Study of Proposed Mandatory Health Insurance Coverage for Early Intervention Services

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

Report No. 99-7
January 1999

THE AUDITOR
STATE OF HAWAII

The Office of the Auditor

The missions of the Office of the Auditor are assigned by the Hawaii State Constitution (Article VII, Section 10). The primary mission is to conduct post audits of the transactions, accounts, programs, and performance of public agencies. A supplemental mission is to conduct such other investigations and prepare such additional reports as may be directed by the Legislature.

Under its assigned missions, the office conducts the following types of examinations:

1. *Financial audits* attest to the fairness of the financial statements of agencies. They examine the adequacy of the financial records and accounting and internal controls, and they determine the legality and propriety of expenditures.

2. *Management audits,* which are also referred to as *performance audits,* examine the effectiveness of programs or the efficiency of agencies or both. These audits are also called *program audits,* when they focus on whether programs are attaining the objectives and results expected of them, and *operations audits,* when they examine how well agencies are organized and managed and how efficiently they acquire and utilize resources.

3. *Sunset evaluations* evaluate new professional and occupational licensing programs to determine whether the programs should be terminated, continued, or modified. These evaluations are conducted in accordance with criteria established by statute.

4. *Sunrise analyses* are similar to sunset evaluations, but they apply to proposed rather than existing regulatory programs. Before a new professional and occupational licensing program can be enacted, the statutes require that the measure be analyzed by the Office of the Auditor as to its probable effects.

5. *Health insurance analyses* examine bills that propose to mandate certain health insurance benefits. Such bills cannot be enacted unless they are referred to the Office of the Auditor for an assessment of the social and financial impact of the proposed measure.

6. *Analyses of proposed special funds* and existing *trust and revolving funds* determine if proposals to establish these funds and existing funds meet legislative criteria.

7. *Procurement compliance audits* and other *procurement-related monitoring* assist the Legislature in overseeing government procurement practices.

8. *Fiscal accountability reports* analyze expenditures by the state Department of Education in various areas.

9. *Special studies* respond to requests from both houses of the Legislature. The studies usually address specific problems for which the Legislature is seeking solutions.

Hawaii's laws provide the Auditor with broad powers to examine all books, records, files, papers, and documents and all financial affairs of every agency. The Auditor also has the authority to summon persons to produce records and to question persons under oath. However, the Office of the Auditor exercises no control function, and its authority is limited to reviewing, evaluating, and reporting on its findings and recommendations to the Legislature and the Governor.

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OVERVIEW

Study of Proposed Mandatory Health Insurance Coverage for Early Intervention Services

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Summary

Senate Concurrent Resolution No. 48, Senate Draft 1, House Draft 1 of the 1998 legislative session requested the Auditor to perform a "sunrise review" of the proposed mandatory health insurance coverage for early intervention services as provided for in Senate Bill (S.B.) No. 2948 of the 1998 session. To the extent feasible, and based upon available information, we assessed the effects of the proposed coverage by examining the social and financial impact issues set forth in Section 23-52, Hawaii Revised Statutes (HRS).

Under the federal Individuals with Disabilities Education Act and Part XXVIII of Chapter 321, HRS, the State of Hawaii provides certain early intervention services free of charge to identified infants and toddlers (children from birth to three years of age) considered to be developmentally delayed or at biological or environmental risk. The federal law encouraged states through grants to develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system providing early intervention services for infants and toddlers with disabilities and their families. Services may include, for example, early identification, family support, speech pathology, physical therapy, medical diagnostic services, and psychological services.

In Hawaii, the Family Health Services Division of the Department of Health administers the Zero-To-Three Hawaii Project, which manages and coordinates early intervention service programs under the federal law. The State also provides early intervention services under the federal law through the Healthy Start program, Infant and Toddler Development Programs, private providers contracted with the health department, and through the department's Public Health Nursing Branch.

In 1996, early intervention services were provided to 3,418 children and the State spent almost $14.9 million on services. Of the $14.9 million, state funds accounted for over $10.5 million, federal funds over $3.3 million, and local sources almost $1.1.

The key elements of S.B. No. 2948 would require all policies that provide family or dependent coverage offered by commercial insurers under Article 431:10A, HRS (Accident and Sickness Insurance Contracts) and mutual benefit societies under Article 432:1, HRS (such as HMSA) to provide coverage for medically necessary early intervention services as part of a basic benefits package. The services would have to be provided by licensed health care providers employed in programs approved by the Department of Health for children from birth until three years of age. Providers of early intervention services would be required to seek payment from all third-party payers, with some exceptions.

Our report includes the following information:

- Demand for mandatory health insurance coverage for early intervention services comes primarily from the Department of Health, advocacy groups, and provider agencies. We found no indication that employers and unions are interested in these services or would demand insurance coverage for them;

- We could not determine whether the proposed mandated coverage would increase or decrease the cost of early intervention services. We found indications that the mandate could increase the use of early intervention services and that these services could serve as an alternative to more expensive treatment or services;

- Insurers are not certain about the characteristics, numbers, and health status of their members already utilizing early intervention services and cannot clearly estimate the potential direct and indirect costs of mandating services. Possible increased costs to policyholders were mentioned by insurers, providers, advocates, and the Department of Health;

- Insurers raised a number of concerns about the proposed mandated benefit, including the bill's broad definition of early intervention; its list of service providers; nonmedical entities influencing a physician's medical determination of necessity; mandated coverage for services that are social in nature; and the State's objective in seeking new funding sources for services that the State is obligated to fund; and

- An employer organization stated that such a broad mandate is unwarranted at a time when businesses are struggling in Hawaii.

We concluded that if the Legislature wishes to enact S.B. No. 2948 or any legislation to mandate private insurance coverage for early intervention services, the concerns raised by insurers, employer organizations, and others should be addressed. Clear communication and an agreement between the affected parties would be needed.

Recommendations and Response

We made no formal recommendations. The department's response to our draft report discussed certain federal requirements and expectations concerning the funding of early intervention service systems. The department emphasized the importance of the State seeking all available public and private funding. Also, the department observed that public discussion regarding the issues raised in the bill could be enhanced by providing additional information to insurers, increasing communication between affected parties, and working toward consensus on apportioning financial responsibility for aspects of services within the early intervention system.

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Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 99-7
January 1999

Foreword

Sections 23-51 and 23-52, Hawaii Revised Statutes, require the State Auditor to study the social and financial impacts of measures that propose to mandate health insurance benefits. As requested by Senate Concurrent Resolution No. 48, Senate Draft 1, House Draft 1 of the 1998 legislative session, this report assesses the impacts of mandating health insurance coverage for early intervention services as proposed in Senate Bill No. 2948 of the 1998 session.

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

Marion M. Higa
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Chapter 1
Introduction

Sections 23-51 and 23-52, Hawaii Revised Statutes (HRS), 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.

Senate Concurrent Resolution (S.C.R.) No. 48, Senate Draft (S.D.) 1, House Draft (H.D.) 1 of the 1998 legislative session requests the Auditor to perform a "sunrise review" of the proposed mandatory coverage of early intervention services as provided for in Senate Bill (S.B.) No. 2948 of the 1998 session. This report responds to the Legislature's request.

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. Between 1978 and 1992, the number of mandates grew dramatically from 343 to 950. Since 1992, the growth of mandated coverage has slowed to about 1,050 mandates in 1997.

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, such as 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, and 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, and 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 an incentive for employers to adopt self-insurance plans that are exempt from the mandates.

Types of insurance plans affected

Laws mandating health insurance in Hawaii can 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 by 1996 covered approximately 80 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 1996 membership of 639,400, HMSA covered about 59 percent of Hawaii's civilian population.[1]

Kaiser Foundation Health Plan is a federally qualified, state-licensed health maintenance organization. In 1996, Kaiser provided insurance coverage for 195,607 people in Hawaii, or about 18 percent of the civilian population.[2] As of May 1998, Health Plan Hawaii, Kapi'olani HealthHawaii, Pacific Health Care, and QPH Health (better known as Queen's/HMSA Premier Plan) also operated as licensed health maintenance organizations in Hawaii.

Queen's health plans (Queen's Island Care, Queen's Hawaii Care, and Queen's Preferred Plan) provided coverage for 33,734 members in 1996, which represented approximately 3 percent of Hawaii's civilian population.[3] Commercial insurance plans and other insurers, such as University Health Alliance (formally Hawaii Dental Service Medical) and Straub Care Plus, covered most of the remaining privately insured population.

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.[4]

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 the ERISA would preempt any subsequent amendments. It is possible, therefore, that in Hawaii any mandated benefit laws passed after 1974 could be viewed, and challenged, as bypassing the limitations placed on the Prepaid Health Care Act.[5]

Background on Early Intervention Services

Under federal law and Part XXVIII of Chapter 321, HRS, the State of Hawaii provides certain early intervention services free of charge to identified infants and toddlers (children from birth to three years of age) considered to be developmentally delayed or at biological or environmental risk. Exhibit 1.1 shows Hawaii's eligibility requirements.

Coordinated state early intervention service systems are based on a framework found in federal law, specifically the Infants and Toddlers with Disabilities part of the federal Individuals with Disabilities Education Act. Passed in Congress in 1986, the federal early intervention law encouraged states through grants to develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency system that would provide early intervention services for infants and toddlers with disabilities and their families. It gave states five years to plan and implement their statewide program. In the fifth year of state participation, the federal law provided that early intervention services would become an entitlement program in which all eligible infants and toddlers and their families would be entitled to appropriate early intervention services. By 1992, all 50 states were receiving funds for infants and toddlers under the federal law.

Hawaii's early intervention services under the federal law are administered by the Department of Health through its Family Health Services Division. Based on and very similar to the federal law, Section 321-351, HRS defines early intervention services as services that are: (1) provided under public supervision; (2) provided at no cost, except when federal or state law provides for a system of payments by families, including a sliding fee schedule; (3) designed to meet the developmental needs of infants and toddlers with special needs, which includes but is not limited to physical development, cognitive development, and self-help skills; (4) provided by qualified professional and paraprofessional personnel; (5) provided in conformity with an Individualized Family Support Plan (IFSP); and (6) inclusive of but not limited to family support,

Exhibit 1.1
State of Hawaii Eligibility Requirements for Early Intervention Services

Developmentally Delayed

Developmentally delayed means a delay in one or more the following areas of development: cognitive development; physical development (including vision and hearing); communication development; social or emotional development; and adaptive development.

Biological Risk

Biological risk means prenatal, perinatal, neonatal, or early developmental events suggestive of biological insults to the developing central nervous system which increase the probability of delayed development. These are the children who have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay. It includes, but is not limited to infants and toddlers in the following categories:

1. Down's syndrome, fetal alcohol syndrome, AIDS, moderate-severe asphyxia, sensory impairments, SGA (small gestational age), gestational ages under 32 weeks, failure to thrive, hearing loss resulting from chronic otitis media, and infants born to mothers with diabetes, history of substance abuse, or history of mental illness.

2. Very low birthweight infants (1,500 grams or less).

Environmental Risk

Environmental risk means physical, social, or economic factors which may limit development. Environmental risk includes, but is not limited to, the following conditions:

One of the Following Conditions:

--Parental age: less than 16 years
--Any existing physical, developmental, emotional, or psychiatric disability in a primary caregiver
--Abuse of any legal or illegal substance by a primary caregiver
--Child abuse and neglect of target child or siblings

Two of the Following Conditions:

--Economically disadvantaged family
--Single parent
--Incarceration of a primary caregiver
--Parental age: 16-18 and less than high school education
--Birthweight: 1,500-2,500 grams
--Presence of physical, developmental, emotional, or psychiatric disability in a sibling or any other family member in the home

Source: Department of Health, Family Health Services Division, Zero-To-Three Hawaii Project

counseling, and home visits; special instruction; speech pathology and audiology; occupational therapy; physical therapy; psychological services; case management services; medical services only for diagnostic or evaluation purposes; early identification, screening, and assessment services; and health services necessary to enable the infant or toddler to benefit from the other early intervention services.

Federal requirements of early intervention service systems

The federal law includes minimum requirements for state early intervention systems. The law requires states to define "developmental delay" and establish a state policy to ensure that appropriate early intervention services are available to all infants and toddlers with disabilities and their families. This law requires states to provide a timely, comprehensive, multidisciplinary evaluation of each infant or toddler with a disability and a family-directed identification of the needs of each family of such an infant or child in order to develop an individualized family service plan. The law also requires states to develop, maintain, and provide a comprehensive child-find system, a public awareness program, a central directory, a data system, and a comprehensive system of personnel development. Moreover, states must develop policies and procedures for: (1) ensuring that necessary personnel are appropriately and adequately prepared and trained; (2) contracting or making arrangements with service providers; (3) securing timely reimbursement of funds; (4) safeguarding programs; and (5) ensuring that to the maximum extent appropriate, early intervention services are provided in a natural environment except where doing so is unsatisfactory.

The federal law requires states to designate a lead agency to provide general administration and supervision of programs and activities (and to meet other federal requirements) and to establish a state interagency coordinating council. Section 321-352, HRS designated the Department of Health as the lead agency for these purposes and for coordinating federal and state funds for early intervention service programs. Section 321-353, HRS established the Hawaii Early Intervention Coordinating Council.

State early intervention services programs

The Family Health Services Division of the Department of Health administers the Zero-To-Three Hawaii Project, which manages and coordinates early intervention service programs under the Individuals with Disabilities Education Act. The State also provides early intervention services under federal law through the Healthy Start program, Infant and Toddler Development Programs (through both state operated and purchase of service providers), private providers contracted with the health department, and through the department's Public Health Nursing Branch. The Zero-To-Three Hawaii Project coordinates early intervention services statewide, including services offered by various provider agencies on the islands of Kauai, Oahu, Molokai, Lanai, Maui, and Hawaii.

In 1996, 3,418 children were provided early intervention services in Hawaii. This was a 64 percent increase in the number of children receiving early intervention services in 1987, when 2,082 children were served. In 1987, the State spent over $4.2 million on services, or $2,046 per child. In 1996, the State spent almost $14.9 million on services, or $4,358 per child, over twice the 1987 amount. Of the $14.9 million, over $3.3 million or about 22 percent, was from federal sources; over $10.5 million, or nearly 71 percent, was from state funds; and almost $1.1 million, or about 7 percent, was from local sources, as identified by the Zero-To-Three Hawaii Project. Exhibit 1.2 shows annual expenditure and child count information of the State's early intervention service programs under the federal law since its inception in 1987.

Exhibit 1.2
State of Hawaii Annual Expenditures and Child Counts for Early Intervention Services

Year*	Expenditures for Services	Children Receiving Services	Average Expenditure Per Child
1987	$ 4,259,585	2,082	$2,046
1988	$ 5,266,019	3,259	$1,616
1989	$ 6,110,592	3,499	$1,746
1990**	$ 8,368,570	2,068	$4,047
1991	$ 9,216,510	2,871	$3,210
1992	$10,921,029	3,225	$3,386
1993	$12,681,735	3,635	$3,488
1994	$15,953,570	3,883	$4,109
1995	$15,118,861	3,875	$3,902
1996	$14,896,494	3,418	$4,358
1997	***	3,135	***

* The Zero-To-Three Hawaii Project has informed us that years represent fiscal years.
** Individualized Family Support (Service) Plans (IFSP) must be included in the count, according to the Project.
*** Information not available.

Source: Department of Health, Family Health Services Division, Zero-To-Three Hawaii Project. (We have not audited the figures.)

Hawaii's early intervention services are currently influenced by efforts to implement the *Felix* consent decree and changes in the program's relationship with the State's Medicaid system.

Complications from the *Felix* lawsuit

Issues related to early intervention services in Hawaii were complicated by the May 4, 1993, filing of the *Felix v. Waihee* lawsuit in federal district court. On May 24, 1994, the State was found to be in violation of two federal laws—the Individuals with Disabilities Education Act and the Rehabilitation Act of 1973. In essence, the federal court held that the defendants (the State) had failed to provide necessary and required educational and mental health services to qualified handicapped children in the state in violation of the two federal laws.

Under the October 25, 1994, *Felix* consent decree, the parties agreed that the State would establish a system of care to meet the educational and mental health needs of the *Felix* class members, consisting of programs, placements, and services and an organizational and managerial infrastructure to support the system, by June 30, 2000. The decree required the State to develop an Implementation Plan to establish the new system of care. (The completed Implementation Plan was dated October 31, 1995. On August 2, 1996, a stipulation was filed in federal court modifying the plan.) The decree also required the State to adhere to the requirements of the Individuals with Disabilities Education Act, Section 504 of the Rehabilitation Act of 1973, and the principles of the Hawaii Child and Adolescent Service System Program (CASSP). CASSP is a program initiated by the National Institute for Mental Health with requirements or principles for community-based services for children and youths with emotional problems.

In 1996, the Zero-To-Three Hawaii Project identified 62 percent of the children it served and 78 percent of the children served under the State's Infant and Toddler Development Programs to be members of the *Felix* class. Services for early intervention and prevention comprised one of 17 operational plans of the *Felix* Modified Implementation Plan, which was filed in federal court on August 2, 1996.

During a January 27, 1998, *Felix* status conference, the federal court ordered the *Felix* court monitor (an individual specified in the consent decree who is responsible for monitoring state implementation efforts) to submit recommendations for corrective orders for funding and other deficiencies in the Zero-To-Three program. In April 1998, the monitor submitted his report recommendations, identifying 65 developmentally delayed children who had been on a waiting list for early intervention services as of March 1998. Along with other recommendations, the monitor recommended that the health department develop a strategy to eliminate the waiting list. Recently, the *Felix* plaintiffs and the State

signed a stipulation withdrawing the plaintiff's motion to approve and adopt the monitor's report (filed in court on an earlier date). The stipulation was based upon the Department of Health's commitment to eliminate delays in obtaining initial evaluations by December 31, 1998, and immediately provide all eligible *Felix* class members with services.

Further complicating the provision of early intervention services, the overall *Felix* Modified Implementation Plan, which includes the early intervention services plan and various other plans, was revised. Also, the *Felix* court monitor, in his third-year implementation report (issued to the public on September 22, 1998) concluded that there were significant problems with implementing plans and efforts, and recommended refinement of the revised plans. While stating that the early intervention system was functioning effectively through its family-centered and single point of entry coordinated system of services, the monitor said that keeping children on a waiting list for services is in violation of the Individuals with Disabilities Education Act. The monitor recommended that the State be given until January 5, 1999, to take corrective actions to satisfy the plaintiffs. The monitor further recommended that if the plaintiffs are not convinced, they should be given permission to conduct discovery activities in preparation for a contempt hearing.

Other developments affecting early intervention services

A recent memorandum of agreement between the Department of Health and the Department of Human Services also affects the provision of early intervention services.

In addition to services provided by the health department, the Department of Human Services, through its Early and Periodic Screening, Diagnosis and Treatment program (EPSDT), administers services to children from birth to under 19 years of age (and under 21 for some in the foster care system). This program is part of the federal Medicaid program for Medicaid-eligible children, which is currently under the State's QUEST (*Q*uality of Care, *U*niversal Access, *E*fficient Utilization, *S*table Cost, and *T*ransformation) Medicaid waiver demonstration project. EPSDT provides reimbursements for medically necessary treatments and services to children eligible for QUEST, including children eligible for early intervention services. The interagency agreement is intended to address the needs of children (infants and toddlers) who fall within both the Department of Health's early intervention program and the Department of Human Services' EPSDT program.

The memorandum covers the provision of early intervention services for QUEST-eligible infants and toddlers provided on and after August 1, 1997. The QUEST project, as a federally approved statewide Medicaid waiver demonstration project, seeks to address the State's need to

stabilize health care costs, use resources more efficiently, and expand access to health care services, with emphasis on preventive health care. The interagency agreement implements what the departments refer to as a Medicaid "carve-out" for early intervention services. This carve-out of Medicaid funds allows the Department of Health to bill the Department of Human Services (the designated agency for Title XIX funds) for early intervention services provided to QUEST eligible children. Under the agreement, the Med-QUEST Division of the Department of Human Services must pay the Family Health Services Division of the Department of Health (which administers and coordinates the early intervention services programs) $325 per month for each Medicaid-eligible infant and toddler served by the division under the Individuals with Disabilities Education Act.

Existing Mandates for Aspects of Early Intervention Services

Hawaii's laws do not currently mandate private health insurance coverage for early intervention services through any specific reference to the Individuals with Disabilities Education Act or Chapter 321, Part XXVIII, HRS, which implements the act. However, Hawaii does mandate coverage for some services that may be associated with early intervention. For instance, Hawaii mandates health insurance coverage for psychological and vision services, both of which are included under the federal law. Commercial insurers (under Sections 431:10A-116, HRS—Individual Accident and Sickness Policies—and 431:10A-207, HRS—Group and Blanket Disability Insurance), mutual benefit societies (under Section 432:1-603, HRS), and health maintenance organizations (under Section 432D-23, HRS) must provide coverage for psychological services performed by physicians or psychologists licensed by the State. Visual or optometric services performed by a licensed physician or optometrist must be covered by commercial insurers (under Section 431:10A-116, HRS—Individual Accident and Sickness Policies—and 431:10A-207, HRS—Group and Blanket Disability Insurance) and health maintenance organizations (under Section 432D-23, HRS).

Also, commercial insurers (under Section 431:10A-115.5, HRS—Individual Accident and Sickness Policies—and 431:10A-206.5, HRS—Group and Blanket Disability Insurance), mutual benefit societies (under Section 432:1-602.5, HRS), and health maintenance organizations (under 432D-23, HRS) must provide coverage for child health supervision services (meaning physician-delivered, physician-supervised or nurse-delivered services) for children from birth through age five. Services such as a history, physical examination, developmental assessment, anticipatory guidance, immunizations, and laboratory tests are covered for 12 visits at specified age intervals.

Current Proposal to Mandate Coverage

S.C.R. No. 48, S.D. 1, H.D. 1 requested the Auditor to assess mandated health insurance coverage for early intervention services as proposed in S.B. No. 2948. The proposal would require certain health insurers to provide coverage for medically necessary early intervention services as specified under Section 321-351, HRS. In addition to changes in the statutes governing certain insurers, the proposal would add a new section to the health statutes.

Coverage for early intervention services

S.B. No. 2948 would require all policies that provide family or dependent coverage offered by commercial insurers governed under Article 431:10A, HRS (Accident and Sickness Insurance Contracts), health care contractors governed under Chapter 431N, HRS (State Health Insurance Program Act), and mutual benefit societies governed under Article 432:1, HRS (Mutual Benefit Societies) to provide coverage for medically necessary early intervention services as defined in Section 321-351, HRS. The coverage would be required as part of a basic benefits package. Medical necessity would be determined by the child's primary care physician or attending physician, who must consider the assessment of an interdisciplinary team operating within a program approved by the health department.

Moreover, the bill specifies that services must be provided by persons who are licensed under a host of statutes and who are employed in programs approved by the Department of Health for children from birth until three years of age. Specifically, the bill lists the following chapters of the HRS: 436E (Acupuncture Practitioners); 442 (Chiropractic); 447 (Dental Hygienists); 448 (Dentistry); 451D (Health Care Professionals); 453 (Medicine and Surgery); 455 (Naturopathy); 457 (Nurses); 457G (Occupational Therapy Practice); 458 (Opticians, Dispensing); 459 (Optometry); 460 (Osteopathy); 461J (Physical Therapy Practice Act); 463E (Podiatrists); 465 (Psychologists); and 468E (Speech Pathologists and Audiologists). Furthermore, the bill states that payments made for services shall not be applied by the insurer or third party against any maximum lifetime or annual limit for coverage.

Related issues

Chapter 431N, HRS (State Health Insurance Program Act) was enacted in 1989 through Act 378, Session Laws of Hawaii 1989. This act established a program within the Department of Health to provide basic health insurance coverage for medically uninsured Hawaii residents. The State Health Insurance Program provided services to uninsured residents through the purchase of health care coverage by the department from health care contractors. In 1994, this program's personnel count, funds, and population to be served were transferred to the Med-QUEST Division of the Department of Human Services. Currently, the program

is unfunded and inactive. A representative of the Med-QUEST Division stated that any amendments to Chapter 431N would not affect any individuals or health insurers.

S.B. No. 2948 would add a new section on payment for early intervention services to Chapter 321 (Department of Health), Part XXVIII (Infants and Toddlers) of the HRS. This section would require providers of early intervention services to seek payment from all third-party payers before seeking payment from recipients except for third-party payers who would apply the payment to an annual or lifetime limit specified by the third-party payer's policy, contract, or benefits package. This section also would require the director of health to adopt rules to reimburse recipients of early intervention services for deductibles and copayments imposed for early intervention services. The director would also be required to develop and implement procedures to exempt recipients of early intervention services from annual or lifetime insurance limits due to payments made for early intervention services.

Health maintenance organizations not affected

While S.B. No. 2948 would amend laws affecting commercial insurers and mutual benefit societies, the bill would not amend the State's Health Maintenance Organization Act, Chapter 432D. Therefore, health maintenance organizations are not affected by S.B. No. 2948.

Related proposal

A 1998 concurrent resolution, House Concurrent Resolution (H.C.R.) No. 192, H.D. 1, would have requested the Auditor to study the social and financial impacts of mandating coverage for early intervention services as set forth in another bill, House Bill (H.B.) No. 481; however, H.C.R. No. 192, H.D. 1 was not approved by both houses of the Legislature. Therefore, H.B. No. 481 was not a subject of our study.

While both S.B. No. 2948 and H.B. No. 481 would mandate coverage for medically necessary early intervention services, the measures differ in their scope and requirements. For example, unlike the senate bill, which would not amend laws affecting health maintenance organizations, the house bill would require commercial insurers, mutual benefit societies, and health maintenance organizations to provide coverage for medically necessary early intervention services as part of their basic benefit package. Furthermore, the house bill would limit required coverage to $4,500 per year per child and to an aggregate benefit of $13,500 over the total enrollment period. The senate bill does not limit third-party coverage.

Mandated Coverage in Other States

Documents from national organizations such as the National Association of Insurance Commissioners, recent reports, and other sources reveal that few states have mandated coverage for early intervention services that are provided to meet requirements of the Individuals with Disabilities Education Act. Private insurance coverage for such early intervention services is mandated by only three states that we know of: Massachusetts, Connecticut, and Virginia. Like Hawaii, a number of states mandate insurance coverage for services that may be associated with early intervention.

In 1990, Massachusetts mandated private insurance coverage for medically necessary early intervention services. The services must be part of a basic benefits package offered by the insurer or third party. Unlike S.B. No. 2948, the Massachusetts statute limits mandated coverage to $3,200 per year and to an aggregate benefit of $9,600 over the total enrollment period.

Connecticut requires coverage for at least $5,000 a year of medically necessary early intervention services. The Connecticut law, enacted in 1996, requires the services to be part of an individualized family service plan as specified in the state's Birth-To-Three program laws. Similar to S.B. No. 2948, Connecticut law exempts payments made for early intervention services from being applied against any maximum lifetime or annual limit specified by the insurer or third party.

Virginia also mandates private insurance coverage for early intervention services. In April 1998, the governor approved a bill requiring insurers and other providers of health care to provide coverage for medically necessary early intervention services. Virginia sets an annual benefits ceiling of $5,000 per insured per policy, and exempts payments made for early intervention services from being applied to any contractual provisions limiting the total amount of coverage specified by the third party. Virginia defines early intervention services to be medically necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology services and devices for children from birth to three eligible for services under the Individuals with Disabilities Education Act.

While other states may not mandate coverage for early intervention services under the federal scheme, some states do address related issues. For example, New York prohibits payments made under an insurance policy or health benefit plan for early intervention services from being applied against any lifetime or annual limit specified in the policy or plan. The state of Washington mandates coverage for medically necessary neurodevelopmental therapies for children six and under by providers of employer-sponsored group policies for comprehensive health. While

Washington's law does not mention "early intervention services" or the federal law, it does cover benefits associated with early intervention, such as those for occupational, speech, and physical therapy. Similarly, Tennessee requires coverage for conditions and disorders for treatments provided by licensed audiologists and speech pathologists.

Objective of the Study

The objective of this study was to describe the social and financial effects of mandating health insurance coverage for early intervention services.

Scope and Methodology

Pursuant to Sections 23-51 and 23-52, HRS, we assessed both the social and financial effects of the proposed coverage.

Scope

We examined the impact of mandatory health insurance coverage for early intervention services and the cost of such services as proposed in S.B. No. 2948. To the extent feasible, we considered the following issues set forth in Section 23-52, HRS.

Social impact

1. Extent to which early intervention services are generally utilized by a significant portion of Hawaii's population.
2. Extent to which insurance coverage for early intervention services is already generally available.
3. Extent to which the lack of coverage results in persons being unable to obtain necessary treatment.
4. Extent to which the lack of coverage results in unreasonable financial hardship on persons needing treatment.
5. Level of public demand for early intervention services.
6. Level of public demand for individual or group insurance coverage for early intervention services.
7. Level of interest of collective bargaining organizations in negotiating privately for this coverage.
8. Impact of providing coverage for early intervention services on the health status, quality of care, practice patterns, provider competition, or other related items.
9. Impact of indirect costs upon the costs and benefits of coverage.

Financial impact

1. Extent to which insurance coverage would increase or decrease the cost of early intervention services.

2. Extent to which this proposed coverage might increase the use of early intervention services.

3. Extent to which mandated early intervention services might serve as an alternative to more expensive treatment or services.

4. Extent to which insurance coverage for early intervention services might increase or decrease the insurance premiums or administrative expenses of policyholders.

5. Impact of insurance coverage for early intervention services on the total cost of health care.

Methodology

We reviewed recent research literature and reports on the social and financial aspects of early intervention services, applicable federal and state statutes, and proposed legislation. We surveyed and obtained information from commercial insurers, mutual benefit societies, health maintenance organizations, employer groups, collective bargaining organizations, professional associations, and other local organizations and entities, specifically the Department of Health and the School of Public Health of the University of Hawaii at Manoa. We interviewed and obtained information from personnel of the state Zero-To-Three Hawaii Project and conducted follow-up interviews with surveyed local organizations and entities as necessary.

We contacted and obtained information from national organizations, including the National Conference of State Legislatures, the Blue Cross and Blue Shield Association, and the National Association of Insurance Commissioners. To the extent that information was available, we reviewed and documented coverage for early intervention services adopted in other states.

Our work was performed from June 1998 to November 1998 in accordance with generally accepted government auditing standards.

Chapter 2

Social and Financial Impact of Mandating Health Insurance Coverage for Early Intervention Services

This chapter summarizes our assessment of the potential social and financial impacts of mandating health insurance coverage for early intervention services as proposed in Senate Bill (S.B.) No. 2948 of 1998. To the extent feasible, and based upon available information, we addressed the social and financial issues set forth in Section 23-52, HRS.

Hawaii's early intervention services under the federal Individuals with Disabilities Education Act are provided by the State through the Department of Health. Through its own staff and private providers, the department delivers services to identified infants and toddlers (children from birth to three years of age) and their families free of charge. In 1996, the department spent almost $14.9 million for services characterized as early intervention. State funds accounted for nearly 71 percent or about $10.5 million of the total, and federal and local funds the remainder.

Through S.B. No. 2948, the health department is determined to tap additional sources of funding for early intervention services: the private sector through private health insurance plans. As expected, we found the private sector, specifically insurers and employer groups, concerned about the proposed mandate.

Overview of the Proposed Mandate

S.B. No. 2948 proposes to mandate private health insurance coverage for early intervention services. The bill would require commercial insurers, health care contractors, and mutual benefit societies to provide coverage for medically necessary early intervention services. These services would have to be part of the insurers' or third parties' basic benefits package offered to members and subscribers.

S.B. No. 2948 specifies who shall provide services and how medical necessity shall be determined. Early intervention services would have to be provided by health care professionals licensed under 16 chapters of the Hawaii Revised Statutes and working in programs approved by the health department to provide services for children from birth to three years of age. Physicians in determining medical necessity would have to consider assessments by personnel working in Department of Health-approved programs. Also, the proposed legislation would exempt payments made under the mandate from being applied against any

maximum lifetime or annual limit for coverage under a policy or benefits package.

The health department would be required to develop and adopt rules and procedures to protect recipients of early intervention services from financial impact. For instance, rules would have to be adopted that specify how the State should reimburse recipients for deductibles and copayments imposed by the health plans, as applicable. The health department also must implement procedures to protect recipients of early intervention services from the impact of these services being applied against specified annual or lifetime limits imposed by the insurer or third party.

Social Impact

1. Extent to which early intervention services are generally utilized by a significant portion of Hawaii's population.

In 1997, the Department of Health provided early intervention services to 3,135 children under the age of three—approximately 6 percent of children under three in the state, according to the department. Of these children, 1,072 were classified as developmentally delayed, while 2,063 were classified as environmentally at-risk. (Note that the federal Individuals with Disabilities Education Act does not mandate the provision of early intervention services to environmentally at-risk infants and toddlers. The federal law *allows* the state to include this at-risk population at each state's discretion. Using its discretion, Hawaii provides services to the environmentally at-risk infants and toddlers.)

Since the State provides the early intervention services, insurers were not able to determine what percentage of their membership receive early intervention services. Kaiser Foundation Health Plan, Inc. (Kaiser), reported that 100 of its members received social, nonmedical services from the Zero-To-Three program in 1997; however, it stated that this figure did not account for members receiving Kaiser medical services that could be covered under the proposed mandate.

2. Extent to which insurance coverage for early intervention services is already generally available.

The Department of Health reported that private insurance rarely provides coverage for early intervention services unless an illness or injury created the need for services. This view is shared by early intervention advocates and provider agencies. The department stated that speech therapy may be covered for a child with delayed language skills due to a traumatic brain injury, but it is almost never covered for a child with delayed language development due to Down's syndrome.

The Hawaii Medical Service Association (HMSA) stated that its insurance coverage for early intervention services is limited, if provided at all. Other insurers reported that medically necessary services already seemed to be covered. Queen's Health Management (Queen's) reported that commercial coverage is already available for medically appropriate services for speech pathology, occupational and physical therapy, psychological and psychiatric services, and case management and medical services for diagnostic or evaluative purposes. However, Queen's stated that early intervention services that are more social in nature are generally not covered under commercial health plans.

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

The lack of coverage normally does not result in children not receiving services, since the State is obligated to provide services to eligible infants and toddlers free of charge.

However, the lack of coverage may have contributed to the State's establishment of a waiting list for services and possibly to the State's inability to serve additional unidentified children who are currently only estimated by the department. The Department of Health identifies the State's fiscal situation as the cause for eligible children not receiving services to which they are entitled. In April 1998 the *Felix* court monitor (an individual specified in the consent decree who is responsible for monitoring state implementation efforts) reported that as of March 1998, 65 developmentally delayed children were on a waiting list for early intervention services. The average time on the waiting list was estimated to be about two months. Early intervention advocates stressed that federal regulations require services to be provided within 45 days of referral to the State's program. They maintain that the waiting list is a violation of the Individuals with Disabilities Education Act. A recent stipulation between the *Felix* plaintiffs and the State reinforced the Department of Health's commitment to eliminate the waiting list for initial evaluations for services by December 31, 1998, and to immediately provide services to eligible *Felix* class members.

Advocates and the health department state that when services are covered by private insurers, the frequency, scope, and duration of services is insufficient to achieve the desired outcomes.

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

The lack of coverage should not result in unreasonable financial hardship on persons needing treatment, since the State is responsible for providing early intervention services free of charge to parents and children

identified as needing services. However, parents of children on the waiting list for services could face unreasonable financial hardship as a result of the lack of insurance coverage.

Parents of children on the waiting list must either pay for the services out-of-pocket or wait for openings in the state program. Out-of-pocket costs for early intervention services can be expensive. The Hawaii Medical Association believes that the lack of coverage results in delayed services, long waiting lists for services, and out-of-pocket expenses for parents who often lack resources for costly treatments.

Insurers did not have specific information regarding this issue; however, HMSA reported receiving no appeals from members who were denied coverage for early intervention services, indicating that lack of coverage may not result in financial hardship. We learned that the health department will pay for services if there has been a denial for services by the insurer.

5. Level of public demand for early intervention services.

Demand for early intervention services comes primarily from individual families needing services, pediatricians and other health care providers, and advocacy groups.

Employers and other members of the public not involved in the provision of early intervention services or not in need of services seem uninterested in this health issue. Kaiser maintains that it has not received requests for additional early intervention services. Queen's reports no demands from employer groups who pay for health benefits.

6. Level of public demand for individual or group insurance coverage for early intervention services.

Demand for individual or group insurance coverage comes from the health department, advocates, and families with children in need of services. However, insurers and organizations representing employers do not perceive a demand.

The demand originated primarily with the Department of Health. The department referred to a federal regulation on early intervention programs that characterizes private insurance coverage as a funding source for early intervention services. The department indicated that health plans know that the State is obligated to provide services free of charge to eligible children. The department recognizes that it would not be in the insurers' best interest to voluntarily assume additional responsibilities.

The Hawaii Chapter of the American Academy of Pediatrics, the Learning Disabilities Association of Hawaii, and other early intervention advocacy organizations, including the Hawaii Early Intervention Coordinating Council and the Hawaii Early Intervention Association, have testified in favor of private insurance coverage.

Insurers and employer organizations are unaware of, or have not received, any demand for additional coverage. For instance, Queen's indicated it is not aware of any interest in insurance coverage from employees, employers, or collective bargaining organizations. The Hawaii Employers Council reported that member companies have not discussed the need for early intervention services in their health coverage.

7. Level of interest of collective bargaining organizations in negotiating privately for this coverage.

We were not able to identify any interest from collective bargaining organizations in negotiating privately for this coverage. Unions surveyed seemed uninterested in the issue. Insurers are not aware of, nor have they received, any indication that collective bargaining organizations have negotiated for this coverage. An employer organization stated that coverage for early intervention services has not been included as a demand by a labor union in negotiations with its members.

8. Impact of providing coverage for early intervention services on the health status, quality of care, practice patterns, provider competition, or other related items.

The health department anticipates that improved health status, better care, and a reduction of the size of the waiting list would result from additional sources of funding provided by passage of S.B. No. 2948. The department's views regarding improved health status and better care are shared by both health care providers and early intervention advocates. Furthermore, the department believes that many of the currently existing paperwork barriers between pediatricians and health plans to ensure payment for services would be reduced through this mandate, which would ensure payment. The Hawaii Medical Association indicated that young children rapidly develop physically, mentally, socially, and behaviorally during the first three years of life. The association maintains that delayed intervention services can often lead to more costly and permanent damage.

The majority of the insurers were not able to respond to this issue. However, one insurer stated that the cost to health plans created by broadening the provider base to include providers that are not currently generally recognized by health plans may lead to increased usage and costs but with possibly an insignificant impact on the quality of care and health status of children.

Also, an insurer raised concerns regarding the proposal's requirement that physicians in determining medical necessity must consider the assessments of personnel who work in Department of Health-approved programs that provide services to children. The insurer thought that this requirement would infringe upon the physician's determination of medical necessity.

One respondent who specializes in public health raised concerns regarding the current state program of early intervention services, saying that services are not integrated and are inefficient and often ineffective in providing interventions. This respondent also commented that state services lack outcome assessments, which hinders families who access services from making choices "intelligently." The respondent also stated that the insurance mandate will increase costs without resolving currently existing problems in the provision of early intervention services.

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

Indirect costs of mandating early intervention services do exist. Insurers were not able to provide quantifiable estimates of indirect costs; however, they did provide a laundry list of identifiable indirect costs created by this mandate. They indicated that indirect costs would be incurred for developing actuarial studies, credentialing new providers, obtaining legal consultation for contracting and risk management, maintaining provider servicing agreements, paying printing costs, negotiating with new providers, and meeting guidelines for monitoring quality of care and services for new providers. One insurer estimated that indirect costs could range from low to moderate, depending on the services encompassed by the mandate.

A provider agency indicated that the impact of indirect costs on early intervention services would be the same for any other benefit covered by an insurer where the risks (that is, costs) are shared by all consumers. The health department believes that administrative (or indirect) costs incurred in its current attempts to secure approval for payments by insurers would be reduced. The resources saved by the department could then be applied to direct provision of services.

Financial Impact

1. Extent to which insurance coverage would increase or decrease the cost of early intervention services.

We were not able to determine whether insurance coverage would increase or decrease the cost of early intervention services. The Department of Health, advocacy groups, and provider agencies do not

anticipate either increases or decreases in the cost of early intervention services due to this insurance mandate. The Hawaii Medical Association suggested that the mandate would merely shift the payment source.

Only one insurer stated that the cost of early intervention services would inevitably increase. Other insurers were uncertain of the mandate's impact on the cost of services. However, insurers did express clear concern over the legislation's expansion of the provider base for services. For example, Kaiser warned that the financial impact would be great if the mandate were to expand covered services to include chiropractors, naturopaths, and other providers not normally covered under health plans.

2. Extent to which this proposed coverage might increase the use of early intervention services.

We found indications that the proposed coverage could increase the use of early intervention services. The Department of Health stated that it recognizes the need to approximately double the number of children currently being provided early intervention services from approximately 6 percent to 12 percent of children under the age of three. If the department's estimate of need holds true, the proposed mandate could surely increase the use of early intervention services.

Only one of the insurers stated that the proposed coverage would increase utilization. Other insurers were uncertain about the mandate's impact on utilization. One insurer informed us that, as a general rule, availability of insurance can increase utilization. It stated that utilization and cost can increase if patients access multiple providers in an effort to find the most appropriate services or seek multiple interventions for a particular problem.

3. Extent to which mandated early intervention services might serve as an alternative to more expensive treatment or services.

We found evidence that early intervention services could serve as an alternative to more expensive treatment or services. In 1991, the National Conference of State Legislatures (NCSL) reported that studies have shown that states may recover between three and seven dollars for each dollar invested in early intervention services. The NCSL report stated that savings would result from avoiding later special education and institutionalization costs. A 1996 article from the *Archives of General Psychiatry* reported on a study that stated that treatment and intervention programs, especially employed in early childhood, could theoretically reduce crime and violence.

The health department informed us that Congress established the early intervention aspect of the federal Individuals with Disabilities Education Act in response to extensive research data that confirmed the preventive nature of early intervention services. While insurers could not respond to this issue, advocates and provider agencies were certain that early intervention services would serve as an alternative to more expensive services. Later intervention, one respondent stated, could be more expensive, must be more intensive, and would be less likely to succeed.

4. Extent to which insurance coverage for early intervention services might increase or decrease the insurance premiums or administrative expenses of policyholders.

The view that mandating coverage for early intervention services could increase the insurance premiums of policyholders was shared by insurers, provider agencies, the Hawaii Medical Association, and the Department of Health. The health department expects that increased costs would be offset by reduced need for services later on in the child's life, and the Hawaii Medical Association stated that the risk (or increases) would be shared by all policyholders.

The insurers were not able to comment on the extent of the expected increase in premiums, since they would need additional information. One insurer stated that additional costs incurred by health plans would be passed on to the members and employers through higher premiums for health coverage.

5. Impact of insurance coverage for early intervention services on the total cost of health care.

The impact of insurance coverage for early intervention services on the total cost of health care is uncertain. Insurers were not able to provide a definitive answer to this question. Kaiser stated that the impact would depend on the precise nature of early intervention services being mandated. Throughout its response, Kaiser maintained that the statutory definition provided by the legislation was unclear, hampering its ability to determine coverage limits and clearly answer the questions of our study. Kaiser warned that costs could be greater if what constitutes early intervention services is not clearly defined. It added that previous mandates in various other health areas were costly.

The Hawaii Employers Council stated that the proposed mandate would definitely impact Hawaii's employers, since "early intervention services" is such a broad term that it can include any health, education, and social service.

The health department and early intervention advocates believe that mandating insurance coverage for early intervention services would decrease health care costs in the long run through savings resulting from avoiding more expensive health care and special education services. However, one respondent, who indicated that the present provision of early intervention services is inefficient and ineffective, implied that increased health care cost will be the major impact of the mandate but will not resolve the problems that the mandate attempts to address.

Conclusion

We found that demand for mandating health insurance coverage for early intervention services originated from the Department of Health. The department stated that mandating private health insurance to include early intervention services would ensure that private insurers assume their fair share of early intervention costs. In 1996, the department spent approximately $14.9 million for services characterized as early intervention under the federal Individuals with Disabilities Education Act. Of this amount, nearly 71 percent, or about $10.5 million, was state funds, and the remainder was from federal and local sources. The health department believes that the proposed mandate would help the State further meet its federal obligations, its responsibilities under the *Felix* consent decree, and ensure that families are better served. While this may be so, policy makers should use caution in mandating private coverage to compensate for what may be a government programmatic decision not to provide all the services at public expense.

The demand for services and insurance coverage comes from the department, advocacy groups, provider organizations, and provider agencies. We found no indication that employers and unions are interested in these services or would demand insurance coverage for them.

Insurers were not certain about the characteristics, numbers, and health status of their members already utilizing early intervention services, since services are provided and managed through the state program. For the same reasons, insurers were not able to clearly estimate the potential direct and indirect costs of mandating services. However, possible increased costs to policyholders were mentioned by insurers, providers, advocates, and the department alike.

Insurers raised a number of concerns regarding the proposed mandated benefit. For instance, insurers were concerned about the broadness of the definition of early intervention services. One insurer stated that the vagueness of the definition makes it impossible to determine coverage limits. Insurers were also concerned about a number of providers listed in the legislation whose services are not generally covered by health

plans. Kaiser suggested that requiring plans to purchase or provide services from these professionals would be inappropriate. Furthermore, Kaiser raised concerns regarding nonmedical entities exerting influence in the determination of medically necessary services. It feared that these nonmedical entities would infringe on a physician's medical determination of necessity. Additionally, an insurer raised concerns about being mandated to cover services that are social in nature and about the State's objective in seeking new funding sources for services that the State is obligated to fund.

An employer organization also raised concerns regarding the broadness of the proposed mandate. It stated that such a broad mandate is unwarranted during a time when businesses are struggling in Hawaii. This sentiment is echoed by Queen's, which doubts that the private sector would be willing to pay for additional benefits.

Furthermore, concerns beyond the scope of our current assessment were raised. One respondent noted that S.B. No. 2948, mandating insurance coverage for early intervention services, is a "quick fix" for existing problems. The respondent commented that current services provided by the State are not integrated within an effective system. The respondent added that a state plan that promoted collaboration and quality, managed through an integrated central information system, would assist consumers (those in need of early intervention) more then mandating insurance coverage at this time.

If the Legislature wishes to enact S.B. No. 2948 or any legislation to mandate private insurance coverage for early intervention services, the concerns raised by the insurers, employer organizations, and other respondents should be addressed. Fundamental questions regarding the precise nature of the services and the types of providers covered should be answered and clarified for insurers prior to passage of any legislation. The Department of Health often refers to a public-private partnership in the provision of early intervention services. For a true partnership to exist between the public and private sectors, clear communication and an agreement between the affected parties would be needed.

Notes

Chapter 1

1. Hawaii, Department of Business, Economic Development and Tourism, *The State of Hawaii Data Book 1997*, Honolulu, p. 404.
2. Ibid.
3. Ibid.
4. Section 393-7, HRS.
5. National Governors' Association, *Roadblock to Reform, ERISA Implications for State Health Care Initiatives*, 1994, pp. 6, 46, 49, and 50.

Response of the Affected Agency

Comments on Agency Response

We transmitted a draft of this report to the Department of Health on December 22, 1998. A copy of the transmittal letter to the department is included as Attachment 1. The department's response is included as Attachment 2.

The department's response discussed certain federal requirements and expectations concerning the funding of early intervention service systems. The department also proposed additional language for our draft report to emphasize the importance of the State seeking all available public and private funding. We did not revise our report in this regard because we believe it is sufficient to include the department's response with the report.

The department also observed that public discussion regarding the issues raised in the bill could be enhanced by providing additional information to insurers, increasing communication between affected parties, and working toward consensus on apportioning financial responsibility for aspects of services within the early intervention system.

We made some editorial changes to the draft report for purposes of clarification.

ATTACHMENT 1

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 22, 1998

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 Mandatory Health Insurance Coverage for Early Intervention Services*. We ask that you telephone us by Thursday, December 24, 1998, 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 Thursday, December 31, 1998.

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

BRUCE S. ANDERSON Ph.D., M.P.H.
DIRECTOR OF HEALTH

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

January 13, 1999

In reply, please refer to:
File:

Ms. Marion M. Higa
State Auditor
Office of the Auditor
465 South King Street, Room 500
Honolulu, Hawaii 96813-2917

RECEIVED
Jan 14 9 28 AM '99
OFC. OF THE AUDITOR
STATE OF HAWAII

Dear Ms. Higa:

We have reviewed the draft report *Study of Proposed Mandatory Health Insurance Coverage for Early Intervention Services.* The following are comments from DOH regarding this report and its recommendations:

Page 5: **Federal requirements of early intervention service systems**

I.D.E.A. (PL 99-457) was reauthorized by Congress as P.L. 105-17 around the time that this report was being generated by the legislative auditor. The new language further clarifies the responsibility of the designated state agency with respect to administering a system of early intervention services. The following concepts and excerpts are pertinent:

1. IDEA Part C services were never intended to be fully funded through federal US DOE and matching state funds. To quote from the Report 89-860, 15 (1986) of the House of the Representatives regarding Public Law 99-457 (the original authorizing legislation): "Thus it is our intent that other funding sources continue: that there is greater coordination among agencies regarding the payment of costs; and that funds under Part H be used only for direct services for handicapped infants and toddlers that are not otherwise provided from other public or private sources".

2. Functions to be provided at public expense: The federal authorizing language specifies which functions are to be provided *at public expense by a State*, and for which no fees may be charged to parents: implementing the child find requirements, evaluation

and assessment, case management, administrative and coordinative activities related to IFSP development, review and evaluation and implementation of procedural safeguards.

3. Payor of last resort: PL 105-17 states that: "Funds provided under section 643 may not be used to satisfy a financial commitment for services that would have been paid for from another public or private source, including any medical program administered by the Secretary of Defense..." and goes on to state, "Nothing in this part may be construed to permit a State to reduce medical or other assistance available or to alter eligibility under Title V of the Social Security Act or Title XIX of the SSA within the State".

4. Mandate to state programs to integrate funding sources: P.L. 105-17 states that a single line of responsibility in a lead agency (...needs to be) designated or established by the governor for carrying out-.....b) the identification and coordination of all available resources within the state from federal, state, local and private sources....

Therefore, consideration should be given to adding a 3rd paragraph to this section: "Congress, when it passed IDEA and reauthorized Part C , clearly did not intend for the cost of services to be exclusively public domain. The legislation specifically directs state programs to use "public and private funding" sources and to be responsible for " identification and coordination of all available resources within the state from federal, state, local and private sources. Further, the recent reauthorization of IDEA clarified that Part C funds are payor of last resort after Champus, Title XIX and private sources of payment for medically necessary services".

Thank you for the opportunity to review and respond to this report. Clearly, public discussion regarding the issues raised in this bill could be enhanced by providing additional information to insurors, increasing communication between affected parties and working toward consensus regarding apportioning financial responsibility for aspects of services within the early intervention system of services.

Sincerely,

Bruce S. Anderson, Ph.D., M.P.H.
Director of Health