Kirk C. Allison, Ph.D., M.S.
Program in Human Rights and Health /
Division of Health Policy and Management
University of Minnesota School of Public Health[1]
420 Delaware Street SE, MMC 164
Minneapolis, MN 55455
Email: alli0001@umn.edu
Tel. 612-626-6559
Fax 612-626-3908

Request for Information Regarding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). FR Doc. E9-9629. Federal Register 79(80):19155-19158. April 28, 2009.

State Comparison: Minnesota

In 1996, Minnesota was the first state to implement comprehensive mental health (MH) and chemical dependency (CD) parity legislation (Minnesota Statute § 62Q.47) that is substantially similar to the current MHPAEA. In passing, the similarity is unsurprising given the MHPAEA honorific and early sponsorship by Senator Paul Wellstone (D-Minnesota).

Minnesota Statute § 62Q.47 required MH and CD benefits to at least match general hospital and surgical benefits. It also fell under the generally applicable a small employer exemption.

> Cost-sharing requirements and benefit or service limitations for outpatient [inpatient] mental health and outpatient [inpatient] chemical dependency services [...] must not place a greater financial burden on the enrollee, or be more restrictive than those requirements and limitations for outpatient [inpatient] medical services.[2]

Such similarities provide an early laboratory and experience set in the context of MHPAEA.

---

[1] For identification purposes only. All analysis and comments are my own rather than on behalf of the University of Minnesota.

[2] Mental Health and Chemical Dependency Services, Minn. Stat. § 62Q.47 (1996); 1995 Minn. Laws c 234 art 2 s 29. [Clause (b) covers outpatient services, clause (c) inpatient services]. https://www.revisor.leg.state.mn.us/statutes/?id=62Q.47

In 2006 I undertook a study[3] examining i.a. health insurance switching comparing mental health service users and nonusers as a natural experiment before and after implementation of Minnesota Statute § 62Q.47.

In this context two questions were of interest:

1. Were MH service users 'held' by plans with higher MH benefits within a set of insurance plan options also when premium repricing and other plan benefit incentives induced non-MH service users to change plans?

2. After the parity legislation was there evidence of MH service users 'releasing' from prior plans in response to parity given premium and other benefit changes?

An affirmative answer would indicate disproportionate selection or retention for plans offering more generous MH benefits with less market responsiveness by MH service users to other price or quality signals.

With the parity law passed in 1995 and effective in 1996, study data derived from the 1994-1996 Minnesota State Employee Group Insurance Program (SEGIP). SEGIP covered circa 57,000 employees statewide; with dependents a total of 144,000 covered lives. The sample drew from the seven-county Minneapolis-St. Paul metropolitan area, which guaranteed a uniform plan set in the sample for each chooser for the annual open enrollment.[4]

The choice set included 5 plans for 1994 and 1995 from 4 firms (including 1 "State Plan" in 1994-95) and 6 plans in 1996 (including a second "State Plan" in 1996). The new low-premium plan provided a novel point of comparison for employee choices in 1996. In this sample 12.5% of all policy holders had a MH data marker (445 of 3556). This included 10.3% Individual and 14.5% Family market enrollees.

Pre-parity MH/CD benefit characteristics: For years 1994-95 inpatient MH covered days ranged from 24 to 58. CD covered days were more generous but ranged more narrowly from 58 to 71. After parity in 1996 all plans offered 365 covered days for both MH and CD coverage - matching general medical and surgical benefits for all plans.

---

[3] Allison KC. *A Discrete Choice Model Analysis of Health Insurance Transition, Branding Effect, and Status Quo*. Health Services Research, Policy and Administration MS Project. University of Minnesota, 2006 (177 pp.)

[4] The data comprised 1) historical health plan premium, cost and benefit information from open enrollment publications; 2) a random sample for a pre-post telephone survey collected in 1995-96, and 3) back-linked administrative data covering plan choice from 1994-1996. The random sample included 1563 individual enrollees who were present across the three years.

Re Request II.B.1.

1) Before parity, MH coverage was more restrictive than CD coverage. Coverage also varied for with different levels within the choice set for both MH and CD.
2) That MH service benefits were lower and differences greater than for CD benefits indicates plans treated MH as a more risk critical domain: More restrictive MH coverage points to a higher per enrollee cost of aggregate MH services compared to CD services. (The upper bound of MH coverage equaled the lower bound of CD coverage.)
3) Lower coverage levels within the choice set are a disincentive for MH enrolment, with lower benefit levels relative to CD benefits in every plan to limit MH cost exposure.

If typical, MHPAEA will have a greater market and cost impact on MH services relative to CD services. Covered plans will no longer be able to use benefit differentials to disincentivize enrollment by MH service users in specific plans nor to limit MH cost exposure differentially relative to CD cost exposure.

Plan choice analysis: Multivariable discrete choice analysis and switching mapping before and after parity were used to investigate baseline and change of choice patterns comparing MH vs. non-MH service users.[5]

For 1996, parity removed coverage incentives unique to either MH and CD service usage (though not necessarily provider relationship incentives): Plans had to compete for all users according to other benefit structures (e.g. differences in co-pays, self-referral, price, etc.).

The results of the switching analysis were as follows:

- Parity was followed by a modest increase in switching by MH service users.

  In the *individual market* MH switchers increased after parity marginally but nonsignificantly by 0.61% (p=.86) while non-MH user switchers decreased significantly by -3.38% (p=.02).

  In the *family market* both MH service users and nonusers increased in switching (MH +2.31%, p=.44, non-MH +3.36%, p=.02).[6] A more marked contrast in the individual market may be due to the fact that the preferences and needs of a single individual do not compete and are not offset by others within the family unit.

[5]The data set did not include a chemical dependency service use marker, hence the analysis concerned MH service users. The benefit structure, however, indicates cost exposure to MH to of greater concern than cost exposure to CD service use.

[6]In the individual post-parity market there were 2 zero premium plans, in contrast to a single low-cost plan in the family market with the former low cost plan now 3rd, whereas one of the zero premium individual plans was the previous low-cost plan.

- In general MH service users switch less than non-MH service users with or without MH benefit parity; that is, MH service users are less responsive to market forces, although the specific MH benefit incentives disappeared with parity aligning with overall plan benefits in situations of competitive choice (which may or may not be the context for small firms offering their employees health insurance). This differential effect however is attenuated through parity (given marginally increased MH service user mobility, in particular in the individual market).

- Given lower levels of switching by MH service users, in multiple plan contexts *new plans* entering the market in the first year will have a lower case mix of MH service users than continuing plans, other factors being equal. Where MH service users have higher than average cost profiles, this will result in a less costly pool for the new plan. (In the family market with a single low cost plan (the new plan), every prior plan had a significant positive MH user coefficient vis. the new plan.)

- Given lower levels of switching by MH service users, plans losing market share will increase their relative case mix of MH service users. Plans gaining market share will decrease their relative mix. In the case of the SEGIP data, on average the highest premium plan had the greatest concentration of MH service users (others switched away) even though that plan had the median benefit level.

- In case of a cost differential between MH and CD benefits and higher pre-parity levels of CD coverage, relative cost mix of MH service exposure will predominate over CD cost exposure after parity.

- Relative to total cost differences in MH/CD to medical/surgical aggregate costs and exemption rules under MHPAEA, language should clarify the 2% first year and 1% subsequent cost increase threshold *per enrollee*.

- Parenthetically from a plan manager point of view, the best strategy for lowering MH/CD mix below average prevalence (aside from being a new plan) is to offer a benefit structure that appeals broadly across the pool in a competitive choice context.

Re 2.A.(ii). In multi-plan contexts, less competitive plans that fall below 100 enrollees will be able to once again disincentivize MH/CD enrollees from remaining in those plans by ratcheting down from parity levels, inducing switching to parity plans. Also rather than offering 1 plan covering say 150 employees, there may be a perverse incentive to offer several plans, none of which reach the 100 member threshold. (To clarify: is the threshold vis. each employer or a specific plan offered to multiple employers pooling by one insurer?)