62J.26 Evaluation of SF 184

Report to the Minnesota Legislature

10/29/2019

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As requested by Minnesota Statute 3.197, no additional costs were incurred in preparing this report.

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Contents

Introduction

Senate File (SF) 184 was introduced during the regular session of the 2019 Minnesota Legislature. It amends Minnesota Statutes, §62Q.47, requiring health plans to eliminate cost-sharing requirements for an enrollee's first four mental health visits during a contract year. The Minnesota Department of Commerce was requested to evaluate SF184 pursuant to requirements in Minnesota Statutes 2019, §62J.26. [1]

The Department has evaluated SF184 according to the criteria listed in Minnesota law. The report provides analysis of the health benefit proposal and its potential public health, economic and fiscal impacts. The report also assesses the extent to which the services in the proposal are already utilized by the population, how coverage is already provided and to what extent the proposal will increase or decrease the costs of service.

This report utilizes data from a number of sources, including the Kaiser Family Foundation, Milliman, Substance Abuse and Mental Health Services Foundation (SAMHSA), the State Health Access Data Assistance Center (SHADAC) and the Agency for Healthcare Research and Quality (AHRQ). Commerce also solicited feedback from the general public, producing a request for information (RFI) for comments on the proposal.

To provide context for the evaluation, this report provides a brief legislative history regarding this proposal and other relevant policy, background information on health insurance coverage, health insurance regulation at the state and federal level and a summary of mental health care in the state and nationwide.

This report summarizes comments received from the distributed RFI and will respond to the substance of the comments based on the Department's evaluation of the proposal. All responses to the RFI are included in the Appendix section of the report. Personal information has been redacted from all comments for the privacy of the commenter.

The Department finds that the coverage proposed in SF184 is generally available to Minnesotans as part of a standard benefit set and therefore would not constitute a new health benefit mandate as understood under the Affordable Care Act (ACA) §1311 (d)(3)). The proposal may have public health and cost benefits for Minnesotans who obtain health coverage in state-regulated insurance markets. The proposal also may impact the design and future use of certain health products such as Health Savings Accounts or Flexible Spending Accounts that are often features of high deductible health plans.

State Mental Health Parity Requirements

Minnesota Statutes §62Q.47 was added to Minnesota law in 1995, establishing parity requirements for health plans already providing mental health and substance use disorder coverage in the state. The parity requirements stipulated that no greater financial burden could be placed on cost-sharing requirements for these services than those placed on other health services. The statute precedes federal parity requirements and was amended in

[1] Minnesota Statutes 2019, Section 62J.26, Subd. 2.

2008, 2013, 2016 and 2019.[2] The 2008 amendment added alcoholism directly to the statute when referring to substance use disorder treatment. The 2013 amendment added language incorporating requirements of the Federal Mental Health Parity Act of 1996, as well as the more comprehensive Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. Revisions made to 62Q.47 in 2016 included minor updates to existing Minnesota Rules and did not change the intent of the statute.

The 2019 changes required health plans to treat outpatient mental health and medication management services the same as medical primary care. Primary care can be broken down into care for illness, and primary care for prevention. Preventive primary care is reimbursed at 100 percent, meaning that the enrollee generally does not have to pay out of pocket for these services. It includes a specific set of services that are typically performed on a annual basis. Primary care for treatment of illness would include non-complex care to address less severe ailments. For example, if a child visits a pediatrician for a fever and cold, this would be considered primary care for the treatment of illness. This level of care is generally subject to enrollee cost-sharing. The 2019 update to Minn. Stat. §62Q.47 is separate and distinct from the evaluation on SF184.

In addition to Minn. Stat. §62Q.47, Minnesota has a number of other laws that impact coverage of mental health and substance use disorder services, including Minn. Stat. §§62A.149, 62A.151, 62A.152, 62Q.137, 62Q.471, 62Q.527, 62Q.53 and 62Q.535. Minnesota law in this area includes: prohibition of discrimination based on provider type, mandated coverage for residential treatment for children, required coverage for non-formulary antipsychotic medications and establishment of a minimum definition of medically necessary care for behavioral health services. Minnesota statutes both supplement and reinforce federal parity requirements.

Legislative History

Senate File 184 was introduced on January 17, 2019 as a proposal to amend Minn. Stat. §62Q.47 adding new cost-sharing requirements for mental health services. Specifically, the cost-sharing requirements would require regulated health plans to provide full coverage for the first four outpatient mental health visits per contract year per enrollee. Any cost-sharing requirements for the enrollee, including deductible, copayment, or coinsurance, would be delayed until after the fourth outpatient mental health visit. The coverage proposal is limited only to mental health services received by enrollees from providers in their health plan network.

The bill was referred to the Commerce and Consumer Protection Finance and Policy Committee after its first reading. No further action was taken on SF184 in the Minnesota Senate beyond the request for evaluation to Commerce.

[2] Minnesota Statutes 2019, section 62Q.47, online.

Federal Mental Health Parity Requirements

The Mental Health Parity Act of 1996 was the first major piece of federal legislation aimed at improving coverage of mental health services for individuals enrolled on employer health plans.[3] The act specifically required that group health plans provide parity on the application of aggregate lifetime and annual dollar limits. As an example, employers were not permitted to include lifetime dollar limits on mental health services that would be lower than those applied to medical/surgical benefits. The act had limited applicability and did not include any requirements for substance use disorder services.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 supersedes requirements established by the Mental Health Parity Act of 1996.[4] MHPAEA expanded on the requirements established in the 1996 Act and extended parity to substance use disorder treatment. MHPEA does not mandate coverage of mental health and substance use disorder treatment, but requires that health plans offering these services do so at parity to medical and surgical services.

MHPAEA protections apply to most commercial health plans. Originally, MHPAEA requirements only extended to most large group health plans but were expanded to include individual and small group as a result of the Affordable Care Act (ACA). The ACA mandates coverage of Essential Health Benefits (EHB), which include services and items in 10 specific categories, as well as mental health and substance use disorders.[5] Including these services as an EHB ensures that plans providing EHBs must be compliant with MHPAEA as well.

MHPAEA protections address financial and quantitative treatment limitations (QTLs) and non-quantitative treatment limitations (NQTLs). Financial requirements and QTLs extend to numerically quantifiable items within a health plan, such as copayments for services, deductibles, out-of-pocket limitations and visit limits or restrictions for certain services. NQTLs include items that cannot be quantified numerically, but still have an effect of limiting coverage. Examples of NQTLs include design of a provider network, items included on a prescription drug list and requirements of medical necessity and prior authorization. Final rules adopted in 2013 solidified compliance requirements regarding these parts of MHPAEA.[6]

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[3] Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2874, H.R. 3666, 104th Cong. (1996) (amending 29 USC 1185a; 42 USC 300gg-5). Accessed at https://www.govinfo.gov/content/pkg/PLAW-104publ204/html/PLAW-104publ204.htm.

[4] Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Pub. L. No. 110-343, 122 Stat. 3765, H.R. 1424, 110th Cong. (2008) (amending 29 USC 1185a; 42 USC 300gg-5; 26 USC § 9812). Accessed at https://www.congress.gov/bill/110th-congress/house-bill/1424/text.

[5] "Information on Essential Health Benefits (EHB) Benchmark Plans." CMS.gov Centers for Medicare & Medicaid Services. The Center for Consumer Information & Insurance Oversight, July 19, 2019. https://www.cms.gov/cciio/resources/data-resources/ehb.html.

[6] Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. 78 Fed. Reg. 682 (Nov. 13, 2013). Accessed at https://www.govinfo.gov/content/pkg/FR-2013-11-13/pdf/2013-27086.pdf.

Minnesota Health Insurance Coverage

A majority of Minnesotans receive their health insurance through employer group health plans (see fig. 1). Employer group health plans include self-funded plans, large group fully insured plans and small employer plans. Self-funded plans are those in which the employer assumes financial risk for their employees' claims. Self-funded plans may choose to act as both a fiduciary and the plan sponsor by accepting financial risk for claims and by performing administrative functions related to claims payment and review. Many self-funded employer plans are managed by third party administrators (TPAs) who perform required administrative functions in exchange for a fee.

Fully insured large group plans include more than 50 eligible full-time employees, but they do not assume financial risk for employee claims. Instead, the employer pays a premium to a health insurance company for coverage of employees. Employees pay a portion of the premium through payroll deductions. Small employee plans include 50 or fewer eligible employees obtaining coverage in the same manner as fully insured large group plans. Nearly 60 percent of the insured population in the state receives coverage through employer-based coverage.

Approximately five percent of Minnesota residents are covered under individual health plans.[7] The remainder of the covered population receives coverage through government programs such as Medicare, Medicaid, MinnesotaCare or TRICARE, or through plans that pre-date the ACA requirements (also known as grandfathered plans). Approximately four to five percent of Minnesotans are uninsured.[8]

Individual health plans, small group and large group plans that are not self-funded represent the fully insured market in Minnesota. The Departments of Commerce and Health have regulatory authority over the fully insured market, which represents approximately 30 percent of covered individuals in the state. The proposed benefit requirement under SF184 impacts only state-regulated insurance markets.

The scope of Commerce's authority over the fully insured market applies to major medical policies of individual, small group and large group plans. Commerce also regulates student health plans and certain joint self-insurance employee health plans. Commerce's authority includes review of submitted rates and forms for compliance with state and federal law.

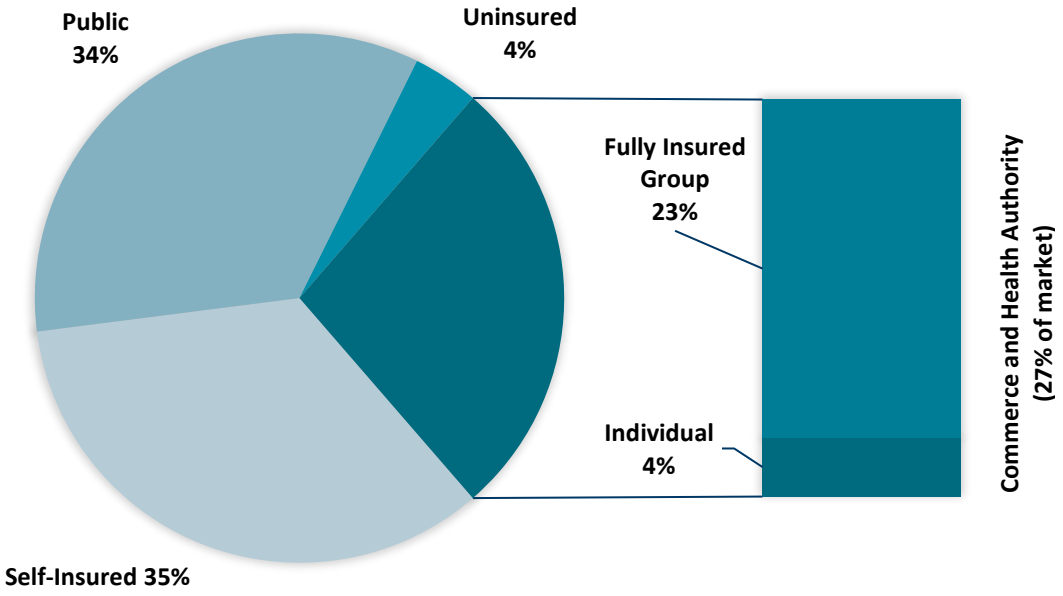
The Department of Health regulates health maintenance organizations (HMOs) and county-based purchasers (CBPs). The Department of Health also reviews health plan network adequacy, as well as Essential Community Provider (ECP) Requirements. The Departments of Commerce and Health work jointly to review health insurance

[7] Shop and Compare. MNSure: Where you choose health coverage. https://www.mnsure.org/shop-compare/index.jsp.

[8] Section 1332 Innovation Waiver: Public Meeting Presentation. Insurance Division, Minnesota Department of Commerce. June 1, 2018. Accessed at http://mn.gov/commerce-stat/pdfs/1332-waiver-presentation.pdf.

filings to ensure compliance with requirements established by the ACA, MHPAEA and other applicable state and federal laws.

Figure 1: Scope of Regulatory Authority for Departments of Commerce and Health



Paying for Healthcare Services

How Minnesotans pay for their health care depends on how they are covered. Most major medical plans cover inpatient and outpatient services, as well as pharmacy and mental health services. The specific benefit set available to Minnesotans, and the costs of those benefits through premiums and cost sharing vary by market. Recent data indicate that more than half of Minnesotans on employer health plans and nearly half of individual market enrollees are covered under a High Deductible Health Plan (HDHP).[9] HDHP requirements are established by the Internal Revenue Service (IRS) and must include a deductible of at least $1,400 per individual per contract year, with a maximum out-of-pocket limit not exceeding established upper limits set at the federal level.[10]

[9] Chartbook Section 4 - Individual and Small Group Health Insurance Markets. Health Economics Program, Minnesota Department of Health. July 11, 2019. Accessed at https://www.health.state.mn.us/data/economics/chartbook/docs/section4.pdf.

[10] Internal Revenue Bulletin 2019-22. United States. Department of Treasury. Internal Revenue Service, 2019. Accessed at https://www.irs.gov/irb/2019-22_IRB#REV-PROC-2019-25.

High Deductible Health Plans must meet the definition established under the ACA and by the IRS, and enrollees of HDHPs are eligible to enroll in a consumer spending account to cover medical expenses, including Flexible Spending Accounts (FSAs) or Health Savings Accounts (HSAs). Coverage standards established for HDHPs are mandatory in order to have an FSA or HSA.

To maintain status as an HDHP, plans must not provide coverage for items before the deductible is reached, with the exception of preventive health care services. Full lists of eligible preventive services that may be covered before the deductible are published by the IRS, Social Security Administration (SSA), the United States Preventive Services Task Force (USPSTF) and the Health Resources Service Administration (HRSA).

Mental Health Care in Minnesota

The current state of mental health care in Minnesota suggests that the state has lower prevalence of mental illness and better access to treatment.[11] Mental health status in Minnesota is overall above average, but problematic barriers to accessing care remain, especially in Greater Minnesota.[12]

The prevalence of any mental illness among Minnesotans is expected to be approximately 18 percent.[13] Serious mental illness, such as bipolar disorder, borderline depression and schizophrenia are estimated to impact about four percent of Minnesotans.

Minnesotans living in the Twin Cities metro area and surrounding counties are much more likely than Minnesotans living in rural counties to have access to mental health services. Ramsey County has the most mental health practitioners per capita at 260 individuals in the county for every one mental health practitioner. Benton County, on the other hand, has a ratio of 13,310 individuals for every mental health practitioner.

Analysis of Proposed Health Benefit Proposal

After analysis, Commerce assumes that SF184 would not constitute a health benefit mandate as understood under the ACA § 1311 (d)(3)). This section specifically states that states are required to defray health plan costs associated with new state-mandated benefits in excess of essential health benefit (EHB) requirements. Senate

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[11] Minnesota -- 2019 County Health Rankings Report. County Health Rankings, Robert Wood Johnson Foundation. Accessed at https://www.countyhealthrankings.org/sites/default/files/state/downloads/CHR2019_MN.pdf.

[12] 2017 Minnesota Statewide Health Assessment. Center for Public Health Practice, Minnesota Department of Health. Accessed at https://www.health.state.mn.us/communities/practice/healthymnpartnership/docs/2017MNStatewideHealthAssessment.pdf.

[13] 2016-2017 National Survey on Drug Use and Health: Model-Based Prevalence Estimates. Substance Abuse and Mental Health Services Administration, U.S. Department of Health & Human Services. Accessed at https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHsaePercentsExcelCSVs2017/NSDUHsaePercents2017.pdf.

File 184 changes cost-sharing requirements for services covered within an established benefit package; it does not impose a new requirement for coverage of specific care, treatment, or services not already being covered by insurers.

Consequently, Commerce assumes that the State would not incur fiscal costs associated with SF184. Health insurers would provide coverage consistent with the proposal, but the State is not required to defray the insurers' cost of providing the coverage.

Senate File 184 would allow individuals to access mental health care at a lower upfront cost, improving utilization of mental health services for some individuals. The proposal may have a minimal increase on enrollee premiums. It may negatively impact those enrolled on HDHPs, potentially jeopardizing enrollment in FSAs or HSAs. Consistent with requirements for evaluation under Minn. Stat. §62J.26, Subdivision 2, this evaluation will address potential impact of the health benefit proposal related to:

1. Scientific and medical information, and the potential for harm or benefit to the patient;
2. Public health, economic, and fiscal impacts of the proposal on Minnesotans; the relative cost-effectiveness of the benefit on the health care system;
3. The extent to which the service is utilized by the population;
4. The extent to which insurance coverage for the proposal is already generally available;
5. The extent to which the proposal will increase or decrease the cost of service.

Potential for Harm or Benefit

The proposal requires health plans to charge no cost-sharing requirements for their enrollees' first four outpatient mental health visits in a contract year. It does not require coverage of a new treatment or service for which additional scientific or medical analysis is needed. Most health plans must already cover outpatient mental health treatment, and are required to provide coverage for care that is both medically necessary and considered standard by the professional community.[14] The Department did not identify any foreseeable harms to individual or population health based on this proposal.

Public Health, Economic, and Fiscal Impact

Public Health

For the approximately 30 percent of the covered population in Minnesota, there would be a potential for increased access to care, representing a benefit to public health.

The continuum of care for mental health treatment ranges from basic clinical services or early intervention, to inpatient or residential treatment for serious conditions. Senate File 184 would require coverage for outpatient

[14] The Mental Health Parity and Addiction Equity Act (MHPAEA). The Center for Consumer Information & Insurance Oversight, The Centers for Medicare and Medicaid Services. Accessed at https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html.

mental health services, which typically would include clinic-based services to address conditions not requiring higher levels of supervision, or where there is immediate risk of harm to the individual's health. Services in this area could include office-visits with a therapist but could also include outpatient services in a hospital setting, where the patient returns home after a visit and is not held overnight, or follow-up care on eating disorder treatment.

It is estimated that 50 percent of adults in Minnesota with a mental health diagnosis end up seeking counseling or treatment.[15] The cost of receiving treatment is considered to be a major barrier to accessing care. Thus, if more Minnesotans may receive coverage for mental health treatment while delaying use of their cost-sharing requirements under their health plan, they may access more care.

Economic and Fiscal

The Department assesses the economic and fiscal impact of the proposal to be minimal to the health care system overall, with no foreseeable cost-increase for consumers and a potential range of increases to the system.

The Department also assumes SF184 would not have a fiscal impact for the State. This determination is based on a number of assumptions. First, the regulation of the benefit would be overseen by the Departments of Commerce and Health as part of the regular review of forms and rates from health insurers. This regulatory activity is already a part of the Departments' normal functions and the bill would not necessitate new staff to accommodate reviewing for form filings and rates for compliance.

Second, Commerce assumes SF184 would not be considered a new mandate of coverage as understood by Section 1311(d)(3)(B) of the Affordable Care Act (ACA). This section of the ACA requires states to defray costs of new benefit mandates that impact the individual and small group market EHB package. Benefits for mental health services already exist under EHBs and this proposal alters the cost-sharing structure of the benefit.

The overall impact to the health care system is limited to outpatient mental health care specifically, and does not appear to address substance use disorder treatment.

Minnesota Management and Budget (MMB) has evaluated a number of mental health treatment modalities delivered in an outpatient setting. MMB's analysis concluded that commonly utilized outpatient mental health treatment modalities were cost-effective, providing return on investment in terms of health care spending.[16]

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[15] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Minnesota, 2015. HHS Publication No. SMA–16–Baro–2015–MN. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

[16] Adult Mental Health. Minnesota Management and Budget, 2019. https://mn.gov/mmb/results-first/adult-mental-health/#header

Most plans, consistent with MHPAEA requirements, already provide coverage for outpatient mental health services. Plans vary in their coverage of outpatient mental health treatment, requiring some form of cost-sharing usually. Consumers would expect a reduction in upfront spending as a result of the proposal, lessening the fiscal impact on them.

The cost of outpatient mental health care is lower than that of comparable physical health care. Minnesota Community Measurement Data shows that the average 45 minute psychotherapy session in Minnesota costs $119, while an office visit as a new patient for medical or surgical care averages $371 per visit.[17] The average cost of a preventive care visit (depending on age) ranges from $193 to $311. In addition, mental health services represent less than five percent of total healthcare spending in the state.

The Department assumes that there would be a range of increases in cost to the health care system, shifting cost from an individual consumer to the insurer. The increase is based on the general prevalence of mental health conditions in an insurer's population and the extent to which individuals access that care.

The extent to which a coverage requirement increases health plan rates is contingent on a number of variables including:

- Prevalence of mental illness diagnoses in the state
- Expected utilization of outpatient mental health care
- Frequency of utilization of outpatient mental health care
- Average cost of outpatient mental health care per visit
- Existing claim experience based on enrollee population

There is no one source of data that captures all of the information above. As such, determining fiscal impact at an insurer level requires analysis of multiple data sources. At an insurer level, it is possible to project financial impact of a proposed benefit by assessing past claims history of existing enrollees. Not all insurers have an enrollee population that fully reflects the general population, so it is necessary to provide analysis using multiple data sources on a national and state level.

The Department estimates there could be a range of impact on premiums on a per member per month (PMPM) basis for health insurers based on analysis of data from state and national levels. It is unlikely that the implementation of this proposed benefit would increase premiums PMPM for individual market plans. The likelihood of a PMPM increase is even smaller for group plans. Our estimate is not based on a formal actuarial analysis but does use methodology that reasonably predicts cost impacts based on multiple sets of data.

The Department utilized data from a number of sources to guide its assumptions on cost increases for health insurers, consistent with the variables listed above to determine cost to the health care system. Data from Milliman and the Centers for Medicare and Medicaid Services (CMS) aided Commerce's projection of utilization

[17] Health Care Cost & Utilization: 2018 Report. Nelson, Gunnar. Scholz, Natalie. 2018 Minnesota Community Measurement Data. Accessed at https://mncm.org/wp-content/uploads/2018/11/mncm-cost-report-2018.pdf.

and cost of outpatient mental health services relative to PMPM. These resources utilize national claims data to provide projected utilization of certain services relative to cost.

The Department utilized overall experience in the individual market in this instance to calculate projected costs. 155,000 enrollees were estimated to be in the individual market in the previous year. The insurer with the largest share of the individual market had approximately 55,000 enrollees. This figure will be the baseline for determining cost in the example.

A combination of data from Milliman and CMS indicates that approximately six percent of total enrollees in aggregate data receive multiple outpatient mental health visits, or at least incur claims in the amount of the average expected amount of four outpatient mental health visits. This calibrates some of our assumptions.

Data indicate that over 75 percent of individual market enrollees in Minnesota have a health plan with an annual deductible over $1,250.[18] The proportion of individuals enrolled in high deductible plans has trended upward over time.[19] The cost of four outpatient mental health visits, on average, would be approximately $540, or less than half of a $1,250 deductible. The Department's analysis assumes an above-average cost of $135 for an outpatient mental health visit. The Department assumes that most individuals would be responsible for the full amount of allowed charges for all four visits because the total cost of those four visits would not exceed a typical individual market deductible.

The Department's analysis produced a range of potential expected costs on a PMPM basis:

Total Premiums Received:		$198,000,000
Total Allowed Claims:		$178,200,000
Total Member Months (12-month period):		660,000
Number of Mental Health Patients		
Projected Number of Enrollees:		55,000
Estimated Prevalence of MH Diagnosis:	x	20%
Number of Enrollees with MH Diagnosis		**11,000**
Estimated Cost of Mental Health Treatment		
Number of Enrollees with MH Diagnosis:		11,000
Percent receiving treatment:	x	50%
Estimated Cost of one 45 min. MH Visit:	x	$135
Benefit Proposal	x	4

[18] Chartbook Section 4 – Individual and Small Group Health Insurance Markets. Health Economics Program, Minnesota Department of Health. July 11, 2019. Accessed at https://www.health.state.mn.us/data/economics/chartbook/docs/section4.pdf.

[19] Minnesota Health Care Spending: 2015 and 2016 Estimates and Ten-Year Projections. Health Economics Program, Minnesota Department of Health. February, 2019. Accessed at https://www.leg.state.mn.us/docs/2019/mandated/190366.pdf

Estimated Total Cost of MH Treatment:	$2,970,000
Estimated PMPM Cost	**$4.50**

These assumptions produce a PMPM that represents the high end of expected costs if SF184 became law, and if every single enrollee with a mental health diagnosis accessing care received four visits. Adjusting for the expected frequency of individuals receiving four or more visits, the PMPM would be expected to be lower.

The following example projects a scenario using the same assumptions above but adjusted for a reduction in visit numbers received by members. In this scenario, Commerce assumes the same visit cost, but adjusts the expected number of individuals who will use four or more outpatient mental health visits to 10 percent:

Estimated Cost of Mental Health Treatment

Number of Enrollees with MH Diagnosis:		11,000
Percent receiving treatment:	x	50%
Percent receiving more than 4 visits:	x	10%
Estimated Cost of one 45 min. MH Visit:	x	$135
Benefit Proposal	x	4
Estimated Total Cost of MH Treatment:		$297,000
Estimated PMPM Cost		**$0.45**

This calculation represents the low end of expected costs. It significantly reduces the PMPM because it calculates a proportion of another proportion in estimating cost. Based on Commerce's analysis, the likelihood of increased PMPM is expected to be less than $4.50 and likely more than 45 cents.

Current Utilization of Services

The current utilization of outpatient mental health services in the general population is estimated to be low. As indicated, the prevalence of individuals diagnosed with mental illness in Minnesota is approximately 20 percent. Of the 20 percent impacted, it is estimated that 50 percent receive some type of treatment.[20] It is unclear how many of those that have received treatment have had more than one visit.

Mental health delivered in an outpatient setting can specifically include:

- Cognitive Behavioral Therapy for anxiety, depression and PTSD
- Dialectical Behavioral Therapy for depression, anxiety and other behavioral conditions
- Mental health medication management
- Co-occurring Dual Diagnosis Treatment

[20] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Minnesota, 2015. HHS Publication No. SMA–16–Baro–2015–MN. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015.

Based on available data, outpatient mental health services are not highly utilized by a significant portion of the population. This conclusion is supported by the generally low prevalence of mental illness in the state, the extent to which that population access care in general, and the assumption that not all individuals seeking treatment have multiple outpatient visits.

The actual availability of outpatient mental health services in Minnesota in general can impact its utilization. This point must be considered when assessing projected use of the services in the state. The physical availability of mental health providers in Minnesota is a factor driving overall utilization. As previously stated, the number of mental health providers in Greater Minnesota, relative to the population, is very low. This ratio has an impact on overall utilization of the services. It is possible that SF184 may increase utilization of outpatient mental health services, but it is not clear to what extent.

Current Coverage Availability for the Proposed Benefit

Coverage for outpatient mental health services is available to most Minnesotans with health insurance. Because of the ACA, mental health services are a required to be covered by plans offering essential health benefits (EHBs). EHBs must be offered by individual and small group plans, subjecting them to requirements established under MHPAEA. Most group plans in Minnesota also provide coverage for outpatient mental health services.

Health plans vary in their coverage level of outpatient mental health services, and most plans will have a general form of cost-sharing required for outpatient services. Cost-sharing can include applying charges to a deductible, assessing a form of coinsurance, or requiring a set copayment per visit.

Impact on Cost of Outpatient Mental Health Services

The Department assumes that there will be no increase to cost of overall outpatient mental health services in Minnesota. The proposal alters cost-sharing requirements for enrollees, requiring insurers to reimburse network providers for the full cost of outpatient visits (less a provider discount) for the first four visits only. Outpatient mental health providers would receive their full contractual payment for the first four visits for patients under plans impacted by the proposal, but would not receive payment in excess of already established reimbursement levels. There is no indication that providers would increase the overall costs of their services as a result of the proposal.

Additional Considerations

Over half of Minnesotans with health insurance have HDHPs, which are necessary for enrollment in a FSA or a health savings account HSA. IRS rules for HDHPs specify that they may not provide coverage for any service before the deductible has been met for an enrollee. The exception to this rule includes coverage of certain preventive services identified by the federal government.[21] The IRS increased the number of items permitted to

[21] Internal Revenue Bulletin 2019-22. United States. Department of Treasury. Internal Revenue Service, 2019. Accessed at https://www.irs.gov/irb/2019-22_IRB#REV-PROC-2019-25.

be covered as preventive without tax penalty in 2019.[22] Outpatient mental health visits are not included under the normal federal list of preventive services, nor was it included in the expansion list. As a result, offering coverage for these services with no cost-sharing for enrollees could impact the status of HDHPs for Minnesotans who have them by exposing those policyholders to potential tax penalties.

Overall, enactment of SF 184 would likely result in a range of increase in cost to the health care system overall in Minnesota, while providing an enhancement to coverage and reduction of costs for individual Minnesotans. The enhancement should be considered in light of potential conflicts between this new state law and federal requirements for FSAs and HSAs.

Request for Information and Summary of Comments

The Department of Commerce published a Request for Information (RFI) on its website on August 27, 2019. Prior to its posting, the Department notified mental health advocates, policy experts, health plans, agents and brokers, MNsure and several other parties regarding the evaluation request and the posting of the RFI in order to increase the disbursement of the RFI. Commerce received 24 responses to the RFI directly from consumers and five organizational letters.

The comments provided from individuals overwhelmingly supported the need for better coverage of mental health care in the state. The majority supported the health benefit proposal and believed it would be a step in the right direction to improving mental health in Minnesota. While most supported the proposal, a small number of comments did indicate concern regarding consumer spending accounts and their status if the proposal were passed. Commerce acknowledges the possibility of HDHP plans being adversely impacted by this proposal.

One commenter requested information on how the bill language will be amended to indicate how providers are reimbursed for the four sessions. Commerce assumes SF184 would reimburse only in-network providers of outpatient mental health services. The reimbursement level for these provider is based on the provider and insurer contract. The insurer will reimburse the provider for the full claim amount for all four services, less the provider discount.

Minnesota's Chapter of the National Alliance on Mental Illness (NAMI) wrote in support of the proposal based on its potential for positive impact on increasing the ability of individuals to receive outpatient mental health care.

[22] Internal Revenue Notice 2019-45. Additional Preventive Care Benefits Permitted to be Provided by a High Deductible Health Plan Under § 223. United States. Department of Treasury. Internal Revenue Service, 2019. Accessed at https://www.irs.gov/pub/irs-drop/n-19-45.pdf.

The Minnesota Association of Health Underwriters (MAHU) and the Minnesota Council of Health Plans both submitted letters in response to the RFI indicating concerns regarding the proposal's impact on HDHPs.

The Minnesota Council of Health Plans also addressed the proposal's impact as a potential new benefit mandate under the ACA, requiring the state to defray the cost of implementing the benefit. Commerce assumes that the proposal would not represent a new benefit mandate consistent with the ACA, as the proposal restructures cost-sharing requirements for a benefit health insurers already are required to offer.

Finally, concerns were raised about the potential impact on cost for Minnesotans.

Appendix A: Individual Comments

Date: Thursday, September 19, 2019 4:28:39 PM

Attachments:MAHU Letterhead -RFI on Mental health mandate..pdf

Comments:

MAHU, response regarding Mental Health Mandates. Although the mandate would only marginally effect rates, especially if the mandate was satisfied via Telehealth. The mandate would eliminate the financial benefits of HSA accounts for all.

M·A·H·U BENEFITS PROFESSIONALS

20 September 2019

Response to impact of SF 184 on ability of Minnesotans to enroll in HSA eligible health insurance

Outpatient Mental Health visit proposal (SF184) will impact Minnesotan's ability to enroll in ACA Health Savings Account plans. SF 184 would amend existing statutes requiring health insurers to provide coverage for the first 4 outpatient mental health visit, in effect excluding Minnesotans from HSA eligible health insurance.

HSA eligible plans are not allowed to offer any 'free' primary care, telemedicine or outpatient visits before the deductible is paid. The tax favored HSA is designed to cover first dollar expenses before a policyholder meets their deductible.

Reporting from the Employee Benefit Research Institute demonstrates the popularity of HSAs is increasing with up to 33.7 policyholders and their dependents choosing eligible high deductible plans to pay their out of pocket expenses. Similar priced non-HSA eligible bronze plans typically include free telemedicine and several primary care visits before policyholders are responsible for paying their deductible.

- See IRS notice 2019-45 regarding HSA eligibility. https://www.irs.gov/pub/irs-drop/n-19-45.pdf
- To review the EBRI HSA reports click here. https://www.ebri.org/docs/default-source/ebri-issue-brief/ebri_ib_478_hsaenrollment-28mar19.pdf?sfvrsn=e86b3f2f_4

Joshua Haberman

President

MN Association of Health Underwriters

MAHU will improve its members' ability to meet the health, financial and retirement security needs of all Minnesotans through advocacy, professional development, and public education.

Date: Thursday, September 19, 2019 4:09:15 PM

Comments:

I strongly support the direction of the changes to the proposed bill. I have many family members who struggle daily with this issue and cost is a factor in deterring them from getting help. Please make it happen.

Date: Thursday, September 19, 2019 3:33:43 PM

Comments:

As a provider of mental health crisis response services in MN we see numerous clients that have private insurance and need mental health care. However due to the client's high deductible plans clients are unable or reluctant to spend limited funds.

Date: Thursday, September 19, 2019 2:47:20 PM

Comments:

I think this is a very valuable amendment and will facilitate getting needed mental health services to people who would otherwise skip getting the help due to prohibitive cost. This would also help employment.

Date: Thursday, September 19, 2019 2:38:09 PM

Comments:

I think this is a wonderful piece of legislation and that Minnesotans will feel more inclined to seek mental health support they need as a direct result of this type of coverage.

Date: Thursday, September 19, 2019 12:30:31 PM

Comments:

Will the bill include language on how the insurance companies reimburse the providers for those 4 sessions? Especially when looking at deductible plans?

Date: Thursday, September 19, 2019 12:08:12 PM

Comments:

I think that allowing people to establish care with a mental health provider will greatly reduce the wait time to see a provider. When someone is seeking mental health assistance they are already in a crisis and can not wait weeks to get connected.

Date: Thursday, September 19, 2019 11:06:12 AM

Comments:

This is an excellent idea, long overdue. Anything to help people get the mental health help they need and erase the stigma of reaching out for that help would help the problem as a whole.If issues are addressed when they are small it keeps them from

Date: Thursday, September 19, 2019 7:42:41 AM

Attachments: Mental Health legislation.docx

Comments:

I think that this proposal has many benefits for clients who are hesitant to take care of their mental health concerns which frequently result in overall higher medical costs if not addressed. There are some difficulties. See attached **[below]**

Mental Health & Substance Use Disorder Treatment

Commerce Request for Information: 62Q.47 Amendment

Overall this legislation is desperately needed. There are some considerations I would like to note. How will the 4 sessions be tracked, by payer? Is this a lifetime for 4 sessions? For example if my 2 year old gets in a car accident, needs 4 sessions of psychotherapy or 10 sessions, then at age 16 needs a few more sessions, or might need a few more sessions when she gets a 2 year old. Are the only sessions covered by this amendment the 4 she received when she was 2? This would benefit the parents but when she has her own insurance, she would not have the benefit.

If someone moves from health plan to health plan how will that be tracked?

Consider, the potential that this could be used every 2 years.

I believe that this may have a significant impact on minority populations and those who are affected by high deductible plans, which are good for individuals in a higher social economic status but not for the low to middle income who are living paycheck to paycheck.

Date: Wednesday, September 18, 2019 10:19:49 PM

Comments:

Does not affect me as I have no copay on Medica Dual solutions maepd for 65year-old+. Those with copays w[ll o.nly.be approved. Or only go to 4 visitm which may mot be enough.. Still, better than nothing I guess. If Is only $1 don't see it as signif

Date: Wednesday, September 18, 2019 2:53:02 PM

Comments:

My (private) insurance plan is not covering mental health outpatient care when it is run through tele health. But it would be covered if it was a medical appt. Please make changes so that people can get the services they need for mental health.

Date: Wednesday, September 18, 2019 2:30:47 PM

Comments:

I am writing in support of this bill and the amended language. Mental illness need to have better insurance coverage, and should be treated like primary care. Increased access to care is an investment in the well-being of our society. Long over. due.

Date: Wednesday, September 18, 2019 12:03:31 PM

Comments:

One positive impact for this proposed bill would be that clients can see a therapist, have a diagnostic assessment completed. For children, what this would mean is that they can be qualified for Children's Mental Health Case Management.

Date: Wednesday, September 18, 2019 11:13:21 AM

Comments:

We have to give people a chance to seek help. Mental health care is very important to the state of Minnesota.

Date: Wednesday, September 18, 2019 11:10:15 AM

Comments:

I believe that the real impact of this legislation will be that insurers will simply lower their rates to providers across the board. Insurers will not "eat" the cost of the elimination of copays and deductibles for 4 sessions.

Date: Wednesday, September 18, 2019 11:08:47 AM

Attachments: Publication3.pdf

Comments:

See attachment

09-18-2019

This is based on my experiences with mental health care and members of my family.

Firstly, this is a step in the right direction. Cost is a huge factor. My daughter suffers from OCD and anxiety to the point it affects her every day life, but fears the doctor bill to get the help she needs. As it usually takes several visits to hone in on the correct medication and/or get to a good spot in therapy to manage.

But, just as important, in the mental health/addiction treatment arena is access to care. Do you know that if you were to call a therapist/ psychologist/ psychiatrist for an appointment, you won't get in for at least 3 months. You get the nerve to make the first call and then find out that you have to wait so long to be seen it just exacerbates the situation. Especially for addiction treatment, when there is such a small window between them finally saying "I need to make a change" and going back to their old ways. Many never get the help they need for this reason.

I've had my son put in on a 72 hour hold. He waiting in the hospital emergency room for 3 days before they could locate a professional to assess him. The clock for the 72 hour hold doesn't begin until you've been assessed. Then they sent him an hour away to begin the 72 hour hold. Of course he was so irate by then he wouldn't cooperate. Plus - he had a bill for a 3 day stay in the emergency room!!

Date: Wednesday, September 18, 2019 11:05:08 AM

Comments:

I am totally in support of this change. In my view physical and mental health are equally important aspects of an individual's overall well-being. Thank you.

Date: Wednesday, September 18, 2019 10:49:12 AM

Comments:

All mental health should have PARITY. By that I mean no co-pays ever. I believe in mentally improving health. The brain where mental/emotional health occur is an organ with its own biochemistry needs. I believe in Universal health care now.

Date: Wednesday, September 18, 2019 10:34:44 AM

Comments:

I think this is a great law that was very much needed but I believe that mental health care should be free. The cost of mental health care from physician visits to medications is the majority of my health care needs and because of cost is not a priority

Date: Monday, September 16, 2019 1:28:00 PM

Comments:

I think eliminating copay for outpatient mental health services is a positive step in the right direction. Seeking mental health treatment is difficult due to stigma and shame - not being able to pay for the service is a huge barrier in seeking treatment

Date: Monday, September 16, 2019 10:58:27 AM

Comments:

This change would save lives. Many people have high deductible policies that prevent them from using their mental health benefits. I

Date: Monday, September 16, 2019 9:30:29 PM

Comments:

I am a mental health therapist and I see so many clients struggle with insurance. Many people are afraid to seek out services and this would definitely increase the number of people who gain access to much needed services as preventative care.

Date: Sunday, September 15, 2019 12:22:38 PM

Comments:

When initially seeking treatment for mental illness it is common for patients to be in situations that have decreased their ability to financially care for themselves due to symptoms. This bill would decrease barriers plus inpatient and jail costs.

Date: Sunday, September 8, 2019 11:53:15 PM

Comments:

This will increase premiums and it would make it so that Minnesota policies are not HSA compliant. You can't mandate coverage at a zero deductible for anything other than preventive services. IRS notice 2019-45 does not include it. Do not take away my HSA

Appendix C: Letters Submitted Separately

MINNESOTA COUNCIL of HEALTH PLANS

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September 13, 2019

Mr. Andrew Kleinendorst
Minnesota Department of Commerce
Health Insurance Division
85 7th Place East, Suite 280
St. Paul, MN 55101-2143

VIA EMAIL

RE: 62J.26 New Mandated Benefit Proposal Analysis – Request for Information for SF 184

Dear Mr. Kleinendorst:

On behalf of the Minnesota Council of Health Plans ("Council"), I am writing in response to the Department of Commerce's Request for Information ("RFI") dated August 28, 2019. The Council is the trade organization representing Minnesota's seven nonprofit health plans. In 2018, the Council's health plans covered over 3.5 million people in the state. The Council values the importance of access to mental health visits and appreciates the opportunity to respond to this RFI.

Our comments are focused on three issues: the premium increases in the fully-insured market; the cost to the State of Minnesota to defray this mandate for the individual market; and compliance concerns for high-deductible health plans.

I. SF 184 WOULD NOT APPLY UNIVERSALLY AND WILL INCREASE PREMIUMS FOR THE FULLY-INSURED MARKET.

The Council opposes additional state-mandated benefits because they apply only to a small portion of the population and make premiums more expensive. Self-insured employers are exempt from state regulation under the federal Employee Retirement and Income Security Act of 1974 ("ERISA") – even if the employers hire a Minnesota health plan or insurance company to administer their plan. The number of Minnesotans enrolled in self-insured ERISA plans is growing, in part because of the strong incentive for employers to avoid the high cost of mandated benefits, state taxes, and other state regulations.

According to 2017 data from the Minnesota Department of Health, state mandated benefits only apply to about 20% of Minnesotans in the fully insured market. Unlike self-insured employers, individuals and small employers typically purchase health coverage in the fully-insured market because they are not able to take on the financial risk for themselves or their employees. Minnesota already has nearly the highest number of benefit mandates. As a result, individuals and small employers are hit hardest by the cost of state-mandated benefits – and they are often least able to afford it. As premiums rise, overall affordability is harmed, which results in decreased access to health care for more individuals and families. We don't have meaningful access to coverage if people cannot afford the coverage in the first place.

We believe that this particular mandate will result in additional costs. In addition, the Department of Commerce should look at existing plan coverage options and the limited reach of a state benefit mandate in commenting on whether this proposed mandate would actually improve access to mental health care. Given that the timeframe for commenting on this RFI is short, we encourage the Department of Commerce to undertake a more in-depth actuarial analysis to inform the legislature on the affordability impact of the proposed mandate to understand more fully the consumer/purchaser impact on premiums across the entire market.

II. THE STATE OF MINNESOTA IS REQUIRED TO REIMBURSE HEALTH PLANS IN THE INDIVIDUAL MARKET FOR BENEFIT MANDATES ENACTED AFTER 2011.

As required by the federal Affordable Care Act ("ACA"), Minnesota established a set of essential health benefits ("EHB") that all health plans must include in their fully insured products. To control the cost of coverage, the ACA requires that if a state enacts a new benefit mandate outside of the existing EHB, then the state must defray the additional costs of that benefit. Those additional costs must be completely paid for by the state in a manner prescribed by federal regulations at 45 CFR § 155.170. Any fiscal note of the cost of the new state-required benefit must be calculated in accordance with generally accepted accounting principles and methodologies. This requirement applies to all Qualified Health Plans ("QHPs") – both on and off the exchange. As such, the Minnesota Legislature must appropriate funds to offset the increased cost of this benefit mandate.

III. ENACTMENT OF SF 184 WOULD CAUSE HIGH-DEDUCTIBLE HEALTH PLANS TO BE OUT OF COMPLIANCE WITH IRS RULES.

The IRS rules for high-deductible health plans prohibit first dollar coverage of items or services unless explicitly required by the IRS' preventive services list. This preventive services list was just updated in the summer of 2019 and does not include mental health visits. As such, if SF 184 were enacted, it could require first dollar coverage before the deductible is satisfied, which would be inconsistent with IRS rules on high-deductible health plans.

In summary, state-mandated benefits add cost and make premiums more expensive. Individuals and small employers need affordable coverage options. Rather than the state enacting benefit mandates, this mandated benefit analysis will help inform whether the added cost to individuals and small employers and the increased disparity between large and small employers is justified.

Again, thank you for the opportunity to provide comments.

Sincerely,

Patsy Riley
Interim President and CEO

NAMI
National Alliance on Mental Illness
MINNESOTA

October 14, 2019

To whom it may concern:

The 2019 Legislative session was hugely impactful for people with mental illnesses due to a bill passed for better enforcement of mental health parity. On behalf of NAMI Minnesota, we would like to submit comments in support of a change that would classify mental health therapy visits and medication management visits as primary care visits for the purpose of cost sharing requirements like a copay or deductible. Unlike other health conditions, routine therapy visits or medication management meetings are charged differently and often require a co-payment. This discriminates against people with mental illnesses and increases barriers to people seeking mental health treatment.

A cornerstone of the Affordable Care Act (ACA) is the requirement that private insurance plans cover recommended preventative services identified as Grade A or B by the U.S. Preventive Services Task Force (USPTF) without any patient cost-sharing, which includes copayments and deductibles. The USPTF currently identifies Depression counseling for Adults and Children as Grade B, as well as a referral for counselling and treatment for women at risk of developing post-partum depression as Grade B. Expanding the protections under the ACA to therapy and medication management will benefit people with mental illnesses and mirrors the protections for other health conditions like people with obesity at risk of developing cardiovascular diseases.

Countless NAMI members delay or avoid regular mental health treatment because of high costs, which increases the risk that they will have a mental health crisis and require more expensive and intensive treatment. Removing copayments for routine outpatient mental health treatment will increase access and reduce financial barriers for people with mental illnesses to obtain preventative mental health treatment. This will improve outcomes for people with mental illnesses and decrease overall costs on the system. NAMI Minnesota strongly encourages the Department of Commerce to embrace this legislative change and ensure that people with mental illnesses obtain equal coverage from health plans. Thank you for your time and consideration.

Sincerely,

Sue Abderholden, MPH
Executive Director

Sam Smith
Public Policy Coordinator

MEMBER

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MEETS STANDARDS