MANDATED BENEFIT REVIEW OF
HOUSE BILL 1194 AND SENATE BILL 643
SUBMITTED TO THE 192ND GENERAL COURT:

AN ACT PROMOTING CONSUMER CHOICE IN HEALTH CARE

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

BerryDunn

CHIA.

Mandated Benefit Review of House Bill 1194 and Senate Bill 643 Submitted to the 192nd General Court

An Act promoting consumer choice in health care.

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1.0 Benefit Mandate Overview: H.B. 1194 and S.B. 643: An Act promoting consumer choice in health care

1.1 History of the Bill

The Committee on Financial Services referred House Bill (H.B.) 1194 and Senate Bill (S.B.) 643, both entitled, "An Act promoting consumer choice in health care,"[i] to the Massachusetts Center for Health Information and Analysis (CHIA) for review. Massachusetts General Law (MGL) Chapter 3 §38C requires CHIA to review the medical efficacy of treatments or services included in each mandated benefit bill referred to the agency by a legislative committee, should it become law. CHIA must also estimate each bill's fiscal impact, including changes to premiums and administrative expenses. The language in the bills is the same, and for the remainder of this report, "the bill" will collectively refer to H.B. 1194 and S.B. 643.

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

1.2 What does the Bill Propose?

As submitted to the 192nd General Court of the Commonwealth, the bill provides that a licensed athletic trainer (AT) acting with a referral from a physician, and acting within the scope of practice authorized by law, may not be denied reimbursement by a health insurer for those covered services if the health insurer would reimburse another healthcare provider for those services. The services may be subject to reasonable deductibles, copayment and coinsurance amounts, fee or benefit limits, practice parameters, and utilization review consistent with applicable rules by the Division of Insurance (DOI), provided the amounts, limits, and review shall not function to direct treatment in a manner unfairly discriminative against athletic trainer care, and are collectively no more restrictive than those applicable under the same policy of care for services provided by other healthcare providers.

The bill defines "health insurance plan" as an individual or group insurance policy, a hospital or medical service corporation or health maintenance organization (HMO) subscriber contract, or another health benefit offered, issued, or renewed for a person by a health insurer. The bill does not apply to benefits providing coverage for specific diseases or other limited benefit coverage.

Upon receiving the bill, CHIA and its consultants submitted an inquiry to the sponsoring legislators and staff to clarify the bill's intent. The sponsors clarified the bill's intent is to increase access to rehabilitative care by allowing clinic, hospital, and rehabilitative settings to bill for services provided by an AT.

[i] The 192nd General Court of the Commonwealth of Massachusetts, House Bill 1194 and Senate Bill 643, "An Act promoting consumer choice in health care." Accessed 10 August 2021: https://malegislature.gov/Bills/192/H1194 and https://malegislature.gov/Bills/192/S643.

1.3 Medical Efficacy of the Bill

ATs are educated in the management, prevention, and recovery of athletic injuries and render service or treatment under the direction of a physician or dentist. They are licensed by the Massachusetts Board of Allied Health Professionals and work in a variety of settings. Because third-party payers often do not reimburse for their services, research based on claims analysis is not available. Additionally, while there are high-quality studies on services an athletic trainer can perform, the studies generally do not distinguish whether an athletic trainer, physical therapist, or other healthcare team member performed the services. ATs in Massachusetts provide services in outpatient settings, but they often work as physical therapist aides instead of ATs.[ii] When working as an AT in an outpatient setting, he or she must work under the supervision of a physician or a dentist, and his or her practice must be limited to athletes of the school, team, or organization with which the AT is associated.[iii] Insurance carriers do not cover AT-provided services in either of these situations. Therefore, if the bill were to be enacted, it would likely provide increased access to AT-provided services in clinics, physician offices, and rehabilitation centers.

1.4 Current coverage

The Commonwealth does not currently require coverage of ATs; however, some of the services they provide are covered when performed by other healthcare providers (e.g., physicians, physical therapists). The Commonwealth benchmark plan is silent with regard to ATs.

The federal ACA prohibits discrimination by a group health plan or a health insurance issuer offering group or individual health insurance coverage against any healthcare provider acting within the scope of the provider's license or certification under the applicable state law. However, the ACA does not require that a group health plan or health insurance issuer contract with any healthcare provider willing to abide by the terms and conditions for participation established by the plan or issuer.

BerryDunn surveyed 10 insurance carriers in the Commonwealth, and seven responded. The insurance carriers that responded indicated they do not cover AT-provided services.

1.5 Cost of Implementing the Bill

Requiring coverage for these benefits by fully insured health plans would result in an average annual increase, over the next five years, to the typical member's monthly health insurance premium of between $0.08 and $0.21 per member per month (PMPM) or between 0.013% and 0.034% of premium. The impact on premiums is driven by the ability of ATs who work in hospital and clinical settings to bill insurance carriers for covered services.

1.6 Plans Affected by the Proposed Benefit Mandate

Although the bill, as written, does not amend the organizing statutes for the license types subject to health insurance benefit mandates, the sponsors verified the intent of the bill is to apply to commercial fully insured health insurance plans, hospital service corporations, medical service corporations, HMOs, and to both fully and self-insured plans operated by the Group Insurance Commission (GIC) for the benefit of public employees.

[ii] Interview with two ATs from Athletic Trainers of Massachusetts (ATOM); 27 July 2021.

[iii] See Mass.gov. Frequently Asked Questions about Athletic Trainers: **https://www.mass.gov/service-details/frequently-asked-questions-about-athletic-trainers**, and MGL Chapter 112 § 23A: **https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter112/Section23A**.

1.7 Plans Not Affected by the Proposed Benefit Mandate

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

2.0 Medical Efficacy Assessment

The bill, as submitted in the 192nd General Court, would require fully insured plans to provide coverage for services provided by a licensed athletic trainer (AT) acting with a referral from a physician, and acting within the scope of practice authorized by law, if the health insurer would reimburse another healthcare provider for those services.

CHIA and its consultants submitted an inquiry to the sponsoring legislators and staff to clarify the bill's intent. The sponsors clarified the bill's intent is to increase access to rehabilitative care by allowing outpatient settings to bill for services provided by an AT. For purposes of this report, "outpatient settings" will refer to clinics, hospitals, and rehabilitation centers.

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

This report proceeds in the following sections:

2.0 Medical Efficacy Assessment

- Section 2.1: AT Profession Overview
- Section 2.2: AT Training and Licensure Requirements
- Section 2.3: AT Employment
- Section 2.4: Efficacy of AT-Provided Services
- Section 2.5: Acceptance of ATs by Insurers

3.0 Conclusion

2.1 AT Profession Overview

ATs are educated in the management, prevention, and recovery of athletic injuries.[1] ATs are frequently first responders at the scene of a sports injury or a more serious event, such as sudden cardiac arrest (SCA). ATs render service or treatment under the direction of or in collaboration with a physician, in accordance with their education and training and the states' statutes, rules, and regulations. Massachusetts state law describes "athletic trainer" as "any person who is duly licensed in accordance with this section [Chapter 112 §23A] as an athletic trainer who limits his practice to schools, teams or organizations with whom he is associated and who is under the direction of a physician or dentist duly registered in the Commonwealth." However, athletic trainers also work in outpatient settings in Massachusetts, such as in hospitals, rehabilitation centers, and physician offices.[iv] There are current state legislative efforts to increase the scope of practice for ATs.

[iv] Interview with two ATs from Athletic Trainers of Massachusetts (ATOM); 27 July 2021.

Athletic trainers are frequently compared to physical therapists because services they provide are similar and overlapping. Below is a side-by-side comparison of how the Commonwealth currently statutorily defines each.[2]

Table 1: Comparison of AT and Physical Therapist (PT) Professionals and Professional Activities

Athletic Trainer	Physical Therapist
Any person who is duly licensed in accordance with this section as an athletic trainer and who limits his practice to schools, teams or organizations with whom he is associated and who is under the direction of a physician or dentist duly registered in the Commonwealth.	A person who is duly licensed to practice physical therapy in the commonwealth in accordance with section twenty-three B.
Athletic Training	**Physical Therapy**
The application of principles, methods and procedures of evaluation and treatment of athletic injuries, preconditioning, conditioning and reconditioning of the athlete through the use of appropriate preventative and supportive devices, temporary splinting and bracing, physical modalities of heat, cold, massage, water, electric stimulation, sound, exercise and exercise equipment under the discretion of a physician. Athletic training includes instruction to coaches, athletes, parents, medical personnel and communities in the area of care and prevention of athletic injuries.	A health profession that utilizes the application of scientific principles for the identification, prevention, remediation and rehabilitation of acute or prolonged physical dysfunction thereby promoting optimal health and function. Physical therapy practice is evaluation, treatment and instruction related to neuromuscular, musculoskeletal, cardiovascular and respiratory functions. Such evaluation shall include but is not limited to performance and interpretation of tests as an aid to the diagnosis or planning of treatment programs. Such treatment shall include but is not limited to the use of therapeutic exercise, physical activities, mobilization, functional and endurance training, traction, bronchopulmonary hygiene postural drainage, temporary splinting and bracing, massage, heat, cold, water, radiant energy, electricity or sound. Such instruction shall include teaching both patient and family physical therapy procedures as part of a patient's ongoing program. Physical therapy also shall include the delegating of selective forms of treatment to physical therapist assistants and physical therapy aides; provided, however, that the physical therapist so delegating shall assume the responsibility for the care of the patient and the supervision of the physical therapist assistant or physical therapy aide.

2.2 AT Training and Licensure Requirements

In Massachusetts, the Board of Allied Health Professions (Board) sets forth AT examination, application, and licensure requirements.[3] In order to apply for licensure as an AT, the applicant must[4]:

- Be a graduate of a college or university approved by the Board and completed such college's or university's curriculum in athletic training, or other curricula deemed acceptable to the Board, and completed a program of practical training in athletic training deemed acceptable to the board.
- Have passed an examination administered by the Board. The examination is written, and, in addition at the discretion of the board, may be oral and demonstrative, and test the applicant's knowledge of the basic and clinical sciences as they apply to the athletic training theory and practice, including the applicant's professional skills and judgment in the utilization of athletic training techniques and methods, and such other

subjects as the Board may deem useful to determine the applicant's fitness to act as an athletic trainer. The examination is conducted at least twice a year at times and places determined by the Board.

The Board of Allied Health Professionals' description of ATs in its Consumer Fact Sheet is provided in Appendix A.

2.3 AT Employment

ATs provide the following types of services in different settings:

- First aid and emergency care
- Examination and clinical diagnosis
- Therapeutic intervention, such as application of injury-preventive devices, such as tape, bandages, and braces
- Rehabilitation of injuries and medical conditions
- Injury wellness and prevention programs
- Wellness promotion and education
- Provide administrative tasks, such as documentation of injuries and treatment programs

These services are provided to a variety of individuals, from young children to professional athletes. Table 2 provides the industries with the highest levels of employment for Athletic Trainers.

Table 2: Industries with the Highest Levels of Employment for ATs (Year 2020)[v,5]

INDUSTRY	EMPLOYMENT	ANNUAL MEAN WAGE
Colleges, Universities, and Professional Schools	5,760	$53,870
General Medical and Surgical Hospitals	5,610	$50,360
Offices of Other Health Practitioners	4,350	$47,380
Elementary and Secondary Schools	3,140	$62,500
Offices of Physicians	3,060	$50,150

[v] Does not include self-employed ATs.

The U.S. Bureau of Labor Statistics ranks the Boston-Cambridge-Nashua, MA-NH metropolitan area as the fifth highest employment location for ATs—640 ATs or 0.25 ATs per 1,000 jobs. There are 810 ATs in Massachusetts, and the AT mean annual salary is $62,110.[6,vi] Similar to other allied health professions, AT job growth is expected to grow much faster than most other professions.[7] The projected percent change in employment from 2019 to 2029 is 16%.[8] The average growth rate for all occupations is 4%.[9] Demand for athletic trainers is expected to increase as more people have health insurance and the population ages.[10]

2.4 Efficacy of AT-Provided Services

Research studies examining the efficacy of AT-provided services are lacking. However, there are a variety of studies related to effectiveness of specific services or programs ATs provide or administer in outpatient settings. Two examples are below:

- Ankle supports (e.g., braces) appear to be effective for reducing risk of ankle sprains in uninjured and previously injured individuals.[11,12,13,14]
- Conservative treatment plans, centered on progressive tendon loading, promotes recovery from patellar tendinopathy[15] and Achilles tendinopathy.[16,17,18]

Athletic training has traditionally been associated with school-based settings. Although this bill is intended to allow for reimbursement of AT services in outpatient settings, ATs might spend time in both an outpatient setting and a school. In states with reimbursement for ATs, outpatient settings have used a model that incorporates both—an outpatient setting bills for an AT's services for a portion of the day and contracts with a school for the AT to provide on-site services at a school for the remainder of the day. School-provided AT services have been found to reduce emergency room use. A study in Oregon analyzed medical claims to determine the cost impact of AT services provided to high school students. The study found that school-provided AT services reduced emergency room visits for both students with Medicaid and those with commercial insurance.[19] There is also evidence of increased productivity, measured by patient throughput, at an outpatient setting after the addition of an AT.[20]

2.5 Acceptance of ATs by Insurers

The American Medical Association (AMA) formally recognized ATs as allied healthcare professionals in 1990, and in 2000, the AMA assigned Current Procedural Terminology (CPT) codes for services. However, insurers in Massachusetts do not recognize or reimburse for services provided under those codes. Furthermore, the Centers for Medicare & Medicaid Services (CMS) provides a National Provider Identifier number for ATs; however, ATs are not recognized and reimbursed by CMS for Medicare patients, although reimbursement varies by state for Medicaid patients.

Since 1999, Georgia has required third-party reimbursement for services within the lawful scope of practice of ATs, and several states have varying amounts of third-party reimbursement for ATs. The other states include: Indiana, Wisconsin, Ohio, and Vermont.

[vi] Total number of ATs and mean salary do not include self-employed ATs.

3.0 Conclusion

Studies comparing the efficacy of AT-provided services to those provided by other providers (e.g., physical therapists) are not available. However, research provides support for effectiveness of services that ATs perform, such as the application of appropriate preventative and supportive devices and provision of injury prevention programs. ATs have traditionally provided these services in school, college, and professional athletic settings. Mandating insurance coverage of AT-provided services would likely increase access to these services in clinic, hospital, and rehabilitative settings.

Appendix A: Excerpt from the [Massachusetts] Allied Health Professionals Consumer Fact Sheet[vii]

Athletic trainers are health professionals who work with clients in preparation for, or participation in, sports activities. They work to treat, rehabilitate and prevent athletic injuries.

The American Medical Association recognizes athletic training as an Allied Health profession that is concerned with the prevention, care and treatment of athletic injuries. Athletic training is a subdivision of sports medicine that is specifically concerned with the health and safety of the athlete.

The athletic trainer's job is divided into five main areas including 1) prevention of athletic injuries, 2) recognition, evaluation and immediate care of athletic injuries, 3) rehabilitation and reconditioning of athletic injuries, 4) health care administration, and 5) education and counseling. The athletic trainer works under the direction of a licensed physician and in conjunction with other health care professionals, coaches, athletic directors and the athlete to make up the sports medicine team. The athletic trainer serves as a liaison between the athlete and the medical community and the athlete and the coaching staff.

The Certified Athletic Trainer is a highly educated and skilled professional specializing in athletic health care. In cooperation with physicians and other allied health personnel, the athletic trainer functions as an integral member of the athletic health care team in secondary schools, colleges and universities, sports medicine clinics, professional sports programs and other athletic health care settings.

The most fundamental requirement for becoming an athletic trainer is a sincere interest in athletics and the athlete's well being. Today's athletic trainer is a highly trained individual who plays an integral role in a comprehensive athletic program. The athletic trainer's duties consist of implementing injury prevention programs, immediate first aid treatment, and establishing rehabilitation protocols for the injured athlete under the direction of a team physician.

The athletic trainer's skills are varied. He or she must have a thorough knowledge of anatomy, physiology, psychology, hygiene, nutrition, taping, conditioning, prevention of injury, and protective equipment. In addition to these many skills and abilities, the athletic trainer must have an excellent rapport with the team physicians, coaches, administrators, and athletes in order to perform effectively.

[vii] Board of Registration of Allied Health Professionals. Allied Health Professionals Consumer Fact Sheet. Accessed 18 July 2021: https://www.mass.gov/files/documents/2017/12/12/Allied%20Health%20Professionals%20Consumer%20Fact%20Sheet.pdf.

Endnotes

[1] Mayo Clinic College of Medicine and Science. Explore Health Careers. Athletic Trainer. Accessed 25 July 2021: **https://college.mayo.edu/academics/explore-health-care-careers/careers-a-z/athletic-trainer/**.

[2] MGL Chapter 112 §23A. Accessed 25 July 2021: **https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter112/Section23A**.

[3] MGL Chapter 112 §23B. Accessed 25 July 2021: **https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter112/Section23B**.

[4] MGL Chapter 112 §23F. Accessed 25 July 2021: **https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter112/Section23F**.

[5] U.S. Bureau of Labor Statistics. Occupational Employment and Wage Statistics. Occupational Employment and Wages. May 2020. 29-9091 Athletic Trainers. Accessed 2021 June 9: **https://www.bls.gov/oes/current/oes299091.htm#(3)**.

[6] U.S. Bureau of Labor Statistics. Occupational Employment and Wage Statistics. May 2020 State Occupational Employment and Wage Estimates Massachusetts. Accessed 12 August 2021: **https://www.bls.gov/oes/current/oes_ma.htm**.

[7] *Op.Cit.* U.S. Bureau of Statistics. Occupational Employment and Wage Statistics.

[8] *Op.Cit.* U.S. Bureau of Statistics. Occupational Employment and Wage Statistics.

[9] *Op.Cit.* U.S. Bureau of Statistics. Occupational Employment and Wage Statistics.

[10] *Op.Cit.* U.S. Bureau of Statistics. Occupational Employment and Wage Statistics.

[11] Kaminiski T, Needle A, Delahunt E. Prevention of Lateral Ankle Sprains. Journal of Athletic Training. J Athl Train. 2019 Jun;54(6):650-661. Accessed 25 July 2021: **https://pubmed.ncbi.nlm.nih.gov/31116041/**.

[12] Handoll H, Rowe B, Quinn R. Interventions for preventing ankle ligament injuries. Cochrane Database Syst Rev. 2001; (3); CD000018. Accessed 25 July 2021: **https://pubmed.ncbi.nlm.nih.gov/11686947/**.

[13] Burger M, Fisher R, Foot D, et.al. The effectiveness of proprioceptive and neuromuscular training compared to bracing in reducing the recurrence rate of ankle sprains in athletes: A systematic review and meta-analysis. J Back Musculoskelet Rehabil. 2018;31(2):221-229. Accessed 25 July 2021: **https://pubmed.ncbi.nlm.nih.gov/29154263/**.

[14] Janssen KW, Hendriks MR, van Mechelen W, Verhagen E. The Cost-Effectiveness of Measures to Prevent Recurrent Ankle Sprains: Results of a 3-Arm Randomized Controlled Trial. Am J Sports Med. 2014 Jul;42(7):1534-41. Accessed 25 July 2021: **https://pubmed.ncbi.nlm.nih.gov/24753237/**.

[15] Breda SJ, Oei EHG, Zwerver J, et.al. Effectiveness of progressive tendon-loading exercise therapy in patients with patellar tendinopathy: a randomised clinical trial. *British Journal of Sports Medicine* 2021;55:501-509. Accessed 2021: **https://bjsm.bmj.com/content/55/9/501**.

[16] Silbernagel K, Hanlon S, Sprague A. Current Clinical Concepts: Conservative Management of Achilles Tendinopathy J Athl Train. 2020 May;55(5):438-447. Accessed 25 July 2021: **https://pubmed.ncbi.nlm.nih.gov/32267723/**.

[17] Silbernagel K, Crossley K. A Proposed Return-to-Sport Program for Patients With Midportion Achilles Tendinopathy: Rationale and Implementation: J Orthop Sports Phys Ther. 2015 Nov;45(11):876-86. Accessed 2021 August 2021: **https://pubmed.ncbi.nlm.nih.gov/26390272/.**

[18] Alfredson H, Cook J. A treatment algorithm for managing Achilles tendinopathy: new treatment options. Br J Sports Med. 2007 Apr;41(4):211-6. Accessed 25 July 2021: **https://pubmed.ncbi.nlm.nih.gov/17311806/.**

[19] Li T, Johnson S, Koester M, et.al. The impact of high school athletic trainer services on medical payments and utilizations: a microsimulation analysis on medical claims. Accessed 25 July 2021: **https://injepijournal.biomedcentral.com/articles/10.1186/s40621-019-0194-y?optIn=true**.

[20] Nicelo T, Pecha F, Omdal R, et.al. Patient Throughput in a Sports Medicine Clinic With the Implementation of an Athletic Trainer: A Retrospective Analysis. Sports Health. Jan/Feb 2017;9(1):70-74. Accessed 16 August 2021: **https://pubmed.ncbi.nlm.nih.gov/27799568/.**

AN ACT PROMOTING CONSUMER CHOICE IN HEALTH CARE

COST REPORT

1.0 Executive Summary

The Committee on Financial Services referred House Bill (H.B.) 1194 and Senate Bill (S.B.) 643, both entitled, "An Act promoting consumer choice in health care,"[1] to the Massachusetts Center for Health Information and Analysis (CHIA) for review. Massachusetts General Law (MGL) Chapter 3 §38C requires CHIA to review the medical efficacy of treatments or services included in each mandated benefit bill referred to the agency by a legislative committee, should it become law. CHIA must also estimate each bill's fiscal impact, including changes to premiums and administrative expenses. The language in the bills is the same, and for the remainder of this report, "the bill" will collectively refer to H.B. 1194 and S.B. 643.

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

1.1 Current Insurance Coverage

The Commonwealth does not currently require coverage of athletic trainers (ATs); however, some of the services they provide are covered when provided by other healthcare providers (e.g., physicians, physical therapists). The Commonwealth benchmark plan is silent with regard to ATs.[2]

The ACA prohibits discrimination by a group health plan or a health insurance issuer offering group or individual health insurance coverage against any healthcare provider acting within the scope of the provider's license or certification under the applicable state law. However, the ACA does not require that a group health plan or health insurance issuer contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer.

BerryDunn surveyed 10 insurance carriers in the Commonwealth, and seven responded. The responding insurance carriers reported they do not cover AT-provided services.

1.2 Analysis

BerryDunn estimated the impact of the bill on premiums by assessing the incremental cost due to the requirement that insurers reimburse an AT, who acts with a referral from a physician and within the scope of practice authorized by law, if the health insurer would reimburse another healthcare provider for those services. The incremental cost of the provision is estimated using claims data from the Massachusetts All Payer Claims Database (APCD) to estimate the hourly rate paid to an AT. BerryDunn used publicly available information and interviews with two Massachusetts AT clinical experts to estimate the number of hours that ATs could bill insurance carriers for their services, and to estimate the number of ATs who would bill for their services. Combining these components, and accounting for carrier retention, results in a baseline estimate of the proposed mandate's incremental effect on premiums, which is projected over the five years following the assumed January 1, 2022, implementation date of the proposed law.

1.3 Summary Results

Table ES-1, on the following page, summarizes the estimated effect of the bill on premiums for fully insured plans over five years. This analysis estimates that the bill, if enacted as drafted for the 192nd General Court, would increase fully insured premiums by as much as 0.034% or $0.21 per member per month (PMPM) on average over the next five years; a more likely increase is approximately 0.022%, equivalent to an average annual expenditure of $3.2 million over the period 2022 – 2026. The impact on premiums is driven by expanding coverage to reimburse an AT, who acts with a referral from a physician and within the scope of practice authorized by law, if the health insurer would reimburse another healthcare provider for those services. Variation between scenarios is attributable to uncertainty surrounding the average hourly billing rate, the number of hours that an AT will bill for covered services, and the number of ATs that will bill for covered services. The impact of the bill on any one individual, employer group, or carrier might vary from the overall results, depending on the current level of benefits each receives or provides, and on how those benefits would change under the proposed language.

Table ES-1: Summary Results

	2022	2023	2024	2025	2026	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
Members (000s)	2,014	2,010	2,007	2,003	2,000		
Medical Expense Low ($000s)	$738	$1,304	$1,585	$1,864	$2,143	$1,618	$7,635
Medical Expense Mid ($000s)	$1,241	$2,175	$2,651	$3,147	$3,737	$2,744	$12,952
Medical Expense High ($000s)	$1,789	$3,233	$4,050	$4,934	$5,889	$4,215	$19,895
Premium Low ($000s)	$865	$1,527	$1,856	$2,184	$2,511	$1,895	$8,943
Premium Mid ($000s)	$1,454	$2,548	$3,106	$3,686	$4,378	$3,214	$15,172
Premium High ($000s)	$2,096	$3,787	$4,744	$5,780	$6,898	$4,937	$23,305
PMPM Low	$0.05	$0.06	$0.08	$0.09	$0.10	$0.08	$0.08
PMPM Mid	$0.08	$0.11	$0.13	$0.15	$0.18	$0.13	$0.13
PMPM High	$0.12	$0.16	$0.20	$0.24	$0.29	$0.21	$0.21
Estimated Monthly Premium	$559	$578	$598	$618	$639	$598	$598
Premium % Rise Low	0.009%	0.011%	0.013%	0.015%	0.016%	0.013%	0.013%
Premium % Rise Mid	0.015%	0.018%	0.022%	0.025%	0.029%	0.022%	0.022%
Premium % Rise High	0.022%	0.027%	0.033%	0.039%	0.045%	0.034%	0.034%

Executive Summary Endnotes

[1] The 192nd General Court of the Commonwealth of Massachusetts, House Bill 1194 and Senate Bill 643, "An Act promoting consumer choice in health care." Accessed 10 August 2021: **https://malegislature.gov/Bills/192/H1194** and **https://malegislature.gov/Bills/192/S643**.

[2] CMS.gov. Centers for Medicare & Medicaid Services. Information on Essential Benefits (EHB) Benchmark Plans. Accessed 15 February 2021: **https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/2017-BMPSummary_MA_4816.zip/.**

2.0 Introduction

House Bill (H.B.) 1194 and Senate Bill (S.B.) 643, both entitled, "An Act promoting consumer choice in health care,"[1] to the Massachusetts Center for Health Information and Analysis (CHIA) for review, as submitted in the 192nd General Court, would require fully insured plans to provide coverage for services provided by a licensed athletic trainer (AT) acting with a referral from a physician and within the scope of practice authorized by law, if the health insurer would reimburse another healthcare provider for those services.

CHIA and its consultants submitted an inquiry to the sponsoring legislators and staff to clarify the bill's intent. The sponsors clarified the bill's intent is to increase access to rehabilitative care by allowing outpatient settings to bill for services provided by an AT. For purposes of this report, "outpatient settings" will refer to clinics, hospitals, and rehabilitation centers.

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

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

3.0 Interpretation of the Bill

3.1 Reimbursement for Covered Services Performed by ATs

As submitted to the 192nd General Court of the Commonwealth, the bill provides that a licensed AT, who acts with a referral from a physician and within the scope of practice authorized by law, may not be denied reimbursement by a health insurer for those covered services if the health insurer would reimburse another healthcare provider for those services. The services may be subject to reasonable deductibles, copayment and coinsurance amounts, fee or benefit limits, practice parameters, and utilization review consistent with applicable rules by the Department of Insurance (DOI), provided the amounts, limits, and review shall not function to direct treatment in a manner unfairly discriminative against athletic trainer care, and are collectively no more restrictive than those applicable under the same policy of care for services provided by other healthcare providers.

The bill defines "health insurance plan" as an individual or group insurance policy, a hospital or medical service corporation or health maintenance organization (HMO) subscriber contract, or another health benefit offered, issued, or renewed for a person by a health insurer. The bill does not apply to benefits providing coverage for specific diseases or other limited benefit coverage.

Upon receiving the bill, CHIA and its consultants submitted an inquiry to the sponsoring legislators and staff to clarify the bill's intent. The sponsors clarified the bill's intent is to increase access to rehabilitative care by allowing clinic, hospital, and rehabilitative settings to bill for services provided by an AT.

3.2 Plans Affected by the Proposed Mandate

Although the bill, as written, does not amend the organizing statutes for the license types subject to health insurance benefit mandates, the sponsors verified the intent of the bill is to apply to commercial fully insured health insurance plans, hospital service corporations, medical service corporations, HMOs, and to both fully and self-insured plans operated by the Group Insurance Commission (GIC) for the benefit of public employees.

3.3 Covered Services

BerryDunn surveyed 10 insurance carriers in the Commonwealth, and seven responded. None of the respondent carriers indicated that they provide benefits for services performed by ATs.

3.4 Existing Laws Affecting the Cost of the Bill

The bill's coverage requirements are not in conflict with or redundant to any existing state or federal coverage requirements. The federal ACA prohibits discrimination by a group health plan or a health insurance issuer offering group or individual health insurance coverage against any healthcare provider acting within the scope of the provider's license or certification under the applicable state law. However, the ACA does not require that a group health plan or health insurance issuer contract with any healthcare provider willing to abide by the terms and conditions for participation established by the plan or issuer.

4.0 Methodology

4.1 Overview

Estimating the impact of the bill on premiums requires assessing the incremental cost due to the requirement that insurers reimburse an AT, who acts with a referral from a physician and within the scope of practice authorized by law, if the health insurer would reimburse another healthcare provider for those services.

The incremental cost of the provision is estimated using claims data from the APCD to estimate the hourly rate paid to an AT. BerryDunn used publicly available information and interviews with two Massachusetts AT clinical experts to estimate the number of hours that ATs could bill insurance carriers for their services and the number of ATs who would bill for their services. Combining these components, and accounting for carrier retention, results in a baseline estimate of the proposed mandate's incremental effect on premiums, which is projected over the five years following the assumed January 1, 2022, implementation date of the proposed law.

4.2 Data Sources

The primary data sources used in the analysis are:

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

4.3 Steps in the Analysis

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

1. Estimated the incremental cost to insurers to pay for covered services when performed by an AT

In order to estimate the cost of covering services performed by ATs, BerryDunn:

A. Used claims data from the APCD to determine total claims cost for ATs.

B. Divided the total claims cost by the number of hourly units to determine the cost per hour for ATs.

C. Projected the hourly unit cost forward over the five-year analysis period using both historical changes in unit cost and estimated increases in physician services over the period.

D. Used input from clinical experts and data from other states enacting similar legislation to determine the number of licensed ATs in Massachusetts who work in clinical settings that will bill for services as indicated in the bill.

E. Used publicly available information, including population data, to determine the number of ATs available to provide services for the fully insured population in Massachusetts.

F. Used input from AT experts to determine the average number of hours per week that ATs will bill insurance carriers for services included in the bill.

G. Using the estimated number of ATs and the average number of billable hours per AT, estimated the total number of hours that will be billed to insurance carriers for the fully insured commercial population.

H. Multiplied the total number of hours from Step G by the unit costs from Step C to calculate the incremental claims cost.

I. Divided the incremental cost in the above step by the corresponding fully insured commercial membership to determine the incremental PMPM.

2. Calculated the impact of the projected claim costs on insurance premiums

To add the other components of health insurance premiums to the estimated claims costs, BerryDunn:

A. Estimated the fully insured Commonwealth population under age 65, projected for the next five years (2022 – 2026).

B. Multiplied the estimated incremental PMPM cost of the mandate by the projected population estimate, to calculate the total estimated marginal claims cost of S.B. 643.

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

4.4 Limitations

Carriers in Massachusetts do not currently provide coverage for services performed by an AT, and the utilization could not be calculated from APCD claims. The APCD does contain limited cost per service information for ATs. Given the limited number of claims in the APCD, the AT hourly rate is uncertain. The number of ATs who work in a setting that would allow them to bill insurance carriers for services is uncertain. It is also uncertain how many hours of their time would be spent on covered services that could be billed to insurance. BerryDunn received input from licensed ATs and clinical practices that employ ATs to help estimate these parameters.

It is uncertain, if the bill is enacted, if it will attract new ATs to Massachusetts, further increasing the number of services that can be billed to insurance companies. It is also uncertain how much billable AT time would be spent on services that would shift from other providers, such as physical therapists. Based on input from clinical experts, there is currently an unmet demand for AT services as the demand for musculoskeletal care is increasing[2]. These two uncertainties have an offsetting impact of the cost of the bill. However, it is likely the shift of services to ATs from physical therapists or other providers has a greater impact than the impact of any new ATs. This analysis conservatively assumes that all of the time billed to insurance companies by ATs is marginal claims cost.

COVID-19 has impacted the number of commercial, fully insured members in 2020. Fully insured membership declined due to decreased enrollment in employer-sponsored insurance (ESI). The impact that COVID-19 will have on unemployment in the 2022 – 2026 projection period is uncertain.

BerryDunn addresses these limitations further in the following section through a detailed, step-by-step description of the estimation process.

5.0 Analysis

This section describes the calculations outlined in Section 4.3 in more detail. The analysis includes development of a best-estimate, middle-cost scenario, as well as a low-cost scenario using assumptions that produced a lower estimate, and a high-cost scenario using more conservative assumptions that produced a higher estimated cost impact.

Section 5.1 describes the steps used to calculate the average cost per hour paid to ATs by insurance carriers. Section 5.2 describes the steps used to calculate the number of LATs in Massachusetts, the number who work in an appropriate setting, and the number who will bill insurance carriers for their services. Section 5.3 describes the steps used to estimate the number of hours on average that an LAT will bill an insurance company and the total number of hours billable to insurance carriers for Massachusetts LATs. Section 5.4 describes the steps used to calculate the marginal claims cost. Section 5.5 describes the steps used to project the fully insured population age 0 – 64 in the Commonwealth over the 2022 – 2026 analysis period. Section 5.6 describes the steps used to calculate the total estimated marginal cost of the bill over the projection period, and Section 5.7 describes the steps used to adjust these projections for carrier retention to arrive at an estimate of the bill's effect on premiums for fully insured plans.

5.1 AT Cost per Hour

Estimated the hourly treatment costs for services performed by an AT.

Currently, the Massachusetts carriers do not cover services performed by ATs. However, the APCD does contain limited claims data for ATs. The APCD was used to calculate an hourly unit cost. Allowed claim amounts from 2016 through 2018 were divided by the number of hourly units and converted to an hourly allowed reimbursement for ATs. The average allowed reimbursement is $116 per hour. Allowed costs per hour came down between 2016 and 2018, suggesting a reduction in the hourly rate. Since the data set is limited, BerryDunn used the three-year average in the mid scenario. Given the limited number of claims data available in the APCD, this analysis assumes a range of paid reimbursement rates. For allowed cost, the low scenario assumes $112 per hour, and the high scenario assumes $120 per hour. BerryDunn multiplied the allowed unit cost by the allowed-to-paid ratio, calculated from the APCD, in order to estimate the average paid reimbursement per hour for ATs. Results are shown in Table 1.

Table 1: Estimated 2018 Paid Cost per Hour for ATs

ALLOWED COST PER HOUR	ALLOWED COST	ALLOWED -TO-PAID RATIO	PAID COST
Low Scenario	$112.00	66%	$73.94
Mid Scenario	$116.00	66%	$76.58
High Scenario	$120.00	66%	$79.22

To project hourly rates in the high scenario, this analysis used the long-term average national projection of 4.6%[3] for cost increases to physician services over the study period. Given that the APCD observed trends for AT hourly costs were negative, BerryDunn conservatively assumed that the trend for hourly rate would be flat in the low scenario. BerryDunn assumed the average trend rate of 2.3% in the mid scenario. BerryDunn multiplied the PMPM amounts from Table 1 by the annual trend factors to estimate the hourly costs for coverage over the projection period (Table 2).

Table 2: Projection Period Estimated Paid Cost per Hour for ATs

	2018	2022	2023	2024	2025	2026
Low Scenario	$73.94	$73.94	$73.94	$73.94	$73.94	$73.94
Mid Scenario	$76.58	$83.88	$85.80	$87.78	$89.80	$91.86
High Scenario	$79.22	$94.84	$99.20	$103.76	$108.54	$113.53

5.2 The Number of ATs Who Will Bill Insurance Carriers

Estimated the number of ATs in Massachusetts and the number who will bill insurance carriers for services for the fully insured population.

Based on the data from the Bureau of Labor Statistics, there are currently 810 ATs in Massachusetts.[4] BerryDunn received Massachusetts-specific data from the Association of Athletic Trainers of Massachusetts (ATOM). There are 760 certified professional members in ATOM. ATOM provided worksite data on 611 of these professionals. Seventeen percent of the 611 ATs work in hospitals or rehabilitative clinics, which are settings that ATs could bill insurance carriers for their services. BerryDunn assumed a similar distribution for ATs where worksite data was unavailable, and calculated that a total of 138 ATs work in a hospital or rehabilitative clinics. Medicare and Medicaid do not reimburse ATs, so only the commercially insured population would reimburse ATs if the proposed mandate were enacted. BerryDunn multiplied the138 ATs by 42%, which is the fully insured portion of the commercially insured population, and estimated that at most 58 ATs would bill insurance carriers. Based on input from ATs in Massachusetts and in Wisconsin, it is anticipated that not all ATs will bill insurance carriers.

Wisconsin and Indiana are states close in population size to Massachusetts that have enacted language similar to the bill. BerryDunn received input on the number of ATs who bill insurance carriers from an athletic trainer and administrator at the University of Wisconsin Hospital and Clinics, who is also a representative of the National Athletic Trainers Association. In Indiana, the overall number of ATs billing insurance carriers is approximately 75, and in Wisconsin, it is approximately 45. ATs have been able to bill for seven years in Indiana, and in Wisconsin, ATs have been able to bill for close to 20 years. When the Indiana legislation passed in 2013, there were only four ATs billing.

In both Indiana and Wisconsin, ATs cannot bill Medicare or Medicaid and are limited to billing the commercially insured populations. Using the number of people in the commercially insured population based on United States Census Bureau America Community Survey Tables for Health Insurance Coverage,[5] BerryDunn calculated the number of ATs per million people in each of the two states. Results are displayed in Table 3.

Table 3: The Number of ATs Who Bill Insurance Carriers per 1 Million Commercially Insured People

	COMMERCIAL POPULATION IN MILLIONS	NUMBER OF ATS WHO BILL	NUMBER OF ATS PER MILLION
Wisconsin	4.275	45	10.5
Indiana	4.610	75	16.3

To estimate the number of ATs who will bill for services in the Massachusetts fully insured commercial market, BerryDunn multiplied the number of ATs per million by the number of commercially insured people in Massachusetts. BerryDunn assumed 10.5, 13.4, and 16.3 ATs per million in the low, mid, and high scenarios, respectively. BerryDunn multiplied the results by 42%, which is the fully insured portion of the commercially insured population. Results are displayed in Table 4. These are the projected numbers of ATs who will bill insurance carriers after legislation has been in effect for five years at the end of projection period.

Table 4: Estimated ATs Who Will Bill the Commercial Fully Insured Population

	COMMERCIAL POPULATION IN MILLIONS	ATS PER MILLION	FULLY INSURED PORTION	ATS SERVING THE FULLY INSURED POPULATION
Low	5.068	10.5	42%	22
Mid	5.068	13.4	42%	29
High	5.068	16.3	42%	35

This analysis conservatively assumes that half of the ATs who will bill at the end of the projection period will bill in the initial year, and it further assumes that the number of ATs billing will increase consistently each year until year five in the projection period. Table 5 shows the estimated number of ATs who will bill each year in the projection period.

Table 5: Estimated Number of ATs Billing Insurance Carriers for Services

	2022	2023	2024	2025	2026
Low Scenario	10	13	16	19	22
Mid Scenario	15	18	21	25	29
High Scenario	17	22	26	30	35

The next section discusses how many hours each AT will bill the insurance carriers.

5.3 The Average Number of Hours ATs Will Bill Insurance Carriers

Estimated the average number of hours that an AT will bill an insurance company and the total number of hours for all ATs billing for services for the fully insured population.

BerryDunn developed the average number of annual billable hours charged by ATs based on a standard 40-hour workweek. Accounting for time between appointments and administrative work, the standard workweek was reduced by eight hours in the mid scenario to estimate the average number of billable hours per week. In the low scenario, 10 administrative hours were assumed, and in the high scenario, six hours of administrative work were assumed. BerryDunn based billable weeks per year on 52 weeks in a calendar year, reduced by eight weeks for vacation, holidays, and sick time, resulting in an estimate of 44 productive billable weeks per year for ATs. BerryDunn multiplied the number of billable hours per week by the number of productive weeks per year to estimate the average number of billable hours per year. Table 6 displays these assumptions and results.

Table 6: Average Annual Billable Hours for ATs

	HOURS PER WEEK	WEEKS PER YEAR	HOURS PER YEAR
Low	30	44	1,320
Mid	32	44	1,408
High	34	44	1,496

To calculate total billable hours per year attributable to this mandate under each scenario, BerryDunn multiplied the number of hours available per AT from Table 6 by the estimated number of ATs who will bill insurance carriers for services from Table 5. The results are displayed in Table 7.

Table 7: Estimated Total Billable Hours per Year for ATs

	2022	2023	2024	2025	2026
Low Scenario	13,805	17,609	21,437	25,265	29,093
Mid Scenario	20,452	25,316	30,216	35,116	40,832
High Scenario	26,076	32,538	39,046	45,553	52,061

5.4 Marginal Claims Cost for ATs

Estimated the PMPM marginal claims costs for services performed by an AT.

BerryDunn multiplied the total number of estimated hours estimated billed by ATs from Table 7 by the average paid reimbursement rates from Table 2 to estimate the total marginal claims costs for services performed by ATs. BerryDunn divided the total marginal claims cost by the corresponding membership to calculate the PMPM marginal claims cost. Results are shown in Table 8.

Table 8: Estimated Marginal Claims PMPM of ATs

	2022	2023	2024	2025	2026
Low Scenario	$0.04	$0.05	$0.07	$0.08	$0.09
Mid Scenario	$0.07	$0.09	$0.11	$0.13	$0.16
High Scenario	$0.10	$0.13	$0.17	$0.21	$0.25

5.5 Projected Fully Insured Population in the Commonwealth

Table 9 presents the projected fully insured population in the Commonwealth (ages 0 to 64) from 2022 through 2026. Appendix A describes the projection methodology and sources of these values.

Table 9: Projected Fully Insured Population in the Commonwealth, Ages 0 – 64

2022	2023	2024	2025	2026
2,014,007	2,010,132	2,006,510	2,003,142	1,999,776

5.6 Total Marginal Medical Expense

Multiplying the total estimated PMPM cost by the projected fully insured membership over the analysis period (2022 – 2026) results in the total cost (medical expense) associated with the proposed requirement, as shown in Table 10. BerryDunn's analysis assumes the bill, if enacted, would be effective on January 1, 2022.[viii]

Table 10: Estimated Incremental Cost of ATs

	2022	2023	2024	2025	2026
Low Scenario	$738,481	$1,303,950	$1,584,558	$1,864,380	$2,143,254
Mid Scenario	$1,241,017	$2,175,413	$2,651,394	$3,146,929	$3,737,092
High Scenario	$1,789,104	$3,232,539	$4,050,172	$4,934,264	$5,888,648

5.7 Carrier Retention and Increase in Premium

Carriers include their retention expense in fully insured premiums. Retention expense includes general administration, commissions, taxes, fees, and contribution to surplus or profit. Assuming an average retention rate of 14.6% based on CHIA's analysis of fully insured premium retention in the Commonwealth,[6] the increase in medical expense was adjusted upward to approximate the total impact on premiums in Table 11.

Table 11: Estimate of Increase in Carrier Premium Expense

	2022	2023	2024	2025	2026
Low Scenario	$865,063	$1,527,460	$1,856,166	$2,183,952	$2,510,627
Mid Scenario	$1,453,739	$2,548,299	$3,105,867	$3,686,342	$4,377,664
High Scenario	$2,095,773	$3,786,627	$4,744,410	$5,780,043	$6,898,017

6.0 Results

The estimated impact of the proposed requirement on medical expense and premiums is explained in Section 6.1 and is summarized in Table 12. 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

[viii] The analysis assumes the mandate would be effective for policies issued and renewed on or after January 1, 2022. Based on an assumed renewal distribution by month, by market segment, and by the Commonwealth market segment composition, 72.1% of the member months exposed in 2022 will have the proposed mandate coverage in effect during calendar year 2022. The annual dollar impact of the mandate in 2022 was estimated using the estimated PMPM and applying it to 72.1% of the member months exposed.

conservative assumptions that produced a higher estimated impact.

The impact on premiums is driven by the provisions of the bill that require carriers to reimburse a licensed AT, who acts with a referral from a physician and within the scope of practice authorized by law, if the health insurer would reimburse another healthcare provider for those services. Variation between scenarios is attributable to uncertainty surrounding the average hourly billing rate, the number of hours that an AT will bill for covered services, and the number of ATs that will bill for covered services.

6.1 Five-Year Estimated Impact

Table 12 (on the following page) presents the projected net impact of S.B. 643 on medical expense and premiums for each year over the 2022 – 2026 period using a projection of Commonwealth fully insured membership. The low scenario would result in $1.9 million per year on average. It assumes on average that ATs will be paid $74 per hour, bill 30 hours per week, and that 22 ATs will bill insurance carriers for fully insured members. The high scenario's projected impact is $4.9 million and assumes on average that ATs will be paid $79 per hour, bill 34 hours per week, and that 35 ATs will bill insurance carriers for fully insured members. The middle scenario would result on average, annual costs of $3.2 million, or an average of 0.022% of premiums. It assumes on average that ATs will be paid $77 per hour, bill 32 hours per week, and that 29 ATs will bill insurance carriers for fully insured members.

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

Table 12: Summary Results

	2022	2023	2024	2025	2026	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
Members (000s)	2,014	2,010	2,007	2,003	2,000		
Medical Expense Low ($000s)	$738	$1,304	$1,585	$1,864	$2,143	$1,618	$7,635
Medical Expense Mid ($000s)	$1,241	$2,175	$2,651	$3,147	$3,737	$2,744	$12,952
Medical Expense High ($000s)	$1,789	$3,233	$4,050	$4,934	$5,889	$4,215	$19,895
Premium Low ($000s)	$865	$1,527	$1,856	$2,184	$2,511	$1,895	$8,943
Premium Mid ($000s)	$1,454	$2,548	$3,106	$3,686	$4,378	$3,214	$15,172
Premium High ($000s)	$2,096	$3,787	$4,744	$5,780	$6,898	$4,937	$23,305
PMPM Low	$0.05	$0.06	$0.08	$0.09	$0.10	$0.08	$0.08
PMPM Mid	$0.08	$0.11	$0.13	$0.15	$0.18	$0.13	$0.13
PMPM High	$0.12	$0.16	$0.20	$0.24	$0.29	$0.21	$0.21
Estimated Monthly Premium	$559	$578	$598	$618	$639	$598	$598
Premium % Rise Low	0.009%	0.011%	0.013%	0.015%	0.016%	0.013%	0.013%
Premium % Rise Mid	0.015%	0.018%	0.022%	0.025%	0.029%	0.022%	0.022%
Premium % Rise High	0.022%	0.027%	0.033%	0.039%	0.045%	0.034%	0.034%

6.2 Impact on GIC

Findings from BerryDunn's carrier surveys indicate that benefit offerings for GIC and other commercial plans in the Commonwealth are similar. For this reason, the bill's estimated impact on GIC's incremental PMPM medical expense is assumed the same as other fully insured plans in the Commonwealth. To separately estimate the total medical expense for the GIC, BerryDunn applied the PMPM medical expense to the GIC membership.

BerryDunn assumed the proposed legislative change will apply to self-insured plans that the GIC operates for state and local employees, with an effective date of July 1, 2022. Because of the July effective date, the results in 2022 are approximately one-half of an annual value. Table 13 breaks out the GIC's self-insured membership, as well as the corresponding incremental medical expense.

Table 13: GIC Summary Results

	2022	2023	2024	2025	2026	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
GIC Self-Insured							
Members (000s)	313	312	312	311	311		
Medical Expense Low ($000s)	$80	$203	$246	$290	$333	$256	$1,151
Medical Expense Mid ($000s)	$134	$338	$412	$489	$580	$434	$1,953
Medical Expense High ($000s)	$193	$502	$629	$767	$915	$668	$3,006

Endnotes

[1] The 192nd General Court of the Commonwealth of Massachusetts, House Bill 1194 and Senate Bill 643, "An Act promoting consumer choice in health care." Accessed 10 August 2021: **https://malegislature.gov/Bills/192/H1194 and https://malegislature.gov/Bills/192/S643**.

[2] World Health Organization. Musculoskeletal Conditions. Updated 8 February 2021. Accessed 20 August 2021: **https://www.who.int/news-room/fact-sheets/detail/musculoskeletal-conditions**.

[3] U.S. Centers for Medicare & Medicaid Services (CMS), Office of the Actuary. National Health Expenditure Projections. Table 7, Hospital Care Expenditures; Aggregate and per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2018-2027; Private Insurance. Accessed: 12 August 2021; **https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html.**

[4]U.S. Bureau of Labor Statistics. Occupational Employment and Wage Statistics. May 2020 State Occupational Employment and Wage Estimates Massachusetts Accessed 12 August 2021: **https://www.bls.gov/oes/current/oes_ma.htm.**

[5] United States Census Bureau, American Community Survey Tables for Health Insurance Coverage, Accessed 16 August 2021: **https://www.census.gov/data/tables/time-series/demo/health-insurance/acs-hi.html.**

[6] Massachusetts Center for Health Information and Analysis. Annual Report on the Massachusetts Health Care System, September 2019. Accessed 29 October 2020: **http://www.chiamass.gov/annual-report**.

Appendix A: Membership Affected by the Proposed Language

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

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

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

CHIA publishes monthly enrollment summaries in addition to its biannual enrollment trends report and supporting databook (enrollment-trends-March-2020-databook[xxix] and Monthly Enrollment Summary – August 2020[xxx]), which provides enrollment data for Commonwealth residents by insurance carrier for most carriers. (Some small carriers are excluded.) CHIA uses supplemental information beyond the data in the Massachusetts APCD to develop its enrollment trends report. The supplemental data was used to adjust the resident totals from the Massachusetts APCD. In 2020, commercial, fully insured membership is 2.9% less than in 2019 with a shift to both uninsured and MassHealth coverage. The impact of COVID-19 on fully insured employers over the five-year projected period is uncertain. BerryDunn took a high-level conservative approach and assumed that membership would revert to 2019 levels by January 1, 2022.

The DOI published reports titled Quarterly Report of HMO Membership in Closed Network Health Plans as of December 31, 2018[xxxi] and Massachusetts Division of Insurance Annual Report Membership in MEDICAL Insured Preferred Provider Plans by County as of December 31, 2018.[xxxii] These reports provide fully insured covered members for licensed Commonwealth insurers where the member's primary residence is in the Commonwealth. The DOI reporting includes all insurance carriers and was used to supplement the Massachusetts APCD membership for small carriers not in the Massachusetts APCD.

The distribution of members by age and gender was estimated using Massachusetts APCD population distribution

ratios and was checked for reasonableness and validated against U.S. Census Bureau data.[xxxiii] Membership was projected from 2019 – 2026 using Massachusetts Department of Transportation population growth rate estimates by age and gender.[xxxiv]

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

Appendix A Endnotes

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

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

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

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

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

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

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