and the incremental impact of the bill, upward by a provider reimbursement differential factor.
3. *Difference in patient cost sharing:* If H.B. 916 requires commercial insurers to cover more services, the insurers will not bear the full expense because they have cost-sharing arrangements in many of their benefit plans; such cost sharing is not required of Medicaid recipients. This reduces the incremental cost of the bill that would be reflected in premiums, so an adjustment is made to remove these costs. In addition, the presence of cost sharing will dampen utilization in the commercial population, further reducing the incremental cost of the bill.
4. *Impact of ACA on required services in commercial insurance:* The incremental cost of the bill must not include the cost of services already required by other state or federal mandates. Therefore, vision and dental benefit expansion costs attributable to the ACA must not be attributed to H.B. 916 in our analysis. The period from which the analysis draws medical expense data does not reflect the full effect of the federal ACA, but the projection period for the analysis is after the ACA implementation. Because of limitations in the vision and dental benefits data, the calculations through item #3 above are made with medical and pharmacy benefit costs only, and a separate calculation is made for the impact of vision and dental benefits. The end result of this approach avoids attributing ACA-required benefit expansions to the bill.

After making these adjustments to MassHealth spending, the resulting per-child spending amount is an estimate of commercial EPSDT per-child spending. Subtracting the current per-child spending under commercial insurance from the estimated commercial EPSDT per-child spending then yields an estimate of the incremental impact of H.B. 916.

3.2. Steps in the analysis

The general approach outlined above was executed in the following steps.

- Medicaid claims cost per child: Using publically-available sources estimate the Massachusetts Medicaid population under age 21 and its per-child per-month (PCPM) claim cost for medical and pharmacy benefits.
- Morbidity adjustment: Using the APCD and the Chronic Illness and Disability Payment System (CDPS), estimate the difference in morbidity between the Medicaid and commercial populations. Using this difference, adjust the estimated Medicaid PCPM expense downward for the lower morbidity in the commercial population.
- Provider payment rate adjustment: Using publically-available sources and the APCD, estimate the difference in average reimbursement rates between the Medicaid and commercial populations. Adjust the risk-adjusted estimated Medicaid PCPM expense for the higher reimbursement rates in the commercial population.

- Adjustment for cost sharing in commercial coverage: Estimate two cost reductions related to the presence of cost sharing in commercial coverage. First, reduce the risk-and-payment-rate-adjusted Medicaid PCPM costs by adjusting for cost-sharing amounts that won't be paid by commercial carriers. Second, reduce the result further by adjusting for the reduction in utilization likely to occur when commercially-insured patients face cost sharing.
- Adjustment for the implementation of the ACA: The ACA mandates dental and vision coverage for individual and small-group policies, so those services do not contribute to the incremental cost of this mandate; in contrast, large-group dental and vision benefits are incremental. Estimate this incremental cost by using the APCD and publically-available sources. Add the large-group dental and vision PCPM cost to the PCPM medical and pharmacy cost, yielding the 2012 estimated commercial EPSDT PCPM.
- Commercial claims cost per child: Using the Massachusetts All Payer Claims Database (APCD), estimate the 2012 commercial fully-insured Massachusetts population under age 21 and its PCPM claim cost for medical and pharmacy benefits.
- Subtract actual commercial costs from estimated EPSDT benefit commercial costs: Estimate the incremental cost of services covered under the EPSDT benefit by subtracting the 2012 commercial PCPM expense from the 2012 estimated commercial EPSDT PCPM, on which adjustments for morbidity, provider payment rates, cost sharing, and ACA coverage effects have been made as described.
- Retention: Estimate the percentage impact on premiums of insurer's retention (administrative costs and profit) and add to incremental claims cost PCPM.
- Population: Estimate the fully-insured Massachusetts population under age 65, projected for the next five years (2015 to 2019).
- Project five Years: Project the estimated cost forward over the next five years, and calculate the estimated dollar impact by multiplying the incremental PCPM cost projections by the population projections.

Section 4 describes these specific steps in more detail.

3.3. Data sources

The primary data sources used in the analysis were:

- Interviews with advocates for the bill, conducted at the request of the sponsor, about its history
- Information from a survey of private health insurance carriers in Massachusetts
- Academic literature, published reports, and population data, cited as appropriate

- Massachusetts insurer claim data from CHIA’s Massachusetts All-Payer Claim Database (APCD) for calendar years 2009 to 2012, for plans covering the overwhelming majority of the under-65 fully-insured population subject to the proposed mandate²⁷

The more detailed step-by-step description of the estimation process below addresses limitations in some of these sources and the uncertainties they contribute to the cost estimate.

3.4. Limitations

In addition to factors discussed in Section 4 that may introduce uncertainty into the final cost estimate, the following are limitations in the data that affect the precision, though not the overall direction, of the analysis.

- An estimate of the cost of outreach programs directed at families and providers is not included in this analysis. These programs inform families about EPSDT and have improved participation in the program. No data were available to allow an estimate; the magnitude of this cost would likely be small relative to the cost of the rest of the services mandates in the bill.
- As noted in Section 2, additional services may be provided to MassHealth recipients that are not required under federal EPSDT service guidelines, such as the state’s Pediatric Asthma Pilot Program; coverage for these additional services would not be required under the proposed mandate. Isolating these additional services in all Medicaid claim cost sources was not possible; they will slightly overstate the EPSDT incremental cost estimate, but to a very small degree, particularly given the size of the overall incremental cost estimate.

4. Analysis

To estimate the impact of the proposed legislation, the calculations outlined in the previous section were executed. This section describes the actual calculations in detail. The analysis includes development of a best estimate “mid-level” scenario, as well as a low-level scenario using assumptions that produced a lower estimate, and a high-level scenario using more conservative assumptions that produced a higher estimated impact.

4.1. Estimated Medicaid claim cost

While commercial cost data in this analysis came from the APCD, Medicaid expense data in that database were incomplete, and instead this analysis used two public sources of data to develop the Medicaid per-child per-month (PCPM) claim expense:

- Annual claim costs for July 2012 through June 2013 for Massachusetts Medicaid children from a study by the University of Massachusetts Medical School Center for Health Law and Economics²⁸

- The Center for Medicare and Medicaid Services Medicaid Statistical Information System (MSIS) database,²⁹ in which 2011 data were the most recent for Massachusetts

Given that resolving differences, including the time periods studied, between the sources was necessary, the calculations led to a range of results. The two sources provided low- and high-end cost estimates, and the average of the two provided a mid-range estimate.

The estimate of the Medicaid PCPM claim cost for children ages zero to 20 drew on the UMass MassHealth study, which contains annual costs for non-disabled and disabled children, and on a member distribution provided in the study, from which a weighted average PCPM cost was estimated, shown in Table 1. Because this number was offset from calendar year 2012 by six months, the \$351.29 PCPM cost was trended back six months using an historical trend rate of 1.1% per year, yielding a \$349.37 PCPM cost for the calendar year.³⁰ This PCPM cost was used as a low-end estimate of the 2012 Medicaid expense.

**Table 1:
Medicaid PCPM Claim Costs**

	<u>PCPY</u>	<u>PCPM</u>	<u>Members</u>	<u>Distribution</u>
Children	\$3,590	\$299.17	527,623	94.3%
Disabled Children	<u>\$14,617</u>	<u>\$1,218.08</u>	<u>31,726</u>	<u>5.7%</u>
All Children	\$4,215	\$351.29	559,349	100.0%

A second source, 2011 data from the MSIS database,³¹ was also used to estimate a PCPM cost for the Medical population. From MSIS a 2011 Medicaid PCPM cost of \$367.15 was estimated and the result was trended to 2012, using the actual -1.0% annual trend for that period, yielding \$363.48 PCPM.³² This was used as a high-end estimate of 2012 expense and the average of the two sources, \$356.43 PCPM, was used as a mid-range estimate. For reasons discussed in detail in section 4.5, the impact on dental and vision benefit costs was calculated separately, so dental and vision expenses were removed from the PCPM estimates, yielding a low-end estimate of \$325.87, a mid-range estimate of \$332.45, and a high-end estimate of \$339.03.

4.2. Medicaid cost adjusted for morbidity

As noted in the methodology overview, comparing per-child medical costs between Medicaid and commercial populations requires accounting for the difference in the general health of the populations, i.e., it requires adjusting for the relative risk of the two populations. The average morbidity of the commercial population is significantly lower than that of the Medicaid population.

Using the Chronic Illness and Disability Payment System (CDPS + Rx, version 5.4)³³ and data from the APCD, relative morbidity, or case mix, scores were calculated and compared for the Medicaid and commercial populations. The analysis calculated an average population weight for each group, applied the appropriate regression models, and divided the commercial result by the Medicaid result to derive a Medicaid-to-commercial risk reduction factor.³⁴ The resulting estimated morbidity of the commercial population was 42 percent lower than that of the Medicaid population. This means that, because the commercial population is healthier, claim costs for the commercial

population, given equivalent benefit plans and unit pricing, would be approximately 58 percent of Medicaid claim costs.

The CDPS + Rx system uses 2001 to 2002 Medicaid claim data from 44 state Medicaid programs to develop risk scores, or weights, based on observed costs for members with a diagnosis or drug claim within a given category.³⁵ Weights are also assigned to gender and age groupings to control for differences in demographic profiles between covered populations. (E.g., claim costs are high in the first year of life; therefore, a population with more recent births would probably be more expensive than an otherwise similar population.)

Drawing on the two options in the CDPS software, separate regression results were developed for TANF populations and disabled populations. As there was no satisfactory way to determine “TANF” vs. disabled status for members in the commercial population, the CDPS + Rx system was run against the target data twice, once using the TANF weights and once using the disabled weights. The resulting Commercial/Medicaid population relative risk score ratios were very similar at 0.582 and 0.594, respectively. The results were then weighted based on the percentage of Medicaid membership that is disabled, resulting in the mid-range or best estimate of 0.5828 for the Commercial/Medicaid morbidity ratio. Adjusting the 5.7 percent of the children who are disabled by plus or minus 3.5 percent and re-weighting the results yields a low (0.5824) and high (0.5833) estimate for this factor.

4.3. Adjusting for differences in reimbursement rates

The cost of covering a given set of services, such as EPSDT services, for a given population will depend on the per-service rates insurers pay to providers. Commercial payers reimburse providers at rates considerably higher than does Medicaid, requiring an adjustment to Medicaid claim cost to estimate what commercial insurers would pay for those same services.

Many factors influence how commercial payers set rates. New technology, expanded services, competition, payer leverage, bad debt, etc., are all factors. In addition, since Medicare and Medicaid rates do not typically cover a hospital’s cost, the projected shortfall can be shifted to commercial payer rates. A Healthcare Financing and Economics (HCFE) study on the Massachusetts hospital cost shift, published in the Milbank Memorial Fund Journal,³⁶ included historical provider payment-to-cost ratios for public and commercial payers. These ratios for the most recent five-year period show that commercial payers pay hospitals more than Medicaid by a factor between 1.422 and 1.535. Market conditions over the most recent five-year period resemble current conditions, providing a better predictor than would a longer perspective. Several potentially-ongoing factors may be contributing to increases in the ratios. However, how this ratio will change in the future is uncertain due to potential changes in federal policy, market power of hospitals and providers, service offerings, bad debt levels, etc.

A 2012 American Academy of Pediatrics cost model developed in a study by OptumInsight³⁷ was used to adjust for physician reimbursement differences. The cost model compares both commercial

and Medicaid reimbursement rates by state to Medicare reimbursement rates for children up to age 21, showing that commercial insurers pay physicians more than Medicaid by a factor of 1.853.

The APCD was used to adjust for differences in contracted reimbursement rates for pharmacy claims. Drugs commonly used for both the Medicaid and the commercial populations were isolated and studied. The commercial weighted-average unit cost was compared to the weighted-average unit cost for the Medicaid population for 2011 and 2012 claims, showing that commercial payers pay higher unit costs than does Medicaid by a factor between 1.096 and 1.121. Predicting how the relative value of contracted pharmacy reimbursement rates will change over time is difficult. Given the level of uncertainty in this ratio in the future, the range of values was used to develop high- and low-cost estimates. The average of the ratios over the two-year period was used in the development of the mid-level cost estimate.

The hospital, professional, and pharmacy reimbursement adjustments were weighted to get an overall reimbursement adjustment factor. Given the uncertainty in future hospital cost shifting and the range in results for the pharmacy cost factors, three scenarios were used. The low scenario represents the lowest historical reimbursement rate ratio, the high scenario represents the highest historical ratio, and the middle scenario represents the average ratio over the study periods for the hospital and pharmacy payment rates. The resulting range of values for the overall reimbursement adjustment factor is 1.590 to 1.639.

4.4. Effect of cost sharing on per-service paid amount and utilization

While MassHealth generally does not allow cost sharing, H.B. 916 does not preclude commercial carriers from imposing cost sharing, and this analysis assumes they will apply to an expanded EPSDT benefit the same cost sharing they apply to other commercial benefits. The presence of cost sharing requires adjusting the Medicaid numbers for two reductions in commercial carrier expenditures.

- First is a coverage effect: cost sharing will reduce the amount the carrier pays for a service, for example, a \$10 co-pay on a \$100 service reduces the carrier's outlay to \$90.
- Second is a utilization effect: the presence of cost sharing will somewhat reduce services delivered compared to those delivered in an environment with no cost sharing, as covered individuals will forego some services when cost sharing is required.

Allowed claim costs are costs before member cost sharing, and paid claim costs are costs after member cost sharing. To estimate the coverage effect of cost sharing, the risk-adjusted PCPM Medicaid cost was reduced to account for cost sharing in the commercial market. Paid-to-allowed ratios were calculated by dividing paid claim costs by allowed claim costs for the commercial population from the APCD. This ratio quantifies the average impact of commercial cost sharing. For each scenario, the estimated PCPM cost of services covered under EPSDT is multiplied by the commercial paid-to-allowed ratio, which lowers the claim costs by a factor of 0.842.

To adjust for the utilization effect of cost sharing, Medicaid PCPM claim costs were reduced by applying a factor of 0.9055. This factor was derived from a table published in a Department of

Health and Human Services (HHS) final rule for the ACA benefit and payment parameters.³⁸ The rule included a benefit utilization table developed for ACA filings specific to Massachusetts; its purpose is to provide carriers a standard utilization adjustment to be used in developing rates for ACA plans with subsidized cost sharing. Developing a factor to apply in this analysis required comparing the adjustment in the table for a plan with the average cost sharing present in the commercial market with the adjustment for a plan with the average cost sharing found in Medicaid. For each scenario the estimated PCPM cost of Medicaid services is multiplied by the utilization adjustment factor which lowers the claim costs by 9.045 percent (i.e., applying a factor of 0.9055).

Table 2 shows the combined effect of adjustments for morbidity, payment levels, and cost sharing on medical and pharmacy benefits. The adjusted PCPM cost represents the “EPSDT commercial insurance benefits” for children’s medical and pharmacy coverage.

**Table 2:
Adjusted Medicaid PCPM Costs**

	Medicaid PCPM	Provider Reimbursement Ratios	Morbidity Ratios	Paid to Allowed Ratio	Utilization Ratios	Adjusted PCPM
Low Scenario	\$325.87	1.590	0.5824	0.842	0.9055	\$230.18
Mid Scenario	\$332.45	1.614	0.5828	0.842	0.9055	\$238.55
High Scenario	\$339.03	1.639	0.5833	0.842	0.9055	\$247.23

A separate calculation, addressed in the next section, was required to estimate the EPSDT commercial benefits for vision and dental.

4.5. Impact of the Affordable Care Act implementation

H.B. 916 mandates coverage for the dental and vision services included in EPSDT. The calculations described above included data for medical and pharmacy benefits. However, implementation of the ACA in January 2014 already required vision and dental benefits for small-group and individual policies, and the only potential impact of the bill on these benefits is for large group insurance. Furthermore, because some large-group plans already have these benefits, the bill would affect only the large-group plans without dental and vision benefits.

Using the APCD, PCPM vision claim costs were estimated for the Medicaid population; using the MSIS system, PCPM dental claim costs were estimated for the Medicaid population. The costs were adjusted for differences between Medicaid and commercial populations in morbidity, provider reimbursement rates, and cost sharing, following steps parallel to those described in sections 4.2 to 4.4 for medical and pharmacy benefits; for purposes of this analysis the scope of dental and vision services covered under commercial insurance were assumed equivalent to that under Medicaid.

To adjust for those large-group plans that already have dental and vision coverage, dental and vision claim costs were prorated first based on the portion of the fully-insured market in the large-group category, and second on the portion of the large-group market that currently does not have dental or vision coverage. The APCD was used to determine the portion of the large group market

that currently covers vision. A study published by the Center for Disease Control (CDC)³⁹ was used to determine the portion of the large group market that currently covers dental; it indicates that 73 percent of commercially-insured people under the age of 65 have dental coverage. Using an MSIS member distribution by age and assuming that children 5 and under do not have dental coverage, this analysis estimated that 53.4 percent of children have dental coverage, which means that 46.6 percent of the children in the commercial market do not have dental coverage. Table 3 illustrates the calculations to prorate the dental and vision expenses.

**Table 3:
Pro Rated Large Group Dental and Vision Allowed PCPM Costs**

	Dental PCPM	Vision PCPM
2012 Allowed Expense	\$24.05	\$0.40
X Morbidity Adjustment	0.5828	0.5828
X Reimbursement Rate Adjustment	1.614	1.614
X Paid to Allowed Ratio	0.842	0.842
X Utilization Adjustment	<u>0.9055</u>	<u>0.0955</u>
= Adjusted Paid Expense	\$17.26	\$0.29
X LG Portion of the FI Market	<u>61.4%</u>	<u>61.4%</u>
= Expense Pro Rated for LG	\$10.59	\$0.18
X Portion without Dental or Vision	<u>46.6%</u>	<u>100.0%</u>
= Prorated for LG without Dental or Vision	\$4.94	\$0.18

The prorated dental and vision claim expense resulted in a dental PCPM cost of \$4.94 and a vision PCPM cost of \$0.18. These amounts were added to the adjusted Medicaid PCPM costs to reflect the impact of mandating large-group dental and vision benefits. Table 4 shows the results of adding the pro-rated large-group dental and vision PCPM costs to the adjusted medical and pharmacy PCPM costs from Table 2.

**Table 4:
Incremental EPSDT Allowed PCPM Costs**

	Adjusted Medicaid PCPM	Plus Dental & Vision PCPM	Total Adjusted PCPM
Low Scenario	\$230.18	\$5.11	\$235.30
Mid Scenario	\$238.55	\$5.11	\$243.67
High Scenario	\$247.23	\$5.11	\$252.34

The Total column in Table 4 represents the estimated cost that would have been incurred in 2012 if the EPSDT benefits required by H.B. 916 had been in place. This number must then be compared to the actual commercial insurance costs in 2012, discussed next.

4.6. Estimated commercial fully-insured claim cost

Using 2012 commercial data for fully-insured children ages zero to 20 from the Massachusetts APCD (drawn from the three largest carriers since pharmacy claim data were limited for other carriers), the analysis estimated a per-child per-month (PCPM) claim cost by dividing paid claim cost, excluding dental and vision claims, by the number of children (expressed in member-months), yielding \$222.26 PCPM.

4.7. Incremental cost calculation

After estimating the total cost that would have been incurred if the EPSDT benefit had been required for children in 2012 (section 4.5) and the actual commercial cost for children in 2012 (Section 4.6), the actual commercial cost is subtracted from the estimated EPSDT-loaded commercial cost to estimate the incremental impact of H.B. 916. Table 5 shows the incremental PCPM EPSDT cost. In addition, to arrive at the per-member per-month (PMPM) claim cost across all commercial members, the PCPM cost was multiplied by the number of children and divided by the number of all members (adult and child). Table 5 also displays the incremental PMPM claim cost.

**Table 5:
Estimated Increase in Carrier Medical Expense PMPM**

	Adjusted Medicaid PCPM	Commercial PCPM	Incremental EPSDT Cost	Number of Children	Members	PMPM
Low Scenario	\$235.30	\$222.26	\$13.03	645,517	2,311,392	\$3.64
Mid Scenario	\$243.67	\$222.26	\$21.40	645,517	2,311,392	\$5.98
High Scenario	\$252.34	\$222.26	\$30.08	645,517	2,311,392	\$8.40

4.8. Retention

Assuming an average retention rate of 11.5 percent, based on CHIA's analysis of administrative costs and profit in Massachusetts,⁴⁰ the increase in medical expense from Table 5 was adjusted upward to account for carrier administrative costs and profit and approximate the full impact on premiums. Table 6 shows the result of this calculation.

**Table 6:
Estimate of Increase in Carrier Premium PMPM**

Low Scenario	\$4.11
Mid Scenario	\$6.75
High Scenario	\$9.49

4.9. Projected fully-insured population in Massachusetts, ages 0-64

Projecting costs over a five-year timeframe requires estimating the total fully-insured commercial population in Massachusetts for the period 2015-2019. Table 7 shows the projection; Appendix A describes the sources of these values.

**Table 7:
Projected fully-insured population in Massachusetts, Ages 0-64**

<u>Year</u>	<u>Total (0-64)</u>
2015	2,144,066
2016	2,120,558
2017	2,096,250
2018	2,071,138
2019	2,045,433

Projecting the five-year cost impact of the bill requires, in addition to the membership projection, a projection of the 2012 baseline PMPM cost forward to the same 2015-2019 period, discussed next.

4.10. Projection

The results, calculated on a calendar year 2012 basis, were projected forward to the five-year projection window of 2015 to 2019. The 2012 estimates were adjusted assuming an annual medical inflation rate of 4.5 percent, producing the results in section 5 below.

5. Results

5.1. Five-year estimated impact

For each year in the five-year analysis period, Table 8 displays the projected net impact of the proposed mandate on medical expense and premiums using a projection of Massachusetts fully-insured membership. Note that H.B. 916 is effective at the end of 2016; therefore the impact before then is zero.

This analysis estimates that the mandate, if enacted, would increase fully-insured premiums by as much as 2.1 percent on average over the three years following the effective date; a more likely increase is in the range of 1.5 percent.

The impact of the bill 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 mandate. In particular, it is possible that in setting premiums, insurers would spread the cost of the bill only across family plans (as opposed to individual plans, which are purchased almost exclusively by adults); in that case family plan premiums would increase by a larger percentage than the overall market estimate of 0.91 to 2.1 percent while individual plan premiums would be relatively unaffected.

The most-likely premium increase totals \$220 million per year across all affected plans. In addition, because many plans have deductibles and other cost-sharing provisions, members and families who benefit from this increased coverage would likely pay, as a group, approximately \$36 million out-of-pocket. The net impact on household expenditures would depend on the extent to which they are currently paying for these services without the aid of insurance.

**Table 8:
Summary Results**

	2015	2016	2017	2018	2019	3-yr Average	3-Yr Total
Members (000s)	2,144	2,121	2,096	2,071	2,045		
Medical Expense Low (\$000s)	\$0	\$0	\$114,543	\$118,630	\$122,941	\$118,705	\$356,114
Medical Expense Mid (\$000s)	\$0	\$0	\$188,093	\$194,805	\$201,884	\$194,927	\$584,782
Medical Expense High (\$000s)	\$0	\$0	\$264,311	\$273,742	\$283,690	\$273,914	\$821,743
Premium Low (\$000s)	\$0	\$0	\$129,427	\$134,045	\$138,916	\$134,129	\$402,388
Premium Mid (\$000s)	\$0	\$0	\$212,535	\$220,119	\$228,118	\$220,257	\$660,771
Premium High (\$000s)	\$0	\$0	\$298,656	\$309,313	\$320,554	\$309,508	\$928,523
PMPM Low	\$0.00	\$0.00	\$5.15	\$5.39	\$5.66	\$5.40	\$5.40
PMPM Mid	\$0.00	\$0.00	\$8.45	\$8.86	\$9.29	\$8.86	\$8.86
PMPM High	\$0.00	\$0.00	\$11.87	\$12.45	\$13.06	\$12.45	\$12.45
Estimated Monthly Premium	\$512	\$537	\$564	\$592	\$622	\$566	\$566
Premium % Rise Low	0.00%	0.00%	0.91%	0.91%	0.91%	0.91%	0.91%
Premium % Rise Mid	0.00%	0.00%	1.50%	1.50%	1.49%	1.50%	1.50%
Premium % Rise High	0.00%	0.00%	2.10%	2.10%	2.10%	2.10%	2.10%

5.2. Impact on the GIC

Because the benefit offerings of GIC for children under age 21 plans are similar to those of most other commercial plans in Massachusetts, the estimated effect of the proposed mandate on GIC coverage is not expected to differ from that estimated for the fully-insured plans. Note that the total medical expense and premium numbers displayed in Table 8 include the GIC fully-insured membership. To estimate the medical expense separately for the self-insured portion of the GIC, the medical expense per member per month was applied to the GIC self-insured membership. Table 9 displays the results.

**Table 9:
GIC Self-Insured Summary Results**

	2015	2016	2017	2018	2019	3-Yr Average	3-Yr Total
Members (000s)	259	259	259	258	258		
Medical Expense Low (\$000s)	\$0	\$0	\$1,178	\$1,233	\$1,292	\$1,234	\$3,703
Medical Expense Mid (\$000s)	\$0	\$0	\$1,935	\$2,025	\$2,122	\$2,027	\$6,081
Medical Expense High (\$000s)	\$0	\$0	\$2,719	\$2,846	\$2,981	\$2,848	\$8,545

Appendix A: Membership Affected by the Proposed Mandate

Membership potentially affected by a proposed mandate may include Massachusetts residents with fully-insured employer-sponsored health insurance (including through the GIC), non-residents with fully-insured employer-sponsored insurance issued in Massachusetts, Massachusetts residents with individual (direct) health insurance coverage, and, in some cases, lives covered by GIC self-insured coverage. Membership projections for 2015 – 2019 are derived from the following sources.

Total Massachusetts population estimates for 2012 and 2013 from U. S. Census Bureau data⁴¹ form the base for the projections. Distributions by gender and age, also from Census Bureau,⁴² were applied to these totals. Projected growth rates for each gender/age category were estimated from Census Bureau population projections to 2030.⁴³ The resulting growth rates were then applied to the base amounts to project the total Massachusetts population for 2015 to 2019.

The number of Massachusetts residents with employer-sponsored or individual (direct) health insurance coverage was estimated using Census Bureau data on health insurance coverage status and type of coverage⁴⁴ applied to the population projections.

To estimate the number of Massachusetts residents with fully-insured employer-sponsored coverage, projected estimates of the percentage of employer-based coverage that is fully-insured were developed using historical data from the Medical Expenditure Panel Survey Insurance Component Tables.⁴⁵

To estimate the number of non-residents covered by a Massachusetts policy – typically cases in which a non-resident works for a Massachusetts employer offering employer-sponsored coverage – the number of lives with fully-insured employer-sponsored coverage was increased by the ratio of the total number of individual tax returns filed in Massachusetts by residents⁴⁶ and non-residents⁴⁷ to the total number of individual tax returns filed in Massachusetts by residents.

The number of residents with individual (direct) coverage was adjusted further to remove the estimated number of people previously covered by Commonwealth Care who will shift into MassHealth due to expanded Medicaid eligibility under the Affordable Care Act.⁴⁸

Projections for the GIC self-insured lives were developed using GIC base data for 2012⁴⁹ and 2013⁵⁰ and the same projected growth rates from the Census Bureau that were used for the Massachusetts population. Breakdowns of the GIC self-insured lives by gender and age were based on the Census Bureau distributions.

Appendix B: Massachusetts Mandated Insurance Benefits for Services for Childrenⁱ

	Title XXII				Title IV	
	c. 175	c. 176A	c. 176B	c. 176G	c. 176I	c. 32A
Autism spectrum disorders and treatment	§47AA	§8DD	§4DD	§4V		§25
Chiropractic services	§108D		§4L			
Cleft-lip and cleft-palate	§47BB	§8EE		§4W	§12	§17J
Clinical trials for treatment of cancer	§110L	§8X	§4X	§4P		
Contraceptive services	§47W	§8W	§4W	§4O		
Cytological screening	§47G	§8J	§4I			
Diabetes-related services and supplies	§47N	§8P	§4S	§4H		§17G
Early intervention services	§47C	§8B	§4C	§4		
Hearing aids for children	§47X	§8Y	§4EE	§4N		
Hearing screening for newborns	§47C	§8B	§4C	§4K		§17F
Home health care	§110	§8I		§4O		
Hospice care	§47S	§8R	§4Q	§4L		§17B
Human leukocyte antigen testing	§47V	§8V	§4V	§4Q		§17H
Lead poisoning screening	§47B	§8B	§4C			
Low protein foods	§47I	§8L	§4K	§4D		
Maternity care	§47W	§8W	§4W	§4O		
Mental health care	§47B	§8A	§4A	§4M		§22
Nonprescription enteral formulas	§47I	§8L	§4K	§4D		§17A
Off-label use of prescription drugs to treat cancer	§47K	§8N	§4N	§4E		
Off-label use of prescription drugs to treat HIV/AIDS	§47O	§8Q	§4P	§4G		
Orally administered anticancer medications	§47DD	§8FF	§4FF	§4X		§17K
Preventive care for children up to age 6	§47W	§8W	§4W	§4O		
Prosthetic devices	§47Z	§8AA	§4AA	§4S		§17I
Speech, hearing and language disorders	§47X	§8Y	§4Y	§4N		§23
Scalp hair prosthesis	§47T	§8T	§4R	§4J		§17E

ⁱ Massachusetts General Laws. Accessed 17 June 2014: <https://malegislature.gov/Laws/GeneralLaws/Search>.

Appendix C: USPSTF Child and Adolescent Recommendations, Grades “A” and “B”ⁱⁱ

1. Cervical cancer screening: Grade: A Recommendation. The U.S. Preventive Services Task Force (USPSTF) recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.
2. Skin cancer counseling: Grade: B Recommendation. The USPSTF recommends counseling children, adolescents, and young adults aged 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
3. Chlamydial infection screening:
 - a. Grade: A Recommendation. The USPSTF recommends screening for chlamydial infection in all sexually active, nonpregnant young women ages 24 and younger and in older nonpregnant women who are at increased risk.
 - b. Grade: B Recommendation. The USPSTF recommends screening for chlamydial infection in all pregnant women ages 24 and younger and in older pregnant women who are at increased risk.
4. Gonococcal ophthalmia neonatorum preventive medication: Grade: A Recommendation. The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.
5. Hepatitis B virus infection in nonpregnant adolescents and adults screening: Grade: B Recommendation. The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.
6. Human Immunodeficiency Virus (HIV) screening:
 - a. Grade: A Recommendation. The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.
 - b. Grade: A Recommendation. The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.
7. Sexually Transmitted Infections counseling: Grade: B Recommendation. The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.

ⁱⁱ U.S. Preventive Services Task Force (USPSTF). Child and Adolescent Recommendations. Updated May 2014; accessed 17 June 2014: <http://www.uspreventiveservicestaskforce.org/tfchildcat.htm>.

8. Alcohol misuse screening and counseling: Grade: B Recommendation. The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse.
9. Depression in children and adolescents screening: Grade: B recommendation. The USPSTF recommends screening for major depressive disorder (MDD) in adolescents (ages 12 to 18 years) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.
10. Smoking (Tobacco use) interventions: Grade: B Recommendation. The USPSTF recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
11. Dental caries in children from birth through age 5 years screening:
 - a. Grade: B recommendation. The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is deficient in fluoride.
 - b. Grade: B recommendation. The USPSTF recommends that primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption.
12. Iron deficiency anemia screening: Grade: B Recommendation. The USPSTF recommends routine iron supplementation for asymptomatic children ages 6 to 12 months who are at increased risk for iron deficiency anemia.
13. Obesity in children and adolescents screening: Grade: B recommendation. The USPSTF recommends that clinicians screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
14. Hypothyroidism, congenital screening: Grade: A Recommendation. The USPSTF recommends screening for congenital hypothyroidism (CH) in newborns.
15. Phenylketonuria screening: Grade: A Recommendation. The USPSTF recommends screening for phenylketonuria (PKU) in newborns.
16. Sickle cell disease screening: Grade: A Recommendation. The U.S. Preventive Services Task Force (USPSTF) recommends screening for sickle cell disease in newborns.
17. Hearing loss, newborn screening: Grade: B Recommendation. The USPSTF recommends screening for hearing loss in all newborn infants.
18. Visual impairment in children ages 1-5 screening: Grade: B Recommendation. The USPSTF recommends vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.

Endnotes

¹ The 188th General Court of the Commonwealth of Massachusetts. Bill H. 916: An Act to provide early and periodic screening, diagnosis and treatment to privately insured children under the age of 21. Accessed 10 April 2014: <https://malegislature.gov/Bills/188/House/H916>. Specifically, the mandate cites: 42 U.S.C. §§ 1396a(a)(10); 1396a(a)(43); 1396d(a)(4)(B); 1396d(r). Details can be found at 42 U.S.C. 1396A - STATE PLANS FOR MEDICAL ASSISTANCE. Accessed 6 May 2014:

<http://www.gpo.gov/fdsys/search/pagedetails.action?st=citation%3A42+USC+60&granuleId=USCODE-2010-title42-chap7-subchapXIX-sec1396a&packageId=USCODE-2010-title42&bread=true>.

² Section 6 of the bill does not extend the effective reach of the bill since the preceding five sections address the full set of commercial insurance licenses.

³ Medicaid.gov: Early and Periodic Screening, Diagnostic and Treatment. Accessed 11 April 2014:

<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html>.

⁴ National Academy for State Health Care Policy. Public Insurance Programs and Children with Special Health Care Needs: A Tutorial on the Basics of Medicaid and The Children's Health Insurance Program (CHIP). February 2012; accessed 16 June 2014: http://www.nashp.org/sites/default/files/Medicaid_101_tutorial.pdf.

⁵ 42 C.F.R. § 441.50 Subpart B—Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of Individuals Under Age 21: Basis and purpose. Accessed 6 May 2014: <http://www.ecfr.gov/cgi-bin/text-idx?rgn=div6&node=42:4.0.1.1.10.2>.

⁶ Goldstein MM, Rosenbaum S. From EPSDT to EHBs: the future of pediatric coverage design under government financed health insurance. *Pediatrics*. 2013 Apr;131 Suppl 2:S142-8. doi: 10.1542/peds.2013-0252e. Accessed 6 May 2014: http://pediatrics.aappublications.org/content/131/Supplement_2/S142.

⁷ *Op. cit.* Medicaid.gov: Early and Periodic Screening, Diagnostic and Treatment.

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⁹ *Ibid.*

¹⁰ Massachusetts Medicaid Policy Institute. Summary of Key New Provisions in the 1115 MassHealth Waiver Renewal. Released 10 January 2012; accessed 29 September 2014:

<http://bluecrossmafoundation.org/sites/default/files/MMPI%201115%20waiver%20renewal%20summary%20FINAL.pdf>.

¹¹ EPSDT applies the concept of medical necessity broadly:

While there is no federal definition of preventive medical necessity, federal amount, duration and scope rules require that coverage limits must be sufficient to ensure that the purpose of a benefit can be reasonably achieved.... Since the purpose of EPSDT is to prevent the onset of [sic] worsening of disability and illness and children, the standard of coverage is necessarily broad... [T]he standard of medical necessity used by a state must be one that ensures a sufficient level of coverage to not merely treat an already-existing illness or injury but also, to prevent the development or worsening of conditions, illnesses, and disabilities.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health (USDHHS-HRSA-MCH): EPSDT Overview, Medical Necessity under EPSDT. Accessed 6 May 2014: <http://mchb.hrsa.gov/epsdt/mednecessity.html>.

¹² American College of Medical Quality (ACMQ): POLICY 8, Definition and Application of Medical Necessity. Accessed 6 May 2014: <http://www.acmq.org/policies/policy8.pdf>.

¹³ For example, the three largest commercial carriers in Massachusetts, which together cover approximately 80 percent of commercially-insured individuals in the Commonwealth, describe their approaches to medical necessity as follows:

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the Plan service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations... The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic. Accessed 16 June 2014: http://www.tuftshealthplan.com/providers/pdf/mng/autism_aba_ri.pdf.

Medically necessary health care: Health care services or products intended to prevent, diagnose, stabilize, or treat an illness, injury, or disease (or its symptoms) in a manner that is: consistent with generally accepted standards of medical practice; clinically appropriate in terms of type, frequency, extent, site and duration; demonstrated through scientific evidence to be effective in improving health outcomes; representative of “best practices” in the medical profession; not primarily for the convenience of the enrollee or physician or other health practitioner. Accessed 16 June 2014:

https://www.harvardpilgrim.org/pls/portal/docs/PAGE/PROVIDERS/MANUALS/PROVIDER/A%20CLINICAL%20DECISIONS_011514.PDF.

Medical necessity: The determination of whether care is required and appropriate given an individual's medical condition and general opinions of experts practicing in the field of medicine. Accessed 16 June 2014: https://www.bluecrossma.com/staticcontent/glossary_content.html?&iphl=necessity:medical:medical:.

¹⁴ *Op. cit.* Peters CP. EPSDT: Medicaid’s Critical But Controversial Benefits Program for Children.

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¹⁶ *Op. cit.* National Academy for State Health Care Policy. Public Insurance Programs and Children with Special Health Care Needs: A Tutorial on the Basics of Medicaid and The Children’s Health Insurance Program (CHIP).

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¹⁸ O’Connell M, Watson S, Butler B, et. al. Introduction to Medicaid: Eligibility, Federal Mandates, Hearings and Litigation. Southern Disability Law Center. Published 24 March 2004; accessed 6 May 2014: <http://209.203.251.64/conf2004/medicaid-intro.htm>.

¹⁹ *Op. cit.* Goldstein MM, Rosenbaum S. From EPSDT to EHBs: the future of pediatric coverage design under government financed health insurance.

²⁰ Affordable Care Act: “The comprehensive health care reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.” U.S. Centers for Medicare & Medicaid Services (CMS): Healthcare.gov glossary. Accessed 10 March 2014: <https://www.healthcare.gov/glossary/affordable-care-act/>.

²¹ Patient Protection and Affordable Care Act, 42 U.S.C. § 1001 §2713. Accessed 11 March 2014: <http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>.

²² Responses taken from survey of Massachusetts health insurance carriers issues March 25, 2014.

²³ *Op. cit.* Patient Protection and Affordable Care Act, 42 U.S.C. § 1001 §2713. Accessed 11 March 2014: <http://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>.

²⁴ Center for Healthcare Research & Transformation (CHRT): The Affordable Care Act and its Effect on Health Insurance Market Segments, CHRT Policy Brief August 2012. Updated 13 August 2012; accessed 11 March 2014: <http://www.chrt.org/publication/affordable-care-act-effect-health-insurance-market-segments/>.

²⁵ U.S. Preventive Services Task Force (USPSTF). Child and Adolescent Recommendations. Updated May 2014; accessed 17 June 2014: <http://www.uspreventiveservicestaskforce.org/tfchildcat.htm>.

²⁶ Summary of the Courts Decision In *Rosie D. v. Romney*:

After detailing the breadth of EPSDT’s informing and treatment components, the Court stressed that the Act requires States to provide all twenty-eight categories of medical assistance, regardless of whether they are in the State’s Medicaid Plan. One of these categories – rehabilitative services – obligates States to ensure that eligible children are offered all “diagnostic, screening, preventative, and rehabilitative services, including any medical or remedial services...for the maximum reduction of physical or mental disability and restoration of an individual to the best functional level.”

Accessed 12 January 2015:

http://www.nami.org/Content/ContentGroups/Policy/Issues_Spotlights/Medicaid/QA_Rosie_D_v_Romney.pdf.

See also *Rosie D. et al. v. Mitt Romney et al.*, 410 F. Supp. 2d 18 (D. Mass. 2006).

²⁷ More information can be found at <http://chiamass.gov/ma-apcd/>.

²⁸ University of Massachusetts Medical School Center for Health Law and Economics. MASS HEALTH: The Basics – Facts, Trends And National Context. Accessed 10 April 2014: <http://bluecrossfoundation.org/publication/updated-masshealth-basics-facts-trends-and-national-context>.

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³³ The software categorization algorithms and weights are provided free under license at <http://cdps.ucsd.edu/>.

³⁴ The Medicaid population consisted of members aged 0 to 20 on the date of service (to ensure data confidentiality, only birth month and year were released to Compass – all birth dates were assumed to be the first of the month for purposes of age calculations) with at least one paid claim with an APCD Medicaid indicator equal to “True” in 2012 (based on service from date). $N = 420,220$. The commercial population consisted of members aged 0 to 20 on the date of service who were eligible for a fully-insured product by Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, or Tufts Health Plan and had at least one paid claim with a service from date in 2012. The “big 3” carrier subset was used because APCD users have been counseled to restrict analyses utilizing the pharmacy data to these carriers, whose submission data quality is generally high. $N = 279,640$.

³⁵ Diagnostic and pharmaceutical grouping risk scores were developed using regression modeling. Separate regression results are presented for TANF populations and disabled populations, as well as for four different benefit package types: a full benefits package for acute care, and packages with carve-outs for mental health, pharmacy, and combined mental health and pharmacy. The current analysis uses the comprehensive acute benefits package weights.

³⁶ Milbank Memorial Fund Journal Volume 89 Issue 1 “How Much Do Hospitals Cost Shift? A review of the Evidence.” Austin Frakt PhD. March 2011; accessed June 2014: <http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0009.2011.00621.x/abstract>.

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