The Florida Senate

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Committee on Banking and Insurance

THE EFFECT OF MANDATING COVERAGE FOR MENTAL AND NERVOUS DISORDERS

SUMMARY

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. In 2003, The President's New Freedom Commission on Mental Health cited data indicating that in the United States, the annual economic, indirect cost of mental illnesses is estimated to be $79 billion, with $63 billion of that amount the result of lost productivity.

The number of people who do not have health insurance is increasing both nationally and in Florida. According to the United States Census Bureau, 44.8 million Americans did not have health insurance in 2005[2], up from 39.6 million in 2000. The number of uninsured persons in Florida is also rising. A University of Florida study indicates that the number of uninsured Floridians under age 65 rose from 2.1 to 2.7 million people from 1999 to 2004, twice the rate that the population increased during that time. A national survey indicates that the average annual premium for employer sponsored coverage is $4,242 for single coverage and $11,480 for family coverage.

A mandated health insurance benefit either must be provided or offered as part of a health insurance policy. Florida has over 30 mandated benefits. Most states have addressed the issue of insurance benefits for mental and nervous disorders. A wide variety of approaches have been taken that can be classified into three approaches: mandated offer laws, mandated benefit laws, and parity laws. Overall, 46 states have enacted some type of law that takes one of these three approaches. Florida requires insurers to offer employers policies for group coverage that include benefits for the treatment of mental and nervous disorders. Florida's law permits limitations on mental health coverage that are different from those applied to physical illness or surgical coverage so long as the limitations meet the minimum required benefits required by statute. Florida's mandatory offering law is less stringent than those found in other states.

Group health insurance coverage that provides mental health benefits is readily available for purchase in Florida. However, group coverage providing mental health benefits that are on par with benefits for physical and surgical benefits is not readily available for purchase in the state in the small group market.

The majority of studies reviewed for this report regarding the financial impact of mandating coverage for mental health benefits indicate that the impact on premiums is approximately 1 to 3 percent if benefits are managed. Health plans that do not manage health care benefits are likely to see greater cost increases involving benefits for mental and nervous disorders than those that do.

Committee staff recommends that group insurers and health maintenance organizations be required to offer coverage for mental and nervous disorders that is on par with coverage for physical and surgical health care benefits with regard to deductibles, co-payments, annual and lifetime benefits available under the group plan, and the number of visits permitted for outpatient treatment or days for inpatient treatment. The mental and nervous disorders for which coverage must be offered should include biologically based mental and nervous disorders as defined in the most recent edition of the APA's Diagnostic and Statistical manual, and

[1] As defined by the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV).

[2] U.S. Census Bureau News, Friday March 23, 2007. CB07-45.

should include or be limited to schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, and obsessive-compulsive disorder. For mental and nervous disorders not specifically listed in statute, the current requirements of ss. 627.668 and 627.669, F.S., should apply (which allow for specific benefit limitations). A cost exemption is recommended that would exempt group plans from the requirement of offering coverage on par for certain mental and nervous disorders if such coverage would cause a cost increase in excess of a specified percentage.

BACKGROUND

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[3] in any given year. Approximately 6 million people suffer from what can be called a serious mental illness. Around 2.4 million American adults have schizophrenia, 5.7 million American adults have bipolar disorder, and 14.8 million American adults have major depressive disorder.[4]

The symptoms of many mental and nervous disorders are severe and debilitating. Schizophrenia includes symptoms that can involve a loss of contact with reality through hallucinations or delusions, thought disorders such as disorganized thinking or use of neologisms, and unusual physical mannerisms.[5] Schizophrenia is a chronic disorder that needs constant management in order to reduce debilitating psychotic symptoms. Depression affects an estimated 20.9 million Americans, or 10 percent of the population in any given 12-month period.[6] A person suffering from an episode of major depression is likely to experience additional episodes later in life. Bipolar disorder is a form of depression that causes alternating mood swings ranging from euphoria to depression.[7] Severe cases of bipolar disorder during a manic episode can result in poor judgment, unrealistic beliefs in one's abilities, abuse of drugs and alcohol and other symptoms, while depressive episodes result in feelings of hopelessness, fatigue, difficulty thinking, and even suicide.

Mental and nervous disorders exact a high cost on individuals, families, and society as a whole. Mental illnesses are the leading cause of disability in the United States, Canada and Western Europe.[8] The World Health Organization reported in 2002 that suicide causes more deaths worldwide each year than homicide or war.[9] The financial cost of mental and nervous disorders is also large. In 2003, The President's New Freedom Commission on Mental Health cited data indicating that in the United States, the annual economic, indirect cost of mental illnesses is estimated to be $79 billion, with $63 billion of that amount the result of lost productivity.

Health Insurance Market

The number of people who do not have health insurance is increasing both nationally and in Florida. According to the United States Census Bureau, 44.8 million Americans did not have health insurance in 2005[10], up from 39.6 million in 2000. The number of uninsured in Florida is also rising. A University of Florida study indicates that the number of uninsured Floridians under age 65 rose from 2.1 to 2.7 million people from 1999 to 2004.[11] The increase in uninsured is twice the rate that the population increased during that time.[12]

The number of uninsured in Florida is concentrated among certain sizes of employers, racial groups, and age groups. Employees of smaller firms are far more likely to lack health insurance.[13] In Florida businesses

[3] As defined by the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV).
[4] *The Numbers Count: Mental Disorders in America*, National Institute of Mental Health (2006).<www.nimh.nih.gov/publicat/numbers.cfm>
[5] *Schizophrenia*, National Institute of Mental Health (2007). <www.nimh.nih.gov/publicat/schizoph.cfm>
[6] *Depression,* National Institute of Mental Health (2006). <www.nimh.nih.gov/publicat/depression.cfm>
[7] *Bipolar Disorde*r, National Institute of Mental Health (2006). <www.nimh.nih.gov/publicat/bipolar.cfm>
[8] *The World Health Report 2001—Mental Health: New Understanding, New Hope*, World Health Organization (2001); *Achieving the Promise, Transforming Mental Health Care in America*, pg. 3. President's New Freedom Commission on Mental Health (2003).
[9] *World Report on Violence and Health*, World Health Organization (2002).
[10] U.S. Census Bureau News, Friday March 23, 2007. CB07-45.
[11] *Highlights from The 2004 Florida Health Insurance Study* (November 2004). <http://www.doh.state.fl.us/Workforce/CommunityHealthResources/Presentations/FloridaHealthInsReport.pdf>
[12] Statistics provided by the Office of Economic and Demographic Research of the Florida Legislature. The number of Floridians under age 65 increased from 12,802,873 in 1999 to 14,465,164 in 2004.
[13] See Id.

with fewer than 25 employees, the rate of uninsured exceeds 30 percent. Conversely, the rate of uninsured is a good deal smaller in larger firms as the uninsured rate is only 16 percent in firms with 50 to 99 employees and only 5.2 percent in firms with 1,000 or more employees.[14] Racial and ethnic minorities also have higher rates of uninsured than the general population. Ages 16 to 34 have the highest rates of uninsured in Florida.[15]

The rising cost of health insurance is the primary reason the rate of uninsured continues to rise. According to a national survey by the Kaiser Family Foundation, between Spring 2005 and Spring 2006, premiums for employer sponsored health insurance rose by 7.7 percent, another large increase that followed increases of 9.2 percent in 2005, 11.2 percent in 2004, and 13.9 percent in 2003.[16] The average annual premium for employer sponsored coverage according to the survey is $4,242 for single coverage, and $11,480 for family coverage nationally. In a presentation to the Florida Health Insurance Advisory Board, Dr. R. Paul Duncan estimated that the current national average price for typical family health insurance coverage is $12,000.[17]

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 been granted the authority to regulate the business of insurance pursuant to the McCarran-Ferguson Act. However, the Employment Retirement Income Security Act (ERISA) pre-empts the states from regulating employer-based health insurance plans that self-insure by bearing the primary insurance risk.[18] Thus, private sector employees in such employer sponsored self-insurance plans are solely regulated by the federal government. This means that in Florida many large group plans, which are often self-funded by employers, fall under federal regulation. The jurisdictional authority to regulate health insurance plans can be summarized as follows:

- Individual insurance policies—state regulation;
- State/local government employees—state regulation;
- Private sector self insurance plans—federal regulation;
- Private sector group insurance plans—both federal and state regulation;
- Federal employees—federal regulation.[19]

Insurance Coverage Mandates

A mandated health insurance benefit either must be provided or offered. Florida has over 30 mandated benefits. A health insurance mandate may be placed on individual health policies, group health policies, or HMO contracts. However, states cannot place coverage mandates on businesses' self-funded insurance plans because federal ERISA law pre-empts employer-sponsored health coverage from direct state regulation. All of Florida's coverage mandates applying to individual and group health policies are located in chapter 627, F.S., while mandates on HMO contracts are found in both chapters 627 and 641, F.S. Representatives from the Office of Insurance Regulation indicate that this is true in Florida and that the great majority of health plans regulated by the OIR are small group plans with 50 or fewer members.

Many representatives from the business and insurer communities generally oppose insurer mandates. The two primary reasons for this opposition are that mandates increase the cost of insurance and that mandates reduce the availability of affordable options for consumers that have difficulty affording health insurance. State mandates generally affect small groups and individual policies, as large groups are more likely to self-insure and thus be regulated under federal law.

Florida Mental Health 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 make an offer of coverage to the policyholder (employer) for mental and nervous disorders as defined by the American Psychological Association. Florida does not require the inclusion of coverage for mental or nervous disorders. Section 627.668, F.S., contains the requirements for an offer of coverage for mental and nervous disorders. 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

[14] See Id.
[15] See Id.
[16] *Employer Health Benefits 2006 Annual Survey* (Kaiser Family Foundation & Health Research and Education Trust 2006).
[17] R. Paul Duncan, Ph.D., Presentation to the Florida Health Insurance Advisory Board (July 19, 2007).
[18] Patricia Butler, *Erisa Preemption Manual for State Health Policymakers*, pg. 17 (National Academy for State Health Policy 2000).
[19] See Id. at 18.

respect to durational limits, dollar amounts, deductibles, and coinsurance factors. An additional appropriate premium may be charged for the coverage. However, the following minimum limits are placed on mental health benefits:

- 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.

Coverage for the treatment of substance abuse also must be made available by insurers and HMOs at the time of application for group health insurance.[20] 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 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.

Federal Regulation of Mental Health Benefits

In 1996, Congress enacted the Federal Mental Health Parity Act.[21] The act amends ERISA and applies to employer-based large group health plans with over 50 employees. It requires all plans that provide mental health benefits along with medical and surgical benefits to establish the same annual and lifetime dollar limits on mental health benefits as are provided for other benefits. The act does not require a plan to include mental health benefits, but instead places requirements on those plans that do offer such benefits. The act allows for cost sharing, limits on the number of visits or days of coverage, and medical necessity determinations so long as annual and lifetime limits are equal. These allowances permit health plans to utilize inpatient day limits and outpatient visit limits as means to control cost and maintain restrictions on mental health benefit use, thus reducing the degree to which parity of coverage is achieved by the federal statute.[22] The act exempts small employers (with 2-50 employees) and the law's requirements do not apply if their application would result in an increase of 1 percent or more in the cost of the health insurance plan. Treatment for substance abuse or chemical dependency is not included. In 1998, the Florida Legislature conformed Florida law to the federal act, but the Florida law was repealed on September 30, 2001.

Currently, both the U.S. Senate and House of Representatives are considering legislation that would expand upon existing federal legislation. The Mental Health Equity Act of 2007 (Senate 558) does not require that a group health plan provide mental health benefits, but rather places requirements on those plans that do provide such benefits. It states that the limitations applicable to mental health benefits cannot be more restrictive than those applied to substantially all medical and surgical benefits, including deductibles, co-payments, coinsurance, out of pocket expenses, and annual and lifetime coverage limits. Limitations on the number of visits, days of coverage and treatment frequency applied to mental health benefits also cannot be more restrictive than those applied for other types of coverage under a policy. The legislation would only apply to group plans with over 50 employees, and exempts plans from its requirements for a plan year if the plan's cost would increase by 2 percent in the first plan year, or 1 percent in subsequent years. The legislation preempts state regulations applicable to large group health plans with regard to the parity requirements of the bill such as the financial requirements placed on mental health care (including deductibles, co-payments, annual and lifetime limits; etc.), the management of mental health benefits, out of network coverage, and the cost exemptions contained in the legislation.

The Paul Wellstone Mental Health and Addiction Equity Act (House 1424) is similar, but is farther reaching than Senate 558. It requires group health plans to cover the same range of mental illness treatment and addiction treatment as the highest enrollment option under the Federal Employee Health Plan. The coverage of treatment for substance abuse and addiction is included in the House proposal, but not in the Senate bill. Another major difference is that the House bill would not pre-empt any stronger state laws regarding mental health parity, while the Senate bill does pre-empt certain state laws. Finally, the House bill requires group health plans to make public information about the criteria used for making medical necessity determinations along with the reasons for a denial of benefits. At the time of this report, both bills have been heard in committee but have yet to move to the floor of either chamber.

[20] Section 627.669, F.S.
[21] 29 U.S.C. 1185a
[22] *Has Mental Health Parity Arrived?*, Steve Melek, Milliman Health Watch pg. 8 (May 2007).

METHODOLOGY

Staff reviewed various state laws to determine the different types of limitations or requirements for such benefits and how such variations are likely to affect costs and benefits provided. An analysis was made of studies on the effects of requiring mental health benefits and the experience in other states under such requirements. A number of state insurance regulators were contacted, as were provider and insurer groups.

FINDINGS

State Approaches to Mental Health Benefits

Most states have addressed the issue of insurance benefits for mental and nervous disorders. A wide variety of approaches have been taken. These approaches can be classified into three types: mandated offer laws, mandated benefit laws, and parity laws. Among the regulatory approaches to mandated coverage for mental and nervous disorders, mandated offer laws are the weakest and least intrusive regulatory scheme, while parity mandates are the strongest and most intrusive regulatory scheme. A state that seeks to ensure the availability of a high level of benefits for mental and nervous disorders is more likely to enact a parity mandate, while a state that wishes to allow the private market a higher degree of leeway to determine the extent of mental health benefit coverage will either have no regulation on the issue or perhaps enact a mandatory offering law. Within these three approaches a multitude of differences exist in the types of insurance plans and policies to which the statutes apply, the mental illnesses that fall under the state law, and rules regarding deductibles and co-payments. As of January 2007, the National Conference of State Legislators (NCSL) reported that 46 states had enacted some type of law that required parity, mandated mental health coverage, or mandated offers for mental health coverage.

Mandatory Offering Laws—A mandatory offering law requires that coverage for mental and nervous benefits be offered. A mandatory offering law does not require the inclusion of mental health benefits in health insurance policies, but instead seeks to ensure that some level of such coverage is available for purchase by employers or in the individual market. Nine states require a mandatory offer of coverage for mental and nervous disorders. Mandatory offering laws differ in strength depending on whether the mental health coverage offered must achieve parity with coverage for physical and surgical benefits under the plan. Florida's mandatory offering law for group and HMO policies permit limitations on mental health coverage that are different than for physical illness or surgical coverage so long as the limitations meet the minimum required benefits required by statute. Florida's mandatory offering law is less stringent than those found in other states with mandatory offering laws.

Many states that mandate an offer of mental health coverage require parity between the mental health benefits being offered and benefits for physical illness and surgical benefits under the policy. Alabama requires that large groups with over 50 members offer mental health benefits at parity for statutorily specified mental disorders and all mental illnesses specified in the International Classification of Diseases (ICD) produced by the World Health Organization.[23] Georgia's mandated offering law is broader than Alabama's as it also requires coverage for substance abuse and places a mandate on the individual market.[24] However, Florida is not the only state that does not require full parity in its mandated offer requirements. South Carolina's mandate[25] on group policies permits different deductibles and co-payments for mental health coverage and Utah's group and HMO mandate[26] permits restrictions regarding deductibles and co-payments.

Mandatory Benefit Laws—States that require coverage for specified mental and nervous disorders, but allow for differences in the level of benefits provided are classified as mandated benefit states. The differences permitted in a state that has a mandated benefit law often include permitting more restrictive policy terms with regard to deductibles, co-payments, annual or lifetime benefit limits, or limitations in the number of visits or days of inpatient care provided for mental health treatment. Eleven states utilize mandated benefit laws.

Examples of states with mandated benefit laws are Pennsylvania and Texas. The mandated benefit laws in Pennsylvania and Texas require group health plans and HMOs with more than 50 employees to include coverage for "serious mental illness."[27] The laws differ in that Texas requires that co-payments and co-insurance be equal to those for non-mental health benefits, while Pennsylvania simply states that co-payments and co-insurance cannot prohibit access to

[23] Alabama Code s. 27-54-4 (2006).
[24] Georgia Code ss. 33-24-28.1 and 33-24-29 (2006).
[25] South Carolina Code s. 38-71-737.
[26] Utah Code s. 31A-22-625.
[27] Texas Insurance Code 3.51-14.

care.[28] Three other states have a variation of a mandated benefit law whereby certain mental disorders must be covered if a health plan offers any such benefits.[29]

Mandatory Parity Laws—A mandatory parity law requires insurers and health care plans to offer the same benefits for mental and nervous disorders as for physical disorders and diseases. When parity is mandated, the lifetime and annual coverage limits, deductibles, co-payments, and limits on treatment visits for mental health benefits are all required to be the same as applied to physical illnesses. A parity mandate is the strongest mandate that can be required for the coverage of mental and nervous disorders. Twenty-six states have enacted mental health parity laws.

The most recent state to enact a mental health parity law is New York. Referred to as "Timothy's Law," the law applies to all group health plans and requires them to provide a minimum of 30 days of inpatient care and 20 days of outpatient care for mental health benefits per year. Additionally, large group plans with more than 50 eligible employees must provide benefits for "biologically-based mental illness" that are equivalent to benefits for other medical services, thus not allowing for limitations on treatment, co-payments, or co-insurance that differ from what is provided for other medical services. The New York parity mandate, unlike those in many other states, applies to small group policies without exception. Concerns that placing the mandate on small group policies could have a greater negative impact on affordability than its application to large groups have caused the state to subsidize the increased cost to such small groups via a $50 million appropriation.

Ten states utilize what could be called a tiered parity system in which parity exists for some specified mental illness benefits, while for other conditions the coverage is not required or limitations such as higher deductibles are permitted to be applied. An example of a tiered parity state is California, which requires group, individual and HMO insurance policies to include full parity for specified severe mental illnesses.[30] A separate mandated offer for mental or nervous disorders applies to group policies in California. Ohio also recently adopted a tiered parity system, requiring parity for seven "biologically based mental illnesses"[31] while maintaining a separate mandate for plans that offer mental health coverage and also mandating benefits for alcoholism.[32]

Coverage for Mental & Nervous Disorders

A large national survey of employer health benefits by the Kaiser Family Foundation indicates that nearly all covered workers (97 percent) had coverage for mental health benefits in 2006.[33] While most workers have coverage, the same survey indicates that limits on the number of visits for mental health outpatient care and days for inpatient care are a common feature in all health plan types. Additionally, the survey shows that workers in small firms (3-199 workers) are far more likely to have limitations on mental health coverage than workers in large firms—for example, 57 percent of workers in small firms are limited to 20 or fewer outpatient visits per year, compared with 23 percent in larger firms. The Kaiser survey indicates that most workers do have coverage for mental health care benefits, but that it is likely of a more limited nature than for medical and surgical benefits.

Pursuant to a request by staff, the Florida Association of Health Plans surveyed a number of the large insurers that offer plans for sale in the Florida market—with a market share of approximately 70 percent—to determine whether those plans offered coverage for mental and nervous disorders. According to FAHP representatives, all of the plans surveyed offered benefits equal to or better than those required to be offered by Florida law.

Representatives from the Office of Insurance Regulation indicated that insurers are offering mental health coverage as required in Florida law. The great majority of health plans that are regulated by Florida are small group plans with 50 or less employees. The Office indicated that most insurers are only offering the minimum coverage requirements in s. 627.688, F.S. This suggests that group coverage providing mental health benefits is readily available for purchase in Florida, but that group coverage providing mental health benefits that are on par with benefits for physical and surgical benefits is not readily available for purchase in the state in the small group market.

[28] Pennsylvania Statutes s. 634 (2005).
[29] Arizona, Indiana, and Nevada.
[30] California Insurance Code ss. 10125 and 10144.5 (2005).
[31] 2006 Ohio Law Senate Bill 116.
[32] Ohio Code s. 3923.30 (2007).
[33] *Employer Health Benefits 2006 Annual Survey*, Kaiser Family Foundation & Health Research and Education Trust (2006).

Defining Mental and Nervous Disorders

The extent of a law that mandates the provision of benefits for mental and nervous disorders has much to do with how such disorders are defined by statute. Broader definitions of mental and nervous disorders result in a mandate covering a wider array of disorders and providing greater coverage for policyholders, but at a greater financial cost.

An examination of the various state law mandates regarding mental health coverage shows that the majority of jurisdictions refer to the Diagnostic and Statistical Manual of Mental Disorders or the International Classification of Diseases to define the mental or nervous disorders that are covered under a mandate. Two approaches are taken. The first is to list in statute the various illnesses that must be covered. Colorado, Massachusetts, Ohio, and Pennsylvania are examples of states that limit in statute which "biologically based" mental illnesses or "severe" mental illnesses are included under the mandate. The second widely used approach is to refer to mental or nervous conditions as defined by the DSM or ICD. This approach results in a wider range of illnesses being covered by the coverage mandate. Arizona, Connecticut, South Carolina, and Nebraska all use this approach. Most states that have adopted a mental health parity model in recent years list in statute the various illnesses that must be covered. Generally, states that have a parity mandate either list the illnesses that must be covered or at minimum refer to the DSM in defining mental illness. States that only require an offer of coverage for mental or nervous disorders are more likely to allow mental illness to be defined by the terms of the policy or contain a definition that is not exacting, perhaps because employers in such states are not required to purchase such coverage.

The Financial Impact of Mandating Benefits

A number of studies have estimated the financial impact of mandating benefits for mental and nervous disorders. A 2006 study in the New England Journal of Medicine analyzes the effects of the mental health parity mandate that was placed on the Federal Employees Health Benefits Program (FEHB) beginning in January 2001.[34] The study is a useful examination of the effects of a parity mandate on large health insurance plans, and focuses on 7 different plans associated with the FEHB program, which has 8.5 million enrollees altogether. The study's authors indicate that there is no evidence of significant increases in spending in the plans that were analyzed that is attributable to the implementation of parity for mental health benefits. The study also indicates that managed care of mental health benefits appears to be an effective means of controlling costs, as the six plans that managed care had minimal to no cost increases, while the one plan that incurred higher costs did not manage benefits. The conclusion that the study's authors reach is that when coupled with the management of care, implementation of parity for mental health benefits can improve the protection of workers with illnesses without increasing total costs.

The Congressional Budget Office (CBO) cost estimate of the Mental Health Parity Act of 2007 (Senate 558) estimates a small fiscal impact on health plans if the legislation is enacted.[35] The CBO estimates that the legislation would increase premiums for group health insurance by an average of approximately .4 percent among plans that offer mental health coverage. The CBO does indicate that the mandate could result in reductions in the number of employers offering insurance to employees and the number of employees enrolling in employer-sponsored coverage due to this price increase, or reductions in the scope of health insurance benefits under the plan through higher deductibles and co-payments. The CBO estimate indicates that a law similar to Senate 558 will have minimal impact on premiums for large groups offering coverage for mental and nervous disorders.

The Council for Affordable Health Insurance reports on behalf of insurers that a mandate for mental health parity can increase costs from 5 to 10 percent for small group and individual health plans.[36] The CAHI study carried out an actuarial analysis using actuaries from smaller insurance plans and the individual market. A representative from the CAHI indicated to staff that cost management and the design of the plan are important factors affecting the cost increase caused by a mandate for mental health parity.[37] The CAHI representative indicated that a preferred provider

[34] Howard Goldman; et al., *Behavioral Health Insurance Parity for Federal Employees*, New England Journal of Medicine (March 30, 2006).

[35] Congressional Budget Office, *Cost Estimate s. 558 Mental Health Parity Act of 2007* (March 20, 2007).

[36] Victoria Bunce, J.P. Wieske, and Vlasta Prikazsky, *Health Insurance Mandates in the States 2007*, Council for Affordable Health Insurance. <http://www.cahi.org/cahi_contents/resources/pdf/MandatesInTheStates2007.pdf>

[37] Interview with J.P. Wieske, Director of State Affairs for the Council on Affordable Health Insurance (September 5, 2007).

organization style health plan may have greater difficulty containing costs than a HMO.

The National Advisory Mental Health Council reported to Congress in 2000 regarding the expected impact of mental health parity on cost, access, and quality of care.[38] The report estimated a 1.4 percent cost increase in total health insurance premiums due to parity.[39] The estimate given by the report was lower than previous estimates provided by the SAMHSA in 1998, previous NAMHC reports and the 1996 Congressional Budget Estimate, with the cause stated to be a decline in mental health and substance abuse costs during the 1990's due to sharply reduced inpatient utilization in all plans including fee-for-service and preferred provider organization plans. The report noted that a reversion to more costly treatment patterns such as those prevalent during the early 1990s, would more than double the estimated cost of parity.

A 1998 study conducted by Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Human Services indicated that state parity mandates showed minimal premium increases when parity was introduced, when coupled with managed care. The study included surveys of health plans in states that mandate parity (Maryland, Minnesota, New Hampshire, and Rhode Island). Most of the insurers and businesses interviewed in the study indicated that parity laws caused an increase in premiums of one to 2 percent. The parties indicated two main reasons for small total premium increases after mental health parity laws were passed—managed care contained cost increases, and parity represented only a small increase in benefits for some states.

Staff conducted interviews with the personnel in states that have recently passed mental health benefit mandates such as New York, Ohio, Illinois and Oregon. Most representatives from these states indicated that it is too early to know what the ultimate premium impact of the mental health parity mandates in their respective states will ultimately be. However, representatives with the New York Insurance Department stated that thus far, the premium impact on large group policies appears to average approximately a 2 to 3 percent increase, on average. The small group (fewer than 50 employees) mandate—which the state is subsidizing entirely—is preliminarily estimated at around a $4 to $5 increase per member, per month. New York is conducting a two year study on the cost impact of the mandate, at which point the financial impact of Timothy's Law should be known.

A number of states that have passed parity mandates for mental and nervous disorders are conducting studies to determine the impact of such mandates on premiums. However, few of these studies have been completed as of the writing of this report. New York, California and Ohio all are in the process of conducting studies mandated by statute that will analyze the impact of each state's recent laws mandating parity of coverage for mental and nervous disorders.

The majority of studies reviewed for this report regarding the financial impact of mandating coverage for mental health benefits indicate that if benefits are managed, the impact on premiums is mitigated, at a level of 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 not. 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.

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 average family policy will increase by $10 per month or $120 per year. Thus, a two percent cost increase would amount to $20 per month or $240 per year for parity coverage of mental and nervous disorders.

[38] National Institutes of Health *Insurance Parity for Mental Health: Cost, Access, and Quality*, Ruth L. Kirschstein, M.D (NIH Publication No. 00-4787)
[39] See id. at pg. 33

RECOMMENDATIONS

Committee staff recommends that group insurers and health maintenance organizations be required to offer coverage for mental and nervous disorders that is on par with coverage for physical and surgical health care benefits. The financial requirements and treatment limitations applied to mental and nervous disorders should not be more restrictive than those applied to medical and surgical benefits under the plan, including deductibles, co-payments, annual and lifetime benefits available under the group plan, the number of visits permitted for outpatient treatment, or days for inpatient treatment.

The mental and nervous disorders for which coverage must be offered should include biologically-based mental and nervous disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of the American Psychological Association. The list should specifically include, or be limited to, schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, and obsessive-compulsive disorder. For mental and nervous disorders not specifically listed in statute, the current requirements of ss. 627.668 and 627.669, F.S., should apply (which allow for benefit limitations that differ from benefits for physical illnesses).

A cost exemption is recommended that would exempt group plans from the requirement of offering coverage on par for certain mental and nervous disorders if such coverage would cause a cost increase over a specified percentage. If the exemption applied, then the provisions of ss. 627.668 and 627.669, F.S., would apply to the provision of coverage for the biologically-based mental and nervous disorders listed in statute, in addition to other disorders defined in the standard nomenclature of the American Psychiatric Association.