# SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

Date: February 17, 1998 Revised: _____ _____ _____ _____

Subject: Health Insurance

| | Analyst | Staff Director | Reference | Action |
|---|---|---|---|---|
| 1. | Johnson | Deffenbaugh | BI | Favorable/CS |
| 2. | | | WM | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |

## I. Summary:

The bill creates the "Diane Steele Mental Illness Insurance Parity Act" which requires large group insurers and health maintenance organizations to provide coverage for serious mental illnesses and benefits generally at the same level provided for physical illness, except that coverage may be limited, annually, to 45 inpatient days and 60 outpatient visits. Serious mental illness means the following psychiatric illnesses, as defined by the American Psychiatric Association in the most current edition of the Diagnostic and Statistical Manual: schizophrenia, schizoaffective disorder, panic disorder, bipolar affective disorder, major depressive disorder, and specific obsessive compulsive disorder.

This mandate would not apply to insurers and health maintenance organizations issuing individual policies and any group health plan of a small employer (50 or fewer employees), as defined in s. 627.6699.

An insurer or health maintenance organization (HMO) is authorized to require that the covered services are provided by an exclusive provider of health care and may enter into capitated contracts with exclusive providers of health care to provide benefits. The insurer or HMO is authorized to impose financial incentives, peer review, and utilization requirements to reduce service costs and utilization without compromising quality of care.

If the application of the mental health insurance parity requirements to a group health plan or health insurance coverage results in an increase in actual claims experience costs of at least 2 percent for at least six months, as determined by the Department of Insurance, the plan or coverage is exempt from the provisions of the bill.

This bill substantially amends section 627.668 of the Florida Statutes. This bill creates section 627.6681 of the Florida Statutes.

## II. Present Situation:

Nationwide, it is estimated that 1 in 5 individuals need mental health care services each year. In Florida, it is estimated that approximately 3 percent of the population, or approximately 400,000, suffers from severe mental illness. While Florida ranks 9th in total state mental health expenditures, it ranks 42nd in per capita state expenditures for mental health services (Florida Mental Health Institute, report entitled, *Mental Health Parity*).

Historically, treatments for mental illness and nervous disorders have been provided primarily through hospitalization or through office visits. The level of insurance coverage appears to be an essential factor in the choice and level of treatment sought by a patient. Insurers have tended to provide substantially reduced benefits of treatment for mental problems, as opposed to physical conditions, to reflect the difficulty in determining the appropriateness of care, particularly in treating illnesses for which the symptoms are subjective.

The debate over this issue centers on the contention, often made by insurers and others, that psychiatric conditions are not well defined, and thus are difficult to control. Advocates and mental health practitioners represent that medical knowledge of these conditions has advanced considerably in recent years, and that physicians are able to diagnose and chemically treat them with high levels of success.

In response, mental health parity legislation has been recently enacted in some states for a limited number of specified illnesses. California requires coverage for schizophrenia, schizo-affective disorder, bipolar disorders, delusional depressions, and pervasive developmental disorders. Colorado mandates coverage for biologically based mental illness, which is defined as schizophrenia, schizo-affective disorder, bipolar affective disorder, major depressive disorder, obsessive-compulsive disorder, and panic disorder. In contrast, some states provide coverage for a broader range of mental illnesses, such as 1) diagnoses listed in the International Classification of Diseases Manual and the Diagnostic and Statistical Manual of Mental Disorders (Arkansas), 2) any mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia, and other psychotic disorders, obsessive compulsive disorder, panic disorder, and pervasive developmental disorder or autism. (Connecticut), and 3) serious mental disorder that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the illness and includes, but is not limited to: schizophrenia, schizoaffective disorder, delusional disorder, bipolar affective disorders, major depression, and obsessive compulsive disorder (Rhode Island).

Many states have enacted mental health parity legislation that allows insurers to manage mental health benefits by cost containment measures commonly used for physical conditions, such as pre-

admission screening, pre-authorization of services, and other medical necessity determinations. For example, Arkansas law defines "medical necessity" as: 1) reasonable and necessary for the diagnosis or treatment of a mental illness, or to improve, maintain or prevent further deterioration of functioning resulting from such illness or developmental disorder; 2) service is furnished in the most appropriate and least restrictive setting in which services can be provided; 3) the most appropriate level or supply of service which can be safely provided; 4) and could not have been omitted without adversely affecting the individual's mental and/or physical health or the quality of care rendered.

California initially enacted legislation in 1989, and later amended in 1992, that allows an insurer to reserve the right to confirm diagnoses and to review the appropriateness of specific treatment plans as to medical necessity. Maine enacted legislation in 1995 that requires a provider to furnish data substantiating that initial or continued treatment is medically necessary and appropriate, using the same criteria for medical treatment for mental illness as for medical treatment for physical illness, upon request by the insurer or HMO.

Arkansas law also provides that an insurer, at the insurer's option, may provide coverage for a health service, such as intensive case management, community residential treatment programs, or social rehabilitation programs, which is used in the treatment of mental illnesses or developmental disorders, but is not generally used for other injuries, illnesses, and conditions.

***Federal Law***

In 1996, the federal Mental Health Parity Act was enacted. The provisions of this act apply to group health plans and group health insurance coverage offered in connection with a group plan. The Act requires a plan that provides both medical and surgical benefits and mental health benefits to establish the same annual and lifetime dollar limits on mental health benefits, as provided for non-mental health benefits. Mental health benefits are defined to mean, with respect to mental health services, those benefits as defined under the terms of the plan or coverage, but not benefits with respect to treatment of substance abuse or chemical dependency.

Exceptions and exemptions for the application of the act are provided. Small employers (2-50 employees) are exempted from the provisions of this act. Moreover, the provisions of the Act do not apply if the implementation would result in an increase in the cost of the plan of 1 percent or more. The act is silent as to how this exemption would be determined, i.e., projected or actual claims' experience.

The Act specifically states that the provisions do not require a group health plan, or health insurance coverage offered in connection with such a plan, to provide any mental health benefits. In addition, the act does not affect the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits.

The Mental Health Parity Act is added to the requirements in the Employee Retirement Income Security Act (ERISA) and the Public Health Services Act, as amended by the Health Insurance Portability and Accountability Act. The Mental Health Parity Act's enforcement requirements are those of HIPAA. The federal Mental Health Parity Act is effective, with respect to group plans, for plan years beginning on or after January 1, 1998. However, the Act will not apply to benefits for services provided on or after September 30, 2001.

***Florida Law***

In Florida there is no statutory requirement that mandates the inclusion of mental health or substance abuse treatment benefits for health insurance coverage. If an individual in Florida has health insurance through a group plan, the individual may or may not be covered for mental health or substance abuse services, depending on whether the employer offers a plan that includes such coverage. However, Florida law presently requires insurers and health maintenance organization to offer the option of coverage for mental illness or nervous disorders to the group policyholder (e.g., employer). Section 627.668, F.S., provides that insurers and health maintenance organization (HMO's) make available at the time of application for group health insurance, the option of coverage for mental illness or nervous disorders. Insurers are authorized to charge an appropriate additional premium, under a group hospital and medical expense policy, a group prepaid policy, or a hospital and medical service contract. The type of mental illnesses or nervous disorders that may be covered are as defined in the standard nomenclature of the American Psychiatric Association (APA). The Department of Insurance rules require that the definition of "mental or nervous disorders" included in individual health insurance policies shall not be more restrictive than a neurosis, psychoneurosis, psychopathy, psychosis, mental or emotional disease disorder of any kind (Rule 4-154.104, F.A.C.).

The Florida standard and basic small group plans define "mental and nervous disorder" as any and all disorders set forth in the diagnostic categories of the most recently published edition of the APA's Diagnostic and Statistic Manual of Mental Disorders, regardless of the underlying cause, or effect, of the disorder. The law requires an insurer to offer a range of coverages from which the applicant may select. Coverage for inpatient hospital benefits may not fall below 30 days per year, and outpatient benefits may be limited to $1,000, payable to any mental health professional licensed under chapter 491. Insurers may separately price the coverage, and may vary the benefits according to whether treatment is for inpatient or outpatient services or hospitalization.

***Staff Interim Project Findings and Recommendations***

In October 1997, the Committee on Banking and Insurance issued a staff report entitled, *Access to Health Insurance* that addressed concerns regarding access to health insurance coverage and a related concern regarding the extent to which coverage for mental illness is generally less favorable than coverage for physical illness. The following is a summary of findings and recommendations noted in the report.

The term “mental health parity” refers generally to insurance coverage for mental health (and sometimes substance abuse) services that is subject to the same benefits and restrictions as coverage for other health services. Parity laws are aimed at correcting the limited health insurance coverage of mental health care that emerges in the insurance market. The extent to which such limitations are corrected varies from state to state. In many cases, parity legislation, including the limited parity law passed by Congress in 1996, could be characterized as moving toward equality between mental health/substance abuse benefits and benefits for other illnesses.

The push for parity has come in response to market conditions that have led to significantly different insurance benefits and restrictions for mental health/substance abuse treatment. Coverage for mental health and substance abuse treatment is generally subject to higher deductibles and copayments (cost sharing), lower limits on the number of covered visits and inpatient days, and lower annual and lifetime limits than for physical illness. These mental health coverage restrictions are the result of insurance companies’ response to two main consumer behavior patterns: increased demand for services in response to health insurance plan generosity and adverse selection by consumers who are high users of mental health services of plans with more generous mental health benefits.

The first consumer behavior pattern produces increased demand for mental health services in response to plan generosity. In general, the lower the out-of-pocket price of services, the higher the demand for those services. If the out-of-pocket costs are reduced or the limits on visits are reduced, the insurer can expect a greater demand for mental health services than for medical or surgical services. This increased demand leads to higher utilization and higher insurance plan costs.

The second consumer behavior pattern occurs in markets where there is a choice of several health insurance plans with different mental health benefits. Consumers will choose the plan that best serves their actual or expected needs. Consumers who are high users of mental health services have a strong incentive to choose plans with more generous mental health coverage. This results in certain plans disproportionately attracting higher cost populations (adverse selection). This results in higher costs for those plans.

Insurers also cite the difficulty in determining appropriateness of care, particularly in treating illnesses for which the symptoms are subjective. Critics also question the increasing number of disorders characterized as mental illness in the Diagnostic and Statistical Manual of Mental Disorders, particularly behaviors once attributed to character flaws. Use of the manual for purposes of reimbursement creates incentives for defining new mental disorders. This later concern is true, to a certain extent, for other illnesses also.

If an individual is not obtaining health insurance through an employer-based group policy, but is buying individual coverage, the issue is primarily one of affordability. Individual policies that provide coverage for mental health and substance abuse benefits are available but, because of the likelihood that individuals will not buy such coverage unless they need it, the premiums are higher than many people can afford.

The Department of Insurance conducted an informal poll of some of the major insurance carriers in the small group and large group markets (both HMO products and indemnity products) to determine what mental health benefits are included in the most commonly sold products. There are considerable variations in the market, but for purposes of this report the mental health benefits most commonly being sold are summarized below as being "typical" mental health coverage in the private insurance market.

*Small Group Market - HMO Products*

- 30 inpatient days per year (one plan had a 10-day limit) (some plans have a $100 per day copayment for the first 5 days of hospital confinement)
- 20 outpatient visits per year (one plan covered 30 visits) ($1,000 maximum per year) (copayments vary from no copayment to $10 per visit to $25 per individual therapy visit and $10 per group therapy visit)
- types of diagnoses and services covered vary widely

*Small Group Market - Indemnity Products*

- 30 inpatient days per calendar year
- outpatient visits capped at $1,000 per calendar year (one company capped inpatient and outpatient at $1,000 per calendar year)
- lifetime maximums (one company had a $10,000 lifetime maximum and one company had a $50,000 lifetime maximum for combined inpatient and outpatient)

*Large Group Market - HMO Products*

- 30 inpatient days per year (one company had a $150 copayment for days 1-7) (one company had a $100 per day copayment for the first five days)
- 20 outpatient visits per year (one company had 30 outpatient visits per year) (copayments ranged from no copayment, to a variable copayment by group up to $25, to a $25 copayment for each individual therapy visit and $10 copayment for each group therapy visit)
- types of diagnoses and services covered vary widely

*Large Group Market - Indemnity Products*

- 30 inpatient days per year (one company had 31 days) (one company had a lifetime maximum of $50,000 for combined inpatient and outpatient) (one company had a $30,000 lifetime maximum and a $10,000 annual maximum)

- outpatient visits capped at $1,000 per calendar year (one company had a $4,000 cap per calendar year with a lifetime maximum of $50,000 for inpatient and outpatient combined) (one company had a limit of 50 outpatient visits per calendar year with a $150 deductible and 50/50 coinsurance payable at $35)

The State of Florida Employees' Group Health Self Insurance Plan has the following benefit limitations for mental or nervous disorders and alcoholism or drug addiction that are more restrictive than for other illnesses. Inpatient treatment is limited to 31 days during a calendar year (unlimited days for other illnesses). Payments for outpatient treatment of an insured under an approved alcohol and drug abuse program may not exceed $2,000 during a calendar year (no annual limits for outpatient treatment for other illnesses). Payment for inpatient services related to alcoholism or drug addiction may not be made in the same calendar year that payment for outpatient services for alcoholism or drug addiction is made, unless inpatient treatment is for the necessary detoxification of the insured prior to beginning outpatient treatment. Payment for covered inpatient and outpatient medical/surgical services and supplies and hospital outpatient services related to alcoholism, drug addiction or mental or nervous disorders may not, when combined, exceed $2,000 during a calendar year (no annual limits for outpatient treatment for other illnesses).

The Florida Healthy Kids mental/behavioral health benefits include the following limitations. There is a $20,000 lifetime limit for mental/behavioral health benefits compared to a $1 million lifetime limit for other illnesses. The length of stay for all hospital inpatient admissions is determined on the medical condition of the patient in relation to the necessary and appropriate level of care. However, there is a 15-day limit per contract year for psychiatric admissions and admissions for alcoholism and drug addiction are limited to pregnant adolescents. There is a similar 15-day limit per contract year for admissions for rehabilitation and physical therapy. Outpatient visits for psychological or psychiatric evaluation, diagnosis, and treatment are limited to 20 visits per contract year. Alcohol and drug abuse detoxification and rehabilitation is limited to pregnant adolescents. There are limits on a number of other (not mental/behavioral health) outpatient benefits, so the limitations on mental/behavioral health benefits cannot be automatically viewed as discriminating against mental/behavioral health (lack of parity).

The financing and delivery of mental health care are undergoing rapid change. There is a significant shift in the health care system from unmanaged care reimbursed on a fee-for-service basis to managed care reimbursed on a capitated or risk-shared basis. In addition, there is a shifting of services-related costs from inpatient care to outpatient care as new therapies (especially new medications) have been developed to provide more effective treatment.

In the last 6 years, fourteen states (Arkansas, California, Colorado, Connecticut, Indiana, Maine, Maryland, Minnesota, Missouri, New Hampshire, North Carolina, Rhode Island, Texas, and

Vermont) have enacted legislation regarding mental health insurance coverage that can be broadly characterized as "mental health parity" legislation. There is significant variation among the laws in these states.

With regard to the cost of mental health parity coverage, few states have had parity requirements in place for long enough to provide experience-based cost figures. Some states have had actuarial studies done to estimate the costs of parity requirements. Estimates of the costs of mental health parity vary widely depending on: the level of mandated mental health benefits or actual market-based mental health coverage that was provided prior to enactment of parity legislation; health insurance market conditions that are unique to each state, such as the number and type of carriers (indemnity and managed care); the market penetration of behavioral managed care; and the range of benefits that are covered under the parity requirements.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has also engaged consultants to evaluate the costs of mental health and substance abuse parity. SAMHSA anticipates releasing its study by late February 1998.

While information about the costs of mental health parity legislation from other states is informative, great caution should be used in applying those estimates or experiences to Florida. States vary considerably with regard to the mandated level of mental health benefits that were in place prior to enactment of parity legislation (a key determinant of the cost to go to parity) and with regard to the benefits that are included in parity legislation.

At a minimum, staff recommended that the Insurance code be amended to conform Florida law to the Federal Mental Health Parity Act, thereby authorizing the Department of Insurance to regulate these provisions that would otherwise be solely enforced by the federal government, principally through the Health Care Finance Administration.

## III. Effect of Proposed Changes:

**Section 1.** Provides that the act may be cited as the "Diane Steele Mental Illness Insurance Parity Act."

**Section 2.** Amends s. 627.668, F.S., relating to optional coverage for mental and nervous disorders required and exemptions, to provide that all of the provisions of the section, except for the confidentiality of records, do not apply to coverage for serious mental illness as defined in the newly created s. 627.6681, F.S.

**Section 3.** Creates s. 627.6681, F.S., relating to required coverage for serious mental illness, to require every insurer and HMO transacting large group health insurance (more than 50 employees) or providing prepaid health care in Florida to provide coverage for the treatment of serious mental illness, which treatment is determined to be medically necessary. Inpatient hospital benefits, partial hospitalization benefits, and outpatient benefits consisting of durational limits, dollar amounts, deductibles, and coinsurance factors are required to be the same for serious

mental illness as for physical illness, generally. However, the insurer or HMO may limit inpatient coverage to 45 days per year and may limit outpatient coverage to 60 visits per year.

Serious mental illness, as used in this section, means the following psychiatric illnesses as defined by the American Psychiatric Association in the most current edition of the Diagnostic and Statistical Manual: schizophrenia, schizoaffective disorder, panic disorder, bipolar affective disorder, major depressive disorder, and specific, obsessive-compulsive disorders.

An insurer or HMO is authorized to require that the covered services are provided by an exclusive provider of health care and may enter into capitated contracts with exclusive providers of health care to provide benefits. The insurer or HMO is authorized to impose financial incentives, peer review, and utilization requirements to reduce service costs and utilization without compromising quality of care.

If an insurance or HMO demonstrates that the application of the mental health insurance parity requirements to a group health plan or health insurance coverage results in an increase in actual claims experience costs of at least 2 percent for at least six months, as determined by the Department of Insurance, the plan or coverage is exempt from the provisions of the bill.

**Section 4.** Amends s. 627.6472, F.S., to require each exclusive provider organization that offers a group plan within Florida to comply with s. 627.6681, F.S.

**Section 5.** Amends s. 627.6515, F.S., to require each out-of-state group, blanket, and franchise health insurance policy that offers a group plan within Florida to comply with s. 627.6681, F.S.

**Section 6.** Amends s. 641.31, F.S., to require each group HMO contract to comply with the provisions of s. 627.6681, F.S.

**Section 7.** Appropriates to the Department of Insurance, for fiscal year 1998-1999, one full-time equivalent position and $38,288 from the Insurance Commissioner's Regulatory Trust Fund to implement the provisions of this bill.

**Section 8.** Creates legislative intent that the bill fulfills an important state interest in promoting the relief and alleviation of health or medical problems that affect a significant portion of the state's population, improving the quality of care for such persons, and ultimately resulting in more cost-efficient and effective treatment.

**Section 9.** Provides that the Act takes effect January 1, 1999, and applies to any policy issued, written, or renewed in Florida on or after such date.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Inasmuch as this bill may require the state and local governments to incur expenses, that is, to pay additional employee health insurance costs, the bill falls within the purview of Article VII, Section 18 of the Florida Constitution, which provides that cities and counties are not bound by general laws requiring them to spend funds or to take an action which requires the expenditure of funds unless certain specified exemptions or exceptions are met. The law is binding on counties and municipalities if the Legislature determines that the law fulfills an important state interest. The bill requires similarly situated persons (private employee health care coverage) to comply with the provisions of the bill and states that the act fulfills an important state interest.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

## V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The implementation of the bill would expand and improve the treatment of persons with serious mental illness. The current limited coverage for mental illness in many health insurance policies acts a disincentive for an individual to seek treatment. The Florida Mental Health Institute has estimated that approximately 146,000 individuals suffering from severe mental illness would benefit from the parity bill provisions in Florida.

Insurers will incur increased cost for providing greater limits of coverage beyond the coverage offered today. As mentioned in the Present Situation, the Federal Mental Health Parity Act is effective for plans years beginning on or after January 1, 1998 for group plans with 50 or more employees (insurers, HMOs, and the state employees insurance program, if the plan does not meet the 1 percent exemption).

The Congressional Budget Office estimated implementing the federal Mental Health Parity Act would result in an increase of 4.0 percent on private health insurance premiums. The

Congressional Research Service estimated that indemnity plans would experience an increase of 5.3 percent (the estimate also assumed coverage for alcoholism and substance abuse). The Association of Private Pension and Welfare Plans estimated that total health plan expenses in a typical preferred provider organization (PPO) plan would experience an increase in the range of 8-11 percent. (Study was based on a bill addressing parity for coverage of severe mental illness.) Another study, conducted by Price Waterhouse, estimated that premiums for fee-for-service plans would increase by 9.9 percent and HMO premiums would increase by 2.9 percent. Another study by RAND evaluated the fiscal impact of implementing parity for 24 managed care plans (for large groups) in the first year noted that insurance costs per enrollee increased only by about $1 per enrollee for the year.

Since the bill would place an additional mandate on employer sponsored health insurance plans, it may increase the number of employers who will opt out of insurance and establish self-insurance plans. In order to control the total costs associated with treating mental illness, employers and insurers may reduce benefit plan maximums in order to control the total costs associated with treating mental illness. The estimated costs of providing such mental illness coverage could increase also due to the factoring in the "pent-up" demand of those who would utilize such insurance-provided services.

According to the Department of Insurance, "While the mandate would certainly benefit persons with serious mental illness, the parity requirement will exert upward pressure on health insurance rates." The department noted that " . . . there will be increased rate impact, but the data is not available to provide an independent estimate."

Insurers ultimately may experience some reduction in total claims associated with certain mental conditions diagnosed. It is also suggested that a reduction in total health care costs may result from the more comprehensive treatment of these conditions, that will approximately equal the increase in treatment costs. According to the Florida Mental Health Institute, the implementation of parity legislation could result in the reduction in the utilization of physical health services. The Institute notes, "There is substantial evidence . . . that both mental health and addictions treatment are effective in reducing the utilization and cost of medical services."

Associations representing mental health practitioners maintain that when the indirect costs are considered that would be avoided by eliminating the treatments for physical conditions associated with 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.

C. Government Sector Impact:

To comply with the federal Mental Health Parity Act, the state self-insurance plan was required to eliminate the $2,000 annual cap on mental health benefits. Consequently, as of

January 1, 1998, in compliance with MHPA, the self-insurance plan no longer has a separate $2,000 limit for mental health benefits.

***1998 Estimated Impact***

The Division of State Group Insurance engaged the actuarial consulting firm of Milliman and Robertson (M & R) to evaluate the fiscal impact of implementing greater mental health parity coverage required by SB 268 on the state employees health insurance program. The differences between current Florida law benefits and the bill were compared.

For the self-insured plan, the actuaries estimated that the implementation of the bill, for the current fiscal year, would be $1.6 million and $2.3 million for fiscal year 1999-2000, and $2.5 million for fiscal year 2000-2001. The impact of the bill on prescription drugs was expected to be negligible. However, these estimates included coverage for a provision in the bill, as originally filed, which required treatment for substance abuse, as well, if a diagnosis of serious mental illness is accompanied by a diagnosis of substance abuse. The estimate provided by M & R also assumed unlimited coverage for inpatient and inpatient days, however, the CS/SB 268 caps inpatient and outpatient days to 45 and 60, respectively, authorizes the use of an exclusive provider of health care, and limits the definition of covered serious mental illness.

According to the Division of State Group Insurance, SB 268 would require group insurance plans and HMOs to cover treatment for serious mental illness in the same manner as treatment for physical illness generally. This would disallow existing limitations in many plans, including the state group health insurance plan. SB 268 would impose requirements that are more stringent than the parity requirements imposed by federal law under the Mental Health Parity Act of 1996 (which abolishes monetary limits, but permits durational limits).

To provide the required level of coverage for “serious mental illness” under both the state self-insured plan and the state HMO contracts in an actuarially sound manner, premium increases would be required. These increases would be in addition to those which may be necessary due to a deficit in the State Employees’ Group Health Self-Insurance Trust Fund. (Rates for the 1998-99 plan year are proposed to increase by about 30 percent to cover a projected $134.5 million deficit. This projected deficit amount *does* include the approximate $3 million in estimated increased costs to comply with the federal Mental Health Parity Act of 1996.)

***Estimated Impact of Parity in Other State Plans***

The state of Texas implemented mental health parity legislation and reported that the average costs of adding mental health coverage for serious mental illness was approximately $2.50 per member per month for the self-insured plan. The plan had approximately 270,000 participants in 1995. This would translate to an additional cost of $675,000 per year.

However, the legislation covers a very limited number of mental disorders (schizophrenia, paranoid and other psychotic disorders, bipolar disorders, major depressive disorders, and schizoaffective disorders).

***Estimated Fiscal on the Department of Insurance***

The Department of Insurance will require the funds described below to administer the provisions of the bill:

| Insurance Commissioner's Regulatory Trust Fund | (FY 98-99) | (FY 99-00) | (FY 00-01) |
|---|---|---|---|
| Recurring: | | | |
| Salaries and Benefits (1 FTE) | $27,556 | $36,741 | $36,741 |
| Expenses | $ 5,181 | $ 5,181 | $ 5,181 |
| Nonrecurring (Expense and OCO) | $ 8,044 | | |

The bill provides an appropriation in the amount of $38,288 and one full-time equivalent position to implement the bill; however, the department has indicated this amount should be increased to $40,781 to incorporate fiscal year 1998-99 appropriation amounts.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

Pursuant to s. 624.215, F.S., every person or organization seeking consideration of a legislative proposal which would mandate a health coverage or the offering of a health coverage by an insurance carrier, health care service contractor, or health maintenance organization as a component of individual or group policies, shall submit to the Agency for Health Care Administration and the legislative committee having jurisdiction a report which assesses the social and financial impacts of the proposed coverage. Such a report was filed with the committee last legislative session for Senate Bill 274.

## VIII. Amendments:

None.