3 Minnesota Parity Law

SUMMARY

The federal government, Minnesota, and most other states enacted mental health parity laws in the 1990s. This legislation was designed to put behavioral health services on an equal footing with other health care coverage. Minnesota's law has been implemented by removing unequal contractual limits on behavioral health services from insurance contracts. The law's proponents hoped that it would promote the availability and use of behavioral health services, but parity laws (including Minnesota's) appear to have had a limited effect. Health service utilization under managed care is controlled by health plan criteria relating to medical necessity rather than the specific contractual limits that were eliminated by the parity law. Because managed care has substantially replaced traditional indemnity plans in Minnesota, the law did not greatly increase service utilization as some had anticipated.

Most states enacted mental health parity laws in the 1990s.

Growing concern about access to mental health treatment led the federal government and most states (including Minnesota) to enact mental health parity laws in the 1990s. According to the General Accounting Office, all but seven states have enacted laws affecting mental health benefits, and 35 states have enacted parity laws that meet or exceed the requirements of the federal parity law.[1] The federal Mental Health Parity Act of 1996, implemented in 1998, prohibits the use of different lifetime and annual dollar limits on coverage for mental and physical illnesses. The 1995 Minnesota Legislature enacted a stronger law prohibiting state-regulated health plans that provide coverage for mental health or chemical dependency services from placing greater restrictions on behavioral health services than on comparable physical health services.[2]

The argument for parity laws rests on the conclusion that some forms of mental illness and chemical dependency are widespread and should be treated as part of regular health care available to people through their health insurance plans. As noted in Chapter 1, the 1999 Surgeon General's report, using a broad definition of mental illness, estimates that 28 percent of the adult population is affected by mental/addictive disorders in a given year, of whom only a third receive behavioral health services.[3]

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1 United States General Accounting Office, *Implementation of the Mental Health Parity Act, (W*ashington, D.C.: May 2000), 8.

2 Minn. Laws (1995), ch. 234, art. 2, sec. 29. The law is codified as Minn. Stat. (2000) §62Q.47

3 United States Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: National Institute of Mental Health, 1999).

There are various reasons why behavioral health treatment historically has not reached everyone who might benefit. Parity laws are designed to address one of them—the fact that insurers used more restrictive limits and copayments for behavioral health than they used for general health care. Insurance companies were reluctant to offer more generous behavioral health benefits because of concerns that it would encourage inappropriate use of behavioral health services and because they feared attracting enrollees in poorer health. Parity laws were designed to broaden behavioral health insurance coverage by removing unequal restrictions on behavioral health benefits. Supporters of parity laws hoped that the laws would result in an increase in behavioral health spending and service utilization.

Minnesota's parity law is one of the strongest in the nation, although it applies only to commercially sold health insurance plans.

To assess the effectiveness of parity laws, we asked:

- **How has the Minnesota parity law been implemented?**
- **What is the impact of the state and federal parity laws in Minnesota?**

To answer these questions, we reviewed insurance policies and certificates of coverage filed with the departments of Commerce and Health. In addition, we interviewed provider and consumer representatives and reviewed the literature on state and federal parity laws.

IMPLEMENTATION OF THE MINNESOTA PARITY LAW

The potential impact of Minnesota's parity law is limited to commercially sold health insurance plans. The law does not apply to "self-insured" plans, which are underwritten by employers. [4] As shown in Figure 1.4, about 34 percent of the state's population is covered by self-insured plans. While these plans are not regulated by the state, they are governed by the federal parity law and regulated by the United States Department of Labor.

Many Minnesotans are covered by a "self-insured" plan under-written by their employer.

The Minnesota Department of Commerce regulates health insurance policies sold by for-profit and non-profit companies and the Minnesota Department of Health regulates health maintenance organizations (HMOs). These agencies review health plans for compliance with the Minnesota parity law by reviewing contract language to see if there are contractual limitations applying to behavioral health services that do not apply to other health services.

For both departments, the parity review is part of a larger review of insurance products. For example, if a company wants to sell an insurance policy in Minnesota, the product has to be approved by the Department of Commerce for compliance with Minnesota law.[5] The department checks insurance products for compliance with a number of statutory provisions governing health benefits, including several that pertain to behavioral health. In addition to the parity law,

4 This type of plan is typically offered by large employers who can afford to assume the financial risk and tend to have relatively good mental health benefits.

5 The principal statutes governing health insurance plans are 62A and 62Q.

Minnesota statutes prohibit the sale of policies that use a more restrictive definition of "medical necessity" for mental health services than the professional standards of providers specializing in mental health treatment.[6]

Health insurance plans are regulated by the departments of Commerce and Health.

In fiscal year 2000, the Department of Commerce reviewed about 1200 health insurance filings, about half of which are comprehensive major medical or small employer health plans. There were 164 major medical filings including "small employer" plans.[7]

According to the Department of Commerce, about 60 percent of filings are deficient in some respect and, in these cases, a letter goes out requiring some change. Although most of the major medical policies submitted each year require some correction, behavioral health benefits are seldom at issue, according to policy review staff.

The health plan approval function in the Minnesota Department of Health is simpler and smaller than that of Commerce because it has far fewer insurance plans to review. Currently, Minnesota has only 11 HMOs.

We reviewed a sample of health plans regulated by the departments of Health and Commerce and interviewed the state agency staff responsible for the review of plans and policies. We found:

- **The health plan review process, by itself, does not assure compliance with the parity law.**

The departments often review generic certificates of coverage that lack the specific detail necessary to show, for example, if a different co-payment is required for behavioral health than other health services. Nevertheless:

- **Awareness of the parity law's requirements has facilitated the elimination of unequal contractual limitations from the health insurance contracts now in use.**

Compliance with the parity law is nearly universal.

The departments of Health and Commerce believe that compliance with the parity law is nearly universal because health plan companies doing substantial business in Minnesota are aware of the requirements. The high degree of consolidation in Minnesota's health insurance industry has made it easier to educate insurers about the parity law's requirement. In addition, department staff and others contend that there is little chance that a violation would go undetected over time by mental health service providers, consumers, competitors, or the department. If a parity violation were to occur now, it would probably involve either an ambiguous circumstance, or a policy sold by a company without much previous Minnesota experience.

The Department of Health has detected two instances of non-compliance in the last two years. In one case, Health Partners was advised in March 2000 that it was

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6 Minn. Stat. (2000) §62Q.53.

7 Small employer plans are defined by *Minn. Stat.* (2000) §62L These plans are exempt from certain regulatory requirements and are designed to be sold to employers with 50 or fewer employees. Small employer plans covered about 10 percent of the Minnesota population in 1999.

inappropriately limiting chemical dependency services in violation of the Minnesota parity law, and the company agreed to revise its certificate of coverage.[8] In another case, the Metropolitan Health Plan, an HMO operated by Hennepin County, was ordered by the Commissioner of Health to bring its practices into compliance. The department concluded that the Metropolitan Health Plan covered Hennepin County employees through an insured HMO, not a self-insured plan that would be exempt from the parity law.

National research studies found that parity laws have minor effects on insurance benefit costs.

IMPACT OF PARITY LAWS ON BEHAVIORAL HEALTH SPENDING AND SERVICES

We reviewed the research literature on the impact of parity laws at the national level and in other states and found:

- **According to the studies we reviewed, the impact of parity laws on insurance benefits and costs has been minimal.**

A 1998 study commissioned by the Substance Abuse and Mental Health Services Administration (SAMHSA) examined state parity laws in five states, including Minnesota. Minnesota's parity law is broader than most because it uses a broad definition of mental illness and includes substance abuse services.[9] The study asked employers, insurers, and insurance regulators about the effects of parity on behavioral health expenditures and premiums. The Minnesota informants said that premium increases due to parity compliance were small—around 1 or 2 percent.

SAMHSA also analyzed the cost of providing parity for mental health and chemical dependency services using actuarial cost models developed by the HayGroup for full and partial parity benefit options.[10] The analysis showed that

8 The Minnesota Department of Health-Health Partners correspondence March to May 2000.

9 United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *The Cost and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits*, 1998. Accessed at http://www.mentalhealth.org/publications/allpubs/Mc99-80/Acknow.htm.

10 The full parity option has behavioral health benefits similar to those required under Minnesota's law. The HayGroup Actuarial model has been used extensively to study the effects of proposed policies for the federal government, including the Mental Health Parity Act of 1996 and the Domenici-Wellstone amendment to the Health Insurance Reform Act of 1996.

full parity (parity in services covered and cost sharing) would raise family premiums for fee-for-service plans by 5 percent, but would increase HMO premiums by only 0.6 percent. Behavioral health expenses more than doubled in the actuarial analysis of fee-for-service plans under full parity, while behavioral health expenses went up only 11.6 percent in HMO plans.

The effect of parity laws is greater under fee-for-service plans than managed care.

Parity laws have had a minimal effect on costs under managed care because managed care controls service use primarily by reviewing the medical necessity of services rather than relying on contractual limits. The differential behavioral health contractual limitations that were eliminated by parity laws were relied upon more by traditional fee-for-service plans than by managed care. Indeed, the prevalence of managed care arrangements in Minnesota and around the country may have facilitated the adoption of parity laws in many states because the financial impact of parity laws under managed care is minimal.

Although parity laws were designed to improve access to behavioral health treatment, the research studies we have reviewed suggest that parity laws have not been significantly effective in promoting access to behavioral health services under managed care. One study looked at parity laws in 18 states (including Minnesota) that enacted parity laws between 1993 and 1998, and found that states with parity laws have *lower* rates of utilization of mental health care services than other states. They also found no measurable effect on utilization in the states that enacted parity laws.[11] Another study concludes that parity laws will have far less impact than benefit mandates enacted in the 1970s and 1980s in a system dominated by indemnity plans and may have little direct effect on how care is delivered under managed care.[12]

Finally, the SAMHSA study also asked respondents in several states, including Minnesota, about the effect of the parity laws on public mental health and chemical dependency expenditures.[13] Nearly all respondents reported no changes in state spending as a result of parity. One reason given was that publicly financed services are provided primarily to people who have serious mental illnesses or substance abuse disorders, most of whom are not covered by private insurance and thus not affected by parity. Also, private insurance does not typically cover many of the social services frequently needed by people with a chronic mental illness.

The federal parity law applies to self-insured plans in Minnesota.

Effectiveness of the Federal Mental Health Parity Act

As noted, the federal parity law prohibits annual or lifetime dollar limits on mental health coverage that are more restrictive than those imposed on medical coverage. Because the federal act has a much narrower scope than the Minnesota parity law, its effect in Minnesota is restricted to self-insured plans that are not regulated by the state. However, self-insured plans cover about 34 percent of the Minnesota population, so it is of some interest what research studies say about the impact of the federal law.

11 Roland Sturm and Rosalie Liccardo Pacula, "State Mental Health Parity Laws: Cause or Consequence of Differences in Use?," *Health Affairs,* Vol. 18, No. 5, 182-192.

12 Richard G. Frank and Thomas G. McGuire, Parity for Mental Health and Substance Abuse Care under Managed Care, Working Paper 6838, National Bureau of Economic Research, Cambridge, MA, December 1998, 15.

13 These informants include state officials, insurers, providers and consumer advocates in Maryland, Minnesota, New Hampshire, Rhode Island, and Texas.

The most recent information on the effect of the federal parity law comes from a May 2000 study by the General Accounting Office.[14] The study looked at compliance with the parity law and the law's effect on the cost of claims in states that did not have parity laws more comprehensive than the federal act.[15] Among other things, the study found:

- Health insurance plans significantly reduced the use of dollar limits for mental health coverage, although about 14 percent of plans were non-compliant with the federal law.
- Although most plans complied with the parity law, 84 percent of compliant plans contain at least one feature that is more restrictive for mental health benefits than for other health benefits.
- The law had a negligible effect on the cost of claims.

The General Accounting Office surveyed 1,656 employers that had more than 50 employees and that offered mental health benefits. Evidence of non-compliance with the federal act was based on voluntary reports by employers, so the finding that 14 percent of plans were non-compliant may understate the true number. About 60 percent of the employers surveyed reported that they did not know whether compliance with the law increased costs, 37 percent reported that compliance had not raised costs, while only 3 percent said that claims' costs increased as a result of the act. The survey findings should be viewed carefully given that 60 percent of respondents were uncertain about the effect of the parity law on their insurance costs. Nevertheless, the study's finding that the parity law has a minimal effect on costs is consistent with the other research reviewed here.

A recent study of the federal law shows only a small impact on benefits or costs.

Mental health advocates in Minnesota hoped and expected that state and federal parity laws would increase spending on mental health and chemical dependency services and utilization of behavioral health services. Advocates have expressed disappointment at the trend of relatively slow growth in behavioral health services. Despite the fact that Minnesota enacted a strong parity law, the removal of contractual limitations on behavioral health services here and elsewhere has not resulted in major changes since most health coverage is provided through managed care plans.

14 U. S. General Accounting Office, *Implementation of the Mental Health Parity Act of 1996*, (Washington D.C., May 2000).

15 The study examined 26 states and the District of Columbia. Since Minnesota has one of the strongest parity laws in the nation, it was not included in the GAO survey.