

**CENTER FOR HEALTH  
INFORMATION AND ANALYSIS**

---

**MANDATED BENEFIT REVIEW OF H.B. 1808:  
AN ACT TO IMPROVE ACCESS TO THE SERVICES  
OF EDUCATIONAL PSYCHOLOGISTS**

---

**JULY 2014**



center  
for health  
information  
and analysis



---

## TABLE OF CONTENTS

Benefit Mandate Overview: H.B. 1808: Educational Psychologists .....	1
History of the bill .....	1
What does the bill propose? .....	1
Licensed educational psychologists.....	1
Current coverage .....	2
Cost of implementing the bill .....	2
Plans affected by the proposed benefit mandate.....	2
Plans not affected by the proposed benefit mandate .....	3
Preliminary estimate of potential Massachusetts liability under the ACA.....	3
H.B. 1808 Medical Efficacy Assessment: Educational Psychologists.....	4
Licensure requirements for educational psychologists .....	4
Efficacy of the provisions of H.B. 1808.....	6
Endnotes.....	8

### Actuarial Appendix



## BENEFIT MANDATE OVERVIEW: H.B. 1808: EDUCATIONAL PSYCHOLOGISTS

### HISTORY OF THE BILL

The Joint Committee on Health Care Financing referred House Bill (H.B.) 1808, “An Act to improve access to the services of educational psychologists,” sponsored by Rep. Rogers of Norwood, to the Center for Health Information and Analysis (CHIA) for review. Massachusetts General Laws, chapter 3, section 38C requires CHIA to review and evaluate the potential fiscal impact of each mandated benefit bill referred to the agency by a legislative committee.

### WHAT DOES THE BILL PROPOSE?

H.B. 1808 expands the list of “licensed mental health professionals” under the Massachusetts mental health parity statutes to include “a licensed educational psychologist within the lawful scope of practice for such educational psychologist.”<sup>i</sup> The parity statutes require insurers to cover mental health services delivered by licensed mental health professionals to diagnose and treat biologically-based mental disorders and non-biologically-based mental, behavioral, or emotional disorders that “substantially interfere with or substantially limit the functioning and social interactions” of a child<sup>ii</sup> Currently, licensed educational psychologists (LEPs) practice predominately as employees of schools, and have traditionally provided educational and psychological testing services that have not been reimbursed as health care services by Massachusetts carriers; but increasingly they are providing a broader set of medical services, some of which can be delivered in private practice. By adding LEPs to the list of mental health providers in the parity law, this bill proposes a statutory basis for including LEPs in carriers’ credentialed provider networks so that LEPs can be reimbursed for delivering those broader services.

### LICENSED EDUCATIONAL PSYCHOLOGISTS

The title “licensed educational psychologist” (LEP), as used in Massachusetts, refers to a school psychologist who has completed additional training and is licensed to practice independently outside of school settings. Under Massachusetts law, LEPs may not provide private practice services to students in school systems by which they are employed.<sup>iii</sup> There are 362 LEPs in Massachusetts.<sup>iv</sup>

- i The 188th General Court of the Commonwealth of Massachusetts. Bill H. 1808: An Act to improve access to the services of educational psychologists. Accessed 7 May 2014: <https://malegislature.gov/Bills/188/House/H1808>.
- ii M.G.L. c.32A §22, c.175 §47B, c.176A §8A, c.176B §4A, c.176G §4M. The current list of licensed professionals includes: psychiatrist, psychologist, independent clinical social worker, mental health counselor, nurse mental health clinical specialist, or marriage and family therapist within the scope of practice for such therapist
- iii M.G.L. c. 112, § 163: Registration of Certain Professions and Occupations, Definitions. Accessed 12 May 2014: <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter112/Section163>.
- iv Email correspondence with Clinton Dick, Executive Director, Massachusetts Board of Allied Mental Health and Human Services Professionals, Bureau of Professional Licenses. Received 8 May 2014.

LEPs provide assessments and interventions focused primarily on children with learning or behavioral problems, disabilities, disorders, or conditions that affect a student's mental health and ability to learn.<sup>v</sup> Such services 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, and consultation.<sup>vi</sup> Training in both educational and mental health disciplines allows LEPs to address problems that intersect a student's academic, social, emotional, and behavioral health. The individual, family, and group therapy increasingly provided by LEPs are the same services for which carriers reimburse the current set of licensed mental health professionals under the mental health parity statutes.

### CURRENT COVERAGE

Unlike many benefit mandates which require coverage of specific services, H.B. 1808 seeks to require coverage for services, already generally covered under the parity statutes, when those services are delivered by LEPs. In a recent survey of ten of the largest insurance carriers in Massachusetts, most plans noted that non-medical services by definition do not meet medical necessity criteria, and cited that as the primary reason they would deny claims for services by a credentialed LEP. As LEPs increasingly provide medically necessary therapeutic services, H.B. 1808 would in effect admit LEPs to carriers' provider networks, allowing LEPs the means to practice privately.

### COST OF IMPLEMENTING THE BILL

Requiring coverage for this benefit by fully-insured health plans would result in an average annual increase, over five years, to the typical member's monthly health insurance premiums of between \$0.09 (0.02%) and \$0.35 (0.06%) per year; a more likely increase is in the range of \$0.21 (0.04%) annually.

Even though H.B. 1808 does not alter the restriction in the LEPs' licensure statute preventing them from billing insurance for students in school districts that employ them, with increased opportunities for commercial reimbursement, and if sufficient LEP capacity is available, the opportunity to shift services currently funded by school systems to the health insurance system might exist. However, this is speculative, and because this analysis found no evidence to support an estimate for the magnitude of this potential shift, it is not incorporated into the estimate.

### PLANS AFFECTED BY THE PROPOSED BENEFIT MANDATE

Individual and group accident and sickness insurance policies, corporate group insurance policies, and HMO policies issued pursuant to Massachusetts General Laws, as well as the Group Insurance Commission (GIC) covering public employees and their dependents, would be subject to this proposed mandate. The proposed benefit mandate would apply to members covered under the relevant plans, regardless of whether they reside within the Commonwealth or merely have their principal place of employment in the Commonwealth.

v National Association of School Psychologists (NASP): What is a School Psychologist? Accessed 12 May 2014: [http://www.nasponline.org/about\\_sp/whatis.aspx](http://www.nasponline.org/about_sp/whatis.aspx).

vi Op. cit. M.G.L. c. 112, § 163: Registration of Certain Professions and Occupations, Definitions.

## PLANS NOT AFFECTED BY THE PROPOSED BENEFIT MANDATE

Self-insured plans (i.e., where the employer policyholder retains the risk for medical expenses and uses an insurer to provide administrative functions) are subject to federal law and not to state-level health insurance benefit mandates. State health benefit mandates do not apply to Medicare and Medicare Advantage plans whose benefits are qualified by Medicare; consequently this analysis excludes members of commercial fully-insured plans over 64 years of age. These mandates also do not apply to federally-funded plans including TRICARE (covering military personnel and dependents), the Veterans Administration, and the Federal Employee's Health Benefit Plan. Finally, this bill does not apply to Medicaid/MassHealth.

## PRELIMINARY ESTIMATE OF POTENTIAL MASSACHUSETTS LIABILITY UNDER THE ACA

Analysis of the cost associated with proposed state benefit mandates is important in light of new requirements introduced by the Affordable Care Act (ACA). In accordance with the ACA, all states must set an Essential Health Benefits (EHB) benchmark that all qualified health plans (QHPs), and those plans sold in the individual and small-group markets, must cover, at a minimum. Section 1311(d)(3)(B) of the ACA, as codified in 45 C.F.R. § 155.170, explicitly permits a state to require QHPs to offer benefits in addition to EHB, provided that the state is liable to defray the cost of additional mandated benefits by making payments to or on behalf of individuals enrolled in QHPs. The requirement to make such payments applies to QHPs sold both on and off the Exchange, but not to non-QHP plans. The state is not financially responsible for the costs of state-required benefits that are considered part of the EHB benchmark plan. In Massachusetts, the Benchmark Plan is the Blue Cross and Blue Shield HMO Blue \$2000 Deductible (HMO Blue). State-required benefits enacted on or before December 31, 2011 (even if effective after that date) are not considered "in addition" to EHB and therefore will not be the financial obligation of the state, if such additional benefits are *not* already covered benefits under the State's EHB Benchmark Plan, HMO Blue. This ACA requirement is effective as of January 1, 2014 and is intended to apply for at least plan years 2014 and 2015.

To provide additional information about the potential state liability under the ACA associated with mandating this benefit, CHIA generated a preliminary estimate of the incremental annual premium costs to QHPs associated with this benefit mandate; incremental premium costs exclude the cost of services already provided absent the mandate, already required by other federal or state laws, or already provided under the Massachusetts benchmark plan, HMO Blue. CHIA's review of the proposed health benefit mandate is not intended to determine whether or not this mandate is subject to state liability under the ACA.<sup>vii</sup> CHIA generated this estimate to provide neutral, reliable information to stakeholders who make decisions that impact health care access and costs in the Commonwealth.

CHIA applied the mid-range PMPM (per-member per-month) actuarial projection for 2015 cost (\$0.19) to an estimated maximum of 800,000 potential QHP members.<sup>viii</sup> This results in an estimated maximum potential incremental premium increase to QHPs of approximately \$152,000 per month or \$1,824,000 per year. An estimate and eventually a final determination of the Commonwealth's liability will require a detailed analysis by the appropriate state agencies, including an assessment of whether this mandate is subject to state liability under the ACA and the actual number of QHP enrollees.

vii The Health Connector, in consultation with the Massachusetts Division of Insurance, will need to be consulted to provide an analysis of estimated state liability associated with a given proposed mandated benefit bill.

viii Estimated maximum QHP membership provided by the Massachusetts Division of Insurance.

## H.B. 1808 MEDICAL EFFICACY ASSESSMENT: EDUCATIONAL PSYCHOLOGISTS

The Massachusetts mental health parity mandate statutes require insurers to provide mental health benefits on a non-discriminatory basis for biologically-based mental disorders, and for diagnosis and treatment of non-biologically-based mental, behavioral, or emotional disorders that “substantially interfere with or substantially limit the functioning and social interactions” of a child.<sup>1</sup> Massachusetts House Bill 1808 expands the list of licensed mental health professionals that insurers must reimburse under the mental health parity statutes to include “a licensed educational psychologist within the lawful scope of practice for such educational psychologist.”<sup>2</sup> M.G.L. c. 3 § 38C charges the Massachusetts Center for Health Information and Analysis (CHIA) with reviewing the medical efficacy of proposed mandated health insurance benefits. Medical efficacy reviews summarize current literature on the effectiveness and use of the mandated service and describe the potential impact of a mandated benefit on the quality of patient care and the health status of the population.”

### LICENSURE REQUIREMENTS FOR EDUCATIONAL PSYCHOLOGISTS

The title “licensed educational psychologist” (LEP), as used in Massachusetts, refers to school psychologists who have completed additional training and are licensed to practice independently outside of school settings. To be a licensed educational psychologist in Massachusetts, one must first become a school psychologist. The Board of Elementary and Secondary Education administers licenses for a variety of professions, including school psychologists, teachers, principals, guidance counselors, school nurses, and administrators.<sup>3</sup>

For initial licensure as a school psychologist in Massachusetts, one must complete, at a minimum, a master’s degree, certificate of advanced graduate study (CAGS), or doctoral degree in school psychology, including practicum and internship requirements. To proceed to professional licensure as a school psychologist, one must complete three years of employment as a school psychologist, as well as meet examination or certification requirements specified in regulations of the Department of Elementary and Secondary Education.<sup>4</sup>

Licensure for educational psychologists is administered by the Board of Registration of Allied Mental Health and Human Services Professionals, Division of Public Licensure Boards in the Massachusetts Office of Consumer Affairs and Business Regulation. In addition to obtaining licensure as a school psychologist, an educational psychologist must complete an additional two years of paid work as a certified school psychologist under the supervision of an educational psychologist, licensed or eligible for licensure in the state.<sup>5,6</sup> Licensure allows educational psychologists to practice independently in Massachusetts outside of a school setting, provided they do not provide private practice services to any students in school systems by which they are employed.<sup>7</sup> At present, LEP services provided outside a school setting are not generally reimbursed by commercial health insurance carriers. There are currently 362 educational psychologists licensed in Massachusetts.<sup>8</sup>

It should be noted that the titles “school psychologist” and “educational psychologist” as defined in Massachusetts do not connote “clinical psychologist” or simply “psychologist”. To legally use the latter titles, one must be licensed by the Board of Registration of Psychologists, and must be certified as a Health Services Provider to practice independently.<sup>9</sup> The profession of psychologist, as defined by the American Psychological Association (APA), requires the minimum of a doctoral degree, and is more specifically focused on mental health issues and the “modification of human behavior”.<sup>10</sup> Clinical psychologists, which fall under the current definition of mental health professional in the mental health parity statutes, are trained to diagnose and treat a wider range of mental health illnesses than are LEPs; their services are generally reimbursed by health insurance carriers.



LEPs in Massachusetts are, by definition, trained and experienced as school psychologists, and provide assessments and interventions focused primarily on children with learning or behavioral problems, disabilities, disorders, or conditions that affect an individual's mental health and ability to learn.<sup>11</sup> The “[p]ractice of educational psychology”, as defined in Massachusetts, is:

the rendering of professional services to individuals, groups, organizations or the public for compensation, monetary or otherwise. Such professional services include: applying psychological principles, methods and procedures in the delivery of services to individuals, groups, families, educational institutions and staff and community agencies for the purpose of promoting mental health and facilitating learning. Such services 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.<sup>12,13</sup>

Training for LEPs “emphasizes preparation in mental health and educational interventions, child development, learning, behavior, motivation, curriculum and instruction, assessment, consultation, collaboration, school law, and systems,” as well as crisis response, data collection, and analysis for both general education and special education students.<sup>14,15</sup> This training in both educational and mental health disciplines allows LEPs to address problems that intersect a student’s academic, social, emotional, and behavioral health. The profession has evolved from being primarily focused on intelligence testing and psychoeducational assessment, to the provision of counseling and instruction to address issues that create barriers to learning and development, as well as crisis intervention and management services for students, educators, and families.<sup>16</sup>

LEPs work in a variety of settings, including educational, medical, social service, and correctional, and serve to coordinate educational, behavioral, and psychological services by applying cognitive, behavioral, social, and affective methods to ensure the healthy development of students.<sup>17</sup>

H.B. 1808 requires LEPs to practice “within the lawful scope of practice for such educational psychologist.” This “lawful scope” is broadly defined in statutes, with indistinct lines between the practice scope of LEPs and that of clinical psychologists. In effect, therefore, the boundaries of practice, are more expressly limited by the professional ethical codes and competency standards of LEPs, which are lengthy and complex, but which can be summarized as:

(a) recognizing one’s professional limitations and needs, (b) understanding one’s professional strengths, (c) confining consultation practice to one’s competence, (d) knowing when to decline work and when to refer to other professionals, (e) ensuring that recommended interventions have an empirical basis, and (f) maintaining a high level of professionalism.<sup>18</sup>

LEPs can be master’s- or doctoral-prepared, an important distinction in providing certain services, especially those related to complex mental health issues. While both master’s- and doctoral-level LEPs receive comparable preparation for psychoeducational assessment services, LEPs that are PhDs often have additional training in mental health issues and treatment.

## EFFICACY OF THE PROVISIONS OF H.B. 1808

As the demand for children’s mental health services continues to grow, there is a shortage of professionals trained to address the need.<sup>19</sup> According to the U.S. Centers for Disease Control and Prevention (CDC), in a given year, 13 to 20 percent of children in America experience a mental disorder, defined as “serious deviations from expected cognitive, social, and emotional development”.<sup>20,21</sup> The total annual cost of these disorders is estimated at \$247 billion, including the costs of health care, special education, juvenile justice services, as well as decreased productivity.<sup>22</sup> And while these disorders are associated with risk-taking behaviors, chronic health conditions, and increased risk for mental disorders in adulthood, a recent report on the children’s mental health system in the U.S. characterized it as “fragile and at-risk.”<sup>23,24</sup> According to the U.S. Department of Health and Human Services Health Resources and Services Administration, all 12 of the mainland counties in Massachusetts are Designated Mental Health Care Health Professional Shortage Areas.<sup>25</sup>

Given the shortage described above, H.B 1808 will modestly increase access to medically necessary mental health services for children by increasing the supply of providers for these services. Clearly, not all mental health disorders that affect children are addressable within the scope of practice of an LEP as defined by statute and the previously-summarized ethical and competency standards. However, the provision of mental health services by LEPs increases the integration of schools and mental health resources for children, expanding treatment options for students with social, emotional, and behavioral issues beyond resources offered within the school, which may include individual treatment and counseling services for mental health issues. Further, increasing the number of professionals trained to address issues that cross over the disciplines of mental health and education potentially increases opportunities to either prevent or intervene early with children who may experience such crossover needs.

Efficacy has been demonstrated for a wide variety of services within the scope of LEP licensure, including both therapeutic mental health services and more strictly school-based educational services. LEPs have been increasingly providing the former, and H.B 1808 would require carriers to pay for these services when they are equivalent to those currently provided by clinical psychologists and other mental health professionals defined in the parity statutes. This review found no published studies comparing the relative quality of these services when provided by LEPs and by other providers.

Although this review found no studies quantifying the efficacy of the work of educational psychologists specifically, there is evidence that selected community-based mental health programs are effective at addressing certain emotional and behavioral problems for children, and LEPs are trained and experienced in delivering these types of programs.<sup>26,27</sup> A recent review of the National Registry of Evidence-Based Programs and Practices (NREPP) of the U.S. Department of Health and Human Services Substance Abuse and Mental Health Administration (SAMSHA) yielded over 100 different interventions, many or most of which could be delivered by LEPs, focused on mental health promotion and treatment for children and adolescents in school- and community-based settings, and proven to be effective.<sup>28</sup> These interventions cover a wide range of topics and treatments, including the reduction and elimination of risk-taking, bullying, aggression, and other violent or destructive behaviors; development of social and emotional skills including resiliency, self-control, goal-setting, problem-solving, and healthy decision-making; suicide prevention; improving communication skills and assertiveness; development of positive self-image and body-image, and avoidance of eating disorders; and teaching stress and anger management and conflict resolution skills. Some interventions are focused on specific disorders or situations, such as attention-deficit hyperactivity disorder (ADHD), anxiety or mood disorders, or children who have experienced traumatic situations, while others are more broadly applicable. These types of evidence-based interventions can be delivered by LEPs, within the scope of their licensure and professional competencies, to children and their families in school or community settings.

---

### **Acknowledgements**

*Primary CHIA staff for this publication:*

Catherine West, MPA, Director of External Research Partnerships

Joseph Vizard, Legislative Liaison

## ENDNOTES

- 1 M.G.L. c.32A §22, c.175 §47B, c.176A §8A, c.176B §4A, c.176G §4M.
- 2 The 188<sup>th</sup> General Court of the Commonwealth of Massachusetts. Bill H. 1808: An Act to improve access to the services of educational psychologists. Accessed 7 May 2014: <https://malegislature.gov/Bills/188/House/H1808>.
- 3 M.G.L. c. 69, § 1B: Board of elementary and secondary education; duties. Accessed 12 May 2014: <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXII/Chapter69/Section1B>.
- 4 Massachusetts Department of Elementary and Secondary Education (MA-DESE): 603 CMR 7.00, Regulations for Educator Licensure and Preparation Program Approval. Updated 26 March 2014; accessed 12 May 2014: <http://www.doe.mass.edu/lawsregs/603cmr7.html?section=11>. Regulatory authority defined under M.G.L. c. 69, § 1B; c. 69, §§ 1J and 1K, as amended by St. 2010, c. 12, § 3; c. 71, § 38G.
- 5 Commonwealth of Massachusetts, Office of Consumer Affairs and Business Regulation, Division of Professional Licensure, Board of Registration of Allied Mental Health and Human Service Professionals: Educational Psychologist Licensure Application. Accessed 7 May 2014: <http://www.mass.gov/ocabr/docs/dpl/boards/mh/ednewapp.pdf>.
- 6 Commonwealth of Massachusetts, Office of Consumer Affairs and Business Regulation: 262 CMR 5.00: Requirements For Licensure As an Educational Psychologist. Accessed 7 May 2014: <http://www.mass.gov/ocabr/licensee/dpl-boards/mh/regulations/rules-and-regs/262-cmr-500.html>. Regulatory authority defined under 262 CMR 5.00; M.G.L. c. 112, §§ 163 through 172, c. 13, §§ 88 through 90, St. 1987 c. 521, as amended by St. 1989 c. 720 and St. 1990 c. 477.
- 7 M.G.L. c. 112, § 163: Registration of Certain Professions and Occupations, Definitions. Accessed 12 May 2014: <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter112/Section163>.
- 8 Email correspondence with Clinton Dick, Executive Director, Board of Allied Mental Health and Human Services Professionals, Bureau of Professional Licenses. Received 8 May 2014.
- 9 Commonwealth of Massachusetts, Office of Consumer Affairs and Business Regulation, Division of Professional Licensure: About the Board of Registration of Psychologists. Accessed 12 May 2014: <http://www.mass.gov/ocabr/licensee/dpl-boards/py/about-the-board.html>. Licensing provisions can be found in M.G.L. Chapter 112, Sections 118 to 129, and M.G.L. Chapter 112, Sections 61 to 65.
- 10 M.G.L. Chapter 112, Sections 118. Accessed 2 June 2014: <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter112/Section118>.
- 11 *Op. cit.* NASP: What is a School Psychologist?
- 12 *Op. cit.* M.G.L. c. 112, § 163: Registration of Certain Professions and Occupations, Definitions.
- 13 *Op. cit.* M.G.L. Chapter 112, Sections 118. Comparatively, the practice of psychology in Massachusetts is defined as: rendering or offering to render professional service for any fee, monetary or otherwise, to individuals, groups of individuals, organizations or members of the public which includes the observation, description, evaluation, interpretation, and modification of human behavior, by the application of psychological principles, methods and procedures, for the purpose of assessing or effecting changes in symptomatic, maladaptive or undesired behavior and issues pertaining to interpersonal relationships, work and life adjustment, personal effectiveness and mental health. The practice of psychology includes, but is not limited to, psychological testing, assessment and evaluation of intelligence, personality, abilities, attitudes, motivation, interests and aptitudes; counseling, psychotherapy, hypnosis, biofeedback training and behavior therapy; diagnosis and treatment of mental and emotional disorder or disability, alcoholism and substance abuse, and the psychological aspects of physical illness or disability; psychoeducational evaluation, therapy, remediation and consultation. Psychological services may be rendered to individuals, families, groups, and the public....
- 14 National Association of School Psychologists (NASP): What is a School Psychologist? Accessed 12 May 2014: [http://www.nasponline.org/about\\_sp/whatis.aspx](http://www.nasponline.org/about_sp/whatis.aspx).
- 15 NASP: School Psychologists: Improving Student and School Outcomes. Published 2010; accessed 12 May 2014: [http://www.nasponline.org/advocacy/SP\\_Improving\\_Student\\_School\\_Outcomes\\_Final.pdf](http://www.nasponline.org/advocacy/SP_Improving_Student_School_Outcomes_Final.pdf).
- 16 Interview with Caroline Wandle, PhD, NCSP, LEP, 7 May 2014.
- 17 *Op. cit.* American Psychological Association (APA): Public Description of School Psychology.
- 18 Wilkinson L. The Role of School Psychologists in Children’s Mental Health. Accessed 2 June 2014: <http://www.examiner.com/article/the-role-of-school-psychologists-children-s-mental-health>.

- 19 National Research Council. Adolescent Health Services: Missing Opportunities. Washington, DC: The National Academies Press, 2009. Accessed 2 June 2014: [http://www.jarwan-center.com/download/english\\_books/english\\_booksandreferences/Adolescent%20Health%20Services.pdf](http://www.jarwan-center.com/download/english_books/english_booksandreferences/Adolescent%20Health%20Services.pdf).
- 20 Perou R, Bitsko RH, Blumberg SJ, et. al.; Centers for Disease Control and Prevention (CDC): Mental health surveillance among children--United States, 2005-2011. MMWR Surveill Summ. 2013 May 17;62 Suppl 2:1-35. Accessed 7 May 2014: <http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm>.
- 21 US Department of Health and Human Services Health Resources and Services Administration, Maternal and Child Health Bureau. Mental health: A report of the Surgeon General. Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, and National Institutes of Health, National Institute of Mental Health; 1999. Accessed 7 May 2014: <http://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf>.
- 22 *Op. cit.* Centers for Disease Control and Prevention (CDC): Mental health surveillance among children-United States, 2005-2011.
- 23 *Ibid.*
- 24 Behrens D, Lear JG, Price OA. Improving Access to Children's Mental Health Care: Lessons from a Study of Eleven States. George Washington University Center for Health and Health Care in Schools. March 2013; accessed 7 May 2014: <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf404627>.
- 25 U.S. Department of Health and Human Services Health Resources and Services Administration: Health Workforce. Designated Mental Health Care Health Professional Shortage Areas. Accessed 2 June 2014: <http://bhpr.hrsa.gov/shortage/hpsas/updates/09012011mentalhpsas.html#Massachusetts>.
- 26 Roness M, Hoagwood K. School-Based Mental Health Services: A Research Review. Clin Child Fam Psychol Rev. 2000 Dec;3(4):223-241. Accessed 2 June 2014: <http://link.springer.com/article/10.1023/A:1026425104386>.
- 27 Mennuti CR, Christner, RW. School-Based Mental Health: A Practitioner's Guide to Comparative Practices. New York, NY: Taylor & Francis Group, 2009. Accessed 2 June 2014: <http://books.google.com/books?hl=en&lr=&id=dMeSAgAAQBAJ&oi=fnd&pg=PP1&dq=School-based+mental+health:+A+practitioner%E2%80%99s+guide+to+comparative+practices&ots=Lwvy83x9MK&sig=ILJ7A7a4ePDuOhgvLe8JPYTz4Oc#v=onepage&q=School-based%20mental%20health%3A%20A%20practitioner%E2%80%99s%20guide%20to%20comparative%20practices&f=false>.
- 28 U.S. Department of Health and Human Services (US-DHHS), Substance Abuse and Mental Health Administration (SAMSHA), National Registry of Evidence-Based Programs and Practices. Updated 28 January 2014; accessed 13 June 2014: <http://www.nrepp.samhsa.gov/SearchResultsNew.aspx?s=v&q=>. Search criteria: 6-12 (Childhood), 13-17 (Adolescent), Mental health promotion, Mental health treatment, School, Other community settings.



**CENTER FOR HEALTH  
INFORMATION AND ANALYSIS**

---

**APPENDIX**

---





**Actuarial Assessment of House Bill 1808:  
“An act to improve access to the services  
of educational psychologists”**

Prepared for  
Commonwealth of Massachusetts  
Center for Health Information and Analysis

July 2014

Prepared by  
Compass Health Analytics, Inc.



**Actuarial Assessment of House Bill 1808:  
“An act to improve access to the services  
of educational psychologists”**

**Table of Contents**

Executive Summary .....	i
1. Introduction.....	1
2. Interpretation of H.B. 1808 .....	2
2.1. Plans affected by the proposed mandate .....	2
2.2. Covered services.....	2
2.3. Existing laws affecting the cost of H.B. 1808.....	3
3. Methodology.....	4
3.1. Steps in the analysis .....	4
3.2. Data sources .....	4
4. Factors Affecting the Analysis .....	5
4.1. LEPs transitioning to private practice .....	5
4.2. Billable hours for LEPs in private practice .....	6
4.3. Level of education of LEPs.....	6
4.4. Medical services and medical necessity .....	6
4.5. Shifting of school-funded services.....	6
5. Analysis.....	6
5.1. Projected fully-insured population in Massachusetts .....	7
5.2. Number of LEPs .....	7
5.3. Estimated number of LEPs moving to private practice .....	7
5.4. Estimate the number of billable hours charged by LEPs .....	8
5.5. Adjust billable hours for medical necessity.....	10
5.6. Estimate the weighted average per hour cost of treatment.....	10
5.7. Net increase in carrier medical expense .....	11
5.8. Net increase in premium .....	11
5.9. Five-year estimated impact .....	11
5.10. Impact on the GIC.....	12
Appendix A: Membership Affected by the Proposed Mandate .....	14
Endnotes .....	15

This report was prepared by Larry Hart, Andrea Clark, MS, Amy Raslevich, MPP, MBA, James Highland, PhD, Lars Loren, JD, and Tina Shields, FSA, MAAA.

# **Actuarial Assessment of House Bill 1808: “An act to improve access to the services of educational psychologists”**

## **Executive Summary**

The Massachusetts mental health parity statutes require insurers to cover mental health services delivered by designated “licensed mental health professionals” on a non-discriminatory basis to diagnose and treat biologically-based mental disorders and non-biologically-based mental, behavioral, or emotional disorders that “substantially interfere with or substantially limit the functioning and social interactions” of a child.<sup>1</sup> Massachusetts House Bill 1808 (H.B. 1808) expands the list of licensed mental health professionals<sup>2</sup> under the Massachusetts mental health parity statutes to include “a licensed educational psychologist within the lawful scope of practice for such educational psychologist.”<sup>3</sup> Currently, licensed educational psychologists (LEPs) practice predominately in schools, and have traditionally provided educational and psychological testing services that generally have not been reimbursed as health care services by Massachusetts health insurance carriers. This bill seeks to create a statutory basis for including LEPs in the credentialed provider networks of the carriers so that LEPs could be reimbursed to deliver in private practice the therapies they are increasingly providing.

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

### Background

The title “licensed educational psychologist” (LEP), as used in Massachusetts, refers to school psychologists who have completed additional training and are licensed to practice independently outside of school settings. To be a licensed educational psychologist in Massachusetts, one must first become a licensed school psychologist, then complete two years of employment as a school psychologist under the supervision of a licensed educational psychologist.<sup>4,5</sup> Licensure allows educational psychologists to practice independently in Massachusetts outside of a school setting provided they do not provide private practice services to any students in school systems by which they are employed.<sup>6</sup> There are 362 educational psychologists licensed in Massachusetts.<sup>7</sup>

LEPs in Massachusetts are, by definition, trained and experienced as school psychologists, and provide assessments and interventions focused primarily on children with learning or behavioral problems, disabilities, disorders or conditions that affect an individual’s mental health and ability to learn.<sup>8</sup> LEPs work in a variety of settings, including educational, medical, social service, and correctional, and serve to coordinate educational, behavioral, and psychological services by

applying cognitive, behavioral, social, and affective methods to ensure the healthy development of students.<sup>9</sup>

The profession has evolved from focusing primarily on intelligence testing and psychoeducational assessment to providing counseling and instruction to address issues that create barriers to learning and development, as well as crisis intervention and management services for students, educators, and families.<sup>10</sup> The individual, family, and group therapy increasingly provided by LEPs are the same services for which reimbursement is made to the current list of licensed mental health professionals under the mental health parity statutes. The proposed mandate is intended to provide insurance coverage for mental health services provided outside the school setting by LEPs. The documented shortage of mental health providers for children in Massachusetts<sup>11</sup> creates an environment in which this additional supply of mental health providers would increase reimbursed utilization of these services and thus increase insurance premiums.

### Analysis

Compass estimated the impact of H.B. 1808 with the following steps:

- Estimate the fully-insured Massachusetts population under age 65, projected for the next five years (2015 to 2019).
- Estimate the current number of LEPs in Massachusetts.
- Estimate the number of LEPs who would go into private practice full-time and the number who would work in the summer months and/or after school.
- Estimate the number of billable hours that would be charged by private practice LEPs.
- Adjust the number of billable hours for the proportion of claims performed by LEPs that would not meet carrier medical necessity criteria.
- Estimate the portion of the LEPs in private practice that would have master's- versus PhD-level training, and calculate the average per-hour cost for private practice LEPs.
- Calculate the proposed mandate's incremental effect on carrier medical expenses.
- Estimate the impact of insurer's retention (administrative costs and profit).
- Project the estimated cost over the next five years.

The analysis requires assumptions about the number and levels of training of LEPs who would enter private practice if the bill were to pass. Despite these sources of uncertainty, the relatively small number of licensed educational psychologists that would enter into private practice, even at the high end of the estimate, produces estimates that are relatively modest.

### Summary results

Table ES-1 summarizes the effect of H.B. 1808 on premium costs for fully-insured plans, averaged over five years. This analysis estimates that the mandate, if enacted, would increase fully-insured premiums by as much as 0.06 percent on average over the next five years; a more likely increase is in the range of 0.04 percent, equivalent to an average annual expenditure of \$5.2 million over

period 2014-2019. As context, if all 362 LEPs entered private practice and delivered 32 hours of service to members of fully insured commercial plans for 46 weeks per year at their estimated hourly cost of \$52.50 per unit, the total additional spending would be approximately \$28 million ( $362 \times 49 \times 32 \times \$52.51 = \$28$  million). However, the analysis assumes that a only a small percentage of LEPs would go into private practice, and that a significant proportion of their services would be educational and not reimbursable by medical insurance, producing a much smaller estimate of incremental medical expense.

The degree of precision achievable in this analysis is hampered by the issues outlined in section 4 of the body of the report; to account for the uncertainty in the number of LEPs that will go into private practice full-time or in the summer, the number of average billable hours incurred by each LEP, and the proportion of those that will bill based on master’s-level vs. PhD-level training, the high scenarios allow for a significant portion of existing LEPs converting to private practice. This results in a costlier high scenario, though still a very small percentage of overall annual premium.

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

**Table ES-1:  
Summary Results**

	2015	2016	2017	2018	2019	Average	5 Yr Total
Members (000s)	2,144	2,121	2,096	2,071	2,045		
Medical Expense Low (\$000s)	\$1,848	\$1,910	\$1,973	\$2,038	\$2,103	\$1,975	\$9,873
Medical Expense Mid (\$000s)	\$4,292	\$4,436	\$4,583	\$4,731	\$4,883	\$4,585	\$22,925
Medical Expense High (\$000s)	\$7,322	\$7,568	\$7,818	\$8,072	\$8,330	\$7,822	\$39,111
Premium Low (\$000s)	\$2,089	\$2,159	\$2,230	\$2,302	\$2,376	\$2,231	\$11,155
Premium Mid (\$000s)	\$4,850	\$5,013	\$5,178	\$5,346	\$5,518	\$5,181	\$25,904
Premium High (\$000s)	\$8,274	\$8,551	\$8,834	\$9,121	\$9,413	\$8,839	\$44,193
PMPM Low	\$0.08	\$0.08	\$0.09	\$0.09	\$0.10	\$0.09	\$0.09
PMPM Mid	\$0.19	\$0.20	\$0.21	\$0.22	\$0.22	\$0.21	\$0.21
PMPM High	\$0.32	\$0.34	\$0.35	\$0.37	\$0.38	\$0.35	\$0.35
Estimated Monthly Premium	\$512	\$537	\$564	\$592	\$622	\$566	\$566
Premium % Rise Low	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%
Premium % Rise Mid	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%
Premium % Rise High	0.06%	0.06%	0.06%	0.06%	0.06%	0.06%	0.06%

## Executive Summary Endnotes

---

<sup>1</sup> M.G.L. c.32A §22, c.175 §47B, c.176A §8A, c.176B §4A, c.176G §4M.

<sup>2</sup> The list of licensed mental health professionals currently includes: psychiatrist, psychologist, independent clinical social worker, mental health counselor, nurse mental health clinical specialist, or marriage and family therapist within the lawful scope of practice for such therapist. M.G.L. c.32A §22, c.175 §47B, c.176A §8A, c.176B §4A, c.176G §4M.

<sup>3</sup> The 188<sup>th</sup> General Court of the Commonwealth of Massachusetts. Bill H. 1808: An Act to improve access to the services of educational psychologists. Accessed 7 May 2014: <https://malegislature.gov/Bills/188/House/H1808>.

<sup>4</sup> Commonwealth of Massachusetts, Office of Consumer Affairs and Business Regulation, Division of Professional Licensure, Board of Registration of Allied Mental Health and Human Service Professionals: Educational Psychologist Licensure Application. Accessed 7 May 2014: <http://www.mass.gov/ocabr/docs/dpl/boards/mh/ednewapp.pdf>.

<sup>5</sup> Commonwealth of Massachusetts, Office of Consumer Affairs and Business Regulation: 262 CMR 5.00: Requirements For Licensure As an Educational Psychologist. Accessed 7 May 2014: <http://www.mass.gov/ocabr/licensee/dpl-boards/mh/regulations/rules-and-regs/262-cmr-500.html>. Regulatory authority defined under 262 CMR 5.00: M.G.L. c. 112, §§ 163 through 172, c. 13, §§ 88 through 90, St. 1987 c. 521, as amended by St. 1989 c. 720 and St. 1990 c. 477.

<sup>6</sup> M.G.L. c. 112, § 163: Registration of Certain Professions and Occupations, Definitions. Accessed 12 May 2014: <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter112/Section163>.

<sup>7</sup> Email correspondence with Clinton Dick, Executive Director, Board of Allied Mental Health and Human Services Professionals, Bureau of Professional Licenses. Received 8 May 2014.

<sup>8</sup> *Op. cit.* NASP: What is a School Psychologist?

<sup>9</sup> *Op. cit.* American Psychological Association (APA): Public Description of School Psychology.

<sup>10</sup> Interview with Caroline Wandle, PhD, NCSP, LEP, 7 May 2014.

<sup>11</sup> U.S. Department of Health and Human Services Health Resources and Services Administration: Health Workforce. Designated Mental Health Care Health Professional Shortage Areas. Accessed 2 June 2014: <http://bhpr.hrsa.gov/shortage/hpsas/updates/09012011mentalhpsas.html#Massachusetts>.

# **Actuarial Assessment of House Bill 1808: “An act to improve access to the services of educational psychologists”**

## **1. Introduction**

The Massachusetts mental health parity statutes require insurers to cover mental health services delivered by designated “licensed mental health professionals” on a non-discriminatory basis to diagnose and treat biologically-based mental disorders and non-biologically-based mental, behavioral, or emotional disorders that “substantially interfere with or substantially limit the functioning and social interactions” of a child.<sup>1</sup> Massachusetts House Bill 1808 (H.B. 1808) expands the list of licensed mental health professionals<sup>2</sup> under the Massachusetts mental health parity statutes to include “a licensed educational psychologist within the lawful scope of practice for such educational psychologist.”<sup>3</sup> Currently, licensed educational psychologists (LEPs) practice predominately in schools, and have traditionally provided educational and psychological testing services that generally have not been reimbursed as health care services by Massachusetts health insurance carriers. This bill seeks to create a statutory basis for including LEPs in the credentialed provider networks of the carriers so that LEPs could be reimbursed to deliver in private practice the therapies they are increasingly providing.

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

Assessing the impact of this bill entails analyzing the incremental effect of the bill on spending by insurance plans. This in turn requires comparing spending under the provisions of the proposed law to spending under current statutes and current benefit plans for the relevant services. The addition of LEPs to the list of mental health providers in the parity statutes would admit LEPs to the provider networks of Massachusetts health insurers, meaning medically necessary services to covered individuals would be reimbursed, thus making private practice more tenable. Since Massachusetts law does not allow LEPs to bill for services they provide in schools that employ them, and since mental health therapists for children are in short supply, an increase in service delivery outside schools (or in schools other than their employer) by LEPs for children covered by insurance has the potential to increase total service spending and therefore increase premiums.

Section 2 of this analysis outlines the provisions of the bill. Section 3 summarizes the methodology used for the estimate. Section 4 discusses important considerations in translating the bill’s language into estimates of its incremental impact on health care costs. Section 5 describes the calculation of the estimate.



## 2. Interpretation of H.B. 1808

The following subsections describe the provisions of H.B. 1808, as drafted for the 188th General Court.

### 2.1. Plans affected by the proposed mandate

The bill amends the statutes that regulate insurers providing health insurance in Massachusetts. The bill includes the following five relevant sections, each addressing statutes dealing with a particular type of health insurance policy:<sup>4</sup>

- Section 1: Insurance for persons in service of the Commonwealth (amending M.G.L. c. 32A, § 22)
- Section 2: Accident and sickness insurance policies (amending M.G.L. c. 175, § 47B)
- Section 3: Contracts with non-profit hospital service corporations (amending M.G.L. c. 176A, § A)
- Section 4: Certificates under medical service agreements (amending M.G.L. c. 176B, §4A)
- Section 5: Health maintenance contracts (amending M.G.L. 176G, § 4M)

The bill requires coverage for members under the relevant plans, regardless of whether they reside within the Commonwealth or merely have their principal place of employment in the Commonwealth.

Self-insured plans are subject to federal law and not to state-level health insurance benefit mandates. State mandates do not apply to Medicare, and this analysis assumes this proposed mandate does not affect Medicare extension/supplement plans even to the extent they are regulated by state law. This bill does not apply to Medicaid.

### 2.2. Covered services

Unlike many benefit mandates which require coverage of specific services, H.B. 1808 seeks to amend the law so that medically necessary services already requiring coverage under the mental health parity statutes can be covered when delivered by educational psychologists, who have training and licensure requirements separate from those of mental health professionals already cited in the parity statutes. The title “licensed educational psychologist” (LEP), as used in Massachusetts, refers to school psychologists who have completed additional training and are licensed to practice independently outside of school settings. To be a licensed educational psychologist in Massachusetts, one must first become a licensed school psychologist, then complete two years of employment as a school psychologist under the supervision of a licensed educational psychologist.<sup>5,6</sup> Licensure allows educational psychologists to practice independently in Massachusetts outside of a school setting provided they do not provide private practice services to any students in school systems by which they are employed.<sup>7</sup> There are currently 362 educational psychologists licensed in Massachusetts.<sup>8</sup>

LEPs in Massachusetts are, by definition, trained and experienced as school psychologists, and provide assessments and interventions focused primarily on children with learning or behavioral problems, disabilities, disorders or conditions that affect an individual's mental health and ability to learn.<sup>9</sup> The profession has evolved from focusing primarily on intelligence testing and psychoeducational assessment to providing counseling and instruction to address issues that create barriers to learning and development, as well as crisis intervention and management services for students, educators, and families.<sup>10</sup> The individual, family, and group therapy increasingly provided by LEPs are the same services for which reimbursement is made to the current list of licensed mental health professionals under the mental health parity statutes.

LEPs work in a variety of settings, including educational, medical, social service, and correctional, and serve to coordinate educational, behavioral, and psychological services by applying cognitive, behavioral, social, and affective methods to ensure the healthy development of students.<sup>11</sup> The proposed mandate is intended to provide insurance coverage for mental health services provided outside the school setting by LEPs.

For carriers to reimburse LEPs for services, the following conditions must be met:

- The provider must be a credentialed member of the carrier's provider network
- The service must be a covered medical (rather than educational) service and meet the diagnostic indications for medical necessity

In a recent survey of ten of the largest insurance carriers in Massachusetts, most plans noted that non-medical services by definition do not meet medical necessity criteria, which would be the primary reason they would deny claims performed by a credentialed LEP. Several carriers noted more specifically that services related to educational testing and generally provided by a school-based provider (including testing for a school-age child) are paid for by the school system and are excluded from coverage. LEPs increasingly provide medically necessary therapeutic services, and in theory, carriers could credential LEPs currently, but H.B. 1808 would in effect require credentialing for LEPs, allowing LEPs the means to practice privately.<sup>12</sup>

### **2.3. Existing laws affecting the cost of H.B. 1808**

Massachusetts has no mandates currently in place regarding insurance coverage for services provided specifically by LEPs. In addition, no existing federal mandates related to the specific subject matter of this bill have been identified.

## 3. Methodology

### 3.1. Steps in the analysis

Compass estimated the impact of H.B. 1808 with the following steps:

- Estimate the fully-insured Massachusetts population under age 65, projected for the next five years (2015 to 2019).
- Estimate the current number of LEPs in Massachusetts.
- Estimate the number of LEPs who would go into private practice full-time and the number who would work in the summer months and/or after school.
- Estimate the number of billable hours that would be charged by private practice LEPs.
- Adjust the number of billable hours for the proportion of claims performed by LEPs that would not meet carrier criteria for medical services.
- Estimate the portion of the LEPs in private practice that would have master's- versus PhD-level training, and calculate the weighted average per hour cost for private practice LEPs.
- Calculate the proposed mandate's incremental effect on carrier medical expenses.
- Estimate the impact on premiums of insurer's retention (administrative costs and profit).
- Project the estimated cost over the next five years.

### 3.2. Data sources

The primary data sources used in the analysis were:

- Responses from the bill's sponsors or legislative staff to written questions regarding legislative intent.
- Information from providers, cited as appropriate.
- Information from a survey of private health insurance carriers in Massachusetts.
- Academic literature, including population data, cited as appropriate.
- Massachusetts insurer claim data from CHIA's Massachusetts All-Payer Claim Database (APCD) for calendar years 2010 to 2012, for plans covering the majority of the under-65 fully-insured population subject to the proposed mandate.<sup>13</sup>

The step-by-step description of the estimation process below addresses limitations in some of these sources and the uncertainties they contribute to the cost estimate.

## 4. Factors Affecting the Analysis

Several issues arise in translating the provisions of H.B. 1808 into an analysis of incremental cost. The primary source of incremental medical expense in the analysis stems from the assumption that a small number of educational psychologists will go into private practice (detailed in Section 5.3), and provide a mix of services that include therapeutic services currently covered when provided by the mental health professionals already listed in the mental health parity statutes. While LEPs might in some cases serve clients who would have been served by other providers, the net effect of the bill will be to increase the supply of providers and, given the identified shortage of children's mental health providers, the overall utilization of such services.

### 4.1. LEPs transitioning to private practice

Estimating the cost of the proposed mandate requires an estimate of the total number of hours for which LEPs would be paid for providing services in private practice. These hours would be provided by (i) some practitioners leaving school employment and entering full-time private practice and (ii) others augmenting their incomes by working in private practice during summers or other breaks. Estimating the proportion of practitioners pursuing each of these paths is difficult without doing a detailed survey of the state's currently-licensed educational psychologists. Based on discussions with several providers, the estimates in this report assume the majority would prefer to stay in the school system and not practice independently. Entering private practice would require a significant change in working hours and other practice patterns and would bring a host of business challenges, including generating enough work to replace salary income and benefits from school employment and contending with business management duties, potentially including record keeping, insurance billing, small business/self-employment tax planning, and other administrative work. A known salary and benefits are factors that will likely keep many LEPs employed in the school systems.

Based on discussions with several providers, this analysis estimates that a small percentage would leave school employment for full-time private practice, and that another 25 to 50 percent of the existing professionals would work 10 weeks full-time in the summer time. In addition to summer work, the same part-time LEPs are likely to work part-time during the school year; this number is also difficult to quantify. The model does not include an explicit assumption for these school-year hours; however, it also does not include a "no-show" factor in the estimates of hours billed to insurers to reflect the fact that a certain percentage of patients do not show up for appointments, which would offset these additional school-year part-time hours. A typical behavioral health "no show" rate is about twenty percent.<sup>14</sup> Using the rate of twenty percent, the number of billable hours lost due to no-shows is comparable to hours that would be billed by part-time educational psychologists during the school year if one assumes a part time educational psychologist would bill for 5 hours per week during the school year. So excluding the school-year part-time hours would seem a reasonable approximation for excluding a factor for no-show appointments in the determination of billable hours.

## 4.2. Billable hours for LEPs in private practice

This analysis includes an estimate of the total number of billable hours that would be charged by the LEPs in private practice. It makes assumptions about the number of hours worked in a typical week, the number of weeks per year that would be spent working, and the number of hours spent during working hours that were not billable. Billable hours would exclude time between appointments, as well as time spent on administrative duties such as billing insurance carriers.

## 4.3. Level of education of LEPs

This analysis estimates the portions of LEPs who have master's-level training versus a PhD, as reimbursement rates vary according to education level. Statistics on current LEPs stratified by graduate degree levels are not available, and the model therefore assumes that the great majority of these practitioners are currently master's-prepared.

## 4.4. Medical services and medical necessity

This analysis assumes that a certain proportion of the services performed by LEPs would be deemed by carriers as not medically necessary. As previously stated, most carriers surveyed cited this issue as the primary reason they would deny claims for LEP services, classifying them as educational rather than medical in nature. While the proposed mandate would draw some LEPs into offering more services that meet existing medical necessity criteria, and may even shape the application of medical necessity criteria to services offered by LEPs in private practice, certain services performed by private practice LEPs will still likely be educational in nature and not meet medical necessity criteria. This analysis assumes that 60, 70, and 80 percent of services will meet medical necessity criteria for the three scenarios analyzed.

## 4.5. Shifting of school-funded services

Even though H.B. 1808 does not alter the statutory restriction preventing LEPs from billing insurance for students in school districts that employ them, with increased opportunities for commercial reimbursement, and if sufficient LEP capacity is available, the opportunity to shift services currently funded by school systems to the health insurance system might exist. However, this is speculative, and because this analysis found no evidence to support an estimate of the magnitude of this potential shift, it is not incorporated into the overall estimate.

## 5. Analysis

To estimate the impact of the proposed legislation, the following calculations were executed. The analysis includes development of a best estimate "mid-level" scenario, as well as a low-level scenario using assumptions that produced a lower estimate, and a high-level scenario using more conservative assumptions that produced a higher estimated impact.

This analysis estimates the potential increase in medical expense due to the proposed mandate for a baseline period (2012). Simplified somewhat, the baseline cost calculation is:

- Total LEPs in Massachusetts
- x Percentage of practitioners going into private practice
- x Hours per year per practitioner
- x Percentage of work hours that are billable
- x Proportion of services that meet carrier medical necessity criteria
- x Hourly carrier reimbursement rate for mental health therapy services

These components are measured/estimated for the baseline period and then divided by the commercial fully-insured enrollment (member months) to develop a per-member per-month (PMPM) cost estimate. That baseline estimate is the starting point for the calculations for the final forward-looking projections (2015 to 2019).

### 5.1. Projected fully-insured population in Massachusetts

Table 1 shows the fully-insured population in Massachusetts ages 0-64 projected for the next five years. Appendix A describes the sources of these values.

**Table 1:  
Projected Fully-Insured Population in Massachusetts, Ages 0-64**

<u>Year</u>	<u>Total (0-64)</u>
2015	2,144,066
2016	2,120,558
2017	2,096,250
2018	2,071,138
2019	2,045,433

### 5.2. Number of LEPs

There are currently 362 licensed educational psychologists in Massachusetts.

### 5.3. Estimated number of LEPs moving to private practice

As noted previously, it is uncertain how many LEPs would go into private practice full-time or part-time. Those who elect part-time are assumed to maintain their contract with a school system and work in private practice primarily during summer months or after hours during the school year. Based on discussions with providers, this model assumes the majority would prefer to stay in the school system and not move to private practice, estimating that only between 5 and 20 percent would move into full-time private practice.

Assuming part-time private practice, including during the summer months, would be more attractive than a full-time private practice, the model assumes that between 25 and 50 percent of

the existing professionals would work in the summer time or part-time during the school year. These assumptions appear in Table 2.<sup>15</sup>

**Table 2:  
Estimated Number of LEPs Moving to Private Practice**

	<u>Full Time</u>	<u>Part Time</u>
Low Scenario	5.0%	25.0%
Medium Scenario	12.5%	37.5%
High Scenario	20.0%	50.0%

#### 5.4. Estimate the number of billable hours charged by LEPs

The average number of annual billable hours charged by LEPs in full- or part-time positions was developed based on a standard 40 hour work week assumed for independent practitioners. Accounting for time between appointments and administrative work, the standard work week was reduced by 8 hours to estimate the average number of billable hours per week. Billable weeks per year was likewise based on 52 weeks in a calendar year, reduced by 6 weeks for vacation, holidays, and sick time, resulting in an estimate of 46 productive billable weeks per year for full-time providers. For part-time providers, 10 of 12 summer weeks were assumed to be available for billable services. Multiplying the number of billable hours per week by the number of productive weeks per year yields an average of 1,472 billable hours per year for full-time providers, or 320 hours for part-time providers. Table 3 displays these assumptions and results.

**Table 3:  
LEP Average Annual Billable Hours**

	<u>Full-time</u>	<u>Part-time</u>
Hours per week	40	40
Less administrative hours	(8)	(8)
Net billable hours per week	32	32
Weeks per year	52	12
Less non productive weeks	(6)	(2)
Net billable weeks per year	46	10
Billable hours per week	32	32
Times billable weeks per year	x 46	x 10
Billable hours per year	1,472	320

While some LEPs are likely to work part-time during the school year, which would increase the number of incremental hours of available services, as discussed in Section 4 this model assumes an equal offset of available hours due to patients who do not show up for appointments across all

providers; therefore, an estimate of available summer hours is used as the basis of assumption for all available part-time hours.

Based on the calculations in Table 3, hours available for a part-time LEP are equivalent to 21.7 percent of hours available to a full-time LEP (320 hours divided by 1,472 hours). This percentage was then multiplied by the percent of LEPs estimated in each scenario to become part-time private practice providers, as outlined in Table 2. This produces the percentage of “prorated” part-time providers moving into private practice, as displayed in Table 4.

**Table 4:  
Estimate of Prorated Part-Time LEPs**

	<u>Part Time</u>	<u>Pro-rated Part Time</u>
Low Scenario	25.0%	5.4%
Medium Scenario	37.5%	8.2%
High Scenario	50.0%	10.9%

Adding together the percent of LEPs who will enter full-time private practice with the pro-rated percent who will enter part-time private practice yields the model’s percent estimates of full-time equivalent (FTE) LEPs who will enter private practice, as displayed in Table 5.

**Table 5:  
Estimate of LEP FTEs**

	<u>Full Time</u>	<u>Pro-rated Part Time</u>	<u>LEP FTEs</u>
Low Scenario	5.0%	5.4%	10.4%
Medium Scenario	12.5%	8.2%	20.7%
High Scenario	20.0%	10.9%	30.9%

To calculate total billable hours per year attributable to this mandate under each scenario, the number of current LEPs (362) is multiplied by the number of hours available per FTE (1,472). This number is then multiplied by the percentage of LEPs who are estimated to become full-time equivalent providers in private-practice. The results are display in Table 6.

**Table 6:  
Educational Psychologists Total Annual Billable Hours**

	<u>Current LEPs</u>	<u>Annual Hours</u>	<u>LEP FTEs</u>	<u>Billable Hours</u>
Low Scenario	362	1,472	10.4%	55,418
Medium Scenario	362	1,472	20.7%	110,303
High Scenario	362	1,472	30.9%	164,655



## 5.5. Adjust billable hours for medical necessity

As noted in Section 4.4, this analysis assumes that a certain proportion of the services performed by LEPs will fail to meet carrier medical necessity criteria. We have assumed that between 20 and 40 percent of billable hours performed by LEP's would be deemed not medically necessary and therefore not covered by the proposed mandate. To calculate the impact, the estimated billable hours would be reduced by 40 percent for the low cost scenario, 30 percent for the medium scenario, and 20 percent for the high scenario. LEPs may receive out-of-pocket payments from patients' families for these services not reimbursed by carriers; these payments do not impact health insurance premiums and are not included in this analysis. Results of the adjustment for medical necessity are the net billable hours and appear in Table 7.

**Table 7:  
Educational Psychologists Total Annual Net Billable Hours**

	<u>Billable Hours</u>	<u>Medical Necessity Adjustment</u>	<u>Net Billable Hours</u>
Low Scenario	55,418	0.600	33,251
Medium Scenario	110,303	0.700	77,212
High Scenario	164,655	0.800	131,724

## 5.6. Estimate the weighted average per hour cost of treatment

To estimate the average cost per treatment, this analysis used claims from the All Payer Claims Database from 2012. No claims were identified as LEP claims; instead, claims from other allied mental health provider types with similar training and hourly rates were used to estimate per-procedure costs. Rates from claims for mental health counselors and marriage and family therapists were used as the basis of master's-level providers. For PhD-level providers, rates from claims for school psychologists who are dually-licensed as psychologists were used.

The model assumes that 90 percent of LEPs who would enter private practice are trained at a master's level, and 10 percent at a PhD level. Table 8 then displays a weighted-average hourly rate for LEPs based on these assumptions.

**Table 8:  
Weighted Average Hourly Rate for LEPs,  
Baseline Year 2012**

	<u>Distribution</u>	<u>Hourly Rate Paid Amount</u>
Master's Level Prepared	90.0%	\$50.70
PhD Level Prepared	10.0%	\$68.80
Weighted Average		\$52.51

## 5.7. Net increase in carrier medical expense

For each scenario, multiplying the estimated average number of incremental billable hours by the cost per hour and then dividing the result by the projected fully-insured membership yields the medical expense per member per month (PMPM) displayed in Table 9.

**Table 9:**  
**Estimate of Increase in Base-Year Carrier Medical Expense**  
**PMPM**

Low Scenario	\$0.06
Mid Scenario	\$0.15
High Scenario	\$0.25

The base-year mid-scenario PMPM of \$0.15 is equivalent to annual medical claims spending of approximately \$4 million (77,212 hours times \$52.51/hour). As context, if all 362 LEPs entered private practice and delivered 32 hours of service to members of fully insured commercial plans for 46 weeks per year at \$52.51 per unit, the total additional spending would be approximately \$28 million (362 x 49 x 32 x \$52.51 = \$28 million). However, the analysis assumes that a only a small portion of LEPs would go into private practice, and that a significant proportion of their services would be educational and not reimbursable by medical insurance, producing a much smaller estimate of incremental medical expense.

## 5.8. Net increase in premium

Assuming an average retention rate of 11.5 percent, based on CHIA's analysis of administrative costs and profit in Massachusetts,<sup>16</sup> the increase in medical expense was adjusted upward to approximate the total impact on premiums. Table 10 shows the result.

**Table 10:**  
**Estimate of Increase in Base-Year Carrier**  
**Medical Expense PMPM**

Low Scenario	\$0.07
Mid Scenario	\$0.17
High Scenario	\$0.28

The mid-level baseline (2012) PMPM of \$0.17 is equivalent to annual spending of approximately \$4.5 million.

## 5.9. Five-year estimated impact

For each year in the five-year analysis period, Table 11 displays the projected net impact of the proposed mandate on medical expense and premiums using a projection of Massachusetts fully-insured membership. The baseline (2012) cost for the incremental LEP services was then projected for the study period 2015 to 2019 using an annual medical inflation rate of 4.5 percent. This analysis estimates that the mandate, if enacted, would increase fully-insured premiums by as much

as 0.06 percent on average over the next five years; a more likely increase is in the range of 0.04 percent. The five-year average annual premium impact on premium spending is \$5.2 million.

The degree of precision achievable in this analysis is hampered by the issues outlined in section 4; to account for the uncertainty in the number of LEPs who would practice privately either full or part time, the number of billable hours on average they would perform, and the distribution of the level of training (master’s level vs. PhD level) for those going into private practice, the high scenarios allow for a combination of more-expensive assumptions. This results in a disproportionately costly high scenario result.

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

**Table 11:  
Summary Results**

	2015	2016	2017	2018	2019	Average	5 Yr Total
Members (000s)	2,144	2,121	2,096	2,071	2,045		
Medical Expense Low (\$000s)	\$1,848	\$1,910	\$1,973	\$2,038	\$2,103	\$1,975	\$9,873
Medical Expense Mid (\$000s)	\$4,292	\$4,436	\$4,583	\$4,731	\$4,883	\$4,585	\$22,925
Medical Expense High (\$000s)	\$7,322	\$7,568	\$7,818	\$8,072	\$8,330	\$7,822	\$39,111
Premium Low (\$000s)	\$2,089	\$2,159	\$2,230	\$2,302	\$2,376	\$2,231	\$11,155
Premium Mid (\$000s)	\$4,850	\$5,013	\$5,178	\$5,346	\$5,518	\$5,181	\$25,904
Premium High (\$000s)	\$8,274	\$8,551	\$8,834	\$9,121	\$9,413	\$8,839	\$44,193
PMPM Low	\$0.08	\$0.08	\$0.09	\$0.09	\$0.10	\$0.09	\$0.09
PMPM Mid	\$0.19	\$0.20	\$0.21	\$0.22	\$0.22	\$0.21	\$0.21
PMPM High	\$0.32	\$0.34	\$0.35	\$0.37	\$0.38	\$0.35	\$0.35
Estimated Monthly Premium	\$512	\$537	\$564	\$592	\$622	\$566	\$566
Premium % Rise Low	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%	0.02%
Premium % Rise Mid	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%
Premium % Rise High	0.06%	0.06%	0.06%	0.06%	0.06%	0.06%	0.06%

## 5.10. Impact on the GIC

Because the benefit offerings of GIC plans are similar to most other commercial plans in Massachusetts, and cover the treatments proposed in the mandate for services performed by educational psychologists similarly to other carriers, the estimated PMPM effect of the proposed mandate on GIC coverage is not expected to differ from that calculated for the other fully-insured plans in Massachusetts. Note that the total medical expense and premium numbers displayed in Table 9 include the GIC fully-insured membership. To calculate the medical expense separately for the self-insured portion of the GIC, the medical expense per member per month was applied to the GIC self-insured membership; the results are displayed in Table 12.

**Table 12:  
GIC Self-Insured Summary Results**

	2015	2016	2017	2018	2019	Average	5 Yr Total
Members (000s)	259	259	259	258	258		
Medical Expense Low (\$000s)	\$19	\$19	\$20	\$21	\$22	\$20	\$102
Medical Expense Mid (\$000s)	\$43	\$45	\$47	\$49	\$51	\$47	\$236
Medical Expense High (\$000s)	\$74	\$77	\$80	\$84	\$88	\$81	\$403

## Appendix A: Membership Affected by the Proposed Mandate

Membership potentially affected by a proposed mandate may include Massachusetts residents with fully-insured employer-sponsored health insurance (including through the GIC), non-residents with fully-insured employer-sponsored insurance issued in Massachusetts, Massachusetts residents with individual (direct) health insurance coverage, and, in some cases, lives covered by GIC self-insured coverage. Membership projections for 2015 to 2019 are derived from the following sources.

Total Massachusetts population estimates for 2012 and 2013 from U. S. Census Bureau data<sup>17</sup> form the base for the projections. Distributions by gender and age, also from Census Bureau,<sup>18</sup> were applied to these totals. Projected growth rates for each gender/age category were calculated from Census Bureau population projections to 2030.<sup>19</sup> The resulting growth rates were then applied to the base amounts to project the total Massachusetts population for 2015 to 2019.

The number of Massachusetts residents with employer-sponsored or individual (direct) health insurance coverage was estimated using Census Bureau data on health insurance coverage status and type of coverage<sup>20</sup> applied to the population projections.

To estimate the number of Massachusetts residents with fully-insured employer-sponsored coverage, projected estimates of the percentage of employer-based coverage that is fully-insured were developed using historical data from the Medical Expenditure Panel Survey Insurance Component Tables.<sup>21</sup>

To estimate the number of non-residents covered by a Massachusetts policy – typically cases in which a non-resident works for a Massachusetts employer offering employer-sponsored coverage – the number of lives with fully-insured employer-sponsored coverage was increased by the ratio of the total number of individual tax returns filed in Massachusetts by residents<sup>22</sup> and non-residents<sup>23</sup> to the total number of individual tax returns filed in Massachusetts by residents.

The number of residents with individual (direct) coverage was adjusted further to remove the estimated number of people currently covered by Commonwealth Care who will shift into MassHealth due to expanded Medicaid eligibility under the Affordable Care Act beginning in 2014.<sup>24</sup>

Projections for the GIC self-insured lives were developed using GIC base data for 2012<sup>25</sup> and 2013<sup>26</sup> and the same projected growth rates from the Census Bureau that were used for the Massachusetts population. Breakdowns of the GIC self-insured lives by gender and age were based on the Census Bureau distributions.

## Endnotes

---

<sup>1</sup> M.G.L. c.32A §22, c.175 §47B, c.176A §8A, c.176B §4A, c.176G §4M.

<sup>2</sup> The list of licensed mental health professionals currently includes: a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist, or a licensed marriage and family therapist within the lawful scope of practice for such therapist. M.G.L. c.32A §22, c.175 §47B, c.176A §8A, c.176B §4A, c.176G §4M.

<sup>3</sup> The 188<sup>th</sup> General Court of the Commonwealth of Massachusetts. Bill H. 1808: An Act to improve access to the services of educational psychologists. Accessed 7 May 2014: <https://malegislature.gov/Bills/188/House/H1808>.

<sup>4</sup> Meeting with sponsor and legislative, CHIA, and Compass staff 10 December 2013.

<sup>5</sup> Commonwealth of Massachusetts, Office of Consumer Affairs and Business Regulation, Division of Professional Licensure, Board of Registration of Allied Mental Health and Human Service Professionals: Educational Psychologist Licensure Application. Accessed 7 May 2014: <http://www.mass.gov/ocabr/docs/dpl/boards/mh/ednewapp.pdf>.

<sup>6</sup> Commonwealth of Massachusetts, Office of Consumer Affairs and Business Regulation: 262 CMR 5.00: Requirements For Licensure As an Educational Psychologist. Accessed 7 May 2014: <http://www.mass.gov/ocabr/licensee/dpl-boards/mh/regulations/rules-and-regs/262-cmr-500.html>. Regulatory authority defined under 262 CMR 5.00: M.G.L. c. 112, §§ 163 through 172, c. 13, §§ 88 through 90, St. 1987 c. 521, as amended by St. 1989 c. 720 and St. 1990 c. 477.

<sup>7</sup> M.G.L. c. 112, § 163: Registration of Certain Professions and Occupations, Definitions. Accessed 12 May 2014: <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter112/Section163>.

<sup>8</sup> Email correspondence with Clinton Dick, Executive Director, Board of Allied Mental Health and Human Services Professionals, Bureau of Professional Licenses. Received 8 May 2014.

<sup>9</sup> *Op. cit.* NASP: What is a School Psychologist?

<sup>10</sup> Interview with Caroline Wandle, PhD, NCSP, LEP, 7 May 2014.

<sup>11</sup> *Op. cit.* American Psychological Association (APA): Public Description of School Psychology.

<sup>12</sup> Subsection g of each of the mental health parity statutes requires the carrier to pay for a set of services to address mental health issues and includes among those services provided by mental health professionals as defined in the section. Reimbursement requires credentialing within the carrier's network. See for example M.G.L. c.176B §4A, subsection g:

(g) Benefits authorized pursuant to this section shall consist of a range of inpatient, intermediate, and outpatient services that shall permit medically necessary and active and noncustodial treatment for said mental disorders . . . Outpatient services may be provided in a licensed hospital, a mental health or substance abuse clinic licensed by the department of public health, a public community mental health center, a professional office, or home-based services, provided, however, services delivered in such offices or settings are rendered by a licensed mental health professional acting within the scope of his license.

- 
- <sup>13</sup> More information can be found at <http://www.mass.gov/chia/researcher/hcf-data-resources/apcd/>
- <sup>14</sup> More information can be found at <http://www.aptrcpsych.org/content/13/6/423.full>.
- <sup>15</sup> H.B. 1808 does not apply to self-insured health insurance plans or government payers. It is possible that LEPs moving to private practice would provide some of their service volume to these other groups. Generally at least some self-insured plans provide mandated benefits that are optional for such plans; it is less clear how self-insured plans would follow what is essentially a provider-credentialing mandate. To the extent the LEPs' work volume is absorbed by other insured groups, it would reduce the net impact of the proposed mandate. This introduces uncertainty into the analysis, but the size of that uncertainty is modest compared to the overall range of estimates.
- <sup>16</sup> Massachusetts Center for Health Information and Analysis. Annual Report on the Massachusetts Health Care Market, August 2013. Accessed 17 March 2014: <http://www.mass.gov/chia/docs/r/pubs/13/ar-ma-health-care-market-2013.pdf>.
- <sup>17</sup> U.S. Census Bureau. Annual Estimates of the Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2013. Accessed 23 January 2014: <http://www.census.gov/popest/data/state/totals/2013/index.html>.
- <sup>18</sup> U.S. Census Bureau. Annual Estimates of the Resident Population by Single Year of Age and Sex for the United States, States, and Puerto Rico Commonwealth: April 1, 2010 to July 1, 2012. Accessed 23 January 2014: <http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkml>.
- <sup>19</sup> U.S. Census Bureau. File 4. Interim State Projections of Population by Single Year of Age and Sex: July 1, 2004 to 2030, U.S. Census Bureau, Population Division, Interim State Population Projections, 2005. Accessed 23 January 2014: <http://www.census.gov/population/projections/data/state/projectionsagesex.html>.
- <sup>20</sup> U.S. Census Bureau. Table HIB-4. Health Insurance Coverage Status and Type of Coverage by State All People: 1999 to 2012. Accessed 23 January 2014: [http://www.census.gov/hhes/www/hlthins/data/historical/HIB\\_tables.html](http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html).
- <sup>21</sup> Agency for Healthcare Research and Quality. Percent of private-sector enrollees that are enrolled in self-insured plans at establishments that offer health insurance by firm size and State (Table II.B.2.b.1), years 1996-2012: 1996 (Revised March 2000), 1997 (March 2000), 1998 (August 2000), 1999 (August 2001), 2000 (August 2002), 2001 (August 2003), 2002 (July 2004), 2003 (July 2005), 2004 (July 2006), 2005 (July 2007), 2006 (July 2008), 2008 (July 2009), 2009 (July 2010), 2010 (July 2011), 2011 (July 2012), 2012 (July 2013). Medical Expenditure Panel Survey Insurance Component Tables. Generated using MEPSnet/IC. Accessed 31 January 2014: [http://www.meps.ahrq.gov/mepsweb/data\\_stats/MEPSnetIC.jsp](http://www.meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp).
- <sup>22</sup> IRS. Table 2. Individual Income and Tax Data, by State and Size of Adjusted Gross Income, Tax Year 2010. Accessed 6 March 2014: <http://www.irs.gov/uac/SOI-Tax-Stats---Historic-Table-2>.
- <sup>23</sup> Massachusetts Department of Revenue. Massachusetts Personal Income Tax Paid by Non-Resident by State for TY2010. Accessed 23 January 2014: <http://www.mass.gov/dor/tax-professionals/news-and-reports/statistical-reports/>.
- <sup>24</sup> Massachusetts Budget and Policy Center. THE GOVERNOR'S FY 2014 HOUSE 1 BUDGET PROPOSAL. Accessed 5 March 2014: [http://www.massbudget.org/reports/pdf/mmpi\\_gov\\_14.pdf](http://www.massbudget.org/reports/pdf/mmpi_gov_14.pdf).
- <sup>25</sup> Group Insurance Commission. Group Insurance Commission Fiscal Year 2012 Annual Report. Accessed 14 March 2014: <http://www.mass.gov/anf/docs/gic/annual-report/arfy2012.pdf>.

---

<sup>26</sup> Group Insurance Commission. GIC Health Plan Membership by Insured Status FY2013. Accessed 22 January 2014: <http://www.mass.gov/anf/employee-insurance-and-retirement-benefits/annual-reports/annual-report-fy-2013-financial-and-trend.html>.







center  
for health  
information  
and analysis

*For more information, please contact:*

**CENTER FOR HEALTH INFORMATION AND ANALYSIS**

Two Boylston Street  
Boston, MA 02116  
617.988.3100

[www.mass.gov/chia](http://www.mass.gov/chia)

*Publication Number 14-190-CHIA-01*