HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 19 Coverage for Mental, Nervous, and Substance-related Disorders
SPONSOR(S): Homan and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 164

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Committee on Health Innovation	6 Y, 1 N	Calamas	Calamas
2) Healthcare Council			
3) Policy & Budget Council			
4)			
5)			

SUMMARY ANALYSIS

House Bill 19 amends s. 627.6688, F.S., to specifically define those mental health conditions that must be covered within the mandated offering, generally including 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 deletes current law limiting mental health benefits by specific service areas, such as inpatient benefits, and inserts a general statement that the mental health benefits may not be more restrictive than the treatment limitations and cost-sharing requirements that are applicable to other diseases, illnesses, and medical conditions.

The bill mandates that the parity requirements be separately applied to each benefit package offered by an employer.

The bill would have an indeterminate negative fiscal impact on the State Employees' Group Health Self-Insurance Trust Fund.

The effective date of the bill is January 1, 2009.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Limited government-The bill increases government's role in private sector health insurance by imposing a mandated offering.

Empower families-The bill may increase access for individuals and families to mental and nervous disorder and substance abuse treatment. Employers choosing to cover mental health and substance abuse services will be required to provide, and individuals and families obtaining health insurance through their employers will only be able to purchase health plans that provide mental health parity in accordance with this bill. Employers and families may incur higher costs when purchasing small group insurance.

B. EFFECT OF PROPOSED CHANGES:

Current Situation

Regulation of Health Plans

Health plans are regulated at both the state and federal level. At the federal level, the Employee Retirement Income and Security Act (ERISA) regulates the operation of voluntary employer-sponsored benefits including pension plans and health plans. Congress also has enacted several laws that regulate the operation of all health benefits regardless of the method insurance including the Health Insurance Portability and Accountability Act of 1996; the Newborns' and Mothers' Health Protection Act of 1996; and the Mental Health Parity Act of 1996.ERISA provides an explicit exemption from state regulation for health plans that are self-funded. State regulations apply to health benefits purchased through private health insurance plans and health maintenance organizations (HMOs).

Health Insurance Mandates and Mandated Offerings

A health insurance mandate is a legal requirement that an insurance company or health plan cover services by particular health care providers, specific benefits, or specific patient groups.

Mandated offerings, on the other hand, do not mandate that certain benefits be provided. Rather, a mandated offering law can require that insurers offer an option for coverage for a particular benefit or specific patient groups, which may require a higher premium and which the insured is free to accept or reject. A mandated offering law in the context of mental health can: require that insurers offer an option of coverage for mental illness, which may require a higher premium and which the insured is free to accept or reject; or, require that if insurers offer mental illness coverage, the benefits must be equivalent to other types of benefits.

Florida currently has at least[1] 48 mandates, ranking 13th highest in the nation for the number of mandates.[2] Those 48 mandates could add as much as 48 percent to the cost of health insurance in Florida.[3] Higher costs resulting from mandates are most likely to be experienced in the small group market since these are the plans that are subject to state regulations. Costs of insurance in Florida

[1] Depending on how liberally the term is defined, an alternate count indicates that there are 51 health insurance mandates in Florida. "Expanding Opportunities for Health Insurance Coverage in Florida" 11, Michael Bond, Ph.D., James Madison Institute; located on March 2, 2008 at http://www.jamesmadison.org/pdf/materials/548.pdf.
[2] "Health Insurance Mandates in the States 2008," Council for Affordable Health Insurance; located on March 2, 2008 at http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2008.pdf.
[3] Id.

average $10,848 per year for a family in the small group market. This amount is somewhat higher than the national average of $9,768[4]

Florida enacted section 624.215, F.S., to take into account the impact of insurance mandates and mandated offerings on premiums when making policy decisions. That section requires that any proposal for legislation that mandates health benefit coverage or mandatorily offered health coverage must be submitted with a report to AHCA and the legislative committee having jurisdictions. The report must assess the social and financial impact of the proposed coverage, including, to the extent information is available, the following:

(a) To what extent is the treatment or service generally used by a significant portion of the population.
(b) To what extent is the insurance coverage generally available.
(c) If the insurance coverage is not generally available, to what extent does the lack of coverage result in persons avoiding necessary health care treatment.
(d) If the coverage is not generally available, to what extent does the lack of coverage result in unreasonable financial hardship.
(e) The level of public demand for the treatment or service.
(f) The level of public demand for insurance coverage of the treatment or service.
(g) The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.
(h) To what extent will the coverage increase or decrease the cost of the treatment or service.
(i) To what extent will the coverage increase the appropriate uses of the treatment or service.
(j) To what extent will the mandated treatment or service be a substitute for a more expensive treatment or service.
(k) To what extent will the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.
(l) The impact of this coverage on the total cost of health care.

Committee staff has not received the report required by section 624.215, F.S., from the proponents of HB 19.

Mental Health Parity

Parity in mental health coverage generally refers to equivalent benefits and limits for mental illness as compared to medical and surgical benefits. According to the United States General Accounting Office, most private health insurance plans limit mental health coverage in three areas:

- Lower annual or lifetime dollar limits;
- Lower service limits, including number of covered hospital days or outpatient office visits; and
- Higher cost-sharing for mental health benefits.

According to the National Conference of State Legislators, 46 states currently regulate the provision of mental health services in three categories:

- Mental health parity;
- Minimum mental health benefits; and
- Mandated mental health offering.

As of 2007, a majority of states now provide full mental health parity.[5]

[4] America's Health Insurance Plans, "Health Insurance: Overview and Economic Impact in the States" November, 2007

Mental Health Parity Act of 1996

Congress enacted the Mental Health Parity Act of 1996 to require group health plans (employer-sponsored and private-sector) that provide medical and surgical benefits to provide the same annual or lifetime dollar limits for mental health benefits. The Act does not, however, require the provision of such benefits. Two exceptions are provided:

- Small employers. The Act does not apply to employers who employed at least 2, but not more than 50, employees during the preceding calendar year.
- Increased cost. The Act does not apply where the result would be an increase in the cost under the plan of at least 1 percent.

The Centers for Medicare & Medicaid Services (CMS) has primary enforcement of the Act in states that do not have legislation that meets or exceeds federal standards, or states that have failed to substantially enforce federal standards. The General Accounting Office has found by nationwide survey that most employers are complying with the Act, with 14 percent reporting that they were not compliant. Data from the private-sector market is not available. The Act expired December 31, 2007, and Congress is currently debating reenactment and revisions.

Mental Health and Substance Abuse Coverage in Florida

Section 627.668, F.S., regulates the provision of mental and nervous disorder services by insurers, health maintenance organizations, and nonprofit hospital and medical service plan corporations providing group health insurance or prepaid health care. Specifically, these entities must make mental and nervous disorder services available to a policyholder for an additional premium. Florida's law is a mandated offering law.

Mental health services must generally include the "necessary care and treatment of mental and nervous disorders, as defined in the standard nomenclature of the American Psychiatric Association."

The Florida mandated offering does not provide full mental health parity.[6] With regard to group policies or contracts, inpatient hospital benefits, partial hospitalization benefits, and outpatient benefits with durational limits, any dollar amounts deductibles and coinsurance factors may not be "less favorable" than those for treatment of physical illness. However, Florida law creates exceptions to parity. Such policies may limit mental and nervous disorder benefits as follows:

- Inpatient benefits may be limited to 30 days per benefit year;
- Outpatient benefits may be limited to $1,000 for consultations with a physician, psychologist, mental health counselor, marriage and family therapist, and a clinical social worker;
- Partial hospitalization benefits must be provided under the direction of a physician, including services offered by a program accredited by the Joint Commission such as alcohol rehabilitation and licensed drug abuse rehabilitation; and
- Partial hospitalization services, or a combination of inpatient and partial hospitalization services, are limited to the cost of 30 days of inpatient hospitalization for psychiatric services, including physician fees.

Section 627.669, F.S., regulates the provision of substance abuse services by insurers, HMOs, and nonprofit health care services plans providing group health insurance or prepaid hospital and medical

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[5] National Conference of State Legislators, State Laws Mandating or Regulating Mental Health Benefits, December, 2007, available at http://www.ncsl.org/programs/health/mentalben.htm.

[6] Prior Florida law imposed a limited mental health parity mandated offering. Section 627.6685, F.S., required parity between mental health benefits and medical/surgical benefits as to lifetime limits and annual limits, if any. The parity requirement expressly did not apply to other terms and conditions, such as cost-sharing, visits or days limits, medical necessity requirements and limits on amount, duration and scope of mental health benefits. The statute did not apply to benefits offered after September 2001, and was repealed in 2005. S. 627.6685(5), F.S.; Ch. 2005-2, § 119, Laws of Florida.

service plan corporations providing group health insurance or prepaid health care. Specifically, these entities must make substance abuse services available to a policyholder. Florida's law is a mandated offering law.

The substance abuse mandated offering does not provide any form of parity with other kinds of coverage. Rather, it requires coverage entities to provide a specific level of benefits, subject to the group policyholder's right to select alternative benefits or level of benefits offered, as follows:

- Minimum lifetime benefit of $2000
- Outpatient visits may be limited to a maximum of 44
- The benefit payable for an outpatient visit shall not exceed $35
- Detoxification shall not be considered an outpatient benefit

Cost of Mental Health Parity

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) within the United States Department of Health and Human Services, four actuarial studies have predicted an increase in health insurance premiums for full parity for mental health benefits. These predictions ranged from 3.2 percent to 8.7 percent.[7] Increased costs are likelier for smaller group plans, as these plans have smaller enrollee pools over which to spread risk. Many studies have examined the effect of mental health parity laws on the cost of health care coverage, with varying results.

For example, the Office of the Insurance Commissioner for the State of West Virginia examined mental health parity in that state. The Office found, of 31 insurance companies studied, four experienced significant cost increases (100 percent, 90 percent or 80 percent) as a result of parity. These companies represented less than 5 percent of the market; other companies experienced small or no increases.[8]

One study analyzed the impact of mental health parity in an unnamed state on a large employer group.[9] That study looked at a fee for service insurer which responded to a state parity mandate by instituting a managed care carve-out for those services. In a managed care carve-out, the insurer carves out the mental health benefits and manages them separately from the physical benefits, perhaps by contracting with a behavioral managed care company to perform that service. The insurer in the study used network management, prior authorization and concurrent utilization review to manage the mental health benefits. The study found that while costs were expected to increase substantially as a result of a state parity mandate, costs actually declined, as a result of managed care techniques. While treatment prevalence rose 50 percent, per member plan costs declined almost 40 percent. The study found this was primarily due to reduced lengths of stay for inpatient treatment, attributable to the managed care carve-out. The study concluded that the increased case management offset the costs of parity's increased benefits. This study looked at a large employer group with over 100,000 enrollees. Smaller group plans will likely experience parity differently.

The Substance Abuse and Mental Health Services Administration (SAMHSA) studied the effect of a parity law for both mental health and substance abuse in Vermont.[10] For one plan, spending for mental health and substance abuse services increased 4 percent; for the other plan which utilized managed care to achieve the purposes of the parity requirement, spending for those services decreased 9 percent. Consumers' share in spending dropped as well. The SAMHSA study found while more

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[7] Merrile Sing, et al, The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits, DHHS Publication No. MC99-80 (1998), Substance Abuse and Mental Health Services Administration, available at http://mentalhealth.samhsa.gov/publications/allpubs/Mc99%2D80/Prtyfnix.asp.

[8] Office of the Insurance Commissioner, State of West Virginia, Mental Health Parity Analysis Report, December 2006.

[9] See Samuel H. Zuvekas, et al, The Impacts of Mental Health Parity and Managed Care In One Large Employer Group, 21 *Health Affairs* 3 (2002).

[10] See Margo Rosenbach, et al, Effects of the Vermont Mental Health and Substance Abuse Parity Law, DHHS Pub. No. (SMA) 03-3822 (2003), Substance Abuse and Mental Health Services Administration, available at http://mentalhealth.samhsa.gov/publications/allpubs/sma03-3822/default.asp.

people received outpatient mental health services under parity, fewer people received any substance abuse services. The Vermont statute specifically authorized a managed care carve-out.[11] Significantly, the SAMHSA study found that managed care for these services was an important factor in controlling the costs of parity.

The Maryland Health Care Commissioner produced a report finding that Maryland's mental health and substance abuse mandate was the most expensive mandate imposed on insurers, with a cost ranging from 4.9 percent to 6.6 percent of the premium.[12] The Commissioner found parity was the second most expensive mandate on a marginal cost basis (after IVF), and noted that the actual cost varies based on the level of managed care or whether a managed care carve-out is used.[13] Older data on Maryland found parity raised costs .6%, which was attributed to high levels of managed care.[14]

The staff of the Senate Banking and Insurance Committee issued an interim project report, The Effect of Mandating Coverage for Mental and Nervous Disorders, (Florida Senate Interim Project 2008-103). After distinguishing between mandated offers and mandated coverage, Senate staff recommended that group insurers and HMOs be required to offer coverage for mental and nervous disorders that is on par with benefits for physical illness, and that any benefit limitations should not be more restrictive than those applied to medical and surgical benefits under the plan. However, the recommendation was to limit this parity requirement to biologically-based mental and nervous disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of the American Psychological Association, including, or specifically limited to, schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, and obsessive-compulsive disorder. For mental and nervous disorders not covered in this category or not specifically listed in statute, the current requirements of ss. 627.668 and 627.669, F.S., should continue to apply, which allow for specified benefit limitations.

The interim project report also recommended a cost exemption that would exempt group plans from the requirement of offering full parity if such coverage would result in a cost increase over a specified percentage. If the exemption applied, then the current requirements and allowable benefit limitations of ss. 627.668, F.S., would apply to all mental and nervous disorders, as defined in the standard nomenclature of the American Psychiatric Association.

Effect of Proposed Changes

House Bill 19 amends s. 627.6688, F.S., to impose a mandated offering for mental and nervous disorders and substance abuse at full parity with coverage offered for other medical conditions. While current law references "necessary care and treatment of mental and nervous disorders, as defined in the standard nomenclature of the American Psychiatric Association" the bill defines those mental and nervous disorders that must be covered within the mandated offering, as all diagnostic categories of mental health conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and those listed in the mental and behavioral disorders section of the current International Classification of Diseases. The bill expressly includes certain disorders:

- schizophrenia
- schizophreniform disorders
- schizo-affective disorders
- paranoid and other psychotic disorders
- bipolar disorders

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[11] See 8 V.S.A. § 4089b (2008).

[12] Maryland Health Commission, Study of Mandated Health Insurance Services: A Comparative Evaluation, January 2008, available at http://mhcc.maryland.gov/health_insurance/required_benefits.html.

[13] Id. Maryland's parity statute specifically authorizes the use of managed care. MD Code, Insurance, § 15-802 (2008).

[14] Bruce Lubotsky Levin, Dr.P.H., et al, Mental Health Parity: National and State Perspectives 1999, Louis de la Parte Florida Mental Health Institute and College of Public Health University of South Florida, available at www.fmhi.usf.edu/institute/pubs/pdf/**parity/parity1999**.pdf.

- panic disorders
- obsessive-compulsive disorders
- major depressive disorders
- anxiety disorders
- mood disorders
- pervasive development disorders or autism
- depression in childhood and adolescence
- personality disorders
- paraphilias
- attention deficit and disruptive behavior disorders
- tic disorders
- eating disorders including bulimia and anorexia
- substance-related disorders
- Asperger's disorder
- intermittent explosive disorder
- posttraumatic stress disorder
- psychosis not otherwise specified when diagnosed in a child under 17 years of age
- Rett's disorder
- Tourette's disorder
- delirium
- dementia

The list appears not to be exclusive; additional disorders might be covered.

The bill imposes full parity by deleting current provisions limiting mental and nervous disorder and substance abuse benefits by specific service areas, such as inpatient benefits, and inserts the requirement that the mental and nervous disorder and substance abuse benefits 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.

The bill maintains current law allowing policyholders to select any alternative benefits or levels of benefits offered by the coverage entity, subject to the minimum level of benefits provided in the statute, but the bill replaces those minimum benefits with the parity requirement. This limits the policyholder's options to either mental and nervous disorder and substance abuse coverage on par with medical benefits, or no mental and nervous disorder and substance abuse coverage at all.

The bill provides 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. This provision requires that parity be measured for each plan separately. The phrase "group health plan that offers" appears to reference the group health plan offered by an employer, which may provide two or more options for employees to choose from. While earlier provisions in the bill clearly address the offer made by the insurer, this language appears to address the offer made by the employer to employees. If that is the case, the language creates a mandated offering for the employer, such that an employer can only offer a health plan with mental health and substance abuse coverage to its employees that has full parity. Unlike the employer's choice (which is between a health plan with parity or a health plan with no mental health and substance abuse coverage), the employee could only choose between a plan with full parity or no health insurance at all.

The bill repeals s. 627.669, F.S., regulating optional coverage of substance abuse services. The bill addresses substance abuse coverage in s. 627.668, F.S., together with coverage of mental and nervous disorders.

Several studies of the financial impact of mental and nervous disorder and substance abuse parity laws found little increased cost (or found reduced cost), after the mandate took effect. However, the laws in those studies differ from the bill. First, those statutes require plans to offer less comprehensive

benefits. The bill requires offered coverage for all diagnostic categories of mental health conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders and the mental and behavioral disorders section of the current International Classification of Diseases, and provides a specific list of conditions which may not be exclusive. However, Vermont's statute, for example, requires offered coverage for "any of the diagnostic categories listed in the mental disorders section of the international classification of disease".[15]

Second, the laws addressed in many parity studies expressly allow managed care, or a managed care carve-out, to limit costs. The bill does not expressly address the use of managed care in providing mental and nervous disorder and substance abuse benefits, but its use is likely to be limited by the parity requirement placed on employers choosing to provide any coverage for mental health and substance abuse services. For entities like HMOs already providing case management in the physical care setting, the bill implies that any case management involving treatment limitations or cost-sharing for mental and nervous disorder and substance abuse benefits may not be any more restrictive than such case management in the physical care setting. For preferred provider plans, or other types of plans involving no or minimal case management with treatment limitations or cost-sharing, the bill implies that additional case management could not be applied to mental and nervous disorder and substance abuse benefits as compared to the physical care setting. Similarly, the bill provides no authority for a managed care carve out. Plans will likely find it difficult to avoid significant cost increases without the ability to disparately manage care. Small group plans will be most affected, as the marginal change in coverage for these plans is likely to be more significant compared to the rich benefit plans of larger employers. This could result in reduced access to mental and nervous disorder and substance abuse coverage, as employers with small group plans may choose to forego such coverage altogether rather than bear the cost of full, unmanaged, parity.

The effective date of the bill is January 1, 2009.

C. SECTION DIRECTORY:

Section 1. Amends s. 627.668, F.S.; relating to optional coverage for mental and nervous disorders required; relating to exceptions.

Section 2. Repeals s. 627.669, F.S.; relating to optional coverage for substance abuse impaired persons; relating to exceptions.

Section 3. Provides an effective date of January 1, 2009.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See fiscal comments below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

[15] See 8 V.S.A. § 4089b (2008).

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Employers purchasing small group insurance may incur additional costs because policies must include coverage for mental, nervous and substance-related disorders on a par with coverage for medical care, through increased utilization and claims costs. Any increased costs will likely be passed through to policyholders in the form of increased premiums.

D. FISCAL COMMENTS:

According to the Department of Management Services, which administers the State Employees Group Health Insurance Program, the bill could result in increased costs to the state. The bill imposes a mandated offering for which the insurer or health plan can charge an additional premium. Because the proposed legislation is expansive and does not provide any guidelines that would allow the State or other insurers to control services, the services that would be provided pursuant to this bill could greatly increase the obligations of the State PPO Plan and the HMOs that contract with the State. The State Employees Group Health Insurance Program may be required to expand its covered benefits. Associated additional cost 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.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

It is unclear whether the phrase “group health plan that offers” refers to the group plan offered by an employer to employees or the group plan offered by an insurer to an employer. If the former, the language may create an employer mandate.

D. STATEMENT OF THE SPONSOR

Credit to the staff for their analysis of a short bill that has large implications for patients, employers, and health insurance companies. The bill attempts to equalize all diseases of the brain and require that they be treated equally in the eyes of the health insurance carrier. Brain tumors, Parkinson’s disease, epilepsy, schizophrenia, and depression should all have the same health insurance benefits if the “Parity” bill becomes law.

There are some inconsistencies in the staff analysis that I would like to point out. The federal SAMSHA (Substance Abuse and Mental Health Services Administration) is footnoted twice, once in the 1998 prediction that parity would cause health insurance premiums to increase between 3.2 and 8.7 percent. What SAMSHA actually found in 2003 was that percent increase for mental health benefits actually only increased .17% from 2.30% to 2.47% of the total health care premium.

A statement is made “those 48 mandates could add as much as 48% to the cost of health insurance in Florida”. This sentence is listed from an insurance company advocacy coalition pamphlet that gives no documentation to back up the statement. A similar statement has been made that a 1% increase in premium results in a 1% increase in the uninsured. If this were true, then 100% of the people should be uninsured because there has been a 100% increase in the cost of health insurance in the last ten years. Statements without data are statements, not facts.

One of the examples of the “costs” of “Parity” was a West Virginia report that would suggest in the analysis that the premium doubled because of parity. What doubled was the part of the premium that went to pay for mental health benefits in companies that had no or little mental health benefits before the legislation passed. I recommend that you review the data of the thirty-one health insurance companies in West Virginia where the MH ratio dropped on the average from 2.77% to 2.29% after “Parity”. These reports can be found on the www.edhomn.com website.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On March 18, 2008, the Health Innovation Committee adopted one strike-all amendment to the bill. This amendment:

- amends s. 627.6688, F.S., to specifically define those mental health conditions that must be covered within the mandated offering, generally including all diagnostic categories of mental health conditions listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association;

- amends s. 627.6688, F.S., to provide that the offered benefits shall not be less than the level of benefits required by that section;

- creates a new s. 627.6688(2), F.S., to require that coverage for certain conditions shall not be less favorable than for physical illness generally. Those conditions are: schizophrenia, schizo-affective disorders, major depression, bipolar disorders, panic disorders, generalized anxiety disorders, posttraumatic stress disorders, substance abuse disorders, eating disorders, delirium, dementia, childhood ADD/ADHD, developmental disorders, borderline personality disorder, and mental disorder due to a medical condition;

- renumbers s. 627.6688(2),F.S., as s. 627.688(3), F.S., and amends s. 627.6688(3), F.S., to require that coverage for mental health disorders not listed in s. 627.688(2), F.S., shall not be less favorable than for physical illness generally, except that inpatient benefits may be limited to not less than 45 days per benefit year and outpatient benefits may be limited to $5,000 for certain services, and allowing for non-parity durational limits and cost-sharing if coverage over the limits is provided;

- repeals s. 627.669, F.S., and conforms a cross-reference in s. 627.6675, F.S.

The bill was reported favorably with one amendment.