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 Regulation Committee

BILL:	SB 182
INTRODUCER:	Senator Crist
SUBJECT:	Coverage for Mental and Nervous Disorders
DATE:	April 15, 2010 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Burgess	BI	**Favorable**
2.	Bell	Wilson	HR	**Favorable**
3.			GA	
4.			WPSC	
5.				
6.				

I. Summary:

The federal Wellstone-Domenici Mental Health Parity and Addiction Equity Act of 2008 requires large group health plans (51 or more employees) 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.

Senate Bill 182 expands the benefits that insurers and health maintenance organizations (HMOs) are required to offer to small and large group policyholders (e.g., employers) for a specific set of mental, nervous, and substance-related disorders. The bill:

- Provides that the benefit limits for specified mental health and substance-related disorders (schizophrenia, psychotic disorders, mood disorders, anxiety disorders, substance abuse disorders, eating disorders, and childhood ADD/ADHD) may not be more restrictive than the treatment limitations and cost-sharing requirements under the plan that are applicable to physical illness and conditions.
- Requires that, for mental health disorders not specified above, the coverage would not be less favorable than for physical illness. However, increased inpatient and outpatient benefit caps would apply. Inpatient care is increased from 30 to 45 days and outpatient benefits are modified from $1,000 a year to 60 visits per year.
- Allows a group health plan to opt out if the application of this law causes an increase in plan costs of more than 2 percent.

Current Florida law provides that small group health plans require a coverage offer that does not require full parity of coverage. These mental health benefits may not be less favorable than those regarding physical illness with respect to durational limits, dollar amounts, deductibles, and

coinsurance factors, except that the policy may contain specified minimum limits on mental health benefits for inpatient, outpatient, and partial 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 in the bill, 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 Statute: 627.668 and 627.6675. The 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.[2]

Mental and nervous disorders exact a high cost on individuals, families, and society as a whole.[3] The financial cost of mental and nervous disorders is also considerably high. In 2003, the President's New Freedom Commission on Mental Health cited data showing the annual economic and indirect cost of mental illnesses was estimated to be $79 billion, and $63 billion of that amount was 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. Therefore, the federal government is the sole regulator of employer sponsored self-insured plans. This means that in Florida, many large group plans, that are often self-funded by employers, fall under federal regulation 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 the McCarran-Ferguson Act.[4]

Florida Mental and 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 offer 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

[1] As defined by the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV).
[2] National Institute of Mental Health, The Numbers Count: Mental Disorders in America, 2008. Found at: <http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml> (Last visited April 15, 2010).
[3] *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 April 15, 2010).
[4] 15 U.S.C. §§ 1011-1015

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 requires 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. Mental health 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 meet the minimum benefit requirements, without making a separate offer of this coverage.

Coverage for the treatment of substance abuse must be made available by insurers and HMOs at the time of application for group health insurance.[5] 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), or approved by the state.

Federal Mental Health Parity Mandate

On October 2, 2008, President George W. Bush signed into law H.R. 1424. The law contains the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The act applies to a group plan of 51 or more employees. The act preempts all state laws that apply to the same group health insurance policies (large group plans) while allowing for state laws to expand upon the federal mandate. Thus, any state parity legislation regarding group health insurance will apply to only 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. The act became effective on October 3, 2009. It applies to policies issued, delivered, amended, or renewed after this date. For calendar year plans, the effective date was January 1, 2010.

The act requires group health plans to provide full parity between mental health benefits and benefits for other medical conditions. The act prohibits plans from imposing financial requirements or treatment limitations on mental health benefits that are more restrictive than the most common requirements and limitations imposed on medical and surgical benefits. These parity requirements apply to substance use disorder benefits. Parity in financial requirements includes: deductibles; copayments; coinsurance; out-of-pocket expenses; and annual and lifetime limits. If no limit is applied to medical and surgical benefits, then a limit may not be applied to mental health benefits. Treatment limitations include limits on the frequency of treatment,

[5] Section 627.669, F.S.

number of visits, days of coverage or similar limits on the scope or duration of treatment. Parity is required for both in-network and out-of-network benefits.

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."[6] 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. 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.

The federal act exempts employers who 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 who 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 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 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.

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

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).[7] 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, that 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., to expand the benefits provided pursuant to the requirement in current law that each insurer, HMO, nonprofit hospital, and medical service plan corporation transacting group health insurance or providing prepaid health care make available group policyholders coverage for mental and nervous disorders. The section provides that, with respect to the state group insurance program, the term, "policyholder," means the State of Florida.

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 APA. 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 generally cannot be less favorable than for physical illness. 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 with regard to:

- Durational limits;
- Dollar amounts;

[7] http://www.flsenate.gov/data/Publications/2008/Senate/reports/interim_reports/pdf/2008-103bi.pdf (Last visited on April 15, 2010).

- 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 – the DSM diagnostic grouping that includes depressive disorders and bipolar disorders.
- Anxiety Disorders – the DSM diagnostic grouping that includes panic disorders, phobias, obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), and generalized anxiety disorders.
- Substance Abuse Disorders – the 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, and 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 – the 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 allows an insurer or HMO to 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 **–** The bill provides that the provisions of s. 627.668, F.S., do not apply 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 (OIR). This provision will exempt a plan from all the requirements of the section, not only the parity requirements.

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

Section 3. Repeals s. 627.669, F.S., that currently requires insurers and HMOs to offer optional coverage for the treatment of substance abuse within group health insurance or prepaid health care plans, 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.

Current law contains the following requirements for this 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.

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. 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 4. Provides that this act is effective January 1, 2011, and applies to policies and contracts issued or renewed on or after that date.

Other Potential Implications:

On March 23, 2010, the federal Patient Protection and Affordable Care Act was signed into law. Some of the provisions in the Act:
- Substantially modify the federal laws relating to health insurance coverage, such as provisions to provide tax credits for small employers that provide health insurance to their

employers, prohibitions on imposing pre-existing condition exclusions on children, the establishment of an interim high-risk pool program, assistance to states to provide health insurance consumers information, and the establishment of a health insurance exchange; and

- Substantially modify the Medicaid program and the Children's Health Insurance program, and support the development of the health care workforce.

The effect of the new federal insurance requirements on the provisions of this bill is not yet clear.

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 Art. I, s. 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.

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 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 of coverage, which does not require full parity of coverage. Thus, even though SB 182 will apply equally to large and small groups, the increase in benefits created by the 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:

Effective January 1, 2010, the federal 2008 mental health parity act applies 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 Senate Bill 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 OIR 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; however, it is expected that the increase in workload may be absorbed within current resources.

VI. Technical Deficiencies:

The bill permits insurers to engage in currently authorized contract provisions that permit an insurer to offer financial incentives, peer review, utilization requirements, and "other methods" used for benefit management – intended to "reduce service costs…without compromising quality of care." This language inserts standards for insurer business practices (financial incentives, other methods, and 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 (AHCA). 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 authority.

This bill allows insurers to file for an exemption if the coverage results in an increase of more than 2 percent in the cost of coverage as determined by actuaries at the OIR. It is unclear to what the 2 percent trigger applies – the premium, to certain rating factors, to total claims, etc. 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.

The federal act allows for 2 percent in the first plan year and 1 percent in the case of each subsequent plan year. If an insurer seeks an exemption, such exemption shall be made after the plan has complied for the first 6 months of the plan year involved and must provide specific data. A plan or issuer that qualifies for and elects to implement the cost exemption must promptly notify the Secretaries of Labor, Health and Human Services, and the Treasury (as appropriate), the appropriate state agencies, and participants and beneficiaries in the plan.

The HMO conversion statute, s. 641.3922(8), F.S., will need to be amended to reference the newly created s. 627.668, F.S.

VII. Related Issues:

Section 624.215, F.S., requires every person seeking consideration of a legislative proposal mandating health coverage to submit to the AHCA 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. These 2009 bills are substantially similar to the 2010 SB 182. 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?* – 26 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 them 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 35 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 2 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.)

None.

B. Amendments:

None.