The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL:	CS/SB 1422
INTRODUCER:	Banking and Insurance Committee and Senator Rouson
SUBJECT:	Insurance Coverage Parity for Mental Health and Substance Use Disorders
DATE:	February 20, 2018 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.	Kidd	Williams	AHS	**Pre-meeting**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1422 codifies the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and related regulations, which will provide the Office of Insurance Regulation (OIR) with the authority to ensure that individual and group policies and contracts of health insurers and health maintenance organizations are complying with these provisions. Generally, the MHPAEA requires benefits for mental health and substance use disorders to be in parity with medical and surgical benefits, as it relates to financial requirements, treatment limitations, in-network and out-of-network coverage, and annual and aggregate lifetime limits for applicable policies or contracts that provide mental health benefits.

The bill also requires health insurers and health maintenance organizations (HMOs) to submit an annual report to the OIR demonstrating their compliance with MHPAEA. Medicaid managed care plans are required to submit an annual report to the Agency for Health Care Administration (AHCA). The OIR is required to submit an annual report to the Legislature describing its methodology for verifying compliance with the MHPAEA.

The bill has no fiscal impact to the Agency for Health Care Administration (agency).

The Office of Insurance Regulation has indicated the need for one additional FTE with associated costs of $69,414, to be funded from the Insurance Regulatory Trust Fund.

The bill has an effective date of July 1, 2018.

II. Present Situation:

In 2016, there were 5,725 opioid-related deaths reported in Florida, which is a 35 percent increase from 2015.[1] Deaths caused by fentanyl increased by 97 percent in 2016. Occurrences of cocaine use increased by 57 percent and deaths caused by cocaine increased by 83 percent. In the United States, approximately 7.9 million adults had co-occurring disorders, which is the existence of both a mental health and a substance use disorder.[2]

Federal Mental Health Parity Laws

Commercial Plans

Prior to 1996, health insurance coverage for mental illness was generally not as comprehensive as coverage for medical and surgical benefits. In response, the Mental Health Parity Act[3] (MHPA) was enacted in 1996, which requires parity of medical and surgical benefits with mental health benefits for annual and aggregate lifetime limits of large group plans.

In 2008, Congress passed the Mental Health Parity and Addiction Equity Act[4] (MHPAEA), which generally applies to large group health plans.[5] The MHPAEA expanded parity of coverage to include financial requirements, treatment limitations, and in- and out-of-network coverage if a plan provided coverage for mental illness. The MHPAEA also applies to the treatment of substance use disorders.[6] Like the MHPA, the MHPAEA does not require large groups to provide benefits for mental health or substance use disorders. The MHPAEA contains a cost exemption, which allows a group health plan to receive a waiver, exempting them from some of the key requirements, if the plan demonstrates that costs increased at least 1 percent because of compliance.[7]

In 2010, the Patient Protection and Affordable Care Act[8] (PPACA) amended the MHPAEA to apply the provisions to individual health insurance coverage. The PPACA mandates that qualified health insurance must provide coverage of 10 essential health benefits,[9] including coverage for mental health and substance use disorders for individual and small group qualified health plans. The final rule, implementing these provisions, generally requires health insurers

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[1] Florida Medical Examiners Commission, *2016 Medical Examiners Commission Drug Report* (Nov. 2017), available at http://www.fadaa.org/resource_center/documents/2016AnnualDrugReport.pdf (last viewed Jan. 31, 2018).
[2] Substance Abuse and Mental Health Services Administration, *Co-occurring* Disorders, available at https://www.samhsa.gov/disorders/co-occurring (last viewed Jan. 31, 2018).
[3] Pub. L. No. 104-204.
[4] Pub. L. No. 110-343.
[5] See final regulations available at http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf (last viewed Jan. 31, 2018).
[6] 45 CFR ss. 146 and 160.
[7] Plans and issuers that make changes to comply with MHPAEA and incur an increased cost of at least 2 percent in the first year that MHPAEA applies to the plan or coverage or at least 1 percent in any subsequent plan year may claim an exemption from MHPAEA based on their increased cost. If such a cost is incurred, the plan or coverage is exempt from MHPAEA requirements for the plan or policy year following the year the cost was incurred. The plan sponsors or issuers must notify the plan beneficiaries that MHPAEA does not apply to their coverage. These exemptions last 1 year. After that, the plan or coverage is required to comply again; however, if the plan or coverage incurs an increased cost of at least 1 percent in that plan or policy year, the plan or coverage could claim the exemption for the following plan or policy year.
[8] Pub. L. No.111-148, as amended by Pub. L. No. 111-152.
[9] 45 CFR s. 156.115.

offering health insurance coverage in the individual and small group markets to comply with the requirements of the MHPAEA regulations in order to satisfy the essential health benefit requirement.[10]

Medicaid and CHIP Programs

In March 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final rule on mental health parity for Medicaid and the Children's Health Insurance Program (CHIP).[11] The AHCA amended the Statewide Medicaid Managed Care (SMMC) contract to require Medicaid managed care organizations (MCOs) to comply with the mental health parity requirements no later than October 2, 2017.[12]

The CMS rule requires the Medicaid MCOs to comply with requirements for aggregate lifetime and annual dollar limits that apply to MCOs in states that cover both medical and surgical benefits and mental health or substance use disorder benefits under the Medicaid State Plan. In addition, Medicaid MCOs must comply with requirements for non-quantitative treatment limitations and must make available upon request the medical necessity criteria used for mental health or substance use disorder medical necessity determinations and the reason for denials of reimbursement for mental health or substance use disorder benefits.

The rule also requires, in instances where the full scope of medical and surgical and mental health and substance use disorder services are not provided through the MCO, that the state must review the mental health and substance use disorder services provided through the MCO and fee-for-service coverage to ensure that the full scope of services available to all enrollees of the MCO complies with the rule. According to the agency, this requirement does not apply to the Florida Medicaid program, as Medicaid has not created a behavioral health services "carve-out" and MCOs offer the full scope of behavioral health services.[13] The rule requires the state to ensure that all services are delivered to the enrollees of the MCO in compliance with the parity requirements. The agency is responsible for ensuring Medicaid MCOs' compliance with Medicaid managed care contracts. Generally under the MHPAEA final rule, the state is required to determine whether the overall Medicaid and CHIP delivery system is compliant with mental health and substance use disorder parity requirements. The MCOs are required to complete a parity analysis and inform the state of changes needed to the MCO contract.

President's Commission on Combating Drug Addiction and the Opioid Crisis

According to the President's Commission on Combating Drug Addiction and the Opioid Crisis, the MHPAEA has been the impetus for much progress towards parity for behavioral health coverage. Plans and employers have largely eliminated policies that are noncompliant, such as policies containing provisions such as dollar-limits, visit limits, and prohibitions on certain treatment modalities that exist only for behavioral health benefits. The report noted the remaining noncompliance is harder for regulators to discern, such as, non-quantitative treatment

[10] *See* 45 CFR 147.150 and 156.115 (78 FR 12834, Feb. 25, 2013).
[11] See 42 CFR 438, Subpart K – Parity in Mental Health and Substance Use Disorder Benefits.
[12] See Medicaid health plan contract Attachment II, Section XII.A.
[13] Agency for Health Care Administration, *Analysis of SB 1422* (Jan. 20, 2018) (on file with Senate Committee on Banking and Insurance).

limits (NQTLs).[14] These hurdles include medical necessity reviews that are more stringent on the behavioral health side than the medical or surgical side, limited provider networks, and onerous prior-authorization requirements. Further, it is often difficult to discern when a behavioral health benefit is on par with a medical/surgical benefit as different care settings and diagnoses have different policies regarding benefits, providers, and authorizations.[15] The Commission recommended that federal and state regulators should use a standardized tool that requires health plans to document and disclose their compliance strategies for non-quantitative treatment limitations (NQTL) parity.[16]

The Office of Insurance Regulation

The Florida Office of Insurance Regulation (OIR) licenses and regulates insurers, health maintenance organizations (HMOs), and other risk-bearing entities.[17] The Agency for Health Care Administration (agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the agency.[18] As part of the certification process used by the agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[19]

The OIR reviews health insurance policies and contracts for compliance with MHPAEA. The OIR communicates any violations of MHPAEA to the insurer or HMO. If the insurer or HMO fails to correct the issue, the OIR would refer the issue to the appropriate federal regulator as a possible violation of federal law. According to the OIR, no referrals to the federal regulator relating to noncompliance have been required.[20]

Coverage for Mental and Nervous Disorders

Section 627.668, F.S., requires insurers and HMOs offering group coverage to make available optional coverage for mental and nervous disorders for an appropriate additional premium that would include benefits delineated in this section.

Coverage for Substance Abuse

Section 627.669, F.S., requires insurers and HMOs offering group coverage to make available optional coverage for substance abuse that would include benefits listed in the section.

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[14] Centers for Medicare and Medicaid, Frequently Asked Questions, Mental Health and Substance Use Disorder Parity Implementation (Oct. 27, 2016). See https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-part-34_10-26-16_FINAL.PDF (last viewed Jan. 31, 2018).
[15] The President's Commission on Combating Drugs Addiction and the Opioid Crisis (Nov. 2017), available at http://www.fadaa.org/resource_center/documents/Opioid%20Commission%20Final%20Report%20-%20November%201%202017.pdf (last viewed Jan. 31, 2018).
[16] *Id*.
[17] Section 20.121(3)(a), F.S.
[18] Section 641.21(1), F.S.
[19] Section 641.495, F.S.
[20] Office of Insurance Regulation, *Analysis of SB 1422* (Dec. 12, 2017) (on file with Senate Banking and Insurance Committee).

Agency for Health Care Administration

The Agency for Health Care Administration (agency) is the state agency responsible for administration of the Medicaid program in Florida. Medicaid is a jointly funded program between the state and the federal government. In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with the agency under the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has two components: the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) Managed Care program. The agency contracts with managed care plans on a regional basis to provide services to eligible recipients. The benefit package offered by the MMA plans is comprehensive and covers all state plan benefits including mental health and substance abuse treatment services. Full implementation of the MMA program occurred in August 2014.

The agency conducted a review[21] of Florida Medicaid fee-for-service policy and practices relating to mental health and substance use disorder services and determined that Florida's robust behavioral health benefit complies with the quantitative limits. With regard to the non-quantitative limits, one area was identified in the provider network standards section of the SMMC contract, namely, ratios for network adequacy standards for psychiatrists versus primary care physicians. The agency amended the Medicaid MCO contracts to ensure the contracts aligned with parity requirements.

The current SMMC contract contains a requirement that the MCOs must comply with the federal rule, including any non-quantitative limits that the MCOs may impose through their credentialing, authorization, contracting, provider reimbursement, standards for accessing out-of-network providers, or other practices. To assist the MCOs in their efforts to achieve compliance, the state has directed the MCOs to the reference materials provided by CMS in the Parity Compliance Toolkit and Implementation Roadmap, which are publically available on the CMS website.[22] The agency has several existing avenues for monitoring MCOs' compliance with parity, including, but not limited to, the review of new or revised MCO policies and procedures (including utilization management), monitoring of provider and recipient complaints submitted to the Medicaid Complaint Operations Center, and monthly submission to the agency by the MCOs of complaint, grievance, and appeals reporting.

III. Effect of Proposed Changes:

Section 1 amends s. 409.967, F.S., relating to Medicaid managed care plan accountability. The provisions added to this section stipulate an annual analysis of mental health parity and reporting requirement for Medicaid MCOs, regarding mental health parity. The MCOs are required to submit the report to the agency no later than July 1, and the report must contain the following information:

- A description of the process used to develop or select the medical necessity criteria for mental or nervous disorder benefits, substance use disorder benefits, and medical and surgical benefits;

[21] *Id.*

[22] See CMS, *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*, (Jan. 17, 2017) available at https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf (last viewed Jan. 31, 2018).

- Identification of all non-quantitative treatment limitations (NQTLs) applied to both mental or nervous disorder and substance use disorder benefits and medical and surgical benefits; and
- The results of an analysis demonstrating, that for the medical necessity criteria described above and for each NQTL, the analysis identifies the processes, strategies, evidentiary standards, or other factors used to apply the criteria and NQTLs to mental or nervous disorder and substance use disorder benefits are comparable to, and are applied no more stringently than, the factors used to apply the criteria and NQTLs to medical and surgical benefits. It also establishes minimum criteria to be contained in the analysis. The analysis must include specific findings and conclusions reached by the MCO that the results of the analysis indicates that the MCO is in compliance with this section and MHPAEA, any federal guidance or regulations relating to MHPAEA, including but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3).

Section 2 amends s. 627.6675, F.S., relating to conversion policies, to provide a technical, conforming cross-reference.

Section 3 transfers the provisions of s. 627.668, F.S., relating to optional coverage for mental and nervous disorders, to newly created s. 627.4193, F.S., and amends the section. The section provides that coverage for mental and nervous disorders, including substance use disorders, provided by individual and group policies or contracts, may not be less favorable than for physical illness in accordance with parity requirements of 45 C.F.R. s. 136(c)(2) and (3). The section also eliminates the requirement that insurers make available optional coverage for mental and nervous disorders.

The section requires every insurer, HMO, and nonprofit hospital and medical service plan corporation, which transacts individual or group health insurance or providing prepaid health care in Florida, to submit an annual report to the OIR, on or before July 1 of each year. The report must contain the same information outlined in the analysis of Section 1 above. The section requires the OIR to enforce the MHPAEA , any federal guidance or regulations relating to MHPAEA, including but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3).

The OIR is required to implement and enforce the applicable provisions of MHPAEA, including but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3), and this section, which includes performing market conduct examinations to determine compliance and responding to consumer complaints regarding possible violations.

Finally, the section requires the OIR to issue an annual report to the Legislature no later than December 31 of each year, which describes the methodology the OIR uses to verify compliance with MHPAEA, and to post the report on the OIR's website for public access.

Section 4 repeals s. 627.669, F.S, relating to optional coverage for substance use disorders.

Section 5 provides the effective date of the bill is July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The new reporting requirement will have an indeterminate fiscal impact on the Medicaid managed care plans and commercial health insurers and health maintenance organizations.

The bill will provide policyholders and subscribers with additional protections for the resolution of coverage issues relating to mental health and substance use disorders parity.

C. Government Sector Impact:

Agency for Health Care Administration. There is no fiscal impact on the Florida Medicaid program.

Office of Insurance Regulation. The OIR has indicated the need for 1 FTE Financial Specialist $69,414 (Salary, Benefits, & Standard Expense Package for new FTE) to implement the provisions of the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.967, 627.6675, and 627.668.

This bill creates section 627.4193 of the Florida Statutes.

This bill repeals section 627.669 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Banking and Insurance on February 6, 2018:
The CS provides technical and conforming changes.

B. Amendments:

None.