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

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

Report No. 04-07
April 2004

THE AUDITOR
STATE OF HAWAII

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.

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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.

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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to the current definition of *serious mental illness.* The proposed mental illness coverage, however, was included in a superseded House Draft of a bill signed into law in June 2003.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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Submitted by

THE AUDITOR
STATE OF HAWAII

Report No. 04-07
April 2004

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 mandatory health insurance benefits. As requested by Senate Concurrent Resolution No. 116, Senate Draft 1, House Draft 1, of the 2003 legislative session, this report assesses the social and financial impacts of mandating parity in coverage for the treatment of additional serious mental illnesses and substance abuse.

We acknowledge the cooperation and assistance of the Department of Commerce and Consumer Affairs, the Department of Health, and other organizations and individuals whom we contacted during the course of our examination.

Marion M. Higa
State Auditor

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Chapter 1

Introduction and Background

Introduction

Currently, Hawaii law mandates general health insurance benefits, with specific limits, for mental illness and substance abuse treatment.[1] For *serious mental illness* as defined by law, health insurance benefits are more expansive. By mandate under Section 431M-5(c), Hawaii Revised Statutes (HRS), coverage must be on a par with other medical and surgical benefits and is accordingly much broader than coverage for mental illness in general. A health plan may not impose rates, terms, or conditions on serious mental illness benefits, if similar rates, terms, or conditions are not applied to benefits for other medical or surgical conditions.

Today, *serious mental illness* includes schizophrenia, schizo-affective disorder, and bipolar types I and II as defined in the most recent version of the Diagnostic and Statistical Manual of the American Psychiatric Association. The definition, as set forth in Section 431M-1, HRS, also requires the illness to be "of sufficient severity to result in substantial interference with the activities of daily living."

Redefinition of serious mental illness

During its 2003 session, the Legislature considered, but did not pass into law, an expanded definition of *serious mental illness* under House Draft 1 of Senate Bill No. 1321 (S.B. No. 1321). This version would have added *delusional disorder*, *major depression*, *obsessive compulsive disorder*, and *dissociative disorder* to the existing list of serious mental illnesses with mandated parity in insurance benefits. The bill also would have re-designated *bipolar disorder* as *bipolar types I and II* and made permanent the mandated parity in benefits for serious mental illness due to sunset on December 31, 2003.

At present, treatment of delusional disorder, major depression, obsessive compulsive disorder, and dissociative disorder is covered by health insurance benefits mandated by law for mental illness in general. If moved into the *serious* mental illness category as proposed by House Draft 1 of S.B. No. 1321, these disorders would be entitled to expanded treatment benefits. General health insurance coverage with its statutory limits would be replaced by the broader coverage mandated for serious mental illness. In essence, the bill would mandate parity in health insurance coverage for treatment of an expanded definition of *serious mental illness*.

What finally emerged, as S.B. No. 1321, House Draft 2, Conference Draft 1, was the re-designation of *bipolar mood disorder* as *bipolar types I and II*, without the expanded definition of *serious mental illness*. The sunset date was removed, and mandated parity in coverage for serious mental illness treatment became permanent. The governor signed the bill into law as Act 197, Session Laws of Hawaii (SLH) 2003, on June 24, 2003.

Analysis of the effects of proposed parity

Even with the passage of Act 197, interest in House Draft 1 of S.B. No. 1321 survived the session, as reflected in Senate Concurrent Resolution No. 116, Senate Draft 1, House Draft 1 (S.C.R. No. 116). By this concurrent resolution, the Auditor was asked to assess the social and financial effects of mandating health insurance coverage of the expanded definition of *serious mental illness* that House Draft 1 had proposed. S.C.R. No. 116 also asked that we include in our assessment the social and financial effects of mandating parity in health insurance coverage for alcohol and drug dependency treatment, although S.C.R. No. 116 did not cite any legislation proposing such parity. For purposes of our analysis, the concurrent resolution asked that we consider substance abuse treatment "at rates and on terms and conditions no less favorable than those applicable to treatment for medical and surgical conditions currently required to be covered by health insurance."

The Legislature requested this assessment pursuant to Section 23-51, HRS. The statute requires passage of a concurrent resolution requesting an impact assessment by the Auditor before any legislative measure mandating health insurance coverage for specific diseases can be considered. The statute also requires that the concurrent resolution designate a specific legislative bill that has been introduced and that includes, at a minimum, the following information identifying:

- Specific health service, disease, or provider that would be covered;
- Extent of the coverage;
- Target groups that would be covered;
- Limits on utilization, if any; and
- Standards of care.

Background

Development of parity laws

Health care insurance serves social as well as economic and medical purposes. Unlike other forms of insurance, health care insurance is the basis by which an essential social good is allocated. It profoundly affects the availability, cost, and use of health care services.

Under employment-based health care insurance, mental health and substance abuse treatment typically receives less coverage than medical and surgical services. This disparity may reflect long-held attitudes that those who are mentally ill or who are substance abusers are not as deserving of treatment as those with physical ailments. In addition, insurers are reluctant to cover mental health and substance abuse treatment on a par with medical and surgical services. This reluctance generally stems from concerns about adverse selection and moral hazard. *Adverse selection* may occur when those who are older or less healthy choose to enroll or continue enrollment in insurance to a greater degree than those who are younger or healthier. *Moral hazard* may occur when reduced cost-sharing by enrollees under insurance plans dampens their motivation to spend health care dollars more economically.

During the past decade, the disparity between mental health and medical insurance coverage has narrowed as states and the federal government began requiring coverage of mental health and substance abuse treatment in the same way as other medical and surgical care. This movement toward same or similar coverage is known as parity. Passed in 1996, the federal Mental Health Parity Act requires employers with more than fifty employees to provide the same annual and lifetime limits for mental health benefits, if offered, as for other health care benefits. The act does not require that mental health benefits be provided—only that, if offered, limits on such benefits be in line with federal requirements. The act also does not apply to substance abuse benefits. Furthermore, businesses are exempt if parity increases costs by more than 1 percent after six months. Set to expire on December 31, 2003, the act was extended to December 31, 2004.

Spurred by the federal parity act, states have also enacted parity laws. Before 1996, only eight states—Maryland, New Hampshire, Rhode Island, Massachusetts, North Carolina, Texas, Maine, and Minnesota—had passed parity laws. Today, the National Alliance for Mental Illness lists 36 states as having some form of parity law; Hawaii is among those states.

Hawaii's parity law

Passed in 1988, Hawaii's mental health benefits statute specifies the minimum coverage that health care plans are to provide for mental health and substance abuse treatment. Initially, the statute did not contain any parity requirements. In 1999, the Legislature established parity, but only in coverage for serious mental illness; treatment of other mental disorders and substance abuse still falls under the minimum requirements of the statute.

Under Hawaii's statute, insurance coverage for basic mental illness and substance abuse treatment may not be discriminatory with respect to deductibles and copayments. The proportion of deductibles or copayments may not be greater than those applied to comparable physical illnesses generally requiring a comparable level of care. On the other hand, coverage for serious mental illness may not be limited or have financial requirements if similar limits or financial requirements are not applied to coverage for other medical or surgical conditions.

Basic mental illness and substance abuse coverage requires not less than 30 days of in-hospital services. Each day of in-hospital services may be exchanged for two days of non-hospital residential services, two days of partial hospitalization services, or two days of day treatment services. Also required are not less than 30 visits per year to a physician, psychologist, clinical social worker, or advanced practice registered nurse in hospital, non-hospital, or mental health outpatient facilities for day treatment or partial hospitalization services. The total covered outpatient service for substance abuse and mental illness is not less than 24 visits annually, but not more than 12 visits may apply to substance abuse treatment. Mandated benefits for substance abuse treatment may not be less than two treatment episodes per lifetime; benefits for mental illness treatment do not have any lifetime limits.

Prior reports

Our office has conducted studies of mandated coverage of mental health and substance abuse treatment benefits in the past. Report No. 88-6, *Study of Proposed Mandatory Health Insurance for Alcohol and Drug Dependence and Mental Illness*, was issued before the Legislature enacted new health coverage for mental illnesses and substance abuse. We analyzed the social and financial impacts of such coverage in a collaborative effort with Peat Marwick Main & Co. For substance abuse benefits, we concluded that coverage in place at that time was not adequate and perhaps reflected prejudices that these conditions are somehow not worthy of the same care assured other illnesses. We cautioned then that legislation mandating expanded coverage must be adequately designed to provide benefits for the appropriate range of treatment for those who seek care and to prevent unnecessary escalation of insurance and treatment costs.

For mental illness benefits, we found we could not provide clear-cut answers on the social and financial impacts of mandated insurance coverage. We suggested that expanding current benefit levels might provide better care for patients with serious conditions whose treatment needs were not being met by the system in place. We observed, however, that it is less clear how insurance alone would affect an individual's decision to seek treatment in early stages of these illnesses. As in cost considerations for substance abuse benefits, we cautioned that legislation should include provisions to prevent unnecessary escalation of insurance and treatment costs.

In Report No. 97-19, *Study of Proposed Mandated Additional Mental Health and Alcohol and Drug Abuse Insurance Benefits*, we examined the social and financial impacts of mandating parity in insurance coverage of mental health and substance abuse benefits. This time, we were assessing benefits that would be no less extensive than coverage provided for any other medical illness. Without a clear definition of parity, however, we were hampered in conducting our assessment. We found very limited information on the extent to which the lack of parity would result in persons being unable to obtain necessary treatment. In light of low demand from employee groups and low utilization under current insurance coverage, we concluded then that mandating parity in coverage for all mental health and substance abuse services is not warranted.

Objectives of the Study

1. Describe the potential social and financial effects of mandating parity in health insurance coverage for an expanded definition of *serious mental illness* and for substance abuse.

2. Make recommendations as appropriate.

Scope and Methodology

Our study examined the social and financial impacts of mandating parity in health insurance coverage for substance abuse and an expanded definition of *serious mental illness* as proposed in S.B. No. 1321, House Draft 1. We reviewed and summarized literature on the positive and negative social and financial experiences of other jurisdictions with mandated parity laws. We reviewed and summarized literature on actuarial and cost-benefit studies relating to parity.

We also surveyed or interviewed local health care insurance organizations and representatives of labor unions and employer organizations to learn their perspectives on the social and financial impacts of mandating parity in insurance coverage for additional serious

mental illnesses and for substance abuse. We also surveyed practitioners (including psychiatrists, psychologists, clinical social workers, and advanced practice registered nurses) and professional associations, consumer advocates, state agencies, and directors of facilities involved in mental health and substance abuse services for their points of view and for utilization and access data. Based on a general guideline for acceptability, we sought a response rate of 50 percent.

To assess the potential social and financial impacts of mandating parity, we used the following criteria set forth in Section 23-52, HRS, as applicable:

Social Impacts

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 coverage of such services is already generally available.

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

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

5. Level of public demand for parity in insurance coverage.

6. Level of public demand for parity in individual and 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 in group contracts.

8. Impact of parity in insurance coverage on health status, quality of care, practice patterns, or provider competition.

9. Impact of indirect costs upon the costs and benefits of parity in insurance coverage.

Financial Impacts

1. Extent to which parity in insurance coverage would increase or decrease health care costs.

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

3. Extent to which parity in coverage would serve as an alternative for more expensive treatment or service.

4. Extent to which parity in insurance coverage would increase or decrease insurance premiums or administrative expenses of policyholders.

5. Impact of parity in insurance coverage on the total costs of health care.

We conducted our study from August 2003 to December 2003 in accordance with generally accepted government auditing standards.

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Chapter 2

Social and Financial Impacts

Summary of Findings

The social and financial impacts of mandating parity in health insurance coverage for an expanded definition of s*erious mental illness* and for substance abuse are unclear.

Data to Fulfill the Study's Requirements Are Not Available

S.C.R. No. 116 asks the Auditor to assess the social and financial effects of mandating parity in health insurance coverage for an expanded definition of s*erious mental Illness* and for alcohol and drug dependency treatment. In performing our assessment, the resolution requires that findings must:

(a) separate the utilization of mental health and substance abuse benefits;

(b) address mental health and substance abuse treatment needs that exceed the level of benefits required by law under Section 431M-4, HRS; and

(c) differentiate between the utilization of each of the respective benefits by adults, children, and adolescents.

The resolution also requests that the Auditor:

(1) identify gaps in data that may prevent an accurate study;

(2) collect data from Hawaii Medical Service Association and Kaiser Permanente Medical Care Program, among others; and

(3) consult with the insurance commissioner, Department of Health, and all interested parties including the Board of Medical Examiners, Board of Psychology, and representatives of insurance carriers, nonprofit mutual benefit associations, health maintenance organizations, public and private providers, consumers, employers, labor organizations, and state agencies that implement policies under Chapter 431M, HRS.

To some extent, our study could meet certain requirements of S.C.R. No. 116. To a larger extent, our study was limited by the following circumstances.

The inapplicability of other states' experiences to Hawaii

For over two decades, many studies have examined and assessed in varying degrees the social and financial impacts of mental health and substance abuse treatment. With the advent of the limited federal mental health parity law and state action in this area, more recent studies have focused on the impact of insurance coverage parity for mental health and substance abuse treatment.

Despite this wealth of research, the applicability of these reports to Hawaii's health environment is limited. State laws vary in scope and application. For example, statutory variations exist in the conditions covered (e.g., some states do not cover or provide parity for substance abuse treatment). Moreover, the definitions of conditions may differ, with some states, for example, adopting a biologically based approach.

In addition, the specificity with which parity is defined may vary. Parity may be expressed in terms of service limits, cost sharing requirements, and annual or lifetime limits. In other cases, parity may be left to an insurer to interpret, or may be deemed to be treatment benefits that are "no less extensive than the coverage provided for any other physical illness."

State statutes also vary in the classes of practitioners that are authorized providers. Some states allow for managed care as an alternative health benefit scheme; others permit "medical necessity" determinations, a concept associated with managed care systems. In addition, certain states exclude small employers from their parity mandates, exempt businesses that would experience a threshold health insurance cost increase, or restrict parity to health plans for government employees only.

Selecting those jurisdictions with one or more features similar to Hawaii would not, in the aggregate, necessarily forecast their impacts for us. These many attributes of health care insurance schemes work dynamically, and generally cannot be examined in isolation.

The absence of proposed legislation identifying the structure of parity for substance abuse treatment

S.C.R. No. 116 points to the expanded definition of *serious mental illness* proposed in House Draft 1 of S.B. No. 1321. However, parity for substance abuse treatment, which we were also directed to study, is not embodied in any legislative measure of the 2003 session. Without a specific legislative bill designated, as required by Section 23-51, HRS, our study had no guidance on essential information, such as authorized providers and standards of care.

The lack of Hawaii data stratified by age and disorder

S.C.R. No. 116 asks that we separate data by disorder and by age group (children, adolescents, and adults) and that such data be collected from the Hawaii Medical Service Association (HMSA) and Kaiser Permanente Medical Care Programs, which is under the Kaiser Permanente Hawaii umbrella (Kaiser Permanente), among others. The two major health insurers in Hawaii could provide stratified data only in a limited number of responses to our survey questions on social and financial impacts. Other respondents, such as providers, mental health facilities, and employee groups, were even less responsive to our survey.

The incompatibility of serious mental illness categories under the proposed legislation with disorders among children and adolescents

The definition of *serious mental illness* proposed in House Draft 1 of S.B. No. 1321 does not adequately reflect emotional disturbances among youth. The term *serious mental illness* is not applied when describing children and adolescents. Rather, the term *serious emotional disturbance* (and more recently, the term *serious emotional and/or behavioral disturbance*) is used. These terms are associated with syndromes that result in disruption in several life areas, including home, school, and community, for a period of time. The more common syndromes associated with serious emotional disturbances include attention and disruptive behavior and mood disorders, among which is a wide range of depression and anxiety-related diagnoses.

The low response rate in our survey of practitioners, consumer groups, employer and labor organizations, and other stakeholders

Through a questionnaire, we requested data and other input on the social and financial impacts of parity in insurance coverage for mental health and substance abuse treatment. We distributed over 200 questionnaires to local health care insurance organizations, labor unions and employer groups, mental health and substance abuse practitioners, professional associations, consumer advocates, and mental health and substance abuse facilities. We received relevant responses from only 33 respondents—a response rate of 16 percent. These responses cannot support definitive conclusions about the social and financial impacts of health insurance parity as mandated in the proposed legislation.

Nonetheless, despite these limitations, we present our findings to the extent they may be helpful to the Legislature in addressing the issue of parity in health care benefits for mental health and substance abuse treatment.

We offer, first, a case study covering Vermont's experience with full parity in health insurance coverage for mental illness and substance abuse. We chose to highlight Vermont because of that state's movement to full parity, in contrast with the varying degrees of parity in most of the other states (including Hawaii). As the Legislature contemplates widening the scope of parity in mental health and substance abuse

treatment, Vermont's experiment may be instructive in where full parity may lead us.

Vermont's Parity Law: A Case Study

Vermont's experience with full mental health and substance abuse parity was examined in a study conducted by Mathematica Policy Research, Inc. under contract with the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services (the Vermont report).[1] As the study points out, "The adoption of parity in Vermont provided a 'natural experiment' in which to learn about the effects of benefit changes on [mental health/substance abuse] access, use, and spending under contrasting health plan experiences."[2]

Vermont's mental health parity statute became effective in 1998. The state's law is the most comprehensive in the nation, broadly defining mental health conditions and encompassing substance abuse treatment as well. The law applies to its entire commercially insured population and makes no exception for small businesses. However, self-insured groups are exempted because of the preemptive effect of the federal Employee Retirement Income Security Act (ERISA). A health plan may carve out mental health coverage for managed care, even if the plan continues to cover medical or surgical treatment on an indemnity basis.

Vermont's major health plans

The two major health plans in Vermont at the time of transition into parity were Blue Cross/Blue Shield of Vermont (Blue Cross) and Kaiser/Community Health Plan (Kaiser)—which mirror Hawaii's health plan market. Kaiser offered an example of the effects of movement into parity within an existing integrated managed care environment. Blue Cross, Vermont's equivalent to Hawaii's HMSA, provided another kind of example—the effects of parity on a plan that shifted a large number of members from indemnity coverage to managed care (Blue Cross still retains some members under unmanaged care).

In 2000, Kaiser ceased operating in Vermont as part of the carrier's withdrawal from the entire northeast region of the U.S. A large number of its enrollees migrated to another health maintenance organization, MVP Health Plan, which already had a presence in Vermont; a lesser number chose Blue Cross or other plans. The transition to MVP Health Plan was reported as generally smooth, although the plan did have to expand its provider network to handle the large influx of new members.

Fortis, another health plan provider in Vermont, also withdrew from the Vermont market in 2000, attributing its departure in part to the requirements of the state's parity law. Servicing mainly the individual market, Fortis believed it would have been required to develop a costly

managed care provider network or face a large increase in mental health and substance abuse utilization and costs. Fortis did not consider either option viable in serving a market that was only a small portion of its overall national operations.

Effects of full parity in Vermont

The study revealed both favorable impacts and problems encountered by Vermont during the first two to three years of parity.

The two dominant carriers, Blue Cross and Kaiser, underwent contrasting health plan experiences during the initial implementation stage, but generally experienced similar results. Kaiser remained relatively stable before and after parity, having already had a system of managed care for its mental health and substance abuse services. After parity, Kaiser implemented programs to increase the use of partial hospitalization treatment and group therapy and reduce the use of inpatient treatment.

For Blue Cross, the shift from an indemnity to a managed care system was not as smooth. Problems arose in educating enrollees of changes when Blue Cross and employers each assumed the other would undertake this task. Moreover, providers expressed concern about disrupted relationships with their patients; consumer advocates were troubled by the loss of choice of providers and treatment approaches.

Blue Cross and Vermont state officials addressed these problems proactively. Education efforts were launched; Blue Cross permitted care by out-of-network providers for a transition period and recruited more providers into its managed care arrangement; and Vermont passed legislation intended to strengthen its managed health care consumer protection law. The full effects of these efforts, however, will require a longer-term view of Vermont's parity law.

Vermont's parity law allows no exception from coverage requirements (except as required by ERISA). Despite the statutory mandates, only 0.3 percent of Vermont employers reported that they terminated health coverage for their workers because of the parity law. Only 0.1 percent of employers reported a migration to self-insurance because of parity coverage requirements.

Access to outpatient mental health services (the number of users per 1,000 members per quarter) increased significantly for both insurers. Kaiser experienced a 6.4 percent increase, while Blue Cross experienced a 7.9 percent increase. The intensity of outpatient mental health treatment (number of mental health services per user per quarter) differed between the two carriers. For Kaiser members, the average

number of visits per user per quarter rose slightly, from 3.26 visits to 3.48 visits.

For Blue Cross members, the average number of outpatient visits decreased by 6 percent, mainly due to the carrier's shift to its managed care carve-out. Interestingly, the average number of visits of members under each of Blue Cross's two care systems differed only slightly—3.4 visits under managed care versus 3.9 visits under non-managed care.

Results between the two carriers were mixed regarding use of inpatient or partial inpatient mental health services. Kaiser members had a significantly lower likelihood of obtaining inpatient services, suggesting that outpatient services may have been substituted for inpatient care under Kaiser's post-parity hospital diversion program. In contrast, access to inpatient services increased for Blue Cross members despite the shift to managed care.

Vermont's experience in full parity for substance abuse treatment, at least in the short-term, is somewhat surprising. Substantial reductions in substance abuse utilization translated into related reductions in spending. Both Kaiser and Blue Cross saw significant decreases in access to substance abuse treatment (as measured by the number of users per 1,000 members), accompanied by large decreases in the number of services used per 1,000 members.

The duration of inpatient treatment (including partial inpatient treatment) for substance abuse increased for Blue Cross members; but given the marked decrease in the number of users per 1,000 members, this increase may have reflected the targeting of more intensive treatment to a higher severity case mix. As a result of these changes in access and use patterns, average spending per Blue Cross member per quarter for substance abuse treatment was nearly halved after parity.

Spending for Blue Cross members with serious mental illnesses (defined as major depression, bipolar disorder, or schizophrenia in Vermont) after parity increased. During the study period, the proportion of users with health plan payments of $5,000 or more rose from 3.9 percent in 1996 to 6.0 percent in 1999. The proportion spending more than $1,000 out-of-pocket declined from 5.8 to 2.7 percent, as the health plan picked up a greater share of costs post-parity.

The Vermont study also analyzed spending patterns, both pre-parity and post-parity. The analysis estimated that the cost of full parity in the state amounted to about $2.32 per member per year, or 19 cents per member per month. As a percent of total health spending (including all types of services), the share attributable to mental health and substance abuse services rose by 0.17 percentage points—from 2.30 to 2.47 percent.

Summary of the impact of parity in Vermont

The Vermont report suggests an overall minimal increase in initial costs associated with movement to full parity, including no substantial increases in premium costs in the first few years. The minimal impact reflects substantial reductions in substance abuse treatment utilization and only a very low increase in mental health treatment utilization. In turn, these outcomes reflect the impact of implementing full parity in a managed care environment.

Social and Financial Impacts

Our findings on the social and financial impacts of expanding the scope of parity in insurance coverage for serious mental illness and substance abuse treatment are gleaned from survey responses and literature review. In addition, we include comments and some data on mental illness and substance abuse treatment needs that exceed the level of current statutory benefit requirements.

Social impacts

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

From the limited responses to our questionnaire, we could not determine the extent to which mental health and substance abuse services are generally utilized by a significant portion of Hawaii's population. As a rough benchmark, we looked to a 1998 report of the Department of Health and the University of Hawaii to the governor and the Legislature that evaluated treatment benefits under Chapter 431M, HRS (the 1998 DOH/UH report).[3] Based on a review of utilization surveys available, the report estimates, nationally, that 4 to 8 percent of the population use mental health and substance abuse treatment services in general. The report concludes that, for Hawaii, the utilization rate departs from the national figure and is lower—at 2 to 6 percent of privately insured individuals.

We solicited utilization data from Hawaii's health care insurers, specifically on the four disorders considered for addition to the definition of *serious mental illness* during the 2003 legislative session and on substance abuse. Exhibit 2.1 provides a detailed breakdown of claims by disorder and age group. A little over 1 percent of HMSA's preferred provider plan members filed claims, or were treated, in 2002, for those disorders. We note that a preferred provider organization encourages its members to use providers it has contracted with for the provision of health care. The services of non-plan providers are also covered, but members usually pay more out-of-pocket for these services.

Exhibit 2.1
Annual Health Insurance Claims Filed or Members Treated, by Disorder and Age Group

Insurer	Total Members	Disorders	0-12 years	13-17 years	18+ years	Percent of Total Members
Aetna	5,056	delusional disorder			2	.06 percent
		obsessive compulsive			1	
University Health Alliance[1]	25,221	delusional disorder			28	5.6 percent
		major depression	4	65	1,248	
		obsessive compulsive	9		50	
		dissociative disorder			3	
		alcohol abuse			131	1 percent
		other substance abuse		32	98	
Hawaii Medical Service Association[2]	462,917	delusional disorder			55	1.2 percent
		major depression	46	359	4,887	
		obsessive compulsive	15	22	257	
		dissociative disorder	2	2	39	
		alcohol abuse		23	265	.1 percent
		other substance abuse	2	68	314	
Kaiser Permanente Hawaii	215,000	alcohol abuse			+300	.6 percent
		other substance abuse			+900	

Source: Responses of individual health insurers to questionnaire of the Office of the Auditor, 2003; figures are latest annual data reported by insurer

[1] Total membership for University Health Alliance was obtained from the website of the Hawaii Insurance Division of the Department of Commerce and Consumer Affairs.

[2] All data shown for the insurer are for its preferred provider population; related total membership was obtained from the website of the Hawaii Insurance Division of the Department of Commerce and Consumer Affairs.

Kaiser Permanente did not provide comparable data. A health maintenance organization, Kaiser Permanente provides full health service to its members, who receive care from physicians and other practitioners affiliated with the organization. As a result, the insurer does not maintain data on claims filed, but maintains diagnostic information in individual patient records.

Aetna, Inc. responded that only three of its over 5,000 members filed similar claims. University Health Alliance reported 1,407 claims, which represent approximately 6 percent of its total membership.

For substance abuse, including alcohol abuse, HMSA indicated 672 claims filed in 2002 among its preferred provider plan members (roughly, .1 percent of its membership). Kaiser estimated that over 1,200 of a total of 215,000 members (roughly, .6 percent) were treated for similar disorders. University Health Alliance reported 261 claims (1 percent of its membership); Aetna, Inc. had no claims for alcohol or other substance abuse treatment among its membership.

Even if future utilization rates prove to be similar, implementation of full parity in treatment benefits would not necessarily signify proportional impacts on the health care system. Only those future claims exceeding what is the current level of health benefits would necessarily be impacted by full parity.

In the aggregate, HMSA estimates that less than one-half of 1 percent (less than .5 percent) of its membership reaches the maximum level of treatment benefits currently available for the disorders in question. Kaiser Permanente, whose response was limited to substance abuse data, counts only six adults among those treated for alcohol abuse and another 18 to 24 adults treated for other substance abuse (about .01 percent of its membership) who exceeded treatment benefit levels. Full parity in health coverage for the treatment of the four disorders and alcohol and substance abuse would apparently benefit only a small portion of the insured population.

2. Extent to which coverage of such services is already generally available.

As we pointed out above, data from the state's major health care insurers suggest that the current level of health care benefits appears, on the most part, to be sufficient and generally available for the treatment of the disorders in question. Only a small percentage of insured individuals exceed the current benefit levels for general mental illness and substance abuse treatment.

The Hawaii Psychological Association points out, however, that many patients ration sessions throughout the year to avoid exhausting their mental health benefits. According to the association, this practice may result in less effective treatment and may increase the risk of hospitalization, suicide, or other health complications. The association also observes that its members frequently continue treatment on a *pro bono* basis for those who exhaust their insurance benefits. These observations suggest that the true measure of coverage availability may be masked by *pro bono* practice and by benefit-rationing.

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

Those comprising the small percentage who exceed current benefit levels are very likely to be substantially impaired and still in need of treatment. Without coverage on a par with other medical or surgical conditions, those in need of further treatment either rely on alternatives offered by their insurers, pay out-of-pocket, seek publicly funded treatment or charity services, go to emergency rooms, or discontinue health care.

Health insurers generally address benefit exhaustion situations on a case-by-case basis. HMSA lists the following as some of the options for the few individuals who need them: paying out of pocket, negotiating for more flexible payment options, requesting an extension of benefits from HMSA, or seeking treatment from a community mental health facility. According to HMSA, none of its members has been denied necessary treatment for substance abuse in the past 15 months. The insurer also points out that, since 1998, only 167 members under private business plans have had a second episode of substance abuse treatment; of that group, 12 have received treatment beyond their second lifetime maximum.

Kaiser Permanente indicated that its mental health treatment benefits are rarely exceeded. It deals with each case individually, and may extend additional benefits if further care is deemed medically necessary. For substance abuse, no member has exhausted benefits while participating in treatment; however, a few patients have exhausted their lifetime two-episode limit.

The Hawaii Psychological Association indicated that psychologists are "ethically prohibited from denying needed services to patients who are unable to continue due to financial reasons." The association also points out that patients who might approach utilizing all of their benefits often make an effort to ration their sessions in order to avoid exhausting their benefits. Both psychologists and psychiatrists frequently offer sliding-scale fees or treatment on a *pro bono* basis in these situations.

Other alternative sources of treatment available to patients who exhaust their benefits include the State's community mental health centers. Patients who qualify may seek Medicaid coverage. Those who are indigent and who suffer from chronic mental illness may be treated at the Hawaii State Hospital.

While options are available after health care benefits have been exhausted, individuals who are substantially impaired may not be capable of pursuing these choices. They also risk breaks in treatment, which may simply exacerbate their conditions. Parity in benefit coverage, for these few, may be a more effective option; it would eliminate any suspension of treatment or any need to consider other coverage options.

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

The extent to which the lack of parity results in unreasonable financial hardship is difficult to ascertain. As data from HMSA and Kaiser Permanente indicate, most of their members do not exhaust mental health or substance abuse treatment benefits under the current coverage scheme, and thus presumably do not bear unreasonable financial hardship from the lack of parity. However, the offer of extended benefits by the insurers and of *pro bono* services suggest that, for at least a few individuals, the exhaustion of insurance coverage does pose financial hardship.

5. Level of public demand for parity in insurance coverage.

We could not determine the public demand for parity in insurance coverage, although different sectors of the health care community render opinions based largely on the interests represented. In the 1998 DOH/UH report cited earlier, stakeholders were surveyed on the existing benefit structure of Chapter 431M, HRS. The survey revealed a consensus among consumers, providers, and health plan representatives. Generally, they agree that the law ought to be amended to ensure greater access to outpatient treatment and that decisions on length and level of treatment should not be based on artificial limits, but on clinical criteria. The 1998 DOH/UH report also offered the opinion held by many consumers and providers—that the inequity between benefits for mental disabilities and those for other disabilities amounts to a form of official discrimination.

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

According to the two major insurers, demand for parity is low or non-existent among their membership. HMSA did not see any demand for parity in every age category and disorder we examined in our study. Kaiser Permanente indicated either little or no demand in these categories. Kaiser has also opined, before the Legislature during the 2003 session, that expanding the definition of serious mental illness extends coverage for which there is no demand and that this measure would not address the problem of mental illness in people without employer-sponsored health insurance, including the homeless who are mentally ill.

All three of the employer organizations that responded to the questionnaire indicated that their members had not expressed an interest in expanding the definition of serious mental illness or in parity in benefits for substance abuse treatment. One organization did comment that there was some interest in a "voluntary add-on" for substance abuse treatment coverage. All three organizations also indicated that their leadership would discourage parity in mental health and substance abuse insurance coverage.

7. Level of interest of collective bargaining organizations in negotiating privately for inclusion of parity in coverage in group contracts.

Most employer organizations who responded to our survey did not know the level of interest of its members in negotiating privately for inclusion of parity in group contracts. We surveyed 18 labor organizations, and responses were received from only two unions (International Brotherhood of Electrical Workers of Local 1357 and International Longshore and Warehouse Union Local 142). Although their responses may not be representative of all labor organizations, one indicated that its membership had little interest in negotiating for such benefits; the other was not sure of its membership's level of interest.

8. Impact of parity in insurance coverage on health status, quality of care, practice patterns, or provider competition.

The two major insurers and practitioner associations differ on the impact of parity on these elements of the health care system. This difference very likely reflects each stakeholder-group's perspective of the system.

For serious mental illnesses, Kaiser Permanente believes the biggest overall impact would be in access to care, which could worsen unless

more staff are added. The insurer surmises that more individuals could get more services under parity; however, under its current benefit structure, it points out that patients are seen as often as necessary for mental health treatment. On the other hand, for substance abuse treatment parity, Kaiser Permanente would not change its practice patterns.

HMSA points out a difficulty with responding to this question because of the lack of an actual proposal for parity in mental health and substance abuse treatment benefits. It nonetheless responded, with a qualification: its assessment rests on the assumption that a parity proposal would allow a health plan to manage utilization to ensure that patients receive clinically appropriate methods of treatment. HMSA believes that quality of care may decrease with a one-size-fits-all approach and that longer treatment periods do not necessarily translate as better treatment. It also believes that providers may change their practice patterns, with utilization of benefits increasing under parity coverage.

Looking to the Vermont experience and the federal employee health care system, the Hawaii Psychological Association concludes it is reasonable to expect that overall quality of care would increase as a result of the availability of continuous care. Without arbitrary limits, the association forecasts a shift in practice patterns to a "more efficacious delivery system." It sees an overall improvement in health outcomes, improved family relations through better illness management, a reduction in the stigma attached to seeking help for mental illness, and higher employment rates.

The Hawaii Psychiatric Medical Association addressed the social justice question involved—that is, the impact of removing the stigma associated with treating mental illnesses differently from physical illnesses. By changing the way we think about mental illness, the association believes treatment will be sought earlier when a mental disorder is easier to manage; treatment will be less expensive in terms of the amount of psychopharmacology needed to manage the illness; and hospitalization can be avoided.

9. Impact of indirect costs upon the costs and benefits of parity in insurance coverage.

We could not obtain data on this impact that are specific to the disorders in question. The responses and information we gathered are applicable generally to parity in insurance coverage. As with other impacts, stakeholders differed on their perspective of the impact of indirect costs upon the costs and benefits of parity in insurance coverage.

HMSA highlights the indirect administrative costs associated with redesigning benefit packages and updating internal systems to comply with any mandated parity. Kaiser Permanente speculates that demand for mental health services may increase, increasing its staffing needs. However, because it would not add more staff unless its membership rolls increase, existing patients may experience difficulty in accessing services.

The Hawaii Psychiatric Medical Association perceives a strong relationship between untreated mental illness and increased use of other medical benefits; patients will see their primary care physician with increased complaints. The association observes that patients who are diagnosed and treated early lessen their medication needs; that increased medication needs cause obesity, diabetes, and other medical side effects; and that acute psychotic episodes lead to brain damage.

The treatment of substance abuse may have a direct or indirect impact on the commission of certain crimes. A 2004 report prepared by the Department of Health presents data from the Bureau of Justice Statistics, Drugs and Crime Facts, 1992, and from the U.S. Department of Transportation on the involvement of substance abuse in the commission of certain crimes and accidents.[4] The statistics show that alcohol or other drugs were involved in half of spousal abuse cases and in nearly half of all traffic fatalities, aggravated assaults, and rapes. Alcohol or other drugs were involved in over one-fourth of robbery cases, murders and manslaughters, and simple assaults.

Financial Impacts

1. Extent to which parity in insurance coverage would increase or decrease health care costs.

Because of the lack of data, we are unable to assess the extent to which parity in insurance coverage would increase or decrease health care costs. The Vermont experience, described above, may be instructive as an illustration of the cost impacts of full parity in benefits for mental health and substance abuse treatment.

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

The responses regarding the extent to which proposed coverage would increase use were speculative at best. The two major insurers in Hawaii report that most of their members who were treated for mental illnesses or substance abuse disorders did not exceed current benefit levels. This phenomenon may suggest, but not conclusively, that added parity benefits would not necessarily increase utilization, except for the few who are exhausting benefits under the current system.

3. Extent to which parity in coverage would serve as an alternative for more expensive treatment or service.

To the extent expanded parity coverage would encourage early treatment, more expensive treatment or service may be avoided. As we pointed out, however, most members of the two major health care insurers in Hawaii do not exceed current benefit levels for the treatment of mental health and substance abuse disorders.

4. Extent to which parity in insurance coverage would increase or decrease insurance premiums or administrative expenses of policyholders.

We did not receive data or responses that would be conclusive in terms of either an increase or decrease in insurance premium or other expenses of policyholders. Vermont experienced no substantial increases in premium costs, reflecting the impact of implementing full parity under a managed care environment.

This outcome is consistent with the findings of an actuarial study published by the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services, which concluded that state laws have had a small effect on premiums.[5] Using an updated actuarial model, the study estimated that full parity for mental health and substance abuse treatment would increase premiums by 3.6 percent, on average.[6] Plans under preferred provider organizations would have a 5 percent premium increase. In contrast, those under managed care would experience only a .06 percent premium increase.[7]

5. Impact of parity in insurance coverage on the total costs of health care.

Without adequate data to measure this impact, we turn again to the 1998 report of the Department of Health. Designing a study to estimate costs and savings achieved as a result of parity in benefits for mental health and substance abuse treatment is difficult. A study would require a sample group of individuals from whom treatment is withheld, which is unethical. But such research design is necessary in order to control for factors such as peer and family support.[8]

It is possible that treating an unmet need in the population will result in a medical cost offset, or a savings in health care dollars because mental health and substance abuse treatment would prevent the need for other health care spending. The medical offset is achieved for a variety of reasons. For instance, such interventions can often empower patients to take care of their own health without unnecessary medical visits. Mental

health and substance abuse treatment can also alleviate stress and the physiological reaction to stress, which contributes to physical illnesses.

In addition, treatment can reduce negative daily behavior patterns and associated diseases. Mental health and substance abuse services can help individuals develop social support systems, which may prevent unnecessary utilization of health care resources when such support is missing. Undiagnosed psychiatric problems such as depression, generalized anxiety disorders, and panic attacks may contribute to feelings that patients identify as physical ailments. Mental health treatment will often resolve these problems more effectively than medical treatment.

The study of the U.S. Department of Health and Human Services cited earlier, found by case study analyses that employers have not opted for self-insurance to avoid parity laws and do not tend to pass on costs to employees. Furthermore, costs under parity have not shifted from the public to the private sector; most individuals who receive publicly funded treatment are not privately insured in the first place; and many publicly funded services are not covered by private insurers, even under parity, because these services are not considered medically necessary.[9]

Conclusion

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. Even within this limited scope, much of the data the Legislature sought is unavailable.

Notes

Chapter 1

1. See generally Chapter 431M, Hawaii Revised Statutes (HRS).

Chapter 2

1. Margo Rosenbach, Tim Lake, Cheryl Young, et al., *Effects of the Vermont Mental Health and Substance Abuse Parity Law*, DHHS Pub. No. (SMA) 03-3822, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (2003).

2. *Ibid*., p. 24.

3. A. Michael Wylie and Andrew Williams, *Evaluation of Mental Health, Alcohol, and Drug Abuse Treatment Insurance Benefits Under Chapter 431M, HRS*, p. 20, Hawaii State Department of Health and University of Hawaii (January 1998).

4. Alcohol and Drug Abuse Division, Department of Health, *Report to the Twenty-Second Legislature, State of Hawaii, 2004, Pursuant to Section 321-195, Hawaii Revised Statutes, Requiring a Report by the Department of Health on Implementation of the State Plan for Substance Abuse*, p. 19 (January 2004).

5. Merrile Sing, et al., *The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits*, executive summary, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services (March 1998).

6. *Ibid*., executive summary.

7. *Ibid*.

8. A. Michael Wylie and Andrew Williams, pp. 24-25.

9. Merrile Sing, *et al*., executive summary.

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Responses of the Affected Agencies

Comments on Agency Responses

We submitted a draft copy of this report to the Department of Commerce and Consumer Affairs and the Department of Health on March 31, 2004. A copy of the transmittal letter to the Department of Commerce and Consumer Affairs is included as Attachment 1. The Department of Commerce and Consumer Affairs chose not to respond to our draft report. The Department of Health's response is included as Attachment 2.

The Department of Health's response to our draft report focused mainly on our concluding statement. We took no affirmative or negative position on expansion of coverage. We concluded that issues arising from the incidence of mental illness and substance abuse in Hawaii require a perspective broader than the statutory analysis required of the Auditor—a narrowly limited analysis as prescribed by statute that was further hampered by the unavailability of data, especially the data specifically requested by the Legislature. The department 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 necessary for a decision on parity rests in the Legislature.

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

March 31, 2004

COPY

The Honorable Mark Recktenwald
Director
Department of Commerce and Consumer Affairs
King Kalakaua Building
335 Merchant Street
Honolulu, Hawaii 96813

Dear Mr. Recktenwald:

Enclosed for your information are three copies, numbered 6 to 8 of our confidential draft report, *Study of Proposed Mandatory Parity in Health Insurance Coverage for Additional Serious Mental Illnesses and for Substance Abuse*. We ask that you telephone us by Thursday, April 1, 2004, 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 Friday, April 2, 2004.

The Department of Health, Governor, and presiding officers of the two houses of the Legislature have also been provided copies of this confidential 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

LINDA LINGLE
GOVERNOR OF HAWAII

CHIYOME L. FUKINO, M.D.
DIRECTOR OF HEALTH

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

In reply, please refer to:
File:

April 2, 2004

The Honorable Marion M. Higa
State Auditor
Kekuanaoa Building
465 South King Street, Room 500
Honolulu, Hawaii 96813

Dear Ms. Higa:

Thank you for the opportunity to review and comment upon the report entitled, *Study of Proposed Mandatory Parity in Health Insurance Coverage for Additional Serious Mental Illnesses and for Substance Abuse.*

Rather than the concluding statement made in the report, we believe that a clear acknowledgement that even with the limited data that is available, the State has essentially reached a point that calls for a policy decision by the Legislature. We have as much access to data as we will ever have. The report could have made an enduring contribution by helping the Legislature understand that the issue before them is primarily a policy dilemma. The dilemma is, "Will Hawaii continue to discriminate against the seriously mentally ill and those who suffer from addiction by allowing current coverage limits to continue?"

It is clear from the limited but consistent data that has been available over the past decade that there will be no significant hidden costs with full or incremental mental health and/or substance abuse parity legislation. There are too few people using mental health and substance abuse treatment services to any large extent for this to happen. The overwhelming majority of people that do use mental health services use them well within the present mental health benefit structure. Further, there is consistent, existing, substance abuse utilization data clearly showing that even fewer--significantly fewer--people with private insurance use substance abuse treatment services than mental health treatment services.

Significant increases in insurance costs are not likely to occur with incremental or full parity. This does not mean that there will be no costs associated with parity. As your report and others have shown, there is a very small group of persons who exhaust annual and lifetime health benefits. Presently, they may or may not access continuing service once their benefit limit is reached and this outcome occurs on a case-by-case basis. It will increase costs to health insurers and policyholders by some unknown small amount to assure continuing services to this group.

In view of the fact that sufficient quality data has never been available to make a clear recommendation whenever we have undertaken an evaluation of the impact of mental health and substance abuse parity, the Department believes that the only way to ascertain the social and financial impact is to provide full parity for the mentally ill and those suffering from addiction for a two to four year period and study the outcomes.

Please feel free to contact the Department if we may be further assistance to you. Thank you for this opportunity to comment on this report.

Sincerely,

Chiyome Leinaala Fukino, M.D.
Director of Health