Evaluation Report Summary: PE01-04a

OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

Insurance for Behavioral Health Care

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Major Findings:

- Public health experts contend that there are significant unmet needs for mental health and chemical dependency services.

There is great uncertainty over private and governmental responsibility for behavioral health care.

- National studies agree that behavioral health spending by insurers has declined relative to overall health spending, but differ on the size of the decline.
- Limited Minnesota data suggest that behavioral health spending by insurers has increased faster than inflation in recent years, though it has declined slightly relative to overall health spending.
- Studies agree that managed care helps control behavioral health costs, but evidence of managed care's effect on the quality of care is mixed.
- Managed care has the potential to improve care by implementing standards of care, but it risks underserving those in need of care because of its incentive to reduce costs.
- Minnesota HMOs perform slightly above the national average on two quality indicators for mental health, but there is considerable room for improvement.
- The Minnesota mental health parity law has removed unequal limitations on behavioral health services from insurance plans, but has had relatively little effect on services actually provided.
- There is anecdotal evidence from providers and consumers that health plans are inappropriately denying financial responsibility for behavioral health treatment, but there is no adequate way to measure the incidence of such behavior.
- Inadequate information systems maintained by state agencies limit the usefulness of consumer complaint data for monitoring health plan problems.
- There is a high potential for disputes over insurance coverage for behavioral health services. Conflicts can arise over what constitutes appropriate treatment and over whether government or private insurance should pay for certain services.
- The incidence of complaints about mental health and chemical dependency coverage is relatively low, as is the incidence for general health insurance coverage issues.

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Report Summary

The need for mental health and chemical dependency services is widespread.

Two key trends have shaped the nation's behavioral health care system during the last half century. The public mental health system has changed from institutionalized care to a highly decentralized community-based system. Second, public and private insurance coverage of behavioral health has expanded greatly over the last 40 years.

The U.S. Surgeon General, using a broad definition of mental illness, recently estimated that 28 percent of Americans have a mental or addictive disorder in a one year period, of which only one-third receives behavioral health care. Although many of these disorders are mild conditions that may not require treatment, public health experts contend that there are significant unmet needs for behavioral health care. Mental health advocates believe that the growth of managed care has aggravated this problem by denying coverage for needed care.

Studies Disagree Over How Much Behavioral Health Spending Has Declined Relative to General Health Spending

A national report by the HayGroup estimated that the cost of behavioral health benefits offered by medium and large employers declined between 1988 and 1998 from 6.1 percent to 3.2 percent of overall health benefits. But a comprehensive national study conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) raises doubts about the magnitude of the decline found by the HayGroup study. The SAMHSA study concluded that behavioral health spending by private insurers declined as a percentage of overall health spending from 6.6 percent in 1987 to 5.6 percent in 1997—only one-third as much as was found by the HayGroup study. One reason for the difference was that the HayGroup study did not include spending on prescription drugs, a large and growing component of behavioral health spending. The SAMHSA study also found that behavioral health spending increased faster than inflation during this period.

In Minnesota, Behavioral Health Spending Has Risen Faster than Inflation, but Slightly Slower than General Health Spending

We surveyed five health insurers that together account for over 80 percent of the commercial health insurance market. Between 1997 and 1999, these insurers increased behavioral health spending from $6.99 to $7.96 per member month, after adjusting for inflation. When measured as a percent of overall health spending, behavioral health spending declined slightly from 5.5 percent in 1997 to 5.3 percent in 1999. Health Department data also suggest that there was not a substantial decline in spending between 1994 and 1997.

Government spending on behavioral health has increased faster than inflation during the last decade. Public mental health spending appears to have increased about as fast as overall health spending, but public chemical dependency spending grew more slowly.

Managed Care Helps Control Costs, but Little Is Known About Its Effect on the Quality of Care

Several case studies and a health insurance experiment indicate that managed care helps control behavioral health spending. In addition, some studies suggest that managed care curtails behavioral health spending more than general health spending.

Managed care is a double-edged sword for behavioral health care. It can improve the effectiveness of care, but introduce an incentive to underserve.

There is debate, however, on whether these reductions are appropriate. Critics of managed care contend that spending reductions reflect inappropriate service cuts, inadequate reimbursement, and cost shifting to public safety-net providers. Managed care proponents counter that managed care reduces costs by challenging ineffective practices and improves the quality of care by increasing compliance with professional standards.

There are respected studies supporting both points of view, suggesting that managed care is not inherently good or bad. The performance of managed care depends on a variety of factors, including the quality of the staff and the degree to which the organization shares a mission to improve health care practices as opposed to merely cutting costs.

Minnesota HMOs perform slightly above the national average on the two effectiveness indicators for mental health developed by a national accrediting organization for HMOs: (1) follow-up care for patients who were hospitalized for mental illness and (2) anti-depressant medication management. However, there is considerable room for improvement. For example, 49 percent of Minnesota's HMO patients who were hospitalized for mental illness received follow-up care within 7 days of discharge, only one percentage point above the national average (48 percent).

The Parity Law Has Had Relatively Little Effect on the Use of Behavioral Health Services

Minnesota enacted a mental health parity law in 1995 that is among the strongest in the nation. The Minnesota parity law prohibits limits on behavioral health insurance coverage that are more restrictive than those applying to other comparable health services. Types of limits covered by the parity law include deductibles, co-payments, and maximum allowable office visits.

Minnesota's parity law has removed unequal contractual provisions, but managed care controls usage primarily by assessing effectiveness and medical necessity rather than imposing contractual limits. As a result, the prevalence of managed care in Minnesota limits the impact of the parity law. National studies indicate that parity laws could have a substantial impact under traditional fee-for-service plans, but do not greatly increase spending under managed care plans.

Another reason for the limited effect of parity laws is that Minnesota's law does not apply to self-insured plans, which cover about 37 percent of Minnesota's population. Under federal law, only the federal government may regulate self-insured plans and the federal parity law is much weaker than Minnesota's law.

Relatively Few Consumers Complain About Behavioral Health Insurance or General Health Insurance

Consumers have several ways to resolve disputes with health insurance companies. State and federal laws require that HMOs, insurance companies, and self-insured employers operate an internal complaint and appeal process. In addition, the departments of Health, Commerce, and Human Services investigate complaints by enrollees of HMOs, other commercial health plans, and certain public plans, respectively. A new state law allows health plan enrollees to obtain an external review of adverse health plan decisions by an arbitrator independent of health plans or

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state agencies. Finally, the Ombudsman for Mental Health and Mental Retardation, a separate state agency, helps individuals and families deal with health plans and state agencies.

State agency information systems do not provide an accurate or useful view of the types of consumer complaints. The codes used to classify complaints do not effectively capture the subject or outcome of complaints.

It appears that the overall incidence of health insurance complaints in Minnesota is fairly low, as is the incidence of complaints relating to behavioral health. Our manual review of Department of Health complaint investigations revealed that about 6 percent involved behavioral health coverage. Our review of complaint outcomes shows that the position of the complainant was upheld in a significant number of cases, suggesting that health plan companies could do better.

We Were Unable to Measure the Extent of Cost Shifting

Providers and consumer representatives, including members of the State Advisory Council on Mental Health, argue that health plan companies inappropriately deny coverage of behavioral health services. They provided examples of tactical delays, burdensome paperwork requirements, and denial of coverage based on consideration of the effectiveness or necessity of care. When insurers deny coverage, safety-net providers such as state and county funded clinics are required to finance services with other revenue sources. These concerns deserve serious consideration because they are widely expressed and believed. But we were unable to obtain data or design a methodology that would allow us to estimate the extent to which inappropriate cost shifting takes place.

The full evaluation report, *Insurance for Behavioral Health Care* (#pe01-04), including the agency responses, is available at 651/296-4708 or:

www.auditor.leg.state.mn.us/ped/2001/pe0104.htm

Summary of Agency Responses:

In a letter dated February 1, 2001, Commissioner of Health Jan K. Malcolm said, "The report offers an informative review of trends in the use of mental health service . . . and how the increased prevalence of managed care has affected the use of mental health services." She also said, "Ensuring that Minnesotans receive mental health services when they are needed is a significant and important public health challenge." "As this report notes, we currently have very limited information on the quality of mental health care. However, the information that we do have suggests that there is substantial room for improvement."

Responding for the Department of Commerce, Health Care Policy Director John Gross said: "The Department of Commerce finds the legislative auditor's report to be very informative and educational." He also said " . . . mental health and chemical dependency services have to be improved within the state of Minnesota." "It is unfortunate, but many consumers and medical providers are not aware of the departments of Health, Human Service, and Commerce role in protecting Minnesota residents . . . . With more awareness of our department's roles, improvement will be made for the individuals in need of adequate treatment . . . ."