# OVERVIEW

## *Study of Proposed Mandatory Parity in Health Insurance Coverage for Additional Serious Mental Illnesses and for Substance Abuse*

**Report No. 04-07, April 2004**

## Summary

We assessed the social and financial effects of mandating parity in health insurance coverage for an expanded definition of *serious mental illness* and for substance abuse. Senate Concurrent Resolution No. 116, Senate Draft 1, House Draft 1 (S.C.R. No. 116), requested this assessment under Section 23-51, Hawaii Revised Statutes, to address the legislatively proposed addition of *delusional disorder*, *major depression*, *obsessive compulsive disorder*, and *dissociative disorder* to the current definition of *serious mental illness.* The proposed mental illness coverage, however, was included in a superseded House Draft of a bill signed into law in June 2003. Moreover, no specific legislation had been introduced during the 2003 session to explicate substance abuse coverage, as required by statute.

Under Hawaii law, disorders included in the definition of serious mental illness benefit from health insurance coverage on a par with other medical and surgical conditions. Coverage of other mental illness and substance abuse treatment is mandated by statute as well, but with benefit limits not applicable to serious mental illnesses.

We found that the social and financial impacts of mandating parity in health insurance coverage for the proposed expanded definition of *serious mental illness* and for substance abuse are unclear. The applicability of other states' parity experiences to Hawaii is limited. Variations in the scope and application of their parity laws present significant factors to account for in forecasting impacts on Hawaii's health environment. In addition, the data required by S.C.R. No. 116 were not available. We surveyed practitioners, consumer groups, employer and labor organizations, and other stakeholders, but could not draw definitive conclusions because of the low response rate (16 percent). Moreover, data stratified by disorder and by age, required by S.C.R. No. 116, were submitted for only a limited number of responses.

Despite these limitations, we presented our findings to the extent they may aid the Legislature in addressing the issue of parity in health care benefits for mental health and substance abuse services. Although other states' experiences may have limited applicability to Hawaii, we turned to Vermont's experience with parity because the state offered a case study for such coverage. In the first two to three years of parity, Vermont experienced no substantial increases in health insurance premiums. The cost of full parity amounted to about $2.32 per member per year, or 19 cents per member per month in a managed care environment. Substance abuse treatment utilization was substantially reduced and mental health treatment utilization increased only slightly.

For Hawaii, the two major health plan insurers report that only a small percentage of insured individuals exceeds the current benefit levels for general mental illness and substance abuse treatment, suggesting that the need to extend parity to additional categories of serious mental illness and to substance abuse is not high. For those who exceed benefit levels, the insurers offered each member the options of paying out of pocket, negotiating for more flexible payment options, requesting benefit extension, or seeking treatment at publicly funded facilities.

Provider associations, on the other hand, point out that many practitioners offer services on a *pro bono* basis when patients exceed insurance benefit levels. In addition, the associations report that patients themselves may ration sessions to avoid exhausting their benefits. These cases of actual or potential benefit exhaustion may not be known to the insurers. The reports were anecdotal and without an indication of their numbers.

Findings on potential financial impacts were sparse. We could not rely on the results of our survey because of the low response rate. Also, as HMSA pointed out, responding to our questions was difficult without an actual proposal for mental health and substance abuse parity to examine. For example, HMSA's responses depended on whether a health plan could manage utilization to ensure that patients receive clinically appropriate treatment.

Issues arising from the incidence of mental illness and substance abuse in Hawaii require a perspective broader than the analysis contemplated under Section 23-52, HRS. Our study's focus was narrowly limited to the social and financial impacts of a particular mandatory health insurance coverage proposal, and in the case of substance abuse coverage, there was none. Even within this limited scope, much of the data the Legislature sought is unavailable.

## Recommendations and Response

The Department of Commerce and Consumer Affairs chose not to respond to our draft report.

The Department of Health urges the Auditor, even with the limited data, to acknowledge that a policy decision by the Legislature is in order. It then presents how that policy question ought to be posed, and what the resulting answer ought to be. The department believes that full parity ought to be provided for a two- to four-year period and the outcomes studied.

The department's advocacy of full parity now is well within its role as an executive agency. The Auditor's role requires an objectivity that forecloses such advocacy. We have laid out what we believe are balanced findings, as required by the standards by which we conduct our work. The broader perspective rests in the Legislature.

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