REPORT # 01-04

OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

PROGRAM EVALUATION REPORT

Insurance for Behavioral Health Care

FEBRUARY 2001

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OFFICE OF THE LEGISLATIVE AUDITOR
State of Minnesota • James Nobles, Legislative Auditor

February 12, 2001

Members
Legislative Audit Commission

In April 2000, the Legislative Audit Commission directed us to study insurance coverage for behavioral health (mental health and chemical dependency) services. Legislators were concerned about allegations that private health plans were spending less on behavioral health and, in a growing number of cases, refusing to pay for needed mental health and chemical dependency services.

We found that private behavioral health spending has declined as a percent of total health spending in recent years, but it has still increased faster than inflation in Minnesota and the nation. While many providers and consumer representatives told us that insurance companies inappropriately deny coverage for behavioral health services, we could not independently verify the extent of the problem because of a lack of systematic data. Nevertheless, insurers have an incentive to delay or deny coverage, and limited evidence suggests that in some cases they may be shifting responsibility for care to publicly funded "safety-net" providers.

This report was researched and written by Elliot Long (project manager), Dan Jacobson, and Alan Frazier. We thank the departments of Commerce, Health, and Human Services, private insurance companies and health plans, and many others in the behavioral health community for their time and assistance in carrying out this study.

Sincerely,

/s/ James Nobles

James Nobles
Legislative Auditor

/s/ Roger Brooks

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

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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.

Many providers and consumer representatives argue that health plan companies inappropriately deny coverage of behavioral health services.

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 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.

Introduction

Over the last 25 years, the health care system in Minnesota and the nation has undergone a significant transformation. Enrollment in health maintenance organizations (HMOs) and other types of managed care arrangements has grown and traditional indemnity health insurance has largely disappeared.[1] Over the last 15 years, managed care has been extended to Medical Assistance and other public health plans in an effort to control costs and improve care.

The State Advisory Council on Mental Health has expressed concern about the effect of managed care on mental health and chemical dependency services, arguing that managed care has led to a decline in health plan spending on "behavioral health" (mental health and chemical dependency) treatment.[2] They argue that the cost of providing these services has been shifted to government-funded safety-net providers. Mental health advocates also question whether the law requiring parity in the coverage of behavioral health services has resulted in greater access to and use of behavioral health services as proponents of the law expected.[3]

The Legislative Audit Commission responded to the State Advisory Council on Mental Health and directed the Program Evaluation Division to undertake a study to address the following questions:

- **What percentage of health plan expenditures goes to mental health and chemical dependency (behavioral health) services? What are the trends in behavioral health spending in private and public health plans? What are the trends in utilization of behavioral health services? To what extent have costs for behavioral health services been shifted from private health insurance plans to publicly funded programs?**

- **How effectively has the Minnesota mental health parity law been implemented?**

- **What is the volume and nature of consumer complaints about behavioral health services expressed to health insurance plans and state regulatory agencies? How are those complaints resolved?**

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1 Managed care is characterized by utilization controls and provider networks that limit consumer choice to providers enrolled in the network. In some types of plans, providers share financially in the managed care organization's success in controlling costs. Traditional indemnity insurance offered a broader choice of providers and minimal utilization controls, but limited insurance risk by imposing copayments, deductibles and other service limitations. Over time nearly all health insurance plans have adopted some of the key features of managed care.

2 The State Advisory Council, was established under *Minn. Stat.* (2000) §245.697 to advise state agencies on policies and programs affecting people with mental illness.

3 *Minn. Stat.* (2000) §62Q.47

We experienced significant data problems in trying to answer almost every question. For example, our examination of trends was limited by a lack of reliable data on Minnesota's experience. We assembled data on the experience of Minnesota's public and private health plans from several sources including state agencies and five health plan companies, but the Minnesota data are quite fragmentary. The information generally covers only a few years, and interpretation of changes in mental health spending over time is difficult. We can, however, report with some confidence the national trends in behavioral health services.

We experienced our most difficult data problems in trying to answer the question about possible cost shifting from private health plans to publicly funded programs. Providers, advocates, and some county officials told us they believe some cost shifting is occurring, and we present their observations in Chapter 2 because we think they deserve consideration. However, despite considerable effort, we were unable to obtain data or design a methodology that would allow us to independently verify their claims.

The report is organized as follows: Chapter 1 presents background information useful to understanding the remainder of the report. Chapter 2 presents what we learned about national and Minnesota trends in spending and utilization of behavioral health services. Chapter 3 examines the implementation and effect of the Minnesota and federal mental health parity laws. Chapter 4 examines the role of health plans and state agencies in responding to consumer complaints against health plan companies.

1 Background

SUMMARY

Several 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, behavioral health benefits expanded significantly under public and private insurance plans during the last four decades. More recently, managed care has largely replaced traditional fee-for-service health insurance plans. The U.S. Surgeon General, using a broad definition of mental illness, 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.

This report examines recent trends in insurance coverage of behavioral health (mental health and chemical dependency) services and several related issues. Concern about the effect of managed care on behavioral health services motivated the State Advisory Council on Mental Health to ask for this study.

This chapter provides some background information on the growth of managed care, but also discusses other important issues and trends that have changed the environment in which mental health services are provided. Specifically, we address the following questions:

- **What is the prevalence of mental illness? To what extent are people with mental illness receiving treatment?**
- **How has the financing and delivery of mental health services changed over the past several decades?**
- **What factors led to the development of managed care?**
- **What are the major types of health plans covering the Minnesota population? How many people have mental health coverage? How many are uninsured? How are health insurance plans regulated in Minnesota?**

PREVALENCE OF MENTAL AND ADDICTIVE DISORDERS

Using a broad definition, the Surgeon General estimated that 28 percent of adults have a mental or addictive disorder.

To address concerns about the adequacy of spending for behavioral health care, it is useful to examine the prevalence of mental illness and the extent to which services reach people needing treatment. In a major 1999 report on mental health, the U.S. Surgeon General estimated that 28 percent of the nation's adults and 21 percent of children ages 9 to 17 have a mental or addictive disorder at some time during a one-year time period.[1] Among adults, 22 percent had a mental disorder and 9 percent had an addictive disorder. Three percent had both a mental health and an addictive disorder.

These estimates are based on two large-scale studies of the population. The interview schedules used in the studies were designed to be consistent with generally accepted diagnoses, but they were not clinical diagnoses. By their nature, prevalence estimates are sensitive to how disorders are defined and measured. For example, the 21 percent estimate for children includes diagnosable disorders with minimal impairment. If only children with "significant" impairments were included, the prevalence estimate would be 11 percent. Similarly, the percentage of adults with "serious" mental disorders would be 5 to 6 percent. About 2 to 3 percent of adults have "severe and persistent" disorders that greatly diminish the quality of life and require intensive specialized services.[2]

Table 1.1 summarizes the prevalence of different disorders. Anxiety disorders are the most prevalent mental health disorders, affecting about 16 percent of American adults and 13 percent of children ages 9 to 17 during a one-year period.[3] Anxiety disorders include phobias, panic disorders, obsessive-compulsive disorders, and post-traumatic stress disorders. About 7 percent of American adults and 6 percent of children have mood disorders, including major depression and mania. Disruptive disorders, including attention-deficit and oppositional-defiant disorders, are common among children, affecting about 10 percent of youth ages 9 to 17. Schizophrenia, which is an especially persistent disabling condition, affects about one percent of adults.

The national studies that measured the prevalence of mental illness also asked respondents about their use of behavioral health services.

- **The Surgeon General concluded that most people in the nation with behavioral health disorders do not receive treatment.**

Approximately one-third of adults and one-half of children with a diagnosable mental or addictive disorder received behavioral health care during a one-year

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1 U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: National Institute of Mental Health, 1999) 408-410. These estimates are based on two epidemiologic surveys: the Epidemiologic Catchment Area survey conducted during the early 1980s and the National Comorbidity Survey conducted during the early 1990s.

2 David Mechanic, *Mental Health and Social Policy: the Emergence of Managed Care*, (Needham Heights, MA: Allyn & Bacon, 1999).149.

3 U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General, 124, 228, 408.*

Table 1.1: Prevalence of Mental and Addictive Disorders in the United States

	Adults Ages 18-54	Children Ages 9-17
Anxiety disorders	16%	13%
Addictive disorders	9	2
Mood disorders	7	6
Disruptive disorders		10
Antisocial personality disorder	2	
Schizophrenia	1	
Severe cognitive impairment	1	
Any disorder	28%	21%

NOTE: The sum of prevalence estimates for specific disorders exceeds the prevalence for any disorder because many people have multiple disorders.

SOURCE: U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, MD: National Institute of Mental Health, 1999).

period.[4] There are several reasons that people with disorders did not receive care. Most adults with a disorder who did not seek care believed that "their problems would go away by themselves or that they could handle them on their own."[5] Second, many people may not seek care because of the stigma associated with mental disorders. A third reason is cost, particularly for people without insurance or who have inadequate insurance. Finally, there is evidence that some primary care physicians do not recognize mental health symptoms when patients seek physical care.[6]

Many people with disorders do not receive treatment, while many people without disorders do receive treatment.

A recent national survey found that 11 percent of the population believed that they currently needed mental health or substance abuse services.[7] Of these, one-fourth said that they had difficulty obtaining needed services, often because of cost. Lack of insurance was a factor, but cost was also the most frequently cited reason among the privately insured, suggesting that adequacy of coverage or high copayments may be factors. For Medicaid recipients, the most common reason was difficulty obtaining an appointment in a reasonable time.

There is also evidence that many people who do not have mental or addictive disorders receive behavioral health care. The Surgeon General estimated that nearly half of the people who received behavioral health services in a year did not have a diagnosable mental or addictive disorder during that year.[8] This apparent

4 U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General, 408-410.*

5 U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General, 409*.

6 David Mechanic, *Mental Health and Social Policy: the Emergence of Managed Care*, 59.

7 Roland Sturm and Cathy D. Sherbourne, *Are Barriers to Mental Health and Substance Abuse Care Still Rising?* Research Center on Managed Care for Psychiatric Disorders Working Paper No. H-156 (Los Angeles, 1999).

8 U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General, 408-410.*

mismatch between mental disorders and mental health services raises questions about whether the mental health system delivers services to those most in need. These data may exaggerate the mismatch because, according to an analysis by one mental health authority, the criteria used to diagnose mental disorders do not always reflect differences in severity of different symptoms.[9] But, this authority still concluded that there is evidence that there are significant unmet needs in mental health care.

CHANGES IN FINANCING AND DELIVERY OF MENTAL HEALTH SERVICES

During the first half of the 20th century, mental health care primarily consisted of private-pay psychiatric care and state institutional care for people with serious disorders. Mental health insurance coverage was rare. Low-income people received little mental health care: those with serious mental disorders were typically placed in state mental institutions, but received little active treatment.

There have been major changes in mental health care over the last half century.

During the last half century, there have been major changes in the way mental health care and chemical dependency care have been financed and delivered. In this section, we examine two key trends that shape our behavioral health system: the deinstitutionalization of care and the expansion of insurance coverage for behavioral health.

Deinstitutionalization of Mental Health Care

After various attempts to improve care within institutions, reformers began a movement during the 1950s to shift patients out of state institutions to community settings. We found:

- **Nationally and in Minnesota, the number of mentally ill patients in state mental hospitals peaked in the 1950s and rapidly declined during the 1960s and 1970s.**

Nationally, the number went from 560,000 in the mid-1950s to about 80,000 in 1999. In Minnesota, the decline was even greater. The number of people with mental disorders in Minnesota's state hospitals fell from 10,000 in the 1950s to 800 in October 1999.[10]

A variety of factors led to the deinstitutionalization of patients from state hospitals. Reformers believed that people with mental disorders should live a more normal life in the community whenever feasible. This belief was reinforced

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9 David Mechanic, *Mental Health and Social Policy: the Emergence of Managed Care 56-58.*

10 The 1950s figure came from: Office of the Legislative Auditor, *Community Residential Facilities for Adults with Mental Illness* (St. Paul, 1989). The 1999 figure came from the Department of Human Services Residential Facilites Monthly Population Report, October 1999. The 1999 figure includes 587 adults with mental illness, 43 adolescents with mental illness, and 170 people at the Minnesota Security Hospital at the St. Peter Regional Treatment Center. It does not include people in the Minnesota Sexual Psychopathic Personality Treatment Center at the Moose Lake Regional Treatment Center.

Institutional care has declined and the use of drug therapies has increased.

by the passage of laws that made it harder to place people in state hospitals. The development of drugs that could manage the symptoms of mental illness enabled more people to live in the community. The expansion of welfare programs (including the Supplemental Security Income program and Medical Assistance) helped support patients who lived in the community. Finally, the state's Medical Assistance program did not cover patients in state mental hospitals, creating a financial incentive for the state to move people from state hospitals to community settings where they would be eligible for Medical Assistance.[11]

As institutional care declined, the mental health care system evolved into a complex decentralized system. Today, mental health care is delivered through community residential treatment facilities, community mental health clinics, primary care clinics, community hospitals, and various mental health professionals in private practice. Counties typically provide case management services. In addition, the state continues to operate five regional treatment centers (formerly called state hospitals) that serve adults with mental illness.

The transition to community based care has been hampered by the lack of community mental health services.

The transition to community based care has not been smooth. It is widely recognized that communities across the country, including Minnesota, lacked the mental health infrastructure to adequately care for the people moving out of state mental institutions. For example, in 1989, a report by our office concluded that Minnesota's community mental health services had serious deficiencies, including too few case managers and support services, and inadequate treatment programs within community residential facilities.[12] According to Department of Human Services' staff, progress has been made since 1989, but the state's mental health system needs further improvement.

Insurance Coverage for Mental Health

While the public sector was changing how it delivered mental health services during the last half century, health insurance began to play an important role. In fact,

11 In Minnesota, Medicaid is called Medical Assistance.

12 Office of the Legislative Auditor, *Community Residential Facilities for Adults with Mental Illness*.

- **Over the past four decades, mental health benefits expanded significantly under public and private insurance programs.**

During the 1960s, Medicaid and Medicare improved access to mental health services for the poor, the disabled, and the aged. In addition, private insurance improved mental health coverage for the working population.[13] By 1997, few employers that provided health insurance benefits did not provide coverage for mental health and chemical dependency. According to a national survey of employer-sponsored health plans, only 9 percent of small firms and 1 percent of large firms did not offer mental health coverage.[14] A 1997 survey of Minnesota employers found that only 1 percent of employees enrolled in health insurance plans did not have mental health coverage.[15]

Mental health coverage is included in most employer-based health plans.

Since public insurance programs and employer insurance programs almost universally provide mental health coverage, people without mental health insurance consist primarily of those without any health insurance. In recent years, the Department of Health has estimated that 5 to 9 percent of Minnesota's population does not have health insurance. Estimates by the U.S. Census Bureau, shown in Figure 1.1, indicate that Minnesota has lowest uninsured rate in the country. The percentage without mental health coverage is somewhat higher than the uninsured rate (5 to 9 percent). We cannot be precise because we do not have mental health coverage data for people who purchase individual health insurance plans, a group that constitutes about 4 percent of the health insurance market in Minnesota.

Historically, private insurance provided relatively good inpatient benefits for mental health care but much more limited coverage of outpatient care. As mental health insurance coverage became more common, insurers controlled their costs by adopting more stringent cost sharing mechanisms (copayments, deductibles, and dollar and office visit limits) than were used in general health care. One reason for this discrepancy may be that employers and employees considered mental health care less important than physical health care.

There are also economic incentives that help explain why insurers treat mental health care differently than general health care. Traditional indemnity insurance (where insurance reimburses the insured for the cost of services used) encourages the use of services even when there is uncertainty over their benefit, risking the overuse of services. Research has found that mental health care usage is much more sensitive to price than other health care and there is greater uncertainty over the benefits of mental health care, particularly for mild mental health conditions.[16] Experimental studies show that as copayments are reduced, consumers increase their use of mental health services by a much greater amount than they do for

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13 David Mechanic, *Mental Health and Social Policy: the Emergence of Managed Care*,.

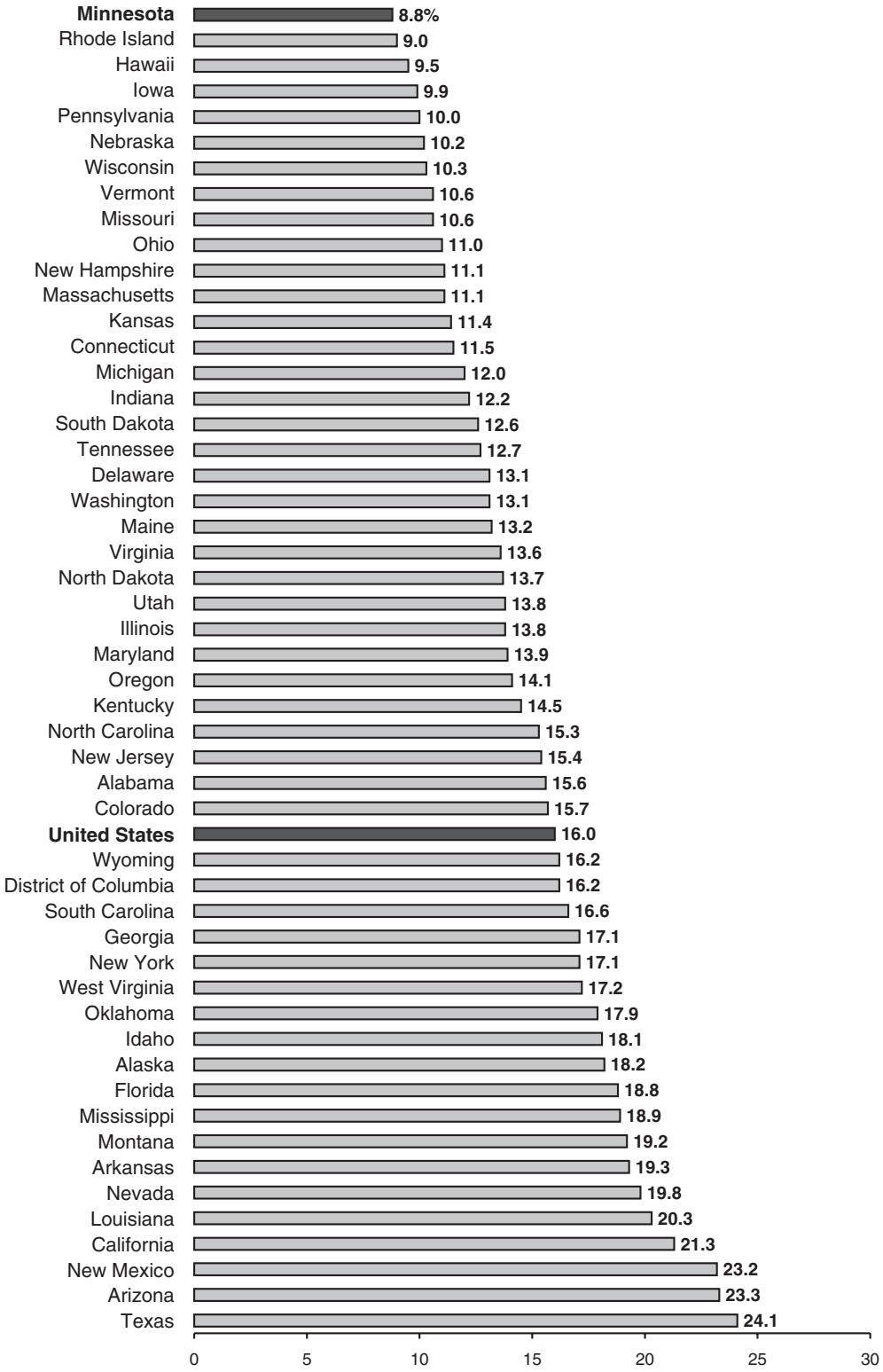
14 The results were based on the *Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans*. See: Jeffrey A. Buck, Judith L. Teich, Beth Umland, and Mitchell Stein, "Behavioral Health Benefits in Employer-Sponsored Health Plans, 1997," Health Affairs 18, no. 2 (1999).

15 Based on Robert Wood Johnson Foundation Employer Health Insurance Survey. See: Minnesota Department of Health, *Employer Based Health Insurance in Minnesota* (St. Paul, February 2000).

16 Richard G. Frank and Thomas G. McGuire, "Economics and Mental Health," National Bureau of Economic Research Working Paper 7052 (Cambridge, MA, March 1999).

Figure 1.1: Percent of Population Without Health Insurance by State, 1997-99 Average

Minnesota has the lowest uninsured rate in the nation.



SOURCE: U.S. Census Bureau, *Health Insurance Coverage*, "Table E. Percent of People Without Health Insurance Coverage Throughout the Year by State (3-Year Average): 1997 to 1999," September 2000, http://www.census.gov/prod/2000pubs/p60-211.pdf.

general health care services. This raises a concern that people with mild mental health problems will consume too large a share of the resources or that many people who do not suffer from mental illness will seek expensive psychotherapy for non-medical reasons, such as to improve one's self-understanding. As one national mental health authority noted, stringent controls on psychotherapy under fee-for-service plans were developed because "psychotherapists, particularly those with a psychoanalytic orientation, would carry out long courses of 'treatment' at great expense with patients who had minimal impairment."[17]

Another problem with offering high quality mental health benefits is that insurers risk attracting people in poorer health if they become identified as having a more liberal coverage policy. This problem, known as "adverse selection," affects health insurance in general, but there is evidence that mental health insurance is particularly vulnerable. Normally, insurers protect themselves against adverse selection by charging higher insurance premiums for individuals (or groups of people) who are more likely to use medical care. However, insurers have not yet developed a method to accurately predict mental health care usage.[18]

Insurers fear that improved mental health benefits will attract enrollees likely to be heavy users of mental health services.

THE GROWTH OF MANAGED CARE

Until the 1990s, the most common type of health insurance was the indemnity plan, which would reimburse hospitals, clinics, and other providers for the usual and customary fee for services provided to covered members. Insured patients could receive any covered service that the provider thought appropriate. Insurers rarely questioned the medical decisions made by providers, though they often imposed copayments, days of care limits, or maximum annual dollar limits to control their costs, particularly for mental health care. However:

- **Over the past few decades, various forms of managed care have largely replaced traditional fee-for-service insurance plans.**

Figure 1.2 illustrates the growth of health maintenance organizations (HMOs), one common form of managed care. In Minnesota, HMO enrollment rapidly grew from less than 5 percent of the population in the early 1970s to almost 30 percent in 1987 and then leveled off. Nationally, the growth of HMOs lagged behind the growth in Minnesota by about 10 years, but caught up to Minnesota's level in 1997.

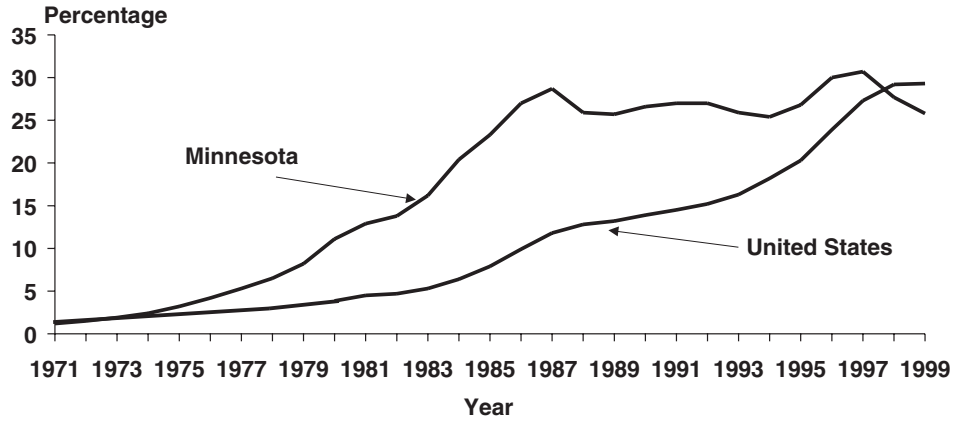
Today, HMOs and other forms of managed care dominate the insurance market in Minnesota and the nation. Though managed care comes in a variety of organizational arrangements, it is designed to provide effective care at lower cost by changing treatment practices. Managed care uses three basic techniques to control costs and shape how health care decisions are made. First, managed care organizations may pay providers a capitated payment (an amount per person covered) for a specified set of services. The provider is at risk for any expenses

17 David Mechanic, *Mental Health and Social Policy: the Emergence of Managed Care*, 134.

18 Richard G. Frank, Thomas G. McGuire, Jay P. Bae, and Agnes Rupp, "Solutions for Adverse Selection in Behavioral Health Care," *Health Care Financing Review* 18, no. 3 (Spring 1997) 109-122.

Until recently, the national growth of HMOs lagged behind HMO growth in Minnesota.

Figure 1.2: Percentage of Population Enrolled in an HMO, 1971-99



NOTE: The United States figure is based on InterStudy data for years 1971, 75, 78 and each year from 1980-99.

SOURCE: Office of the Legislative Auditor analysis of: Health Care Financing Administration, 1998 State Estimates: Population, http://www.hcfa.gov /stats/nhe-oact/stateestimates/Tables98/us120.htm, accessed December 13, 2000; InterStudy, "Managed Care: A Decade in Review 1980-1990" ,1991; InterStudy, "HMO's Lose Over 500,000 Enrollees Since January 1, 1999", 2000; Minnesota Department of Health; U.S. Census Bureau, *Historical National Population Estimates,* http://www.census.gov/population/estimates/nation/popclockest.txt, accessed December 13, 2000.

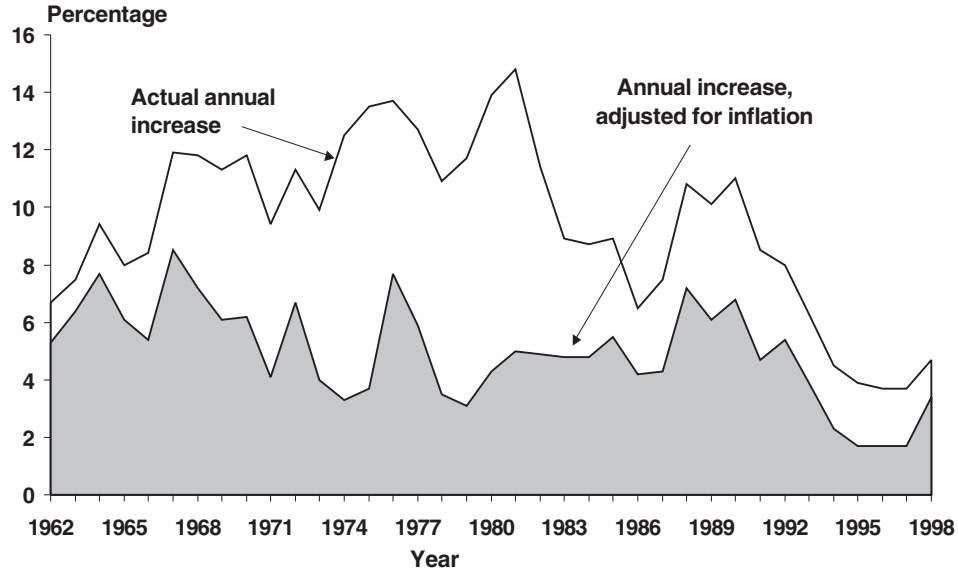
over the amount of the payment and thus has an incentive to carefully think about how to provide services in a cost-effective way. The second technique used by managed care organizations is utilization review, which can require professionals to obtain approval for specified health care decisions such as extending a hospital stay or providing additional therapy. Third, managed care typically restricts coverage to a network of providers who agree to abide by criteria for cost effective care.

There are several reasons for the rapid ascent of managed care. First, health care spending has been rapidly increasing for many years, placing pressure on individuals, employers, and public agencies to control costs. During the three decades before managed care became dominant (1960 through 1990), the nation's health care expenditures increased from $141 to $2,689 per capita. Even after adjusting for inflation, this is nearly a five-fold increase. During the 1990s, health care spending growth rates declined, both in actual and inflation-adjusted dollars (see Figure 1.3). This slowdown in cost increases may in part be due to the growth of managed care.

Another factor behind the growth of managed care was the belief that fee-for-service plans encouraged or at least did not constrain unnecessary or wasteful medical services. Mental health analysts have come to believe that long stays of inpatient psychiatric care and long intensive outpatient treatments persisted under fee for service plans despite the absence of evidence supporting the effectiveness of such treatment.[19]

19 David Mechanic, *Mental Health and Social Policy: the Emergence of Managed Care.*

Figure 1.3: Annual Percentage Increases in U.S. Per Capita Health Expenditures, 1962-98



SOURCE: Health Care Financing Administration, National Health Expenditures (1998); http://www.hcfa.gov/stats/nhe-oact/tables/nhegdp98; accessed December 13, 2000.

Health care costs have grown rapidly in recent decades, leading to the use of managed care to control costs.

Managed care was designed to be a remedy for many of the weaknesses of traditional health insurance, but managed care has its own weaknesses. Many mental health practitioners are concerned that mental health services will be cut arbitrarily because of managed care's incentive to reduce costs. When there is uncertainty over the benefit of services, the financial incentive of managed care is to provide less service, possibly resulting in legitimate needs not being met.

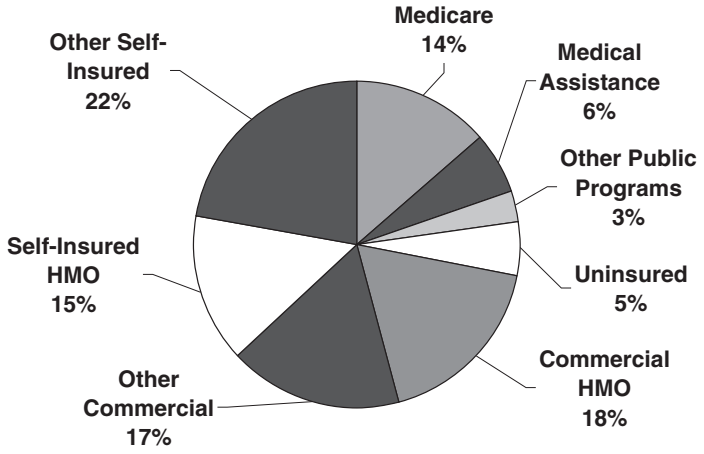
In short, managed care is not inherently good or bad. Its impact depends on many factors, including the degree to which the organization shares a mission to improve health care practices as opposed to merely cutting costs. In Chapter 2, we summarize what existing studies tell us about the impact of managed care on the cost and quality of mental health care.

TYPES OF HEALTH INSURANCE PLANS

This section looks at the types of insurance plans covering the Minnesota population, how each type of plan is regulated, and how many people are uninsured. Figure 1.4 shows the primary source of insurance coverage of the Minnesota population for 1999, the most recent date for which the Minnesota Department of Health has compiled this information. As the figure shows:

- **About 35 percent of Minnesota's population was covered by commercial plans regulated by state government.**

Figure 1.4: Distribution of Minnesota Population by Type of Insurance Coverage, 1999



NOTE: Other Public includes General Assistance Medical Care (GAMC), Minnesota Care, and the Minnesota Comprehensive Health Association.

SOURCE: Minnesota Department of Health.

In 1999, more people obtained health insurance through employer-based, self-insured plans than through regular commercial insurance.

- **About 37 percent of coverage was through self-insured plans regulated by the federal government.**
- **About 23 percent of the population was covered by public plans, principally Medical Assistance and Medicare.**

Overall, 72 percent of Minnesota's population was covered by private health insurance, including commercial insurance and self-insurance. Commercial insurance refers to insurance sold by insurance companies to individuals or employers. Under self-insurance plans, employers assume the insurance risk for the cost of health care.[20]

As the figure shows, 18 percent of the population is covered by health maintenance organization (HMO) plans sold in the commercial market and 17 percent were enrolled in other types of commercial plans sold by insurance companies. The Minnesota Department of Health regulates commercial HMOs and the Minnesota Department Commerce regulates non-HMO commercial health plans, insurance companies, third-party administrators who administer self-insured health plans, and utilization review organizations. Under the federal Employee Retirement Income Security Act statute, self-insured plans are regulated by the United States Department of Labor and are not subject to state requirements including those that govern mental health benefits.[21]

20 Typically, the employer contracts with another company to administer and manage the claims, but the employer is responsible for the cost of care.

21 Employee Retirement Income Security Act, U.S. Code Title 29, Chapter 18.

In recent years, there have been several consolidations of health plan companies. As a result:

- **Three companies now dominate the commercial health plan market.**

In 1999, three companies (Medica, Health Partners, and Blue Cross/Blue Shield) accounted for about 82 percent of health insurance premiums in Minnesota's commercial health insurance market. The consolidation of health plan companies is due to the demand by large purchasers for broad provider networks and to the economies of scale that characterize health plan operations. Medica and Blue Cross plans use large behavioral health subsidiaries to provide behavioral health care to their enrollees. Behavioral Health Services Inc. operates clinics and networks and provides utilization management services for Blue Cross enrollees and United Behavioral Health, a subsidiary of UnitedHealth Group, provides behavioral health services for Medica enrollees.

Three companies account for about 82 percent of Minnesota's commercial health insurance market.

About 23 percent of the Minnesota population is covered by public plans administered by the United States Health Care Financing Administration or the Minnesota Department of Human Services. Medicare, which covers 14 percent of the population, is administered by the Health Care Financing Administration. Medical Assistance, which covers 6 percent of Minnesota's population, is a federal-state program administered by the Minnesota Department of Human Services. General Assistance Medical Care and Minnesota Care, which together cover 3 percent of the population, are state programs administered by the Department of Human Services.

This report looks further at two regulatory activities of state government in later sections. Chapter 3 examines how the departments of Health and Commerce have implemented the Minnesota parity law that prohibits more restrictive conditions on mental health services in state-regulated plans than apply to other health services. Chapter 4 looks at state agency investigations of health insurance complaints.

2 Trends in Behavioral Health Spending and Utilization

SUMMARY

National studies agree that behavioral health spending by insurers has declined relative to overall health spending, but differ on the size of the decline. Private and public insurance spending on behavioral health services in Minnesota has increased faster than inflation in recent years, largely because of the rapidly growing use of prescription drugs to treat depression and other mental health disorders. Private health insurance spending on behavioral health apparently has not quite kept pace with overall health spending. Studies agree that managed care plans tend to spend less on behavioral health than fee-for-service plans, but evidence of managed care's effect on the quality of care is mixed. 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.

Some mental health advocacy groups have asserted that the growth of managed care has led to a decline in behavioral health in comparison with other health care spending. They contend that this decline reflects inappropriate denials of behavioral health coverage, substandard care, and cost shifting to the public sector. As a first step in addressing these concerns, this chapter examines trends in behavioral health spending and utilization. Specifically, we address the following questions:

- **How has behavioral health spending by insurers changed as a percent of all health spending? How has it changed compared with the rate of inflation?**
- **How has the use of behavioral health services changed over time?**
- **How has public funding of behavioral health care changed over the past decade?**
- **To what extent have costs for behavioral health services been shifted from private health insurance plans to publicly funded programs?**
- **What has been the impact of managed care on the cost and quality of behavioral health care?**

To answer these questions, we examined data from state and national sources. We collected state data on behavioral health spending and utilization from health plans in Minnesota, the Minnesota Department of Human Services, and the

Minnesota Department of Health. We examined several national studies of behavioral health spending. National data allow us to track private insurer spending over a longer time period than can be done with Minnesota data. We also examined research on the effects of managed care on behavioral health spending, utilization, and quality of care.

It is important to emphasize that examining trends is only a first step in answering the concerns of mental health advocates that behavioral health services are inappropriately being cut back by managed care organizations. Many factors may affect behavioral health spending and utilization trends, including improvements in mental health drug therapies, a change to a more goal-oriented therapeutic approach, changes in the population's need for and willingness to seek treatment, and changes in the role of private insurance and public agencies. By themselves, spending trends generally do not indicate whether a change in spending is appropriate.

A national study showing a sharp decline in behavioral health spending raised concerns among mental health advocates.

NATIONAL EXPENDITURE TRENDS

The State Advisory Council on Mental Health cited a national report by the HayGroup as evidence that behavioral health care spending has declined significantly during the past decade. This study estimated that the cost of behavioral health benefits offered by medium and large employers declined during a ten-year period from 6.1 percent to 3.2 percent of overall health benefits.[1] In this section, we compare the results of the HayGroup study with a study

1 HayGroup, *Health Care Plan Design and Cost Trends – 1988 through 1998*, Prepared for: National Association of Psychiatric Health Systems and Association of Behavioral Group Practices, (April 1999).

conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA).[2] As a starting point, we can say that:

- **Two national studies found that behavioral health spending declined in proportion to all health care, but the studies differed greatly on the size of the decline.**

However, another major study sponsored by a federal agency found a much smaller decline in spending.

The SAMHSA study found that among private insurers, the percentage of health spending attributable to behavioral health declined from 6.6 percent in 1987 to 5.6 percent in 1997.[3] The HayGroup study examined a similar time period (1988 to 1998), but estimated that the decline was 2.9 percentage points, nearly three times as large as the 1 percentage point decline found by the SAMHSA study.[4]

The two studies also differed on whether mental health and substance abuse spending increased faster than inflation. After adjusting for inflation, the cost of behavioral health benefits declined by 55 percent according to the HayGroup study, but increased by 45 percent, according to the SAMHSA study. These differences are magnified by the fact that the HayGroup study used a medical inflation index that provided a much higher rate of inflation than the general inflation index used by the SAMHSA study. In our view, the general inflation index used by the SAMHSA study is more suitable for tracking trends in behavioral health spending.[5]

Reconciliation of Differences Between Two National Studies

Because of the size of these differences, SAMHSA is sponsoring a study to reconcile the findings of these two studies. Although the results of that study

2 Substance Abuse and Mental Health Services Administration, *National Estimates of Expenditures for Mental Health and Substance Abuse Treatment, 1997* (SAMHSA publication No. SMA-00-3499, Rockville, MD, July 2000).

3 The SAMHSA study estimates for behavioral health spending included spending by all types of providers for treating patients with a primary diagnosis for mental health or substance abuse. Excluded were Alzheimer's disease, dementia, tobacco abuse, and developmental mental delays. Spending estimates were based on surveys of specialty behavioral health facilities (such as psychiatric hospitals) and a national sample of individual encounters with other providers.

4 The HayGroup study is based on an actuarial model that estimates the cost of providing health benefits to a typical group of employees. The model used actual claims data from a sample of plans to estimate costs for different benefit designs (including deductibles, coinsurance payments, types of services covered, and coverage limits) and delivery systems (ranging from an HMO to a fee-for-service system). The study then estimated costs in a broader market by applying the model to a larger sample of plans from medium and large employers over a ten-year period..

5 Medical price indexes that cover the period 1988 through 1998 may greatly overstate the change in the cost of treating mental health conditions. See: Jack E. Triplett, *What is Different About Health? Human Repair and Car Repair in National Accounts and in National Health Accounts*, (Washington D.C., The Brookings Institution, 1999). One reason that medical price indexes overstate inflation is that they do not take into account changes in the way services are provided. For example, a recent study found that the cost of treating depression declined between 1991 and 1995 because drugs or a combination of drugs and therapy were substituted for longer, more expensive therapy. See: Richard G. Frank, Ernst R. Berndt, and Susan H. Busch, "Price Indexes for the Treatment of Depression," in Jack E. Triplett, ed., *Measuring the Prices of Medical Treatments*, (Washington, D.C.: The Brookings Institution Press, 1999). The SAMHSA study used the gross domestic product price index, an index for the U.S. economy. Although this index does not measure behavioral health treatment costs, it is more consistent with changes in behavioral health treatment costs than are medical price indexes.

have not been finalized, the study has identified major areas of differences for investigation.[6] First, the HayGroup study did not include the cost of retail prescription drugs, a large and rapidly growing part of mental health care spending. We estimate that retail prescription drugs explain about one-third of the difference in growth rates between the two studies.[7]

Another potential source for the divergent results is the representativeness of the data used in each study. The HayGroup study was based on a sample of commercial insurance plans that cover medium and large employers, but the SAMHSA used data from all types of plans. It is possible that managed care reduced behavioral health spending in large employer commercial plans to a greater extent than it did under small employer plans.

Comparable treatment of the cost of retail prescription drugs reduces the difference between the two studies.

Finally, both studies made many extrapolations and adjustments that could introduce error in their estimates. For example, the HayGroup study based its model on claim data from a limited number of health plans, raising questions about the representativeness of its results. The SAMHSA study used a complex methodology to combine a variety of different data sources, making some error inevitable.

Reasons for Slower Growth in Behavioral Health Spending

The national studies cited several reasons that behavioral health spending did not keep pace with overall health spending. Both studies identified the rise of managed care as an important reason for the slower growth in behavioral health care spending. The HayGroup study also cited the increased use of coverage limits for behavioral health services. For example, among health plans it surveyed, the percentage imposing day limits on inpatient psychiatric care increased from 38 percent in 1988 to 62 percent in 1998. During the same time period, the percentage of plans imposing outpatient day limits went from 26 to 57 percent.

The SAMHSA study also noted that behavioral health care was marked by larger reductions in hospital-based services and adopted alternatives such as outpatient treatment and prescription drugs faster than all health care. For example, the study found that prescription drug spending for mental health increased faster than prescription drug spending for all health care. It also increased faster than overall health care spending. Prescription drug spending rose primarily because of greater utilization, though higher prices were also a factor.[8]

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6 Communication with project officer for the reconciliation study, November 8, 2000 and January 17, 2001.

7 We estimate that removing retail prescription drug spending from the SAMHSA data changes the decline in behavioral health spending as a percentage of total health care spending to 1.7 percentage points (from 6.1 percent in 1987 to 4.4 percent in 1997).

8 Substance Abuse and Mental Health Services Administration, *National Estimates of Expenditures for Mental Health and Substance Abuse Treatment, 1997, 36.*

Applying National Trends to Minnesota

National behavioral health spending trends during the past decade may not parallel Minnesota trends for several reasons. First, because Minnesota moved to managed care earlier than the rest of the nation, it may have experienced much of the cost impact of managed care prior to the time period examined by national studies. For example, between 1987 and 1997, the percentage of the national population enrolled in HMOs increased from 12 percent to 27 percent, whereas Minnesota's HMO enrollment reached 27 percent in 1986 and has not increased significantly since then.

Minnesota moved to managed care before most other states, and, as a result, recent national trends in behavioral health spending may not apply to Minnesota.

A second reason that national results may not apply to Minnesota is that the 1995 Minnesota parity law is much stronger than the federal parity law. The federal parity law prohibits annual and lifetime dollar limits, but can easily be circumvented by imposing day or visit limits. In contrast, Minnesota's parity law prohibits plans from imposing mental health limits or copayments that are more restrictive than those for general health care. According to the HayGroup study, health plans provided by a national sample of large and medium employers increased the use of behavioral health limits during the past decade. For example, between 1988 and 1998, the percentage of plans imposing day limits on inpatient psychiatric care increased from 38 to 62 percent. During the same time period, the percentage of plans imposing outpatient day limits went from 26 to 57 percent. Since Minnesota does not allow these limits under most regulated health plans, it is doubtful that the national trend toward more restrictive limits on mental health care occurred to the same extent in Minnesota.

MINNESOTA BEHAVIORAL HEALTH SPENDING IN 1999

In Minnesota, public agencies and private insurers both perform important roles in behavioral health care. In this section, we summarize behavioral health spending by private insurers and human service agencies in 1999. In the following sections, we examine trends over time in private and public spending. We obtained data on spending by private insurers from the Minnesota Department of Health and our survey of five large health insurers that make up over three-fourths of the private insurance market. We obtained data on spending by state and local human service agencies (including federal money that supports state and local administered programs) from the Minnesota Department of Human Services.

Collectively, we estimate that state and local human service agencies and insurance companies spent about $941 million on behavioral health in 1999 (See Table 2.1). These estimates do not include out-of-pocket expenses, nor spending by schools, correctional agencies, and federally administered programs, such as Medicare and programs of the Veterans' Home Administration.

- **Public programs accounted for most behavioral health spending in Minnesota.**

In Minnesota, public programs accounted for two-thirds of behavioral health spending in 1999.

Table 2.1: Estimated Behavioral Health Spending in Minnesota, 1999

	Millions of Dollars	Percent
Private Insurance	$310	33%
Commercial	153	16
Self-insured	157	17
Public Programs	631	67
Public Mental Health Programs	561	60
Public Insurance	216	23
Medical Assistance	115	12
General Assistance Medical Care	10	1
Minnesota Care	4	0
Prescription drugs	87	9
Public Direct or Contracted Service Programs	345	37
State payments	187	20
County payments	122	13
Federal payments	36	4
Public Chemical Dependency Programs	70	7
TOTAL	$941	100%

SOURCES: Office of Legislative Auditor's analysis of data from Department of Human Services, Department of Health, and five health plans.

In 1999, state and local human service agencies spent about $631 million on behavioral health, or roughly two-thirds of the total spending. Private insurers, which cover about two-thirds of Minnesota's population, account for about one third of behavioral health spending. These estimates probably understate the public portion because they do not include spending by Medicare and some other public programs.[9] These figures reflect the fact that public programs still have primary responsibility for treating people who have a serious mental illness.

About $216 million was spent by public insurance programs administered by state and county governments—Medical Assistance, General Assistance Medical Care, and MinnesotaCare. State and county human service agencies spent another $345 million on regional treatment centers, community residential treatment, community support services, and publicly subsidized inpatient and outpatient care provided by community mental health clinics and county hospitals.

In the following section, we examine spending and utilization trends of Minnesota insurers, including private commercial insurance, self-insurance, and prepaid public insurance provided through HMOs. Later we examine trends of publicly funded mental health and chemical dependency programs.

9 According to the national SAMHSA study, Medicare funded about 12 percent of total behavioral health services in 1997.

BEHAVIORAL HEALTH TRENDS FOR MINNESOTA INSURERS

To analyze spending trends by insurers in Minnesota, we used behavioral health spending data that the Minnesota Department of Health has collected annually from health insurers since 1994 as well as data we obtained from five insurers. These data have a number of limitations. First, the health department data included prescription drug spending for mental health in a general prescription drug category for all health care. Also, sometimes insurers did not accurately allocate spending to behavioral health. The data we obtained from five insurers includes prescription drugs and appears to avoid the allocation problems we found in the MDH data. However, although we sought data from 1985 to 1999, we obtained reasonably complete data only for the 1997-99 time period. Another problem with insurer data is that mental health care provided by primary-care physicians may not have been coded as mental health care. Finally, neither set of data has been audited by an independent party. We found:

- **Insurer data indicate that behavioral health spending under private insurance has increased faster than inflation since 1994.**

Private insurance spending on behavioral health care has increased faster than inflation in recent years.

Both the MDH data and our survey of large health insurers indicate that private insurance spending on behavioral health has increased faster than inflation in recent years.[10] According to MDH data, private insurance spending on behavioral health increased from $2.72 per member month in 1994 to $3.20 in 1999, an increase of 18 percent. After adjusting for inflation, the increase would be 8 percent (see Table 2.2).

Our survey of five health insurers indicates that behavioral health spending may have increased faster than shown by the MDH data because the MDH behavioral health category did not include prescription drug spending. In fact, prescription drug spending increased by 47 percent in just two years (1997 to 1999), as shown in Table 2.3.[11] Between 1997 and 1999, behavioral health spending per member month changed by only 1 percent if drug spending were excluded, but increased by 14 percent after including drug spending. While we do not have data on prescription drug spending prior to 1997, the national SAMHSA study and

10 This discussion of private insurance includes commercial insurance and self-insurance. We adjusted trend data for inflation based on the gross domestic product (GDP) price index. As we discussed earlier, we think that this index is better than available medical price indexes. An alternative index used by the Department of Human Services is the Employment Cost Index for Private Industry Workers. Using this index instead of the GDP index would not change our finding that beahvioral health spending has increased faster than inflation, but the estimated increase would be about 5 percentage points less for the 1997-99 period and 8 percentage points less for the 1994-99 period. The department's rationale for using the employer cost index is that employee compensation is about 80 percent of mental health treatment costs. However, we prefer the GDP index because the employer cost index does not reflect the changing nature of behavioral health treatment, particularly treatment of depression. As we previously noted, there has been a significant decline in the cost of treating depression because of the substitution of drugs for more expensive therapy.

11 Prescription drug spending includes insurer spending on mental health drugs regardless of whether they were prescribed by mental health specialists or primary-care physicians. A small percentage of mental health drugs may be used for other purposes.

Table 2.2: Behavioral Health Spending by Private Insurance Plans (Excluding prescription drugs), 1994-99

	1994	1995	1996	1997	1998	1999	Percent Change
Behavioral health spending per member month	$2.97	$3.08	$3.34	$3.27	$3.33	$3.20	7.7%
Behavioral health spending as a percent of all health spending	2.7%	2.8%	2.8%	2.7%	2.5%	2.2%	

NOTE: Spending per member month figures are adjusted for inflation based on the GDP price deflator. They are expressed in 1999 dollars.

SOURCE: Financial data submitted by insurers to the Minnesota Department of Health.

Minnesota Medical Assistance data both suggest that prescription drug spending also increased rapidly prior to 1997.

We also examined trends in behavioral health spending as a percentage of all health care spending. We found:

- **There is evidence that behavioral health spending did not keep pace with all health care spending in recent years, but there is no evidence that Minnesota experienced the sharp decline found by the HayGroup national study.**

Insurer data indicate that behavioral health spending declined slightly as a percentage of all health spending between 1997 and 1999. Our data indicate that with prescription drugs, behavioral health spending declined from 5.5 percent in 1997 to 5.3 percent in 1999. According to MDH data, private insurance spending on behavioral health declined from 2.7 to 2.2 percent of total health care spending. Spending estimates based on MDH data are lower than estimates based on our data because MDH data do not categorize certain types of behavioral health

Behavioral health spending increased because of the rapid growth of spending on prescription drugs.

Table 2.3: Behavioral Health Spending by Five Insurers Under Private Insurance Plans, 1997-99

	1997	1999	Percent Change
Spending per member month			
Behavioral health, excluding drugs	$4.83	$4.78	-1%
Mental health drugs	2.16	3.17	47
Total behavioral health	$6.99	$7.96	14%
Spending as a percent of total health spending			
Behavioral health, excluding drugs	3.8%	3.2%	
Mental health drugs	1.7	2.1	
Total behavioral health	5.5%	5.3%	

NOTES: Spending per member month figures are adjusted for inflation based on the GDP price deflator. They are expressed in 1999 dollars. Sum of subcategories may not add to total shown because of rounding.

SOURCE: Office of Legislative Auditor's survey of five health insurers.

spending as behavioral health, including prescription drugs for mental health. The absence of prescription drugs also explains why MDH data show a larger decline.

It is not clear whether behavioral health spending kept pace with all health care prior to 1997, but there is no evidence of a significant decline. According to MDH data, behavioral health spending as a percent of overall health spending remained between 2.7 and 2.8 percent between 1994 and 1997. However, the data are not precise enough to determine whether there was a decline prior to 1997.

Self-insured versus Commercial Plans

Although self-insured plans are not subject to state requirements governing behavioral health care, self-insured plans spent about the same amount as state-regulated plans on behavioral health.

In 1998, about 48 percent of Minnesota residents covered by private insurance were enrolled in self-insured plans. As we discussed in Chapter 1, these self-insured plans are not regulated by the state and are not subject to Minnesota's parity law. We found:

- **Data from major health insurers indicate that self-insured plans spent about the same amount on behavioral health as did commercial plans.**

Data from the five insurers that we surveyed indicate that in 1999 behavioral health spending was 5.3 percent of all health care spending for both self-insured plans and commercial plans. Self-insured plans spent about $8.05 per member month, compared with $7.93 for commercial plans.

Minnesota's parity law prohibits state-licensed health plans that cover mental health from placing more restrictions on mental health services than on medical services. One way to measure limits imposed on mental health coverage is to examine the percentage of service expenditures paid for by members through deductibles, co-payments, coinsurance, and amounts exceeding plan coverage. We compared the percentage of behavioral health expenditures paid by members under regulated plans with self-insured plans. We found:

- **Members of self-insured plans made more out-of-pocket payments for behavioral health services than did members of regulated commercial plans.**

In 1998, MDH data indicate that members of self-insured plans paid for about 20 percent of the cost of behavioral health services compared with 10 percent for members of commercial plans.

Prepaid Public Insurance Programs

Beginning in the late 1980s, Minnesota's public insurance programs gradually increased the use of prepaid plans operated by HMOs. In this section, we examine trends for three of these public programs—Medical Assistance, General Assistance Medical Care, and MinnesotaCare. Each of these programs provides health insurance for low-income individuals or families and is funded in whole or part by the state. Currently, most people who are covered by one of these insurance programs are enrolled in a prepaid plan. As of the end of 2000, Medical Assistance offered prepaid plans in 63 counties, including all of the counties in the

Twin Cities area. However, people with disabilities remain in fee-for-service plans. Since disabled enrollees use more mental health services than average, most mental health services continue to be delivered on a fee-for-service basis.

Public insurance programs have expanded their reliance on HMOs.

As with private insurance, we examined data reported to MDH and data provided to us by five insurers. We found:

- **Between 1995 and 1999, prepaid Medical Assistance plans appear to have increased behavioral health spending somewhat faster than inflation and about the same pace as general health care spending.**

Insurer data suggest that increases in prescription drug spending by public insurance programs more than offset reductions in other behavioral health spending between 1995 and 1999. After adjusting for inflation, HMOs' spending on behavioral health for public insurance programs fell from $7.68 per member month in 1995 to $6.25 in 1999, according to MDH data (shown in Table 2.4). However, data reported to us by three insurers suggest that prescription drug spending increased enough between 1997 and 1999 to offset this.[12] As Table 2.5 shows, spending on mental health drugs increased by $2.21 per member month, well above the decline of $1.43.

Table 2.4: Behavioral Health Spending by Prepaid Public Insurance Plans, 1995-99 (Excluding prescription drugs)

	1995	1996	1997	1998	1999	Percent Change
Behavioral health spending per member month	$7.68	$8.64	$6.11	$5.86	$6.25	-18.6%
Behavioral health spending as a percent of all health spending	3.9%	4.6%	3.6%	3.3%	3.2%	

NOTE: Spending per member month figures are adjusted for inflation based on the GDP price deflator. They are expressed in 1999 dollars.

SOURCE: Financial data submitted by insurers to the Minnesota Department of Health.

Another factor that may affect these trends is the changing composition of prepaid plans during this time period. In 1995, only the seven counties in the Twin Cities metropolitan area and Itasca County participated in the Prepaid Medical Assistance Program. By 1999, 55 counties were participating. As a result, the trend may reflect differences between Medical Assistance recipients in the Twin Cities area and recipients from counties that started after 1995.

Insurer data also suggest that prescription drug spending offsets the decline in other behavioral health spending *as a percentage of total health care spending*.

12 Four of the five plans that we surveyed had prepaid Medical Assistance plans, including one which could not break down prescription drug costs for Medical Assistance members. The three plans who reported data on drug spending make up 41 percent of the prepaid insurance market for Medical Assistance, MinnesotaCare, and General Assistance Medical Care.

Table 2.5: Behavioral Health Spending by Five Insurers Under Prepaid Public Plans, 1997-99

	1997	1999	Percent Change
Spending per member month			
Behavioral health, excluding drugs	$ 7.07	$ 7.82	11%
Mental health drugs	3.56	5.77	62
Total behavioral health	$10.63	$13.59	28%
Spending as a percent of total health care spending			
Behavioral health, excluding drugs	4.8%	4.5%	
Mental health drugs	2.4	3.3	
Total behavioral health	7.2%	7.8%	

NOTE: Data are based on Prepaid plans for Medical Assistance, General Assistance Medical Care, and Minnesota Care. Spending per member month figures are expressed in 1999 dollars, based on the gross domestic product price index.

SOURCE: Office of Legislative Auditor's survey of five health insurers.

MDH data indicate that between 1995 and 1999, behavioral health spending by prepaid plans fell from 3.9 percent of overall health spending to 3.2 percent. Spending data from three insurers indicate that in just two years (1997-99), spending on mental health drugs went from 2.4 to 3.3 percent of overall spending. If prescription drug spending kept pace with overall health care prior to 1997, this would more than offset the decline in non-drug spending.

Trends in Behavioral Health Utilization

To examine trends in behavioral health utilization, we examined data collected by the Minnesota Department of Health from Health Maintenance Organizations (HMOs). The Department of Health collects data for private commercial plans and public insurance plans, but not self-insured plans. In 1998, the commercial HMO plans in these MDH data covered 890,000 people, about 27 percent of the private insurance market. Public HMO plans covered an additional 420,000 people, about 38 percent of public insurance enrollees.

There are two main reasons to examine these utilization data in addition to spending data. First, these data allow us to examine trends in more detail. Second, it partially addresses the concern that the spending data we reported above are not audited. As part of state licensing requirements, MDH requires all HMOs to collect utilization data for state-regulated plans based on the procedures specified by the National Committee for Quality Assurance (NCQA), a national accrediting organization for HMOs. NCQA requires HMOs to collect certain data on plans for which it seeks accreditation, including utilization data for mental health and chemical dependency services. In 1998, NCQA audited the procedures used by the three accredited HMOs in Minnesota—Medica, Health Partners, and Blue Plus. NCQA does not audit the data submitted to the health department, but the NCQA audit provides some assurance that the data collection procedures have been reviewed.

We examined mental health and chemical dependency utilization rates for private commercial plans and the three public programs administered by the state (Medical Assistance, General Assistance Medical Care, and MinnesotaCare).[13] We found:

- **Among commercial and public HMO plans, outpatient mental health usage declined slightly in recent years, but inpatient usage increased.**

Table 2.6 shows that the percentage of HMO members under commercial plans who received outpatient mental health service increased from 6.5 percent in 1996 to 7.0 percent in 1997 and then declined to 6.3 percent in 1999. Inpatient days of care increased from 24 days per 1,000 members in 1996 to 29 days in 1999. This increase reflects higher admission rates because average length of stay declined slightly during this time period.

About 6 to 7 percent of commercial HMO members used mental health services in 1999.

Table 2.6: Mental Health Utilization Trends, Minnesota HMOs, 1996-99

	1996	1997	1998	1999
Percent of Members Receiving Outpatient Mental Health Services				
Commercial	6.5%	7.0%	6.7%	6.3%
Public Programs (Prepaid only)	10.2	10.2	9.8	N/A
Medical Assistance	9.0	8.9	8.8	N/A
Minnesota Care	10.3	9.8	9.1	N/A
General Assistance Medical Care	22.9	25.2	25.1	N/A
Inpatient Admissions per 1,000 Members				
Commercial	3.0	3.2	3.3	3.8
Public Programs (Prepaid only)	7.7	8.4	8.8	N/A
Medical Assistance	6.3	6.4	7.5	N/A
Minnesota Care	3.7	7.2	6.1	N/A
General Assistance Medical Care	30.7	33.3	35.1	N/A
Inpatient Days of Care per 1,000 Members				
Commercial	24	25	27	29
Public Programs (Prepaid only)	55	64	64	N/A
Medical Assistance	44	49	57	N/A
Minnesota Care	23	48	40	N/A
General Assistance Medical Care	234	262	247	N/A
Number of Members				
Commercial	983,275	919,436	854,565	931,995
Public Programs (Prepaid only)	190,892	207,427	210,143	N/A
Medical Assistance	151,661	152,540	151,536	N/A
Minnesota Care	25,275	40,491	46,345	N/A
General Assistance Medical Care	13,956	14,396	12,262	N/A

SOURCE: Office of Legislative Auditor's analysis of data from the Health Plan Employer Data and Information Set (HEDIS) collected for the Minnesota Department of Health.

13 NCQA's definition of inpatient utilization for chemical dependency includes hospital stays that are designed to stabilize the patient and do not necessarily include treatment. This differs from DHS chemical dependency databases (Consolidated fund database and the Drug and Alcohol Abuse Normative Evaluation System (DAANES) database), which only include placements involving a treatment program.

Although prepaid public insurance programs had higher utilization rates than commercial plans, the trends were similar. For public programs, the percentage of HMO members who used outpatient mental health services declined from 10.2 to 9.8 percent between 1996 and 1998. During the same time period, inpatient days of care increased from 55 to 64 days per 1,000 members.[14]

Among HMO plans, the percentage of Medical Assistance members using mental health services ranged from 6 to 11 percent.

Mental health utilization rates varied considerably among health plans. For example, among the five prepaid Medical Assistance plans that covered at least 16,000 members, the percentage of members who used mental health services in 1998 ranged from 6 percent to 11 percent.

Table 2.7 summarizes chemical dependency utilization rates for HMOs by type of market. We found that chemical dependency trends were generally similar to mental health trends. Specifically:

- **Outpatient chemical dependency utilization rates declined slightly in recent years, but inpatient rates increased for commercial HMO plans. There was no clear trend for inpatient usage among public insurance plans.**

Table 2.7: Chemical Dependency Utilization Trends, Minnesota HMOs, 1996-99

	1996	1997	1998	1999
Percent of Members Receiving Outpatient Chemical Dependency Services				
Commercial	0.60%	0.60%	0.51%	0.56%
Public programs (prepaid only)	1.29	1.45	1.14	N/A
Medical Assistance	1.01	1.06	0.86	N/A
Minnesota Care	0.32	0.88	0.75	N/A
General Assistance Medical Care	6.15	7.13	6.08	N/A
Inpatient Admissions per 1,000 Members				
Commercial	1.7	1.7	1.7	2.1
Public programs (prepaid only)	3.6	3.7	3.6	N/A
Medical Assistance	2.5	2.1	2.2	N/A
Minnesota Care	1.5	1.7	1.9	N/A
General Assistance Medical Care	19.1	25.9	27.4	N/A
Inpatient Days of Care per 1,000 Members				
Commercial	10	9	11	15
Public programs (prepaid only)	24	30	25	N/A
Medical Assistance	18	18	15	N/A
Minnesota Care	6	11	11	N/A
General Assistance Medical Care	115	205	201	N/A
Number of Members				
Commercial	983,275	919,436	854,565	931,995
Public programs (prepaid only)	190,892	207,427	210,143	N/A
Medical Assistance	151,661	152,540	151,536	N/A
Minnesota Care	25,275	40,491	46,345	N/A
General Assistance Medical Care	13,956	14,396	12,262	N/A

SOURCE: Office of Legislative Auditor's analysis of data from the Health Plan Employer Data and Information Set (HEDIS) collected for the Minnesota Department of Health.

14 HMO utilization data was not collected for state administered public programs in 1999.

Among commercial HMO plans, the percentage of members receiving outpatient chemical dependency services declined slightly, going from .60 percent to .56 percent between 1996 and 1999. Among public HMO plans, outpatient rates declined from 1.29 percent in 1996 to 1.15 percent in 1998.

Commercial inpatient rates increased noticeably in 1999 after changing slowly between 1996 and 1998. Public program inpatient rates also changed slowly between 1996 and 1998, but we can not tell what happened in 1999 because utilization data were not collected in that year for public programs.

In summary, we found that utilization data is generally consistent with spending data. Specifically:

- **Utilization data supports the finding that there is no large decline in behavioral health spending in recent years.**

We found that outpatient utilization rates fell slightly but inpatient rates either increased moderately or held steady. During the same time period, spending per member month increased faster than inflation, though perhaps not as fast as general health care.[15]

PUBLIC SPENDING TRENDS

Many people in the mental health community told us that they consider Minnesota's mental health system to be under-funded. Under Minnesota's complex mental health system, it is necessary to examine public and private funding to address this concern. In this section we look at broad trends in public spending for mental health and chemical dependency. Then we look at funding for community mental health clinics to illustrate how managed care and medical assistance reimbursement policies affect the state's mental health system.

Mental Health

Public programs have long played an important role in delivering mental health services. To examine how public funding of mental health services has changed over time, we examined Department of Human Services data on mental health spending by state and local human service agencies over the past decade. We found that:

- **During the past decade, mental health spending by state and local human service agencies grew considerably faster than inflation and about as fast as overall health spending.**

Table 2.8 shows that between 1989 and 1999, public mental health spending went from $298 million to $475 million, an increase of 59 percent. During the same time period, Minnesota's population increased by 10 percent. Public insurance

15 One difference between spending and utilization trends is that spending for public insurance programs declined by more than 25 percent between 1996 and 1997, but utilization rates increased slightly. It is not clear what explains this difference.

Table 2.8: Public Mental Health Spending by Payment Source, 1989-99 (In millions of dollars, after adjusting for inflation)

	1989	1999	Percent Change
Public Insurance Programs			
Medical Assistance	$77.2	$114.5	48%
General Assistance Medical Care	13.9	10.4	-25
Minnesota Care	0.0	3.8	-
Subtotal	$91.2	128.7	41%
Public Non-insurance programs			
State payments	110.4	187.5	70
County payments	69.5	122.2	76
Federal payments	27.1	36.3	34
Subtotal	$207.0	$346.1	67%
TOTAL	$298.1	$474.8	59%

NOTE: Figures exclude prescription drug spending. Figures are in constant state fiscal year 1999 dollars (adjusted for inflation with the gross domestic product price deflator). Years are state fiscal years.

SOURCE: Office of Legislative Auditor's analysis of data obtained from the Minnesota Department of Human Services.

programs as well as other public programs substantially increased their mental health spending during this time period. Estimates of the public insurance increase are conservative because the data for public insurance programs do not include prescription drug spending, a large and rapidly growing component of Medical Assistance expenditures. DHS does not have data on prescription drug spending for the entire decade, but its data indicate that prescription drug spending nearly doubled between 1995 and 1999 (see Table 2.9).[16]

Public programs nearly doubled their spending on mental health drugs between 1995 and 1999.

Table 2.9: Spending Trends for Mental Health Drugs Under Medical Assistance, GAMC, and Minnesota Care, 1995-99

	(Millions of Dollars) 1995	1999	Percent Change
Mental health drugs			
Anti-psychotics	$15.2	$37.8	150%
Anti-depressants	16.4	23.4	42
Anti-anxiety	2.6	4.6	77
TOTAL	$34.2	$65.9	93%

NOTE: Figures are based on spending for members enrolled in a fee for service plan. They exclude spending for members enrolled in prepaid plans.

SOURCE: Minnesota Department of Human Services, Mental Health Division.

16 Between 1995 and 1999, spending by Medical Assistance and GAMC for anti-psychotics, anti-depressants, and anti-anxiety drugs increased from $34 million to $66 million. These figures only include fee-for-service payments. They do not include HMO payments on behalf of MA and GAMC members enrolled in prepaid plans.

Public insurance program spending on mental health increased by 41 percent, not counting prescription drugs. General Assistance Medical Care (GAMC) spending was the exception, almost doubling between 1989 and 1992, but then falling to only 75 percent of its 1989 level in 1999. This decline does not necessarily reflect service cutbacks, but was primarily due to the fact that the state moved many GAMC recipients to smaller facilities in order to make them eligible for Medical Assistance. Under federal law, people living in facilities with more than 16 beds for mental illness are not eligible for Medical Assistance.

Among non-insurance programs, county, state, and federal programs all increased their spending, particularly county and state programs. As Table 2.10 shows, community support services accounted for most of the increase, building a community infrastructure that was widely regarded as inadequate.

Community support/day treatment was the fastest growing category of public mental health spending between 1989 and 1999.

Table 2.10: Public Mental Health Spending by Type of Service, 1989-99 (In millions of dollars, after adjusting for inflation)

	1989	1999	Percent Change
Public Insurance Programs			
Community support/ day treatment	$ 3.0	$ 30.4	923%
Regional treatment centers	16.4	16.3	-1
Community residential treatment	0.0	0.0	
Outpatient services	25.6	28.3	11
Acute care hospital	46.1	53.0	15
Other	0.0	0.7	
Subtotal	$ 91.2	$128.7	41
Public Non-Insurance Programs			
Community support/ day treatment	$ 32.8	116.3	254
Regional treatment centers	73.3	106.9	46
Community residential treatment	61.4	70.4	15
Outpatient services	22.8	22.2	-2
Acute care hospital	3.6	7.0	95
Other	13.1	23.2	77
Subtotal	$207.0	$346.1	67
TOTAL	$298.1	$474.8	59%

NOTE: Public insurance figures exclude spending on prescription drugs. Spending figures are in constant state fiscal year 1999 dollars (adjusted for inflation with the gross domestic product price deflator). Years are state fiscal years.

SOURCE: Office of Legislative Auditor's analysis of Department of Human Service's data.

Regional treatment centers increased spending by 41 percent during the first five years and then leveled off. Even though the state reduced the number of beds for mentally ill during the 1990s, spending increased for two reasons. First, after a 1989 federal audit found that Minnesota's Regional Treatment Center's staff ratios were too low, the federal government required Minnesota to hire more staff. Second, as the state moved people with developmental disabilities out of regional treatment centers into the community, there were fewer patients over which to spread the centers' fixed overhead costs.

Chemical Dependency

As is the case for mental health services, public programs play a large role in providing chemical dependency treatment in Minnesota. In 1988, the state consolidated public funding of chemical dependency services under one fund in order to standardize eligibility, assessment, and placement for chemical dependency treatment. In 1999, DHS chemical dependency placement data indicate that private sources (including insurance, self-pay, and other private parties) funded at least one-third of chemical dependency treatment placements in Minnesota.[17] Public insurance programs, state and federal block grants, and counties funded up to two thirds of chemical dependency placements. The DHS data also indicate that:

- **Between 1989 and 1999, public funding of chemical dependency services increased somewhat faster than inflation, but well under the rate of increase for overall health care.**

Table 2.11 shows that after adjusting for inflation, chemical dependency spending went from $62.4 million in 1989 to $70.2 million in 1999. This 13 percent spending increase is well below Minnesota's 65 percent increase in overall health care spending. One reason that spending increased was that the number of placements appeared to increase during this decade.[18]

During the last decade, the public decreased spending on inpatient chemical dependency treatment, but increased spending on other types of treatment.

Table 2.11: Public Chemical Dependency Treatment Spending, 1989-99

	(Millions of Dollars) 1989	1999	Percent Change
Inpatient	$34.3	$26.0	-24%
Outpatient	9.2	14.4	56
Extended Care	8.8	14.3	62
Halfway House	9.2	14.2	54
Methadone	0.8	1.4	65
TOTAL	$62.4	$70.2	13%

NOTE: Spending figures are in constant 1999 dollars (adjusted for inflation with the gross domestic product price deflator). Years are calendar years.

SOURCE: Consolidated Treatment Fund, Department of Human Services.

17 The consolidated fund has a complete count of publicly funded chemical dependency placements. The DAANES system counts publicly and privately funded placements, but depends on providers to report placements. To the extent that the DAANES system undercounts placements, the private share of placements would be higher than one-third.

18 The number of placements recorded by the chemical dependency data increased by 28 percent. However, treatment programs that involve a combination of inpatient, outpatient, extended care, and halfway house placements often are counted as multiple placements. To the extent that multiple placements increased over time, the data would overstate the increase in placements.

After adjusting for inflation, the average cost of publicly funded chemical dependency placements appears to have declined by about 11 percent.[19] Public programs reduced the average cost of a chemical dependency placement because they increased the use of outpatient treatment, which costs about one-third as much as inpatient treatment. After the state changed its placement criteria in 1989 to promote greater use of outpatient treatment, outpatient service's share of primary treatment placements increased from 45 percent in 1989 to 57 percent in 1991. By 1999, outpatient service's share of primary placements reached 62 percent. Another reason for the lower average cost is that public programs reduced the average length of stay for inpatient treatment.

Community Mental Health Clinics

We also examined trends in funding for community mental health clinics, which are contracted by counties to provide subsidized care for people without insurance on a sliding fee basis. Typically, these clinics serve insured and self-pay patients as well as subsidized patients. Many of the clinics are in smaller communities and are the only mental health care provider in the area. We obtained data on funding of community clinics from an annual survey conducted by the Minnesota Association of Community Mental Health Programs. We found:

- **Community mental health clinics reported declining revenues between 1995 and 1998 from public and private insurance programs, but increasing revenues from counties.**

Medical Assistance reimbursement increased by only 3 percent since 1992 for psychologists and social workers.

Data from a group of 20 mental health clinics shows that their total budget remained about $65 million between 1995 and 1998. Approximately $38 million was for services normally funded by insurance—outpatient treatment, day treatment, and psychiatric services. The share of these services funded by public and private insurance declined from about 55 percent to 43 percent between 1995 and 1998. Meanwhile, the share funded by counties increased from 23 to 38 percent.

Association members attribute much of the decline in public and private insurance revenue to inadequate reimbursement by public and private insurance programs for mental health services. For example, between fiscal years 1992 and 2001, Medical Assistance increased its reimbursement for certain mental health services (psychologists and social workers) by only 3 percent. During the same time period, increases were 6 percent for day treatment services and 18.4 percent for physicians (including psychiatrists). In contrast, Medical Assistance increased reimbursement rates by 38 percent for inpatient services, 64 percent for nursing facilities, and 74 percent for facilities serving people with developmental disabilities (ICF-MR facilities). Clinics claim that as a result, Medical Assistance reimbursement falls well short of meeting their costs for many services. This, in turn, stretches available county and foundation dollars and limits the amount of services that can be provided.

19 The estimated decline in average cost is based on the average cost of all placements funded by the consolidated treatment fund. It does not include placements financed by prepaid public insurance programs. The decline in the consolidated fund may underestimate the decline in all public programs because prepaid plans more often place patients in outpatient programs.

COST SHIFTING

In requesting this study, representatives from the State Advisory Council on Mental Health argued that insurance companies are inappropriately denying coverage for behavioral health services and forcing people to seek services from public programs. We heard similar allegations from behavioral health providers and county officials. Although we think these concerns deserve serious consideration, we were unable to obtain data or design a methodology that would allow us to verify the claims of cost shifting.

Acting completely independent of our study, the Minnesota Attorney General's Office filed a lawsuit in October 2000 against Blue Cross Blue Shield of Minnesota alleging that the company has established a "pattern and practice" of denying payment for behavior health services, resulting in those services being provided by publicly-funded programs. Although not a substitute for systematic research, it is possible that the lawsuit will bring to light information about cost shifting that we were not able to obtain.

Many provider and consumer representatives say that health plan companies delay and deny coverage of behavioral health services.

In addition, we learned that Hennepin County officials believe the county may be paying for some behavioral services that should be provided to clients covered by Medical Assistance managed care plans. These officials contend that restrictive managed care policies and practices result in people seeking services from more accessible county-operated clinics. They plan to study the problem more thoroughly in the near future.

Provider Concerns

Although we were unable to verify their claims, we think the concerns expressed to us by behavioral health service providers deserve consideration. We talked, for example, to a group of directors of community mental health centers from around the state.[20] They serve private clients, as well as clients on Medical Assistance and other public insurance plans. They told us that, in their opinion:

- Insurance reimbursement rates are low and do not cover the cost of services.

20 This group consisted of 16 members of the Minnesota Association of Community Mental Health Programs. The boards of directors of many community mental health programs are appointed by county boards and a few are county-operated. Association members provide a substantial part of the non-hospital based public mental health care in Minnesota.

- Very limited prior approval is granted by health plan companies for certain services; therefore, clinics have to spend too much administrative time seeking approval.

- They are required to deal with many different plans, different protocols, and people who give them conflicting advice.

- The advent of effective drugs means they are seeing a harder-to-treat group of patients.

- Court-ordered treatment is often not reimbursed because insurance plans say it is not medically necessary.

- The insurance companies are more accommodating for physical health services where the use of para-professionals is allowed, but they impose strict credential requirements for mental health services.

We also asked members of the Minnesota Council of Child Caring Agencies, which represents operators of residential and community programs, to describe the problems they have experienced with insurance companies. They told us that, in their opinion:

- Many providers cannot survive without charity or foundation support because reimbursement rates are not high enough.

- Insurance companies are too restrictive on the use of non-licensed people. Many providers cannot succeed financially if they are required to hire only licensed staff.

- Medical Assistance worked better under fee-for-service rather than managed care plans. Specifically, Medical Assistance is supposed to pay for family-community support services, but it is difficult to collect from Medical Assistance managed care plans.

The Department of Human Services collects less than 40 percent of the amount it bills insurance companies for county-authorized chemical dependency services.

Department of Human Services Collections

We also talked with officials at the Minnesota Department of Human Services (DHS) about the cost-shifting issue. DHS pays for chemical dependency services authorized by county courts or social service agencies, and for placement of people with mental illness in state regional treatment centers.[21] The department then seeks reimbursement from insurance companies where there is an indication that a client has coverage. We asked DHS financial management staff about their experience collecting reimbursements from insurance companies for residential and outpatient chemical dependency services and for services to people in regional treatment centers.

We found that over a period of 11 years the department has billed insurance companies about $23.6 million for chemical dependency treatment, but insurance

21 The state pays for chemical dependency services through a consolidated fund that is financed by state and federal block grants and other sources.

companies have denied about $14.7 million (62 percent of the amount billed). Financial management staff said that about half the private insurance companies ask for medical records, arguing that the services are not medically necessary even though they were authorized by the county corrections or social service system.

While there are legitimate reasons why the amount recovered could be less than the amount billed, DHS staff told us they believe a significant amount is inappropriately denied by insurers. They also said that judges and social workers inappropriately tell people they do not have to pay for services in some cases, and this results in a lack of cooperation in providing insurance company information.

There are legitimate reasons for denial of some claims, but DHS believes that some claims are inappropriately denied.

We also examined data on the amount billed versus the amount collected for placements in regional treatment centers between fiscal years 1996 and 1999. According to DHS records, about $9.5 million of $23.3 million billed was collected from insurance companies during this period. Again, the department does not know what part of the total represents a true obligation of the insurance companies. DHS staff believes that recoveries could be improved. In order to improve recoveries, the department is switching to a system of having staff in the individual regional treatment centers do the billing under the supervision of central DHS financial management staff. In the past, one person in the department's central office was responsible for all collections.

Cost Shifting in Perspective

Cost shifting is a complex issue. Both insurance companies and governments—at the federal, state, and local level—have an incentive to shift the financial burden of providing health services to another payer. Long before most private health insurance plans covered any aspect of behavioral health, state and local governments were direct providers of mental health services. For example, one of the most visible state institutions historically has been the "state hospital" for persons with mental illness. Indeed, when the Medical Assistance program was established, its coverage was not extended to adult residential treatment in state hospitals because the federal government did not want responsibility for a service that state governments had been funding for decades. Interestingly, Minnesota and other states have subsequently moved many people with mental illness out of state institutions. While deinstitutionalization was carried out primarily to improve treatment, a secondary reason was to shift the financial burden back to the federal government through the Medical Assistance program and to counties and private insurance carriers.

It is also worth noting that, even when Medical Assistance pays for services, its reimbursement rates for a wide range of services are regarded by providers and DHS itself as inadequate to cover the cost of the services. As a result, part of the cost of the services is shifted to private payers, counties, or the state. Providers and consumer representatives have complained for years that low Medical Assistance rates depress the rates that private insurers are willing to pay. They also dispute the medical necessity and level of care criteria used by Medical Assistance managed care companies and accuse the companies of burdensome paperwork requirements that makes it too time-consuming and difficult to obtain reimbursement.

There is little doubt that the current system is marked by fragmentation, conflict, and dissatisfaction among consumers and providers. It is a system in which both governments and insurance companies look for ways to diminish their financial liabilities and shift the cost to another payer. The concern that was brought to us, however, focused only on possible cost shifting from the private insurance companies to the public programs. And, as stated before, we were unable to obtain the data or design a methodology that would allow us to measure the extent to which this kind of cost shifting may be occurring.

EFFECTS OF MANAGED CARE ON BEHAVIORAL HEALTH CARE

As we discussed in Chapter 1, during the 1990s managed care emerged as the dominant form of health care in the nation in response to rapidly rising health care costs. Managed care was designed to control health care costs without jeopardizing the effectiveness of health care. In this section we examine evidence on the effects of managed care on the cost and quality of behavioral health care.

Managed care has reduced behavioral health costs more than other health care costs, according to national studies.

To examine the effects of managed care on behavioral health, we looked at both state and national sources. Although national trends may not be the same as Minnesota trends, national studies contain the best available information on the impact of managed care on mental health services. When Minnesota was changing to managed care during the 1970s and 1980s, the impact on mental health was not monitored. In preparing this study, we could only obtain data on mental health spending by Minnesota's private insurers back to the mid-1990s, well after the time managed care had become established in Minnesota.

- **National studies generally agree that managed care reduces costs for behavioral health and general health care, but there is some evidence that managed care affects behavioral health care more than general health care.**

Numerous studies have examined the effect of managed care on general health care costs. According to one review of the literature, managed care typically reduces general health care costs by between 20 and 30 percent.[22]

Various case studies as well as a major health care experiment have found that managed care also substantially reduces behavioral health care costs.[23] The RAND health insurance experiment in Seattle probably provides the best

22 David Mechanic, *Mental Health and Social Policy: the Emergence of Managed Care*, 135.

23 David Mechanic and Donna D. McAlpine, Mission Unfulfilled: Potholes on the Road to Mental Health Parity, *Health Affairs* 18, no. 5 (1999) 10-12; William Goldman, Joyce McCulloch, and RolandSturm, "Costs and Use of Mental Health Services Before and After Managed Care," *Health Affairs* 17, no. 2 (1998): 40-52; Roland Sturm, William Goldman, and Joyce McCulloch, "Mental Health and Substance abuse Parity: A Case Study of Ohio's State Employee Program," *The Journal of Mental Health Policy and Economics* 1, 129-134 (1998); and Ching-to Albert Ma and Thomas G. McGuire, "Costs and Incentives in a Behavioral Health Carve-out," *Health Affairs* 17, no. 2 (1998) 53-69.

evidence that managed care can have a large effect on behavioral health care costs.[24] This study randomly assigned people to various plans, including a prepaid HMO style of managed care and a fee-for-service plan (termed free care because there were no deductibles, copayments, or limits). Overall mental health expenditures under managed care were less than one-third of the spending under fee-for-service plans.

There is some evidence that managed care has a greater impact on behavioral health than general health care. The HayGroup study found that managed care reduced behavioral health spending by a substantially larger amount than it reduced general health care spending. Another study found that utilization review of hospital stays denied a substantially higher percentage of requested days of care for behavioral health than general health.[25]

There are sharply conflicting opinions about the impact of managed care.

While managed care reduces the cost of behavioral health care, there is not agreement whether the reductions are appropriate. Some mental health advocates have argued that the decline represents inappropriate service cutbacks, inadequate reimbursement of behavioral health care services, and cost shifting from insured plans to public payers of last resort. 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. A number of studies have examined managed care and quality of care, but the results are inconclusive. In fact,

- **The impact of managed care on the quality of mental health services is largely unknown.**

Existing evidence does not definitively answer questions about managed care's impact on quality for several reasons. First, studies have used only a few indicators of quality, reflecting the relatively primitive status of quality measurement for mental health.[26] Another reason that managed care's impact on quality is not well understood is that managed care arrangements vary widely around the nation and have changed over time, making generalizations from a few studies questionable. Few existing studies attempted to identify the specific features of managed care organizations that were successful or ineffective. Studies of organizations suggest that there are many factors that can influence the effectiveness of managed care. Among these are the degree to which the organization shares a mission to improve health care practices as opposed to merely cutting costs, staff characteristics, and external pressures from employers and state agencies that purchase health insurance.

Nonetheless, national studies illustrate some of managed care's potential benefits and drawbacks for behavioral health. On the positive side, some long-term case studies of private insurance plans found that a higher percentage of members used

24 Richard G. Frank and Thomas G. McGuire, "Economics and Mental Health," and David Mechanic, *Mental Health and Social Policy: the Emergence of Managed Care.*

25 Thomas M.Wickizer and Daniel Lessler, "Effects of Utilization Management on Patterns of Hospital Care among Privately Insured Adult Patients," *Medical Care* 36, no.11 (1998): 1545-54.

26 David Mechanic, *Mental Health and Social Policy: the Emergence of Managed Care*, 18.

mental health services after the plans implemented managed care.[27] Also, the RAND health care experiments found that a higher percentage of managed care enrollees used mental health services than did enrollees under fee-for-service plans.[28]

Some studies found that managed care reduced costs without any apparent decline in quality. For example, in the RAND health experiment, researchers found that the HMO plan had lower costs than the fee-for service plans, but there was no differences in three mental health outcome measures.[29]

Another example of managed care reducing costs without any apparent reduction in quality of care is the impact of CD treatment provided under Minnesota's Prepaid Medical Assistance Program. A DHS study found that prepaid plans (HMOs) placed 25 percent of sample CD patients in inpatient settings, compared with 41 percent of a matched sample under a fee for service plan.[30] The study found no significant differences in patient satisfaction or post-treatment abstinence rates.

Evidence of managed care's effect on health care quality is mixed.

Other studies raise concerns about managed care. One study found that managed care reduced the length of stay at hospitals, which increased the odds of readmission.[31] After Utah established a managed care plan for its Medicaid program, an evaluation found that the care received by serious schizophrenia cases changed in a variety of ways that raised questions about "the vigor of care provided to a highly vulnerable group of patients."[32] An analysis of the RAND Medical Outcomes study found that primary care physicians in HMOs were less likely to recognize depressed patients than were physicians under fee-for-service systems.[33] Also, depressed HMO patients who were identified were less likely to receive "medication continuity" and had poorer outcomes.[34]

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27 William Goldman, Joyce McCulloch, and RolandSturm, "Costs and Use of Mental Health Services Before and After Managed Care," 40-52.

28 David Mechanic, *Mental Health and Social Policy: the Emergence of Managed Care*, 136.

29 David Mechanic, Mark Schlesinger, and Donna D. McAlpine, "Management of Mental Health and substance abuse Services: State of the Art and Early Results," The Milbank Quarterly 73, no. 1 (1995) 29-30.

30 Patricia A. Harrison and Stephen E. Asche, *Fee-for service versus Prepaid Public Health Plans: An examination of chemical dependency treatment provided through two public funding systems in Minnesota*, (St. Paul, Minnesota Department of Human Services, 1999).

31 Thomas M.Wickizer and Daniel Lessler, "Do Treatment Restrictions Imposed by Utilization Management Increase the Likelihood of Readmission for Psychiatric Patients?" *Medical Care* 36, no.6 (1998): 844-50.

32 Michael K. Popin, Nicole Lurie, Willard Manning, Jeffrey Harman, Allan Callies, Donald Gray, and Jon Christianson, "Changes in the Process of Care for Medicaid Patients With Schizophrenia in Utah's Prepaid Mental Health Plan," *Psychiatric Services* 49, no. 4 (April 1998) 518-523.

33 Kenneth B. Wells, Ron D. Hays, M. Audrey Burnam, William Rogers, Sheldon Greenfield, John E. Ware, "Detection of Depressive Disorder for Patients Receiving Prepaid or Fee-for-Service Care: Results from the Medical Outcomes Study," *Journal of the American Medical Association* 262, no. 23 (1989): 518-523.

34 W.H.Rogers et al., "Outcomes for Adult Patients with Depression Under Prepaid or Fee-for-Service Financing," *Archives of General Psychiatry* 50, no. 7 (1993): 517-25.

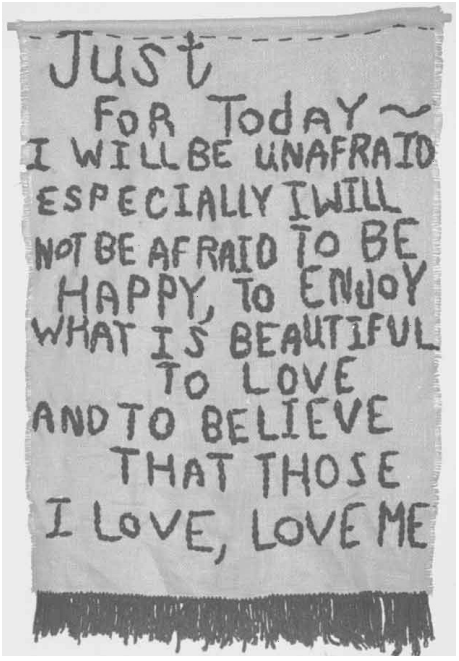
QUALITY OF CARE IN MINNESOTA

There is even less information on the effect of managed care on quality of mental health care in Minnesota as there is nationally. Nevertheless, the Minnesota Department of Health recently began collecting data on two mental health effectiveness indicators. In addition, the Department of Human Services recently completed an outcome study for chemical dependency treatment programs. We discuss the results of these efforts below.

Mental Health Care

A national HMO accrediting organization has established two indicators of mental health care quality.

The Department of Health requires HMOs to annually report various effectiveness indicators developed by the National Committee for Quality Assurance (NCQA), including two mental health care indicators. These indicators measure (1) whether HMO enrollees who were hospitalized for mental illness receive appropriate follow-up care and (2) whether HMOs appropriately manage antidepressant medication. The health department first required Minnesota HMOs to report these measures for 1999 encounters. As a result, it is too early to measure trends with these data. We can compare Minnesota HMOs with the national average for commercial HMOs, though data are not collected for other types of health plans.



According to NCQA, regular follow-up therapy is important for patients who have been hospitalized for mental illness. To ensure that the patient makes an appropriate transition to home and work, patients should have an outpatient visit with a mental health practitioner within 30 days of discharge. In fact, officials from Medica's behavioral health plan (United Behavioral Health) told us that 30 days is too long and that 7 days is a more appropriate standard. NCQA uses both the 7 and 30-day standards to assess follow-up care performance.

Table 2.12 compares follow-up rates after hospitalization for mental illness in Minnesota with the nation for 1999. We found:

- **Minnesota HMOs provided appropriate follow-up care after hospitalization for mental illness slightly more often than the national average, but there is considerable room for improvement.**

Table 2.12: Percentage of Commercial HMO Patients Hospitalized for Mental Illness Receiving Follow-up Care, 1999

		Percentage Receiving Follow-Up Care	
	(*N*)	Within 7 Days	Within 30 Days
National Average		48%	70%
Minnesota HMOs	1,966	49	74
Medica	795	67	79
Health Partners	570	40	79
Blue Plus	538	32	64
Other	63	41	62

NOTE: The above figures represent the following: Among patients who were hospitalized for mental illness, the percentage who were seen on an outpatient basis by a mental health practioner within the specified time after discharge.

SOURCES: The figures for Minnesota came from the Minnesota Department of Health. The national figures came from the National Committee for Quality Assurance.

In Minnesota, 49 percent of commercial HMO patients hospitalized for mental illness received follow-up care within 7 days of discharge.

In Minnesota, 49 percent of commercial HMO patients received follow-up care within 7 days of discharge, and 75 percent received follow-up care within 30 days. Comparable national follow-up rates for commercial HMO plans were 48 percent for 7 days and 70 percent for 30 days.[35] Follow-up rates varied considerably among Minnesota's health plans, particularly for the 7-day follow-up rate. Among Minnesota's three major health plans, 7-day follow-up rates ranged from 67 percent to 32 percent.

Effective follow-up depends both on the HMO as well as the patient, so a 100 percent follow-up rate may not be realistic. But the range of follow-up rates achieved by individual health plans gives some indication of what is possible. Nationally, 10 percent of health plans had follow-up rates that met or exceeded 67 percent for the 7-day measure and 86 percent for the 30-day measure.

Three other mental health effectiveness indicators used by NCQA assess antidepressant medication management. Effective medication treatment depends on patients remaining on medication for extended time periods.[36] NCQA uses two indicators to track whether patients remained on antidepressant medication for the first 12 weeks (the acute phase) and the first six months (the continuation phase) of treatment. It is also important to monitor the patient in order to identify side effects, assess the drug's effectiveness, and make appropriate adjustments in dosage. NCQA's third indicator tracks whether patients receive optimal practitioner contacts, defined as at least three outpatient visits within the first 12 weeks.

35 National Committee for Quality Assurance, *The State of Managed Care Quality, 2000*, (Washington D.C., National Committee for Quality Assurance, 2000).

36 Kenneth B. Wells, Roland Sturm, Cathy D. Sherbourne, and Lisa S. Meredith, *Caring for Depression* (Cambridge, MA: Harvard University Press, 1996): 18-23.

Table 2.13 compares the performance of Minnesota HMOs with commercial HMO plans in the nation. We found:

- **The two large commercial HMO plans in Minnesota that reported data appear to have managed antidepressant medication about as well or better than the national average. Again, there is considerable room for improvement.**

Table 2.13: Anti-Depressant Medication Management, 1999

		Percentage of Patients who Remained on Antidepressant Medication for the First		Percentage of Patients who Received at Least 3 Visits During the First 12 Weeks
	(*N*)	12 Weeks	6 Months	
National average (commercial HMOs)		59%	42%	21%
Minnesota HMOs				
Commercial				
Medica		68	50	30
Health Partners		57		
Medical Assistance	970	46	32	26
Minnesota Care	628	56	38	18
General Assistance Medical Care	198	51	38	29
Medicare	483	48	33	22

NOTE: According to the National Committee for Quality Assurance, it is important to meet the three standards shown above to ensure effective antidepressant medication treatment. The three measures are based on patients with new episodes of depression who were treated with antidepressant medication.

SOURCES: Figures for Minnesota public programs came from the Minnesota Department of Health. The figures for Minnesota commercial programs came from the health plans. The national figures came from the National Committee for Quality Assurance.

HMO members in public insurance programs continued their antidepressant medication less often than members of commercial HMO plans.

Among commercial plans, Medica's performance was consistently above the national average and Health Partners was close to the national average.[37] But many patients treated with antidepressant medication did not continue their treatment for the first 12 weeks and half or more did not maintain treatment for six months.

Patients were less likely to continue their antidepressant management under prepaid public insurance programs than under commercial plans. For example, 50 percent of patients insured by public programs continued their medication for at least 12 weeks, compared with 57 and 68 percent under the two commercial plans.

According to mental health practitioners we interviewed, low performance can reflect two problems. First, people with depression are not getting the medication treatment they need to be effective. Second, antidepressant medication may be

37 MDH did not collect data on antidepressant medication management for commercial plans in 1999. As a result, only the three plans accredited by NCQA collected these data for commercial plans.

prescribed for mild, short-term cases of depression that may not require antidepressant medication. It is not clear to what extent each of these factors explains the medication management performance. As with the follow-up measure, the medication management measures reflect patient motivation as well as HMO performance.

Only recently have state agencies begun to systematically analyze the quality of mental health care.

State agencies in Minnesota have only begun to systematically examine the quality of mental health care in the state. The Department of Human Service's performance measurement and quality improvement program for Medical Assistance contains the components typically used by other states, such as collecting encounter data from HMOs, conducting consumer satisfaction surveys, and developing a consumer complaint process. However, only recently has DHS made the encounter data suitable for detailed analysis. The consumer satisfaction surveys do not specifically address mental health issues. And as we show in Chapter 5, consumer complaint data do not provide much useful information to help assess the quality of mental health care. Currently DHS is nearing the end of the first phase of a major three-part study on mental health in Minnesota. Under the first phase, which DHS expects to finish in early 2001, the department is assessing the extent to which mental health needs are being met in Minnesota. Later phases will examine the quality of mental health care and mental health outcomes.

Chemical Dependency Treatment

Critics of managed care have questioned spending cutbacks in chemical dependency services, particularly the substitution of outpatient treatment for inpatient treatment and reductions in inpatient length of stay.[38] During the past decade, Minnesota's public programs increased the use of outpatient treatment and reduced the average length of stay for inpatient treatment. As we explained earlier in this chapter, a change in placement criteria by the state explains much of the increase in outpatient usage. The DHS study we discussed above suggests that another factor might be the increased use of pre-paid plans under Medical Assistance. The study found that pre-paid plans placed a higher percentage of chemical dependency patients in outpatient settings than fee-for-service plans, but achieved similar outcomes. In addition,

- **A recent DHS study suggests that Minnesota could further increase its use of outpatient placements for chemical dependency treatment without reducing effectiveness.**

This DHS study compared chemical dependency outcomes among a sample of nearly 5,000 adult patients from over 200 inpatient and outpatient treatment

38 E.A.Renz, R.Chung, Y.O.Fillman, D.Mee-Lee, and M.Sayama, "The Effect of Managed Care on the Treatment Outcomes of Substance Abuse Disorders,"*General Hospital Psychiatry*, 17 (1995), 287-92.

programs.[39] It found that inpatient programs had superior results than outpatient programs among patients who were seriously impaired in at least four out of five problem areas or who reported recent suicidal behavior. But patients that did not meet these criteria did not have significantly higher posttreatment abstinence rates under inpatient programs than patients with the same problem severity level had under outpatient programs.

Most inpatient placements in Minnesota (61 percent) did not meet the conditions that, based on the DHS study, would justify inpatient treatment. These results suggest that many adults treated on an inpatient basis could be treated on an outpatient basis (at about one-third the cost) without reducing their chances of achieving abstinence. The study also noted that 16 percent of patients who were treated in an outpatient setting met the conditions that would justify inpatient treatment.

39 Patricia A. Harrison and Stephen E. Asche, *The Challenges and Benefits of Chemical Dependency Treatment: Results from Minnesota's Treatment Outcomes Monitoring System, 1993-1999*, (St. Paul: Minnesota Department of Human Services, 2000). Results were based on a sample of 4,953 adults who received publicly funded chemical dependency treatment from an inpatient or outpatient program between 1993 and 1999. Participants were obtained from 41 inpatient treatment programs and 167 outpatient programs. The study also examined smaller samples of extended care patients, halfwayhouse residents, and adolescent patients. Each program sought volunteer participants until the target of 30 participants was reached. Post-treatment follow-up interviews were successfully completed for 63 percent of the sampled adults.

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.

Further Reading

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Protecting, maintaining and improving the health of all Minnesotans

February 1, 2001

Mr. James Nobles
Legislative Auditor
Office of the Legislative Auditor
Centennial Building
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

The Minnesota Department of Health appreciates the opportunity to respond to your February 2001 report on insurance for behavioral health care. Your staff has done an excellent job of describing and analyzing this complicated issue. The report offers an informative review of trends in the use of mental health services and information that is currently available on how the increased prevalence of managed care has affected the use of mental health services.

Ensuring that Minnesotans receive mental health services when they are needed is a significant and important public health challenge. Neglected mental health needs have an impact on citizens' ability to fully participate in their families and communities. Mental illness also has a negative impact on physical health, and all too often results in the tragic and unnecessary loss of lives. Yet, according to a 1999 report from the U.S. Surgeon General, nearly half of all Americans who have a severe mental illness do not seek treatment.

In 1995, Minnesota made steps toward ensuring that its citizens have access to adequate mental health services by enacting a parity law that prohibits health plans from using more restrictive limits and copayments for behavioral health services than they do for other types of health care services. However, there are many other factors impeding access to effective mental health services. These barriers include the limited effect of parity laws on self-insured plans, a lack of awareness of different types of mental illness and their treatability, the perceived stigma of mental illness and help-seeking, and for some, financial barriers such as the lack of health insurance coverage.

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. We need to work toward improving access to, and effectiveness of, mental health services in areas that have already been identified, but we also need to improve our ability to assess the quality of mental health services provided in Minnesota across a range of measures and populations.

Ensuring that all Minnesotans have access to appropriate, high-quality mental health services will require coordinated efforts on many fronts, including:

- education about mental illness and its impact on individuals and the community;
- mental health promotion and prevention efforts, including promoting public awareness of the many types of mental health services that are available in the community;
- promoting public awareness of the treatability of mental illness and fostering linkages to mental health services available in the community;
- continued monitoring to ensure that Minnesotans who need mental health services have the appropriate level of access to those services; and
- improved ways of measuring the quality of mental health services provided in Minnesota, including improved measurement of health outcomes.

This effort requires a strong partnership among state agencies, health plans, providers of mental health services, public and community health professionals, and consumers. MDH is committed to efforts that will improve the mental health of our citizens, and in particular to efforts to reduce health disparities in our state.

Thank you again for the opportunity to respond to this important report.

Sincerely,

/s/ Jan K. Malcolm

Jan K. Malcolm
Commissioner

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January 31, 2001

Elliott Long
Roger Brooks
Deputy Legislative Auditors
Office of Legislative Auditor
140 Centennial Building
658 Cedar Street
St. Paul, Minnesota 55155-1603

RE: Insurance for Behavioral Health Care Report

Dear Mr. Long and Mr. Brooks:

The Department of Commerce finds the legislative auditor's Insurance for Behavioral Health Care report to be very informative and educational.

We agree that mental health and chemical dependency services have to be improved within the state of Minnesota. This can be accomplished by an ongoing discussion between the recipients of these mental health and chemical dependency services, the medical providers and the payers (health carriers and self-insured employers). Once this level of communication has been implemented, progress can be completed in treating the patient's health care needs.

As a regulator of all licensed health care companies, Blue Cross and Blue Shield of Minnesota, TPAs and UROs, we strongly enforce all of our statutes, rules and regulations that pertain to mental health and chemical dependency parity. We also review the quality and accessibility of mental health and chemical dependency services by monitoring the health plan company's provider networks, their utilization review, staffing and appeals process, and a thorough investigation of all complaints.

The Departments of Health and Commerce developed and helped enact the current health dispute resolution process, which provides all Minnesotans who have a fully insured health plan the assurance of a fair and unbiased appeals process. Upon a denial from the health plan company or the utilization review process, an appeal can be made to the Commissioners or an outside entity that will provide a timely and impartial medical decision for the consumer.

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, advocating new legislation changes and educating the public about federal and state requirements. With more awareness of our department's roles, improvements will be made for the individuals in need of adequate treatment of mental health and chemical dependency services.

If the Department of Commerce or I can be of further service to the Office of Legislative Auditor, please feel free to contact us.

Sincerely,

/s/ John E. Gross

JOHN E. GROSS
DIRECTOR, HEALTH CARE POLICY

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