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 Health Policy Committee

BILL:	CS/SB 164
INTRODUCER:	Health Policy Committee and Senator Crist
SUBJECT:	Insurance Coverage for Mental, Nervous, and Substance-Related Disorders
DATE:	March 20, 2008 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Deffenbaugh	BI	**Favorable**
2.	Garner	Wilson	HP	**Fav/CS**
3.			GA	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

Committee Substitute for Senate Bill 164 expands the benefits that insurers and health maintenance organizations (HMOs) are required to offer to group policyholders (e.g., employers) for a specific set of mental, nervous, and substance-related disorders. The committee substitute specifies that the benefit limits for these listed mental health and substance-related disorders (i.e., inpatient hospitalization, partial hospitalization, 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 committee substitute also specifies that health plans may have benefit limits for all other mental health disorders not specifically listed in the bill lower than those for physical illnesses generally within certain parameters (i.e., inpatient benefits may be limited to not less than 30 days per benefit year as defined in the policy or contract).

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.

The committee substitute repeals the current optional coverage requirement for substance abuse impaired persons specified in s. 627.669, F.S., because substance-abuse disorders are included within the group of listed conditions in the optional coverage for mental and nervous disorders requirement, as amended by this bill.

This committee substitute amends ss. 627.6675 and 627.668, F.S., and repeals s. 627.669, F.S.

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.

Health 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

[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). Found at www.nimh.nih.gov/publicat/numbers.cfm (last visited on March 15, 2008).
[3] *The World Health Report 2001—Mental Health: New Understanding, New Hope*, World Health Organization (2001). Found at http://www.who.int/whr/2001/en/whr01_en.pdf (last visited March 15, 2008); *Achieving the Promise, Transforming Mental Health Care in America*, pg. 3. President's New Freedom Commission on Mental Health (2003). Found at http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf (last visited on March 15, 2008).
[4] *World Report on Violence and Health*, World Health Organization (2002). Found at http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf (last visited on March 15, 2008).

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 only and are not subject to the laws of Florida. 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 available (offer) to the policyholder (e.g., employer) coverage for mental and nervous disorders as defined by the American Psychiatric Association (APA). 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.

[5] Patricia Butler, Erisa Preemption Manual for State Health Policymakers, pg. 17 (National Academy for State Health Policy 2000). Found at http://statecoverage.net/pdf/erisa2000.pdf (last visited on March 15, 2008).
[6] See Id. at 18.
[7] S. 627.669, F.S.

Benefits must be provided by certain licensed providers and detoxification is not considered an outpatient benefit.

The benefits provided under this section only apply if treatment is provided by, or under the supervision of, or is prescribed by, a licensed physician or licensed psychologist and if services are provided in a program accredited by the Joint Commission on Accreditation of Hospitals (currently named the Joint Commission on Accreditation of Healthcare Organizations) or approved by the state.

Coverage for Mental & Nervous Disorders

The great majority of health plans that are regulated by Florida are small group plans with 50 or fewer employees. Representatives from the Office of Insurance Regulation (OIR) indicated that insurers are offering mental health coverage as required in Florida law, but 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 Senate professional staff, the Florida Association of Health Plans (FAHP) 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 Program (FEHB) beginning in January 2001. The study is a useful examination of the effects of a parity mandate on large health insurance plans, and focuses on seven 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.[8]

The Council for Affordable Health Insurance (CAHI) 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

[8] Howard Goldman; et al., *Behavioral Health Insurance Parity for Federal Employees.* New England Journal of Medicine. Vol. 354, Iss. 13. Pgs. 1378-1386. (March 30, 2006).
[9] Victoria Bunce, J.P. Wieske, and Vlasta Prikazsky, *Health Insurance Mandates in the States 2007*, Council for Affordable Health Insurance. Found at http://www.cahi.org/cahi_contents/resources/pdf/MandatesInTheStates2007.pdf (last visited on March 15, 2008).

Senate professional 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 an HMO.

The National Advisory Mental Health Council (NAMHC) 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 Substance Abuse and Mental Health Services Administration (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 the SAMHSA 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 be. However, representatives with the New York Insurance Department stated 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 of 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 manage benefits. 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

[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). Found at http://www.nimh.nih.gov/about/advisory-boards-and-groups/namhc/reports/nimh-parity.pdf (last visited on March 15, 2008).
[12] See Id. at pg. 33.

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

Professional 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 professional staff recommended that group health 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 APA, 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 s. 627.668, F.S., would apply to all mental and nervous disorders, as defined in the standard nomenclature of the APA.

III. Effect of Proposed Changes:

Section 1. Amends s. 627.668, F.S., requiring each insurer, HMO, nonprofit hospital and medical service plan corporation transacting group health insurance or prepaid health care to make available (offer) to a group policyholder, coverage for a specific set of mental health and substance related disorders. The coverage must provide full parity with coverage provided for other diseases, illnesses, and medical conditions. 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 physical conditions generally.

[13] http://www.flsenate.gov/data/Publications/2008/Senate/reports/interim_reports/pdf/2008-103bi.pdf (last visited on March 15, 2008).

The committee substitute allows 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 for the specific set of mental and nervous disorders. 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 specific mental and nervous disorders (as defined by the Diagnostic and Statistical Manual of Mental Disorders[14]) required to be covered under this full parity requirement include: schizophrenia, schizo-affective disorders, major depression, bipolar disorders, panic disorders, generalized anxiety disorders, posttraumatic stress disorders, substance abuse disorders, eating disorders, delirium, dementia, childhood ADD/ADHD, developmental disorders, borderline personality disorder, and mental disorder due to a medical condition.

Health plans are required to offer specific minimum benefits (which permit lower benefit levels than are provided for other physical conditions in general) for other mental disorders not listed in the committee substitute.

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., making a conforming change to the statute governing the continuance of group health insurance policies, due to the repeal of s. 627.669, F.S.

Section 4. Provides that this act is effective January 1, 2009, and shall apply to policies and contracts issued or renewed on or after that date.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

[14] 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.

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 **Section II: 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 an average family policy will increase by $10 per month or $120 per year. Thus, a 2 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:

Department of Management Services

The bill will result in an indeterminate negative fiscal effect on the State Employees' Group Health Self-Insurance Trust Fund. The mandate would possibly require the state group plan to cover some conditions for which no treatment, cure, physical improvement, or medical benefit has been established by the medical community. The bill would eliminate the current in-patient limitation of 31 days for mental, nervous, and substance abuse hospital admissions under the group plan, and may eliminate partial hospitalizations. The state could choose to increase premiums to compensate for any increases and the plans size may minimize its effect. 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.

(The department has not had an opportunity to provide an updated fiscal analysis reflecting the changes in the committee substitute that limit the full parity requirement to a smaller group of mental and nervous conditions.)

Office of Insurance Regulation

The Office of Insurance Regulation indicates that the bill will not fiscally impact the office. The review and approval of new policy forms and contracts needed to implement the bill will increase the workload of the OIR's Life and Health Product Review (LHPR) staff; however, it is expected that the increase in workload may be absorbed within current resources.

(The office has not had an opportunity to provide an updated fiscal analysis reflecting the changes in the committee substitute that limit the full parity requirement to a smaller group of mental and nervous conditions.)

VI. Technical Deficiencies:

On line 49, the word "postraumatic" is misspelled. It should be spelled "posttraumatic."

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.)

CS by Health Regulation on March 19, 2008:
The committee substitute reduces the number of mental and nervous conditions that must be covered under the full parity provision of the optional coverage to 15 specific disease

conditions, and applies the current required minimum benefits (which permit lower benefit levels than are provided for other physical conditions in general) for other mental disorders not listed in the committee substitute

B. Amendments:

None.