VERMONT

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To: Sen. Claire Ayer, Chairperson, Senate Health & Welfare Committee
Sen. Tim Ashe, Chairperson, Senate Finance Committee
Rep. Michael Fisher, Chairperson, House Health Care Committee

From: Susan L. Donegan, Commissioner, Department of Financial Regulation (DFR)

Date: January 15, 2013

Re: Recommendation on Guidelines for Distinguishing Between Primary and Specialty Mental health Services and Estimate of the Impact on Health Insurance Premiums

Legislative directive

Section 11c. of Act 171 asks that I make a recommendation to your committees regarding ". . . guidelines for distinguishing between primary and specialty mental health services, taking into consideration factors such as mental health providers' scope of practice and patterns of patient visitation. In addition, the commissioner . . . shall provide the committees with an estimate of the impact on health insurance premiums if such guidelines are enacted into law."

Following this, Section 11e. states: "No later than October 1, 2013, the commissioner of financial regulation shall adopt rules pursuant to V.S.A. chapter 25 establishing the guidelines for distinguishing between primary and specialty mental health services developed pursuant to Section 11c. of this act, taking into account any recommendations received from the committees of jurisdiction."

Distinguishing primary and specialty mental health & substance abuse services

In preparing the recommendation on guidelines, called for in Section 11c., DFR consulted with a wide array of stakeholders, providers, and staff of state agencies.[1] Based on providers' scope of practice and patient visit patterns, there was consensus among them that

[1] Included were representatives from the Department of Vermont Health Access, University of Vermont/Fletcher Allen Health Care, Vermont Council of Developmental & Mental Health Agencies, Vermont Department of Mental Health, Vermont Division of Alcohol & Substance Abuse Programs, Vermont Psychiatric Association, Vermont Psychological Association as well as several Designated Mental Health Agencies and practicing licensed mental health counselors, licensed clinical social workers, and licensed master's level psychologists.

those procedure codes which define routine, outpatient mental health and substance abuse services should be defined as primary care. As such, they would be assessed a co-pay equal to the co-pay for primary care medical services, rather than the specialty care co-pay rate currently charged for these procedure codes. The complete list of codes that would be affected is included at the end of the attached letter from Oliver Wyman.

Analysis of premium impact

DFR then engaged the actuarial firm, Oliver Wyman, to calculate an estimate of the premium impact of providing these proposed primary mental health and substance abuse services at parity with primary medical care services. Their analysis is the first attachment to this memo. In brief, Oliver Wyman found that:

- the premium impact is estimated to be only 0.11% for every $5.00 decrease in co-pay in 2013. For example, Table 7 in their letter indicates that a $10 decrease in co-pay would result in an increase in premium of $1.14 per month for single person coverage and
  $2.97 for family coverage in 2013 (or $13.68 per year and $35.64 per year respectively);
- as a result of the metallic level requirements for plans in the exchange, the projected premium impact in the individual and small group market is estimated to be 0% in 2014; and furthermore,
- a separate analysis of induced utilization (i.e.- the phenomenon that consumers will utilize more services when cost sharing requirements are reduced) indicated an increase in premiums of less than $0.02 per member per month for each $5 decrease in the co- pay.

Response from insurance industry

The Oliver Wyman analysis was sent to Blue Cross and Blue Shield, Cigna, and MVP for their comments. Cigna responded by noting that they agreed with the actuarial analysis, but offered no comments on reducing the co-pay for mental health and substance abuse services. MVP indicated that its own actuarial analysis of this change had been delayed. This had not been received at the time my memo was prepared.

KSE Partners, on behalf of Blue Cross and Blue Shield, sent a memo on January 2, 2013, (Attachment 2) including an earlier memo from September 28, 2012, (Attachment 3) concerned that reducing co-pays have a tendency to increase both premiums and utilization. They state that “multiple, seemingly small, increases also have a cumulative impact on affordability.” KSE also noted Oliver Wyman’s comment (related to exchange plans) that, by increasing mental health and substance abuse benefits, plans would need to reduce other benefits in order for the actuarial value to be unchanged in exchange plans, if it resulted in a greater than +/-2% de minimis threshold for the exchange metallic levels. If this is the case, KSE asks for guidance on which “other benefits” Blue Cross and Blue Shield should or could reduce.

DFR comments

Regarding speculative concerns that reducing mental health and substance abuse co-pays might increase utilization and premiums, it could also be argued that lower co-pays will encourage members to seek needed care earlier and that the resulting savings from avoided ER services and inpatient care could more than offset the increased office visit utilization.

A follow up with Oliver Wyman clarified that plans would not need to reduce other benefits, but that *cost-sharing* for other benefits might need to be revised – a change that would be at the discretion of the carriers. In fact, Oliver Wyman and the actuary for the Vermont exchange program indicated that the recommended change in the mental health and substance abuse co-pays would be within the +/-2% threshold for exchange metallic levels and would not necessitate a change in cost-sharing for other benefits.

Department of Financial Regulation recommendation

It is my department's recommendation that the routine outpatient mental health and substance abuse codes, included in the attached Oliver Wyman letter, be designated as primary care and that they be subject to a reduced co-pay, equivalent to that charged by insurance plans for primary medical care services. We find that the premium impact will be small and worth the gain in advancing the state's long term goals for mental health parity and integration.

Next steps

Pending any further recommendations made by your committees, my department will proceed to adopt rules to implement the recommendation outlined above by October 1, 2013, as required in Act 171.

Randall Fitzpatrick, FSA, MAAA

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December 20, 2012

Mr. David Reynolds
Deputy Commissioner of Health Care Administration
Vermont Department of Financial Regulation
89 Main Street
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Subject: Primary Care Mental Health and Substance Abuse Services

Dear David:

Pursuant to Vermont Act 171, Section 11c. "Parity for Primary Mental Health Care Services;" by January 15, 2013 the Commissioner of the Department of Financial Regulation (the Department) must provide a recommendation on financial guidelines for distinguishing primary and specialty mental health and substance abuse services to the House Committee on health care and the Senate committees. The Commissioner's recommendation must include an estimated impact on health insurance premiums if such recommendations are enacted into law. You have engaged Oliver Wyman to provide an estimate of the premium impact of providing primary mental health and substance abuse services at parity with other primary care services. The purpose of this letter is to briefly outline the analysis undertaken, and to present our results.

Premium Impact

Currently, the services that are being evaluated are most often provided to members and subject to the specialist copay. The premium increase resulting from the proposed change would reflect the decrease in cost sharing as a result of requiring plans to instead cover primary mental health and substance abuse services subject to the primary care copay.

Based on our analysis which is described in detail below, we estimate that providing primary mental health and substance abuse services at parity with other primary care services would result in a 2013 premium increase of roughly 0.11% for every $5 decrease in the member's copay in the large group market. For example, if a plan has a $5 primary care copay and a $15 specialist copay the estimated increase in premium would be roughly 0.22%.[1]

The projected premium impact in the small group and individual markets is estimated to be 0% starting in 2014 as a result of the metallic level requirements for plans in the exchange. If the benefits for primary mental health and substance abuse services increase (i.e. cost sharing is reduced), plans would need to reduce other benefits so that the actuarial value is unchanged. Keep in mind that there is a proposed +/- 2% de minimis threshold allowed for the metallic levels, so theoretically a plan could increase the primary mental health and substance abuse services benefit and not make any other changes if the actuarial value is within the proposed +/- 2% de minimis.

[1] 0.22% = ($15 - $5) / 5 x 0.11%

The remainder of this letter briefly describes the assumptions and data that were used to complete the analysis.

Analysis

In order to undertake this analysis, we relied upon the Department to provide us with a list of mental health and substance abuse procedure codes that are under consideration as primary care services. We have included the full list of codes we used in our analysis in the attached Appendix. Using our internal claims dataset for members enrolled in group comprehensive medical plans in 2010, we estimated the additional plan cost to reduce the member's copay for primary mental health and substance abuse services. Our claims dataset includes medical and prescription drug claims for over 45 million members nationwide, of which over 36,000 are in Vermont. For our analysis we relied solely on the Vermont experience to appropriately reflect the geographic cost and utilization of these services. In Table 1 below we summarize the 2010 Vermont cost and utilization statistics for the proposed primary mental health and substance abuse services.

Table 1[2]
2010 PMPM Cost Development

	Vermont
Cost per Service	$ 83.87
Util per 1,000	1,027.65
Allowed PMPM	$ 7.18

The next step was to trend the results to 2013. Oliver Wyman completes a quarterly pricing trend analysis for a large sample of companies that covers over 115 million group and individual members. Our most recent published survey was in July 2012. In Table 2 we have summarized the group HMO and PPO pricing trends used by participating companies in the development of their rates for July 2012.

Table 2
Carrier Pricing Trends – July 2012

	Group PPO	Group HMO
75th Percentile	11.9%	10.7%
Median	10.4%	8.4%
25th Percentile	7.0%	7.0%

As you can see from Table 2, the pricing trend for the majority of groups that purchase PPO and HMO plans is between the range of 7% and 12%. Based on our work reviewing comprehensive major medical rate filings for the Department, we have observed that health plans in Vermont are using much lower pricing trends, more in the range of 5%. Consequently, we have performed three 2013 pricing scenarios using 5%, 9% and 12% annual PMPM trends. Table 3 below shows the trended 2013 cost and utilization estimates for primary mental health and substance abuse

[2] Allowed PMPM = (Cost per Service x Annual Util per 1,000) / 12,000

services in Vermont under the three trend scenarios. It was assumed the annual PMPM trend was evenly distributed between cost and utilization.

Table 3
2013 PMPM Cost Development

	Cost per Service	Util per 1,000	Allowed PMPM
@ 5% Trend	$ 90.23	1,105.68	$ 8.31
@ 9% Trend	$ 95.44	1,169.46	$ 9.30
@ 12% Trend	$ 99.41	1,218.07	$ 10.09

The estimates provided in Table 3 represent the gross allowable charges collected by the provider for primary mental health and substance abuse services. Or in other words, they represent the total amount received by the provider for the service rendered regardless of the payer. The additional cost to the insurance carrier can be estimated as the change in member copay times the utilization of services. Table 4 shows the PMPM additional cost with a $5 decrease in copay per service.

Table 4
PMPM Cost for $5 Decrease in Copay

	Additional PMPM cost
@ 5% Trend	$ 0.46
@ 9% Trend	$ 0.49
@ 12% Trend	$ 0.51

As you can see, the additional PMPM cost in 2013 is not impacted considerably under different trend scenarios.

The next step in our analysis is to estimate the 2013 premium in Vermont. To do this we relied upon the 2011 Supplemental Health Exhibit as filed by each carrier as part of their statutory financial statements. This exhibit shows the earned premium and membership for individual medical, small group and large group, separately. We then projected the premium to 2013 by trending the premium under the same scenarios we trended the claims for mental health and substance abuse services. Table 5 summarizes the 2013 premium estimates under each trend scenario for individual medical, small group and large group, separately.

Table 5
2013 Vermont PMPM Premium Estimates

Market	@ 5% Trend	@ 9% Trend	@ 12% Trend
Individual	$ 355.79	$ 383.41	$ 404.81
Small Group	$ 355.50	$ 383.10	$ 404.48
Large Group	$ 410.33	$ 442.19	$ 466.86

These results reflect the 2011 market average premiums, trended to 2013. We have not attempted to adjust the projected premiums to reflect changes in demographics, benefits, or regulatory changes that have or will occur from 2011 to 2013.

Given the results discussed above, we estimate that a $5 decrease in copay would result in a roughly a 0.11% increase in premium in the large group market and a 0.13% increase in the individual and small group markets. Please keep in mind the projected premium impact in the small group and individual markets could be 0% starting in 2014 as a result of the metallic level requirements. Table 6 is a grid that summarizes the estimated 2013 increase in premium PMPM under different copay change scenarios, assuming a 9% annual trend. For example, reducing the copay charged from $50 to $25 would result in an estimated increase in premium of $2.44 PMPM.

Table 6
Estimated Increase in Premium PMPM - 2013

	Specialist Copay							
PCP Copay	$20	$25	$30	$35	$40	$45	$50
$ -	$ 1.95	$ 2.44	$ 2.92	$ 3.41	$ 3.90	$ 4.39	$ 4.87
$ 5.00	$ 1.46	$ 1.95	$ 2.44	$ 2.92	$ 3.41	$ 3.90	$ 4.39
$ 10.00	$ 0.97	$ 1.46	$ 1.95	$ 2.44	$ 2.92	$ 3.41	$ 3.90
$ 15.00	$ 0.49	$ 0.97	$ 1.46	$ 1.95	$ 2.44	$ 2.92	$ 3.41
$ 20.00	$ -	$ 0.49	$ 0.97	$ 1.46	$ 1.95	$ 2.44	$ 2.92
$ 25.00	N/A	$ -	$ 0.49	$ 0.97	$ 1.46	$ 1.95	$ 2.44

Please note that the analysis outlined in this letter does not include an assumption for induced utilization (i.e., the phenomenon that consumers will utilize more services when cost sharing requirements are reduced). We have separately analyzed the impact of induced utilization and estimate that it would increase total premiums less than $0.02 PMPM for each $5 decrease in the copay.

In today's health insurance market, it is common to rate policyholders based on marital status and number of dependent children. This is referred to as tier rating. In this pricing approach, contracts purchased at each tier are charged the same rate, all other things equal. For example, a family of four and a family of six would be charged the same rate. The Department has requested we provide the estimated premium increase for a single contract. Based on our work reviewing comprehensive major medical rate filings for the Department, we commonly observe a three tier rating structure (single, two-person, and family). Using a three tier rating structure, Table 7 summarizes the single contract 2013 increase in premium per month under different copay change scenarios.

Table 7
Estimated Increase in Single Contract Premium per Month - 2013

	Specialist Copay						
PCP Copay	$20	$25	$30	$35	$40	$45	$50
$ -	$ 2.29	$ 2.86	$ 3.43	$ 4.00	$ 4.57	$ 5.14	$ 5.72
$ 5.00	$ 1.71	$ 2.29	$ 2.86	$ 3.43	$ 4.00	$ 4.57	$ 5.14
$ 10.00	$ 1.14	$ 1.71	$ 2.29	$ 2.86	$ 3.43	$ 4.00	$ 4.57
$ 15.00	$ 0.57	$ 1.14	$ 1.71	$ 2.29	$ 2.86	$ 3.43	$ 4.00
$ 20.00	$ -	$ 0.57	$ 1.14	$ 1.71	$ 2.29	$ 2.86	$ 3.43
$ 25.00	N/A	$ -	$ 0.57	$ 1.14	$ 1.71	$ 2.29	$ 2.86

The estimates in Table 7 are for a single contract. For a two-person and family contracts, the premium estimates in Table 8 need to be increased by the tier factors shown in Table 8.

Table 8
3-Tier Factors

Tier	Tier Factors
Single	1.00
Two-Person	2.00
Family	2.60

If you have any questions, please feel free to contact me at your convenience. I can be reached at 414-277-4605.

Sincerely,

Randall Fitzpatrick, FSA, MAAA
Senior Consultant

Copy: Tammy Tomczyk, Oliver Wyman

Common Outpatient Mental Health & Substance Abuse Procedure Codes Identified by VT Stakeholders w/ Cross Walk to 2013 CPT Codes November 2, 2012

2012 Code	2013 Code(s)
Initial Psychiatric Evaluation	
90801, psychiatric diagnostic interview examination (deleted)	**90791**, Psychiatric diagnostic evaluation (no medical services) **90792**, psychiatric diagnostic evaluation with medical services (E/M new patient codes may be used in lieu of 90792)
90802, interactive psychiatric diagnostic evaluation (deleted)	**90791** or **90792**, with **+90785** (interactive complexity add-on code)
Outpatient Psychotherapy	
(Time is face-to-face with patient)	**(Time is face-to-face with patient and/or family)**
90804, Individual psychotherapy, in an office or outpatient facility, 20 to 30 minutes face-to-face with the patient (deleted)	**90832**, psychotherapy, 30 min.
90805, With medical evaluation and management services (deleted)	**Appropriate outpatient E/M code** (not selected on the basis of time), and **+90833**, 30-minute psychotherapy add–on-code
90806, Individual psychotherapy, in an office or outpatient facility, 45 to 50 minutes face-to-face with the patient (deleted)	**90834**, psychotherapy, 45 min.
90807, With medical evaluation and management services (deleted)	**Appropriate outpatient E/M code** (not selected on the basis of time), and **+90836**, 45-minute psychotherapy add on-code
90808, Individual psychotherapy, in an office or outpatient facility, 75 to 80 minutes face-to-face with the patient (deleted)	**90837**, psychotherapy, 60 min.
90809,With medical evaluation and management services (deleted)	**Appropriate outpatient E/M code** (not selected on the basis of time), and **+90838**, 60-minute psychotherapy add–on-code

2012 Code	2013 Code(s)
Outpatient Interactive Psychotherapy	
(Time is face-to-face with patient)	**(Time is with patient and/or family)**
90810, Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient (deleted)	**90832,** psychotherapy, 30 min., and **+90785**, interactive complexity add–on-code
90811, With medical evaluation and management services (deleted)	**Appropriate outpatient E/M code** (not selected on the basis of time), and **+90833**, 30-minute psychotherapy add–on-code, and **+90785**, interactive complexity add–on-code
90812, Individual psychotherapy, interactive, using play equipment . . . 45 to 50 minutes face-to-face with the patient (deleted)	**90834**, psychotherapy, 45 min., and **+90785**, interactive complexity add–on-code
90813, With medical evaluation and management services (deleted)	**Appropriate outpatient E/M code** (not selected on the basis of time), and **+90836**, 45-minute psychotherapy add–on-code, and **+90785**, interactive complexity add–on-code
90814, Individual psychotherapy, interactive, using play equipment . . . 75 to 80 minutes face-to-face with the patient (deleted)	**90837,** psychotherapy, 60 min., and **+90785**, interactive complexity add–on-code
90815, With medical evaluation and management services (deleted)	**Appropriate outpatient E/M code** (not selected on the basis of time), and **+90838**, 60-minute psychotherapy add–on-code, and **+90785**, interactive complexity add–on-code
Other Psychotherapy	
90846, Family psychotherapy (without the patient present)	**90846,** retained
90847, Family psychotherapy (conjoint psychotherapy) (with patient present)	**90847,** retained
90853, Group psychotherapy (other than of a multiple-family group)	**90853,** retained (for other than multiple-family group), **+90875**, interactive complexity add-on
90857, Interactive group psychotherapy (deleted)	Not retained, use **90853,** (for other than multiple-family group), **+90875**, interactive complexity
Other Psychiatric Services or Procedures	
90862, Pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy (deleted)	Use appropriate E/M code (Psychologists will use +90863)
HCPCS Codes for Substance Abuse Treatment No Changes in 2013	
H0001, Alcohol and/or drug assessment	
H0004, Behavioral health counseling and therapy, per 15 minutes	

HCPCS Codes for Substance Abuse Treatment
H0005, Alcohol and/or drug services; group counseling by a clinician
H0006, Alcohol and/or drug services; case management
H0015, Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education
H0015, Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling; crisis intervention, and activity therapies or education
H0020, Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)

Attachment 2

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M E M O R A N D U M

TO: David Reynolds, HCA Deputy Commissioner

FROM: Jacqueline A. Hughes, KSE Partners, LLP

DATE: January 2, 2013

SUBJECT: Comments on Primary/Specialty Mental Health Co-Payments Analysis

On behalf of BCBSVT, we thank you for providing the opportunity to comment on the actuarial analysis that you circulated. We attach our earlier comments because they continue to reflect some of our concerns but we add a few additional comments in this memorandum.

First, although the wording in the actuarial analysis minimizes the magnitude of the expected premium increases, the opinion does acknowledge that reducing cost share will increase premium. Each incremental reduction of cost sharing, small or large, will increase premium and thereby reduce premium affordability. Multiple, seemingly small, increases also have a cumulative impact on affordability. Negative impacts on affordability remain a concern even when the changes are proposed in order to advance desirable clinical or social goals.

Second, we have a concern with the language in the analysis that states: "If the benefits for primary mental health and substance abuse services increase (i.e. cost sharing is reduced), plans would need to reduce other benefits so the actuarial value is unchanged." See, December 20, 2012 Oliver Wyman analysis, Premium Impact, third paragraph. This statement appears to be contrary to the requirement to provide the full range of mandated essential benefits. Health plans will need guidance on which "other benefits" should or could be reduced.

Finally, the analysis acknowledges that there is a potential for induced increase in utilization but we have not independently analyzed or quantified the impact.

Attachment 3

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M E M O R A N D U M

TO: David Reynolds, Deputy Commissioner of HCA

FROM: Jackie Hughes, KSE Partners, LLP

DATE: September 28, 2012

SUBJECT: Parity for Mental Health Co-Payments and Parity for Primary Mental Health Care Services

Thank you for the opportunity to provide input on the guidelines for distinguishing primary and specialty mental health and substance abuse (MH/SA) treatment services. We offer the following comments on behalf of Blue Cross and Blue Shield of Vermont and The Vermont Health Plan, LLC.

The Department has been tasked by the Vermont General Assembly with making recommendations on finance guidelines for distinguishing between primary and specialty mental health services taking into consideration factors such as mental health care providers' scope of practice and patterns of patient visitation. The Department has circulated a list of service codes that "MH/SA experts both within state government and from organizations and providers of MH/SA services" have provided to the Department as encompassing routine outpatient care. The same group has "recommended that these [service codes] should be subject to the same co-pay charge as primary care medical services." The Department has also consulted with its actuary on the recommendations and she has concluded that the proposal would have no impact on premiums.

The proposal to make essentially all office based services "primary" regardless of the providers' scope of practice will have the tendency to increase both premiums and utilization. BCBSVT's mental health utilization manager estimates that a decrease in cost share will increase the cost to the health plans, leading to increases in premium. Moreover, a lower cost share for members will have the tendency to increase their utilization of these services which in turn could mean a further increase in premiums.