The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Banking and Insurance Committee

BILL:	SB 164
INTRODUCER:	Senator Crist
SUBJECT:	Insurance/Mental & Substance Related Disorders
DATE:	February 26, 2008 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Deffenbaugh	BI	**Favorable**
2.			HP	
3.			GA	
4.				
5.				
6.				

I. Summary:

Senate Bill 164 significantly expands the benefits that insurers and health maintenance organizations (HMOs) are required to offer to group policyholders (e.g., employers) for mental and nervous disorders. The bill requires that the benefit limits for mental health (inpatient, partial hospitalization, and outpatient durational limits, dollar amounts, deductibles, and coinsurance) 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 also specifies a broad list of mental health conditions that must be covered under this optional group coverage.

Presently, group insurers and HMOs are required to make available (offer) at the time of application for group health insurance, the option of coverage for mental illness or nervous disorders, as defined in the standard nomenclature of the American Psychiatric Association. The law provides that mental health benefits may not be less favorable than for physical illness generally with respect to durational limits, dollar amounts, deductibles, and coinsurance factors, except that the policy may have the following minimum limits on mental health benefits:

- Inpatient benefits may be limited to not less than 30 days per benefit year;
- Outpatient benefits may be limited to $1,000 per benefit year; and
- Partial hospitalization benefits may be limited to the equivalent of 30 days of inpatient hospitalization.

This bill substantially amends the following sections of the Florida Statutes: 627.668, 627.669, and 627.6675.

II. Present Situation:

Mental and Nervous Disorders

Mental and nervous disorders are commonplace in the population. The National Institute of Mental Health reports that an estimated 26.2 percent of Americans ages 18 and older suffer from a diagnosable mental disorder[1] in any given year. Approximately 6 million people suffer from what can be called a serious mental illness. Around 2.4 million American adults have schizophrenia, 5.7 million American adults have bipolar disorder, and 14.8 million American adults have major depressive disorder.[2]

Mental and nervous disorders exact a high cost on individuals, families, and society as a whole. Mental illnesses are the leading cause of disability in the United States, Canada and Western Europe.[3] The World Health Organization reported in 2002 that suicide causes more deaths worldwide each year than homicide or war.[4] The financial cost of mental and nervous disorders is also large. In 2003, The President's New Freedom Commission on Mental Health cited data indicating that in the United States, the annual economic, indirect cost of mental illnesses is estimated to be $79 billion, with $63 billion of that amount the result of lost productivity.

Insurance Regulation

The authority to regulate the various sources of private health insurance coverage is divided between the states and the federal government. The states have been granted the authority to regulate the business of insurance pursuant to the McCarran-Ferguson Act. However, the Employment Retirement Income Security Act (ERISA) pre-empts the states from regulating employer-based health insurance plans that self-insure by bearing the primary insurance risk.[5] Thus, private sector employees in such employer sponsored self-insurance plans are solely regulated by the federal government. This means that in Florida many large group plans, which are often self-funded by employers, fall under federal regulation. The jurisdictional authority to regulate health insurance plans can be summarized as follows:

- Individual insurance policies—state regulation;
- State/local government employees—state regulation;
- Private sector self insurance plans—federal regulation;
- Private sector group insurance plans—both federal and state regulation;
- Federal employees—federal regulation.[6]

Florida Mental & Substance-Related Disorder Benefit Requirements

Section 627.668, F.S., requires every insurer, health maintenance organization and other specified entities transacting group, blanket, and franchise health insurance plans to make

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[1] As defined by the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV).
[2] *The Numbers Count: Mental Disorders in America*, National Institute of Mental Health (2006).<www.nimh.nih.gov/publicat/numbers.cfm>
[3] *The World Health Report 2001—Mental Health: New Understanding, New Hope*, World Health Organization (2001); *Achieving the Promise, Transforming Mental Health Care in America*, pg. 3. President's New Freedom Commission on Mental Health (2003).
[4] *World Report on Violence and Health*, World Health Organization (2002).
[5] Patricia Butler, *Erisa Preemption Manual for State Health Policymakers*, pg. 17 (National Academy for State Health Policy 2000).
[6] See Id. at 18.

available (offer) to the policyholder (e.g., employer) coverage for mental and nervous disorders as defined by the American Psychological Association. Florida does not require the inclusion of coverage for mental or nervous disorders. Section 627.668, F.S., requires the offer of coverage for mental and nervous disorders. The statute mandates that mental health inpatient hospital benefits, partial hospitalization benefits, and outpatient benefits under group coverage may not be less favorable than for physical illness generally with respect to durational limits, dollar amounts, deductibles, and coinsurance factors. An additional appropriate premium may be charged for the coverage. However, the policy may have the following minimum limits on mental health benefits:

- Inpatient benefits may be limited to not less than 30 days per benefit year;
- Outpatient benefits may be limited to $1,000 per benefit year; and
- Partial hospitalization benefits may be limited to the equivalent of 30 days of inpatient hospitalization.

The current law has been interpreted to allow insurers to include coverage in the group policy for mental and nervous disorders that meets the minimum benefit requirements, without making a separate offer of this coverage.

Coverage for the treatment of substance abuse also must be made available by insurers and HMOs at the time of application for group health insurance.[7] Benefits are limited by statute only to covered individuals in a group health plan. There is a minimum lifetime benefit of $2,000, a maximum of 44 outpatient visits, and maximum benefit payable for an outpatient visit of $35. Benefits must be provided by certain licensed providers and detoxification is not considered an outpatient benefit.

Coverage for Mental & Nervous Disorders

Representatives from the Office of Insurance Regulation indicated that insurers are offering mental health coverage as required in Florida law. The great majority of health plans that are regulated by Florida are small group plans with 50 or less employees. The Office indicated that most insurers are only offering the minimum coverage requirements in s. 627.688, F.S. This suggests that group coverage providing mental health benefits is readily available for purchase in Florida, but that group coverage providing mental health benefits that are on par with benefits for physical and surgical benefits is not readily available for purchase in the state in the small group market.

Pursuant to a request by staff, the Florida Association of Health Plans surveyed a number of the large insurers that offer plans for sale in the Florida market—with a market share of approximately 70 percent—to determine whether those plans offered coverage for mental and nervous disorders. According to FAHP representatives, all of the plans surveyed offered benefits equal to or better than those required to be offered by Florida law.

The Financial Impact of Mandating Benefits

A number of studies have estimated the financial impact of mandating benefits for mental and nervous disorders. A 2006 study in the New England Journal of Medicine analyzes the effects of the mental health parity mandate that was placed on the Federal Employees Health Benefits

[7] Section 627.669, F.S.

Program (FEHB) beginning in January 2001.[8] The study is a useful examination of the effects of a parity mandate on large health insurance plans, and focuses on 7 different plans associated with the FEHB program, which has 8.5 million enrollees altogether. The study's authors indicate that there is no evidence of significant increases in spending in the plans that were analyzed that is attributable to the implementation of parity for mental health benefits. The study also indicates that managed care of mental health benefits appears to be an effective means of controlling costs.

The Council for Affordable Health Insurance reports on behalf of insurers that a mandate for mental health parity can increase costs from 5 to 10 percent for small group and individual health plans.[9] The CAHI study carried out an actuarial analysis using actuaries from smaller insurance plans and the individual market. A representative from the CAHI indicated to staff that cost management and the design of the plan are important factors affecting the cost increase caused by a mandate for mental health parity.[10] The CAHI representative indicated that a preferred provider organization style health plan may have greater difficulty containing costs than a HMO.

The National Advisory Mental Health Council reported to Congress in 2000 regarding the expected impact of mental health parity on cost, access, and quality of care.[11] The report estimated a 1.4 percent cost increase in total health insurance premiums due to parity.[12] The estimate given by the report was lower than previous estimates provided by the SAMHSA in 1998, previous NAMHC reports and the 1996 Congressional Budget Estimate, with the cause stated to be a decline in mental health and substance abuse costs during the 1990's due to sharply reduced inpatient utilization in all plans including fee-for-service and preferred provider organization plans. The report noted that a reversion to more costly treatment patterns such as those prevalent during the early 1990s, would more than double the estimated cost of parity.

A 1998 study conducted by Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Human Services indicated that state parity mandates showed minimal premium increases when parity was introduced, when coupled with managed care. The study included surveys of health plans in states that mandate parity (Maryland, Minnesota, New Hampshire, and Rhode Island). Most of the insurers and businesses interviewed in the study indicated that parity laws caused an increase in premiums of one to 2 percent. The parties indicated two main reasons for small total premium increases after mental health parity laws were passed—managed care contained cost increases, and parity represented only a small increase in benefits for some states.

States such as New York, Ohio, Illinois and Oregon have all recently enacted mental health parity legislation. Most representatives from these states indicated that it is too early to know what the ultimate premium impact of the mental health parity mandates in their respective states will ultimately be. However, representatives with the New York Insurance Department stated

[8] Howard Goldman; et al., *Behavioral Health Insurance Parity for Federal Employees*, New England Journal of Medicine (March 30, 2006).
[9] Victoria Bunce, J.P. Wieske, and Vlasta Prikazsky, *Health Insurance Mandates in the States 2007*, Council for Affordable Health Insurance. <http://www.cahi.org/cahi_contents/resources/pdf/MandatesInTheStates2007.pdf>
[10] Interview with J.P. Wieske, Director of State Affairs for the Council on Affordable Health Insurance (September 5, 2007).
[11] National Institutes of Health *Insurance Parity for Mental Health: Cost, Access, and Quality*, Ruth L. Kirschstein, M.D (NIH Publication No. 00-4787)
[12] See id. at pg. 33

that thus far, the premium impact of their mandate on large group policies appears to average approximately a 2 to 3 percent increase, on average. The small group (fewer than 50 employees) mandate—which the state is subsidizing entirely—is preliminarily estimated at around a $4 to $5 increase per member, per month. New York is conducting a two year study on the cost impact of the mandate, at which point the financial impact the state's parity law should be known.

The majority of studies regarding the financial impact of mandating coverage for mental health benefits indicate that if benefits are managed, the impact on premiums is approximately 1 to 3 percent. Health plans that do not manage health care benefits are likely to see greater cost increases than those that do not. The studies reviewed indicate that if a mandate does not drastically change the level of benefits that are included in a health plan, then the premium impact will be minimal. However, if the level of benefits is increased substantially by the mandate and the health plan does not manage the benefits to contain costs, then the plan's costs and corresponding premiums are far more likely to increase. Finally, the premium impact of a mental health mandate is less certain on small group plans of less than 50 employees as the majority of recent studies on the issue deal with the effects of mental health parity on larger plans.

In Florida, the average cost of family coverage is about $1,000 a month or $12,000 a year. Essentially, for each percentage point that premiums increase due to expanded coverage of mental and nervous disorders, the cost of average family policy will increase by $10 per month or $120 per year. Thus, a two percent cost increase would amount to $20 per month or $240 per year for parity coverage of mental and nervous disorders.

Interim Project Report

The staff of the Senate Banking and Insurance Committee issued the interim project report, *The Effect of Mandating Coverage for Mental and Nervous Disorders*, (Florida Senate Interim Project 2008-103).[13] Committee staff recommended that group insurers and HMOs be required to offer coverage for mental and nervous disorders that is on par with benefits for physical illness, and that any benefit limitations should not be more restrictive than those applied to medical and surgical benefits under the plan. However, the recommendation was to limit this parity requirement to biologically-based mental and nervous disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of the American Psychological Association, including, or specifically limited to, schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, and obsessive-compulsive disorder. For mental and nervous disorders not covered in this category or not specifically listed in statute, the current requirements of ss. 627.668 and 627.669, F.S., should continue to apply, which allow for specified benefit limitations.

The interim project report also recommended a cost exemption that would exempt group plans from the requirement of offering full parity if such coverage would result in a cost increase over a specified percentage. If the exemption applied, then the current requirements and allowable benefit limitations of ss. 627.668, F.S., would apply to all mental and nervous disorders, as defined in the standard nomenclature of the American Psychiatric Association.

[13] http://www.flsenate.gov/data/Publications/2008/Senate/reports/interim_reports/pdf/2008-103bi.pdf

III. Effect of Proposed Changes:

Section 1. Amends s. 627.668, F.S., to require each insurer, HMO, nonprofit hospital and medical service plan transacting group health insurance or prepaid health care to make available (offer) to a group policyholder, coverage for mental health and substance related disorders. The coverage must provide full parity with coverage provided for other diseases, illnesses, and medical conditions. Specifically, the durational limits, dollar amounts, deductibles and coinsurance factors applied to inpatient hospital benefits, partial hospitalization benefits, and outpatient benefits may not be more restrictive than those applied to benefits provided for other conditions. The bill deletes the minimum benefit requirements for mental and nervous disorders in current statute that permits lower benefit levels than are provided for other conditions.

The bill would allow a group policyholder (e.g. employer) to either elect or reject the full-parity mental health benefits, and would prohibit any alternative level of benefits that did not meet the parity requirements. Based on the interpretation historically given to the current law, this may also allow an insurer to include the full mental health parity coverage in the policy, without providing an option to the group policyholder to reject this coverage.

The disorders to be included are all diagnostic categories listed in the most recent editions of the Diagnostic and Statistical Manual of Mental Disorders and the mental and behavioral disorders section of the current International Classification of Diseases. Specifically, the bill includes the following conditions: Schizophrenia, schizophreniform disorders, schizo-affective disorders, paranoid and other psychotic disorders, bipolar disorders, panic disorders, obsessive-compulsive disorders, major depressive disorders, anxiety disorders, mood disorders, pervasive development disorders or autism, depression in childhood and adolescence, personality disorders, paraphilias, attention deficit and disruptive behavior disorders, tic disorders, eating disorders including bulimia and anorexia, substance-related disorders, Asperger's disorder, intermittent explosive disorder, posttraumatic stress disorder, psychosis not otherwise specified (NOS) when diagnosed in a child under 17 years of age, Rett's disorder, Tourette's disorder, delirium, and dementia. The listed conditions are intended to be a comprehensive list of the conditions that would be covered in the mandate.

The Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV-TR), published in 2000 by the APA, contains a listing of psychiatric disorders and their corresponding diagnostic codes. The DSM-IV-TR diagnostic codes are limited to those contained within the ICD-9-CM coding system.

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is the official coding system of the United States. The ICD-9-CM is a listing of diagnoses and identifying codes used by physicians for reporting diagnoses. The coding and terminology provide a uniform language that can accurately designate primary and secondary diagnoses and provide reliable, consistent communication on claim forms. The ICD-9-CM is designed for the classification of morbidity and mortality information for statistical purposes, for the indexing of hospital records by disease and operation, and for data storage and retrieval. The ICD-9-CM system is required by most governmental agencies and private insurers.

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.

Section 2. Repeals s. 627.669, F.S., relating to coverage for substance abuse treatment. Provisions regarding coverage for treatment of substance abuse are placed in s. 627.668, F.S., in section 1 of the bill.

Section 3. Amends s. 627.6675, F.S., to make a conforming change to the statute governing the continuance of group health insurance policies, due to the elimination of s. 627.669, F.S.

Section 4. The bill is effective January 1, 2009.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The implementation of the bill would expand the coverage for the treatment of mental disorders for group policyholders electing to buy this optional coverage. The current limited coverage for mental illness in many health insurance policies or HMO contracts acts as a financial disincentive for an individual to seek treatment.

Proponents of the bill, representing mental health practitioners, maintain that when the indirect costs are considered that would be avoided by eliminating the treatments for physical conditions associated with a mental illness, significant net savings are possible. Employers may experience further reductions in total health care costs and improvements in productivity. The level of these impacts is indeterminate.

Employers and employees may incur increased premiums associated with the benefits required under this optional coverage. The majority of studies reviewed for Florida Senate Interim Project Report 2008-103 regarding the financial impact of mandating

coverage for mental health benefits indicate that if benefits are managed, the impact on premiums is approximately 1 to 3 percent. Health plans that do not manage health care benefits are likely to see greater cost increases than those that do not. The studies reviewed indicate that if a mandate does not drastically change the level of benefits that are included in a health plan, then the premium impact will be minimal. However, if the level of benefits is increased substantially by the mandate and the health plan does not manage the benefits to contain costs, then the plan's costs and corresponding premiums are far more likely to increase. Additionally, larger plans (such as the state plan) generally see less significant increases than smaller group plans because of their ability to spread risk. The financial impact of mental health parity on smaller employers and small group plans is more difficult to predict than for large group plans. For instance, the state of New York created a $50 million state subsidy to pay for the increased costs on small group plans due to the recent expansion of mandatory coverage for mental and nervous disorders. (See Present Situation for summaries of studies on the cost of mental health parity coverage.)

In Florida, the average cost of family coverage is about $1,000 a month or $12,000 a year. Essentially, for each percentage point that premiums increase due to expanded coverage of mental and nervous disorders, the cost of average family policy will increase by $10 per month or $120 per year. Thus, a two percent cost increase would amount to $20 per month or $240 per year for parity coverage of mental and nervous disorders.

C. Government Sector Impact:

The bill will result in an increase in costs for the State Group Health Plan and local government health plans. Larger plans (such as the state plan) generally see less significant increases than smaller group plans because of their ability to spread risk. As stated above, the majority of studies reviewed indicate that if benefits are managed, the impact on premiums is approximately 1 to 3 percent. See Private Sector Impact for further detail.

The Office of Insurance Regulation indicates that the bill will not fiscally impact the office.

VI. Technical Deficiencies:

It may not be clear whether a condition must be listed in both the Diagnostic and Statistical Manual and the International Classification of Diseases in order to be included under the parity mandate. It may also be unclear whether the conditions specifically listed in Section 1 of the bill constitute an exclusive list of the conditions covered by the mandate.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.