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 Committee on Banking and Insurance

BILL:	SB 1024
INTRODUCER:	Senator Brodeur
SUBJECT:	Increasing Access to Mental Health Care
DATE:	March 8, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Pre-meeting**
2.			AEG	
3.			AP	

I. Summary:

SB 1024 requires the Department of Financial Services (DFS), in collaboration with the Agency for Health Care Administration (Agency), to establish a system to track complaints regarding the adequacy of coverage and access to mental health services, which are submitted by Medicaid enrollees and individuals covered by an individual or group health insurance policy or health maintenance organization (HMO) contract. The Agency and DFS are required to submit an annual report to the Legislature and the Governor regarding complaint information relating to mental health services by January 1, 2022.

Insurers and HMOs are required to provide Medicaid enrollees, insureds, and subscribers a written notice regarding the federal and state coverage requirements for mental health services, as well as the toll-free number of the Division of Consumer Services of the Department of Financial Services.

The bill will have minimal fiscal impact on the Agency. The bill will have an indeterminate fiscal impact on the DFS.

The bill provides an effective date of July 1, 2021.

II. Present Situation:

Mental health is a state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life.[1] Mental illness refers collectively to all diagnosable mental disorders — health conditions involving

[1] American Psychological Association, APA Dictionary of Psychology, https://dictionary.apa.org/mental-health (last visited Feb. 20, 2021).

significant changes in thinking, emotion or behavior or distress or problems functioning in social, work or family activities.[2] In the United States, mental illnesses are common. Nearly one in five U.S. adults or 51.5 million in 2019, live with a mental illness, which represents 20.6 percent of all U.S. adults. [3] Mental illnesses include many different conditions that vary in degree of severity, ranging from mild to moderate to severe. Serious mental illness (SMI) is a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities.[4] The burden of mental illnesses is particularly concentrated among those who experience disability due to SMI. In 2019, there were an estimated 13.1 million adults aged 18 or older in the United States with SMI. This number represented 5.2 percent of all U.S. adults. In 2019, among the 13.1 million adults with SMI, 8.6 million (65.5%) received mental health treatment in the past year.[5]

Some mental health conditions have been identified as risk factors for developing a substance use disorder.[6] For example, research suggests that people with mental illness may use drugs or alcohol as a form of self-medication.[7] In the United States, approximately 8.2 million adults (3.4 percent of all adults) had co-occurring disorders, which is the existence of both a mental health and a substance use disorder.[8]

Mental Health Insurance Coverage in the Private Health Insurance Market

Federal Requirements

Prior to 1996, health insurance coverage for mental illness was generally not as comprehensive as coverage for medical and surgical benefits. In response, Congress enacted the Mental Health Parity Act of 1996[9] (MHPA), 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[10] (MHPAEA), which generally applies to large group health plans.[11] 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.[12] Like the MHPA, the MHPAEA does not require large groups to provide benefits for mental health or substance use disorders. The MHPAEA contains

[2] American Psychological Association, What is Mental Illness? https://www.psychiatry.org/patients-families/what-is-mental-illness (last visited Jan. 30, 2021).
[3] National Institute of Mental Health, *Mental Illness*, available at https://www.nimh.nih.gov/health/statistics/mental-illness.shtml (last viewed Feb. 20, 2021).
[4] *Id.*
[5] *Id.*
[6] Baigent M. Managing patients with dual diagnosis in psychiatric practice. Curr Opin Psychiatry. 2012;25(3):201-205.
[7] Santucci K. Psychiatric disease and drug abuse. *Curr Opin Pediatr.* 2012;24(2):233-237.
[8] Key Substance Use and Mental Health Indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (Sep. 2017) available at https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf (last viewed Feb. 20, 2021).
[9] Pub. L. No. 104-204.
[10] Pub. L. No. 110-343.
[11] See 45 CFR Parts 146 and 147final regulations available at http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf (last viewed Jan. 31, 2018).
[12] 45 CFR Parts 146 and 160.

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.[13]

In 2010, the Patient Protection and Affordable Care Act[14] (PPACA) amended the MHPAEA to apply the provisions to individual health insurance coverage. The PPACA mandates that qualified health plans must provide coverage of 10 essential health benefits,[15] 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 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.[16]

State Requirements

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

Mental Health Coverage in Medicaid and CHIP Programs

In March 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to implement mental health parity for Medicaid managed care organizations (MCOs) and the Children's Health Insurance Program[17] (CHIP).[18] The rule applies certain provisions of the MHPAEA to requirements for Medicaid managed care organizations, Medicaid alternative benefit plans, and CHIP [19]

According to CMS, the rule is designed to align as much as possible with the approach taken in the final MHPAEA regulation to create consistency between the commercial and Medicaid

[13] 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.
[14] Pub. L. No.111-148, as amended by Pub. L. No. 111-152.
[15] 45 CFR s. 156.115.
[16] *See* 45 CFR 147.150 and 156.115.
[17] The Florida Kidcare Program was created in response to the federal State Children's Health Insurance Program or CHIP. Sections 409.810-409.821, F.S. The program provides subsidized health insurance coverage to uninsured children who do not qualify for Medicaid but who meet other requirements.
[18] See 42 CFR 438, Subpart K – Parity in Mental Health and Substance Use Disorder Benefits.
[19] *See* final rule regarding application of requirements of MHPAEA to Medicaid MCOs, CHIP, and Alternative Benefit (Benchmark) Plans, https://www.federalregister.gov/articles/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of (last visited Mar. 2, 2021).

markets.[20] The rule requires 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.[21] 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.[22]

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. [23] 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.[24] The SMMC program has two components: the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) Managed Care program.[25] 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.[26]

Federal rules relating to SMMCs require states to adopt a model enrollee handbook that provides enrollees with information about the managed care program, including information on covered services and limitations, and provide access to online and printed provider networks by specialty (including behavioral health).[27] Further, federal laws and rules require SMMC plans and CHIP plans to implement a comprehensive grievance and appeals system. (Complaints are a sub-category of grievances.) The SMMC contracts currently require plans to submit a detailed report to the Agency on a monthly basis of all complaints received and of each complaint's resolution. In addition, the Agency accepts, addresses, and tracks complaints submitted directly to it. This complaint information is part of a comprehensive monitoring and tracking system utilized by the Agency to monitor all aspects of service delivery and plan performance.[28]

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[20] Centers for Medicare and Medicaid Services, *Medicaid Fact Sheet: Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP*, (Mar. 29, 2016), https://www.medicaid.gov/sites/default/files/2019-12/fact-sheet-cms-2333-f.pdf (last visited Feb. 21, 2021).
[21] *Id.*
[22]The federal rule requires states are required to include contract provisions requiring compliance with parity standards in all applicable contracts for these Medicaid managed care arrangements that provide services to enrollees in managed care organizations. *See* Florida's Medicaid 2018-2023 Model Health Plan Contract, ATTACHMENT II SCOPE OF SERVICE - CORE PROVISIONS UPDATE: OCTOBER 1, 2020, Section XV. Special Terms and Conditions, Formatted Document (myflorida.com) (last viewed Feb. 20, 2021).
[23] Section 20.42(3), F.S.
[24] Agency for Health Care Administration, Medicaid, AHCA: Medicaid Landing Page (myflorida.com) (last viewed Feb. 20, 2021).
[25] *Id.*
[26] *Id.*
[27] 2021 Agency for Health Care Administration, *Bill Analysis and Economic Impact Statement for HB 701* (companion to SB 1024), (Mar. 4, 2021).
[28] *Id.*

Department of Financial Services

The Chief Financial Officer (CFO) is an elected member of the Cabinet, serves as the chief fiscal officer of the State of Florida,[29] is designated as the State Fire Marshal,[30] and is known as the Treasurer. [31] The CFO is the head of the Department of Financial Services (DFS).[32] Section 20.121, F.S., establishes the Office of the Insurance Consumer Advocate and numerous divisions within the DFS, including the Division of Consumer Services.

Division of Consumer Services

The Division of Consumer Services (Division) of the DFS assists consumers with issues and complaints related to products or services regulated by the DFS or the Office of Insurance. The Division:

- Receives inquiries and complaints from consumers;
- Prepares and disseminates information as the DFS deems appropriate to inform or assist consumers;
- Provides direct assistance and advocacy for consumers; and
- Reports potential violations of law or applicable rules by a person or entity licensed by the DFS or the OIR to the appropriate division within the DFS or the OIR, as applicable.[33]

A consumer may request assistance from the Division regarding coverage questions and concerns, or file a formal complaint by telephone, email, or online.[34] An insurer or other entity licensed or issued a certificate of authority by the DFS or the Office of Insurance Regulation (OIR) must respond in writing to the Division within 20 days after receipt of a written request for information from the Division concerning a consumer complaint.[35] The Division may impose an administrative penalty on an entity licensed by DFS or the OIR that fails to respond to the Division.[36]

The Division currently tracks and monitors complaint activity using a database known as ServicePoint.[37] The Division can generate reports, by request, on any entity, individual, line of business, or reason by accessing ServicePoint codes along with the use of key word searches. Individuals requesting reports can request any key words to be used in their report request. The Division refers managed care consumer complaints regarding allegations of lack of an adequate provider network to the Agency once the Division has assisted the individual to the extent of its ability.[38]

[29] FLA. CONST. art. IV, s. 4.
[30] Section 633.104(1), F.S.
[31] Section 20.121(1), F.S.
[32] Section 20.121, F.S.
[33] Section 624.307(10), F.S.
[34] Department of Financial Services, Division of Consumer Services, *File an insurance complaint*, at https://www.myfloridacfo.com/Division/Consumers/needourhelp.htm (last viewed Feb. 24, 2021).
[35] Section 624.307(10)(b), F.S.
[36] *Id*.
[37] Department of Financial Services, *2021 Legislative Bill Analysis of SB 1024* (Feb. 25, 2021).
[38] *Id*.

The Office of Insurance Regulation

The Florida Office of Insurance Regulation (OIR) regulates insurers, health maintenance organizations (HMOs), and other risk-bearing entities.[39] Health insurers and HMOs are required to submit rates and forms to the OIR for prior approval.[40] The OIR reviews health insurance rates and forms for compliance with state and federal laws, such as the MHPAEA.[41] 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.[42]

III. Effect of Proposed Changes:

Section 1 requires the Department of Financial Services (DFS), in collaboration with the Agency for Health Care Administration (Agency), to establish a system to track complaints regarding the adequacy of coverage and access to mental health services, which are submitted by Medicaid enrollees and individuals covered by an individual or group health insurance policy or health maintenance organization (HMO) contract. The Agency and DFS are required to submit an annual report to the Legislature and the Governor regarding complaint information relating to mental health services by January 1, 2022.

Further, health insurers and HMOs are required to provide Medicaid enrollees, insureds and subscribers a written notice regarding the federal and state coverage requirements for mental health services, as well as the toll-free number of the Division of Consumer Services of the Department of Financial Services.

Section 2 provides the bill has an effective date of July 1, 2021.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[39] Section 20.121(3)(a), F.S.
[40] Sections 627.410, 627.411, and 627.413, F.S.
[41] Office of Insurance Regulation, MHPAEA Compliance Checklist to be Completed by Regulated Entity, https://www.floir.com/sitedocuments/2021ACAEnhancedAttestation.pdf (last viewed Feb. 21, 2021).
[42] Section 624.26(2), F.S.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The written disclosures regarding the state and federal mental health coverage requirements and the contact information for the DFS Consumer Hotline that insurers and HMOs would provide insureds and subscribers may assist insureds and subscribers in understanding their coverage and obtaining mental health services.

C. Government Sector Impact:

Agency for Health Care Administration[43]

Current Florida SMMC plans and CHIP plans would experience minimal fiscal impact due to existing contract requirements and Agency practices. For example, the model enrollee handbook would need to be updated to include the toll-free number for the DFS Division of Consumer Services.

Further, the agency notes that the creation of an online complaint system with DFS would duplicate or bifurcate complaint reporting between health plans and the DFS system; currently health plans receive such complaints. For enrollees who report their complaints to the DFS system instead of their health plan, enrollees may experience delays in complaint resolution, which in turn would increase the number of grievances tracked by health plans. Any increases in grievances would result in additional administrative workload for the health plan by increasing the number of written notifications that must be provided to recipients for untimely complaint resolution.

There will be minimal impact to the Agency as the DFS has the lead by housing the Division of Consumer Services. The Agency would need to supply the DFS with any complaint data specific to behavioral health network adequacy and coverage that the Agency may have received for the legislative report.

[43] *See Supra* note 27.

Department of Financial Services[44]

The Division of Consumer Services currently uses a database for monitoring and tracking complaints. It is unknown how the DFS would coordinate its database with the Agency, or develop a new database jointly with the Agency without an appropriation for costs associated with such development.

VI. Technical Deficiencies:

The bill does not provide rulemaking authority to the DFS relating to the written notice insurers and HMOs are required to send to insureds and subscribers. The bill does not specify when a notice must be sent; how often a notice must be sent, nor minimum standards for the notice as it outlines federal and state laws. The readability of Federal and state laws and regulations on behavioral health care issues are voluminous and involve highly technical legal language that may not be easily understood by a typical consumer.

VII. Related Issues:

The statutory provision amending ch. 624, F.S., that requires insurers and HMOs to provide written notices regarding coverage and the DFS Consumer Hotline might be more appropriate in in chs. 627 and 641, relating to the regulation of rates, forms, and market conduct of insurers and HMOs by the OIR.

VIII. Statutes Affected:

This bill creates section 624.36 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.)

None.

B. Amendments:

None.

[44] *See Supra* note 36.