

**CENTER FOR HEALTH
INFORMATION AND ANALYSIS**

**BENEFIT MANDATE REVIEW:
MENTAL HEALTH AND SUBSTANCE USE DISORDER SCREENING**

**PROPOSED IN CHAPTER 258 OF THE ACTS OF 2014: AN ACT TO
INCREASE OPPORTUNITIES FOR LONG-TERM SUBSTANCE ABUSE RECOVERY**

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Benefit Mandate Review: Mental Health and Substance Use Disorder Screening

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Benefit Mandate Overview: Mental Health and Substance Use Disorder Screening

HISTORY OF THE PROPOSED MANDATE

Chapter 258 of the Acts of 2014 (Chapter 258) was signed by Governor Deval Patrick on August 6, 2014, enacting Senate Bill 2341. Section 32 of the law requires the Center for Health Information and Analysis (CHIA) to conduct a mandated benefit review – evaluating the legislation’s potential impact on the health of the population and on insurance premiums – of two proposed mandated insurance benefits, consistent with its responsibilities under section 38C of chapter 3 of the Massachusetts General Laws.

WHAT DOES THE MANDATE PROPOSE?

Section 32 of Chapter 258 instructs CHIA to review a proposed mandate requiring health insurance plans to “reimburse providers for mental health and substance use disorder screening when a primary care physician deems it necessary.”ⁱ

EFFICACY OF MENTAL HEALTH AND SUBSTANCE USE DISORDER SCREENING

Screening and follow-up assessment are important first steps in identifying and treating individuals who may be at risk for mental illness, substance abuse, or addiction. According to the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), “[u]nderstanding the extent and nature of a [behavioral health] disorder and its interaction with other life areas is essential for careful diagnosis, appropriate case management, and successful treatment. This understanding begins during the screening and assessment process, which helps match the client with appropriate treatment services.”ⁱⁱ

SAMHSA recommends that “[t]o ensure that important information is obtained, providers should use standardized screening and assessment instruments and interview protocols, some of which have been studied for their sensitivity, validity, and accuracy in identifying problems.”ⁱⁱⁱ To the extent tools used by providers have been proven valid and reliable and are administered appropriately, the proposed mandate should result in increased identification of individuals who should be referred to treatment.

CURRENT COVERAGE

Some mental health or substance use disorder screenings are already mandated by federal or state law. The federal Affordable Care Act (ACA) requires all health insurance plans to cover certain preventive

ⁱ Massachusetts Acts of 2014, Chapter 258, “An Act to Increase Opportunities for Long-Term Substance Abuse Recovery”. Accessed 2 October 2014: <https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter258>.

ⁱⁱ SAMHSA, Center for Substance Abuse Treatment: Treatment Improvement Protocol (TIP) Series, No. 51. Substance Abuse Treatment: Addressing the Specific Needs of Women, Chapter 4: Screening and Assessment. Published 2009; accessed 11 November 2014: <http://www.ncbi.nlm.nih.gov/books/NBK83253/>.

ⁱⁱⁱ *Op. cit.*, SAMHSA. Substance Abuse Treatment: Addressing the Specific Needs of Women: Treatment Improvement Protocol (TIP) Series, No. 51.

health services with no patient cost-sharing;^{iv,v} these include screening for depression in adults, for major depressive disorder in children and adolescents ages 12 to 18, and for alcohol misuse by adults.^{vi} In addition, Massachusetts mandates “neuropsychiatric evaluation and development screening” for children under age six.^{vii}

In a recent survey of ten of the largest insurance carriers in Massachusetts, all reported coverage for mental health and substance abuse screenings. In general, carriers indicated these screenings are covered as part of preventive care services typically delivered through primary care or as a part of an intake and evaluation process by a mental health or substance use disorder provider.

COST OF IMPLEMENTING THE PROPOSED MANDATE

The likely impact of this proposed legislation on insurance premiums is very small. Several common mental health and substance use disorder screenings are already required by the ACA; the proposed legislation would have no effect on insurers’ payments for them. Furthermore, provider billing patterns visible in Massachusetts insurance claim data suggest that insurers rarely pay for screenings as separate services. To the extent insurers pay for screenings, even when coverage for them is required, they appear to do so mostly as part of reimbursements for general preventive exams; such a pattern would likely continue as new screenings are added. 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 less than a penny per member per month.

PLANS AFFECTED BY THE PROPOSED BENEFIT MANDATE

Chapter 258 outlines the general terms of the proposed mandate but does not specify to which plans it would apply. This review assumes the proposed legislation, if enacted, would apply to the same plans as most other mandates: 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. This review assumes the proposed legislation 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.

^{iv} 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>.

^v 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/public-policy/policy-briefs/the-affordable-care-act-and-its-effect-on-health-insurance-market-segments/>.

^{vi} USPSTF: Final Recommendation Statement: Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care. Current as of September 2013. Webpage updated February 2014. Accessed 4 November 2014: <http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care>.

^{vii} M.G.L. c.175 §47C, c.176A §8B, c.176B §4C, c.176G §4.

PLANS NOT AFFECTED BY THE PROPOSED MANDATE

Self-insured plans (i.e., plans in which the employer policyholder retains the risk for medical expenses and uses a carrier 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 review 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 proposed mandate is assumed not to 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.^{viii} CHIA generated this estimate to provide neutral, reliable information to stakeholders who make decisions that impact health care access and costs in the Commonwealth.

The likely impact of this proposed legislation on insurance premiums is very small, less than a penny per member per month. The analysis assumes the mandate, if enacted, would be effective for policies issued or renewed on or after October 1, 2015, consistent with the effective date of mandate provisions already enacted in Chapter 258. Only a small proportion of policies renew between October 1 and the end of 2015, limiting the amount added to the Commonwealth's potential obligation to defray mandate costs in 2015. CHIA applied the mid-range PMPM (per-member per-month) actuarial projection for 2015 cost

^{viii} 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.

(\$0.001) to an estimated maximum of 800,000 potential QHP members,^{ix} adjusted for the portion of the 800,000 members with policies likely to be issued or renewed in the last quarter of the year. The resulting estimated maximum potential incremental premium increase to QHPs for 2015 is not material.

The federal government may remove or modify the obligation after 2015, but, for reference, if it remains the same, CHIA estimated the 2016 cost – the first full year after the assumed effective date – of the proposed legislation by applying the mid-range PMPM (per-member per-month) actuarial projection for 2016 cost (\$0.001) to an estimated maximum of 800,000 potential QHP members. This results in an estimated maximum potential incremental premium increase to QHPs of under \$10,000 per year. 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.

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

Medical Efficacy Assessment: Mental Health and Substance Use Disorder Screening

Chapter 258 of the Massachusetts Acts of 2014¹ requires the Massachusetts Center for Health Information and Analysis (CHIA) to analyze potential legislation “mandating that insurance companies reimburse providers for mental health and substance use disorder screening when a primary care physician deems it necessary.” M.G.L. c. 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 the health status of the population.

MENTAL ILLNESS AND SUBSTANCE USE DISORDERS

Mental illness and substance use disorders and their consequences take a heavy toll on the health and well-being of the U.S. population. According to the National Institute of Mental Health (NIMH), the leading cause of disability in the United States is neuropsychiatric disorders,^x ahead of heart disease and cancer.² Suicide, most instances of which occur in individuals with a mental illness,³ is the fourth leading cause of death in the U.S. for adults ages 18 to 65,⁴ and tenth for people of any age;⁵ an estimated two suicide deaths per day occur on average in Massachusetts.⁶

A 2013 report of the U.S. Substance Abuse and Mental Health Services Administration (SAMSHA) summarized behavioral health (mental health and substance misuse) incidence and treatment measures for Massachusetts between 2008 and 2012.⁷ Almost 8 percent of young people ages 12 to 17 in Massachusetts had at least one major depressive episode within each survey year, or about 37,000 young people annually; of these, 57.4 percent did not receive any treatment for this episode. For adults, 3.7 percent had serious thoughts of suicide in each survey year, or about 189,000 people annually. Similarly, 3.9 percent of adults had a serious mental illness (SMI) in each of the survey years. For adults with any mental illness, almost 51 percent did not receive treatment for their illness.

Substance abuse is a widespread health problem that is also undertreated. According to the National Institute on Drug Abuse (NIDA), “[u]ntreated substance use disorders (SUDs) place individuals at significantly greater risk for a wide range of diseases and are a significant public health burden, yet only one tenth of Americans with SUDs received treatment in 2012.”⁸ In 2010, 641 people in Massachusetts died unintentionally from alcohol or drug misuse, an increase of almost 40 percent from 2000.⁹

SAMHSA also reported that, on average across the 2008–2012 survey years, 12.8 percent of youths in Massachusetts reported using illicit drugs and 7.7 percent reported using cigarettes. Approximately 434,000 people (7.8 percent) age 12 or older in Massachusetts reported they abused or were dependent on alcohol; of these, almost 92 percent received no treatment for their alcohol use. Similarly, of the

^x Mental and behavioral disorders, including substance use disorders, account for 73 percent of neuropsychiatric disorders and neurological diseases for the other 27 percent.

173,000 people (3.1 percent) in this age group who reported abuse of or dependence on illicit drugs, 86 percent did not receive treatment.¹⁰

MENTAL HEALTH AND SUBSTANCE ABUSE SCREENING AND ASSESSMENT

A “screening” has several definitions, varying in the extent to which it overlaps with a more extensive “assessment.” The U.S. National Research Council and Institute of Medicine defines “prevention screening” as a “two-part process that first identifies risk factors...[that make] the development of psychological or behavioral problems more likely,” and then identifies individuals to receive appropriate “preventive intervention.”¹¹ In contrast, SAMHSA describes a somewhat simpler concept; in one of its published Treatment Improvement Protocols, it outlines screening as “a process for evaluating the possible presence of a particular problem. The outcome is normally a simple yes or no.”¹² According to this definition, SAMHSA asserts that “[m]any screening instruments require little or no special training to administer.”¹³

The purpose of screening is to determine whether the patient merits an assessment, which in turn gathers more specific detail used for “defining the nature of [the] problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.”¹⁴ Stated differently: “In general, screening tools are frequency-based and categorize patients according to their risk. Patients who demonstrate moderate to high risk on the initial screening evaluation are then provided with a follow-up assessment to identify specific problems.”¹⁵

EFFICACY OF SCREENING AND TOOLS

Screening and related assessment are important first steps in identifying and treating individuals who may be at risk for mental illness or substance abuse or addiction. According to SAMHSA, “[u]nderstanding the extent and nature of a [behavioral health] disorder and its interaction with other life areas is essential for careful diagnosis, appropriate case management, and successful treatment. This understanding begins during the screening and assessment process, which helps match the client with appropriate treatment services.”¹⁶ Echoing this is the American Society for Addiction Medicine (ASAM), which states:

[s]creening for alcohol and/or drug misuse is critical to the prevention of or early intervention in addiction. For those at risk of developing a serious problem with drinking or drugs, the identification of early warning signs can be enough to change negative drinking or drug use habits. For others, these assessments are important first steps toward treatment of and recovery from addiction.¹⁷

And the 2003 report of the President’s New Freedom Commission on Mental Health concluded that:

[f]or consumers of all ages, early detection, assessment, and linkage with treatment and supports can prevent mental health problems from compounding and poor life outcomes from accumulating. Early intervention can have a significant impact on the lives of children and adults who experience mental health problems.... Emerging research indicates that intervening early can interrupt the negative course of some mental illnesses and may, in some cases, lessen long-term disability. New understanding of the brain indicates that early identification and intervention can sharply improve outcomes...¹⁸

Many screening and assessment tools are available for evaluating a patient's mental health and substance use. For example, a review of screening tools compiled for clinical practice by SAMHSA yielded dozens of different listings, including screening and assessment instruments, online resources, publications and guides, and comprehensive public health approaches.^{19,20} Broad-based behavioral health assessments were included, along with specific tools for depression, alcohol and drug use, bipolar disorder, suicide risk, anxiety disorders, and traumatic events. The listings also included a database maintained by the University of Washington Alcohol and Drug Abuse Institute which links to 996 substance use screening and assessment tools for adults and adolescents, of which 58 are listed as "measures that are widely used and have proven reliability and validity."²¹ One example study – out of many available – of a suicide screening tool found it could meaningfully predict potential for suicide attempts, helping to identify people at imminent risk and in need of treatment.^{22,23}

COMPARING RISKS AND BENEFITS OF SCREENING

The advantages of screening asymptomatic individuals, such as identifying those who would benefit from early intervention and treatment, must be balanced against risk for potential harms, including any negative impact of the screening itself, or potential consequences of a false-positive result. The United States Preventive Services Task Force (USPSTF), which evaluates these benefits and risks, recommends several screenings for mental health and substance use disorders. The USPSTF is an "independent, volunteer panel of national experts in prevention and evidence-based medicine" convened by the U.S. Agency for Healthcare Research and Quality.²⁴ Based on analysis of peer-reviewed evidence, the USPSTF recommends preventive services for patients to primary care clinicians. The panel grades each of their recommendations on "the strength of the evidence and the balance of benefits and harms of a preventive service." Their recommendations apply to people with no signs or symptoms of the evaluated condition or disease, and to services offered in primary care settings or to patients referred by primary care clinicians.

Among mental health screenings, the USPSTF has given a grade 'B' to depression screening in adults when staff-assisted depression care supports are in place,²⁵ meaning that, overall, research has shown this screening service to be moderately to substantially beneficial.²⁶ The USPSTF reviewed many depression screening instruments, but found no evidence to recommend one over another, leaving tool selection to the discretion of the provider. However, it recommended that "[a]ll positive screening tests should trigger full diagnostic interviews that use standard diagnostic criteria."²⁷ The USPSTF has also given a grade 'B' to screening for major depressive disorder for adolescents ages 12 to 18, but only "when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up."²⁸

For substance abuse screenings, the USPSTF has thus far recommended only screening and behavioral counseling interventions for adult alcohol misuse, again giving the service a grade 'B'.²⁹ The task force found evidence that "numerous screening instruments can detect alcohol misuse in adults," and considered three specific tools in its analysis, including a single-question assessment.³⁰

Beyond the USPSTF's endorsement of selected screenings, SAMHSA recommends that “[t]o ensure that important information is obtained, providers should use standardized screening and assessment instruments and interview protocols, some of which have been studied for their sensitivity, validity, and accuracy in identifying problems.”³¹ In an online continuing medical education program for providers, the training material states that “[a] wide range of substance use screening and assessment tools have been validated...many are appropriate for use in primary care settings.”³² These other screenings may ultimately be worthwhile, depending largely on the extent to which they are easy to execute and interpret, are reliable in their results, and increase the probability that patients are accurately identified and referred for appropriate interventions or treatments.

EFFECT OF THE PROPOSED MANDATE ON SCREENING RATES

To the extent the proposed mandate, if enacted, increases rates of mental health and substance use disorder screening, it is likely to have a positive effect on the health of the insured population, as described previously. However, some screenings are already required, and any benefit they provide to the health of the insured population is already in effect. The federal Affordable Care Act (ACA)³³ requires all health insurance plans to cover certain preventive health services with no patient cost-sharing,^{34,35} including preventive health services with an “A” or “B” rating in the USPSTF recommendations. The previously-outlined USPSTF recommendations are therefore already mandated by the ACA; i.e., federal law already requires screening for depression in adults, for major depressive disorder in children and adolescents ages 12 to 18, and for alcohol misuse by adults.³⁶ In addition Massachusetts mandates “neuropsychiatric evaluation and development screening” for children under age six.³⁷

By mandating coverage for screenings not already required, the potential legislation – requiring coverage for additional tools for a variety of other diseases and conditions – if enacted, might improve the health of the population. To the extent that tools used by providers have proven valid and reliable and are administered appropriately, the proposed mandate should result in increased identification of individuals who should be referred to treatment.



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ENDNOTES

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³⁷ M.G.L. c.175 §47C, c.176A §8B, c.176B §4C, c.176G §4.

**Actuarial Assessment of the Mandate for
Mental Health and Substance Use Disorder Screening
Proposed in Chapter 258 of the Acts of 2014:
“An Act to increase opportunities for
long-term substance abuse recovery”**

Prepared for
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Center for Health Information and Analysis

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Prepared by
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Actuarial Assessment of the Mandate for Mental Health and Substance Use Disorder Screening Proposed in Chapter 258 of the Acts of 2014

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Actuarial Assessment of the Mandate for Mental Health and Substance Use Disorder Screening Proposed in Chapter 258 of the Acts of 2014

Executive Summary

Section 32 of Chapter 258 of the Massachusetts Acts of 2014¹ requires the Massachusetts Center for Health Information and Analysis (CHIA) to analyze proposed legislation “mandating that insurance companies reimburse providers for mental health and substance use disorder screening when a primary care physician deems it necessary.” Massachusetts General Laws (M.G.L.) c.3 §38C charges the Massachusetts Center for Health Information and Analysis (CHIA) with reviewing the potential impact of proposed mandated health care insurance benefits on the premiums paid by business and consumers. CHIA has engaged Compass Health Analytics, Inc. to provide an actuarial estimate of the effect enactment of the proposed legislation would have on the cost of health care insurance in Massachusetts.

Chapter 258 outlines the general terms of the proposed mandate but does not specify to which insurance plans it would apply. This analysis will assume the proposed legislation, if enacted, will amend the statutes that regulate insurers providing health insurance in Massachusetts, applying the mandate to the full set of commercial insurance licenses, and to all plans offered by the Group Insurance Commission.

Background

Screening and related assessment are demonstrably effective first steps in identifying and treating individuals who may be at risk of mental illness or substance abuse or addiction.^{2,3,4} The proposed legislation does not define a “screening,” which can have several definitions, varying in the extent to which a screening overlaps with a more extensive “assessment.” This analysis assumes the primary purpose of screening is to determine whether the patient merits an assessment, which in turn gathers more specific detail used for “defining the nature of [the] problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.”⁵ However, as a practical matter, the scope of “screening” services as they appear in studies, or even as defined in the procedure coding used in claim data, is not always cleanly delineated and will introduce some uncertainty into the analysis.

In a recent survey of ten of the largest insurance carriers in Massachusetts, all report coverage for mental health and substance abuse screenings. In general, carriers indicated that these screenings are covered as part of preventive care services typically delivered through primary care or as a part of an intake and evaluation process by a mental health or substance use disorder provider.

Other laws affecting screening services

Some screenings are already required by law, and therefore do not contribute to the incremental effect of this proposed legislation on premiums. The federal Affordable Care Act (ACA)⁶ required all

health insurance plans to cover, starting in late 2010, certain preventive health services with no patient cost-sharing,^{7,8} including preventive health services with an 'A' or 'B' rating in the recommendations of the United States Preventive Services Task Force (USPSTF). These include several related to mental health and substance abuse disorders: screening for depression in adults, for major depressive disorder in children and adolescents ages 12 to 18, and for alcohol misuse by adults.

Effect of the proposed mandate on provider billing procedures

The extent to which the proposed mandate would result in changes to medical billing practice is not clear. The proposed language requires coverage for relevant screenings, but does not explicitly require insurers to pay for screenings performed and billed at the same time as a periodic preventive exam. That is, for screenings that occur during a preventive exam visit, insurers and providers might negotiate contracts under which the insurer pays for the screening as part of the bundled exam fee, or contracts under which insurers pay for screenings separately.

Presumably, only screenings added to standard practice after enactment of this proposed mandate would be attributable to the mandate itself, and not those stemming from the requirements of the ACA or from voluntary coverage by insurers. To the extent providers succeed in negotiating incremental reimbursement for those added screenings, insurance premiums will rise. Should insurers succeed in including the cost of those screenings in reimbursements for preventive exams, premium increases will be minimal.

Analysis

Data from the Massachusetts All Payer Claim Database (APCD) provide an opportunity to measure the effect of the 2010 ACA screening requirement on medical expense. This analysis compared claims from 2012 (after a year for implementation in 2011) to a 2010 baseline. The base levels and the changes between 2010 and 2012 for claim expense for separately billed screening services, on a PMPM basis, are very small, less than a tenth of a penny. These data suggest that, to the extent screening services are provided, they are generally provided as part of preventive office visits and not billed separately.

The data allow the calculation of a factor capturing the increase in screening services between 2010 and 2012, which was approximately 60 percent. While this percentage increase is large, it stems from a very small base, so the absolute value of the increase is small.

It is not clear whether the additional screening that Chapter 258 may generate will be of a smaller or larger magnitude than the ACA-driven changes measured by the 60 percent increase. On one hand, under Chapter 258, many more screening instruments could potentially qualify as valid services that must be covered, not just the few screening tools the ACA provision mandated via its reference to the USPSTF's assessment. On the other hand, the ACA mandate already included those screens with the USPSTF (grade B or higher) imprimatur, and so may already capture the bulk of generally-accepted screening that will take place. To allow for this uncertainty, this analysis

assumes, in the mid-level scenario, that Chapter 258 would have an additional impact equal to the ACA impact, half that level in the low scenario, and twice that level in the high scenario.

Summary results

The baseline incremental increase in medical expense was estimated as the difference between the 2012 spending, with the increase factor applied, minus the measured 2012 baseline spending. This increment was projected through 2019, the end of the five year timeframe of the analysis. Table ES-1 displays the results. Note that the proposed mandate is assumed effective October 1, 2015, consistent with the effective date of mandate provisions already enacted in Chapter 258.

This analysis estimates that the mandate, if enacted, would increase fully-insured premiums by as much as 0.0004 percent on average over the three years following the effective date; a more likely increase is in the range of 0.0002 percent. While the overall impact of this proposed legislation would be small, the impact of the proposed legislation 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.

**Table ES-1:
Summary Results**

	4Q 2015	2016	2017	2018	2019	Weighted Average	5 Yr Total
Members (000s)	2,144	2,121	2,096	2,071	2,045		
Medical Expense Low (\$000s)	\$0	\$11	\$11	\$11	\$12	\$11	\$45
Medical Expense Mid (\$000s)	\$1	\$21	\$22	\$23	\$23	\$22	\$90
Medical Expense High (\$000s)	\$1	\$43	\$44	\$46	\$47	\$45	\$180
Premium Low (\$000s)	\$0	\$12	\$12	\$13	\$13	\$13	\$51
Premium Mid (\$000s)	\$1	\$24	\$25	\$26	\$27	\$25	\$102
Premium High (\$000s)	\$1	\$48	\$50	\$51	\$53	\$51	\$204
PMPM Low	\$0.000	\$0.000	\$0.000	\$0.001	\$0.001	\$0.000	\$0.000
PMPM Mid	\$0.001	\$0.001	\$0.001	\$0.001	\$0.001	\$0.001	\$0.001
PMPM High	\$0.002	\$0.002	\$0.002	\$0.002	\$0.002	\$0.002	\$0.002
Estimated Monthly Premium	\$512	\$537	\$564	\$592	\$622	\$566	\$566
Premium % Rise Low	0.0001%	0.0001%	0.0001%	0.0001%	0.0001%	0.0001%	0.0001%
Premium % Rise Mid	0.0002%	0.0002%	0.0002%	0.0002%	0.0002%	0.0002%	0.0002%
Premium % Rise High	0.0004%	0.0004%	0.0004%	0.0003%	0.0003%	0.0004%	0.0004%

Executive Summary Endnotes

¹ Massachusetts Acts of 2014, Chapter 258, Section 32 “An Act to Increase Opportunities for Long-Term Substance Abuse Recovery”. Accessed 2 October 2014: <https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter258>.

² *Op. cit.*, SAMHSA. Substance Abuse Treatment: Addressing the Specific Needs of Women: Treatment Improvement Protocol (TIP) Series, No. 51.

³ American Society of Addiction Medicine (ASAM): Screening and Assessment. Accessed 5 November 2014: <http://www.asam.org/research-treatment/screening-and-assessment>.

⁴ Hogan MF. The President's New Freedom Commission: recommendations to transform mental health care in America. Published 22 July 2003; accessed 11 November 2014: http://www.nami.org/Template.cfm?Section=New_Freedom_Commission&Template=/ContentManagement/ContentDisplay.cfm&ContentID=28321. Full publication at <http://www.nami.org/Template.cfm?Section=Policy&Template=/ContentManagement/ContentDisplay.cfm&ContentID=16699>.

⁵ *Op. cit.*, SAMHSA. Substance Abuse Treatment: Addressing the Specific Needs of Women: Treatment Improvement Protocol (TIP) Series, No. 51.

⁶ 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](http://www.healthcare.gov/glossary). Accessed 10 March 2014: <https://www.healthcare.gov/glossary/affordable-care-act/>

⁷ 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>.

⁸ 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/public-policy/policy-briefs/the-affordable-care-act-and-its-effect-on-health-insurance-market-segments/>.

Actuarial Assessment of the Mandate for Mental Health and Substance Use Disorder Screening Proposed in Chapter 258 of the Acts of 2014

1. Introduction

Section 32 of Chapter 258 of the Massachusetts Acts of 2014¹ requires the Massachusetts Center for Health Information and Analysis (CHIA) to analyze potential legislation “mandating that insurance companies reimburse providers for mental health and substance use disorder screening when a primary care physician deems it necessary.”

Massachusetts General Laws (M.G.L.) c.3 §38C charges the Massachusetts Center for Health Information and Analysis (CHIA) with reviewing the potential impact of proposed mandated health care insurance benefits on the premiums paid by business and consumers. CHIA has engaged Compass Health Analytics, Inc. to provide an actuarial estimate of the effect enactment of the proposed legislation would have on the cost of health care insurance in Massachusetts.

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

Section 2 of this analysis outlines the provisions of the proposed legislation. Section 3 summarizes the methodology used for the estimate. Section 4 discusses important considerations in translating the legislation’s language into estimates of its incremental impact on health care costs and steps through the calculations. Section 5 summarizes the results.

2. Interpretation of the Proposed Mandate

The following subsections describe the provisions of the proposed legislation.

2.1. Plans affected by the proposed mandate

Chapter 258 outlines the general terms of the proposed mandate but does not specify to which insurance plans it would apply. This analysis will assume the proposed legislation, if enacted, will amend the statutes that regulate insurers providing health insurance in Massachusetts, applying the mandate to the full set of commercial insurance licenses and all plans offered by the Group Insurance Commission, as listed below.

- Insurance for persons in service of the Commonwealth (amending M.G.L. c. 32A)
- Accident and sickness insurance policies (amending M.G.L. c. 175)
- Contracts with non-profit hospital service corporations (amending M.G.L. c. 176A)

- Certificates under medical service agreements (amending M.G.L. c. 176B)
- Health maintenance contracts (amending M.G.L. 176G)

The analysis assumes the proposed legislation 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. This analysis will not consider potential impact on Medicaid/MassHealth.

This analysis assumes the proposed legislation, if enacted, would be effective for policies issued or renewed on or after October 1, 2015, consistent with the effective date of mandate provisions already enacted in Chapter 258.

2.2. Covered services

The description of the proposed legislation described in Chapter 258 is general, requiring insurers to cover “mental health and substance use disorder screening when a primary care physician deems it necessary.”

Value of screening

Screening and related assessment are important first steps in identifying and treating individuals who may be at risk of mental illness, substance abuse, or addiction. According to SAMHSA, “[u]nderstanding the extent and nature of a [behavioral health] disorder and its interaction with other life areas is essential for careful diagnosis, appropriate case management, and successful treatment. This understanding begins during the screening and assessment process, which helps match the client with appropriate treatment services.”² Echoing this is the American Society for Addiction Medicine (ASAM), which states “[s]creening for alcohol and/or drug misuse is critical to the prevention of or early intervention in addiction.”³ And the 2003 report of the President’s New Freedom Commission on Mental Health concluded: “[f]or consumers of all ages, early detection, assessment, and linkage with treatment and supports can prevent mental health problems from compounding and poor life outcomes from accumulating.”⁴ Many screening and assessment tools are available for evaluating a patient’s mental health and substance use; a review of screening tools SAMHSA compiled for clinical practice yielded dozens of listings.^{5,6}

Scope of “screening”

The proposed legislation does not define a “screening,” which can have several definitions, varying in the extent to which a screening overlaps with a more extensive “assessment.” The U.S. National Research Council and Institute of Medicine define “prevention screening” as a “two-part process that first identifies risk factors...[that make] the development of psychological or behavioral

problems more likely,” and then identifies individuals to receive appropriate “preventive intervention.”⁷ In contrast, SAMHSA describes a somewhat simpler concept; in one of its published Treatment Improvement Protocols, it outlines screening as “a process for evaluating the possible presence of a particular problem. The outcome is normally a simple yes or no.”⁸ According to this definition, SAMHSA asserts that “[m]any screening instruments require little or no special training to administer.”⁹

This analysis assumes the primary purpose of screening is to determine whether the patient merits an assessment, which in turn gathers more specific detail used for “defining the nature of [the] problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.”¹⁰ Stated differently: “Patients who demonstrate moderate to high risk on the initial screening evaluation are then provided with a follow-up assessment to identify specific problems.”¹¹

However, as a practical matter, the scope of “screening” services as they appear in studies, or even as defined in the procedure coding used in claim data, is not always cleanly delineated. In some contexts, a “screening” could include interactions, standardized or not, between provider and patient that might be characterized as a part of assessment, i.e., gathering data on someone who has already been identified as a candidate for assessment, perhaps leading to diagnosis. This is important because assessment and diagnosis for mental health and substance use disorders are already mandated, notably under the Massachusetts mental health parity statutes,¹² and are generally already covered by insurers. Services already mandated or covered do not contribute to the impact of the proposed legislation on premiums.

2.3. Current coverage

In a recent survey of ten of the largest insurance carriers in Massachusetts, all reported coverage for mental health and substance abuse screenings. In general, carriers indicated these screenings are covered as part of preventive care services typically delivered through primary care or as a part of an intake and evaluation process by a mental health or substance use disorder provider.

2.4. Other laws affecting screening services

Some screenings are already required by law, and therefore do not contribute to the incremental effect of this proposed legislation on premiums. The federal Affordable Care Act (ACA)¹³ required all health insurance plans to cover, starting in late 2010, certain preventive health services with no patient cost-sharing,^{14,15} including preventive health services with an ‘A’ or ‘B’ rating in the recommendations of the United States Preventive Services Task Force (USPSTF).¹⁶ These include several related to mental health and substance abuse disorders: screening for depression in adults, for major depressive disorder in children and adolescents ages 12 to 18, and for alcohol misuse by adults.^{17,18,19,20} In addition, Massachusetts mandates “neuropsychiatric evaluation and development screening” for children under age six.²¹

2.5. Effect of the proposed mandate on provider billing procedures

The extent to which the proposed mandate would result in changes to medical billing practice is not clear. The clause in the proposed legislation about who orders screenings – “when a primary care physician deems it necessary” – suggests the mandate is targeted at primary care physicians and preventive or wellness exams, and possibly a few additional preventive settings, such as a gynecological screening. The proposed language requires coverage for relevant screenings, but does not explicitly require insurers to pay for screenings performed and billed at the same time as a periodic preventive exam, in contrast to other proposed mandates, e.g., House Bill 847, which would require insurers to pay separately for cytology screening performed at the same time as a physical exam.²² That is, for screenings that occur during a preventive exam visit, insurers and providers might negotiate contracts under which the insurer pays for the screening as part of the bundled exam fee, or contracts under which insurers pay for screenings separately.

Presumably, only screenings added to standard practice after enactment of this proposed mandate would be attributable to the mandate itself and not to the requirements of the ACA or to voluntary coverage by insurers. To the extent providers succeed in negotiating incremental reimbursement for those added screenings, insurance premiums will rise. Should insurers succeed in including the cost of those screenings in reimbursements for preventive exams, premium increases will be minimal.

3. Methodology

3.1. Overview

As described above, the proposed legislation would require insurers to cover screening for mental health and substance use disorders, and follows the Affordable Care Act’s (ACA) 2010 mandate of coverage for screening for depression in adults, for major depressive disorder in children and adolescents ages 12 to 18, and for alcohol misuse by adults. These earlier federal mandates provide an historical utilization baseline for assessing the Chapter 258 screening requirement. The Massachusetts All Payer Claim Database (APCD) is used to measure the impact between 2010 and 2012 of the 2010 ACA changes and to estimate a range of factors applied to the baseline to estimate the impact of Chapter 258’s proposed screening mandate.

3.2. Steps in the analysis

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

- Summarize carriers’ current mental health and substance use disorder screening coverage
- Using the APCD, measure the cost and number of services for mental health and substance use disorder screenings for fully-insured members for 2010 and 2012 in total and on a per-member per-month (PMPM) basis

- Using utilization information from the carriers over time, measure the impact on utilization that occurred when screenings for depression and alcohol misuse were mandated by the ACA
- Estimate incremental screenings within the potential scope of the proposed legislation and estimate cost ranges for potential growth in utilization
- Estimate the impact of insurer retention (administrative costs and profit) on premiums.
- Estimate the fully-insured Massachusetts population under age 65, projected for the next five years (2015 to 2019)
- Project the estimated cost over the next five years

Section 4 describes these specific steps in more detail.

3.3. Data sources

The primary data sources used in the analysis were:

- Information from a survey of private health insurance carriers in Massachusetts
- Professional coding documentation, published reports, and population data, cited as appropriate
- Massachusetts insurer claim data from the Massachusetts All Payer Claim Database for calendar years 2010 and 2012, for plans covering the overwhelming majority of the under-65 fully-insured population subject to the proposed mandate²³

The more detailed step-by-step description of the estimation process described 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.

- Hundreds of screening tools are available, and the degree to which Chapter 258 will encourage their use beyond the level of the specific screens already mandated by the ACA is unclear
- Sampling claim and other data to measure the volume of current screening services in Massachusetts is likely to capture inadvertently, to at least some degree, interactions that are better characterized as assessment; this will contribute to some uncertainty in the final estimate of the impact of this proposed legislation on premiums

This uncertainty requires the use of ranges to create low-, mid-, and high-level estimates.

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 included 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. Effect of Chapter 258 on coverage for screenings

All carriers responding to a survey of questions about their screening coverage indicated they cover screening services. Some carriers assume that screening is provided as part of preventive office visits and do not provide separate payment, and some indicated they provide separate payment for certain screening services. Based on these responses, the primary impact of the mandate would be to broaden substantially the scope of screening tools that would be included in the current coverage.

The 2010 ACA requires screening for specific screening tools rated B or better by the USPSTF. Chapter 258 does not limit itself to screenings for particular mental health or substance use disorder (MH/SUD) conditions or to particular screening tools, and so would apply to a wide array of generally-accepted and valid MH/SUD screenings and available tools.

4.2. Impact of 2010 ACA screening requirements

Data from the Massachusetts APCD provide an opportunity to measure the effect of the 2010 ACA screening requirement on medical expense. This analysis compared claims from 2012 (after a year for implementation in 2011) to a 2010 baseline. Both fully-insured and self-insured plans were analyzed to increase the sample size; the ACA requirement applied to both. The resulting measured factor is applied only to the fully-insured plans, as state mandates do not apply to self-insured plans.

Table 1 displays the change between insurers’ 2010 and 2012 PMPM medical claim expense for screening procedure codes identified in the survey of carriers and in professional coding resources.²⁴ The bottom rows of Table 1 summarize the change for all codes combined and for two subsets of codes that will be used in the analysis of the impact on medical expense described below.

The base levels and the changes between 2010 and 2012 for claim expense for separately billed screening services, on a PMPM basis, are very small, less than a tenth of a penny. These data suggest that, to the extent screening services are provided, they are generally provided as part of preventive office visits and not billed separately. The above interpretation of Chapter 258, one that assumes carriers may continue a policy of not paying separately for screening services, is supported by the very small impact made by the ACA’s screening provisions. Neither the ACA nor Chapter 258 explicitly requires separate payment. After the rollout of the 2010 ACA requirements, either that policy continued (more likely), or the impact on volume of separately paid codes is very small; in either case the financial impact of the potential mandate is likely to be very small.

Table 1
2010-2012 Change in PMPM for Screening Services

CPT Code	Description	2010 PMPM	2012 PMPM	Change
99420	Administration and interpretation of health risk assessment instrument (e.g., health hazard appraisal)	\$0.0003	\$0.0008	\$0.0005
G0442	Annual alcohol misuse screening, 15 minutes	\$0.0000	\$0.0000	\$0.0000
G0444	Annual depression screening, 15 minutes	\$0.0000	\$0.0007	\$0.0007
H0049	Alcohol and/or drug screening	\$0.0000	\$0.0000	\$0.0000
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes	\$0.0003	\$0.0001	(\$0.0002)
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes	\$0.0002	\$0.0002	(\$0.0000)
G0396	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes	\$0.0000	\$0.0000	\$0.0000
G0397	Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes	\$0.0000	\$0.0000	(\$0.0000)
Total		\$0.0009	\$0.0018	\$0.0009
Annual alcohol misuse and depression screenings (G0442 and G0444)		\$0.0000	\$0.0007	\$0.0007
All codes except annual alcohol misuse and depression screenings (G0442 and G0444)		\$0.0009	\$0.0011	\$0.0003

4.3. Assumptions about Chapter 258 screening requirements

Table 1 allows the calculation of a factor capturing the increase in screening services between 2010 and 2012, which was approximately 60 percent. While this percentage increase is large, it stems from a very small base, so the absolute value of the increase, as shown in Table 1, is small.

It is not clear whether the additional screening that Chapter 258 may generate will be of a smaller or larger magnitude than the ACA-driven changes measured by the 60 percent increase. On one hand, under Chapter 258, many more screening instruments could potentially qualify as valid services that must be covered, not just the few screening tools the ACA provision mandated via its reference to the USPSTF's assessment. On the other hand, the ACA mandate already included those screens with the USPSTF (grade B or higher) imprimatur, and so may already capture the bulk of generally-accepted screening that will take place. To allow for this uncertainty, this analysis assumes, in the mid-level scenario, that Chapter 258 would have an additional impact equal to the ACA impact (an additional 60 percent), and incremental impacts of half that level (30 percent) in the low scenario and twice that level (120 percent) in the high scenario.

4.4. Incremental medical expense calculation

The incremental increase in medical expense was estimated as the difference between the 2012 spending, with the increase factor from Section 4.3 applied, minus the measured 2012 baseline spending. This was calculated for each of the three scenarios using the three factors discussed above. Table 2 displays the results.

Table 2
Medical Expense Impact of Chapter 258 Screening Mandate

	<u>Low</u>	<u>Mid</u>	<u>High</u>
Impact of c 258 relative to Impact of ACA	0.5	1.0	2.0
Total PMPM Impact	\$0.0007	\$0.0014	\$0.0027
Medical Claim Impact	\$11,688	\$23,371	\$46,742

4.5. Retention

Assuming an average retention rate of 11.5 percent, based on CHIA's analysis of administrative costs and profit in Massachusetts,²⁵ the increase in medical expense was adjusted upward to approximate the total impact on premiums.

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

Table 3 shows the fully-insured population in Massachusetts ages 0 to 64 projected for the next five years. Appendix A describes the data sources and methodology for the population projections.

Table 3
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 proposed legislation requires, in addition to the membership projection, a projection of the 2012 baseline PMPM cost forward to the same 2015-2019 period, discussed next.

4.7. Projection

To project over the five-year (2015-2019) period, the increased medical expense for each time period was estimated by multiplying the net utilization increases by the corresponding average unit costs for the appropriate time period. The 2012 base period unit prices are adjusted using an average annual projected health care cost trend of 4.5 percent.

5. Results

5.1. Five-year estimated impact

For each year in the five-year analysis period, Table 4 displays the projected net impact of the proposed mandate on medical expense and premiums using a projection of Massachusetts fully-insured membership. Note that the proposed mandate is assumed effective October 1, 2015, consistent with the effective date of mandate provisions already enacted in Chapter 258; therefore the 2015 impact is for policies issued/renewing in the fourth quarter, or about fifteen percent of policies, as most renew in January and July. On average, the mandate will affect policies issued/renewed in the fourth quarter for only two months, so the impact in 2015 is very small, less than 3 percent of the annualized amount.

This analysis estimates that the mandate, if enacted, would increase fully-insured premiums by as much as 0.0004 percent on average over the three years following the effective date; a more likely increase is in the range of 0.0002 percent.

The impact of the proposed legislation 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.

Table 4
Summary Results

	4Q 2015	2016	2017	2018	2019	Weighted Average	5 Yr Total
Members (000s)	2,144	2,121	2,096	2,071	2,045		
Medical Expense Low (\$000s)	\$0	\$11	\$11	\$11	\$12	\$11	\$45
Medical Expense Mid (\$000s)	\$1	\$21	\$22	\$23	\$23	\$22	\$90
Medical Expense High (\$000s)	\$1	\$43	\$44	\$46	\$47	\$45	\$180
Premium Low (\$000s)	\$0	\$12	\$12	\$13	\$13	\$13	\$51
Premium Mid (\$000s)	\$1	\$24	\$25	\$26	\$27	\$25	\$102
Premium High (\$000s)	\$1	\$48	\$50	\$51	\$53	\$51	\$204
PMPM Low	\$0.000	\$0.000	\$0.000	\$0.001	\$0.001	\$0.000	\$0.000
PMPM Mid	\$0.001	\$0.001	\$0.001	\$0.001	\$0.001	\$0.001	\$0.001
PMPM High	\$0.002	\$0.002	\$0.002	\$0.002	\$0.002	\$0.002	\$0.002
Estimated Monthly Premium	\$512	\$537	\$564	\$592	\$622	\$566	\$566
Premium % Rise Low	0.0001%	0.0001%	0.0001%	0.0001%	0.0001%	0.0001%	0.0001%
Premium % Rise Mid	0.0002%	0.0002%	0.0002%	0.0002%	0.0002%	0.0002%	0.0002%
Premium % Rise High	0.0004%	0.0004%	0.0004%	0.0003%	0.0003%	0.0004%	0.0004%

5.2. Impact on the GIC

The proposed mandate is assumed to apply to both fully-insured and self-insured plans operated for state and local employees by the Group Insurance Commission (GIC), with an effective date for all GIC policies on October 1, 2015.

The benefit offerings of GIC plans are similar to those of most other commercial plans in Massachusetts. However, based on data from the 2012 Massachusetts APCD, the GIC’s utilization rate of substance abuse screenings (per thousand members) is about 23 percent higher than that of the general fully insured population. As a result, the estimated effect of the proposed mandate on GIC substance abuse screening medical expense is expected to be about 23 percent higher than that estimated for the other fully-insured plans in Massachusetts. It is important to note approximately 30 percent of the GIC membership was cleanly identifiable in the APCD, and the utilization estimate assumes the available portion represents a reasonable sample of the overall GIC membership. To estimate the medical expense separately for the GIC, the PMPM medical expense for the general fully-insured population was applied to the GIC membership and increased by 23 percent starting in October of 2015.

Table 5 breaks out the GIC-only fully-insured membership and the GIC self-insured membership and the corresponding incremental medical expense and premium. Note that the total medical expense and premium values for the general fully-insured membership displayed in Table 4 also include the GIC fully-insured membership. Finally, the proposed mandate is assumed to require the GIC to implement the provisions fully on October 1, 2015; therefore, the fourth quarter of 2015 represents approximately one quarter of an annual value.

**Table 5:
GIC Summary Results**

	Q4 2015	2016	2017	2018	2019	Weighted Average	5 Yr Total
GIC Fully-Insured							
Members (000s)	57	57	57	57	57		
Medical Expense Low (\$000s)	\$0	\$0	\$0	\$0	\$0	\$0	\$2
Medical Expense Mid (\$000s)	\$0	\$1	\$1	\$1	\$1	\$1	\$3
Medical Expense High (\$000s)	\$0	\$1	\$1	\$2	\$2	\$2	\$6
Premium Low (\$000s)	\$0	\$0	\$0	\$0	\$0	\$0	\$2
Premium Mid (\$000s)	\$0	\$1	\$1	\$1	\$1	\$1	\$4
Premium High (\$000s)	\$0	\$2	\$2	\$2	\$2	\$2	\$7
GIC Self-Insured							
Members (000s)	259	259	259	258	258		
Medical Expense Low (\$000s)	\$0	\$2	\$2	\$2	\$2	\$2	\$7
Medical Expense Mid (\$000s)	\$1	\$3	\$3	\$4	\$4	\$3	\$15
Medical Expense High (\$000s)	\$2	\$6	\$7	\$7	\$7	\$7	\$29

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 data²⁶ form the base for the projections. Distributions by gender and age, also from Census Bureau,²⁷ were applied to these totals. Projected growth rates for each gender/age category were estimated from Census Bureau population projections to 2030.²⁸ 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 coverage²⁹ 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.³⁰

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 residents³¹ and non-residents³² 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 subtract the estimated number of people previously covered by Commonwealth Care who moved into MassHealth due to expanded Medicaid eligibility under the Affordable Care Act.³³

Projections for the GIC self-insured lives were developed using GIC base data for 2012³⁴ and 2013³⁵ 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.

Endnotes

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¹⁰ *Op. cit.*, SAMHSA. Substance Abuse Treatment: Addressing the Specific Needs of Women: Treatment Improvement Protocol (TIP) Series, No. 51.

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¹² M.G.L. c.32A §22, c.175 §47B, c.176A §8A, c.176B §4A, c.176G §4M.

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](http://www.healthcare.gov/glossary/affordable-care-act/). 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 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/public-policy/policy-briefs/the-affordable-care-act-and-its-effect-on-health-insurance-market-segments/>.

¹⁶ The United States Preventive Services Task Force (USPSTF), a panel of experts in prevention and evidence-based medicine convened by the U.S. Agency for Healthcare Research and Quality, recommends preventive services for patients to primary care clinicians, grading each of their recommendations on “the strength of the evidence and the balance of benefits and harms of a preventive service.” Their screening recommendations apply to people with no signs or symptoms of the evaluated condition or disease, and to services offered in primary care settings or to those referred by primary care clinicians.

¹⁷ USPSTF: Final Recommendation Statement: Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care. Current as of September 2013. Webpage updated February 2014. Accessed 4 November 2014: <http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care>.

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¹⁹ “Grade B: The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.” U.S. Preventive Services Task Force (USPSTF): Grade Definitions. Updated October 2014; accessed 10 November 2014: <http://www.uspreventiveservicestaskforce.org/Page/Name/grade-definitions>.

²⁰ USPSTF: Final Recommendation Statement: Depression in Children and Adolescents: Screening. Current as of March 2009. Webpage updated October 2014; accessed 4 November 2014: <http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-children-and-adolescents-screening>.

“The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening of children (7-11 years of age).”

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²³ More information can be found at <http://www.mass.gov/chia/researcher/hcf-data-resources/apcd/>.

²⁴ American Medical Association 2012 CPT® and HCPCS Level II data files.

²⁵ Massachusetts Center for Health Information and Analysis. Annual Report on the Massachusetts Health Care Market, August 2013. Accessed 17 March 2014: <http://www.mass.gov/chia/docs/r/pubs/13/ar-ma-health-care-market-2013.pdf>.

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