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 Appropriations

BILL:	CS/SB 1024
INTRODUCER:	Banking and Insurance Committee and Senator Brodeur and others
SUBJECT:	Increasing Access to Mental Health Care
DATE:	April 14, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.	Sanders	Betta	AEG	**Recommend: Fav/CS**
3.	Sanders	Sadberry	AP	**Pre-meeting**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1024 requires the Department of Financial Services (DFS) to submit a report to the Legislature and the Governor regarding complaints submitted by individuals covered by an individual or group health insurance policy or health maintenance organization (HMO) contract about the adequacy of coverage and access to mental health services. The report is due January 31, 2022.

Insurers and HMOs are required to provide insureds and subscribers a written notice regarding the federal and state coverage requirements for mental health services, as well as contact information for the Division of Consumer Services within the DFS. Insurers and HMOs are also required to make this information available on their website.

The bill will have an insignificant fiscal impact on the DFS that can be absorbed within existing resources.

The bill is effective October 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 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 people, in 2019, were living 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 percent) 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

[1] American Psychological Association, APA Dictionary of Psychology, https://dictionary.apa.org/mental-health (last visited Feb. 20, 2021).
[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] M. Baigent, Managing patients with dual diagnosis in psychiatric practice. Curr Opin Psychiatry. 2012;25(3):201-205.
[7] K. Santucci, 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] 45 CFR Parts 146 and 147.

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 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 one 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.

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,[17] is designated as the State Fire Marshal,[18] and is known as the Treasurer. [19] The CFO is the head of the DFS.[20] 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.

[12] 45 CFR Parts 146 and 160.
[13] Plans and issuers that make changes to comply with MHPAEA and incur an increased cost of at least two percent in the first year that MHPAEA applies to the plan or coverage or at least one 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 one 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 one 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] 45 CFR ss. 147.150 and 156.115.
[17] FLA. CONST. art. IV, s. 4.
[18] Section 633.104(1), F.S.
[19] Section 20.121, F.S.
[20] Id.

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 (OIR). 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.[21]

A consumer may request assistance from the division regarding coverage questions and concerns, or file a formal complaint by telephone, email, or online.[22] An insurer or other entity licensed or issued a certificate of authority by the DFS or the 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.[23] The division may impose an administrative penalty on an entity licensed by the DFS or the OIR that fails to respond to the division.[24]

The division currently tracks and monitors complaint activity using a database known as ServicePoint.[25] 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.[26]

The Office of Insurance Regulation

The OIR regulates insurers, HMOs, and other risk-bearing entities.[27] Rates and forms of health insurers and HMOs are subject to prior approval by the OIR.[28] The OIR reviews health insurance rates and forms for compliance with state and federal laws, such as the MHPAEA.[29] 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.[30]

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[21] Section 624.307(10), F.S.
[22] DFS, Division of Consumer Services, *File an insurance complaint,* at https://www.myfloridacfo.com/Division/Consumers/needourhelp.htm (last viewed Feb. 24, 2021).
[23] Section 624.307(10)(b), F.S.
[24] *Id*.
[25] DFS, *2021 Legislative Bill Analysis of SB 1024* (Feb. 25, 2021).
[26] *Id*.
[27] Section 20.121(3)(a), F.S.
[28] Sections 627.410, 627.411, and 627.413, F.S.
[29] 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).
[30] Section 624.26(2), F.S.

III. Effect of Proposed Changes:

Section 1 creates s. 624.36, F.S., to require the DFS to submit a report by January 31, 2022, to the Legislature and the Governor regarding the disposition of complaints relating to access and affordability of mental health services and benefits during the prior calendar year. The report must include all of the following information:

- The total number of complaints received.
- The nature of the complaints; including but not limited to, concerns related to access to providers, facilities, and inpatient or outpatient services; affordability of services. equivalency of mental health benefits with respect to medical and surgical benefits; quality of care; and denial of services.
- The disposition of complaints.
- Any recommendations made by the DFS to the Legislature for ensuring access to and the affordability of mental health services to insureds and subscribers.

Further, the section also requires the DFS to make available on its website a description of mental health benefits required to be made available pursuant to state and federal law for individual and group policies and contracts.

Sections 2 and 3 create ss. 627.4215 and 641.31085, F.S., to require health insurers and HMOs, respectively, to provide written notices to insureds and subscribers and make information available on their websites. Health insurers and HMOs are required to provide insureds and subscribers an annual written notice regarding the federal and state requirements for coverage of mental health services, as well as contact information for the DFS' Division of Consumer Services. Further, insurers and HMOs are required to make the same information contained in the written notices available at their respective websites.

Section 4 provides the bill has an effective date of October 1, 2021.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

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:

Department of Financial Services[31]

The fiscal impact is indeterminate. The Division of Consumer Services of the DFS currently uses a database for monitoring and tracking complaints and generating reports. The DFS may incur insignificant costs associated with producing a complaint report for the prior calendar year and modifying their website to include a description of mental health benefits required to be made available pursuant to state and federal law. These costs can be absorbed within existing resources.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates the following section of Florida Statutes: 624.36, 627.4215, and 641.31085.

IX. Additional Information:

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

CS by Banking and Insurance on March 10, 2021:
The CS:

[31] *See Supra* note 36.

- Requires the DFS to submit a report to the Legislature and the Governor using information generated from their current complaint database and eliminates the requirement that the Agency for Health Care Administration collaborate on complaint tracking and the issuance of a joint report with the DFS.
- Revises the information that must be included in the DFS report about complaints received from insureds and subscribers relating to the access and affordability of mental health services and benefits.
- Requires the DFS to make available on their website a description of mental health benefits required to be made available pursuant to state and federal laws for individual and group policies and contracts.
- Requires insurers and HMOs to provide written notices to insureds and subscribers, respectively, and information on their website regarding federal and state requirements for coverage of mental health services and contact information for the Division of Consumer Services of the DFS.
- Revises the report due date from January 1, 2022, to January 31, 2022 and the effective date of the bill from July 1, 2021, to October 1, 2021.

B. Amendments:

None.