NEIL ABERCROMBIE
GOVERNOR OF HAWAII

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In reply, please refer to:
File:

Senate Committee on Ways and Means

S.B. 2105 SD1, Relating to Health

Testimony of Loretta J. Fuddy, A.C.S.W., M.P.H.
Director of Health

March 1, 2012

Department's Position: The Department of Health (DOH) supports the intent of this measure as long as its implementation does not impact or replace the priorities set forth in the Executive Supplemental Budget for Fiscal Year 2012-2013.

Fiscal Implications: Although no funds are appropriated in this measure for staffing and operating costs, it is estimated that approximately $506,260 will be needed to convene the mental health and substance abuse parity working group.

Purpose and Justification: The Department of Health lauds the intent of this bill which calls for the convening of a mental health and substance abuse parity working group to determine how the State will effectuate compliance with federal mental health and substance abuse parity laws and regulations and enhance the State's own existing parity laws.

This bill or portions of the bill as currently drafted may be unnecessary since Section 431M-6, Hawaii Revised Statutes (HRS), codified the responsibility of the Insurance Commissioner to organize and implement mental health and substance abuse benefit statutes, in conjunction with state agencies,

insurers, providers and consumers. The Commissioner is granted authority to implement rules governing medical or psychological necessity criteria, quantity of benefits and levels of care.

Hawaii has achieved parity in serious mental illness as codified in Section 431M-5(c), HRS. DOH recommends that consideration be given to: 1) expanding parity diagnoses by amending existing statute; and 2) reinstituting the substance abuse parity provisions in Part V (Sections 15-18) of Act 44 Session Laws of Hawaii 2004, which lapsed on June 30, 2011.

Coordination with health transformation and systems planning in the Governor's Office will produce more desirable and informed results, as opposed to a working group. We must organize our planning in a way that is consistent with our desired outcome: an integrated and coordinated healthcare system.

Significant resources will be needed to synthesize the quantity and quality of data to transform and integrate behavioral health care. Stakeholders should be encouraged to share existing data, for example between payers and providers, but this will likely yield little new information. The opportunity is investments in systems that focus on data we do not have such as those related to social determinants of health. Another option is to focus the working group strictly on parity, which is more within the Insurance Commissioner's scope as defined in Chapter 431M, HRS, and remove workforce development, education and research issues.

Any recommendations on improving our behavioral health care system should emphasize primary and secondary prevention and de-stigmatization. These cost-effective and evidence-based strategies are not a deliverable of this bill as currently drafted.

Lastly, we respectfully recommend the inclusion of organizations that represent 'qualified providers' (i.e., physicians, psychologists, clinical social workers, marriage and family therapists, mental health counselors and advanced practice registered nurses) cited in Section 431M-1, HRS.

Thank you for the opportunity to testify on this measure.

HAWAII SUBSTANCE ABUSE COALITION

SB2105 Relating to Health Director of Health to convene a behavioral health parity working group to comply with federal parity laws and enhance existing state parity laws.

- SENATE COMMITTEE ON WAYS AND MEANS: Senator David Ige Chair; Senator Michelle Kidani, Vice Chair
- Thursday, March 1, 2012; 9:35 a.m.
- Conference Room 211

HAWAII SUBSTANCE ABUSE COALITION Supports SB2105

Aloha Chair Ige, Vice Chair Kidani and Distinguished Committee Members. I am Alan Johnson, the current chair of the Hawaii Substance Abuse Coalition (HSAC), a statewide hui of more than 20 non-profit treatment and prevention agencies.

SUMMARY

While the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 puts coverage of mental health and substance abuse benefits on an equal footing with general medical benefits, the State is responsible for enforcement provisions as well as defining applicable benefit disorders terms, which if not defined could limit coverage.

At this time parity is not universal among insurers in Hawaii. Without State legislation, parity is neither enforceable nor definable.

We support a workgroup of insurers, state agencies, and various providers to prepare a bill for legislation that addresses both quality of care and cost-effectiveness.

SUPPORTING INFORMATION

State law must be revised to at least meet the intent of federal law.:

1. The Federal government urges States to enact legislation to meett the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008. About 1/3 of the states have done so.

2. Previous parity legislation did sunset and would not have been adequate. There are vague references of parity, which does not meet the requirements of the Federal law.

3. Not all insurance providers and/or plans are following parity rules, the state needs to determine the applicability of the rules and obligations to insurers, insurance plans and/or services.

4. If legislation is not passed, parity interpretations may have to be resolved in the courts, which would be much more costly and possibly confusing.

5. Enforcement of parity is the state's responsibility, the state needs to develop policies in order to effectively enforce compliance with the federal law. Currently, there is no enforcement, and as a result many providers could be non-compliant with the federal law.

6. It is the state's responsibility to determine who or what entities are subject to parity laws; for example: small businesses, plan types of commercial insurance, out of state insurers, state run or funded plans, etc. There are provisions in the federal law that outlines special rules or exemptions, though the state has some flexibility.

7. The state can determine which services are subject to parity rules; for example, a standardized definition of diagnostic services would determine what is applicable to parity – most states name the International Classification of Diseases (ICD) as the approved manual to define services for parity since the ICD is used for Medicaid.

8. Key to the inclusion of benefits under the Affordable Care Act (ACA) is enforcement of the parity law. The State would provide further guidance on scope of service, disclosure of medical criteria, and non-quantitative treatment limitations.

9. Providers, insurers, and state agencies most likely do not agree to which extent parity is applied for Hawai'i. However, most parties are amenable to work out the differences in a work group.

Further, the Task Force would address more clarity with respect to:

- Service limits, cost-sharing requirements, and annual/lifetime spending limits.
- Minimum benefit packages pertaining to whether there are no annual limit on outpatient visits and/or specify minimal financial coverages by insurers for outpatient visits.
- Whether coverage levels include allowable institutional and professional charges for inpatient psychiatric care, outpatient psychotherapy, intensive outpatient crisis management, partial hospitalization, and residential care and treatment.
- Address requirements with respect to whether inpatient, day treatment, and outpatient services must be provided.
- Address whether diagnosis and treatment would be provided, or at least supervised, by qualified mental health providers and what is defined as "qualified substance abuse provider." For example, definitions for "providers" could include licensed physicians, accredited public hospitals or psychiatric hospitals, certified counselors and community agencies licensed at the comprehensive service level by the Department of Health.

- Address whether there are specified exemptions for Medicare and Medicaid, federal employee health insurance plans, and employer self-insured plans, which are not regulated by state health insurance laws as well as private employers who are self-insured are exempt from state health insurance laws under the federal Employee Retirement Income Security Act of 1974 (ERISA).
- Address whether parity is limited to only those plans that offer behavioral health benefits or else to mandate the coverage for mental health illnesses and substance use disorders for all plans. Some states are adding to Federal law to remove any limit to groups under a certain size claiming that discrimination is prohibited regardless of the size of the employer group.
- Address whether out of state plans are subject to state laws.

CONCLUSION

There are many complex changes happening in the health care arena in our time. The Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 requires health insurance companies to be in parity between medical services and behavioral health services with respect to medical cost-sharing rules, deductibles and out-of-pocket limits. Working together for the sake of our shared community, the effects of parity legislation will bring about a positive change to individuals, health care plans, and managed behavioral health care organizations (MHBOs) and other key stakeholders.

As substance use and mental disorder treatment centers, we very much appreciate the opportunity to be part of this work group.

We appreciate the opportunity to provide testimony and are available for questions.