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:	CS/SB 354
INTRODUCER:	Banking and Insurance Committee and Senator Crist
SUBJECT:	Health Insurance Coverage for Mental and Nervous Disorders
DATE:	March 17, 2009 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Knudson	Burgess	BI	**Fav/CS**
2.			HR	
3.			GA	
4.			WPSC	
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:

The Committee Substitute to Senate Bill 354 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 bill 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 benefit limits for mental health disorders not specifically listed in the bill may not be lower than those for physical illnesses generally, but authorizes limitations on inpatient benefits, outpatient benefits, and partial hospitalization benefits within certain parameters. The bill authorizes an insurer or HMO to manage benefits in order to reduce service costs and utilization without compromising quality of care. The bill also provides that the provisions of s. 627.688, F.S., will not apply to a group health plan if the application of this section causes an increase in plan costs of more than 2 percent.

Recently, Congress passed the Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008, which requires a group health plan to apply financial requirements and treatment

limitations to mental health disorders and substance abuse that are no more restrictive than those predominantly applied to medical and surgical benefits under the policy. The federal parity act applies only to large employer sponsored health plans and large groups; small group health plans currently need only comply with the state law requiring a coverage offer that does not require full parity of coverage. Current Florida 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 bill 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 for which parity benefits must be included if a group health plan provides coverage for mental and nervous disorders.

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

This bill repeals the following section of the Florida Statutes: 627.669.

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

[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).

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 the authority to regulate the business of insurance pursuant to the McCarran-Ferguson Act. However, the Employment Retirement Income Security Act (ERISA) preempts the states from regulating employer-based health insurance plans that self-insure by bearing the primary insurance risk. Thus, the federal government is the sole regulator of employer sponsored self-insurance plans. 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 states are the primary regulators of individual plans, small group plans, and large group plans under McCarran Ferguson. However, there are federal requirements on specific areas—portability of coverage under COBRA is an example—that apply to insurance plans and policies that are primarily under the jurisdiction of state law. Nevertheless, the jurisdictional authority to regulate health insurance plans can be summarized as follows:

- Individual insurance policies—state regulation;
- State/local government employees—state regulation;[5]
- Private sector self insurance plans—federal ERISA regulation;
- Private sector group insurance plans—primarily state regulation, but with federal regulation on specified areas; and
- Federal employees—federal regulation.

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). Small group insurers must also include such coverage in a standard health benefit plan or the basic health benefit plan pursuant to s. 627.6699(12)(b)7., F.S. Florida does not require the inclusion of coverage for mental or nervous disorders, instead requiring an offer of coverage. 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;

[5] State and local health insurance plans are exempt from federal ERISA regulation. However, federal requirements placed on health insurance (particularly group plans) may be applicable to insurance for state and local government employees depending on the size of the health plan and how it is structured.

- 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.[6] 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 a 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.

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.

Federal Mental Health Parity Mandate

On October 2, 2008, President George W. Bush signed into law H.R. 1424, which contains the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The federal parity act applies to employer-sponsored ERISA group health plans and large group health insurance plans. The federal act will preempt all state laws that apply to the same group health insurance policies (large group plans) while allowing for state laws that expand upon the federal mandate. Thus, any state parity legislation regarding group health insurance will only apply to small group health insurance (2-50 employees) and large group health insurance to the extent that the state act expands the benefits provided under the federal parity act.

Pursuant to the act, a group health plan that provides medical and surgical benefits and offers benefits for the treatment of mental health conditions or substance abuse must apply financial requirements and treatment limitations to mental health disorders and substance abuse that are no more restrictive than those predominantly applied to medical and surgical benefits under the policy. Parity with regard to financial requirements includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but not annual and lifetime limits. Parity with regard to treatment limitations includes limits on treatment frequency, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. Annual and lifetime coverage limits for mental health benefits must be equivalent to the limits on substantially all medical and surgical benefits; if no limit is applied to medical and surgical benefits then a limit may not be applied to mental health benefits. Additionally, out-of-network benefits for mental health and substance abuse treatment must be provided on par with out-of-network medical and surgical benefits.

[6] Section 627.669, F.S.

The federal parity act does not specify a set of mental health benefits that must be provided. Instead, the act requires that benefits for mental health and substance abuse be defined under the terms of the health care plan, in accordance with applicable state and federal law. Florida law requires an offer of coverage for mental and nervous disorders "as defined by the standard nomenclature of the American Psychiatric Association subject to the right of the applicant for a group policy or contract to select any alternative benefits or level of benefits as may be offered."[7] Thus, insurers must offer a policy covering all conditions defined by the APA, but may also offer policies that provide benefits for a greater or lesser number of conditions, so long as the benefits are provided in accordance with the minimum limits contained in statute. Generally, a state law may be applied to insurance plans to the extent that it does not prevent the application of the federal law.[8] Using this standard, it is likely in Florida a large group health plan will have to offer a coverage plan providing coverage for mental and nervous disorders as defined by the standard nomenclature of the APA and that meets the requirements of the federal parity law. Alternative coverage plans may also be offered pursuant to Florida law, but such coverage would have to provide benefits in conformity with the federal parity mandate. Any change in Florida law creating an alternate set of parity benefits will not only apply to small groups, but also to large groups governed by the federal parity act.

The federal act exempts employers that have an average of between two and 50 employees (small groups). The act also exempts health plans if application of parity for benefits results in a 2 percent or greater increase in total plan costs for the first year parity is applied, and an increase of 1 percent or greater in subsequent plan years. To qualify for an exemption, the determination that plan costs exceed the applicable percentage must be made in a written report by a qualified and licensed actuary that is a member in good standing of the American Academy of Actuaries. If an insurer or group health plan claims an exemption it must notify federal and state regulators, as well as plan participants and beneficiaries. Federal and state regulators both are authorized to conduct an audit of the books, records, and actuarial reports of a group health plan or insurer claiming an exemption.

The Financial Impact of Mandating Benefits

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

[7] Section 627.668(1), F.S.

[8] An alternative interpretation would be to say that the federal parity act supersedes the requirement that an offer of benefits for mental and nervous disorder coverage must include coverage for all such conditions defined in the standard nomenclature of the APA (s. 627.668(1), F.S.). Such interpretation would hinge on linking the requirement that benefits include APA defined conditions with the limitations on such coverage contained in statute. Thus, if the federal act preempts the coverage limitations contained in the Florida law, then it must also preempt how such coverage is defined under Florida law. The interpretation is that subsections (1) and (2) of section 627.668, F.S., are all part of a single statutory requirement that, if imposed, would prevent the proper application of the federal act. Thus, the federal act invalidates the entirety of both subsections, leaving Florida law without a statement regarding which mental or nervous disorders must be included within an offer of coverage. That determination would be left to the insurers and HMOs offering plans for sale. This interpretation is less likely to be adopted because a requirement that an offer of coverage must be made that includes APA defined mental and nervous disorders does not appear to prevent the application of federal law. Additionally, it arguably creates a result that appears contrary to the purposes of the federal act, which contemplates the imposition of state laws that expand coverage for the treatment of mental disorders.

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 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 an 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 in November 2007 the interim project report, *The Effect of Mandating Coverage for Mental and Nervous Disorders,* (Florida Senate Interim Project 2008-103).[9] 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. Expands the benefits provided pursuant to the requirement in current law that each insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation transacting group health insurance or providing prepaid health care make available (offer) group policyholders coverage for mental and nervous disorders.

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

Mental and Nervous Disorders Defined – The bill defines the amount of benefits that must be offered for the treatment of mental and nervous disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. The DSM lists the conditions that qualify as mental disorders and contains various diagnostic criteria that a person must meet in order to have a particular diagnosis applied to him or her. Use of the DSM in defining mental and nervous disorders for purposes of the statute makes clear that a condition must meet DSM diagnostic criteria in order for benefits to be provided.

Parity of Benefits – Under large and small group policies or contracts, benefits for the treatment and care of specified mental and nervous disorders cannot be less favorable than for physical illness generally. Specifically, inpatient hospital benefits, partial hospitalization benefits, and outpatient benefits for the treatment of mental and nervous disorders cannot be less favorable than for physical illness generally with regard to:

- Durational limits;
- Dollar amounts;
- Deductibles; and
- Coinsurance factors.

The mental and nervous disorders that must receive parity of benefits include:

Schizophrenia and Psychotic Disorders – Psychotic disorders is a DSM diagnostic grouping that includes schizophreniform and schizoaffective disorders as well as delusional disorders.

Mood Disorders – DSM diagnostic grouping that includes depressive disorders and bipolar disorders.

Anxiety Disorders – DSM diagnostic grouping that includes panic disorders, phobias, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), and generalized anxiety disorders.

Substance Abuse Disorders – DSM diagnostic sub-grouping. Substance abuse is defined as a "maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances." A diagnosis is predicated not on addiction, but on recurrent problems resulting from substance abuse (failure to carry out major obligations, use of the substance that creates a hazard such as driving a car, substance-related legal problems, continued use of the substance despite the interpersonal problems that it causes). Substance abuse can involve the use of alcohol, legal and illegal drugs, but does not include caffeine or nicotine.

Eating Disorders – DSM diagnostic grouping that includes anorexia and bulimia.

Childhood Attention Deficit Disorder and Attention Deficit Hyperactivity Disorder.

Coverage for Mental and Nervous Disorders Not Receiving Parity –This level of coverage would apply to any mental or nervous disorder not listed as qualifying for parity of coverage, but

defined in the DSM. Coverage for mental health disorders not specified as receiving full parity of benefits cannot be less favorable coverage than for physical illness generally. However, the following benefit limits are applicable to such conditions:

- Inpatient benefits may be limited to not less than 45 days per benefit year. If inpatient hospital benefits are provided beyond 45 days per benefit year, the durational limits, dollar amounts, and coinsurance factors may differ from those applied to physical illness. Under current law, inpatient benefits may be limited to not less than 30 days per benefit year for all mental and nervous disorders.
- Outpatient benefits may be limited to 60 visits per benefit year for consultations with a licensed physician, psychologist, mental health counselor, a marriage and family therapist, and a clinical social worker. If benefits are provided beyond 60 visits per benefit year, the durational limits, dollar amounts, and coinsurance factors may differ from those applied to physical illness. Under current law, such outpatient benefits may be limited to not less than $1,000 per benefit year for all mental and nervous disorders.
- Partial hospitalization services or combined inpatient and partial hospitalization benefits shall not exceed the cost of 45 days of inpatient hospitalization for psychiatric services (including physician fees) which prevail in the community in which the partial hospitalization services are rendered. If partial hospitalization services benefits are provided beyond such limits, the durational limits, dollar amounts, and coinsurance factors need not be the same as applicable to physical illness. The bill maintains the requirements in current law that partial hospitalization benefits must be provided under the direction of a licensed physician and meet specified accreditation standards, however under the bill this requirement would only apply to treatment of conditions not receiving parity of benefits.

Management of Benefits – The bill states an insurer or HMO may impose financial incentives, peer review, utilization requirements, and other methods used for the management of benefits provided for other medical conditions in order to reduce service costs and utilization without compromising quality of care.

Cost Exemption **–** Does not apply the provisions of s. 627.668, F.S., to a group health plan or insurance provided in connection with a group health plan if the application of this section causes an increase in plan costs of more than 2 percent. The determination of the plan cost increase must be certified by an independent actuary to the Office of Insurance Regulation. This provision will exempt a plan from all the requirements of the section, not only the parity requirements.

Section 2. Deletes s. 627.669, F.S., which currently requires insurers and HMOs to offer optional coverage for the treatment of substance abuse within group health insurance or prepaid health care plans.

Treatment of Substance Abuse – Current law contains strict requirements for the coverage:

- The basic benefit is an intensive treatment program for the treatment of substance abuse.
- Minimum lifetime benefit of $2,000.
- A maximum of 44 outpatient visits with a maximum benefit of $35 payable per visit.

- Detoxification is not a benefit under the outpatient program.
- Treatment must be provided, supervised, or prescribed by a licensed physician or licensed psychologist. Further, the services must be provided in a program accredited by the Joint Commission on Accreditation of Hospitals or approved by the state.

Instead, the bill (in section 1) will require an offer of coverage for mental and nervous disorders that includes treatment of substance abuse disorders that is on-par with coverage generally provided under the policy for physical illness. The bill eliminates all the current law requirements listed above. However, only "substance abuse disorders" defined in the DSM would be eligible for such treatment. Further, the condition must meet any diagnostic criteria in the DSM in order for the mandate to apply.

Section 3. Makes a technical change to s. 627.6675, F.S., deleting a reference to s. 627.669, F.S., (which is deleted in section 2 of the bill).

Section 4. The act is effective January 1, 2010, and applies to policies and contracts issued or renewed on or after that date.

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 bill requires all small and large group health insurance plans governed by Florida law to offer coverage for mental and nervous disorders and substance abuse defined in the DSM. The impact of the bill will be greater on small groups. The recently passed federal parity act applies only to large groups; small group health plans currently need only comply with the state law requiring an offer coverage, which does not require full parity of coverage. Thus, even though SB 354 will apply equally to large and small groups, the increase in benefits created by the Senate Bill will be greater with regard to small groups.

Proponents of the bill, representing mental health practitioners, maintain that when 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. Representatives of health plans also voice concerns that some employees may receive less mental health coverage if the bill passes because an employer buying the group coverage may choose not to include coverage for mental and nervous disorders in the policy offered to employees because of the increased cost of 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.

C. Government Sector Impact:

The federal 2008 mental health parity act will apply to the State Group Insurance Plan. The plan will be required to offer coverage for mental disorders defined in the standard nomenclature of the APA that is on-par with coverage provided for medical and surgical benefits. The federal act will result in an indeterminate negative fiscal effect on the State Employees' Group Health Self-Insurance Trust Fund. 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. The Committee Substitute for Senate Bill 354 may further expand treatment to the extent that the bill expands the types of conditions that must be afforded parity treatment beyond what is currently required pursuant to Florida law and the federal parity act.

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.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 624.215, F.S., requires every person or organization seeking consideration of a legislative proposal mandating a health coverage to submit to the Agency for Health Care Administration and the appropriate legislative committees having jurisdiction a report assessing the social and financial impacts of the proposed coverage. The statute contains twelve

assessments that the report is to include, if information is available. Representative Ed Homan delivered to the Banking and Insurance Committee on March 6, 2009, a report assessing the social and financial impacts of the CS for SB 354 and its companion legislation HB 147. Their report makes the following findings using the assessment criteria of s. 624.215, F.S, as summarized by committee staff. A copy of the report is available from the Senate Banking and Insurance Committee:

- *To what extent is the treatment or service generally used by a significant portion of the population?* – Twenty-six percent.
- *To what extent is the insurance coverage generally available?* – The coverage is not available or only available at a restricted amount pursuant to statute.
- *To what extent does the lack of coverage result in persons avoiding necessary health care treatment?* – Mental and nervous disorders are significantly under-treated at great social expense.
- *To what extent does lack of coverage result in unreasonable financial hardship?* – Significant rates of unemployment and underemployment. A very large percentage of incarcerated people have mental illness creating a financial hardship for themselves and for society.
- *The level of public demand for the treatment or service* – Forty-six other states have passed mental health parity legislation.
- *The level of public demand for insurance coverage of the treatment* – Twenty-six percent; the only more common disease is hypertension at thirty-five percent.
- *Interest of collective bargaining agents in negotiating for inclusion of this coverage in group contracts* – Significant as demonstrated by the Tampa Employers Health Coalition.
- *Extent to which the coverage will increase or decrease the cost of the treatment or service* – Treating mental illness will lower the costs of treating accompanying medical illnesses.
- *Extent to which the coverage will increase the appropriate uses of the treatment or service* – Covering specialty psychiatric care and medication will improve both mental and physical health.
- *Extent to which the mandated treatment or service will be a substitute for a more expensive treatment or service* – Hospitalization for mental "breakdowns" is exceedingly more expensive than the medication to prevent such events. Resulting decreases in "absenteeism" and "presenteeism" at work also pay for mental treatment many times over.
- *Extent to which the coverage will increase or decrease the administrative expenses of insurers, and the premium and administrative expenses of policyholders* – Minimal as experienced by the national health care companies like Cigna, United, and Aetna.
- *Impact of this coverage on the total cost of health care* – The experience documented by other states is that health care insurance premiums increased by less than one percent in the group market and less than two percent in the individual market.

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 Banking and Insurance on March 17, 2009:

- Changes the list of conditions for which parity coverage must be offered for mental and nervous disorders or substance abuse treatment.
- Changes the benefit limits applicable to mental and nervous disorders for which an offer of parity coverage is not required.
- Authorizes an insurer or HMO to manage benefits in order to reduce service costs and utilization without compromising quality of care.
- Exempts application of s. 627.668, F.S., to a group health plan if application of the section causes an increase in plan costs of more than 2 percent.

B. Amendments:

None.