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MANDATED BENEFIT REVIEW OF  
SENATE BILL 2282  
SUBMITTED TO THE 190TH GENERAL COURT:

**AN ACT TO REQUIRE  
HEALTH CARE COVERAGE  
FOR EMERGENCY  
PSYCHIATRIC SERVICES.**

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NOVEMBER 2018

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



# Mandated Benefit Review of Senate Bill 2282

## Submitted to the 190<sup>th</sup> General Court:

### An act to require health care coverage for emergency psychiatric services.

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# 1.0 Benefit Mandate Overview: S.B. 2282: An Act to require health care coverage for emergency psychiatric services

## 1.1 History of the Bill

The Joint Committee on Mental Health, Substance Use, and Recovery referred Senate Bill (S.B.) 2282, “An Act to require health care coverage for the emergency psychiatric services,”<sup>1</sup> to the Center for Health Information and Analysis (CHIA) for review. Massachusetts General Laws (MGL), chapter 3, section 38C, requires CHIA to review and evaluate the potential fiscal impact of each mandated benefit bill referred to the agency by a legislative committee.

This report is not intended to determine whether S.B. 2282 would constitute a health insurance benefit mandate for purposes of state defrayal under the Affordable Care Act, nor is it intended to assist with state defrayal calculations if it is determined to be a health insurance benefit mandate requiring state defrayal.

## 1.2 What Does the Bill Propose?

Massachusetts S.B. 2282, as submitted in the 190th General Court of the Commonwealth of Massachusetts (Commonwealth), requires fully insured plans to cover medically necessary emergency psychiatric service programs, defined by the bill as “all programs subject to contract between the Massachusetts Behavioral Health Partnership and nonprofit organizations.”<sup>i</sup> The Massachusetts Behavioral Health Partnership (MBHP) manages the Commonwealth’s Emergency Services Program (ESP) that provides emergency psychiatric services including mobile crisis intervention (MCI) 24 hours per day, seven days per week, for individuals experiencing a mental health or substance use disorder crisis, including crisis assessment, intervention, and stabilization services.<sup>2</sup> Benefits under the bill “shall be provided on a non-discriminatory basis, and shall not be subject to any greater deductible, coinsurance, copayments or out-of-pocket limits than any other benefit provided by the carrier.”<sup>ii</sup>

Subsequent to referral of the bill to CHIA for review, CHIA and its consultants submitted an inquiry to sponsoring legislators and staff, and their response indicated that the intent of S.B. 2282 is to mandate coverage of “medically necessary emergency assessment, intervention, and stabilization services for individuals in mental health or substance use disorder crisis, defined by the sponsors as ‘the initial encounter.’”

## 1.3 Medical Efficacy of S.B. 2282

ESP is a statewide community-based crisis stabilization program for patients experiencing a behavioral health crisis. The program is intended as an alternative to behavioral health emergency department (ED) utilization and boarding,<sup>iii</sup> which has consistently risen in Massachusetts in recent years,<sup>3</sup> and inpatient hospital psychiatric treatment. Providers reduce immediate risks to patients through the provision of short-term services and facilitate referrals to appropriate programs and treatments along the behavioral health continuum of care.

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<sup>i</sup> The Massachusetts Behavioral Health Partnership (MBHP) manages behavioral health care for MassHealth members statewide. This report is limited to the programs that fall within the Emergency Services Program (ESP).

<sup>ii</sup> This language has been interpreted to mean that the benefit cannot have cost-sharing in excess of similar existing benefits.

<sup>iii</sup> ED boarding is defined as a length of stay in the ED of more than 12 hours from time of registration to time of discharge.

ESP is managed by MBHP on behalf of the state. MBHP is a Beacon Health Options company that manages all behavioral health care for MassHealth (Medicaid) members, as well as the state's ESP for covered members, Medicare beneficiaries, and uninsured individuals.<sup>4</sup> There are currently 17 MBHP-managed ESP catchment areas in Massachusetts, as well as 4 ESPs operated by the state's Department of Mental Health (DMH) located in the Southeast region.<sup>5</sup> Each catchment area has at least one locally based provider who is to help improve access to community-based emergency behavioral health services in the area, and to facilitate access to other levels of care in the behavioral health continuum.

The four service components of ESP are:<sup>6</sup>

1. **ESP Community-Based Locations (CBL)** are the “hubs” intended to coordinate all ESP service components and are intended to provide an alternative to hospital EDs.
2. **MCI** refers to ESP services provided by contracted providers to youth under age 21, and is to be a short-term, mobile, on-site, face-to-face therapeutic response to patients experiencing a behavioral health crisis.<sup>7</sup>
3. **Adult MCI** is also intended to reduce hospital ED visits and inpatient psychiatric utilization by providing ESP services to adults on a mobile basis as needed.
4. **Adult Community Crisis Stabilization (CCS)** is used primarily as a diversion from inpatient psychiatric services for patients 18 and older and provides additional clinical services, including nursing care, in a staff-secure, safe, and structured environment.

The intent of S.B. 2282 is to mandate coverage of the “initial encounter.” The initial encounter is provided by 1, 2, and 3 above.

Research regarding crisis intervention services has shown that there are many different models of community-based services. Different models, coupled with the inherent complexities in acute mental health care treatment, make comparisons and generalizations difficult. Although study quality is frequently lacking in the research, most studies find that community-based services can be provided at a lower cost with similar outcomes when compared to hospital-based services. However, most studies suggest additional research is needed to further assess their impact on hospital use, global state, mental state, quality of life, participant satisfaction, and family burden in order to generalize research findings.

## 1.4 Current Coverage

For commercial coverage, no Massachusetts state or federal law requires coverage of mobile emergency psychiatric services. The benefits are defined for Massachusetts according to the state's benchmark health plan, which does not specifically include mobile crisis emergency psychiatric services or initial encounters provided by ESP.<sup>8</sup> Under the federal Affordable Care Act (ACA), emergency services and mental health and substance abuse services and treatment are considered essential health benefits (EHBs), and coverage is required.<sup>9</sup>

BerryDunn surveyed ten insurance carriers in the Commonwealth, and five already cover ESP and contract with MBHP providers for these services. One carrier provides coverage, but only when the MBHP provider is in an

emergency room setting. One carrier considers MBHP providers out of network. Three carriers did not respond to the survey.

### **1.5 Cost of Implementing the Bill**

Requiring coverage for this benefit by fully insured health plans would result in an average annual increase, over five years, to the typical member's monthly health insurance premium of between \$0.03 and \$0.10 PMPM<sup>iv</sup> or between 0.006% and 0.019% of premium. The increase is driven primarily by the cost of coverage by carriers that either do not cover or only partially cover ESP service.

### **1.6 Plans Affected by the Proposed Benefit Mandate**

H.B. 2282 applies 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. It applies to plans grandfathered as exempt from the EHB requirements of the ACA. The proposed services are currently covered for MassHealth (Medicaid) members.<sup>10</sup>

### **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 Employee's Health Benefit Plan, the benefits for which are determined by or under rules set by the federal government. Thus, this analysis excludes members over 64 years of age with commercial fully insured plans. MHBP has indicated that Medicare members are eligible to receive ESP services.

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<sup>iv</sup> PMPM refers to "per member per month."

## Executive Summary Endnotes

<sup>1</sup> The 190th General Court of the Commonwealth of Massachusetts, Senate Bill 2282, “An Act to require health care coverage for the emergency psychiatric services.” Accessed 10 July 2018: <https://malegislature.gov/Bills/190/S2282>.

<sup>2</sup> Massachusetts Behavioral Health Partnership (MBHP). Emergency Services Program/Mobile Crisis Intervention. Accessed 11 July 2018: <https://www.masspartnership.com/member/ESP.aspx>.

<sup>3</sup> Massachusetts Health Policy Commission (MHPC). Annual Health Care Cost Trends Report 2016. Published February 2017; accessed 25 July 2018: <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2016-cost-trends-report.pdf>.

<sup>4</sup> Massachusetts Behavioral Health Partnership (MBHP). MBHP Massachusetts Emergency Services Program Overview Presentation. August 2016; accessed 17 July 2018: <https://www.masspartnership.com/pdf/ESPOverview.pdf>.

<sup>5</sup> Ibid. MBHP

<sup>6</sup> Ibid. MBHP

<sup>7</sup> Commonwealth of Massachusetts, Executive Office of Health and Human Services, MassHealth. Mobile Crisis Intervention: Performance Specifications. Accessed 13 July 2018: <https://www.mass.gov/files/documents/2016/07/oi/ps-mobile-crisis-intervention.pdf>.

The service includes: A crisis assessment; engagement in a crisis planning process that may result in the development/update of one or more Crisis Planning Tools (Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) that contain information relevant to and chosen by the youth and family, up to 7 days of crisis intervention and stabilization services including: on-site face-to-face therapeutic response, psychiatric consultation and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

For youth who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention staff will coordinate with the youth’s ICC care coordinator throughout the delivery of the service. Mobile Crisis Intervention also will coordinate with the youth’s primary care physician, any other care management program or other behavioral health providers providing services to the youth throughout the delivery of the service.

<sup>8</sup> CMS. Massachusetts State Required Benefits. Accessed 11 July 2018: [https://downloads.cms.gov/cciio/State%20Required%20Benefits\\_MA.PDF](https://downloads.cms.gov/cciio/State%20Required%20Benefits_MA.PDF). Emergency Services: M.G.L.c.175§47U(e); M.G.c.176A§8U(e); M.G.L.c.176B§4U(e); M.G.L.c.176G§5(e). Mental health care: M.G.L.c.175§47B(g); M.G.L.c.176A§8A(g); M.G.L.c.176B§4A(g); M.G.L.c.176G§4M(g).

<sup>9</sup> Center for Medicare and Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight, Information on Essential Health Benefits (EHB) Benchmark Plans. Accessed 11 July 2018: <https://www.cms.gov/cciio/resources/data-resources/ehb.html>.

<sup>10</sup> Op. cit. MBHP.



## 2.0 Medical Efficacy Assessment

Massachusetts Senate Bill (S.B.) 2282, as submitted in the 190th General Court, requires fully insured plans to cover medically necessary emergency psychiatric service programs, defined by the bill as “all programs subject to contract between the Massachusetts Behavioral Health Partnership and nonprofit organizations.”<sup>v,1</sup> The Massachusetts Behavioral Health Partnership (MBHP) manages the state’s ESP that provides emergency psychiatric services including MCI 24 hours per day, seven days per week, for individuals experiencing a mental health or substance use disorder crisis, including crisis assessment, intervention, and stabilization services.<sup>2</sup> Cost sharing for these services must be similar to that for other services covered under the plan.

Subsequent to referral of the bill to CHIA for review, CHIA and its consultants submitted an inquiry to sponsoring legislators and staff, and their response indicated that the intent of S.B. 2282 is to mandate coverage of “medically necessary emergency assessment, intervention, and stabilization services for individuals in mental health or substance use disorder crisis, defined by the sponsors as ‘the initial encounter.’”

MGL chapter 3, section 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.

### 2.1 Emergency Psychiatric Services

The Massachusetts ESP is a statewide community-based crisis stabilization program for patients experiencing a behavioral health crisis. The program is intended as an alternative to behavioral health ED utilization and boarding,<sup>vi</sup> which has consistently risen in Massachusetts in recent years,<sup>3</sup> and inpatient hospital psychiatric treatment. Providers reduce immediate risks to patients through the provision of short-term services, and facilitate referrals to appropriate programs and treatments along the behavioral health continuum of care.

The state created the ESP system for patients in crisis. Patients, or others on their behalf, call a toll-free number and receive an immediate assessment of their situation and referral to an appropriate treatment service.

According to licensing reports from the Massachusetts Department of Mental Health (DMH), inpatient psychiatric bed capacity has grown in recent years to its current level of 1,956 adult; 356 child, adolescent, or child/adolescent; and 528 geriatric licensed psychiatric beds.<sup>4</sup> At the same time, ED utilization by patients for a primary behavioral health diagnosis has increased, growing 13% between 2011 and 2015, reflecting a need for increased accessibility and capacity of services across the care continuum.<sup>5</sup> Moreover, while behavioral health patients comprise approximately 7% of ED visits, their length of stay in the ED is twice as long on average as that of physical health patients.<sup>6</sup> In fact, almost 25% of these behavioral health patients “board” in the ED for more than 12 hours, accounting for over 70% of all ED boarders.<sup>7</sup>

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<sup>v</sup> The Massachusetts Behavioral Health Partnership (MBHP) manages behavioral health care for MassHealth members statewide. This report is limited to the programs that fall within the Emergency Services Program (ESP).

<sup>vi</sup> ED boarding is defined as a length of stay in the ED of more than 12 hours from time of registration to time of discharge.

And while ED utilization for behavioral health continues to grow, ED treatment of behavioral health crises is not ideal, given:

- The complexity and resource needs of behavioral health patients and the prompt discharge and treatment model of emergency medicine;
- The potential additional stressors of the ED environment for behavioral health patients which may increase their agitation, aggression, and anxiety;
- The risk of patient “elopement” or leaving before receiving treatment or stabilization services; and
- The general increased costs of treatment provided through hospital EDs.<sup>8</sup>

In response to these and other trends, the state created the ESP system for patients in crisis. Patients, or others on their behalf, call a toll-free number, and receive an immediate assessment of their situation, and referral to an appropriate treatment service.

ESP is a program of services delivered by MBHP-contracted providers to patients of all ages, including assessment, intervention, and stabilization services for patients experiencing a behavioral health crisis, and operates 24 hours per day, 365 days per year.<sup>9</sup> The goals include ensuring safety, promoting recovery, and facilitating access to other levels of care.<sup>10</sup> Services may be mobile at a patient’s location, or accessed at community-based locations either by appointment or on a walk-in basis.<sup>11</sup> Services may include on-site, face-to-face, short-term counseling, psychiatric consultation and urgent psychopharmacotherapy, referrals to other behavioral health services, and development of patient safety plans in collaboration with the patient and their behavioral health providers.

ESP is managed by MBHP on behalf of the state. MBHP is a Beacon Health Options company that manages all behavioral health care for MassHealth (Medicaid) members, as well as the state’s ESP for covered members, Medicare beneficiaries, and uninsured individuals.<sup>12</sup> There are currently 17 MBHP-managed ESP catchment areas in Massachusetts, as well as 4 ESPs operated by the Commonwealth’s Department of Mental Health (DMH) located in the Southeast region.<sup>13</sup> Each catchment area has at least one locally based provider who helps improve access to community-based emergency behavioral health services in the area, and facilitates access to other levels of care in the behavioral health continuum.

The four service components of ESP are:<sup>14</sup>

1. **ESP Community-Based Locations (CBL)** are the “hubs” intended to coordinate all ESP service components and are meant to provide an alternative to EDs. Functions include management of a toll-free hotline, triage, dispatch, and referrals, as well as operation of on-site locations for a minimum of 12 hours per day on weekdays and 8 hours per day on weekends.<sup>15</sup>
2. **MCI** refers to ESP services delivered by contracted providers to youth under age 21, and a short-term, on-site, face-to-face therapeutic response to patients experiencing a behavioral health crisis. Providers will identify, assess, treat, and stabilize the crisis while reducing immediate risks to the patient or those around them, and must work in conjunction with the patient’s risk management and safety plan if one exists. Services are available seven days a week, 24 hours per day, 365 days per year.<sup>16</sup>

3. **Adult MCI** is intended to reduce hospital ED visits and inpatient psychiatric utilization by providing ESP services to adults on a mobile basis as needed at any location in the community between 7 a.m. and 8 p.m. daily, and in residential programs, other supervised settings, and hospital EDs during other hours.
4. **Adult CCS** is used primarily as a diversion from inpatient psychiatric services for adults 18 and older and provides additional clinical services, including nursing care, in a staff-secure, safe, and structured environment. Treatment is voluntary and community-based; current capacity averages 4 to 20 beds per catchment area, for 153 beds statewide.<sup>17</sup> CCS facilities are sites licensed by the state as adult mental health community-based private residential programs organized “primarily to provide treatment of mental illness to persons in a residential environment...[that] includes...rehabilitation, support or supervision.”<sup>18,19</sup> According to the MBHP’s performance specifications for CCS,<sup>20</sup> services include:

- Crisis stabilization
- Initial and continuing bio-psychosocial assessment
- Care coordination
- Psychiatric evaluation and medication management
- Peer support and/or other recovery-oriented services
- Mobilization of family and natural supports and community resources

CCS services are short-term, providing 23-hour observation and supervision, and continual reevaluation. Note that the primary differences between CCS and inpatient level of care is the acuity of the patient, the unlocked setting, the level of psychiatry services, and an absence of immediate need for hospital-based diagnostic tests or general medical treatment. Admissions to CCS occur 24/7/365 based on determinations made by mobile and site-based ESP/MCI staff. Discharges from CCS occur 7/365, and discharge processes include efficiencies that maximize service capacity. Readiness for discharge is evaluated on a daily basis, and the length of stay is expected to be very brief. S.B. 2282 does not mandate coverage for CCS services.

The intent of S.B. 2282 is to mandate coverage of the “initial encounter.” The initial encounter is provided by 1, 2, and 3 above.

## 2.2 Efficacy Research

Very few quality studies exist to evaluate the effectiveness of community-based crisis interventions for people experiencing acute behavioral health crisis episodes. Further complicating research is the variety of crisis treatment models and components included in various programs, making valid comparisons and generalizations difficult.<sup>21,22,23</sup>

In reviewing crisis intervention services, one group of researchers found that utilization of community-based crisis intervention resulted in a lower rate (8%) of hospitalization than utilization of hospital-based interventions.<sup>24</sup> One systematic review of five studies concluded that, in general, community-based crisis intervention “appears to be a viable and acceptable way of treating people with serious mental illnesses,” but that “evidence for the main outcomes of interest [hospital use, global state, mental state, quality of life, participant satisfaction and family burden] is low to moderate quality.”<sup>25</sup> These studies did not provide data on staff satisfaction, career input, compliance with medication, and number of relapses. This review built upon similar reviews published in 2000,<sup>26</sup> 2004,<sup>27</sup> 2006,<sup>28</sup> and

2012,<sup>29</sup> all with comparable conclusions: “[i]f this [crisis intervention] approach is to be widely implemented it would seem that more evaluative studies are still needed.” All the studies, except some reviewed in 2012, concluded that home care was more cost effective than hospital care, but all data were found to be skewed or unusable. Another review noted the difficulty in studying complex interventions for people experiencing behavioral health crisis, leading to evidence that is rated as low or very low quality.<sup>30</sup>

Research evaluating the specific use of mobile treatment services for behavioral health crisis intervention is likewise somewhat lacking. In a study of crisis resolution and home treatment teams (CRTs), the researchers concluded that the balance of evidence suggests that community response teams can reduce hospitalizations and costs with similar symptomatic outcome and service user satisfaction.<sup>31</sup> A few studies noted the value of mobile crisis teams in engaging patients with behavioral health issues who had not received treatment previously, though the impact of this initiation of treatment on hospital admission rates and overall costs was mixed.<sup>32,33,34</sup>

### 2.3 Conclusion

Increasing numbers of patients are seeking care for behavioral health conditions in EDs throughout the state.<sup>35</sup> And while inpatient psychiatric bed capacity has grown in Massachusetts, behavioral health patients in EDs are experiencing longer lengths of stay than patients presenting with physical health emergencies, indicating a need for services more responsive to their behavioral health conditions.<sup>36</sup>

The ESP was created to respond to these issues, and intended to provide behavioral health patients in crisis with more effective services in less restrictive environments at lower cost.<sup>37</sup> Interventions at the patient’s home or in the community are available when needed, and the program provides for transfer to beds in less-restrictive, community-based facilities as alternatives to inpatient psychiatric hospital-based care. Research regarding crisis intervention services has shown that community-based services can be provided at a lower cost with similar outcomes when compared to hospital-based services. However, most studies have found that additional research is needed to further assess their impact on hospital use, global state, mental state, quality of life, participant satisfaction, and family burden in order to generalize research findings.

## Endnotes

<sup>1</sup> The 190th General Court of the Commonwealth of Massachusetts, Senate Bill 2282, “An Act to require health care coverage for the emergency psychiatric services.” Accessed 10 July 2018: <https://malegislature.gov/Bills/190/S2282>.

<sup>2</sup> Massachusetts Behavioral Health Partnership (MBHP). Emergency Services Program/Mobile Crisis Intervention. Accessed 11 July 2018: <https://www.masspartnership.com/member/ESP.aspx>.

<sup>3</sup> Massachusetts Health Policy Commission (MHPC). Annual Health Care Cost Trends Report 2016. Published February 2017; accessed 25 July 2018: <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2016-cost-trends-report.pdf>.

<sup>4</sup> Massachusetts Department of Mental Health (DMH). DMH Licensed Hospitals: Hospital Listings. Published 2 July 2018; accessed 25 July 2018: <https://www.mass.gov/files/documents/2018/07/13/dmh-licensed-hospitals-list-july-18.pdf>.

<sup>5</sup> Op. cit. MHPC

<sup>6</sup> Op. cit. MHPC.

<sup>7</sup> Op.cit. MHPC.

<sup>8</sup> Op. cit. MHPC.

<sup>9</sup> Commonwealth of Massachusetts, Executive Office of Health and Human Services, MassHealth. Mobile Crisis Intervention: Performance Specifications. Accessed 13 July 2018: <https://www.mass.gov/files/documents/2016/07/oi/ps-mobile-crisis-intervention.pdf>.

The service includes: A crisis assessment; engagement in a crisis planning process that may result in the development/update of one or more Crisis Planning Tools (Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) that contain information relevant to and chosen by the youth and family, up to 7 days of crisis intervention and stabilization services including: on-site, face-to-face therapeutic response, psychiatric consultation and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

For youth who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention staff will coordinate with the youth’s ICC care coordinator throughout the delivery of the service. Mobile Crisis Intervention also will coordinate with the youth’s primary care physician any other care management program or other behavioral health providers providing services to the youth throughout the delivery of the service.

<sup>10</sup> Massachusetts Behavioral Health Partnership (MBHP). MBHP Massachusetts Emergency Services Program Overview Presentation. August 2016; accessed 17 July 2018: <https://www.masspartnership.com/pdf/ESPOverview.pdf>.

<sup>11</sup> Massachusetts Children’s Behavioral Health Initiative (CBHI). Emergency Services Program, Mobile Crisis Intervention Practice Guidelines. Accessed 17 July 2018: <https://www.mass.gov/files/documents/2016/07/uk/practice-guidelines-mci.pdf>.

<sup>12</sup> Op. cit. MBHP

<sup>13</sup> Op. cit. MBHP

<sup>14</sup> Op. cit. MBHP

<sup>15</sup> Op. cit. CBHI

<sup>16</sup> Commonwealth of Massachusetts, Executive Office of Health and Human Services, MassHealth. Mobile Crisis Intervention: Performance Specifications. Accessed 13 July 2018: <https://www.mass.gov/files/documents/2016/07/oi/ps-mobile-crisis-intervention.pdf>.

The service includes: A crisis assessment; engagement in a crisis planning process that may result in the development/update of one or more Crisis Planning Tools (Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) that contain information relevant to and chosen by the youth and family, up to 7 days of crisis intervention and stabilization services including: on-site face-to-face therapeutic response, psychiatric consultation and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

For youth who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention staff will coordinate with the youth's ICC care coordinator throughout the delivery of the service. Mobile Crisis Intervention also will coordinate with the youth's primary care physician, any other care management program or other behavioral health providers providing services to the youth throughout the delivery of the service.

<sup>17</sup> Op. cit. MBHP ESP Overview

<sup>18</sup> Commonwealth of Massachusetts Department of Mental Health (DMH). Licensing Guidelines: Community Based Residential Sites. Effective September 2017, revised October 2017; accessed 25 July 2018: <https://www.mass.gov/files/documents/2018/01/11/licensing-guidelines.pdf>.

<sup>19</sup> Massachusetts 104 CMR 28.00: Licensing and Operational Standards for Community Services. Accessed 25 July 2018: [https://www.mass.gov/files/documents/2018/02/26/104cmr28\\_0.pdf](https://www.mass.gov/files/documents/2018/02/26/104cmr28_0.pdf).

28.15: General Provisions

(1) Licensing Requirements. In accordance with M.G.L. c. 19, § 19, the Department shall issue and renew a license to operate residential sites to providers under contract with the Department and providers of private residential programs if the residential sites meet the requirements set forth in 104 CMR 28.15. For purposes of 104 CMR 28.15, a private residential program is a program not operated by or under contract to the Department that is organized primarily to provide treatment, of mental illness to persons in a residential environment that operates one or more residential sites. Treatment includes but is not be limited to rehabilitation, support, or supervision.

<sup>20</sup> Massachusetts Behavioral Health Partnership (MBHP). Performance Specifications: Community Crisis Stabilization (CCS). Effective 1 July 2014; accessed 25 July 2018: <https://www.masspartnership.com/pdf/CCSFINALJul2014.pdf>.

<sup>21</sup> Wheeler C, Lloyd-Evans B, Churchard A, et. al. Implementation of the Crisis Resolution Team model in adult mental health settings: a systematic review. BMC Psychiatry. 2015 Apr 8;15:74. Accessed 23 July 2018: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4405828/>.

<sup>22</sup> Sjølie H, Karlsson B, Kim HS. Crisis resolution and home treatment: structure, process, and outcome – a literature review. J Psychiatr Ment Health Nurs. 2010 Dec;17(10):881-92. Accessed 23 July 2018: <https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1365-2850.2010.01621.x>.

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**AN ACT TO REQUIRE  
HEALTH CARE COVERAGE  
FOR EMERGENCY  
PSYCHIATRIC SERVICES.**

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ACTUARIAL ASSESSMENT



## 1.0 Executive Summary

Massachusetts Senate Bill (S.B.) 2282, as submitted in the 190th General Court of the Commonwealth of Massachusetts (Commonwealth), requires fully insured plans to cover medically necessary emergency psychiatric service programs, defined by the bill as “all programs subject to contract between the Massachusetts Behavioral Health Partnership (MBHP) and nonprofit organizations.”<sup>vii</sup> MBHP manages the Commonwealth’s Emergency Services Program (ESP) that provides emergency psychiatric services including mobile crisis intervention (MCI) 24 hours per day, seven days per week, for individuals experiencing a mental health or substance use disorder crisis, including crisis assessment, intervention, and stabilization services.<sup>2</sup> Benefits under the bill “shall be provided on a non-discriminatory basis, and shall not be subject to any greater deductible, coinsurance, copayments or out-of-pocket limits than any other benefit provided by the carrier.”<sup>viii</sup>

Subsequent to referral of the bill to Center for Health Information and Analysis (CHIA) for review, CHIA and its consultants submitted an inquiry to sponsoring legislators and staff, and their response indicated that the intent of S.B. 2282 is to mandate coverage of “medically necessary emergency assessment, intervention, and stabilization services for individuals in mental health or substance use disorder crisis, defined by the sponsors as ‘the initial encounter.’”

Massachusetts General Laws (MGL), chapter 3, section 38C, charges the Massachusetts Center for Health Information and Analysis (CHIA) with, among other duties, reviewing the potential impact of proposed mandated health care insurance benefits on the premiums paid by businesses and consumers. CHIA has engaged BerryDunn<sup>ix</sup> to provide an actuarial estimate of the effect enactment of the bill would have on the cost of health insurance in the Commonwealth.

This report is not intended to determine whether S.B. 2282 would constitute a health insurance benefit mandate for purposes of state defrayal under the Affordable Care Act, nor is it intended to assist with state defrayal calculations if it is determined to be a health insurance benefit mandate requiring state defrayal.

### 1.1 Current Insurance Coverage

BerryDunn surveyed 10 insurance carriers in the Commonwealth and found that five insurers already cover ESP and contract with MBHP providers for these services. One carrier provides coverage only when the MBHP provider is in an emergency room setting. One carrier considers MBHP providers out of network. Three carriers did not respond to the survey.

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<sup>vii</sup> The MBHP manages behavioral health care for MassHealth members statewide. This report is limited to the programs that fall within the ESP.

<sup>viii</sup> This language has been interpreted to mean that the benefit cannot have cost-sharing in excess of similar existing benefits.

<sup>ix</sup> Formerly Compass Health Analytics, Inc.

## 1.2 Analysis

BerryDunn estimated the impact of S.B. 2282 by assessing the incremental impacts of two components:

- Incremental cost due to the requirement of EPS for adults, when performed by an MBHP provider
- Incremental cost due to the requirement of EPS for children, when performed by an MBHP provider

The incremental costs of both provisions were estimated using claims data from the All Payer Claims Database (APCD) for carriers currently covering EPS for MBHP providers and for carriers that partially cover these services.

BerryDunn then aggregated these components and projected them forward over the next five years (2019 – 2023) for the fully insured Commonwealth population, using the bill's effective date of January 1, 2019. Insurer retention (administrative cost and profit) was added to arrive at an estimate of the bill's effect on premiums. Note the estimates assume carriers would fully comply with the provisions of the bill if it becomes law.

BerryDunn did not include a reduction to projected claims for services displaced by EPS. For example, if someone is treated by an MBHP provider, and that avoids an emergency room visit, there is an offsetting reduction to claims cost. In addition, there is likely an overall increase in utilization since prior to the implementation of the proposed mandate not everyone would have gone to the emergency room. It is uncertain if these factors would offset each other.

## 1.3 Summary Results

Table ES-1, on the following page, summarizes the estimated effect of S.B. 2282 on premiums for fully insured plans over five years. This analysis estimates that the bill, if enacted as drafted for the General Court, would increase fully insured premiums by as much as 0.019% on average over the next five years; a more likely increase is in the range of 0.013%, equivalent to an average annual expenditure of \$1.7 million over the period 2019 – 2023.

The impact on premiums is driven by the cost of coverage by carriers that either do not cover or only partially cover ESP services.

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

**Table ES-1: Summary Results**

	2019	2020	2021	2022	2023	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
Members (000s)	2,154	2,150	2,146	2,142	2,138		
Medical Expense Low (\$000s)	\$498	\$724	\$751	\$779	\$808	\$756	\$3,561
Medical Expense Mid (\$000s)	\$990	\$1,439	\$1,493	\$1,547	\$1,606	\$1,502	\$7,075
Medical Expense High (\$000s)	\$1,482	\$2,155	\$2,234	\$2,315	\$2,403	\$2,247	\$10,590
Premium Low (\$000s)	\$561	\$816	\$847	\$878	\$911	\$851	\$4,012
Premium Mid (\$000s)	\$1,116	\$1,622	\$1,682	\$1,743	\$1,809	\$1,692	\$7,972
Premium High (\$000s)	\$1,670	\$2,428	\$2,518	\$2,609	\$2,708	\$2,532	\$11,932
PMPM Low	\$0.03	\$0.03	\$0.03	\$0.03	\$0.04	\$0.03	\$0.03
PMPM Mid	\$0.06	\$0.06	\$0.07	\$0.07	\$0.07	\$0.07	\$0.07
PMPM High	\$0.09	\$0.09	\$0.10	\$0.10	\$0.11	\$0.10	\$0.10
Estimated Monthly Premium	\$493	\$502	\$512	\$523	\$533	\$513	\$513
Premium % Rise Low	0.006%	0.006%	0.006%	0.007%	0.007%	0.006%	0.006%
Premium % Rise Mid	0.012%	0.013%	0.013%	0.013%	0.013%	0.013%	0.013%
Premium % Rise High	0.018%	0.019%	0.019%	0.019%	0.020%	0.019%	0.019%

## Executive Summary Endnotes

<sup>1</sup> The 190th General Court of the Commonwealth of Massachusetts, Senate Bill 2282, “An Act to require health care coverage for the emergency psychiatric services.” Accessed 10 July 2018: <https://malegislature.gov/Bills/190/S2282>.

<sup>2</sup> Massachusetts Behavioral Health Partnership (MBHP). Emergency Services Program/Mobile Crisis Intervention. Accessed 11 July 2018: <https://www.masspartnership.com/member/ESP.aspx>.

## 2.0 Introduction

Massachusetts Senate Bill (S.B.) 2282, as submitted in the 190th General Court, requires fully insured plans to cover medically necessary emergency psychiatric service programs, defined by the bill as “all programs subject to contract between the Massachusetts Behavioral Health Partnership (MBHP) and nonprofit organizations.”<sup>x,3</sup> The Massachusetts Behavioral Health Partnership manages the Commonwealth’s ESP that provides emergency psychiatric services including MCI 24 hours per day, seven days per week, for individuals experiencing a mental health or substance use disorder crisis, including crisis assessment, intervention, and stabilization services.<sup>4</sup> Cost sharing for these services must be similar to that for other services covered under the plan.

Subsequent to referral of the bill to CHIA for review, CHIA and its consultants submitted an inquiry to sponsoring legislators and staff, and their response indicated that the intent of S.B. 2282 is to mandate coverage of “medically necessary emergency assessment, intervention, and stabilization services for individuals in mental health or substance use disorder crisis, defined by the sponsors as ‘the initial encounter.’”

The Joint Committee on Mental Health, Substance Use, and Recovery referred S.B. 2282, “An Act relative to require health care coverage for the emergency psychiatric services,”<sup>5</sup> to CHIA for review. MGL chapter 3, section 38C, requires CHIA to review and evaluate the potential fiscal impact of each mandated benefit bill referred to the agency by a legislative committee.

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

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 health care costs and steps through the calculations. Section 6.0 discusses results.

This report is not intended to determine whether S.B. 2282 would constitute a health insurance benefit mandate for purposes of state defrayal under the Affordable Care Act, nor is it intended to assist with state defrayal calculations if it is determined to be a health insurance benefit mandate requiring state defrayal.

### 2.1 Background

The Massachusetts ESP is a statewide community-based crisis stabilization program for patients experiencing a behavioral health crisis. The program is intended as an alternative to behavioral health emergency department (ED) utilization and boarding,<sup>xi</sup> which has consistently risen in Massachusetts in recent years,<sup>6</sup> and inpatient hospital psychiatric treatment. Providers reduce immediate risks to patients through the provision of short-term services, and facilitate referrals to appropriate programs and treatments along the behavioral health continuum of care.

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<sup>x</sup> The MBHP manages behavioral health care for MassHealth members statewide. This report is limited to the programs that fall within the ESP.

<sup>xi</sup> ED boarding is defined as a length of stay in the ED of more than 12 hours from time of registration to time of discharge.

The Commonwealth created the ESP system for patients in crisis. Patients, or others on their behalf, call a toll-free number and receive an immediate assessment of their situation and referral to an appropriate treatment service.

ESP is a program of services delivered by MBHP-contracted providers to patients of all ages, including assessment, intervention, and stabilization services for patients experiencing a behavioral health crisis, 24 hours per day, 365 days per year.<sup>7</sup> The goals include ensuring safety, promoting recovery, and facilitating access to other levels of care.<sup>8</sup> Services may be mobile at a patient's location, or accessed at community-based locations either by appointment or on a walk-in basis.<sup>9</sup> Services may include on-site, face-to-face, short-term counseling, psychiatric consultation and urgent psychopharmacotherapy, referrals to other behavioral health services, and development of patient safety plans in collaboration with the patient and their behavioral health providers.

ESP is managed by MBHP on behalf of the state. MBHP is a Beacon Health Options company that manages all behavioral health care for MassHealth (Medicaid) members, as well as the state's ESP for covered members, Medicare beneficiaries, and uninsured individuals.<sup>10</sup> There are currently 17 MBHP-managed ESP catchment areas in Massachusetts, as well as 4 ESPs operated by the state's Department of Mental Health (DMH) located in the Southeast region.<sup>11</sup> Each catchment area has at least one locally based provider who helps improve access to community-based emergency behavioral health services in the area and facilitates access to other levels of care in the behavioral health continuum.

The four service components of ESP are:<sup>12</sup>

- 1. ESP Community-Based Locations (CBL)** are the "hubs" intended to coordinate all ESP service components, and are meant to provide an alternative to EDs. Functions include management of a toll-free hotline, triage, dispatch, and referrals, as well as operation of on-site locations for a minimum of 12 hours per day on weekdays and 8 hours per day on weekends.<sup>13</sup>
- 2. MCI** refers to ESP services delivered by contracted providers, to youth under age 21, and is a short-term, on-site, face-to-face therapeutic response to patients experiencing a behavioral health crisis. Providers will identify, assess, treat, and stabilize the crisis while reducing immediate risks to the patient or those around them, and must work in conjunction with the patient's risk management and safety plan, if one exists. Services are available seven days a week, 24 hours per day, 365 days per year.<sup>14</sup>
- 3. Adult MCI** is intended to reduce hospital ED visits and inpatient psychiatric utilization by providing ESP services to adults on a mobile basis, as needed, at any location in the community between 7 a.m. and 8 p.m. daily, and in residential programs, other supervised settings, and hospital EDs during other hours.
- 4. Adult Community Crisis Stabilization (CCS)** is used primarily as a diversion to inpatient psychiatric services for adults 18 and older, and provides additional clinical services, including nursing care, in a staff-secure, safe, and structured environment. Treatment is voluntary and community-based; current capacity averages 4 to 20 beds per catchment area, for 153 beds statewide.<sup>15</sup> CCS facilities are sites licensed by the state as adult mental health community-based private residential programs organized "primarily to provide treatment of mental illness to persons in a residential environment...[that] includes...rehabilitation, support or supervision."<sup>16,17</sup> According to the MBHP's performance specifications for CCS,<sup>18</sup> services include:

- Crisis stabilization
- Initial and continuing bio-psychosocial assessment
- Care coordination
- Psychiatric evaluation and medication management
- Peer support and/or other recovery-oriented services
- Mobilization of family and natural supports and community resources

CCS services are short-term, providing 23-hour observation and supervision, and continual reevaluation. Note that the primary differences between CCS and inpatient level of care is the acuity of the patient, the unlocked setting, the level of psychiatry services, and an absence of immediate need for hospital-based diagnostic tests or general medical treatment. Admissions to CCS occur 24/7/365 based on determinations made by mobile and site-based ESP/MCI staff. Discharges from CCS occur 7/365, and discharge processes include efficiencies that maximize service capacity. Readiness for discharge is evaluated on a daily basis, and the length of stay is expected to be very brief.

The intent of S.B. 2282 is to mandate coverage of the “initial encounter.” The initial encounter is provided by 1, 2, and 3 above.

### 3.0 Interpretation of S.B. 2282

No Massachusetts state or federal law requires coverage of mobile emergency psychiatric services. Under the federal Affordable Care Act (ACA), emergency services and mental health and substance abuse services and treatment are considered essential health benefits (EHB), and are required for coverage.<sup>19</sup> The benefits are defined for Massachusetts according to the state’s benchmark health plan, which do not specifically include mobile crisis emergency psychiatric services or other initial encounters provided by the ESP program.<sup>20</sup>

BerryDunn clarified with the sponsor that the bill’s intent is to only require insurance coverage of “medically necessary emergency assessment, intervention, and stabilization services for individuals in mental health or substance use disorder crisis (i.e., an initial encounter).” This report includes developing this cost of requiring coverage for the initial assessment including MCI services and excludes the cost impact of covering CCS services,<sup>xii</sup> except for the initial crisis stabilization.

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<sup>xii</sup> CCS services were not included in this analysis. The majority of CCS claims in the APCD are MassHealth claims. There were a few commercial claims, and average per diem in 2016 was about \$300. To determine the impact of CCS on commercial claims costs, many factors would need to be considered including the per diem cost, the projected utilization rate, and capacity constraints among others.

### 3.1 Plans Affected by the Proposed Mandate

The bill as drafted amends statutes that regulate health care carriers in the Commonwealth. The bill includes the following sections (Section 2 also pertains to Chapter 175), each of which addresses statutes dealing with a particular type of health insurance policy:

- Section 1: Chapter 32A – Plans Operated by the Group Insurance Commission (GIC) for the Benefit of Public Employees
- Section 3: Chapter 175 – Commercial Health Insurance Company Plans
- Section 4: Chapter 176A – Hospital Service Corporation Plans
- Section 5: Chapter 176B – Medical Service Corporation Plans
- Section 6: Chapter 176G – Health Maintenance Organization (HMO) Plans

MassHealth (Medicaid) currently covers the proposed services for its members.<sup>21</sup>

Self-insured plans, except for those managed by the GIC, are not subject to state-level health insurance benefit mandates. State mandates do not apply to Medicare or Medicare Advantage plans, the benefits of which are qualified by Medicare; this analysis excludes members of fully insured commercial plans over 64 years of age and does not address any potential effect on Medicare supplement plans, even to the extent they are regulated by state law. This analysis does not apply to MassHealth, although as noted this program is already provided to MassHealth members.

### 3.2 Covered Services

BerryDunn surveyed 10 insurance carriers in the Commonwealth, and five insurers already cover EPS and contract with MBHP providers for these services. Once carrier provides coverage, but only when the MBHP provider is in an emergency room setting. One carrier considers MBHP providers out of network. Three carriers did not respond to the survey.

### 3.3 Existing Laws Affecting the Cost of S.B. 2282

The proposed mandate is not redundant to or in conflict with any existing state or federal mandates.

## 4.0 Methodology

### 4.1 Overview

Estimating the impact of S.B. 2282 on premiums requires assessing the incremental impacts of two components:

- Incremental cost due to the requirement of EPS for adults, when performed by an MBHP provider
- Incremental cost due to the requirement of EPS for children, when performed by an MBHP provider



The incremental costs of both provisions are estimated using claims data from the APCD for carriers currently covering EPS from MBHP providers and for carriers that partially cover these 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, 2019, 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 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 various clinical experts and providers

## 4.3 Steps in the Analysis

To implement the analysis, BerryDunn performed the steps summarized in this section.

### 1. Estimated marginal costs to insurers for adult EPS not currently covered

In order to estimate the impact of the cost of EPS for adults, BerryDunn:

- A. Used claims data from the APCD for four carriers<sup>xiii</sup> that fully cover EPS to determine total claims cost.
- B. Divided the total claims cost for the four carriers by their corresponding membership to determine the PMPM cost of EPS.
- C. For the carriers that partially cover EPS and for the carriers whose current coverage is unknown, used the APCD to determine total claims cost.
- D. Divided the total claims cost in the previous step by the corresponding membership to determine the PMPM cost of EPS.
- E. Subtracted the PMPM for the carriers that partially cover EPS and those whose current coverage is unknown (D) from the PMPM for the carriers that fully cover EPS (B) to determine the incremental PMPM amount of increased coverage.
- F. Multiplied the membership of the carriers that partially cover EPS and for those whose current coverage is unknown by the incremental PMPM cost calculated in the previous step to determine the incremental claims cost.

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<sup>xiii</sup> Based on a survey of Massachusetts insurance carriers and claims data from the APCD, it was determined that five insurers in Massachusetts cover EPS and contract with MBHP providers. BerryDunn was unable to distinguish EPS claims data for one carrier in the APCD and, as such, that carrier was omitted from the analysis.

- G. Divided the incremental cost by the total of the membership used in the above steps to determine the weighted average incremental PMPM.
- H. Projected the baseline cost forward over the five-year analysis period using an estimated increase in physician services over the period.

## 2. Estimated marginal costs to insurers for child EPS not currently covered.

In order to estimate the cost of EPS for children, BerryDunn:

- A. Used claims data from the APCD for three carriers<sup>xiv</sup> that fully cover EPS to determine total claims cost.
- B. Divided the total claims cost for the three carriers by their corresponding membership to determine the PMPM cost of EPS.
- C. For the carriers that partially cover EPS and for the carriers whose current coverage is unknown, used the APCD to determine total claims cost.
- D. Divided the total claims cost in the previous step by the corresponding membership to determine the PMPM cost of EPS.
- E. Subtracted the PMPM for the carriers that partially cover EPS and those whose current coverage is unknown (D) from the PMPM for the carriers that fully cover EPS (B) to determine the incremental PMPM amount of increased coverage.
- F. Multiplied the membership of the carriers that partially cover EPS and for those whose current coverage is unknown by the incremental PMPM cost calculated in the previous step to determine the incremental claims cost.
- G. Divided the incremental cost by the total of used in the above steps to determine the weighted average incremental PMPM.
- H. Projected the baseline cost forward over the five-year analysis period using an estimated increase in physician services over the period.

## 3. Calculated the impact of the combined projected claim costs on insurance premiums.

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

- A. Summed the estimated incremental paid PMPM costs for adult and child EPS.
- B. Estimated the fully insured Commonwealth population under age 65, projected for the next five years (2019 – 2023).
- C. Multiplied the estimated aggregate incremental paid PMPM cost of the mandate by the projected population estimate to calculate the total estimated marginal claims cost of S.B. 2822.

<sup>xiv</sup>In addition to the carrier where BerryDunn was unable to distinguish EPS claims data in the APCD, a second carrier had no EPS data for children in the APCD and their membership was, conservatively, omitted from the calculation of the full coverage EPS PMPM for children.

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

#### 4.4 Limitations

While measuring costs in the MA APCD is relatively straightforward, this analysis also rests on assumptions that hold some uncertainty. For example, it is not known how the distribution of claims by place of service will change for a carrier that currently covers EPS only in an ED setting. In addition, for carriers currently either partially or not covering EPS, it is unknown what the reimbursement rate will be to providers for the newly covered services.

BerryDunn assumed that in the most likely scenario, the total PMPM cost of the carriers that either partially cover or do not cover EPS services would, in aggregate, resemble the average PMPM cost for those carriers that fully cover EPS. To account for the uncertainty surrounding this assumption, BerryDunn applied a 30% lower PMPM rate in the low-cost scenario, and assumed a 30% higher PMPM rate in the high-cost scenario. The upper and lower bound are reasonable in relation to the carrier PMPMs seen in the data and produce a range of estimates of incremental cost. The more detailed step-by-step description of the estimation process outlined in the next sections addresses these uncertainties further.

BerryDunn did not include a reduction to projected claims for services displaced by EPS. For example, if someone is treated by an MBHP provider, and that avoids an emergency room visit, there is an offsetting reduction to claims cost. In addition, there is likely an overall increase in utilization since prior to the implementation of the proposed mandate not everyone would have gone to the emergency room. It is uncertain if these factors would offset one another.

## 5.0 Analysis

This section describes the calculations outlined in the previous section 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 PMPM expenses associated with EPS services for adults. Section 5.2 describes the PMPM expenses for EPS services for children. Section 5.3 aggregates the marginal PMPM costs. Section 5.4 projects the fully insured population age 0 – 64 in the Commonwealth over the 2019 – 2023 analysis period. Section 5.5 calculates the total estimated marginal cost of S.B. 2282, and Section 5.6 adjusts these projections for carrier retention to arrive at an estimate of the bill's effect on premiums for fully insured plans.

### 5.1 EPS for Adults

#### Estimated marginal costs to insurers to cover EPS for adults

S.B. 2282 requires insurers cover EPS. One component of the bill's effect on premiums is the coverage requirement for the adult population. To measure the impact of this, BerryDunn reviewed carrier surveys and determined that five

insurers in Massachusetts currently cover EPS for adults and contract with MBHP providers. Next BerryDunn analyzed APCD data for each of the five carriers. EPS claims for one of the five carriers could not be distinguished in the APCD, so claims were omitted from the analysis for that carrier and it was treated like the carriers who currently cover EPS when computing a weighted average marginal impact (see below). BerryDunn used the APCD for the other four carriers to determine total paid claims cost. BerryDunn divided the paid claims cost by the corresponding membership to calculate a baseline PMPM cost for carriers that currently cover EPS and contract with MBHP providers.

The remaining carriers with claims in the APCD either partially cover EPS, or the current EPS coverage is unknown. Based on the carrier surveys, it was determined that one carrier covers EPS as out of network and another carrier covers the services when performed in an emergency room setting only. Five other carriers in the APCD had EPS claims costs present but did not respond to the carrier survey, so current coverage for those carriers is unknown. For these seven carriers, BerryDunn used the APCD to determine total paid claims cost. BerryDunn divided the paid claims cost by the corresponding membership to calculate a PMPM cost, and results are displayed in Table 1.

**Table 1: 2016 Cost for EPS for Adults**

CARRIERS	PAID CLAIM COST	MEMBER MONTHS	PMPM CLAIM COST
Cover EPS	\$350,168	4,123,393	\$0.085
Partially Cover EPS and Coverage Unknown	\$387,405	12,895,586	\$0.030

BerryDunn assumed that in the most likely scenario, the total PMPM cost of the carriers that either partially cover or whose coverage of EPS services is unknown would, in aggregate, resemble the average PMPM cost for those carriers that fully cover EPS. However, the utilization rate, distribution by place of service, and provider reimbursement for services by the carriers not fully covering EPS using MBHP providers is unknown. The range of PMPM costs for carriers that cover EPS is \$0.05 to \$0.12. To account for the uncertainty discussed, BerryDunn applied a 30% lower PMPM rate in the low-cost scenario, and assumed a 30% higher PMPM rate in the high-cost scenario. The results fall within the range of cost by carrier, and span the majority of that range. Results are displayed in Table 2.

**Table 2: Estimated Adult PMPM Cost for Carriers that Cover EPS**

2016	
Low Scenario	\$0.059
Mid Scenario	\$0.085
High Scenario	\$0.110

Next BerryDunn subtracted the PMPM for the carriers that partially cover EPS (or whose coverage is unknown) from the PMPM for the carriers that fully cover EPS to determine the incremental PMPM amount. The incremental claims cost is displayed in Table 3.

**Table 3: Estimated Adult Incremental PMPM Cost**

2016	
Low Scenario	\$0.029
Mid Scenario	\$0.055
High Scenario	\$0.080

BerryDunn multiplied the membership of the carriers that partially cover EPS (or whose coverage is unknown) by the incremental PMPM cost to determine the incremental claims cost. The incremental claims cost was divided by the total medical member months of 25.9 million, and increased by the trend factor to project the PMPM impact of requiring coverage for EPS. Table 4 displays the results.

**Table 4: Estimated Marginal PMPM Cost of EPS for Adults**

	2016	2019	2020	2021	2022	2023
Low Scenario	\$0.02	\$0.02	\$0.02	\$0.02	\$0.03	\$0.03
Mid Scenario	\$0.04	\$0.04	\$0.04	\$0.05	\$0.05	\$0.05
High Scenario	\$0.06	\$0.06	\$0.07	\$0.07	\$0.07	\$0.07

## 5.2 EPS for Children

### Estimated marginal costs to insurers to cover EPS for children

The second component contributing to S.B. 2282's effect on premiums is the requirement that insurers cover EPS for children. To measure the impact of this, BerryDunn reviewed carrier surveys and determined that five insurers in Massachusetts already cover EPS for children and contract with MBHP providers. Next BerryDunn analyzed APCD data for each of the five carriers. EPS claims for one of the five carriers could not be distinguished in the APCD so claims were omitted from the analysis for that carrier. Another carrier had no EPS claims for children so BerryDunn took a conservative approach and eliminated that carrier's membership when developing the PMPMs. Both carriers

that were omitted from the PMPM analysis were treated like the carriers who currently cover EPS when computing a weighted average marginal impact (see below). BerryDunn used the APCD for the other three carriers to determine total paid claims cost. BerryDunn divided the paid claims cost the corresponding membership to calculate a baseline PMPM cost for carriers that currently cover EPS and contract with MBHP providers.

The remaining carriers with claims in the APCD either partially cover EPS or the current EPS coverage is unknown. Based on the carrier surveys it was determined that one carrier covers EPS as out of network and another carrier covers the services when performed in an emergency room setting only. There were five other carriers in the APCD that had EPS claims costs present but did not respond to the carrier survey, so current coverage for those carriers is unknown. For these seven carriers, BerryDunn used the APCD to determine total paid claims cost. BerryDunn divided the paid claims cost by the corresponding membership to calculate a PMPM cost, and results are displayed in Table 5.

**Table 5: Cost for EPS for Children**

CARRIERS	PAID CLAIM COST	MEMBER MONTHS	PMPM CLAIM COST
Cover EPS	\$106,750	3,708,943	\$0.029
Partially Cover EPS and Coverage Unknown	\$193,183	12,895,586	\$0.015

BerryDunn assumed that in the most likely scenario the total PMPM cost of the carriers that either partially cover or whose coverage of EPS services is unknown would, in aggregate, resemble the average PMPM cost for those carriers that fully cover EPS. However, the utilization rate, distribution by place of service, and provider reimbursement for services for the carriers not fully covering EPS using MBHP providers is unknown. The range of PMPM costs for carriers that cover EPS is \$0.02 to \$0.04. To account for the uncertainty discussed, BerryDunn applied a 30% lower PMPM rate in the low-cost scenario, and assumed a 30% higher PMPM rate in the high-cost scenario. The results fall within the range of cost by carrier that currently cover EPS and span the majority of that range. Results are displayed in Table 6.

**Table 6: Estimated Child PMPM Cost for Carriers that Cover EPS**

	2016
Low Scenario	\$0.020
Mid Scenario	\$0.029
High Scenario	\$0.037

Next BerryDunn subtracted the PMPM for the carriers that partially cover EPS (or whose coverage is unknown) from the PMPM for the carriers that fully cover EPS to determine the incremental PMPM amount. The incremental claims cost is displayed in Table 7.

**Table 7: Estimated Child Incremental PMPM Cost**

	2016
Low Scenario	\$0.005
Mid Scenario	\$0.014
High Scenario	\$0.022

BerryDunn multiplied the membership of the carriers that partially cover EPS (or whose coverage is unknown) by the incremental PMPM cost to determine the incremental claims cost. The incremental claims cost was divided by the total medical member months of 25.9 million, and increased by the trend factor to project the PMPM impact of requiring coverage for EPS. Table 8 displays the results.

**Table 8: Estimated Marginal PMPM Cost of EPS for Children**

	2016	2019	2020	2021	2022	2023
Low Scenario	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Mid Scenario	\$0.01	\$0.01	\$0.01	\$0.01	\$0.01	\$0.01
High Scenario	\$0.02	\$0.02	\$0.02	\$0.02	\$0.02	\$0.02

### 5.3 Marginal Cost Per Member Per Month

Adding together the estimated PMPM costs associated with the two relevant provisions (from Tables 4 and 8) yields the total PMPM marginal cost, shown in Table 9.

**Table 9: Estimated Marginal PMPM Cost of EPS Mandate**

	2019	2020	2021	2022	2023
Low Scenario	\$0.03	\$0.03	\$0.03	\$0.03	\$0.03
Mid Scenario	\$0.05	\$0.06	\$0.06	\$0.06	\$0.06
High Scenario	\$0.08	\$0.08	\$0.09	\$0.09	\$0.09

### 5.4 Projected Fully Insured Population in the Commonwealth

Table 10 shows the fully insured population in the Commonwealth ages 0 to 64 projected for the next five years. Appendix A describes the sources of these values.

**Table 10: Projected Fully Insured Population in the Commonwealth, Ages 0 – 64**

YEAR	TOTAL (0-64)
2019	2,153,622
2020	2,149,554
2021	2,145,579
2022	2,141,700
2023	2,137,917

### 5.5 Total Marginal Medical Expense

Multiplying the total estimated PMPM cost by the projected fully insured membership over the analysis period results in the total cost (medical expense) associated with the proposed requirement, shown on in Table 11. This analysis assumes the bill, if enacted, would be effective January 1, 2019.<sup>xv</sup>

**Table 11: Estimated Marginal Cost of EPS**

	2019	2020	2021	2022	2023
Low Scenario	\$498,137	\$724,380	\$751,307	\$778,816	\$808,182
Mid Scenario	\$990,052	\$1,439,477	\$1,492,889	\$1,547,146	\$1,605,618
High Scenario	\$1,481,967	\$2,154,574	\$2,234,471	\$2,315,476	\$2,403,053

### 5.6 Carrier Retention and Increase in Premium

Assuming an average retention rate of 11.2% based on CHIA's analysis of administrative costs and profit in the Commonwealth,<sup>22</sup> the increase in medical expense was adjusted upward to approximate the total impact on premiums. Table 12 shows the result.

**Table 12: Estimate of Increase in Carrier Premium Expense**

	2019	2020	2021	2022	2023
Low Scenario	\$561,264	\$816,178	\$846,516	\$877,512	\$910,599
Mid Scenario	\$1,115,517	\$1,621,895	\$1,682,076	\$1,743,209	\$1,809,090
High Scenario	\$1,669,770	\$2,427,613	\$2,517,635	\$2,608,905	\$2,707,581

<sup>xv</sup> The analysis assumes the mandate would be effective for policies issued and renewed on or after January 1, 2019. Based on an assumed renewal distribution by month, by market segment, and by the Commonwealth market segment composition, 71.3% of the member months exposed in 2019 will have the proposed mandate coverage in effect during calendar year 2017. The annual dollar impact of the mandate in 2017 was estimated using the estimated PMPM and applying it to 71.3% of the member months exposed.



## 6.0 Results

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

The impact on premiums is driven by the provisions of S.B. 2282 that require that carriers cover EPS when performed by an MBHP provider. Variation between scenarios is attributable to the uncertainty surrounding the utilization rate, distribution by place of service, and provider reimbursement for services by the carriers not fully covering EPS using MBHP providers.

Starting in 2021, the federal ACA will impose an excise tax, commonly known as the “Cadillac Tax,” on expenditures on health insurance premiums and other relevant items (e.g., health savings account contributions) that exceed specified thresholds. To the extent that relevant expenditures exceed those thresholds (in 2021), S.B. 2282, by increasing premiums, has the potential of creating liability for additional amounts under the tax. Estimating the amount of potential tax liability requires information on the extent to which premiums, notwithstanding the effect of S.B. 2282, will exceed or approach the thresholds, and is beyond the scope of this analysis.

### 6.1 Five-Year Estimated Impact

For each year in the five-year analysis period, Table 13 (on the following page) displays the projected net impact of the proposed language on medical expense and premiums using a projection of Commonwealth fully insured membership. Note that the relevant provisions of S.B. 2282 are assumed effective January 1, 2019.<sup>23</sup>

The low scenario impact is \$0.9 million per year on average and is based on an assumption that the PMPM cost of the carriers that partially cover EPS would move 30% below the average PMPM cost for those carriers that fully cover EPS. The high scenario is based on an assumption that the PMPM cost of the carriers that partially cover EPS would move 30% above the average PMPM cost for those carriers that fully cover EPS. The middle scenario uses the assumption between these, that, in aggregate, the PMPM cost of the carriers that partially cover EPS would resemble the average PMPM cost for those carriers that fully cover EPS and has average annual costs of \$1.7 million, or an average of 0.013% of premium.

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

**Table 13: Summary Results**

	2019	2020	2021	2022	2023	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
Members (000s)	2,154	2,150	2,146	2,142	2,138		
Medical Expense Low (\$000s)	\$498	\$724	\$751	\$779	\$808	\$756	\$3,561
Medical Expense Mid (\$000s)	\$990	\$1,439	\$1,493	\$1,547	\$1,606	\$1,502	\$7,075
Medical Expense High (\$000s)	\$1,482	\$2,155	\$2,234	\$2,315	\$2,403	\$2,247	\$10,590
Premium Low (\$000s)	\$561	\$816	\$847	\$878	\$911	\$851	\$4,012
Premium Mid (\$000s)	\$1,116	\$1,622	\$1,682	\$1,743	\$1,809	\$1,692	\$7,972
Premium High (\$000s)	\$1,670	\$2,428	\$2,518	\$2,609	\$2,708	\$2,532	\$11,932
PMPM Low	\$0.03	\$0.03	\$0.03	\$0.03	\$0.04	\$0.03	\$0.03
PMPM Mid	\$0.06	\$0.06	\$0.07	\$0.07	\$0.07	\$0.07	\$0.07
PMPM High	\$0.09	\$0.09	\$0.10	\$0.10	\$0.10	\$0.10	\$0.10
Estimated Monthly Premium	\$493	\$502	\$512	\$523	\$533	\$513	\$513
Premium % Rise Low	0.006%	0.006%	0.006%	0.007%	0.007%	0.006%	0.006%
Premium % Rise Mid	0.012%	0.013%	0.013%	0.013%	0.013%	0.013%	0.013%
Premium % Rise High	0.018%	0.019%	0.019%	0.019%	0.020%	0.019%	0.019%

## 6.2 Impact on the GIC

The proposed legislative change is assumed to apply to both fully insured and self-insured plans operated for state and local employees by the GIC, with an effective date for all GIC policies on July 1, 2019.

Because the benefit offerings of GIC plans are similar to those of most other commercial plans in the Commonwealth, and based on our carrier surveys that did not indicate GIC had different coverage, the estimated incremental PMPM of the proposed legislative language on GIC medical expense is assumed not to differ from that calculated for the other fully insured plans in the Commonwealth. However, the GIC has a different enrollment distribution between carriers that fully cover EPS and those that partially cover EPS or whose coverage is unknown. For GIC, 54% of the members are enrolled in plans that fully cover EPS as compared to 30% for all commercial plans. As a result, the weighted average impact is 33% lower for GIC plans overall.

To estimate the medical expense separately for the GIC, the PMPM medical expense for the general fully insured population was reduced by 33% and then applied to the GIC membership starting in July 2019.

Table 14 breaks out the GIC-only fully insured membership and the GIC self-insured membership, as well as 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 13 also include the GIC fully insured membership. Finally, the proposed legislative requirement is assumed to require the GIC to implement the provisions on July 1, 2019; therefore, the results in 2019 are approximately one-half of an annual value.

**Table 14: GIC Summary Results**

	2019	2020	2021	2022	2023	WEIGHTED AVERAGE	FIVE-YEAR TOTAL
<b>GIC Fully Insured</b>							
Members (000s)	54	54	54	54	55		
Medical Expense Low (\$000s)	\$6	\$12	\$13	\$13	\$13	\$13	\$57
Medical Expense Mid (\$000s)	\$12	\$24	\$25	\$26	\$27	\$25	\$113
Medical Expense High (\$000s)	\$17	\$36	\$37	\$39	\$40	\$38	\$169
Premium Low (\$000s)	\$7	\$14	\$14	\$15	\$15	\$14	\$64
Premium Mid (\$000s)	\$13	\$27	\$28	\$29	\$30	\$28	\$127
Premium High (\$000s)	\$20	\$40	\$42	\$43	\$45	\$42	\$190
<b>GIC Self-Insured</b>							
Members (000s)	269	269	268	267	267		
Medical Expense Low (\$000s)	\$29	\$60	\$63	\$65	\$67	\$63	\$284
Medical Expense Mid (\$000s)	\$58	\$120	\$124	\$129	\$134	\$126	\$565
Medical Expense High (\$000s)	\$87	\$180	\$186	\$193	\$200	\$188	\$845

## Endnotes

<sup>1</sup> The 190th General Court of the Commonwealth of Massachusetts, Senate Bill 2282, “An Act to require health care coverage for the emergency psychiatric services.” Accessed 10 July 2018: <https://malegislature.gov/Bills/190/S2282>.

<sup>2</sup> Massachusetts Behavioral Health Partnership (MBHP). Emergency Services Program/Mobile Crisis Intervention. Accessed 11 July 2018: <https://www.masspartnership.com/member/ESP.aspx>.

<sup>3</sup> The 190th General Court of the Commonwealth of Massachusetts, Senate Bill 2282, “An Act to require health care coverage for the emergency psychiatric services.” Accessed 10 July 2018: <https://malegislature.gov/Bills/190/S2282>.

<sup>4</sup> Massachusetts Behavioral Health Partnership (MBHP). Emergency Services Program/Mobile Crisis Intervention. Accessed 11 July 2018: <https://www.masspartnership.com/member/ESP.aspx>.

<sup>5</sup> The 190th General Court of the Commonwealth of Massachusetts, Senate Bill 2282, “An Act to require health care coverage for the emergency psychiatric services.” Accessed 10 July 2018: <https://malegislature.gov/Bills/190/S2282>.

<sup>6</sup> Massachusetts Health Policy Commission (MHPC). Annual Health Care Cost Trends Report 2016. Published February 2017; accessed 25 July 2018: <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/publications/2016-cost-trends-report.pdf>.

<sup>7</sup> Commonwealth of Massachusetts, Executive Office of Health and Human Services, MassHealth. Mobile Crisis Intervention: Performance Specifications. Accessed 13 July 2018: <https://www.mass.gov/files/documents/2016/07/oi/ps-mobile-crisis-intervention.pdf>.

The service includes: A crisis assessment; engagement in a crisis planning process that may result in the development/update of one or more Crisis Planning Tools (Safety Plan, Advance Communication to Treatment Providers, Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) that contain information relevant to and chosen by the youth and family, up to 7 days of crisis intervention and stabilization services including: on-site face-to-face therapeutic response, psychiatric consultation and urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

For youth who are receiving Intensive Care Coordination (ICC), Mobile Crisis Intervention staff will coordinate with the youth’s ICC care coordinator throughout the delivery of the service. Mobile Crisis Intervention also will coordinate with the youth’s primary care physician, any other care management program or other behavioral health providers providing services to the youth throughout the delivery of the service.

<sup>8</sup> Massachusetts Behavioral Health Partnership (MBHP). MBHP Massachusetts Emergency Services Program Overview Presentation. August 2016; accessed 17 July 2018: <https://www.masspartnership.com/pdf/ESPOverview.pdf>.

<sup>9</sup> Massachusetts Children’s Behavioral Health Initiative (CBHI). Emergency Services Program, Mobile Crisis Intervention Practice Guidelines. Accessed 17 July 2018: <https://www.mass.gov/files/documents/2016/07/uk/practice-guidelines-mci.pdf>.

<sup>10</sup> Op. cit. MBHP ESP Overview.

<sup>11</sup> Op. cit. MBHP ESP Overview.

<sup>12</sup> Op. cit. MBHP ESP Overview.

<sup>13</sup> Op. cit. CBHI.

<sup>14</sup> Op. cit. Mobile Crisis Intervention Performance Specifications.

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<sup>15</sup> Op. cit. MBHP ESP Overview

<sup>16</sup> Commonwealth of Massachusetts Department of Mental Health (MA-DMH). Licensing Guidelines: Community Based Residential Sites. Effective September 2017, revised October 2017; accessed 25 July 2018: <https://www.mass.gov/files/documents/2018/01/11/licensing-guidelines.pdf>.

<sup>17</sup> Massachusetts 104 CMR 28.00: Licensing and Operational Standards for Community Services. Accessed 25 July 2018: [https://www.mass.gov/files/documents/2018/02/26/104cmr28\\_0.pdf](https://www.mass.gov/files/documents/2018/02/26/104cmr28_0.pdf).

28.15: General Provisions

(1) Licensing Requirements. In accordance with M.G.L. c. 19, § 19, the Department shall issue and renew a license to operate residential sites to providers under contract with the Department and providers of private residential programs if the residential sites meet the requirements set forth in 104 CMR 28.15. For purposes of 104 CMR 28.15, a private residential program is a program not operated by or under contract to the Department that is organized primarily to provide treatment, of mental illness to persons in a residential environment that operates one or more residential sites. Treatment includes but is not be limited to rehabilitation, support, or supervision.

<sup>18</sup> Massachusetts Behavioral Health Partnership (MBHP). Performance Specifications: Community Crisis Stabilization (CCS). Effective 1 July 2014; accessed 25 July 2018: <https://www.masspartnership.com/pdf/CCSFINALJul2014.pdf>.

<sup>19</sup> Centers for Medicare and Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight, Information on Essential Health Benefits (EHB) Benchmark Plans. Accessed 11 July 2018: <https://www.cms.gov/ccio/resources/data-resources/ehb.html>.

<sup>20</sup> CMS. Massachusetts State Required Benefits. Accessed 11 July 2018: [https://downloads.cms.gov/ccio/State%20Required%20Benefits\\_MA.PDF](https://downloads.cms.gov/ccio/State%20Required%20Benefits_MA.PDF). Emergency Services: M.G.L.c.175§47U(e); M.G.c.176A§8U(e); M.G.L.c.176B§4U(e); M.G.L.c.176G§5(e). Mental health care: M.G.L.c.175§47B(g); M.G.L.c.176A§8A(g); M.G.L.c.176B§4A(g); M.G.L.c.176G§4M(g).

<sup>21</sup> Op. cit. MBHP.

<sup>22</sup> Massachusetts Center for Health Information and Analysis. Annual Report on the Massachusetts Health Care System, September 2017. Accessed 27 December 2017: <http://www.chiamass.gov/annual-report>.

<sup>23</sup> With an assumed start date of January 1, 2016, dollars were estimated at 70.7% of the annual cost, based upon an assumed renewal distribution by month (Jan through Dec) by market segment and the Massachusetts market segment composition.

## Appendix A: Membership Affected by the Proposed Language

Membership potentially affected by a proposed mandated change to the use of medical necessity criteria may include Commonwealth residents with fully insured employer-sponsored health insurance issued by a Commonwealth-licensed company (including through the GIC); non-residents 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. BerryDunn's 2019 – 2023 membership projections for these populations are derived from the following sources.

The 2014 MA APCD formed the base for the projections. The MA APCD provided fully insured and self-insured membership by insurance carrier. The MA APCD was also used to estimate the number of non-residents covered by a Commonwealth policy. These are typically cases in which a non-resident works for a Commonwealth employer that offers employer-sponsored coverage. Adjustments were made to the data for membership not in the MA APCD, based on published membership reports available from CHIA and the Massachusetts Department of Insurance (DOI).

CHIA publishes a quarterly enrollment trends report and supporting databook (enrollment-trends-july-2016-databook<sup>1</sup>), 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 MA APCD to develop its enrollment trends report and provided BerryDunn with details regarding the use of supplemental carrier information for its December 2014 reported enrollment. The supplemental data was used to adjust the resident totals from the MA APCD.

The DOI published reports titled Quarterly Report of HMO Membership in Closed Network Health Plans as of December 31, 2014<sup>2</sup> and Massachusetts Division of Insurance Annual Report Membership in MEDICAL Insured Preferred Provider Plans by County as of December 31, 2014.<sup>3</sup> These reports provide fully insured covered members for licensed Commonwealth insurers where the member's primary residence is in Commonwealth. The DOI reporting includes all insurance carriers and was used to supplement the MA APCD membership for small carriers not in the MA APCD.

The distribution of members by age and gender was estimated using MA APCD population distribution ratios and was checked for reasonableness and validated against U.S. Census Bureau data.<sup>4</sup> Membership was projected forward from the 2014 base year to 2016 using the American Community Survey<sup>5</sup>, and then from 2016 through 2023 using Census Bureau population growth rate estimates by age and gender.<sup>6</sup>

Projections for the GIC self-insured lives were developed using the GIC base data for 2014<sup>7</sup> and 2015,<sup>8</sup> 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

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<sup>1</sup> Center for Health Information and Analysis. Estimates of fully insured and self-insured membership by insurance carrier. Accessed 22 September 2016. [www.chiamass.gov/enrollment-in-health-insurance/](http://www.chiamass.gov/enrollment-in-health-insurance/).

<sup>2</sup> Massachusetts Department of Insurance. HMO Group Membership and HMO Individual Membership <http://www.mass.gov/ocabr/docs/doi/managed-care/hmo/4q14dist-group.pdf>, <http://www.mass.gov/ocabr/docs/doi/managed-care/hmo/4q14dist-individual.pdf>.

<sup>3</sup> Massachusetts Department of Insurance. Membership 2014. Accessed 22 September 2016 <http://www.mass.gov/ocabr/docs/doi/managed-care/prefprov/2014-prefprov2.pdf>.

<sup>4</sup> U.S. Census Bureau. Annual Estimates of the Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2015. Accessed 28 April 2016: <http://www.census.gov/popest/data/state/totals/2015/index.html>.

<sup>5</sup> American Factfinder U.S. Census Bureau, Annual estimate of populations. Accessed 22 September 2016 [http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP\\_2015\\_PEPANNRES&src=pt](http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2015_PEPANNRES&src=pt)  
Methodology described <http://www.census.gov/popest/methodology/2015-natstcopr-meth.pdf>.

<sup>6</sup> U.S. Census Bureau. Annual Estimates of the Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2015. Accessed 28 April 2016: <http://www.census.gov/popest/data/state/totals/2015/index.html>.

<sup>7</sup> Group Insurance Commission. GIC Health Plan Membership by Insured Status FY2014. Accessed 28 March 2016: <http://www.mass.gov/anf/docs/gic/annual-report/fy2014annual-report.pdf>.

<sup>8</sup> Group Insurance Commission, Group Insurance Commission Fiscal Year 2015 Annual Report. Accessed 25 January 2016: <http://www.mass.gov/anf/docs/gic/annual-report/gic-annual-reportfy15.pdf>.



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