HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 291 Coverage for Mental and Nervous Disorders
SPONSOR(S): Homan and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1834

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Innovation		Ciccone	Calamas
2) Healthcare Council			
3) Policy & Budget Council			
4)			
5)			

SUMMARY ANALYSIS

House Bill 291 amends s. 627.6688, F.S., to specifically define those mental health conditions that must be covered within the mandated offering, generally including all diagnostic categories of mental health conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and as listed in the mental and behavioral disorders section of the current International Classification of Diseases.

The bill deletes current law limiting mental health benefits by specific service areas, such as inpatient benefits, and inserts a general statement that the mental health benefits may not be more restrictive than the treatment limitations and cost-sharing requirements that are applicable to other diseases, illnesses, and medical conditions.

The fiscal impact of the bill is indeterminate.

The effective date of the bill is July 1, 2007.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Empower families - the bill defines optional group health plan coverage of mental health conditions that must be covered within the mandated offering, generally including all diagnostic categories of mental health conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and as listed in the mental and behavioral disorders section of the current International Classification of Diseases. Individual and families may have access to additional mental and nervous disorder coverage through the option provided in this proposal.

Provide Limited Government – The bill increases government's role in private sector health insurance by imposing a mandated offering.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

Regulation of Health Plans
Health plans are generally regulated at both the state and federal level. At the federal level, the Employee Retirement Income and Security Act (ERISA) exclusively regulates, among other employer benefits, voluntary employee-sponsored (i.e., self-funded) health plans.[1] In contrast, private-sector health insurance plans and health maintenance organizations are generally regulated by each state.[2] Congress, however, has enacted several laws that regulate the private-sector market, including the Health Insurance Portability and Accountability Act of 1996; the Newborns' and Mothers' Health Protection Act of 1996; and the Mental Health Parity Act of 1996.

Mandated Offering Laws
Mandated offering laws do not mandate that certain benefits be provided. Rather, a mandated offering law in the context of mental health can: require that insurers offer an option of coverage for mental illness, which may require a higher premium and which the insured is free to accept or reject; or, require that if insurers offer mental illness coverage, the benefits must be equivalent to other types of benefits.[3]

Mental Health "Parity"
Parity in mental health coverage generally refers to equivalent benefits and limits for mental illness as compared to medical and surgical benefits. According to the United States General Accounting Office, most private health insurance plans limit mental health coverage in three areas:

- Lower annual or lifetime dollar limits;
- Lower service limits, including number of covered hospital days or outpatient office visits; and
- Higher cost-sharing for mental health benefits.[4]

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) within the United States Department of Health and Human Services, four actuarial studies have predicted an

[1] *See* http://www.dol.gov/dol/topic/health-plans/erisa.htm.
[2] In Florida, Chapters 627 and 641, F.S., generally regulate health insurance and health maintenance organizations, respectively.
[3] "State Laws Mandating or Regulating Mental Health Benefits", January 2007, National Conference of State Legislatures, (viewed March 25, 2007) http://www.ncsl.org/programs/health/mentalben.htm.
[4] United States General Accounting Office, Mental Health Parity Act, Despite New Federal Standards, Mental Health Benefits Remain Limited (2000).

increase in health insurance premiums for full parity for mental health benefits. These predictions ranged from 3.2 percent to 8.7 percent.[5]

Mental Health Parity Act of 1996
Congress enacted the Mental Health Parity Act of 1996[6] to require group health plans (employer-sponsored and private-sector) that provide medical and surgical benefits to provide the same annual or lifetime dollar limits for mental health benefits.[7] The Act does not, however, require the provision of such benefits. Two exceptions are provided:

- Small employers. The Act does not apply to employers who employed at least 2, but not more than 50, employees during the preceding calendar year.[8]
- Increased cost. The Act does not apply where the result would be an increase in the cost under the plan of at least 1 percent.[9]

The Act's original sunset date was September 30, 2001. The act has been extended six times since that time and is currently set to expire on December 31, 2007.[10] The Centers for Medicare & Medicaid Services (CMS) has primary enforcement of the Act in states that do not have legislation that meets or exceeds federal standards, or states that have failed to substantially enforce federal standards.[11]

The General Accounting Office has found by nationwide survey that most employers are complying with the Act, with 14 percent reporting that they were not compliant.[12] Data from the private-sector market is not available.

Mental Health Coverage in Other States
According to the National Conference of State Legislators (NCSL),[13] as of early 2007, 46 states currently regulate the provision of mental health services in three categories:

- Mental health parity;
- Minimum mental health benefits; and
- Mandated mental health offering.

As of 2007, a majority of states now provide full mental health parity.[14]

Mental Health Parity in Florida
In Florida, s. 627.668, F.S., regulates the provision of mental health services by insurers, health maintenance organizations, and nonprofit hospital and medical service plan corporations providing group health insurance or prepaid health care. In particular, these entities must make mental health services available to a policyholder for an additional premium. Such services must generally include the "necessary care and treatment of mental and nervous disorders, as defined in the standard nomenclature of the American Psychiatric Association."[15]

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[5] The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits (viewed March 23, 2007) http://mentalhealth.samhsa.gov/publications/allpubs/Mc99-80/prtych3.asp.
[6] H.R. 3666, 104th Cong. (1996) (enacted).
[7] *Id.*
[8] *Id.*
[9] *Id.*
[10] H.R. 6111, 109th Cong. (2006) (enacted). *See* Mental Health Parity, 72 Fed. Reg. 8629 (2007) (to be codified at 29 C.F.R. pt. 2590).
[11] United States General Accounting Office, Mental Health Parity Act, Despite New Federal Standards, Mental Health Benefits Remain Limited 11 (2000).
[12] *Id.* at 20.
[13] State Laws Mandating or Regulating Mental Health Benefits (viewed March 23, 2007) http://www.ncsl.org/programs/health/mentalben.htm.
[14] *Id.*
[15] s. 627.668(1), F.S.

With regard to group policies or contracts, inpatient hospital benefits; partial hospitalization benefits; and outpatient benefits that are limited by durational limits; dollar amounts; deductibles; and coinsurance factors may not be "less favorable" than treatment for physical illness,[16] except that:

- Inpatient benefits may be limited to 30 days per benefit year;
- Outpatient benefits may be limited to $1,000 for consultations with a physician, psychologist, mental health counselor, marriage and family therapist, and a clinical social worker;
- Partial hospitalization benefits must be provided under the direction of a physician, including services offered by a program accredited by the Joint Commission such as alcohol rehabilitation and licensed drug abuse rehabilitation; and
- Partial hospitalization services, or a combination of inpatient and partial hospitalization services, are limited to the cost of 30 days of inpatient hospitalization for psychiatric services, including physician fees.

If services are provided beyond these minimum amounts, then the durational limits, dollar amounts, and coinsurance factors are not required to be equivalent to those for treatment of physical illness.

Florida's law is a "mandated offering" law and does not provide full mental health parity, as the mandated offering requires the policyholder to pay an additional premium.

Effect of Proposed Changes

House Bill 291 amends s. 627.6688, F.S., to specifically define those mental health conditions that must be covered within the mandated offering, generally including all diagnostic categories of mental health conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and as listed in the mental and behavioral disorders section of the current International Classification of Diseases.

The bill deletes current law limiting mental health benefits by specific service areas, such as inpatient benefits, and inserts a general statement that the mental health benefits may not be more restrictive than the treatment limitations and cost-sharing requirements under the plan that are applicable to other diseases, illnesses, and medical conditions.

The bill states that, for a group plan that offers a participant two or more benefit package options, the requirements of the bill must be applied separately to each option.

C. SECTION DIRECTORY:

Section 1. Amends s. 627.668, F.S.; relating to optional coverage for mental and nervous disorders required; relating to exceptions.

Section 2. Provides an effective date of July 1, 2007.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   N/A

2. Expenditures:

   N/A

[16] s. 627.668(2), F.S.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

N/A

2. Expenditures:

N/A

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Groups that elect to purchase the new benefit offering provided in this proposal, may incur additional costs to include such coverage for mental-nervous disorders through increased claims costs that will be passed through to policyholders in the form of increased premiums.

D. FISCAL COMMENTS:

The Department of Management Services noted several fiscal issues of concern regarding this proposal. The Department of Management Services issues notification to plan enrollees regarding benefit changes. Since this proposal may require such notification to all State Group Health Insurance Program enrollees the notification could cost the department $67,860, and is based on approximately 174,000 enrollees and a production/rate mailing cost of $0.39 per mail notice. In addition, the department noted that the State Employees Group Health Insurance Program may be required to expand its covered benefits. Associated additional costs to the self-insured PPO and fully insured HMOs would have an indeterminate negative fiscal impact on the State Employees Group Health Self-Insurance Trust Fund.

The Office of Insurance Regulation noted that there is no direct impact on the Office of Insurance Regulation and that the approval of new policy forms and contracts needed to implement this proposal could be absorbed within current resources.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

N/A

2. Other:

N/A

B. RULE-MAKING AUTHORITY:

N/A

C. DRAFTING ISSUES OR OTHER COMMENTS:

The July 1, 2007 effective date appears to provide insufficient time for carriers to develop new rider and rates to submit to the Office of Insurance Regulation. An October 1, 2007 date would allow insurers sufficient time for compliance.

An amendment will be prepared to reflect an October 1, 2007 effective date.

D. STATEMENT OF THE SPONSOR

Recently in the NEJM (New England Journal of Medicine), a study was published that found when health plans implemented "parity" under the FEHB (Federal Employee Health Benefit) program that insurance coverage for mental illness equal to physical illness did not drive up the cost of care as many insurers feared and no significant increase in mental health spending was found relative to other ongoing expenses and health care spending. The FEHB program is the nation's largest employer sponsored health insurance program providing over $29 billion in benefits to 8 million federal employees and their dependents through 250 health plans across the country. This in-depth study confirmed that treatment of mental illness and substance abuse is affordable for health plans.

The National Mental Health Advisory Council in a report prepared for the US Senate Committee on Appropriations concluded that "parity" coverage for severe mental illnesses resulted in a net saving of 2.2 billion dollars a year when adding up days missed from work and other social losses.

The U.S. Department of HHS studies have shown that the costs and effects of "Parity" for mental health increase insurance premium less that 1%.

The facts are in, the evidence is clear. It is time for us to come out of the dark ages and join the other 46 states that recognize that the brain is an organ and it can get sick just like any other organ. Great advances in treatment of the common mental health disorders have been made in the last twenty years and our citizens with these problems would do so much better if we do not continue to hinder access to them getting the proper treatment. Be thankful that you don't wake up each and every day knowing that it will be a "bad" and "hopeless" day no matter what.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES