

*Commonwealth of Massachusetts*  
**Mandated Benefits Review**

**Review and Evaluation of Legislation Related to  
Educational Psychologists  
Senate Bill No. 868**

**Provided for:**

**The Joint Committee On Financial Services**

**Division of Health Care Finance and Policy  
Commonwealth of Massachusetts  
July, 2005**

## **EXECUTIVE SUMMARY**

This report was prepared by the Division of Health Care Finance and Policy (DHCFP) pursuant to the provisions of M.G.L. c. 3, § 38C, which requires DHCFP to evaluate the impact of mandated benefit bills referred by legislative committee for review and to report to the referring committee. This report evaluates Senate Bill No. 868, which would add licensed educational psychologists to the definition of “licensed mental health professional.” If an insurer covers services by licensed mental health professionals, the proposed bill would require them to cover services provided by educational psychologists. This bill would not require insurers to reimburse for the services of educational psychologists in the absence of coverage of general mental health services.

Educational psychologists provide evaluation and therapeutic services to children, adolescents, and young adults who need help with their educational experience. Educational psychologists are licensed by the Board of Registration of Allied Mental Health Professions, which operates under the Massachusetts Division of Professional Licensure. Educational psychologists have graduate training, a minimum of two academic years of post-degree clinical experience, and 60 hours of supervised clinical experience. The majority of educational psychologists practice in the school setting, but they are permitted by law to see patients privately as long as those patients are not students in the school district in which the educational psychologists are employed.

There were over 150,000 Massachusetts students enrolled in special education services during the 2004/2005 school year. Presumably, some of these students required services provided by educational psychologists; some students probably were already receiving services from a salaried school educational psychologist, from an educational psychologist for whom their parents were paying out of pocket, or from another licensed mental health provider.

The financial impact of this proposed mandate is difficult to predict for a few reasons. First, other mental health providers may also provide services to clients experiencing learning difficulties, even if those services are more likely to be directed at emotional difficulties rather than learning difficulties. The two are often so closely intertwined that it may be difficult to determine which is the root or primary cause of a student’s problems. Learning problems can easily lead to emotional problems and vice versa, making it extremely difficult to determine what type of professional can best treat each student. Therefore, it is not known whether educational psychologists would be largely substitutive of other mental health providers or complementary to them. Second, educational screening and evaluation are currently the responsibility of the school district, but it is likely that some cost shifting to private insurers would occur if these services became widely covered by private health insurance. School districts increasingly face budgetary pressures and it is widely reported that educational psychologists within schools, test and evaluate at risk students, but have no time to offer therapeutic services.

The Lewin Group (contracted by DHCFP) conducted an actuarial analysis to estimate the financial impact of mandating health insurance coverage for educational psychologists. In the first year of implementation, the Lewin Group estimates that the average increase in cost for fully insured plans would range from \$6.9 million to \$47.7 million. By 2010 (calculated as year five of implementation), the average increase in cost would range from \$8.7 million to \$60.1 million.

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## **OVERVIEW OF PROPOSED LEGISLATION**

The proposed bill S. 868, entitled *AN ACT AUTHORIZING EDUCATIONAL PSYCHOLOGISTS TO RECEIVE CERTAIN INSURANCE PAYMENTS*, would add a “licensed educational psychologist” to the definition of a “licensed mental health professional” in various chapters of the Massachusetts General Laws that pertain to different types of insurers. Currently, a “licensed mental health professional” is defined as a licensed psychiatrist, a licensed psychologist, a licensed independent clinical social worker (LICSW), a licensed mental health counselor (LMHC), and a licensed nurse mental health clinical specialist. The proposed legislation would apply to health benefits offered through the Group Insurance Commission, commercial insurers such as Aetna, Blue Cross Blue Shield, and health maintenance organization (HMO) plans. It would not apply to self-insured firms. The bill would not apply to MassHealth plans; however, it should be noted that MassHealth already covers limited services by educational psychologists.

The proposed legislation would not require insurers to cover the services provided by educational psychologists per se; however, it would require insurers who cover services that are rendered by a “licensed mental health professional” to expand their definition of such professionals to include educational psychologists.

## **INTRODUCTION**

The Joint Committee on Financial Services in the 2003/2004 Legislative Session referred S. 868 to the Division of Health Care Finance and Policy (DHCFP) for review and evaluation. The bill’s lead sponsor is Senator Richard T. Moore.

## **BACKGROUND OF ISSUE AND CURRENT LAW**

Educational psychology "focuses on the study of learning outcomes, student attributes, and instructional processes directly related to the classroom and the school, such as amount of instructional time or individual differences in school learning. An educational psychologist helps gather information for teachers and parents when students have academic or behavioral problems. They assist by evaluating students’ thinking abilities and assessing individual strengths and weaknesses. Together, the parents, teachers, and educational psychologist formulate plans to help students learn more effectively. Educational psychologists work mostly in elementary and secondary school classrooms. They also may work in other settings such as colleges, consulting organizations, corporations, industry, the military, and religious institutions."<sup>1</sup> At least one hospital in Massachusetts, Massachusetts General Hospital, has a learning disorders unit that employs educational psychologists. Parenthetically, according to the Director of the unit, very few health insurance companies currently reimburse for their services.

Educational psychologists are licensed by the Board of Registration of Allied Mental Health Professions, which operates under the Massachusetts Division of Professional Licensure, in contrast to general psychologists who are licensed by the Board of Registration of Psychologists. Educational Psychologists have graduate training (a master’s degree, Certificate of Advanced Graduate Studies, or doctoral degree) in school psychology. After graduation from an accredited program, an educational psychologist must meet the following criteria for licensure: a current certification as a school psychologist from the Massachusetts Department of Education, a minimum of two full-time academic years or the part-time equivalent of post-degree clinical

experience, a minimum of 60 hours of supervised clinical experience in the practice of school psychological services, and passage of the licensure examination.<sup>2</sup> Pursuant to the Massachusetts General Laws, Chapter 112, Section 163, this license allows educational psychologists to provide “services [that] may be preventative, developmental, or remedial and include psychological and psychoeducational assessment, therapeutic intervention, program planning and evaluation, research, teaching in the field of educational psychology, consultation and referral to other psychiatric, psychological, medical, and educational resources when necessary.”

Most educational psychologists are currently employed by school systems and practice in the school setting. In addition, educational psychologists are permitted by Massachusetts General Laws to see clients privately as long as these students do not attend the school system in which the educational psychologist is employed. However, such clients must now pay for these services out of pocket unless they are enrolled in a Medicaid program that currently covers some of the services provided by educational psychologists on a limited basis.

## **MEDICAL EFFICACY**

*The Division of Health Care Finance and Policy is charged with reporting: 1) the expected impact of the benefit on the quality of patient care and the health status of the population, and 2) the results of any research demonstrating the medical efficacy of the treatment or service compared to alternative treatments or services or not providing the treatment or service.*

An increasing number of Massachusetts students have been assessed for special education services in recent years. These students are among those who would be most likely to seek out services provided by educational psychologists privately. During the 2002/2003 school year, 155,204 students officially received some type of special education service or accommodation; that number decreased slightly during the 2003/2004 school year to 154,391 students and then substantially increased to 157,108 students during the 2004/2005 school year.<sup>3</sup> The types of disabilities recognized range from speech/language problems to mobility impairment. Not all students with one or more such disabilities need the services of a private educational psychologist but this is the cohort most likely to avail themselves of such services in their school settings.

Insurance coverage for educational psychologists would benefit privately insured students who live in school districts where educational psychologists do not work during the summer. These students could potentially continue treatment during the summer months rather than experience an interruption in services due to seasonal school closings. Currently, educational psychologists in the Boston Public School system, for example, do not work in the summer except for a handful who provide emergency services, while educational psychologists in the Springfield Public School system work during the summer.<sup>4,5</sup>

According to professional literature and the Director of Supportive Services of the Springfield Public School System, salaried school educational psychologists spend the majority of their time providing evaluation and testing services.<sup>5,6,7</sup> Therefore, another benefit of insurance coverage for this provider group would be that educational psychologists could go beyond testing to provide counseling to a student as long as he or she were insured. Counseling services are in high demand according to reports from school officials; students do not have access to the

psychological services they need, partly because there has been an increase in the need for these types of services.<sup>8</sup>

Another advantage of insurance coverage for educational psychologists is that any insured family could obtain services that are currently available only to families paying out of pocket or, in limited instances, families with Medicaid coverage. Families currently paying out of pocket would save money when their insurer picks up the cost of the services.

It is currently the financial responsibility of the school district to provide the testing and therapeutic services that educational psychologists provide. Some parents (those paying out of pocket) obtain private testing to either augment or counter the findings of a school-administered test and some contract for private ongoing therapeutic services when dissatisfied with what the school district provides. For example, one of the more common mental health diagnoses for which insured young adults are treated is Attention Deficit Hyperactivity Disorder (ADHD) (as reported by two health insurers in Massachusetts), a condition that educational psychologists are trained to treat. In this era of cash-strapped towns, parents who can obtain extra services for their children privately sometimes do so rather than relying on what they perceive as the inadequate services provided by the school system. If the proposed mandated benefit passes, it is not hard to imagine that some schools might come to rely on privately insured families to obtain the help their children need through their insurance rather than through the school.

The proposed mandate does not stipulate an allowable scope of services, thus there would be no limit on the types of problems that educational psychologists could treat; presumably there would be some overlap with other mental health professionals indicating a possible substitutive effect. For instance, in speaking with the Director of Supportive Services at the Springfield Public School System, it became clear that while treating a client, it is hard to determine whether an emotional/behavioral problem is leading to a learning problem, or whether a learning problem is so frustrating to a student that it leads to an emotional or behavioral problem. One could argue that an educational psychologist would be better suited to treat students in the latter circumstance, but this may not always occur due to the complicated nature of mental health problems. Unfortunately, after a literature review and consultation with other states, DHCFFP was not able to find research that evaluated the effectiveness of educational psychologists compared to other mental health professionals.

## **ORGANIZATIONS THAT SUBMITTED INFORMATION TO DHCFFP**

Four health insurers in Massachusetts responded to DHCFFP inquiries regarding their current coverage of educational psychologists. The Massachusetts Professional Association of School Psychologists also submitted testimony to DHCFFP.

## **CURRENT COVERAGE LEVELS**

Only one of the health insurers that submitted information to DHCFFP covers educational psychologists. However, the nature of this plan's data is such that services provided by educational psychologists cannot be broken out. The following chart shows relevant data for insured members ages 23 and younger provided by the four health insurers that responded to DHCFFP:

	<b>Health Plan 1</b>	<b>Health Plan 2</b>	<b>Health Plan 3</b>	<b>Health Plan 4</b>
<b>Type of Enrollees</b>	Employer-sponsored	Employer-sponsored	MassHealth	Employer-sponsored and MassHealth (Data for Employer-sponsored Only)
<b>Current Coverage for Educational Psychologists?</b>	No	No	Contract with facilities where educational psychologists may provide services but do not contract individually with educational psychologists	Yes
<b>Average Age of Unique Enrollees</b>	13.5	14	-	-
<b>Most Common Diagnoses</b>	(1) Adjustment reaction with mixed emotional features* (2) Dysthymic disorder** (3) Attention Deficit Hyperactivity Disorder	(1) Adjustment reaction with mixed emotional features (2) Attention Deficit Hyperactivity Disorder (3) Dysthymic disorder	-	-

\* Adjustment disorder with symptoms of anxiety and depression<sup>9</sup>

\*\* Chronic, mild depression<sup>10</sup>

MassHealth covers educational psychologists but only in limited circumstances for screening and testing services; however, the proposed mandate excludes MassHealth.

## **COST OF EDUCATIONAL PSYCHOLOGY SERVICES**

The Board of Registration of Allied Mental Health Professions records 545 currently licensed educational psychologists in Massachusetts. According to the Massachusetts School Psychologists Association, the clientele that are seen by educational psychologists range in age from 3 to 22. The average length of treatment is 10 hours for academic problems, 12 to 40 hours for mental health counseling (12 to 20 hours for less severe cases, 20 to 40 hours for more severe cases), and 10 to 15 hours for full evaluations. The average rate at which educational psychologists are reimbursed is \$50 to \$75/hour.<sup>11</sup> As mentioned previously, educational psychologists are permitted by law to see clients privately as long as these students do not attend the school system in which the educational psychologist is employed. The Massachusetts School Psychologists Association estimates that approximately 50 educational psychologists currently see clients privately, mostly on a part-time basis, with an average number of cases ranging from 5 to 25 per year.<sup>11</sup>

## FINANCIAL IMPACT

The financial impact of this proposed mandate is difficult to predict due to several uncertainties. There is no reference in the mandate to limiting the scope of services that educational psychologists could provide and for which they could receive reimbursement. Thus, there is the potential for the services provided by educational psychologists to be substitutive, but it is difficult to predict if and to what extent that would happen. In addition, school districts are currently responsible for educational screening and evaluation services. While that may not change, the insured would have the option of hiring a private educational psychologist for such services, especially if dissatisfied with the services provided by cash-strapped cities and towns.

The results of a financial analysis performed by an actuary from The Lewin Group (contracted by DHCFP) are briefly summarized in the answers to the following questions. Please refer to Appendix I for The Lewin Group's complete report.

- 1. The extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next five years.*

It is expected that more educational psychologists will see clients privately if they receive reimbursement for their services from insurance companies, which would result in an increase in the total overall cost of services provided by educational psychologists. This assumes that there would be an increase in demand for educational psychologists' services as well, which is supported by reports that residents of Massachusetts are seeking more therapy services overall<sup>12</sup> and by reports from school officials that students do not have access to the psychological services they need and that there has been an increase in the need for these types of services.<sup>8</sup> That there would be an increase in demand for educational psychologists' services is further supported by the increasing number of students who are receiving special education services in Massachusetts.<sup>3</sup> Thus, there appears to be a growing need for the services that educational psychologists provide. It is important to note that there are only 545 licensed educational psychologists in Massachusetts. While some may see clients privately if this legislation passes, this may not have a huge effect on utilization.

This proposed mandate could have a somewhat muted effect on cost if for the most part only those individuals already seeking psychological services switch to educational psychologists when more appropriate for their condition. Passage of this mandate could even decrease overall costs to the system if this substitution effect occurs, since educational psychologists would likely be reimbursed at a lower rate than other licensed psychologists (to the degree the latter have doctoral degrees, and educational psychologists have master's degrees). One thing to note, however, is that even with a substitution effect for therapeutic services, there could be some cost shifting if private educational psychologists provide more screening services, which have been provided primarily by the school system. This cost shift would be from the taxpayer to the private health insurance system.

Finally, the unit cost of service would most likely rise since private educational psychologists would have to factor the cost of third party billing into their charges. To some degree, the current price for private services reflects what a family can reasonably afford to ensure that the educational psychologist can attract private clients. That would no longer be the case if insurance



were to cover the cost. Utilization could also increase as a result of the “moral hazard” effect—a tendency to use more services when financial barriers are removed. Thus, some individuals may be more inclined to obtain services from educational psychologists or to obtain more of them if the services provided are covered by their insurance plan. Of course, this mandate would also make needed services accessible to families who currently cannot afford to pay out of pocket.

The Lewin Group projected the annual cost/savings of the mandate for the next 5 years (through 2010). The Lewin Group approximates that the total cost for fully insured plans would increase over the next 5 years as a result of this mandate. In the first year of implementation, the Lewin Group estimates that the average increase in cost for fully insured plans would range from \$6.9 million to \$47.7 million. By 2010 (calculated as year five of implementation), the average increase in cost would range from \$8.7 million to \$60.1 million. The range estimates represent low and high impact scenarios, respectively. These costs correspond to a range in per member per month cost increases of \$0.18 to \$1.28 (low to high impact) in the first year of implementation to \$0.23 to \$1.59 in the fifth year of implementation.

	<b>Low Estimate of Average Cost Increase</b>	<b>High Estimate of Average Cost Increase</b>
<b>2006 (Year One)</b>	\$6.9 million	\$47.7 million
<b>2010 (Year Five)</b>	\$8.7 million	\$60.1 million

Please see Appendix I for The Lewin Group’s full results and methodology.

- 2. The extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next five years.*

For those students who obtain therapeutic services from educational psychologists during the school year, passage of this bill might enable some privately insured students to continue treatment over the summer, perhaps accelerating their progress.

- 3. The extent to which the mandated treatment or service might serve as an alternative for a more expensive or a less expensive treatment or service.*

The proposed mandate could result in cost savings to insurers should a substitution effect occur as it is likely that educational psychologists would be reimbursed at a lower rate than other licensed psychologists. However, the potential increase in the number of providers and resulting increase in demand, as well as the increase in screening services provided by educational psychologists, could offset any savings.

One group that could have a significant impact on the costs associated with the passage of this mandate is the parents of privately insured children. It is quite possible that some number of parents whose children require evaluation or therapeutic services will turn to private educational psychologists instead of their school system if such services are covered by their health insurance. It is difficult to predict the increased number of parents that might seek out these services and the financial impact that would result.

4. *The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next five years.*

The passage of this mandate would likely result in some increase in the number of educational psychologists who see clients privately.

5. *The effects of the mandated benefit on the cost of health care, particularly the premium, administrative expenses and indirect costs of large and small employers, employees and non-group purchasers.*

The cost of health care would likely increase if the number of educational psychologists who see clients privately and the number of clients seeking services increases. Alternatively, if there is a substitution effect, then the cost of health care could decrease due to the lower reimbursement rate for educational psychologists compared to other licensed psychologists. Even with a substitution effect, premiums and other costs could increase if educational psychologists provide more screening services previously paid for by the school systems.

Mandating coverage for educational psychologists would also mean additional credentialing and contracting activities on the part of health insurers, since only one of those surveyed currently contracts with this provider group.

This mandate would disproportionately affect small employers and their employees since many large employees self-insure, thereby exempting themselves from abiding by state approved mandates. However, there are large employers who voluntarily abide by state mandates.

The Lewin Group projected the effect of the mandate on insurance premiums for the next five years (through 2010). They estimate that in the first year of implementation, the average increase in the annual cost per member for the purchaser of health insurance due to this mandate would range from \$2.22 to \$15.33. By 2010 or year five of implementation, the average increase in the annual cost per member would range from \$2.76 to \$19.06. The range estimates represent low and high impact scenarios, respectively.

	<b>Low Estimate of Annual Cost Increase</b>	<b>High Estimate of Annual Cost Increase</b>
<b>2006 (Year One)</b>	\$2.22	\$15.33
<b>2010 (Year Five)</b>	\$2.76	\$19.06

Please see Appendix I for The Lewin Group's report.

6. *The potential benefits and savings to large and small employers, employees and non-group purchasers.*

Employees who currently pay for an educational psychologist's services out of pocket would experience savings with passage of this mandate, as these services would be covered by their insurance plans. However, premiums could rise to account for an increase in services covered by insurance plans. The non-group market is not included in the mandate and thus would not be affected.

7. *The effect of the proposed mandate on cost shifting between private and public payers of health care coverage.*

There is substantial overlap among services that school districts are required to provide, services currently provided by educational psychologists privately, and services educational psychologists would provide should this bill pass. Pursuant to Massachusetts Regulation 603 CMR 28.00, Massachusetts school districts are required to provide initial evaluations, if requested, for those students whose parents reside in the school district. School districts are also responsible for the creation and implementation of an Individualized Education Plan (IEP) for those students who need such a plan. Passage of this mandate could set the stage for school districts to shift the responsibility of providing such services to private insurers explicitly or, more likely, implicitly.

8. *The cost to health care consumers of not mandating the benefit in terms of out-of-pocket costs for treatment or delayed treatment.*

It is difficult to estimate the number of privately insured health care consumers who are currently paying out of pocket for treatment from educational psychologists; however, some amount of health care consumer cost would be reduced with the passage of this mandate. For example, assuming there are 50 educational psychologists who see clients privately and assuming an average caseload of 10 patients per year, that would mean approximately 500 people are currently paying out of pocket for treatment in Massachusetts. Although the number of privately insured clients and the amount that these clients are actually paying for the services is unknown, some consumer cost savings would result.

It is unlikely that privately insured consumers are currently delaying treatment since other approved provider groups and school districts are available to provide similar services.

9. *The effect on the overall cost of the health care delivery system in the Commonwealth.*

Mandating coverage for educational psychologists would likely result in some increase in the overall cost of the health care delivery system. With guaranteed reimbursement, the number of educational psychologists who see clients privately would undoubtedly increase to some extent. In addition, mandating coverage for educational psychologists would mean additional credentialing and contracting activities on the part of health insurers, since so few of them currently contract with this provider group. If educational psychologists serve in substitution for other mental health professionals, the bill might save the health care system some money if reimbursements are lower for this type of professional.

## **LEGISLATIVE ACTIVITY IN OTHER STATES AND ON THE FEDERAL LEVEL**

DHCFP contacted the state government offices in Tennessee, Virginia, Wisconsin, Ohio, and Maryland to inquire about the existence of mandated coverage for educational psychologists. Though some of the health insurers in these states might reimburse for services provided by educational psychologists, none of them have mandated coverage for this provider group.

## ENDNOTES

[1] West Chester University of Pennsylvania. Accessible at: [www.wcupa.edu](http://www.wcupa.edu). Accessed in November 2004.

[2] The Board of Registration of Allied Mental Health Professions. Accessible at <http://www.mass.gov/dpl/boards/mh/>. Accessed in November 2004 – July 2005.

[3] Massachusetts Department of Education. Accessible at: <http://www.doe.mass.edu/>. Accessed in November 2004 – July 2005.

[4] Personal Communication in June, 2005, with the Director of Psychological Services of the Boston Public School System.

[5] Personal Communication in June, 2005, with the Director of Supportive Services of the Springfield Public School System.

[6] Prout S. Prout H. 1998. A meta-analysis of school-based studies of counseling and psychotherapy: an update. *Journal of School Psychology* 36(2): 121-136.

[7] Friedman R. 2003. Improving outcomes for students through the application of a public health model to school psychology: a commentary. *Journal of School Psychology* 41: 69-75.

[8] Ware S. "Schools Answer Mental Health Needs Educators Forced to Pick Up Slack." *The Boston Globe*. February 10, 2002.

[9] eMedicine World Medical Library. Accessible at: <http://www.emedicine.com/med/topic3348.htm>. Accessed in May 2005.

[10] National Institute of Mental Health. Accessible at: <http://www.nimh.nih.gov/>. Accessed in May 2005.

[11] Personal communication in November, 2004 – June, 2005 with representatives from the Massachusetts School Psychologists Association.

[12] Kowalczyk L. "Mental Health Visits Climb in Bay State." *The Boston Globe*. December 4, 2002.

## **APPENDIX I**



<sup>e</sup>LEWIN GROUP

# **Actuarial Assessment of Senate Bill No. 868: “An Act Authorizing Educational Psychologists to Receive Certain Insurance Payments”**

*Prepared for:*

**Division of Health Care Finance and Policy  
Commonwealth of Massachusetts**

*June 30, 2005*

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## I. SUMMARY AND RESULTS

The Massachusetts Division of Health Care Finance and Policy retained The Lewin Group to perform an actuarial assessment of Senate Bill No. 868, which would amend certain chapters of the General Laws of Massachusetts having to do with health insurance, health care benefits, health maintenance organizations, and medical/hospital service corporations. In the affected chapters, the definition of “licensed mental health professional” would be amended to include educational psychologists, “within the lawful scope of [their] practice” (presumably defined in accordance with the requirements of the Massachusetts Board of Registration of Allied Mental Health Professions, which licenses educational psychologists). The bill would not affect non-group insurance plans and policies. Also, due to the ERISA preemption, it would not affect self-insured private-sector employee benefit plans. However, the bill would apply to public-sector employees covered by plans administered by the Group Insurance Commission (GIC), since the chapter of the General Laws that governs these plans (32A) is among those that the bill specifically identifies and would amend as described above. (Also, the GIC tends to follow any benefit mandate that applies to fully insured plans, even if the mandate does not legally apply to GIC-administered plans.)

Our actuarial assessment includes estimates of the following:

- The total number of Massachusetts residents who are covered by plans that would be affected by the proposed legislation (including fully-insured employment-based plans and GIC-administered plans), and the total number of such persons who are 0 to 23 years of age (since that is the population segment that is likely to utilize the services of educational psychologists)
- The year-to-year increase in the total number of affected persons that we expect to occur between the base year (2004) and the last year of the projection period (2010), and – for each year – the percentage of that group that is between 0 and 23 years of age
- The average annual and monthly gross premium (including insurer expenses) and the average annual and monthly net benefit cost (i.e., claims cost) for these plans, per covered person, under current law (i.e., in the absence of the proposed legislation)
- The anticipated underlying trend (i.e., annual increase) in per-member benefit costs and premiums – that is, the increase that would occur regardless of whether the proposed legislation is enacted
- The current utilization rates for services performed by currently covered providers that might also be performed by educational psychologists if the proposed legislation is enacted
- The extent to which utilization for these services might increase as a result of the proposed legislation, versus the extent to which educational psychologists might simply be substituted for some of the providers who currently are performing these services
- The expected increase in costs (both on a per-member basis and in the aggregate) that would occur as a result of the proposed legislation being enacted, based on the anticipated utilization increases and the current unit costs for the affected services (adjusted for underlying cost trends in future years).

The cost projections included in this analysis are based on the assumption that the proposed bill, if enacted, would go into effect at the beginning of 2006. Five-year population and cost projections (through 2010) were developed under a variety of scenarios. Low, medium (or “best estimate”), and high values were selected for the following key input variables: (a) the number of persons affected by the legislation, (b) the underlying trend in per-member health insurance costs, and (c) the impact of the legislation on the utilization of affected services.



\* \* \* \* \*

The results of our analysis are presented in the exhibits below, labeled Part 1a through Part 2c.

**Parts 1a through 1c** of our analysis show projections of health insurance costs under current law (i.e., disregarding the effect that the proposed legislation would have if enacted):

- Part 1a shows the projected population and costs under medium or “best estimate” assumptions, both for the size of the affected population (i.e., the number of persons covered by fully insured group plans and by GIC) and for the underlying trend in per-member costs. The projected costs include the annual net benefit costs and the annual gross premiums, both on a per-member basis and for the total affected population.
- Part 1b shows the projected population and costs under both low and high assumptions for the size of the affected population. This indicates the range of results that could occur in the number of affected persons and in the total annual cost for their health insurance, due solely to variations in the population parameters versus our “best estimate” assumptions.
- Part 1c shows the projected population and costs under both low and high assumptions for the underlying trend in per-member costs. This indicates the range of results that could occur in the annual per-member and aggregate cost for health insurance for persons who would be affected by the proposed legislation, due solely to variations in the underlying cost trend versus our “medium” assumption.

Again, the projections shown in these exhibits are based on the insurance laws currently in effect in Massachusetts, without regard to any changes that would be made upon enactment of the proposed legislation. The sources and/or derivations for the low, medium (or “best estimate”), and high population and trend assumptions are described in Section II of this report.

**Parts 2a through 2c** provide a set of estimates of the cost effect of the proposed legislation, all using the medium or “best estimate” assumptions for the size of the affected population and the underlying trend in per-member costs. Part 2a corresponds to the low estimate of the cost effect of the proposed legislation, Part 2b corresponds to the medium estimate, and Part 2c corresponds to the high estimate.

- The low-impact assumption is that the proposed legislation would raise health insurance costs for all affected plans by 0.09%, based on the proportion of the population in 2004 (the year for which the division collected cost and utilization data) that is between 0 and 23 years of age (30.71%). Adjusting the 2004 cost impact to reflect the lower “0 to 23” percentage (30.50%) anticipated for 2006 yields a slightly lower cost impact (0.0894%) in the year that the new law would actually take effect.
- The medium-impact assumption is that the proposed legislation would raise health insurance costs for all affected plans by 0.22%, based on the proportion of the population in 2004 that is between 0 and 23 years of age. Adjusting the 2004 cost impact to reflect the lower “0 to 23” percentage anticipated for 2006 yields a slightly lower cost impact (0.2185%) in the year that the new law would actually take effect.
- The high-impact assumption is that the proposed legislation would raise health insurance costs for all affected plans by 0.41%, based on the proportion of the population in 2004 that is between 0 and 23 years of age. Adjusting the 2004 cost impact to reflect the lower “0 to 23” percentage

anticipated for 2006 yields a slightly lower cost impact (0.4072%) in the year that the new law would actually take effect.

In each case, the estimated cost impact is a one-time addition to the underlying trend, occurring in the first year (2006) that the proposed legislation is assumed to be in effect. Note that, based on the National Health Expenditure (NHE) projections produced by the Centers for Medicare and Medicaid Services (CMS), we already were anticipating a decrease in the underlying trend from 6.8% for 2005 to 5.6% per year from 2006 through 2010. Thus, even with the cost impact of the proposed legislation added in, the total trend decreases from 2005 to 2006 under all three cost-impact scenarios.

In the bottom half of each of these exhibits, we show the *increase* both in the per-member cost and in the total cost for fully insured persons for each year on a dollar basis. (This is compared to the “current law” projections from Part 1a.) Note that the increase is \$0 for 2004 and 2005, since the mandate is not assumed to go into effect until 2006.

**Cost Projections for Educational Psychologists Mandate**

**Part 1a: Projected Health Insurance Costs Under Current Law**

*(Population Projection: Best Estimate)*

*(Underlying Trend in Per-Member Costs: Medium)*

	2004	2005	2006	2007	2008	2009	2010
<b>POPULATION PROJECTION</b>							
<b>Total MA Population</b>	6,416,505	6,416,505	6,422,922	6,435,767	6,455,075	6,480,895	6,506,819
<i>Growth rate over prior year</i>	-0.1%	0.0%	0.1%	0.2%	0.3%	0.4%	0.4%
<b>Age 0-23 Population</b>	1,970,608	1,962,300	1,959,306	1,961,844	1,965,271	1,967,631	1,967,995
<i>Percent of total population</i>	30.71%	30.58%	30.50%	30.48%	30.45%	30.36%	30.25%
<b>BEST ESTIMATE OF AFFECTED POPULATION:</b>							
<b>Fully Insured + GIC (total)</b>	3,110,082	3,110,082	3,113,192	3,119,419	3,128,777	3,141,292	3,153,857
<b>Fully Insured + GIC (age 0-23)</b>	906,077	902,256	900,880	902,047	903,623	904,708	904,875
<b>PER-MEMBER PER-MONTH COST</b>							
<b>Net Benefit Cost</b>	\$268.26	\$286.50	\$302.54	\$319.48	\$337.37	\$356.27	\$376.22
<i>Underlying trend</i>	---	6.8000%	5.6000%	5.6000%	5.6000%	5.6000%	5.6000%
<b>Gross Premium</b>	\$304.84	\$325.56	\$343.80	\$363.05	\$383.38	\$404.85	\$427.52
<i>Margin as % of gross premium</i>	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%
<b>ANNUAL COST PER MEMBER</b>							
<b>Net Benefit Cost</b>	\$3,219	\$3,438	\$3,630	\$3,834	\$4,048	\$4,275	\$4,515
<b>Gross Premium</b>	\$3,658	\$3,907	\$4,126	\$4,357	\$4,601	\$4,858	\$5,130
<b>TOTAL COST FOR ALL AFFECTED PLANS</b>							
<b>Benefit Costs (\$millions)</b>		\$10,692	\$11,302	\$11,959	\$12,667	\$13,430	\$14,238
<b>Gross Premiums (\$millions)</b>		\$12,150	\$12,844	\$13,590	\$14,394	\$15,261	\$16,180

**Cost Projections for Educational Psychologists Mandate**

**Part 1b: Projected Health Insurance Costs Under Current Law**

*(Population Projections: Low and High)*

*(Underlying Trend in Per-Member Costs: Medium)*

	2004	2005	2006	2007	2008	2009	2010
<b>POPULATION PROJECTION</b>							
<b>Total MA Population</b>	6,416,505	6,416,505	6,422,922	6,435,767	6,455,075	6,480,895	6,506,819
<i>Growth rate over prior year</i>	-0.1%	0.0%	0.1%	0.2%	0.3%	0.4%	0.4%
<b>Age 0-23 Population</b>	1,970,608	1,962,300	1,959,306	1,961,844	1,965,271	1,967,631	1,967,995
<i>Percent of total population</i>	30.71%	30.58%	30.50%	30.48%	30.45%	30.36%	30.25%
<b>LOW ESTIMATE OF AFFECTED POPULATION:</b>							
<b>Fully Insured + GIC (total)</b>	3,040,898	3,040,898	3,043,938	3,050,026	3,059,176	3,071,413	3,083,699
<b>Fully Insured + GIC (age 0-23)</b>	884,387	880,658	879,315	880,454	881,992	883,051	883,214
<b>HIGH ESTIMATE OF AFFECTED POPULATION:</b>							
<b>Fully Insured + GIC (total)</b>	3,179,267	3,179,267	3,182,446	3,188,811	3,198,378	3,211,171	3,224,016
<b>Fully Insured + GIC (age 0-23)</b>	927,766	923,854	922,445	923,640	925,253	926,364	926,536

**ANNUAL COST PER MEMBER**

<b>Net Benefit Cost</b>	\$3,219	\$3,438	\$3,630	\$3,834	\$4,048	\$4,275	\$4,515
<i>Underlying trend</i>	---	6.8000%	5.6000%	5.6000%	5.6000%	5.6000%	5.6000%
<b>Gross Premium</b>	\$3,658	\$3,907	\$4,126	\$4,357	\$4,601	\$4,858	\$5,130
<i>Margin as % of gross premium</i>	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%

**TOTAL COST FOR ALL AFFECTED PLANS**

**LOW-POPULATION COST ESTIMATES:**

<b>Benefit Costs (\$millions)</b>	\$10,454	\$11,051	\$11,693	\$12,385	\$13,131	\$13,922
<b>Gross Premiums (\$millions)</b>	\$11,880	\$12,558	\$13,288	\$14,074	\$14,921	\$15,820

**HIGH-POPULATION COST ESTIMATES:**

<b>Benefit Costs (\$millions)</b>	\$10,930	\$11,554	\$12,225	\$12,949	\$13,728	\$14,555
<b>Gross Premiums (\$millions)</b>	\$12,421	\$13,129	\$13,892	\$14,714	\$15,600	\$16,540

**Cost Projections for Educational Psychologists Mandate**

**Part 1c: Projected Health Insurance Costs Under Current Law**

*(Population Projection: Best Estimate)*

*(Underlying Trends in Per-Member Costs: Low and High)*

	2004	2005	2006	2007	2008	2009	2010
<b>LOW UNDERLYING TREND:</b>							
<b>PER-MEMBER PER-MONTH COST</b>							
<b>Net Benefit Cost</b>	\$268.26	\$283.63	\$296.52	\$309.99	\$324.08	\$338.81	\$354.20
<i>Underlying trend</i>	---	5.7320%	4.5440%	4.5440%	4.5440%	4.5440%	4.5440%
<b>Gross Premium</b>	\$304.84	\$322.31	\$336.95	\$352.27	\$368.27	\$385.01	\$402.50
<i>Margin as % of gross premium</i>	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%
<b>ANNUAL COST PER MEMBER</b>							
<b>Net Benefit Cost</b>	\$3,219	\$3,404	\$3,558	\$3,720	\$3,889	\$4,066	\$4,250
<b>Gross Premium</b>	\$3,658	\$3,868	\$4,043	\$4,227	\$4,419	\$4,620	\$4,830
<b>TOTAL COST FOR ALL AFFECTED PLANS</b>							
<b>Benefit Costs (\$millions)</b>		\$10,585	\$11,077	\$11,604	\$12,168	\$12,771	\$13,405
<b>Gross Premiums (\$millions)</b>		\$12,029	\$12,588	\$13,186	\$13,827	\$14,513	\$15,233
<b>HIGH UNDERLYING TREND:</b>							
<b>PER-MEMBER PER-MONTH COST</b>							
<b>Net Benefit Cost</b>	\$268.26	\$289.36	\$308.62	\$329.16	\$351.07	\$374.44	\$399.36
<i>Underlying trend</i>	---	7.8680%	6.6560%	6.6560%	6.6560%	6.6560%	6.6560%
<b>Gross Premium</b>	\$304.84	\$328.82	\$350.71	\$374.05	\$398.95	\$425.50	\$453.82
<i>Margin as % of gross premium</i>	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%
<b>ANNUAL COST PER MEMBER</b>							
<b>Net Benefit Cost</b>	\$3,219	\$3,472	\$3,703	\$3,950	\$4,213	\$4,493	\$4,792
<b>Gross Premium</b>	\$3,658	\$3,946	\$4,208	\$4,489	\$4,787	\$5,106	\$5,446
<b>TOTAL COST FOR ALL AFFECTED PLANS</b>							
<b>Benefit Costs (\$millions)</b>		\$10,799	\$11,530	\$12,322	\$13,181	\$14,115	\$15,114
<b>Gross Premiums (\$millions)</b>		\$12,272	\$13,102	\$14,002	\$14,979	\$16,039	\$17,175

**Cost Projections for Educational Psychologists Mandate**

**Part 2a: Projected Health Insurance Costs Under Proposed Legislation**

*(Population Projection: Best Estimate)*

*(Underlying Trend in Per-Member Costs: Medium)*

*(Low Impact of Proposed Legislation: 0.09%)*

	2004	2005	2006	2007	2008	2009	2010
<b>PER-MEMBER PER-MONTH COST</b>							
<b>Net Benefit Cost</b>	\$268.26	\$286.50	\$302.70	\$319.65	\$337.56	\$356.46	\$376.42
<i>Trend plus legislation impact (adjusted for age distribution)</i>	---	6.8000%	<b>5.6567%</b>	5.6000%	5.6000%	5.6000%	5.6000%
<b>Gross Premium</b>	\$304.84	\$325.56	\$343.98	\$363.24	\$383.59	\$405.07	\$427.75
<i>Margin as % of gross premium</i>	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%
<b>ANNUAL COST PER MEMBER</b>							
<b>Net Benefit Cost</b>	\$3,219	\$3,438	\$3,632	\$3,836	\$4,051	\$4,277	\$4,517
<b>Gross Premium</b>	\$3,658	\$3,907	\$4,128	\$4,359	\$4,603	\$4,861	\$5,133
<b>TOTAL COST FOR ALL AFFECTED PLANS</b>							
<b>Benefit Costs (\$millions)</b>		\$10,692	\$11,308	\$11,966	\$12,674	\$13,437	\$14,246
<b>Gross Premiums (\$millions)</b>		\$12,150	\$12,851	\$13,597	\$14,402	\$15,269	\$16,189
<b>INCREASE IN PER-MEMBER PER-MONTH COST</b>							
<b>Net Benefit Cost</b>	\$0.00	\$0.00	<b>\$0.16</b>	\$0.17	\$0.18	\$0.19	\$0.20
<b>Gross Premium</b>	\$0.00	\$0.00	\$0.18	\$0.20	\$0.21	\$0.22	\$0.23
<b>INCREASE IN ANNUAL COST PER MEMBER</b>							
<b>Net Benefit Cost</b>	\$0.00	\$0.00	\$1.95	\$2.06	\$2.17	\$2.30	\$2.42
<b>Gross Premium</b>	\$0.00	\$0.00	\$2.22	\$2.34	\$2.47	\$2.61	\$2.76
<b>INCREASE IN TOTAL COST FOR ALL AFFECTED PLANS</b>							
<b>Benefit Costs (\$millions)</b>		\$0.0	\$6.1	\$6.4	\$6.8	\$7.2	\$7.6
<b>Gross Premiums (\$millions)</b>		\$0.0	\$6.9	\$7.3	\$7.7	\$8.2	\$8.7

**Cost Projections for Educational Psychologists Mandate**

**Part 2b: Projected Health Insurance Costs Under Proposed Legislation**

*(Population Projection: Best Estimate)*

*(Underlying Trend in Per-Member Costs: Medium)*

*(Med. Impact of Proposed Legislation: 0.22%)*

	2004	2005	2006	2007	2008	2009	2010
<b>PER-MEMBER PER-MONTH COST</b>							
<b>Net Benefit Cost</b>	\$268.26	\$286.50	\$303.09	\$320.07	\$337.99	\$356.92	\$376.91
<i>Trend plus legislation impact (adjusted for age distribution)</i>	---	6.8000%	<b>5.7931%</b>	5.6000%	5.6000%	5.6000%	5.6000%
<b>Gross Premium</b>	\$304.84	\$325.56	\$344.42	\$363.71	\$384.08	\$405.59	\$428.30
<i>Margin as % of gross premium</i>	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%
<b>ANNUAL COST PER MEMBER</b>							
<b>Net Benefit Cost</b>	\$3,219	\$3,438	\$3,637	\$3,841	\$4,056	\$4,283	\$4,523
<b>Gross Premium</b>	\$3,658	\$3,907	\$4,133	\$4,365	\$4,609	\$4,867	\$5,140
<b>TOTAL COST FOR ALL AFFECTED PLANS</b>							
<b>Benefit Costs (\$millions)</b>		\$10,692	\$11,323	\$11,981	\$12,690	\$13,454	\$14,264
<b>Gross Premiums (\$millions)</b>		\$12,150	\$12,867	\$13,615	\$14,420	\$15,289	\$16,210
<b>INCREASE IN PER-MEMBER PER-MONTH COST</b>							
<b>Net Benefit Cost</b>	\$0.00	\$0.00	<b>\$0.55</b>	\$0.58	\$0.62	\$0.65	\$0.69
<b>Gross Premium</b>	\$0.00	\$0.00	\$0.63	\$0.66	\$0.70	\$0.74	\$0.78
<b>INCREASE IN ANNUAL COST PER MEMBER</b>							
<b>Net Benefit Cost</b>	\$0.00	\$0.00	\$6.64	\$7.01	\$7.40	\$7.82	\$8.25
<b>Gross Premium</b>	\$0.00	\$0.00	\$7.54	\$7.97	\$8.41	\$8.88	\$9.38
<b>INCREASE IN TOTAL COST FOR ALL AFFECTED PLANS</b>							
<b>Benefit Costs (\$millions)</b>		\$0.0	\$20.7	\$21.9	\$23.2	\$24.6	\$26.0
<b>Gross Premiums (\$millions)</b>		\$0.0	\$23.5	\$24.8	\$26.3	\$27.9	\$29.6

**Cost Projections for Educational Psychologists Mandate**

**Part 2c: Projected Health Insurance Costs Under Proposed Legislation**

*(Population Projection: Best Estimate)*

*(Underlying Trend in Per-Member Costs: Medium)*

*(High Impact of Proposed Legislation: 0.41%)*

	2004	2005	2006	2007	2008	2009	2010
<b>PER-MEMBER PER-MONTH COST</b>							
<b>Net Benefit Cost</b>	\$268.26	\$286.50	\$303.66	\$320.67	\$338.63	\$357.59	\$377.62
<i>Trend plus legislation impact (adjusted for age distribution)</i>	---	6.8000%	<b>5.9924%</b>	5.6000%	5.6000%	5.6000%	5.6000%
<b>Gross Premium</b>	\$304.84	\$325.56	\$345.07	\$364.40	\$384.80	\$406.35	\$429.11
<i>Margin as % of gross premium</i>	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%	12.0%
<b>ANNUAL COST PER MEMBER</b>							
<b>Net Benefit Cost</b>	\$3,219	\$3,438	\$3,644	\$3,848	\$4,064	\$4,291	\$4,531
<b>Gross Premium</b>	\$3,658	\$3,907	\$4,141	\$4,373	\$4,618	\$4,876	\$5,149
<b>TOTAL COST FOR ALL AFFECTED PLANS</b>							
<b>Benefit Costs (\$millions)</b>		\$10,692	\$11,344	\$12,004	\$12,714	\$13,480	\$14,291
<b>Gross Premiums (\$millions)</b>		\$12,150	\$12,891	\$13,641	\$14,448	\$15,318	\$16,240
<b>INCREASE IN PER-MEMBER PER-MONTH COST</b>							
<b>Net Benefit Cost</b>	\$0.00	\$0.00	<b>\$1.12</b>	\$1.19	\$1.25	\$1.32	\$1.40
<b>Gross Premium</b>	\$0.00	\$0.00	\$1.28	\$1.35	\$1.42	\$1.50	\$1.59
<b>INCREASE IN ANNUAL COST PER MEMBER</b>							
<b>Net Benefit Cost</b>	\$0.00	\$0.00	\$13.49	\$14.24	\$15.04	\$15.88	\$16.77
<b>Gross Premium</b>	\$0.00	\$0.00	\$15.33	\$16.19	\$17.09	\$18.05	\$19.06
<b>INCREASE IN TOTAL COST FOR ALL AFFECTED PLANS</b>							
<b>Benefit Costs (\$millions)</b>		\$0.0	\$42.0	\$44.4	\$47.1	\$49.9	\$52.9
<b>Gross Premiums (\$millions)</b>		\$0.0	\$47.7	\$50.5	\$53.5	\$56.7	\$60.1



## II. METHODS, ASSUMPTIONS, AND SOURCES

We used the following methods and assumptions, with the sources noted, to derive the results described and shown in the first section of this report:

1. We took the 2003 Massachusetts population by age group and health insurance status (whether covered, and by what type of insurance) from the U.S. Census Bureau's Current Population Survey (CPS), 2004 Annual Social and Economic Supplement. Overlap categories (e.g., Medicaid and Medicare; Medicare and private health insurance) were allocated to the contributing categories in a manner that we considered to be reasonable and internally consistent. The numbers in each category were adjusted so that the sum equaled the most recent estimate of the total population of Massachusetts in 2003 from the U.S. Census Bureau.
2. The percentage of employer-insured persons who are public-sector employees or their dependents, and therefore are covered by plans administered by the Group Insurance Commission (GIC), was estimated based on data from the Medical Expenditure Panel Survey (MEPS) for 2002, produced by the U.S. Agency for Healthcare Research and Quality (AHRQ). The percentage of *private* employer-insured persons who are covered by plans that are self-funded (as opposed to fully insured) also was taken from the 2002 MEPS.
3. The result derived from Steps 1 and 2 was used as the low estimate of the population that would be affected by the proposed legislation (i.e., privately fully-insured persons, plus those covered by GIC-administered plans) in 2003.

We developed a high estimate of the fully insured population by making the following adjustment: in place of the CPS statistics on the percentage of each age group that was uninsured in 2003, we used the corresponding statistics from the Division's report entitled *Health Insurance Status of Massachusetts Residents (Fourth Edition)*, published in November 2004. We took the average of the 2002 and 2004 percentages to estimate the 2003 percentage of each age group that was uninsured.

We used a 50%/50% weighting of the low and high population distributions, respectively, to produce the "best estimate" distribution, which is shown in Exhibit A-1.

4. The percentage of the Massachusetts population that was between 0 and 23 years of age in 2004, and the corresponding percentage for 2003, were taken from the U.S. Census Bureau's "Estimates of the Resident Population by Single-Year of Age and Sex for the United States and States: July 1, 2004." The projected annual population growth rates for each age group, for the years 2005 through 2010, were taken from the Census Bureau's "Interim State Projections of Population by Single Year of Age: July 1, 2004 to 2030." Both of these files were accessed through the Census Bureau's website. The data is summarized in Exhibit A-2.
5. Based on the 2002 MEPS, we determined the average premium per contract and the distribution of contracts by family status for Massachusetts residents with employment-based coverage, separately for private-sector and public-sector enrollees (using the New England statistics for public-sector enrollees, since state-by-state data are not available for that subgroup).
6. The net benefit costs were derived by assuming that 10.5% of the gross premium for private employee plans and 7.5% of the gross premium for public employee plans is used to cover the health plan or health insurer expenses and margins. This works out to an average margin of about 10% across both types of plans.
7. The underlying trends in per-member benefit costs and premiums were derived from the National Health Expenditure (NHE) projections, which are produced each year by the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS). For the medium underlying trend assumptions, we used the year-to-year changes in the sum of the personal health care expenditures by private health insurance plans and by state and local governments. The resulting trends are

1.070 for 2003 (i.e., 2003 per-person costs are 7.0% higher than 2002 costs), 1.067 for 2004, 1.068 for 2005, and 1.056 for each year from 2006 through 2010. For the low underlying trend assumptions, the medium trend factors for 2005 and for 2006 through 2010 were multiplied by 0.99. For the high underlying trend assumptions, the medium trend factors were multiplied by 1.01.

8. The Division provided us with information they gathered from a survey of Massachusetts health plans, including:
  - a. 2004 member month counts for persons age 0 to 23,
  - b. typical cost sharing and other coverage provisions for these members, and
  - c. summary statistics on their utilization of outpatient mental health services, including the number of utilizers, the number of sessions, unit costs, and the most common diagnoses.

The Division also provided us with such information as the current number of licensed educational psychologists in the state, their typical fees, and the average length of treatment for the various services they provide.

9. We first wanted to get a “macro” estimate of the potential increase in claim costs from the proposed legislation, based on (a) the current production capacity of the educational psychology profession in Massachusetts (most of which is consumed by the schools), and (b) different estimates of the increase in production that might result from induced demand among insured persons. We assumed that, on average, each of the 545 educational psychologists in Massachusetts works 2000 hours per year, for a total of 1.09 million hours. Multiplying this by the average hourly rate of \$62.50 gives us a current annual production of \$68.1 million. An increase of 5%, 10%, or 15% (due to a greater number of hours billed by current educational psychologists, or to additional entrants into the profession) would yield an increase in production – and therefore in spending – of \$3.4 million, \$6.8 million, or \$10.2 million, respectively.
10. To build up a “micro” estimate of the potential increase in claim costs, we performed the following analysis:
  - a. First, we estimated what educational psychologists might charge per case for the various services they provide. We started with their average hourly rate of \$62.50 and multiplied it by the number of hours per case for academic counseling, mental health counseling, and full evaluations. We assumed a 50%/30%/20% split between these services, and within the mental health counseling category we assumed an 80%/20% split between mild-to-moderate cases and more severe cases. Based on these assumptions, we derived a weighed average charge per case of \$840.
  - b. Second, we calculated the average charge per case for the most common outpatient mental health diagnoses reported by the health plans for their age 0-23 members, and weighted them by “rank points” (15 minus the average numerical rank among the most common diagnoses) to come up with an overall weighted average charge of \$403 per case. That this is less than half the calculated average charge for educational psychologists might be due to insurer discounts or utilization management, in which case the average charge for educational psychologists could be expected to drop to the level that prevails for currently covered providers, and perhaps even lower. We incorporated that scenario (resulting in an assumption that the average charge per case for covered educational psychology services will be 0.9 times the current amount of \$403) into our low estimate of the cost effect of the proposed legislation. We assumed that the average charge will be 1.3 times the current amount under the medium-impact scenario and 1.6 times the current amount under the high-impact scenario.
  - c. Third, we estimated the share of the current outpatient mental health claim costs of \$26.8 million that are attributable to services that could be performed by educational psychologists.

From the list of common diagnoses provided by the health plans, we selected ADD/ADHD, adjustment disorder with mixed emotional and conduct disturbance, and oppositional defiant disorder as likely candidates for diagnoses that educational psychologists would treat. Based on the “rank points” and charge per case for each diagnosis, we estimated that these diagnoses represent about 32% of current outpatient mental health claim costs for members aged 0 to 23. We used this percentage to calculate educational psychology claim costs under the medium-impact scenario. We used 75% of the medium assumption, or 24%, to calculate claim costs under the low-impact scenario, and we used 125% of the medium assumption, or 40%, to calculate claim costs under the high-impact scenario. We also used these percentages (but in reverse order) to estimate the substitution effect, that is, the portion of all educational psychology claim costs that would merely be substituting for costs that previously were associated with other mental health providers. Thus, under the medium-impact scenario, we assumed that 32% of all educational psychology claim costs (which in turn were assumed to be 32% of current outpatient mental health claim costs) were merely substituting for previously incurred charges, so that the *net* new spending would be 32% x (100% - 32%) = 21.8% of current outpatient mental health spending. The corresponding percentages under the low-impact and high-impact scenarios are 24% x (100% - 40%) = 14.4% and 40% x (100% - 24%) = 30.4%, respectively.

11. The components described above were combined as follows to produce the final estimates of the cost effect of the proposed legislation:

a. Under the low-impact scenario, the increase in claim costs was assumed to be

$$\text{avg } (\$68.1 \text{ mil } \times 5\%, \$26.8 \text{ mil } \times 24\%) \times (100\% - 40\%) \times 0.9 = \$2.66 \text{ million},$$

or 0.09% of current total claim costs.

b. Under the medium-impact scenario, the increase in claim costs was assumed to be

$$\text{avg } (\$68.1 \text{ mil } \times 10\%, \$26.8 \text{ mil } \times 32\%) \times (100\% - 32\%) \times 1.3 = \$6.80 \text{ million},$$

or 0.22% of current total claim costs.

c. Under the high-impact scenario, the increase in claim costs was assumed to be

$$\text{avg } (\$68.1 \text{ mil } \times 15\%, \$26.8 \text{ mil } \times 40\%) \times (100\% - 24\%) \times 1.6 = \$12.73 \text{ million},$$

or 0.41% of current total claim costs.

**2003 Massachusetts Population by Source of Coverage:  
Best Estimate of Affected Population (Fully Insured plus GIC)**

	0-17	18-64	65&up	total
+ Total population	1,473,655	4,091,052	855,650	<b>6,420,357</b>
- Uninsured	5.5% 81,504	11.9% 486,889	0.7% 6,171	<b>8.9% 574,563</b>
= Insured Population	1,392,151	3,604,163	849,479	<b>5,845,794</b>
<hr/>				
Employment-based	1,048,895	2,988,262	286,584	<b>4,323,740</b>
<i>Medicare supplement</i>	0	0	262,959	<b>262,959</b>
<i>Other emp.-based</i>	1,048,895	2,988,262	23,625	<b>4,060,782</b>
37.8% <i>Self-funded</i>	396,482	1,129,563	8,930	<b>1,534,976</b>
>> <i>adj: 1.06</i> <b>GIC (st ees)</b>	<b>150,724</b>	<b>429,406</b>	<b>6,013</b>	<b>586,143</b>
<i>Other</i>	245,758	700,157	2,917	<b>948,832</b>
>> <b>62.2% Fully insured</b>	<b>652,413</b>	<b>1,858,699</b>	<b>14,695</b>	<b>2,525,806</b>
Direct purchase	85,562	222,927	235,225	<b>543,714</b>
<i>Medicare supplement</i>	0	0	216,735	<b>216,735</b>
<i>Other direct purchase</i>	85,562	222,927	18,489	<b>326,979</b>
Medicaid	245,615	324,541	45,196	<b>615,351</b>
Medicare (excl. med. supp.)	0	60,579	259,980	<b>320,559</b>
Military / other	12,079	7,854	22,495	<b>42,429</b>
>> <b>Total fully insd. &amp; GIC</b>	<b>803,136</b>	<b>2,288,105</b>	<b>20,708</b>	<b>3,111,949</b>

**Massachusetts Population Estimates and Projections**

Age	Estimate 2000	Estimate 2001	Estimate 2002	Estimate 2003	Estimate 2004	Estimate 2005	Estimate 2006	Estimate 2007	Estimate 2008	Estimate 2009	Estimate 2010
Total	6,362,127	6,395,414	6,412,554	6,420,357	6,416,505	6,445,221	6,473,487	6,500,721	6,526,764	6,551,446	6,575,046
<i>growth:</i>		0.5%	0.3%	0.1%	-0.1%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
0-17	1,497,858	1,474,062	1,483,312	1,473,655	1,464,189	1,462,841	1,458,049	1,451,118	1,440,735	1,430,990	1,423,686
<i>growth:</i>		-1.6%	0.6%	-0.7%	-0.6%	-0.1%	-0.3%	-0.5%	-0.7%	-0.7%	-0.5%
18-23	503,029	510,803	510,710	511,349	506,419	508,241	516,682	530,526	546,362	558,060	564,944
<i>growth:</i>		1.5%	0.0%	0.1%	-1.0%	0.4%	1.7%	2.7%	3.0%	2.1%	1.2%
0-23	2,000,887	1,984,865	1,994,022	1,985,004	1,970,608	1,971,082	1,974,731	1,981,644	1,987,097	1,989,050	1,988,630
<i>growth:</i>		-0.8%	0.5%	-0.5%	-0.7%	0.0%	0.2%	0.4%	0.3%	0.1%	0.0%
<i>% of tot:</i>	31.4%	31.0%	31.1%	30.9%	30.7%	30.6%	30.5%	30.5%	30.4%	30.4%	30.2%
18-64	4,003,104	4,062,172	4,072,366	4,091,052	4,097,973	4,125,829	4,155,014	4,180,534	4,202,908	4,225,373	4,246,031
<i>growth:</i>		1.5%	0.3%	0.5%	0.2%	0.7%	0.7%	0.6%	0.5%	0.5%	0.5%
65+	861,165	859,180	856,876	855,650	854,343	856,551	860,425	869,070	883,121	895,083	905,329
<i>growth:</i>		-0.2%	-0.3%	-0.1%	-0.2%	0.3%	0.5%	1.0%	1.6%	1.4%	1.1%

## **APPENDIX II**

# **Massachusetts School Psychologists Association**

## **Testimony in Favor of Senate 868 and Senate 918, An Act Authorizing Licensed Educational Psychologists to Receive Certain Insurance Payments**

My name is Terry Davis and I am the Chair of the Legislative Committee of the Massachusetts School Psychologists Association. I would like to say a few words about cost in relation to this bill.

Educational Psychologists can provide psychological services more inexpensively compared to some other providers currently reimbursed by insurance companies. Providers that currently get insurance reimbursement are psychiatrists, psychologists, licensed independent clinical social workers, and licensed mental health counselors.

This bill only allows consumers greater choice in selecting a mental health provider - reimbursement will not create a new demand. Because a consumer may choose an Educational Psychologist rather than another type of mental health provider, reimbursing Educational Psychologists for their services will not result in increased use of psychological services and higher costs to the health care system.

Massachusetts's law requires insurers to provide a certain level of mental health benefits to subscribers. Because it is within these limits that subscribers may use the services of an Educational Psychologist, there will be no additional cost to the insurer or to the health care system.

Studies by the U.S. Office of Personnel Management, The Rand Corporation and Champus all agree that reimbursement for additional categories of mental health providers does not result in increased services. A 1989 Massachusetts study of Blue Shield data shows that providing reimbursement for Licensed Independent Social Workers did not increase the demand for psychotherapy services (Fairbank, 1989).

And finally, because this bill does not affect the wide contracting freedom of HMO's, because HMO's are not required to contract with all Educational Psychologists, there is no cost associated with this bill as it relates to managed care.

In conclusion, this legislation will not create a new demand and new costs. Because Educational Psychologists will get reimbursed at a lower rate than some other mental health providers, there actually may be some savings to the health care system. The legislation is about consumer choice within the confines of an existing mental health benefit. Please once again give it a favorable report.

Terry Davis, Legislative Chair, Massachusetts School Psychologists Association  
10 Drake Circle  
Walpole, MA 02032  
508-660-8986

4-28-03



May 10, 2005

Maria Schiff  
Health Policy Manager  
Massachusetts Division of Health Care Finance and Policy  
Two Boylston Street  
Boston, MA 02116

Dear Maria:

The Massachusetts Association of Health Plans, on behalf of our member health plans, which provide health care coverage to approximately 2 million Massachusetts residents, appreciates the opportunity to offer our comments as part of the mandate review process concerning proposed Senate Bill 868. The legislation would amend the definition of "covered mental health professional" to include educational psychologists.

MAHP and its member health plans oppose Senate Bill 868, because expanding the mental health parity law (Chapter 80 of the Acts of 2000) to cover another group of providers is unnecessary and will increase the cost of coverage. Further, the legislation raises significant quality of care concerns, because educational psychologists are not required to have the same amount of supervised clinical experience as other practitioners.

The current definition of licensed mental health professional is sufficiently broad, making it unnecessary to expand the definition. The parity law requires that all outpatient services be rendered by a "licensed mental health professional," which is defined to include "licensed physicians specializing in psychiatry, licensed psychologists, licensed independent clinical social workers, licensed mental health counselors and licensed nurse mental health clinical specialists." It specifically exempts health plans from paying for educational services that a school district must provide.

By definition, educational psychologists, who must be certified by the Department of Education as a condition of licensure, may render preventive, developmental or remedial services that include the facilitation of learning and the promotion of mental health. These services should not be covered by health plans as they are intended more for educational purposes than for the medically necessary treatment of any illness or disease. Payment for non-health care services that take place in settings other than a medical facility should be the responsibility of the appropriate public sector entities, as opposed to shifting the cost of these services onto health plans. Requiring health plans to pay for non-medical services would represent an expansion of what health insurance is intended to be, adding to the cost of coverage.

Further, educational psychologists are not required to have the same amount of supervised clinical experience as other licensed mental health practitioners. Licensed educational psychologists are only required to have had 30 hours of supervision, whereas licensed mental health counselors are required to have had 200 hours of supervised clinical experience. This supervised instruction is an important component in the overall training of mental health providers.

There is ample evidence to indicate that health plan members have sufficient access to mental health services. According to statistics compiled by the state's Bureau of Managed Care, in 2003, Massachusetts health plans covered over 2 million mental health visits and more than 90,000 mental health inpatient days for the treatment of major depression, attention deficit hyperactivity disorder, eating disorders, and chemical dependency. Through the first six months of 2004, Massachusetts health plans covered nearly 1.1 million mental health visits and over 44,000 mental health inpatient days.

The very low numbers of external complaints regarding access to mental health care services demonstrates that health plan members are able to access necessary services. For example, in 2004, the Office of Patient Protection



received only 89 eligible appeals that concerned mental health issues, down from 156 eligible cases in 2003. Nearly 3 million fully insured Massachusetts residents are eligible for the state's external appeals program. The low number of external appeals based on mental health demonstrates that the state's health plans maintain a high level of quality and access to needed care regardless of whether mental health services are administered directly or through a contracted mental health vendor.

In general, MAHP opposes mandating health care benefits because it removes the flexibility employers and consumers need to manage their health care costs and can lead to significant increases in the cost of coverage. In its January 2002 report, the Massachusetts Health Care Task Force found that mandates enacted by the Massachusetts Legislature have significantly contributed to the rising cost of health insurance. The Task Force report went on to state that "To avoid losing private sector coverage in the face of cost increases, flexibility in design is needed."

Adding new mandates also will encourage more employers to self-insure and avoid benefits required by the state. Employers that do not or cannot self-insure, typically small businesses, would be compelled to include benefits they do not desire, which may result in them either shifting the additional costs to their employees or ceasing to offer health insurance altogether.

While any one mandate may not significantly increase the cost of coverage, the cumulative effect over time of adding mandate on top of mandate can and does affect cost. For example, the cost of the 11 proposed mandates DHCFP has examined since the mandate review law passed could collectively cost as much as \$165 million in new health care spending if all were to become law.

Again, we appreciate the opportunity to offer our comments on this issue. Please let me know if you have any questions or if there is any other information we can provide.

Sincerely,

A handwritten signature in cursive script that reads "Marylou Buyse, M.D.".

Marylou Buyse, M.D.  
President