HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7 Coverage for Mental and Nervous Disorders
SPONSOR(S): Homan and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 182

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1)	Health Care Regulation Policy Committee	11 Y, 2 N	Shaw	Calamas
2)	Insurance, Business & Financial Affairs Policy Committee			
3)	Government Operations Appropriations Committee			
4)	General Government Policy Council			
5)				

SUMMARY ANALYSIS

Section 627.668, F.S., regulates the provision of mental and nervous disorder services by insurers, health maintenance organizations, and nonprofit hospital and medical service plan corporations providing group health insurance or prepaid health care. Specifically, these entities must make mental and nervous disorder services available to a policyholder for an additional premium; however, these services do not have to be the same as those offered for physical illness. Florida mandates mental and nervous disorder coverage, but does not mandate parity of coverage.

House Bill 7 amends s. 627.668, F.S., to impose a mandated health insurance offering for the care and treatment of schizophrenia and psychotic disorders, mood disorders, anxiety disorders, substance abuse disorders, eating disorders, and childhood ADD/ADHD at full parity with coverage offered for physical illness. The bill maintains the partial parity of current law with respect to all other mental disorders, but with increased benefits as follows:

- The limit on inpatient benefits is increased from 30 to 45 days per benefit year;
- The limit on outpatient benefits is changed from $1,000 per year to 60 visits per year for consultations with a physician, psychologist, mental health counselor, marriage and family therapist, and a clinical social worker; and
- The limit on partial hospitalization services, or a combination of inpatient and partial hospitalization services, is increased from the cost of 30 days to 45 days of inpatient hospitalization for psychiatric services, including physician fees.

The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 presently requires large group insurers to provide mental and nervous disorder parity; therefore, it appears the provisions of HB 7 allowing partial parity for certain conditions will only apply to small group insurers.

The Department of Management Services states that the state's group health insurance plans are in compliance with federal law; therefore, the bill will have no additional fiscal impact on the state employee plans.

The bill has an effective date of January 1, 2011, and shall apply to policies and contracts issued or renewed on or after that date.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Regulation of Health Plans

Health plans are regulated at both the state and federal level. At the federal level, the Employee Retirement Income and Security Act (ERISA) regulates the operation of voluntary employer-sponsored benefits including pension plans and health plans. Congress also has enacted several laws that regulate the operation of all health benefits regardless of the method insurance including the Health Insurance Portability and Accountability Act of 1996; the Newborns' and Mothers' Health Protection Act of 1996; the Mental Health Parity Act of 1996; and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. ERISA provides an explicit exemption from state regulation for health plans that are self-funded. State regulations apply to health benefits purchased through private health insurance plans and health maintenance organizations (HMOs).

Health Insurance Mandates and Mandated Offerings

A health insurance mandate is a legal requirement that an insurance company or health plan cover services by particular health care providers, specific benefits, or specific patient groups.

Mandated offerings, on the other hand, do not mandate that certain benefits be provided. Rather, a mandated offering law can require that insurers offer an option for coverage for a particular benefit or specific patient groups, which may require a higher premium and which the insured is free to accept or reject. 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.

Florida currently has at least 52 mandates.[1] The Council for Affordable Health Insurance estimates that mandated benefits currently increase the cost of basic health coverage from a little less than 20 percent to perhaps 50 percent, depending on the number of mandates, the benefit design and the cost of the

[1] Office of Insurance Regulation list of state health insurance mandates on file with Health Care Regulation Policy Committee staff; and "Health Insurance Mandates in the States 2009," Council for Affordable Health Insurance; *available* at: http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2009.pdf. *(*last viewed March 9, 2010)

initial premium.[2] Each mandate adds to the cost of a plan's premiums, in a range of less than 1 percent to 10 percent, depending on the mandate.[3] Higher costs resulting from mandates are most likely to be experienced in the small group market since these are the plans that are subject to state regulations. The national average cost of insurance for a family of four is $13,375.[4]

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.

According to the National Conference of State Legislators, 49 states currently regulate the provision of mental health services in three categories:

- Mental health parity;
- Minimum mental health benefits; and
- Mandated mental health offering. [5]

As of 2009, a majority of states now provide a variety of forms of mental health parity.[6]

Mental Health and Substance Abuse Coverage in Florida

Section 627.668, F.S., regulates the provision of mental and nervous disorder services by insurers, health maintenance organizations, and nonprofit hospital and medical service plan corporations providing group health insurance or prepaid health care. Specifically, these entities must make mental and nervous disorder services available to a policyholder for an additional premium. Florida's law is a mandated offering law.

Mental health 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."

The Florida mandated offering does not provide full mental health parity.[7] With regard to group policies or contracts, inpatient hospital benefits, partial hospitalization benefits, and outpatient benefits with durational limits, any dollar amounts deductibles and coinsurance factors may not be "less favorable" than those for treatment of physical illness. However, Florida law creates exceptions to parity. Such policies may limit mental and nervous disorder benefits as follows:

- Inpatient benefits may be limited to 30 days per benefit year;

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[2] "Health Insurance Mandates in the States 2009," Council for Affordable Health Insurance; *available* at: http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2009.pdf. *(*last viewed March 9, 2010)
[3] *Id.*
[4] Kaiser Family Foundation, Employer Health Benefits 2009 Annual Survey, *available* at: http://ehbs.kff.org/?CFID=20695941&CFTOKEN=84763322&jsessionid=6030bac21268c605c7863526585a397e6175 (last viewed March 9, 2010).
[5] National Conference of State Legislators, State Laws Mandating or Regulating Mental Health Benefits, February 2009; reposted with additions February 11, 2010, available at http://www.ncsl.org/programs/health/mentalben.htm.
[6] *Id*.
[7] Prior Florida law imposed a limited mental health parity mandated offering. Section 627.6685, F.S., required parity between mental health benefits and medical/surgical benefits as to lifetime limits and annual limits, if any. The parity requirement expressly did not apply to other terms and conditions, such as cost-sharing, visits or days limits, medical necessity requirements and limits on amount, duration and scope of mental health benefits. The statute did not apply to benefits offered after September 2001, and was repealed in 2005. S. 627.6685(5), F.S.; Ch. 2005-2, § 119, Laws of Florida.

- 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.

Section 627.669, F.S., regulates the provision of substance abuse services by insurers, HMOs, and nonprofit health care services plans providing group health insurance or prepaid hospital and medical service plan corporations providing group health insurance or prepaid health care. Specifically, these entities must make substance abuse services available to a policyholder. Florida's law is a mandated offering law.

The substance abuse mandated offering does not provide any form of parity with other kinds of coverage. Rather, it requires coverage entities to provide a specific level of benefits, subject to the group policyholder's right to select alternative benefits or level of benefits offered, as follows:

- Minimum lifetime benefit of $2,000
- Outpatient visits may be limited to a maximum of 44
- The benefit payable for an outpatient visit shall not exceed $35
- Detoxification shall not be considered an outpatient benefit

Mental Health Parity and Addiction Equity Act

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 Act). The Act applies to employer-sponsored ERISA group health plans and large group health insurance plans. The 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. 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 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.

The 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. As discussed above, current Florida law requires an offer of coverage for mental and nervous disorders as defined by the standard nomenclature of the American Psychiatric Association (APA) 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. 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.

It appears that under the Act, 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.

The 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.

Cost of Mental Health Parity

Many studies have examined the effect of mental health parity laws on the cost of health care coverage, with varying results. Recognizing these differing results, the Substance Abuse and Mental Health Services Administration (SAMHSA) within the United States Department of Health and Human Services designed a study to analyze the costs of parity. [8] At the time of the study most states had parity laws that were limited to serious mental illnesses and did not include substance abuse, small plans, or government employees. The study found that these types of plans with tightly managed care have a small effect on premiums; however, plans with full parity for mental health and substance abuse increased premiums by an average of 3.6 percent.[9]

The Office of the Insurance Commissioner for the State of West Virginia examined mental health parity in that state. The Office found four of 31 insurance companies experienced significant increases in the cost of providing mental health benefits (100 percent, 90 percent or 80 percent) as a result of parity. These companies represented less than 5 percent of the market; other companies experienced small or no increases.[10] West Virginia's parity provisions contain authority for plans to use additional cost containment measures if parity would result in a premium cost increase of 2 percent or more. Some insurers incurred such increased costs, but none exercised their option to use additional cost containment measures.[11] Similarly, the Mental Health Parity Act of 1996[12] contained an exemption for plans that would incur a premium cost increase of at least 1 percent as a result of parity.

One study analyzed the impact of mental health parity in an unnamed state on a large employer group.[13] That study looked at a fee for service insurer which responded to a state parity mandate by instituting a managed care carve-out for those services. In a managed care carve-out, the insurer carves out the mental health benefits and manages them separately from the physical benefits, perhaps by contracting with a behavioral managed care company to perform that service. The insurer in the study used network management, prior authorization and concurrent utilization review to manage the mental health benefits. The study found that while costs were expected to increase substantially as a result of a state parity mandate, costs actually declined, as a result of managed care techniques. While treatment prevalence rose 50 percent, per member plan costs declined almost 40 percent. The study found this was primarily due to reduced lengths of stay for inpatient treatment, attributable to the managed care carve-out. The study concluded that the increased case management offset the costs of

[8] Merrile Sing, et al, The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits, DHHS Publication No. MC99-80 (1998), Substance Abuse and Mental Health Services Administration, available at http://mentalhealth.samhsa.gov/publications/allpubs/Mc99%2D80/Prtyfnix.asp.
[9] Id.
[10] Office of the Insurance Commissioner, State of West Virginia, Mental Health Parity Analysis Report, December 2006.
[11] Id.
[12] The Act was in effect at the time of the study, but expired December 31, 2007.
[13] See Samuel H. Zuvekas, et al, The Impacts of Mental Health Parity and Managed Care In One Large Employer Group, 21 *Health Affairs* 3 (2002).

parity's increased benefits. This study looked at a large employer group with over 100,000 enrollees. Smaller group plans will likely experience parity differently.

SAMHSA studied the effect of a parity law for both mental health and substance abuse in Vermont.[14] For one plan, spending for mental health and substance abuse services increased 4 percent; for the other plan, which utilized managed care to achieve the purposes of the parity requirement, spending for those services decreased 9 percent. Consumers' share in spending dropped as well. The SAMHSA study found while more people received outpatient mental health services under parity, fewer people received any substance abuse services. The Vermont statute specifically authorized a managed care carve-out.[15] Significantly, the SAMHSA study found that managed care for these services was an important factor in controlling the costs of parity.

The Maryland Health Care Commissioner produced a report finding that Maryland's mental health and substance abuse mandate was the most expensive mandate imposed on insurers, with a cost ranging from 4.9 percent to 6.6 percent of the premium.[16] The Commissioner found parity was the second most expensive mandate on a marginal cost basis (after IVF), and noted that the actual cost varies based on the level of managed care or whether a managed care carve-out is used.[17] Older data on Maryland found parity raised costs .6 percent, which was attributed to high levels of managed care.[18]

The staff of the Senate Banking and Insurance Committee issued an interim project report, The Effect of Mandating Coverage for Mental and Nervous Disorders (Florida Senate Interim Project 2008-103). After distinguishing between mandated offers and mandated coverage, Senate 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.[19] 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 Senate 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.

Health Insurance Mandate Report

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[14] See Margo Rosenbach, et al, Effects of the Vermont Mental Health and Substance Abuse Parity Law, DHHS Pub. No. (SMA) 03-3822 (2003), Substance Abuse and Mental Health Services Administration, available at http://mentalhealth.samhsa.gov/publications/allpubs/sma03-3822/default.asp.

[15] See 8 V.S.A. § 4089b (2008).

[16] Maryland Health Commission, Study of Mandated Health Insurance Services: A Comparative Evaluation, January 2008, available at http://mhcc.maryland.gov/health_insurance/required_benefits.html.

[17] Id. Maryland's parity statute specifically authorizes the use of managed care. MD Code, Insurance, § 15-802 (2008).

[18] Bruce Lubotsky Levin, Dr.P.H., et al, Mental Health Parity: National and State Perspectives 1999, Louis de la Parte Florida Mental Health Institute and College of Public Health University of South Florida, available at www.fmhi.usf.edu/institute/pubs/pdf/parity/parity1999.pdf.

[19] The Diagnostic and Statistics Manual of the American Psychiatric Association (DSM) includes universally accepted definitions and descriptions of mental illnesses and conditions. There are 13 DSM diagnoses commonly referred to as biologically-based mental illnesses by mental health providers and consumer organizations. Between 3 and 13 of these diagnoses are referred to in various state parity laws. For example, in Alabama, mental illness is defined as: 1) schizophrenia, schizophrenia form disorder, schizo-affective disorder; 2) bipolar disorder; 3) panic disorder; 4) obsessive-compulsive disorder; 5) major depressive disorder; 6) anxiety disorders; 7) mood disorders; 8) Any condition or disorder involving mental illness, excluding alcohol and substance abuse, that falls under any of the diagnostic categories listed in the mental disorders section of the International Classification of Disease, as periodically revised. See, "State Laws Mandating or Regulating Mental Health Benefits," National Conference of State Legislatures, February 2009; reposted with additions February 11, 2010, available at http://www.ncsl.org/programs/health/mentalben.htm.

Florida enacted section 624.215, F.S., to take into account the impact of insurance mandates and mandated offerings on premiums when making policy decisions. That section requires that any proposal for legislation that mandates health benefit coverage or mandatorily offered health coverage must be submitted with a report to AHCA and the legislative committee having jurisdictions. The report must assess the social and financial impact of the proposed coverage to the extent information is available, shall include:

- To what extent is the treatment or service generally used by a significant portion of the population.[20]
- To what extent is the insurance coverage generally available.[21]
- If the insurance coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatment.[22]
- If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship.[23]
- The level of public demand for the treatment or service.[24]
- The level of public demand for insurance coverage of the treatment or service.[25]
- The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.[26]
- To what extent will the coverage increase or decrease the cost of the treatment or service.[27]
- To what extent will the coverage increase the appropriate uses of the treatment or service.[28]
- To what extent will the mandated treatment or service be a substitute for a more expensive treatment or service.[29]
- To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.[30]
- The impact of this coverage on the total cost of health care.[31]

Effects of the Bill

House Bill 7 amends s. 627.668, F.S., to impose a mandated offering for the care and treatment of schizophrenia and psychotic disorders, mood disorders, anxiety disorders, substance abuse disorders, eating disorders, and childhood ADD/ADHD at full parity with coverage offered for physical illness.

The bill maintains the partial parity of current law with respect to all other mental disorders, but with increased benefits as follows:

- The limit on inpatient benefits is increased from 30 to 45 days per benefit year;
- The limit on outpatient benefits is changed from $1,000 per year to 60 visits per year for consultations with a physician, psychologist, mental health counselor, marriage and family therapist, and a clinical social worker; and

[20] s. 624.215(2)(a), F.S.
[21] s. 624.215(2)(b), F.S.
[22] s. 624.215(2)(c), F.S.
[23] s. 624.215(2)(d), F.S.
[24] s. 624.215(2)(e), F.S.
[25] s. 624.215(2)(f), F.S.
[26] s. 624.215(2)(g), F.S.
[27] s. 624.215(2)(h), F.S.
[28] s. 624.215(2)(i), F.S.
[29] s. 624.215(2)(j), F.S.
[30] s. 624.215(2)(k), F.S.
[31] s. 624.215(2)(l), F.S.

- The limit on partial hospitalization services, or a combination of inpatient and partial hospitalization services, is increased from the cost of 30 days to 45 days of inpatient hospitalization for psychiatric services, including physician fees.

It appears that the provisions of the bill providing partial parity for certain conditions will only apply to small group insurers since the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 requires large group insurers to provide full parity.

Current law refers to mental and nervous disorders "as defined by standard nomenclature of the American Psychiatric Association." The bill replaces "standard nomenclature" with a specific reference to the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)[32] 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.

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.

The bill provides an exemption for a group health plan or insurance provided in connection with a group health plan if the mandated care 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.

The bill repeals 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. Instead, the bill requires 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 provides that the mandated care for mental and nervous disorders also apply to state group insurance policies.

The Health Insurance Mandate Report

The health insurance mandate report[33], dated February 2, 2010, was submitted by the bill sponsor to the Health Regulation Policy Committee. Section 624.215, F.S., provides that the report must assess the social and financial impacts of "the proposed coverage." The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 mandates parity of coverage for mental and nervous disorders for large group insurers, thus, the "proposed converge" would be primarily for small group insurers. Many of the responses submitted in the report appear to be an assessment of the social and financial impacts of mental illness rather than of the effect of the specific insurance coverage proposed by the bill.

The report provided a response to each provision of s. 624.215, F.S.[34]

Extent to which the treatment or service generally used by a significant portion of the population.[35]

[32] Available at: http://allpsych.com/disorders/dsm.html
[33] The health insurance mandate report is on file with Health Care Regulation Policy Committee staff.
[34] The report itself provides no citation to any supporting data, report, or study. Reference materials were attached to the report and the report noted that more information could be found at www.edhoman.com. Staff reviewed the attached material and information on the website in an attempt to find the appropriate reference to the assertions in the report.
[35] s. 624.215(2)(a), F.S.

The proponent states the following: "22% at some time during their lifespan and by 10% on any given day according to published research."

These statistics appear to be the portion of the population that have mental or substance abuse disorders rather than the extent to which the treatment or service is generally used.

Extent to which the insurance coverage is generally available.[36]

The proponent states the following: "either not available or at a restricted amount according to statute."

No documentation was provided supporting this assertion. Federal law currently mandates parity of coverage for large group insurers and Florida law currently mandates that more limited coverage be offered.

Extent to which the lack of insurance coverage results in persons avoiding necessary health care treatment, if insurance coverage is not generally available.[37]

The proponent states the following: "significantly under treated at great social expense."

In the supporting documentation, the proponent references a study published in 2001 using data collected from respondents to a 1996 survey. The study concludes that even among those with the most serious and impairing mental illness, only 25 percent received guideline-concordant treatment.[38] Predictors of receiving guideline-concordant care included being white, female, severely ill, and having mental health insurance coverage.[39] It is unclear if the results of this study can be extrapolated to Florida today since the study was conducted before the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which made mental health coverage widely available.

Extent to which insurance coverage is generally not available and results in an unreasonable financial hardship.[40]

The proponent states the following: "Significant rates of unemployment and under employment. A very large percentage of incarcerated people have mental illness creating a financial hardship for themselves and for society. The mental hospitals of the past nave a new name – prisons."

No documentation was provided linking lack of availability of insurance to unemployment, under employment, or incarceration. Federal law currently mandates parity of coverage for large group insurers and Florida law currently mandates that more limited coverage be offered.

The level of public demand for the treatment or service.[41]

The proponent states the following: "46 other states and Congress have passed "parity" legislation".

Florida presently mandates an offering of coverage for mental and nervous disorders and Florida insurers are subject to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. No documentation was provided to support demand for more treatment or services than what is presently available.

The level of public demand for insurance coverage of the treatment or service.[42]

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[36] s. 624.215(2)(b), F.S.
[37] s. 624.215(2)(c), F.S.
[38] Wang, et. Al, *Recent Care of Common Mental Disorders in the United States*, Journal of General Internal Medicine, Volume 15 Issue 5, Pages 284 – 292 (2001) Available at: http://www3.interscience.wiley.com/journal/120137964/abstract
[39] Id.
[40] s. 624.215(2)(d), F.S.
[41] s. 624.215(2)(e), F.S.

The proponent states the following: "26%. The only more common disease is hypertension at 35% of the adult population."

These appears to be statistics on the prevalence of mental disorders in the adult population rather than as assessment of the level of public demand for insurance coverage for the treatment or service. No documentation was provided to support demand for coverage broader than what is presently available.

The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.[43]

Insufficient documentation was provided to determine the interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts. Since Florida insurers are subject to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 it is unlikely that collective bargaining would be necessary for inclusion of mental and nervous disorders in most group contracts.

Extent to which the coverage increases or decreases the cost of the treatment or service.[44]

The proponent states the following: "Treating mental illness will lower the costs of treating the costs of accompanying medical illness."

A study of the Federal Employees Health Benefits Program found that mental health parity reduced the out of pocket expenses of those employees who took advantage of the benefits; however, having coverage did not significantly increase the use of the benefits.[45] Consequently, the study concluded that when coupled with care management, implementation of parity in insurance benefits for behavioral health care can "improve insurance protection without increasing total costs."

Extent to which the coverage increases the appropriate uses of the treatment or service.[46]

The proponent states the following: "Covering specialty psychiatric care and medication will improve both mental and physical health."

The proponent provides documentation which quotes a benefits guide for federal employees which states "adequate mental health and substance abuse benefits coverage has been shown to improve patient health, provide patients with greater financial protection against unforeseen costs, and to reduce work place absences and employee disabilities."[47]

Extent to which the mandated treatment or service be a substitute for a more expensive treatment or service.[48]

The proponent states the following: "Hospitalization for mental "breakdowns" is exceedingly more expensive than medication to prevent such events. Decreases in "absenteeism" and "presenteeism" at work also pay for mental illness treatment many times over."

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[42] s. 624.215(2)(f), F.S.
[43] s. 624.215(2)(g), F.S.
[44] s. 624.215(2)(h), F.S.
[45] Goldman, Frank, et. al., *Behavioral Health Insurance Parity for Federal Employees*, N Engl J Med 2006 354: 137-1386;
[46] s. 624.215(2)(i), F.S.
[47] Federal Employee Health Benefits Program guide available at: http://www.opm.gov/insure/archive/health/consumers/parity/faq.asp#3 (last viewed on March 24, 2010)
[48] s. 624.215(2)(j), F.S.

Extent to which the coverage increases or decreases the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.[49]

The proponent states the following: "Minimal as experienced by national health care companies like Cigna, United, and Aetna. These companies already do this is 46 other states."

The documentation provided related to the implementation of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. No documentation was provided that related to the proposed coverage.

The impact of this coverage on the total cost of health care.[50]

The proponent states the following: "The experience documented by other states is that health care insurance premiums increased by less than 1% in the group market and less than 2% in the individual market."

See discussion above, Cost of Mental Health Parity.

The bill takes effect January 1, 2011, and shall apply to policies and contracts issued or renewed on or after that date.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.668, F.S., relating to optional coverage for mental and nervous disorders required.
Section 2: Amends s. 627.6675, F.S., relating to conversion on termination of eligibility.
Section 3: Repeals s. 627.669, F.S., relating to optional coverage required for substance abuse impaired persons.
Section 4: Provides the bill shall take effect January 1, 2011, and shall apply to policies and contracts issued or renewed on or after that date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

[49] s. 624.215(2)(k), F.S.
[50] s. 624.215(2)(l), F.S.

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. 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 the bill applies equally to large and small groups, the increase in benefits will have a greater impact on small groups. Employers purchasing small group insurance may incur additional costs through increased utilization and claims costs. Any increased costs will likely be passed through to policyholders in the form of increased premiums.

D. FISCAL COMMENTS:

The Department of Management Services states that since the state's group health insurance plans are in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 there will be no additional fiscal impacts related to the bill.

The Office of Insurance Regulation states that 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 can be absorbed within current resources.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None; however, the Office of Insurance Regulation is concerned that it may have difficulty implementing the bill without specific rulemaking authority.[51]

C. DRAFTING ISSUES OR OTHER COMMENTS:

The Office of Insurance Regulation notes the following technical concerns:[52]

- The Insurance Code does not govern the state group health insurance program – even by narrative cross-reference. Technically correct drafting would dictate that the benefit requirements proposed in this legislation be either replicated within Chapter 110 or at the very minimum, be established by cross reference in those Chapter 110 statutes governing the State Employee Health Insurance Plan.
- [The bill] inserts standards for insurer business practices ("financial incentives," other methods", "quality of care") that are not otherwise defined or governed within the Insurance Code. Quality of care for medical services provided by an HMO is regulated by the Agency for Health Care Administration. Violations of a standard of care by a provider under contract to an insurer are likely to be governed by that practitioner's/facility's licensing board.
- The Office notes the proposal does contain some level of ambiguity related to the "2% trigger" – i.e., it may be more appropriate to further define "increase in costs" to reference experience rating factors, total claims costs or other factors more precisely related to claims expense related to this required benefit.

[51] Office of Insurance Regulation, 2010 Bill Analysis of HB 7, on file with the Health Regulation Policy Committee.
[52] *Id.*

- The HMO conversion statute s. 641.3922(8) will need to be amended to reference s. 627.668.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

None.