COMMERCE DEPARTMENT

Evaluation of HF 3479 / SF 3510 – Coverage for Mental Health Services for Children

Report to the Minnesota Legislature Pursuant to Minn. Stat. § 62J.26

January 28, 2025

Report Prepared By

This report was prepared by the American Institutes for Research (AIR) at the request of the Minnesota Department of Commerce. AIR created this document for internal use by the Minnesota Department of Commerce pursuant to Contract No. 216732. The document assumes reader familiarity with the proposed mandated health benefits currently under consideration by the Minnesota State Legislature. The document was prepared solely to assist the Minnesota Department of Commerce. No other use of this document or the information or conclusions contained herein is authorized. The period of data collection for any policies and literature analyzed for the proposed mandate ended on December 31, 2024.

Defrayal analysis completed by the Minnesota Department of Commerce is independent of AIR's evaluation.

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Introduction

In accordance with Minn. Stat. § 62J.26, the Minnesota Department of Commerce (Commerce), in consultation with the Minnesota Department of Health (MDH) and Minnesota Management and Budget (MMB), performs an evaluation of benefit mandate proposals. For evaluation criteria and required evaluation components, please review the Evaluation Report Methodology, available at https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

Bill Requirements

House File (HF) 3479 and Senate File (SF) 3510 are sponsored by Representative Zack Stephenson and Senator Alice Mann and were introduced in the 93rd Legislature (2023-2024) on February 12, 2024.

If enacted, this bill would prohibit co-payment for mental health services for children under the age of 18, except in the case of high deductible health plans (HDHP). For HDHPs with a health savings account, a health issuer may only apply cost-sharing (e.g., co-payments) at the minimum level necessary to preserve the enrollee's ability to maintain the health savings account, as outlined in section 223 of the Internal Revenue Code of 1986.

This proposed mandate would apply to fully insured small and large group commercial health plans, individual market plans, Medicare supplemental policies, and the State Employee Group Insurance Program (SEGIP). This would not apply to self-insured employer plans and grandfathered plans. While the proposed mandate, as written, doesn't explicitly apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare), licensed health maintenance organizations (HMOs) that participate in the programs as managed care organizations (MCOs) are required to meet the requirements of coverage in chapter 62Q.

This bill would create Minn. Stat. § 62Q.474.

Related Health Conditions and Associated Services

There are no specific conditions identified by the proposed mandate. Mental health services are provided for children across a broad spectrum of conditions and symptoms including,[1] but not limited to:

- Depression;
- Attention-deficit/hyperactivity disorder;
- Behavior problems; and
- Anxiety.

There are a broad range of mental health services available for children with mental and behavioral health disorders, which vary depending on a child's age, symptoms, and symptom severity.[2,3] Examples of mental health services for children include, but are not limited to:

- Medication and medication management;

- Counseling and psychotherapy (e.g., cognitive behavioral therapy); and
- Caregiver/family education.

Public Comments Summary

Commerce solicited public input on the potential health benefit mandate through a request for information (RFI) posted to Commerce's website and the Minnesota State Register. The summary below represents only the opinions and input of the individuals and/or organizations who responded to the RFI.

Key Stakeholder Comment Themes

For this proposed mandate, Commerce received RFI responses from four commercial health issuers, one health care organization, one health care provider, and three advocacy organizations.

Current Coverage and Nondiscrimination Standards. Two respondents confirmed that some commercial health insurance plans in Minnesota cover mental health services for children aged 18 and under, but the service settings (e.g., inpatient versus outpatient) and cost-sharing vary across plans. However, they also highlighted that offering this benefit to a specific age group might conflict with federal nondiscrimination standards by favoring individuals based on age.

Clarity of Bill Language. Several respondents noted the ambiguity in the proposed mandate language and stated that coverage could include outpatient services, inpatient services (e.g., partial hospitalization program, intensive outpatient program, residential services), and prescription drugs. Another respondent supported the proposed mandate as it ensures access to mental health services but noted the omission of non-pharmaceutical approaches, such as acupuncture, which provide holistic care without pharmaceutical risks.

Cost-Sharing. Some respondents expressed concerns with the proposed elimination of cost-sharing for services as it would result in increased costs which would be passed to consumers through premiums. However, another respondent emphasized that removing cost barriers for children's mental health services could help address the adolescent mental health crisis. Two respondents expressed concern that removing co-pays may increase utilization but could further strain mental health staff shortages. Additionally, some respondents noted a preference for in-network coverage to avoid fraud, waste, and abuse.

General Comments. One respondent highlighted Minnesota's implementation of Minn. Stat. § 62M.07, effective January 1, 2026, which prohibits prior authorization for certain medical conditions, including outpatient mental health or substance use disorder treatment, antineoplastic cancer treatment per National Comprehensive Cancer Network® guidelines (excluding medications), preventive services, pediatric hospice care, neonatal abstinence program treatment by pediatric pain or palliative care specialists, and chronic condition treatment. The respondent suggested that many of this year's proposed benefit mandates fall under this new statute and expressed concerns that removing prior authorization could increase health care costs and negatively affect health outcomes for Minnesotans.

Another respondent noted that all of the proposed health benefit mandates have the potential to broadly improve health outcomes for Minnesotans by enhancing their quality of life, supporting individuals, families, and caregivers, and increasing workforce participation, while also benefiting the broader health care system.

Cost Estimates Provided in Stakeholder Comments

Stakeholders and MMB provided the following cost estimates related to the proposed health benefit mandate:

- MMB's health plan administrators expect that this proposed mandate will have a fiscal impact on SEGIP, but they could not estimate the average cost per member per month (PMPM) due to recent changes to mental health benefits under the state plan. The state plan covers mental health benefits with no cost-sharing for some services while others have varying out-of-pocket costs (see State Fiscal Impact section).
- Respondents indicated that some commercial health insurance plans provide coverage for mental health services for children aged 18 and under with cost-sharing. If enacted, respondents indicated that this expanded coverage may result in an increase of up to $2.40 PMPM, assuming all mental health services (i.e., inpatient and outpatient) are included in coverage requirements.

Stakeholders' results may or may not reflect generalizable estimates for the mandate, depending on the methodology, data sources, and assumptions used for analysis.

Evaluation Limitations

Children's mental health services include a vast array of services, provider types, procedures, medications, and diagnosis codes. As a result, it is not feasible to reliably identify a representative set of codes for the services, medications, facilities, and diagnoses covered by the mandate at no cost-sharing for this evaluation. Care provided to children may take place across a broad range of settings, including schools, which may be covered through other public programs (e.g., education) and not captured in claims within the Minnesota All Payer Claims Database (MN APCD). Additionally, inpatient care claims may present as bundled service claims in the MN APCD, increasing the complexity of evaluation for service-specific utilization and associated cost. While there is literature to address some public health considerations for the proposed coverage, given the broad scope of the mandate, there are no studies that specifically address the effectiveness, cost, and potential utilization of all covered services, and the degree to which cost-sharing specifically would impact health expenditures and outcomes.

State Fiscal Impact

The potential state fiscal impact of this proposed mandate includes the estimated cost to SEGIP as assessed by MMB in consultation with health plan administrators, the cost of defrayal of benefit mandates as understood under the Patient Protection and Affordable Care Act (ACA), and the potential impact to Minnesota Health Care Programs.

- MMB expects the proposed mandate to have a fiscal impact on the state plan, but costs could not be estimated at this time due to recent changes to mental health benefits.
- There are no estimated defrayal costs associated with this proposed mandate.
- While the proposed mandate, as written, does not explicitly apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare), licensed health maintenance organizations (HMOs) that participate in the programs as managed care organizations (MCOs) are required to meet the requirements of coverage in chapter 62Q. However, there is no estimated cost to Minnesota Health Care Programs given the current level of cost-sharing for the required coverage.

Fiscal Impact Estimate for SEGIP

The state plan covers mental health prescription drugs with co-pays and mental health services including outpatient and inpatient professional services for diagnosis and treatment of behavioral health disorders, evaluation, and crisis intervention with cost-sharing. Additionally, as of January 1, 2024, the plan also covers mental health and substance use disorder office visits with different cost-sharing requirements, including some services with no cost-sharing and others with varying out-of-pocket costs depending on the place of service.

MMB expects the proposed mandate to have a fiscal impact on SEGIP, but PMPM costs could not be estimated due to the recent changes to mental health benefits. A full year of claims, effective after January 1, 2024, is needed for assessment.

MMB assumes the state plan already covers most children's mental health office visit co-pays due to 2024 benefit changes. However, MMB assumes for this estimate that co-payments for children's mental health prescription drugs and cost-sharing for clinician-administered drugs will be allowed under the bill. If prescription drugs and cost-sharing for clinician-administered drugs were included in the prohibition on cost-sharing, this would increase the cost impact to SEGIP.

Patient Protection and Affordable Care Act Mandate Impact and Analysis

States may require qualified health plan issuers to cover benefits in addition to the 10 essential health benefits (EHBs) defined by the ACA but must defray the costs, either through payments to individual enrollees or directly to issuers, and can partially defray the costs of proposed mandates if some of the care, treatment, or services are already covered in the state's benchmark plan or mandated by federal law, pursuant to section 1311(d)(3)(b) of the ACA. For further defrayal requirements and methodology, please visit https://mn.gov/commerce/insurance/industry/policy-data-reports/62j-reports/.

If enacted, the proposed mandate would not constitute an additional benefit mandate requiring defrayal, as HF 3479/SF 3510 does not relate to any new requirements for specific care, treatment, or services that are not already covered by Minnesota's benchmark plan. The Minnesota EHB Benchmark Plan requires coverage for mental and behavioral health services.[4] The proposed mandate only alters cost-sharing associated with required coverage.

Fiscal Impact of State Public Programs

While the proposed mandate, as written, does not explicitly apply to Minnesota Health Care Programs (e.g., Medical Assistance and MinnesotaCare), licensed health maintenance organizations (HMOs) that participate in the programs as managed care organizations (MCOs) are required to meet the requirements of coverage in chapter 62Q. However, there is no estimated cost to Minnesota Health Care Programs as there is currently no enrollee cost-sharing in Medical Assistance, and there is no cost-sharing for MinnesotaCare enrollees under the age of 21.

Appendix A. Bill Text

Section 1**. [62Q.474] MENTAL HEALTH AND CO-PAYMENTS FOR CHILDREN.**

(a) A health plan company is prohibited from requiring a co-payment to be paid for mental health services received by a child under the age of 18.

(b) A health plan that is a high-deductible health plan in conjunction with a health savingsaccount must require a co-payment for mental health services received by a child under the age of 18 at the minimum level necessary to preserve an enrollee's ability to make tax-exemptcontributions and withdrawals from the health savings account, as provided under section of the Internal Revenue Code of 1986, as amended.

EFFECTIVE DATE. This section is effective January 1, 2025, and applies to health plans offered, issued, or renewed on or after that date.

Works Cited

1. Centers for Disease Control and Prevention. About Children's Mental Health. Updated August 20, 2024. Accessed September 11, 2024. https://www.cdc.gov/children-mental-health/about/index.html

2. Walter HJ, Bukstein OG, Abright AR, et al. Clinical Practice Guideline for the Assessment and Treatment of Children and Adolescents With Anxiety Disorders. *J Am Acad Child Adolesc Psychiatry*. 2020;59(10):1107-1124. doi:10.1016/j.jaac.2020.05.005

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4. Centers for Medicare & Medicaid Services. Minnesota EHB Benchmark Plan (2025-2027*).* Accessed November 4, 2024. https://www.cms.gov/files/document/mn-bmp-summary-py2025-2027.pdf