
Study of Proposed Mandated Additional Mental Health and Alcohol and Drug Abuse Insurance Benefits

A Report to the
Governor
and the
Legislature of
the State of
Hawaii

Report No. 97-19
December 1997

THE AUDITOR
STATE OF HAWAII

OVERVIEW

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STATE OF HAWAII

Study of Proposed Mandated Additional Mental Health and Alcohol and Drug Abuse Insurance Benefits

Summary

House Concurrent Resolution No. 18, House Draft 1, Senate Draft 1 of the 1997 legislative session requested the Auditor to assess the social and financial impact of mandating parity in mental health and substance abuse insurance coverage. House Bill No. 427 was introduced in the 1997 legislative session to mandate that insurance coverage for mental health and alcohol and drug abuse treatment be no less extensive than that provided for other medical illnesses. The current law mandating health insurance coverage for mental illness and substance abuse treatment insurance benefits is scheduled to sunset on July 1, 1998.

Mandated insurance coverage for mental health and substance abuse services is provided under Chapter 431M, Hawaii Revised Statutes, "Mental Health and Alcohol and Drug Abuse Treatment Insurance Benefits." Coverage for mental health and substance abuse services is also provided under Hawaii's workers' compensation and motor vehicle insurance laws. Under the current law, a wide variety of mental health and substance abuse services are presently available. Providers include psychiatrists, psychologists, advanced practice registered nurses, and clinical social workers.

House Bill No. 427 would amend Chapter 431M, HRS, by deleting the required benefits for inpatient hospital services, non-hospital, and outpatient mental health services, and alcohol and drug treatment and detoxification services. The proposed amendment would require benefits for mental health and substance abuse services be no less extensive than coverage provided for any other medical illness. It would put coverage for mental health and substance abuse services on par (or provide parity) with services provided for other medical illnesses.

Interest and momentum for parity in insurance coverage for mental health and substance abuse services follows Congress' enactment of the Mental Health Parity Act of 1996. Thus far, nine states have parity laws.

The lack of a definition of parity affects the assessment of H.B. 427. Depending on the insurance plan, there *are* limits on coverage for other medical illness services. These limits include the number of covered authorized visits, copayment provisions, types of services covered, and medical necessity of the service. Parity, then, would mean varying limits on mental health services—depending upon the individual insurance plan.



There is very limited information on the extent to which the lack of parity in coverage results in persons being unable to obtain necessary treatment. Currently, insurers and mental health advocates indicate that a small proportion of Hawaii's population is using mental health and substance abuse services. Of those, few reach their benefit maximums. Therefore, there appears to be adequate access to mental health services for members who use these services. For individuals with severe mental disorders, the lack of parity in mental health coverage may result in hardship under the current coverage.

In light of the low demand from employee groups, and low utilization under the coverage currently available, we conclude that mandating parity in coverage for all mental health and substance abuse services is not warranted at this time. Also, changing the law to define treatment in hours instead of visits might provide sufficient additional coverage.

Recommendations and Response

The Department of Health supports a process through which health insurance mandates are periodically and collectively reviewed. The department expects over the long term, parity in private insurance would allow patients to get treatment earlier and have a better chance of remaining employed and covered by private insurance. The department has concerns about the limited scope of our review. It questions whether parity is not warranted and whether hours of treatment instead of visits is a solution for outpatient treatment.

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Submitted by

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Foreword

Sections 23-51 and 23-52, Hawaii Revised Statutes, require the State Auditor to study the social and financial impact of measures that propose to mandate health insurance benefits. The purpose of these studies is to give the Legislature an objective basis for evaluating the merits of the proposals. As requested by House Concurrent Resolution No. 18, House Draft 1, Senate Draft 1 of the 1997 legislative session, this report assesses the social and financial impact of mandating parity in coverage for mental health and alcohol and drug abuse be no less extensive than that provided for other medical illnesses.

We wish to express our appreciation for the cooperation and assistance of those state agencies, private insurers, and other interested organizations and individuals whom we contacted during the course of this study.

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State Auditor

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Chapter 1

Introduction

Sections 23-51 and 23-52, Hawaii Revised Statutes, require the Legislature to pass concurrent resolutions requesting the State Auditor to study the social and financial effects of any proposed legislative measure that would mandate health insurance for specific services, diseases, or providers.

The law stems from legislative concern over the increasing number of these proposals in recent years and their impact on the cost and quality of health care. The purpose of the assessment is to provide the Legislature with an independent review of the social and financial consequences of each proposal.

House Concurrent Resolution No. 18, House Draft 1, Senate Draft 1, of the 1997 legislative session requests the Auditor to assess the social and financial effects of mandated parity in health insurance coverage of mental health and substance abuse services. House Bill No. 427 was introduced in the 1997 legislative session to mandate that insurance coverage for mental illness and alcohol and drug abuse be no less extensive than that provided for other medical illnesses. The current law mandating health insurance coverage for mental illness and substance abuse treatment insurance benefits is scheduled to sunset on July 1, 1998.

Background on Mandated Health Insurance

Since the 1960s, states have enacted a variety of laws mandating the health coverage that insurers must provide. These laws have required insurers to cover specific medical conditions and treatments, particular groups of people, and services of certain health practitioners. By 1992, states had enacted 950 mandates, up from 343 in 1978. However, the growth of mandated coverage has since slowed. Between 1992 and 1996, only 27 new mandates were added, for a total of 977.

Arguments for and against mandated health insurance

Mandated health insurance may be appropriate in certain circumstances. However, proponents and opponents disagree about several key issues: whether a particular coverage is necessary, whether it is justified by the demand, and whether it will increase costs. Generally, providers and recipients of medical care support mandated health insurance, while businesses and insurers oppose it.

Proponents say gaps in existing coverage prevent people from obtaining the care they need. They believe the current system is not equitable because it does not cover all providers, medical conditions, or needed treatments and services. Proponents also argue that mandated coverage could increase competition and the number and variety of treatments available. In some instances, it could also reduce costs by making preventive care, early treatment, or alternate care more available.

Opponents argue that mandated benefits add to the cost of employment and production and reduce other more vital benefits. They create particular hardship for small businesses that are less able to absorb rising premium costs. Opponents also argue that mandates reduce the freedom of employers, employees, and unions to choose the coverage they want. Insurers state that premium rates may rise beyond what employers and consumers are willing to pay. They see mandates as creating incentives for employers to adopt self-insurance plans that are exempt from the mandates.

Types of insurance plans affected

Laws to mandate health insurance in Hawaii would affect three main types of private insurance: (1) Blue Cross and Blue Shield plans, (2) health maintenance organizations (HMOs), and (3) commercial insurance plans. Private insurance plans cover approximately 88 percent of Hawaii's civilian population.

The Hawaii Medical Service Association (HMSA) is the Blue Cross and Blue Shield insurer in Hawaii. It offers traditional fee-for-service plans that reimburse physicians and hospitals for services. HMSA also has various HMO plans that offer a package of preventive and treatment services for a fixed fee. With a 1995 membership of 749,600, HMSA covers about 69 percent of Hawaii's population covered by insurance.¹

Kaiser Foundation Health Plan is a federally qualified health maintenance organization. In 1995, Kaiser served 186,066 people in Hawaii, or about 17 percent of the population covered by insurance.²

Commercial insurance plans such as University Health Alliance (formerly Hawaii Dental Service Medical) and Straub Care Plus, cover most of the remaining privately insured population. Some mainland companies such as Aetna and United Health Care (formerly Travelers) also provide insurance coverage in Hawaii.

Potential legal challenge

Hawaii's Prepaid Health Care Act, enacted in 1974, requires employers to provide a qualified prepaid health care plan to regular employees who work at least 20 hours per week. A qualified plan is one with benefits that are equal to, or are medically reasonable substitutes for, the benefits provided by the plan with the largest number of subscribers in Hawaii.³

Federal courts have ruled that the Prepaid Health Care Act is preempted by the federal Employee Retirement Income Security Act (ERISA), which has a provision preempting state laws relating to employment benefit plans. A subsequent congressional amendment exempted Hawaii's Prepaid Health Care Act from ERISA. The exemption, however, applied only to the law as it was enacted in 1974. In effect, this has frozen the law at its original provisions since ERISA would preempt any subsequent amendments. In Hawaii, any mandated benefit laws could be viewed, and challenged, as bypassing the limitations placed on the Prepaid Health Care Act.⁴

Existing Mandated Mental Health and Alcohol and Drug Abuse Insurance Benefits

Mandated insurance coverage of mental health and substance abuse services is provided under Chapter 431M, Hawaii Revised Statutes, "Mental Health and Alcohol and Drug Abuse Treatment Insurance Benefits." This law is scheduled to sunset on July 1, 1998.

Chapter 431M establishes the minimum benefits to be included in health insurance plans. Often the minimum benefits required by law become the maximum benefits provided by the various insurers. The legally required benefits for mental health services are 30 days of inpatient hospital services per year. One day of inpatient hospital services can be exchanged for two days of nonhospital, partial hospitalization, day treatment, or outpatient services. The required benefits also include 30 visits per year to physicians, psychologists, advanced practice registered nurses or clinical social workers in hospital, nonhospital, or mental health outpatient facilities. The required benefit for outpatient services is 12 outpatient visits per year.

Mandated benefits for alcohol and drug dependence are two treatment episodes per lifetime.

The law requires the benefits of alcohol dependence, drug dependence, and mental illness treatment services to be included within the hospital and medical coverage of all individual and group accident and sickness insurance policies issued in the state, individual or group hospital or medical service plan contracts, and nonprofit mutual benefit association and health maintenance organization health plan contracts. Therefore, everyone in Hawaii covered by an insured or prepaid health plan is covered by the mandated benefits. Only groups covered by union contracts may offer less comprehensive coverage.

Current Proposal to Mandate Additional Coverage

House Bill (H.B.) No. 427 would amend Chapter 431M, Hawaii Revised Statutes (HRS), by deleting the required benefits for inpatient hospital services, nonhospital, and outpatient mental health services, and alcohol and drug treatment and detoxification services. The proposed amendment would require benefits for mental health and substance abuse services to be no less extensive than coverage provided for any other medical illness. The proposal would put coverage for mental health and substance abuse services on par (or provide parity) with services provided for other medical illnesses.

There was a considerable amount of testimony on this bill. Local mental health organizations and numerous providers strongly supported H.B. No. 427. HMSA acknowledged the concerns for and against the bill and recommended that substance abuse services be excluded.

Proponents of parity legislation state that it is necessary to eliminate discrimination in coverage against people with mental illness, reduce out-of-pocket expenses for people with severe mental illness and their families, reduce disability through access to effective treatment, and increase productivity for people with treated mental illness.

Mandated Coverage in Other States

As of July 1997, nine states—Arkansas, Colorado, Connecticut, Maine, Maryland, Minnesota, New Hampshire, Rhode Island, and Vermont—have adopted parity laws of varying degrees. Some parity laws cover all mental illnesses, while others cover only biologically-based serious mental illness. Four states—Arkansas, Maryland, Minnesota, and Vermont—extend parity to all mental illness. In Maryland and Minnesota, medically necessary services are based on clinical need.

Five states—Colorado, Connecticut, Maine, New Hampshire, and Rhode Island—extend parity only to biologically-based serious mental illness. In New Hampshire, mental health advocates sought parity only for serious mental illness. According to New Hampshire's Division of Behavioral Health, the parity law has not increased costs nor had any adverse impact in the three years it has been in effect.

Of the nine states with parity laws, only three, Maryland, Minnesota, and Vermont extend parity to substance abuse services. Maryland's law applies to treatable addictive disorders and medically necessary services. Vermont's law, which extends parity to all mental illness and substance abuse services, is described as the most comprehensive. It will go into effect on January 1, 1998.

In Colorado and New Hampshire, there was strong opposition to parity for substance abuse services.

A 1996 report prepared by the Bazelon Center for Mental Health Law, a proponent of mental health services, examined mental health parity laws implemented in Maryland and Minnesota in 1995. The study concluded that mental health parity does not increase the demand for mental health services, or significantly increase health insurance premiums. The Employment Benefits Research Institute, which conducts research on behalf of insurance companies, unions, and other interest parties, disputes the Bazelon study. The institute contends that not enough time has elapsed to conduct a comprehensive study in those states, and other factors, such as managed care, limit insurance premium increases and reduce utilization.

New Federal Parity Law

Interest and momentum for parity in insurance coverage for mental health and substance abuse services follows Congress' enactment of the Mental Health Parity Act of 1996. Under the new law, if a group health plan offers any mental health benefits, it cannot impose more restrictive annual or lifetime spending limits for mental illness than for coverage of physical illnesses. In Hawaii, the federal law has limited impact because current mandated mental health benefits specify the number of visits, not dollar limits on coverage.

The federal law is generally viewed as providing limited parity because of several exemptions in it. It does not extend parity to substance abuse treatment, does not *require* health plans to provide mental health benefits, and does not apply to employers with two to fifty employees, among others. Health plans will be allowed to set higher deductibles and copayments and impose requirements that distinguish between acute and chronic care. The federal law becomes effective on January 1, 1998, and sunsets on September 30, 2001.

Recent federal substance abuse parity initiative

Efforts are also underway at the federal level for parity in health insurance coverage for substance abuse treatment services. Legislation seeking nondiscriminatory coverage for private, group and individual health coverage was introduced in Congress in September 1997. It is very similar to the federal Mental Health Parity Act of 1996, which did not extend parity to substance abuse treatment.

Under this legislation, insurance plans that provide medical and surgical benefits would be prohibited from imposing treatment limitations (day or visit limits) or financial requirements (deductible, coinsurance, cost sharing, or annual or lifetime dollar limits) on substance abuse treatment benefits unless similar limitations or requirements are imposed for medical and surgical benefits.

Comparison of Existing, Proposed, and Federal Coverage

Exhibit 1.1 presents a side-by-side comparison of mental health and substance abuse benefits under Hawaii's current law, proposed additional coverage under H.B. 427, and the federal Mental Health Parity Act of 1996.

Objective of the Study

The objective of this study is to describe the social and financial effects of mandating parity in health insurance coverage for mental health and substance abuse services.

Scope and Methodology

Pursuant to Sections 23-51 and 23-52, HRS, we assessed both the social and financial effects of the proposed additional coverage. In addition, we examined the issue of the impact of parity as mandated coverage.

Scope

To the extent feasible, however, we considered the following issues set forth by law:

Social impact

1. Extent to which mental health and substance abuse services are generally utilized by a significant portion of Hawaii's population.
2. Extent to which this coverage is already generally available.
3. Extent to which the lack of parity in coverage results in persons being unable to obtain necessary treatment.
4. Extent to which the lack of parity in coverage results in unreasonable financial hardship on those needing treatment.
5. Level of public demand for parity in mental health and substance abuse services.
6. Level of public demand for parity in individual or group insurance coverage for mental health and substance abuse services.
7. Level of interest of collective bargaining organizations in negotiating privately for inclusion of parity in coverage for mental health and substance abuse services in group contracts.

Exhibit 1.1 Comparison of Existing Mental Health and Substance Abuse Coverage, Proposed Coverage Under H.B. 427, and the Federal Mental Health Parity Act of 1996

Benefits Covered	Current Mental Health & Substance Abuse Law in Hawaii	H.B. 427 Mental Health & Substance Abuse Parity Law (Proposed)	Mental Health Parity Act of 1996 (federal law)
In-Hospital Services	In-hospital services of not less than 30 days per year. Allows the option of exchanging one day of in-hospital services for two days of non-hospital residential services, two days of partial hospitalization services or two days of day treatment services.	Would delete the existing language for in-hospital services, physician and other provider visits, and outpatient services. Covered benefits under Chapter 431M (mental illness, alcohol and drug dependence benefits) shall be no less extensive than coverage provided for any other medical illness.	N/A
Physician, Psychologist, Advanced Practice Registered Nurses, or Clinical Social Worker Visits	At least 30 physician, psychologist, advanced practice registered nurses, or clinical social worker visits per year to hospital or non-hospital facilities or to mental health outpatient facilities for day treatment or partial hospitalization services.	See above.	See above.
Outpatient Benefits	Not less than 12 outpatient visits per year.	See above.	See above.
Substance Abuse Services	Allows policies to limit the coverage of alcohol and drug treatment to not less than two treatment episodes per lifetime. Detoxification services must be covered as part of the in-hospital benefit, but may not count against any lifetime limit on alcohol and drug abuse treatment episodes.	See above.	Federal law does not apply to substance abuse services.
Spending Limits	Does not incorporate spending limits on mental health or substance abuse.	Covered benefits under Chapter 431M shall be no less extensive than coverage provided for any other medical illness.	If a group health plan offers any mental health benefits, it cannot impose more restrictive annual or lifetime limits on spending for mental illness than on coverage of physical illnesses.
Exceptions	N/A	N/A	Federal law does not: require an insurer to provide or offer mental health benefits, apply to cost sharing, include benefits for chemical dependency treatment or, apply to small employers (2 to 50 employees). Additionally, if a health plan experiences increased costs of at least one percent as a result of the new law, these health plans can also be exempt.

Source: Chapter 431M, HRS; Act 247, SLH 1997; Act 273, SLH 1997; H.B. 427, 1997 legislative session; Mental Health Parity Act of 1996.

8. Impact of providing additional coverage for mental health and substance abuse services on health status, quality of care, practice patterns, or provider competition.
9. Impact of indirect costs upon the costs and benefits of coverage.

Financial impact

1. Extent to which parity in insurance coverage would increase or decrease the cost of mental health and substance abuse services.
2. Extent to which the proposed additional coverage would increase or decrease the use of mental health and substance abuse services.
3. Extent to which parity in mental health and substance abuse services would serve as an alternative for more expensive treatments, or services.
4. Extent to which parity in insurance coverage of mental health and substance abuse services might increase or decrease insurance premiums or administrative expenses of policyholders.
5. Impact of parity in insurance coverage for mental health and substance abuse services on the total costs of health care.

The resolution further requests the Auditor to include estimated annual costs for inpatient and outpatient coverage allocated separately to mental health and to substance abuse services.

Methodology

We reviewed recent research literature and reports on the social and financial effects of parity for mental health and substance abuse services. We reviewed applicable statutes and proposed legislation. We obtained information from commercial insurers, mutual benefit societies, health maintenance organizations, employer groups, collective bargaining organizations, professional associations, and state agencies. We did not test the data on coverage and utilization provided by HMSA, Kaiser, and other insurers. We also contacted officials from states with parity laws and national organizations, including the National Conference of State Legislatures and the Blue Cross and Blue Shield Association.

Our work was performed from May 1997 to November 1997 in accordance with generally accepted government auditing standards.

Chapter 2

Social and Financial Impact of Parity in Insurance Coverage for Mental Health and Substance Abuse Services

This chapter summarizes the results of our efforts to assess the potential social and financial impact of mandating parity in mental health and substance abuse insurance coverage. The assessment is limited by the lack of a definition of parity and the lack of specificity in the mental health and substance abuse benefits to be covered under the proposed amendment to Chapter 431M, Hawaii Revised Statutes.

Lack of a Definition of Parity Affects Assessment

The proposal to mandate equal insurance coverage for mental illness to be no less extensive than coverage for any medical illness is subject to broad interpretation. Different definitions of parity for mental health and substance abuse services lead to different impacts.

Respondents to our surveys advocate very different interpretations of parity. Some perceive that parity for mental health services would cover not only biologically-based mental illnesses, but also might open the door for claims for services for any emotional problems. Some perceive mental health parity as unlimited mental health services.

H.B. No. 427 would amend the current law so that parity means mental health and substance abuse insurance coverage would be “*no less extensive than coverage provided for any other medical illness.*” However, depending on the insurance plan, there *are* limits on coverage for other medical illness services. These limits include number of covered authorized visits, types of services covered, and medical necessity of the service. Parity, then, would mean varying limits on mental health services—depending upon the individual insurance plan.

Social Impact

- 1. Extent to which mental health and substance abuse services are generally utilized by a significant portion of Hawaii’s population.**

Currently, a small proportion of Hawaii’s insured population is using mental health and substance abuse services. This is consistent with national data and information in Coopers and Lybrand’s 1994 report for the Department of Health on mental health and substance abuse services. HMSA reports that approximately two percent or about 16,500 of its

members used mental health and substance abuse services in 1996. Of those, approximately 94 percent of its members using outpatient services did not exceed 12 outpatient services per year. For members using inpatient visits, 97 percent did not exceed the 30-day limit. HMSA cannot readily report the number using substance abuse services. Kaiser reports that approximately four to five percent of its commercial membership uses specialty mental health and/or substance abuse services. Of those, less than one percent ever reach their benefit maximums. In 1996, approximately 5,800 Kaiser commercial plan members used its mental health services, and approximately 850 members used chemical dependency services.

One local mental health organization commented that most people in need of mental health services will not exhaust their inpatient benefits in a given year, but many exhaust their outpatient benefits.

2. Extent to which this coverage is already generally available.

Under the current law, a wide variety of mental health and substance abuse services are presently available. Providers include psychiatrists, psychologists, advanced practice registered nurses, and clinical social workers. Hawaii's motor vehicle insurance law (Chapter 431, HRS, Article 10C) covers mental health services linked to accidents under policyholders' auto insurance. Mental health services for personal injury arising out of and in the course of employment are covered under Chapter 386, HRS, Workers' Compensation Law. Injuries resulting from substance abuse are not covered by workers' compensation and treatment for substance abuse is highly unlikely under auto insurance coverage.

3. Extent to which the lack of parity in coverage results in persons being unable to obtain necessary treatment.

There is very limited information on the extent to which the lack of parity in coverage results in persons being unable to obtain necessary treatment. Insurers report that very few members exhaust their mental health and/or substance abuse benefits. Mental health advocates also acknowledge that only a small minority, particularly those with serious mental illness, exhaust their benefits. Therefore, there appears to be adequate access to mental health services for members who use these services. For individuals with severe mental disorders, the lack of parity in mental health coverage may result in hardship under the current coverage.

Some of the concern about limits on care is based on the perceived limitation of the definition of an outpatient visit. One provider group expressed concern about limits placed on outpatient visits and suggests

the number of outpatient visits of 12 per year could be changed instead to, say, 12 treatment hours. The group noted that some individuals on treatment plans may only need one quarter or one half hour of service per visit. If the limit were changed to 12 treatment hours, an individual could be covered for up to 48 quarter-hour treatment visits per year.

4. Extent to which the lack of parity in coverage results in unreasonable financial hardship on those needing treatment.

The lack of parity in coverage may result in unreasonable financial hardship for some individuals when treatment exceeds insurance coverage limits. However, the majority of employees do not exhaust their mental health or substance abuse benefits. HMSA and Kaiser indicated that only a small percentage of its members exhaust their mental health benefits. In addition, Kaiser offers employers the opportunity to purchase additional mental health coverage to augment the regular plan benefits. However, only three percent of its employers purchase the additional coverage. For the nearly three percent of the population with serious mental illness, for which no cure is available, advocates note that financial hardship is a major concern.

5. Level of public demand for parity in coverage for mental health and substance abuse services.

Public demand for parity comes from mental health and substance abuse advocacy groups, individual care providers, and at least one union. However, the low utilization data from insurers indicates that parity is not in demand.

6. Level of public demand for parity in individual or group insurance coverage for mental health and substance abuse services.

Public demand for parity in insurance coverage is very limited. Of the five unions contacted, only two submitted written responses. One strongly supported the concept of parity but did not provide information on demand for parity by their membership. Another reported that demand has been low. Insurers noted that employer groups are not seeking parity. Employers responding to our study emphasized their opposition to any additional mandated health benefits.

7. Level of interest of collective bargaining organizations in negotiating privately for inclusion of parity in coverage for mental health and substance abuse services in group contracts.

There is very little interest from collective bargaining units for parity in mental health and substance abuse services. Only one union responded that it favors parity in mental health and substance abuse services. One

union reports demand for these services has been low. Another union stated that providing mandated coverage may result in having to cut back on another part of their members' health coverage. Insurers report that they have not been contacted by unions seeking additional coverage.

8. Impact of providing additional coverage for mental health and substance abuse services on health status, quality of care, practice patterns, provider competition, or related items.

We found no comprehensive data on whether parity of insurance coverage improves patients' health status, changes practice patterns, or increases provider competition. Proponents of parity believe it would improve morbidity, mortality, and quality of care for patients. Insurers maintain that providing parity in coverage will have little impact beyond the existing coverage on the health status of employees. One insurer indicated that if parity legislation is not well defined, lower quality of care may result.

Healthcare providers responded that parity may affect practice patterns but it is not expected to affect competition.

9. Impact of indirect costs upon the costs and benefits of coverage.

Adopting parity is expected to increase both utilization and administrative costs. HMSA expects an increase in costs due to additional claims processing and increased utilization review. The health department expects increased administrative costs commensurate with the expanded coverage.

Financial Impact

1. Extent to which parity in insurance coverage would increase or decrease the cost of mental health and substance abuse services.

Opinion is divided on whether parity will increase or decrease the cost of mental health and substance abuse services. Projections depend upon whether parity laws cover all mental illnesses or only biologically-based serious mental illness, and whether substance abuse services are included. One mental health organization predicts access to less expensive preventative services will result in lower utilization of costly intensive services. However, insurers expect parity to increase the cost of mental health and substance abuse services.

2. Extent to which the proposed additional coverage would increase or decrease the use of mental health and substance abuse services.

There is some agreement that the use of outpatient services is likely to increase and the use of inpatient hospital services to decrease. The health department notes that parity may redistribute some mental health usage from publicly funded to privately funded sources. One insurer is certain that parity will result in an increase in utilization commensurate with health care providers' behavior as a *supplier* who can create *demand* to maintain or enhance one's desired level of income. Given this potential, the more a provider is able to *supply*, the greater the potential for *demand* and, ultimately, costs. Another expects very little increase in utilization, but actual experience will depend upon the extent of the benefits provided under any definitions of parity.

3. Extent to which parity in mental health and substance abuse services would serve as an alternative for more expensive treatments, or services.

There is some agreement that parity may result in greater access to less expensive services and could thus serve as an alternative to more expensive treatments, or services. Providers and an insurer indicate that early intervention is beneficial since it can reduce long term morbidity and prevent associated medical problems. Such care can avoid costly hospitalization and the need for long term care.

4. Extent to which parity in insurance coverage of mental health and substance abuse services might increase or decrease insurance premiums or administrative expenses of policyholders.

All insurers expect parity to increase premiums and administrative expenses. Two insurers predict an increase of about four or five percent if required to provide coverage on a parity basis. HMSA predicts that increased costs, such as administrative expenses, would be passed directly to employers. According to Kaiser, the proposed parity legislation could increase the cost of services by one or two percent.

5. Impact of parity in insurance coverage for mental health and substance abuse services on the total costs of health care.

In the absence of verifiable data, the impact of additional coverage through parity on the total cost of health care in Hawaii cannot be determined at this time.

There are mixed opinions on parity's effect on the total cost of health care. HMSA notes that the smallest increase in premiums due to mental health parity will have a significant impact on employers. Some may

need to eliminate coverage of other non-mandated options such as family or dental coverage. Another insurer believes that if services are provided through managed care and items such as absenteeism, disability claims, use of medical services, and use of publicly funded programs are included as part of the total cost, then the total cost of health care should drop. If total cost means the total insurance premium, there should be a slight increase relative to the overall premium for all general medical and behavioral health services. Ultimately, much will depend on the exact features of parity and on utilization rates.

Response to the Request for Additional Information

The resolution requesting this study also asked that the study include estimated annual costs allocated separately to mental health and to substance abuse services. It asked that the services include, but not be limited to:

1. Providing mandated health insurance coverage for mental illness and alcohol and drug dependence for a minimum of 30 days of in-hospital services per year;
2. Allowing the exchange of each day of in-hospital services for: two days of nonhospital residential services, two days of partial hospitalization services, or two days of day treatment services;
3. Providing a minimum of 30 physician or psychologist visits per year to hospital and nonhospital facilities or visits to mental health outpatient facilities for day treatment and partial hospitalization services;
4. Allowing the exchange of each day of in-hospital services for two outpatient visits;
5. Providing a minimum of 24 visits per year for outpatient services; and,
6. Providing alcohol and drug dependence benefits that limit the number of treatment episodes but may not limit the number to less than two treatment episodes per lifetime.

We asked insurers to provide us with this information as part of our survey. Insurers provided limited comparative information on the estimated annual cost allocated to the preceding categories. None of the information can be compared among the insurers who responded.

One insurer did not provide dollar amounts, noting that costs depend upon the population to be covered and the level of management of benefits and costs. Guaranteed Trust Life Company estimated the 30

day in-hospital benefit and the alternative service provisions outlined would increase costs approximately three percent. Kaiser did not have this information available, but noted that, on average, the per member per month cost for these services is approximately \$2.80 given its current benefit levels and utilization.

Only HMSA provided estimates for the various services outlined in the resolution requesting this study. Depending on how parity is defined, HMSA estimates the increased costs for its members to be between \$6 million and \$53 million.

Assessment of House Bill No. 427

Chapter 431M, HRS, sets minimum covered benefits for mental health and substance abuse services. The minimum benefits include 30 days of inpatient hospital care; 30 visits with a physician, psychologist, advanced practice registered nurse, or clinical social worker; and 12 outpatient visits per year. Alcohol and drug abuse benefits can be limited to two treatment episodes per lifetime. Health insurance plans generally have provided the minimum coverage required by law.

The purpose of H.B. No. 427 is to remove these existing limitations on the number of visits and treatments. It would do so by removing the reference to the minimum benefits and replacing it with the general statement that “the covered benefits under this chapter shall be no less extensive than coverage provided for any other medical illness.”¹ It is not clear how or which mental health and substance abuse services or treatments would be provided in a manner as for any other medical illness. The meaning of *no less extensive* is not explained.

Conclusion

There is insufficient detail about the exact coverage for the parity law proposed in H.B. No. 427 to estimate its financial impact. Coverage for mental health and substance abuse services is already required by statute, and is also provided under Hawaii’s workers’ compensation and motor vehicle insurance laws.

Current utilization of mental health and substance abuse services is low with even fewer employees using services up to the maximum allowed benefits. Establishing a plan to provide additional services to meet the needs of those who exceed their maximum benefits may be an alternative solution to parity. Demand for this type of additional coverage is primarily from care providers and local mental health and substance abuse organizations. There is very little demand for this coverage from collective bargaining groups and none from employer groups.

We could not assess separately the impact of mandated parity in health insurance coverage for mental health services and for substance abuse services. Insurers cannot readily separate costs for these two kinds of services. With parity, insurance premiums are expected to increase.

Information from other states with parity laws indicates that adopting parity for mental health, with or without substance abuse coverage, has not led to unacceptably high costs. Factors such as managed care, whether coverage is for all mental illness or for serious mental illness only, and the inclusion or exclusion of substance abuse services influence the impact of parity in other states.

In light of the low demand from employee groups, and low utilization under the coverage currently available, we conclude that mandating parity in coverage for all mental health and substance abuse services is not warranted at this time. To address the concerns reportedly imposed by the definition of outpatient visit, some statutory changes to define treatment in terms of hours rather than discrete visits might suffice.

Notes

Chapter 1

1. Hawaii, Department of Business, Economic Development and Tourism, *Data Book 1996*, p. 410.
2. Ibid.
3. Section 393-7, HRS.
4. National Governors' Association, *Roadblock to Reform, ERISA Implications for State Health Care Initiatives*, 1994, pp. 6, 46, 49, 50.

Chapter 2

1. House Bill No. 427, Regular Session of 1997.

Response of the Affected Agency

Comments on Agency Response

We transmitted a draft of this report to the Department of Health on December 8, 1997. A copy of the transmittal letter to the department is included as Attachment 1. The response from the department is included as Attachment 2.

The department supports a process through which health insurance mandates are periodically and collectively reviewed. The health department expects over the long term, that parity in private insurance would allow patients to get treatment earlier and have a better chance of remaining employed and covered by private insurance. It believes that substance abuse and mental health treatment benefits should be determined by medical necessity and governed by standards using best practices criteria.

The department also has concerns about the limited scope of our analysis and evaluation of the existing mental health and alcohol and substance abuse statute. It questions our conclusion that there was not enough demand to warrant mandated parity coverage. It also questions our suggestion that statutory changes to define certain treatment in terms of hours rather than discrete visits might provide sufficient coverage.

In accordance with Sections 23-51 and 23-52, Hawaii Revised Statutes, our study assessed the impact of this proposed health coverage mandate to the extent that information was available. We believe our conclusions are soundly based on the information available. We also incorporated some technical clarifications suggested by the department.

Attachments that accompanied the department's letter of response are on file at our office.

STATE OF HAWAII
OFFICE OF THE AUDITOR
465 S. King Street, Room 500
Honolulu, Hawaii 96813-2917



MARION M. HIGA
State Auditor

(808) 587-0800
FAX: (808) 587-0830

December 8, 1997

COPY

The Honorable Lawrence Miike
Director of Health
Department of Health
Kinau Hale
1250 Punchbowl Street
Honolulu, Hawaii 96813

Dear Dr. Miike:

Enclosed for your information are three copies, numbered 6 to 8 of our draft report, *Study of Proposed Mandated Additional Mental Health and Alcohol and Drug Abuse Insurance Benefits*. We ask that you telephone us by Wednesday, December 10, 1997, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Wednesday, December 17, 1997.

The Governor, and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa
State Auditor

Enclosures

BENJAMIN J. CAYETANO
GOVERNOR OF HAWAII



STATE OF HAWAII
DEPARTMENT OF HEALTH
P.O. BOX 3378
HONOLULU, HAWAII 96801

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OFC. OF THE AUDITOR
STATE OF HAWAII

LAWRENCE MIIKE
DIRECTOR OF HEALTH

In reply, please refer to:
File:

December 18, 1997

The Honorable Marion M. Higa
State Auditor
Office of the Auditor
465 South King Street, Room 500
Honolulu, Hawaii 96813

Dear Ms. Higa:

Thank you for the opportunity to comment on the draft "Study of Proposed Mandated Additional Mental Health and Alcohol and Drug Abuse Insurance Benefits," which was prepared in response to H.C.R. 18, HD1, SD1.

Our previous communication (dated February 3, 1997) to the Chairs of the House and Senate Health Committees during the 1997 Session, stated that the Department supports a process through which there is a periodic, collective review of the mandated health insurance package, so that current benefits are reviewed in total, and identified gaps in coverage can be addressed in proper perspective and ranked in order of importance. Without a broader perspective on what the basic benefits package would consist of, decisions on when to add specific benefits have to be made in isolation, and without a rational planning basis. The Department does not intend to become involved in the merits of individual mandated benefits, without this prior planning and policy formulation basis.

With the adoption of H.C.R. 18, HD1, SD1, however, the Department is providing the following comments from a public health perspective, with a particular concern for the impact of changes in mental health and substance abuse treatment benefits that extend beyond the issue of health insurance coverage.

Social Impact. Mental health and substance abuse treatment benefits under Chapter 431M, HRS, are applicable to those who are employed twenty hours or more per week. The Department is impacted by changes in the

configuration of benefits. The Department funds mental health and substance abuse treatment services to the "public client," who is likely to be unemployed or works less than 20 hours per week, or has exhausted mental health and substance abuse treatment benefits covered under Chapter 431M, HRS.

The lack or limitation on coverage shifts the cost of mental health and substance abuse treatment to publicly funded services for which the Department is the primary and often sole source of public funding. Coverage under other sources of treatment funding (i.e., through QUEST, insurance plans, HMO's, etc.) affects costs for State funded services.

It is difficult to document that the establishment of parity in private health insurance would cause any remarkable public-to-private cost shifting, since few of the patients receiving public services are employed sufficiently to have access to private insurance. A few such patients might have access to private insurance through employed relatives and thus benefit immediately from parity. Over the long term, however, parity in private insurance would be expected to allow patients to get treatment earlier in the development of their mental health and substance abuse problems, and have a better chance of remaining employed in the private insurance subscriber pool.

Benefits Configuration. Substance abuse and mental health treatment benefits should be determined by medical necessity and standardized criteria for patient placement, admission, discharge and continuing care criteria, which reflect best practices for mental health and substance abuse treatment. Cost control could be achieved as insurers exercise oversight of utilization and the authorization of payment for treatment.

According to the Institute of Medicine, addiction is a bio-psycho-social disease, a disorder requiring ongoing treatment and intervention, not only episodic or acute care. As a complex bio-psycho-social disorder, substance abuse tends to be chronic and relapsing by nature. From a clinical standpoint, it should be likened to hypertension or diabetes, diseases which require ongoing treatment and intervention, if the patient is to attain and maintain recovery. Some patients, by virtue of the severity of their addiction, will require a lifetime of intervention in order to maintain recovery.

Under Chapter 431M, HRS, current benefits for alcohol and drug dependence provide for a minimum of two treatment episodes per lifetime. In practice, health plans often have interpreted this to be a maximum of two treatment episodes per lifetime. The study did not address this part of the benefit.

Limiting lifetime substance abuse treatment episodes is inconsistent with the nature of the disease of addiction. We believe that the two episodes per lifetime limit under §431M-4(a), HRS, should be eliminated for this recurring disorder.

Utilization. This study cites low usage rates (two percent for HMSA and four to five percent for Kaiser in 1996) for mental health and/or substance abuse services. The number of persons who accessed these services, however, is not necessarily reflective of the demand or need for added treatment benefits. The low rates cited may be a reflection of: the availability, affordability or accessibility of services; the limits on admission for treatment; or the non-assertive approach by health care providers who are not trained in screening and referral for mental health and substance abuse disorders.

National statistics indicate that about 28% of the general population suffer from mental illness and/or substance abuse in a given year, while only 6% of the population obtains services from mental health or substance abuse professionals. This suggests that there is a large reservoir of untreated mental health and substance abuse problems among our citizens. The unavailability of treatment insurance benefits is probably part of the reason for this discrepancy, but so also are unawareness of mental health and substance abuse issues among the public and general health providers, as well as the continuing stigma associated with seeking mental health and substance abuse services. Insurance parity would probably need to be coupled with intensified outreach and public/professional education efforts to reach this marginalized and untreated segment of our population.

Presently, according to HMSA, 3% of its users of mental health and substance abuse benefits exhausted the inpatient mental health benefit and 6% exhausted outpatient benefits. Kaiser reported that less than 1% of those using mental health and/or substance abuse benefits exhausted the benefit. This data supports the recognition that only a small minority of patients would need more than what current benefits provide. Rather than concluding that treatment benefits are adequate, however, we would argue that the need for treatment of this minority population ought to be accommodated as would be done for other health problems. For example, a small percentage of patients requiring surgery or chemotherapy does not invalidate the need for covering costs for the procedures.

Nationally, the large majority of patients receiving mental health and substance abuse services use less than five visits per year. However, there is another

significant group of patients who need 25 to 50 visits per year. The fact that the latter group is much smaller does not mean that we can safely ignore their continuing need for services.

Given that the State's largest health care insurer could not readily report the number of people using substance abuse services, the substance abuse treatment benefit and the lifetime treatment episode limit was not comprehensively analyzed. Before any changes to mental health and substance abuse treatment benefits are considered, it should be reiterated that the nature of the disease of addiction will usually require occasional lifetime interventions and treatment.

Financial Impact. Treating mental illness and substance abuse reduces secondary conditions, including but not limited to HIV disease, fetal alcohol syndrome, cardio-pulmonary disease, cirrhosis, injuries resulting from vehicular crashes, and other related incidents. Untreated mental illness and substance abuse result in increased costs to the overall health care system. Limiting coverage increases utilization of costly emergency room services and inpatient hospitalization, and shifts the cost of treatment to the public sector as patients with chronic problems exhaust limited benefits. (See ATTACHMENT I and ATTACHMENT II.)

Providing insurance coverage at a level consistent with the nature of mental illness and substance abuse disorders can assure that people having private insurance are not cost shifted to public funding because of an inadequate private insurance benefit. Public funds would then be made available to those who do not qualify for private insurance or who at a level of poverty that makes private insurance unaffordable. For the Department, the primary financial concern is that costs for mental health and/or substance abuse treatment that should be covered by insurers is not shifted to limited taxpayer funded services for "public clients."

While making parity available may increase utilization for certain high risk or chronic groups and thus increase premiums, it is just as likely that because the risk would be spread over all insurance subscribers, the premiums could remain the same. Also, it is possible to build in disincentives for high utilization for services that could include a co-payment and managed care gatekeepers whose approval is required prior to authorization for reimbursement. Under these circumstances, it is unlikely that high utilization will drive costs up, since mental illness and addiction are conditions that individuals will typically deny having until treatment is desperately needed.

The Honorable Marion M. Higa
December 18, 1997
Page 5

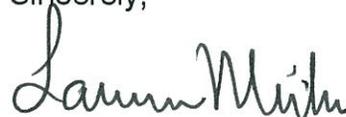
It is not clear in this study whether the analysis done was based on actual costs or whether it included such cost factors as changes in the benefits package or method(s) of service delivery, inflation, or cost increases arising from other benefits provided under a given plan. Also, presently, the Department of Commerce and Consumer Affairs does not review rate filings for health insurance. Part of a complete analysis would need to include an analysis of this information. Without an analysis of this information, analysis of the financial impact of adjustments to benefits would be difficult to ascertain.

Public Perception. The complexity of the task, time constraints, and staffing may have precluded a comprehensive review to include public perception issues. It should be noted, however, that in the evaluation of Chapter 431M, HRS, to be submitted to the 1998 Legislature, the Hawaii Health Survey reveals an unambiguously favorable opinion (75%) among the general population of consumers in Hawaii with respect to the basic idea of covering mental health and substance abuse treatment services. The Department's report will provide the consumer input into the review process for Chapter 431M, HRS, that was missing from your study.

This study undertook a complex analysis in the absence of complete data that is essential to such a task. The inability to separate the impact of parity for mental health and substance abuse, the inability to analyze the lifetime episode limit for substance abuse treatment, the minimizing of the treatment needs of a small number of chronic patients, and other methodological limitations of the study lead the Department to question the conclusion that parity is not warranted and that redefining outpatient treatment in terms of hours rather than visits is a viable solution.

Thank you for the opportunity to provide a departmental response. If additional information or clarification is needed, the Department of Health would be pleased to provide any further assistance.

Sincerely,



LAWRENCE MIIKE
Director of Health

Enclosures