**STORAGE NAME**: h0081.hcs
**DATE**: December 8, 1998

# HOUSE OF REPRESENTATIVES
# COMMITTEE ON
# HEALTH CARE SERVICES
# ANALYSIS

**BILL #**: HB 81

**RELATING TO**: Health Insurance

**SPONSOR(S)**: Rep. Hafner & others

**COMPANION BILL(S)**: SB 302 (s)

**ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE**:
(1) HEALTH CARE SERVICES
(2) INSURANCE
(3) ELDER AFFAIRS & LONG TERM CARE
(4) GENERAL GOVERNMENT APPROPRIATIONS
(5)

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## I. SUMMARY:


This bill creates the “Dianne Steele Mental Illness Insurance Parity Act.” According to the provisions of the act, health insurance contracts must include coverage for the treatment of serious mental illness to the same extent coverage is provided for a physical illness. The act applies to small group and large group health insurance policies and health maintenance organization contracts, including exclusive provider organization contracts. In addition, the act applies to out-of-state group, blanket, and franchise health insurance policies sold within the state. Under such group policies, benefit limits for serious mental illnesses must be the same as for physical illnesses as they relate to inpatient, outpatient, and partial hospitalization benefits, including limits in dollar amounts, duration, deductibles and coinsurance factors.

The bill authorizes health insurers and HMOs to adjust deductibles, coinsurance or limits that apply under the act if the coverage of serious mental illnesses increases annual premiums more than 2.5 percent. Health insurers and HMOs are required to file a rate factor with the Department of Insurance which sets forth in detail any rate increase attributable to coverage for serious mental illnesses.

“Serious Mental Illness” is defined in the act to include any mental illness that is recognized in the edition of relevant manuals of the American Psychiatric Association or by the International Classification of Diseases in effect on October 1, 1999 and affirmed by medical science as caused by a biological disorder of the brain which substantially limits the life activities of the patient. Included in the term are the following diagnoses: schizophrenia, autism, schizo affective disorders, anxiety and panic disorders, bipolar affective disorders, major depression, and obsessive compulsive disorder.

The bill appropriates $38,288 and one FTE from the Insurance Commissioners Regulatory Trust Fund to the Department of Insurance for fiscal year 1999-2000 to fund the provisions of the act. In addition, the bill will increase costs to the state for employee health benefits in the amount of approximately $4.1 million in FY 1999-2000.

II. SUBSTANTIVE ANALYSIS:

A. PRESENT SITUATION:

The Florida Insurance Code currently contains two major provisions related to coverage of mental health. The first of these is s. 627.6685, F.S., which codifies into Florida statutes the provisions of the federal Mental Health Parity Act. In essence, this provision prohibits group health insurance policies and HMOs, excluding small group policies, from placing limits on coverage of mental health conditions which differ from limits of coverage on physical conditions, ***when the policy provides both mental health and physical health benefits***.

A second provision relating to coverage for mental health is contained in s. 627.668, F.S. This section requires group health insurers and HMOs ***to make available to the policyholder, for an appropriate additional premium***, benefits for the necessary care and treatment of mental and nervous disorders. A summary of these statutory provisions follows.

**Mental Health Parity Act of 1996**

On September 26, 1996, the Federal Mental Health Parity Act of 1996 (MHPA) was signed into law, and provides for parity in the application of limits for certain mental health benefits. These limits include:

- Aggregate Lifetime Limits--Where a group health plan (or health insurance offered in connection with such a plan) provides both medical and surgical benefits, and mental health benefits:

  *No Lifetime Limits.* Such plan or coverage may not impose any aggregate lifetime limits on mental health benefits if it does not include such an aggregate lifetime limit on substantially all of its medical and surgical benefits.

  *Lifetime Limits.* If such a plan or coverage does include an aggregate lifetime limit on substantially all of its medical and surgical benefits, the plan or coverage shall either:

  -- Apply its applicable lifetime limits both to medical and surgical benefits, and to mental health benefits without distinction in the application of the limits between these categories of benefits; or

  -- Not include any aggregate lifetime limit on mental health benefits that is less than the plan's applicable lifetime limit for substantially all of its medical and surgical benefits.

  *Different Limits.* In the case of a plan or coverage that is not described above and that includes no or different aggregate lifetime limits for different categories of medical and surgical benefits, regulations shall establish rules that calculate an average aggregate lifetime limit for mental health benefits.

- Annual Limits--

*No Limits.* Similarly, in the case of a group health plan providing both medical and surgical benefits and mental health benefits, a plan which does not include annual limits on all of its medical and surgical benefits may not impose any annual limit on mental health benefits.

*Annual Limits.* A plan which imposes annual limits on its medical and surgical benefits may either:

-- Apply the applicable annual limit without distinction to both its medical and surgical benefits and its mental health benefits; or

-- Not include any annual limit on mental health benefits that is less than the applicable annual limit for any other benefits.

*Different Limits.* In the case of plans which have no or different annual limits on different categories of medical and surgical benefits, regulations shall establish rules that calculate an average annual limit for mental health benefits.

- Exemptions--

  *Small Employer Exemption.* The new law does not apply to any plan or coverage of any employer who employed between 2 and 50 employees during the preceding calendar year, and who employed less than 2 employees on the first day of the plan year.

  *Increased Cost Exemption.* This mental health parity provision shall not apply to a group health plan if the application of the new provision results in an increase in cost of at least 1% under the plan or coverage.

- Separate Application to Each Option Offered--In the case of a plan that offers a participant or beneficiary two or more benefit packages under the plan, the statutory provisions shall be applied separately with respect to each option.

- Construction--

  -- The new law does not require any plan or coverage to provide any mental health benefits.

  -- The new law does not affect any existing terms or 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 such plans, except as specifically provided regarding parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits.

  -- The new legislation also does not apply to benefits for substance abuse or chemical dependency.

- Effective Date--

  -- The MHPA applies to group health plans beginning on or after January 1, 1998.

-- Under a so-called “sunset” provision, the MHPA requirements do not apply to benefits received on or after September 30, 2001.

- There is no separate effective date for collectively bargained plans.

During the 1998 Legislative Session, the Federal Mental Health Parity Act of 1996 was codified into the Florida Insurance Code in s. 627.6685, F.S. It is important to note that the provisions of the Federal Mental Health Parity Act were codified in Part VII of Chapter 627, F.S., which relates to group health insurance policies; therefore these provisions do not apply to individual health insurance policies, small group health insurance policies issued under s. 627.6699, F.S., or out-of-state group policies under s. 627.6515, F.S.

**Potential Shortcomings of the Federal Mental Health Parity Act**

There appear to be several loopholes in the federal Mental Health Parity Act. Companies can still limit specific types of treatments and interventions. For example, a company's health plan may specify that an individual can receive no more than 30 inpatient days in a psychiatric hospital. They could also limit the specific number of outpatient visits per year. Companies can increase the co-payment required at each visit, and can also do so unequally. So while an employee may continue to only have to pay 10% of a medical doctor's bill, the employee still may have to pay 50% to go see a mental heath provider.

The MHPA also allows for companies to opt out of the law. First, companies with less than 50 employees aren't covered by the law. Second, companies who can show that be offering equal access to care for mental health will increase their health-insurance costs by 1% or more are exempted from the law.

**Mandated Option for Mental Health Benefits**

Section 627.668, F.S., relates to optional coverage for mental and nervous disorders. This law requires every insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation transacting group health insurance or providing prepaid health care in this state to make available to the policyholder as part of the application, **for an appropriate additional premium**, benefits for the necessary care and treatment of mental and nervous disorders.

When a subscriber selects this optional benefit under a group health insurance policy or health maintenance contract, benefits, exclusions, or limitations may not be less favorable for mental health than for physical illness generally, except that:

- Inpatient benefits may be limited to not less than 30 days per benefit year as defined in the policy or contract. If inpatient hospital benefits are provided beyond 30 days per benefit year, the durational limits, dollar amounts, and coinsurance factors thereto need not be the same as applicable to physical illness generally.

- Outpatient benefits may be limited to $1,000 for consultations with a licensed mental health professional. If benefits are provided beyond the $1,000 per benefit year, the durational limits, dollar amounts, and coinsurance factors thereof need not be the same as applicable to physical illness generally.

- Partial hospitalization benefits must be provided under the direction of a licensed physician. Alcohol rehabilitation programs accredited by the Joint Commission on Accreditation of Hospitals or approved by the state and licensed drug abuse rehabilitation programs must also be qualified providers under this section. In any benefit year, if partial hospitalization services or a combination of inpatient and partial hospitalization are utilized, the total benefits paid for all such services must not exceed the cost of 30 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 these limits, the durational limits, dollar amounts, and coinsurance factors thereof need not be the same as those applicable to physical illness generally.

**Potential Impact on the Rate of Uninsured**

At the January 6, 1999 meeting of the Health Care Services Committee, Dr. William Custer of Georgia State University, presented data from a study he conducted for the Health Association of America. Dr. Custer's study showed that although the percentage of Americans who obtain health insurance through their employer increased since 1993, the total number of uninsured Americans continues to increase overall. According to Dr. Custer, if current trends continue, and if the country experiences a recession, by the year 2007 as many as 25% of non-elderly Americans could be uninsured. He attributed these increased number of uninsured to the rising cost of health insurance. Dr. Custer presented a chart which shows the effect of specific state insurance regulation on the probability of being uninsured. For example, according to the chart, **mandating coverage of mental health benefits will result in an increase in the rate of uninsured by 5.8%**.

**Prevalence Rate for Mental Illness**

According to a report prepared by the Louis de la Parte Florida Mental Health Institute at the College of Public Health at the University of South Florida, the prevalence rate for an active mental disorder during any one year ranges from 20 percent to 29 percent, with a lifetime prevalence of from 32 percent to 49 percent. In addition, the Institute estimates the prevalence rate for severe mental illnesses ranges from 2.8 percent to 3.2 percent.

**Access to Mental Health Care**

Many Americans lack access to mental health care even when their primary care physicians believe it is medically necessary. According to a survey of over 5,000 primary care physicians (PCPs), conducted by the Center for Studying Health System Change, more than two out of three PCPs report they cannot always or almost always obtain needed high-quality mental health care for their patients. The survey also found physicians report high-quality mental health care is more difficult to get for their patients than many other medical services.

Sixty-eight percent of primary care physicians nationwide say they cannot always or almost always obtain high-quality inpatient mental health care for their patients,

compared with 36 percent of primary care physicians reporting the same level of difficulty obtaining non-emergency medical hospitalizations.

Seventy-two percent of primary care physicians nationwide say they cannot always or almost always obtain high-quality outpatient mental health services. This is four times the percent who report they cannot always or almost always obtain referrals to high-quality medical specialists.

**State Employee Health Benefits**

According to the Division of State Group Insurance, Department of Management Services, the State Employees' PPO Plan, in compliance with the Mental Health Parity Act of 1996, eliminated dollar limits associated with out-patient mental health benefits. The Plan maintained its 31 day inpatient limitation which was in compliance the MHPA. The only difference between coverage for mental illness and substance abuse is that coverage in a non-network specialty facility is limited to the active employee and only for the treatment of substance abuse. State employees' HMO benefits are also in compliance with the MHPA - there is no dollar limit but there is a 31 day inpatient limitation.

B. EFFECT OF PROPOSED CHANGES:

Certain group health insurance subscribers and HMO subscribers will gain access to benefits for serious mental illnesses which are equivalent to the benefits the subscribers receive for physical disorders. However, this will likely result in some increase in premiums for these group health insurance policies and HMO contracts, which may increase the number of uninsured due to employers dropping health insurance benefits.

The state employee PPO and HMO plan designs will be required to abolish the 31 day inpatient limitation when a participant is hospitalized for a serious mental illness.

C. APPLICATION OF PRINCIPLES:

1. Less Government:

a. Does the bill create, increase or reduce, either directly or indirectly:

(1) any authority to make rules or adjudicate disputes?

Yes, the bill gives the Department of Insurance additional rule making authority.

(2) any new responsibilities, obligations or work for other governmental or private organizations or individuals?

Yes, insurance companies and HMOs must comply with the provisions of the act in terms of providing additional benefits to subscribers.

(3) any entitlement to a government service or benefit?

No.

b. If an agency or program is eliminated or reduced:

(1) what responsibilities, costs and powers are passed on to another program, agency, level of government, or private entity?

N/A

(2) what is the cost of such responsibility at the new level/agency?

N/A

(3) how is the new agency accountable to the people governed?

N/A

2. Lower Taxes:

a. Does the bill increase anyone's taxes?

Not directly. Increased tax revenues may be needed in order to pay for any related increased costs for state or local government health benefits.

b. Does the bill require or authorize an increase in any fees?

No, but is does authorize an increase in insurance premiums.

c. Does the bill reduce total taxes, both rates and revenues?

No.

d. Does the bill reduce total fees, both rates and revenues?

N/A

e. Does the bill authorize any fee or tax increase by any local government?

No.

3. Personal Responsibility:

a. Does the bill reduce or eliminate an entitlement to government services or subsidy?

No.

b. Do the beneficiaries of the legislation directly pay any portion of the cost of implementation and operation?

Yes, through increased insurance premiums.

4. Individual Freedom:

a. Does the bill increase the allowable options of individuals or private organizations/associations to conduct their own affairs?

No.

b. Does the bill prohibit, or create new government interference with, any presently lawful activity?

No.

5. Family Empowerment:

a. If the bill purports to provide services to families or children:

(1) Who evaluates the family's needs?

N/A

(2) Who makes the decisions?

N/A

(3) Are private alternatives permitted?

N/A

(4) Are families required to participate in a program?

N/A

(5) Are families penalized for not participating in a program?

N/A

b. Does the bill directly affect the legal rights and obligations between family members?

N/A

c. If the bill creates or changes a program providing services to families or children, in which of the following does the bill vest control of the program, either through direct participation or appointment authority:

(1) parents and guardians?

N/A

(2) service providers?

N/A

(3) government employees/agencies?

N/A

D. STATUTE(S) AFFECTED:

ss. 627.668, 627.6681, 627.6472, 627.6515, and 641.31, F.S.

E. SECTION-BY-SECTION ANALYSIS:

**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 exceptions, to provide that the provisions of the section do not apply to coverage for serious mental illness as defined in the newly created s. 627.6681, F.S. In addition, this section specifies that insurers providing coverage pursuant to this section and s. 627.6681, F.S., (as created in this act) must maintain strict confidentiality regarding psychiatric and psychotherapeutic records submitted to an insurer for the purpose of reviewing a claim for benefits payable under this section.

**Section 3.** Creates s. 627.6681, F.S., relating to required coverage for serious mental illness consisting of the following subsections:

**Subsection (1).** Requires 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. If a diagnosis of serious mental illness is accompanied by substance abuse, treatment for the patient who is dually diagnosed must include, but not be limited to, treatment for substance abuse.

**Subsection (2).** Requires that inpatient hospital benefits, partial hospitalization benefits, and outpatient benefits consisting of durational limits, dollar amounts, deductibles, and coinsurance factors be the same for serious mental illness as for physical illness.

**Subsection (3).** Applies the provisions of this section to small group policies regulated under s. 627.6699, F.S. In addition, the standard, basic, and limited health benefit plan committee created in s. 627.6699(12), F.S., is required by this subsection to submit any recommended modifications of these plans incorporating the requirements of this subsection to the Department of Insurance for approval.

**Subsection (4).** Requires an insurer or health maintenance organization to file with the department a rate factor which details the increase in rates attributable to the coverage specified in this section. If the factor indicates an annual premium rate increase of greater than 2.5 percent, the insurer or HMO may adjust deductibles, coinsurance, or coverage limits to hold annual premium increases to less than 2.5 percent.

**Subsection (5).** Defines "serious mental illness" as any mental illness that is recognized in the latest edition of relevant manuals of the American Psychiatric Association or by the International Classification of Diseases in effect on October 1, 1999, and affirmed by medical science as caused by biological disorder of the brain, and that substantially limits the life activities of the patient. This definition includes, but is not limited to, schizophrenia, schizo affective disorders, delusional disorders, bipolar affective disorders, major depression, and obsessive compulsive disorders. In addition, this subsection authorizes the department to adopt by rule a subsequent edition of the manuals referenced in the foregoing if a subsequent version is substantially similar to the October 1, 1999 version. In addition, this subsection authorizes the department to adopt rules to implement the section, including specifications for rate making. Finally, this subsection authorizes an insurer to require that an insured person be referred for covered services for serious mental illness by a designated health care provider who is responsible for coordinating such services.

**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 1999-2000, 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 an effective date of October 1, 1999, and specifies the act applies to any policy issued, written, or renewed in Florida on or after such date.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE AGENCIES/STATE FUNDS:

1. Non-recurring Effects:

   See item 4.

2. Recurring Effects:

   See item 4.

3. Long Run Effects Other Than Normal Growth:

   See item 4.

4. Total Revenues and Expenditures:

   The bill appropriates $38,288 from the Insurance Commissioner's Regulatory Trust Fund and one FTE to the Department of Insurance for FY 1999-2000 to implement the provisions of the act. Whether these are recurring or non-recurring revenues is not specified.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS AS A WHOLE:

1. Non-recurring Effects:

   See item 3.

2. Recurring Effects:

   See item 3.

3. Long Run Effects Other Than Normal Growth:

   The enactment of this legislation may result in increased costs to some units of local government for coverage of serious mental illnesses. However, the amount of this increase is unknown.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

1. Direct Private Sector Costs:

Premiums for certain group health insurance policies and HMO policies will increase. This premium increase may result in some employers dropping health insurance coverage.

2. Direct Private Sector Benefits:

Certain group health insurance and HMO policyholders will gain access to coverage for mental health related illnesses.

3. Effects on Competition, Private Enterprise and Employment Markets:

Providers of mental health benefits should see increased demand for their services.

D. FISCAL COMMENTS:

The actual increase in health insurance premiums which will occur if this bill is adopted is difficult to determine. According to a report prepared by the Louis de la Parte Florida Mental Health Institute at the College of Public Health at the University of South Florida, relatively few states have sufficient experience to evaluate the impact parity laws have on the utilization and costs of mental health services. In addition, since parity laws differ from state to state, one state's parity structure and resulting cost/utilization outcome is not necessarily applicable to another state. The report estimates the annual cost to the state of Texas for providing coverage for state and local employees with serious mental disorders at $3.47 per person annually. Estimates in Minnesota have placed post-parity premium increases in the costs of health insurance for all state employees at 1 - 2 percent.

The Division of State Group Insurance, Department of Management Services, provided the following information regarding the potential fiscal impact of HB 81 on state government. According to the division's actuary, John Colberg, of Milliman & Robertson, Inc., the bill would increase PPO Plan cost by approximately .7 percent, or $2.3 million for FY 1999-2000. The division projects this same percentage increase on HMO premiums, which would result in increased costs for FY 1999-2000 of $1.8 million. Thus, the total cost to state government for employee health benefits of implementing HB 81 is projected at $4.1 million for the upcoming fiscal year.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

The health insurance mandate of this bill would apparently apply to local government health insurance plans, as described in the fiscal analysis above. This requirement may be deemed to be a general law requiring a county or municipality to spend funds that triggers the application of Article VII, Section 18. Since this expenditure is required to comply with a law that applies to all persons similarly situated, including the state and

local governments, the constitutional provision would allow such a general law if the Legislature determines that the law fulfills an important state interest. The bill includes a provision that expresses this Legislative determination.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that counties or municipalities have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

## V. COMMENTS:

The language in this bill which imposes the mandate to provide mental health parity is cumbersome and difficult to interpret. It is suggested the bill be rewritten for clarity and ease of understanding. Staff has prepared language to accomplish this goal.

## VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

N/A

## VII. SIGNATURES:

COMMITTEE ON HEALTH CARE SERVICES:

| Prepared by: | Staff Director: |
|---|---|
| Michael P. Hansen | Michael P. Hansen |