The Florida Senate

PROFESSIONAL STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

Prepared By: Banking and Insurance Committee

BILL: CS/SB 1834

INTRODUCER: Banking and Insurance Committee and Senator Jones

SUBJECT: Health-Related Disorders/Coverage

DATE: April 23, 2007 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Deffenbaugh	BI	**Fav/CS**
2.			CF	
3.			GA	
4.				
5.				
6.				

I. Summary:

Presently, group insurers and health maintenance organizations (HMOs) are required to *offer* at the time of application for group health insurance, the option of coverage for mental illness or nervous disorders. The law provides coverage for mental illnesses or nervous disorders defined in the standard nomenclature of the American Psychiatric Association. The law provides 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 except for certain limits on the duration and dollar amounts for such benefits, except for certain services or care specified.

The committee substitute significantly revises benefits that insurers and HMOs are required to provide under the coverage required to be offered to group policyholders for mental and nervous disorders by specifying the mental disorders that would be covered. The bill also provides that the such inpatient, partial hospitalization, and outpatient benefits consisting of durational limits, dollar amounts, deductibles, and coinsurance for mental health may not be more restrictive than the treatment limitations and cost-sharing requirements under the plan that are applicable to other diseases, illnesses, and medical conditions.

Presently, insurers and health maintenance organizations (HMOs) are required to *offer* at the time of application for group and individual health insurance, the option of coverage for enteral formulas. The committee substitute revises these requirements by mandating coverage for amino-acid-based elemental formulas, regardless of the method of intake, for the medically necessary treatment of medically diagnosed conditions such as severe multiple allergies, gastroesophageal reflux, and eosinophilic disorders when ordered by a licensed physician.

This bill substantially amends the following sections of the Florida Statutes: 627.42395 and 627.668.

II. Present Situation:

According to the Centers for Disease Control and Prevention (CDC), mental illness is a major and expensive cause of lowered work productivity among working-age adults.[1] In the same report, it was noted that bipolar major depression, bipolar disorder, schizophrenia, and obsessive compulsive disorder are among the top ten leading causes of disability worldwide. According to the American Psychological Association, approximately 44 million people suffer from mental health disorders; however, only a third receive treatment. A lack of insurance and significant costs were the leading factors for not seeking mental health services.[2]

Mental Health Parity
The term "mental health parity" generally refers to insurance coverage for mental health (and sometimes substance abuse) services that is subject to the same benefits and restrictions as coverage for other physical disorders and diseases. Parity laws are aimed at correcting the limited health insurance coverage of mental health care in the health insurance market. Coverage for mental health and substance abuse treatment is generally subject to lower limits on the number of covered office visits, inpatient days, and annual or lifetime dollar amounts to address an insurer's concern about the high costs associated with long-term, intensive psychotherapy, and extended hospital stays. In many cases, parity legislation, including the limited parity law passed by Congress in 1996, discussed below, could be characterized as moving toward equality between mental health and substance abuse benefits and benefits for other illnesses.

Federal Mental Health Parity Act of 1996
In 1996, Congress enacted the federal Mental Health Parity Act.[3] The act's original sunset date was September 30, 2001; however, the act has been extended six times since that time, and is currently set to expire on December 31, 2007.[4]

The provisions of this act apply to group health plans and group health insurance coverage offered in connection with a large group plan (employer based). 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 or physical 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

[1] Pratt LA, Dey AN, Cohen AJ. *Characteristics of adults with serious psychological distress as measured by the K6 scale: United States, 2001-04.* Advance data from vital and health statistics*;* no. 382. Hyattsville, MD: National Center for Health Statistics. 2007.
[2] American Psychological Association website, www.apahelcenter.org.
[3] H.R. 3666, 104th Cong. (1996).
[4] Public Law 109-432.

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.

In 2000, the U.S. General Accounting Office (GAO) evaluated the impact of the federal act.[5] In order to determine employers' compliance and responses to the law, the GAO conducted a survey of 1,656 employers with more than 50 employees offering mental health benefits. Approximately 52 percent of the employers responded. The survey found approximately 14 percent of the employers noncompliant with the law. Although most employers' plans had parity in dollar limits for mental health coverage, 87 percent of those that complied contained at least one other plan design feature that was more restrictive for mental health benefits than for medical and surgical benefits. For example, about 65 percent of plans restricted the number of covered outpatient office visits and hospital days for mental health treatment further than those for other health treatment. It was noted that the federal law had a negligible effect on claims costs. Only 3 percent of employers reported that compliance with the law increased claims costs, and virtually no employers dropped their mental health benefits or health coverage completely since the law was enacted.

The GAO estimate is consistent with estimates provided by the National Advisory Mental Health Council (council) and the Substance Abuse and Mental Health Services Administration (SAMHSA). In 1998, the SAMSHA estimated that the overall parity cost would result in a 3.6 percent increase.[6] In 2000, the council predicted that the federal act would result in a 1.4 percent increase in the total costs of health insurance premiums.

Subsequently, in January 2001, the Federal Health Benefits Program (FEHB) begin offering mental health and substance abuse benefits that were equivalent with general medical benefits. The FEHB program has 8.5 million enrollees. The claims experience was reviewed to evaluate the impact on the service use, total spending, and out-of-pocket spending on mental health. The experience of the FEHB was compared with the claims experience of health plans that did not provide mental parity benefits. The results of the FEHB study indicated that spending in three of the seven plans of the FEHB decreased and spending associated with the implementation of parity decreased significantly for the remaining four plans. It was also noted that, in five of the plans, the parity policy was associated with significant reductions in out-of-pocket spending.[7]

[5] U.S. General Accounting Office, *Mental Health Parity Act Despite New Federal Standards, Mental Health Benefits Remain Limited.* 2000.
[6] National Advisory Mental Health Council. *Insurance Parity for Mental Health: Cost, Access, and Quality.* June 2005.
[7] N Engl J Med 2006:354: 1378-86.

Florida Mental Health and Substance Abuse Coverage

In 1998, the Legislature conformed Florida law to the federal Mental Parity Act, thereby authorizing the former Florida Department of Insurance to enforce such provisions under state law. The law was repealed on September 30, 2001 pursuant to the sunset provision.[8]

Presently, there is no statutory requirement that mandates the inclusion of mental health or substance abuse treatment benefits for health insurance coverage. If an individual 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 requires that group insurers *offer* coverage for mental and nervous disorders and for substance abuse (ss. 627.668 and 627.669, F.S.). If the employer selects a plan that covers mental health services, substance abuse services, or both, then certain statutorily established minimum coverage must be provided or offered.

Section 627.668, F.S., requires insurers and health maintenance organizations to make available at the time of application for group health insurance, the option of coverage for the necessary care and treatment of mental illness and nervous disorders. The types of mental illnesses or nervous disorders that may be covered are as defined in the standard nomenclature of the American Psychiatric Association. An additional appropriate premium may be charged for this coverage. 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, except for the following limits:

- 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.

Section 627.669, F.S., requires insurers and health maintenance organizations to make available at the time of application for group health insurance, the option of coverage for intensive treatment of substance abuse impaired persons that meet certain statutorily prescribed limitations; however, an applicant is free to choose any other benefits offered by the insurer or health maintenance organization. The limitations on benefits include:

- Benefits are available only to covered individuals in a group health plan;
- Minimum lifetime benefit of $2,000;
- Maximum of 44 outpatient visits; and
- Maximum benefit payable for an outpatient visit is $35.

Detoxification is not considered an outpatient benefit. Benefits must be provided by certain licensed providers.

[8] Ch. 98-159, L.O.F.

There are no statutory requirements for the offering of coverage for mental health or substance abuse benefits under individual health insurance policies comparable to the group health insurance requirements. 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.

Mental Health Coverage in Other States

As of January 2007, the National Conference of State Legislators (NCSL)[9] noted that 46 states had enacted some type of law that required mental health parity, mandated mental health coverage; or mandated an offer of coverage for mental health. Seventeen states, require insurers and HMOs to offer such parity coverage. For purposes of mental health coverage, significant statutory variations exist among the state laws in the definition of mental health illness, terms and conditions, and small-employer and cost increase exemptions.

Optional Coverage for Prescription and Nonprescription Enteral Formulas

Presently, s. 627.42395, F.S., requires insurers and health maintenance organizations to offer at the time of application for individual or group coverage, the option of coverage for prescription and non-prescription enteral formulas, which are nutrient and food supplements for the treatment of certain inherited diseases of amino acids and organic acids. Such coverage must include food products modified to be low protein; and the amount of such coverage may not exceed $2,500 per year for any insured individual through age 24.

III. Effect of Proposed Changes:

Section 1 amends s. 627.42395, F.S., to revise coverage requirements for prescription and nonprescription enteral formulas. Currently, insurers and health maintenance organizations are required to offer at the time of application for individual or group coverage, the option of coverage for prescription and non-prescription enteral formulas, which are nutrient and food supplements for the treatment of certain inherited diseases of amino acids and organic acids. Such coverage must include food products modified to be low protein; and the amount of such coverage may not exceed $2,500 per year for any insured individual through age 24. The bill amends this section by requiring coverage for amino-acid-based elemental formulas, regardless of the method of intake, for the medically necessary treatment of medically diagnosed conditions such as severe multiple allergies, gastroesophageal reflux, and eosinophilic disorders when ordered by a licensed physician. Unlike the current requirements, these new benefits would not be capped at $2,500 annually and would not be limited to persons age 24 or younger.

Section 2 amends s. 627.668, F.S., to revise the mental disorders that would be covered in the coverage that is required to be offered to group policyholders. The provides that such coverage would include all diagnostic categories of mental health conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and as listed in the mental and behavioral disorders section of the current International Classification of Diseases. The bill provides a list of the mental orders that would be covered. The bill removes the current benefit

[9] State Laws Mandating or Regulating Mental Health Benefits. http://www.ncsl.org/programs/health/mentalben.htm.

limitations by requiring that such mental health services be provided for inpatient, outpatient, and partial hospitalizations consisting of durational limits, dollar amounts, deductibles, and coinsurance factors may not be more restrictive than the treatment limitations and cost-sharing requirements under the plan that are applicable to other diseases, illnesses, and medical conditions.

Under current law, 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, except for the following limits:

- 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 also requires such coverage to provide for the necessary care and treatment of mental and nervous disorders, as defined in the standard nomenclature of the American Psychiatric Association (APA). The bill limits such coverage to medically necessary care and treatment and eliminates the term, "necessary care and treatment" for purposes of this coverage. The APA reference for defining which mental disorders are covered is deleted and replaced with references to mental health conditions listed in the Diagnostic and Statistical Manual and the International Classification of Diseases.

The Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV-TR), published in 2000 by the APA, contains a listing of psychiatric disorders and their corresponding diagnostic codes. The DSM-IV-TR diagnostic codes are limited to those contained within the ICD-9-CM coding system.

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is the official coding system of the United States. The ICD-9-CM is a listing of diagnoses and identifying codes used by physicians for reporting diagnoses. The coding and terminology provide a uniform language that can accurately designate primary and secondary diagnoses and provide reliable, consistent communication on claim forms. The ICD-9-CM is designed for the classification of morbidity and mortality information for statistical purposes, for the indexing of hospital records by disease and operation, and for data storage and retrieval. The ICD-9-CM system is required by most governmental agencies and private insurers.

The bill states that, for a group plan that offers a participant two or more benefit package options, the requirements of the bill must be applied separately to each option.

Section 3 provides that this act will take effect on January 1, 2008, and apply to policies and contracts issued or renewed on or after that date.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The implementation of the bill would expand the coverage for the treatment of mental disorders for persons buying this optional coverage. The current limited coverage for mental illness in many health insurance policies or HMO contracts acts as a financial disincentive for an individual to seek treatment.

Proponents of the bill, 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 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.

Insurers may incur increased cost for providing greater levels of coverage beyond the coverage offered today. However, proponents contend that insurers and HMOs 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, which 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."[10]

[10] Florida Mental Health Institute. *Mental Health Parity: 1998 National and State Perspective*. 1998.

Employers and employees may incur increased costs for additional premiums, copayments, and deductibles associated with the benefits required under this optional coverage.

See Present Situation for summaries of studies on the cost of mental health parity coverage.

Individuals required to use enteral formulas due to chronic health conditions will benefit from the expanded insurance coverage for amino-acid based elemental formulas, regardless of the method of intake, provided in the bill. Such persons will incur less out-of-pocket expenses due to such coverage, which does not have any annual dollar limits or age limits for purposes of eligibility.

The fiscal impact of expanding the coverage for enteral formulas is indeterminate. According to proponents of this coverage, the prevalence rate for babies needing amino acid based elemental formulas is 0.3 percent or 3 in 1,000 Florida babies.

C. Government Sector Impact:

The Department of Management Services (the department) has indicated that the State Employees Group Health Insurance Program would be required to expand its covered benefits and the associated additional costs to the self-insured PPO and fully insured HMOs would have an indeterminate negative fiscal impact on the State Employees Group Health Self-Insurance Trust Fund.

The Office of Insurance Regulation noted that there is no direct impact on the Office of Insurance Regulation and that the approval of new policy forms and contracts needed to implement this proposal could be absorbed within current resources.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Summary of Amendments:

None.