

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 701 Behavioral Health Care Services Coverage and Access

SPONSOR(S): Insurance & Banking Subcommittee, Stevenson

TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Finance & Facilities Subcommittee	17 Y, 1 N	Grabowski	Lloyd
2) Insurance & Banking Subcommittee	17 Y, 0 N, As CS	Rowley	Luczynski
3) Health & Human Services Committee	19 Y, 0 N	Grabowski	Calamas

SUMMARY ANALYSIS

The term “behavioral health” refers to the promotion of mental health, resilience and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities. Mental illness affects millions of people in the United States each year. Nearly one in five adults live with a mental illness. An estimated 49.5 percent of adolescents aged 13-18 have a mental disorder. Substance abuse also affects millions of people in the United States each year.

Until the late 1990s, private health insurance coverage for mental illness was generally not as comprehensive as coverage for medical and surgical benefits. Likewise, Medicaid has not traditionally provided coverage of mental health conditions at the same level of generosity as coverage for physical health conditions. Changes to federal law in the past two decades have resulted in mental health parity requirements applicable to most health insurers, health maintenance organizations, and Medicaid managed care plans. Although the federal government is responsible for enforcing many of these requirements, the Florida Department of Financial Services (DFS) plays a meaningful role in monitoring health plan compliance.

The bill requires health insurers and health management organizations to provide written notice to covered individuals outlining the federal and state requirements for coverage of behavioral health care services. In addition, this notice must include the statewide toll-free telephone number established by the Division of Consumer Services at the DFS for reporting complaints related to the availability, affordability, and adequacy of behavioral health care services.

The bill also requires the DFS to provide a report to the Legislature by January 31, 2022, which includes information on the complaints received by the Division of Consumer Services related to behavioral health care services.

The bill has no fiscal impact on state or local government.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Behavioral Health

The term “behavioral health” refers to the promotion of mental health, resilience and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities. Behavioral health conditions and the behavioral health field have historically been financed, authorized, structured, researched, and regulated differently than other health conditions.¹

Mental Illness and Substance Abuse

Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community.² The primary indicators used to evaluate an individual’s mental health are:³

- **Emotional well-being-** Perceived life satisfaction, happiness, cheerfulness, peacefulness;
- **Psychological well-being-** Self-acceptance, personal growth including openness to new experiences, optimism, hopefulness, purpose in life, control of one’s environment, spirituality, self-direction, and positive relationships; and,
- **Social well-being-** Social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, and sense of community.

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning.⁴ Thus, mental health refers to an individual’s mental state of well-being whereas mental illness signifies an alteration of that well-being.

Mental illness affects millions of people in the United States each year. Nearly one in five adults live with a mental illness.⁵ An estimated 49.5 percent of adolescents aged 13-18 have a mental disorder.⁶ Suicide is the tenth overall leading cause of death in the nation and the second leading cause of death among individuals between the ages of 10 and 24.⁷

Substance abuse also affects millions of people in the United States each year. Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.⁸ Substance abuse disorders occur when the chronic use of alcohol or drugs causes significant impairment, such as health problems, disability, and failure to meet major responsibilities at work,

¹ Substance Abuse and Mental Health Services Administration, “SAMHSA – Behavioral Health Integration”, available at <https://www.samhsa.gov/sites/default/files/samhsa-behavioral-health-integration.pdf> (last accessed February 22, 2021).

² World Health Organization, *Mental Health: Strengthening Our Response*, available at <https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response> (last accessed February 22, 2021).

³ Centers for Disease Control and Prevention, *Learn About Mental Health*, available at <http://www.cdc.gov/mentalhealth/basics.htm> (last accessed February 22, 2021).

⁴ *Id.*

⁵ National Institute on Mental Health, *Mental Illness*, <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml> (last accessed February 22, 2021).

⁶ National Institute on Mental Health, *Mental Illness – Prevalence of Any Mental Disorder Among Adolescents*, https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_155771 (last accessed February 22, 2021).

⁷ National Institute on Mental Health, *Suicide*, <https://www.nimh.nih.gov/health/statistics/suicide.shtml> (last accessed February 22, 2021).

⁸ World Health Organization, *Substance Abuse*, http://www.who.int/topics/substance_abuse/en/ (last accessed February 22, 2021).

school, or home.⁹ Repeated drug use leads to changes in the brain's structure and function that can make a person more susceptible to developing a substance abuse disorder.¹⁰ Brain imaging studies of persons with substance abuse disorders show physical changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control.¹¹

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, a diagnosis of substance abuse disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.¹² The most common substance abuse disorders in the United States are from the use of alcohol, tobacco, cannabis, stimulants, hallucinogens, and opioids.¹³

Mental illness and substance abuse commonly co-occur. Approximately 9.2 million adults have co-occurring disorders.¹⁴ In fact, more than half of all adults with severe mental illness are further impaired by substance abuse disorders (abuse or dependence related to alcohol or other drugs).¹⁵ Drug abuse can cause individuals to experience one or more symptoms of another mental illness.¹⁶ Additionally, individuals with mental illness may abuse drugs as a form of self-medication.¹⁷ Examples of co-occurring disorders include the combinations of major depression with cocaine addiction, alcohol addiction with panic disorder, alcoholism and drug addiction with schizophrenia, and borderline personality disorder with episodic drug abuse.¹⁸

Federal Mental Health Parity Laws

Commercial Plans

Prior to 1996, private health insurance coverage for mental illness was generally not as comprehensive as coverage for medical and surgical benefits. In response, the Mental Health Parity Act¹⁹ (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 Act²⁰ (MHPAEA), which generally applies to large group health plans.²¹ 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.²² Like the MHPA, the MHPAEA does not require large groups to provide benefits for mental

⁹ Substance Abuse and Mental Health Services Administration, *Substance Use Disorders*, <http://www.samhsa.gov/disorders/substance-use> (last accessed February 22, 2021).

¹⁰ National Institute on Drug Abuse, *Drugs, Brains, and Behavior: The Science of Addiction*, <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction> (last accessed February 22, 2021).

¹¹ *Id.*

¹² Substance Abuse and Mental Health Services Administration, *Substance Use Disorders*, <http://www.samhsa.gov/disorders/substance-use> (last accessed February 22, 2021).

¹³ *Id.*

¹⁴ Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the U.S.: Results from the 2018 National Survey on Drug Use and Health*, (August 2019), <https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf> (last accessed February 22, 2021).

¹⁵ Psychology Today, *Co-Occurring Disorders*, <https://www.psychologytoday.com/conditions/co-occurring-disorders> (last accessed February 22, 2021).

¹⁶ *Comorbidity: Addiction and Other Mental Illnesses*, National Institute on Drug Abuse, NIH Publication Number 10-5771 (September 2010), <https://www.drugabuse.gov/sites/default/files/rcomorbidity.pdf> (last accessed February 22, 2021).

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ Pub. L. No. 104-204.

²⁰ Pub. L. No. 110-343.

²¹ Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program, 78 FR 68239 (November 13, 2013) (codified at 26 CFR Part 54, 29 CFR Part 2590, 45 CFR Parts 146 and 147).

²² 45 CFR ss. 146 and 160.

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.²³

In 2010, the Patient Protection and Affordable Care Act²⁴ (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,²⁵ 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.²⁶

Medicaid and CHIP

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families, which makes eligibility determinations. Florida uses a comprehensive managed care delivery model for primary and acute care services to serve the bulk of its Medicaid population, known as the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) program.²⁷ The MMA program was enacted in 2011 and fully implemented in 2014.

The Florida Kidcare Program was created by the Florida Legislature in 1998 in response to the federal enactment of the State Children's Health Insurance Program in 1997, later known more simply as the Children's Health Insurance Program (CHIP). The CHIP provides subsidized health insurance coverage to uninsured children who do not qualify for Medicaid but who meet other eligibility requirements. The state statutory authority for the Kidcare Program is found in part II of ch. 409, F.S.

Federal law requires state Medicaid programs and the CHIP to comply with mental health and substance use disorder parity requirements. On March 30, 2016, the Centers for Medicare and Medicaid Services (CMS) issued final regulations dictating that the parity requirements established by the MHPAEA apply to Medicaid managed care organizations (MCOs), such as those in Florida's MMA program, and CHIP programs.²⁸

The federal regulations require MCOs to comply with strict requirements associated with the establishment of annual and lifetime dollar limits on coverage. If an MCO elects to use an annual or lifetime dollar limit on the coverage of mental health and substance abuse disorder treatments, that limit may not be less generous than any dollar limit on coverage for medical and surgical treatments. In addition, 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

²³ 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.

²⁴ Pub. L. No. 111-148, as amended by Pub. L. No. 111-152.

²⁵ 45 CFR s. 156.115.

²⁶ See 45 CFR 147.150 and 156.115 (78 FR 12834, Feb. 25, 2013).

²⁷ S. 409.964, F.S.

²⁸ Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, 81 FR 18389 (March 30, 2016)(codified at 42 CFR Parts 438, 440, 456, 457).

disorders and the rationale for denials of reimbursement for mental health or substance use disorder benefits.²⁹

State Regulation of Mental Health Coverage

Office of Insurance Regulation

The regulatory oversight of health insurance is generally reserved to the states, except when explicitly preempted by federal law. In Florida, the Office of Insurance Regulation (OIR) is responsible for all activities concerning insurers and other risk bearing entities, including licensing, rates, policy forms, market conduct, claims, issuance of certificates of authority, solvency, viatical settlements, premium financing, and administrative supervision, as provided under the Florida Insurance Code.³⁰

All health insurance policies issued in Florida, with the exception of certain self-insured policies,³¹ must meet certain requirements that are detailed throughout the Florida Insurance Code. Chapter 627, F.S., sets parameters and requirements for health insurance policies and ch. 641, F.S., provides requirements for health plans issued by health maintenance organizations (HMOs). At a minimum, insurance policies must specify premium rates, services covered, and effective dates. Insurers must document the time when a policy takes effect and the period during which the policy remains in effect.³²

The OIR reviews health insurance policies and contracts for compliance with the MHPAEA.³³ The OIR communicates any violations of the 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.³⁴

Department of Financial Services

The Florida Department of Financial Services (DFS) includes several divisions and offices that supplement the work of the OIR. The Division of Consumer Services deals with consumer issues and complaints related to the jurisdiction of the DFS and the 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.³⁵

Specifically, the Division is responsible for receiving consumer complaints related to the PPACA, and by extension, the MHPAEA.³⁶

Agency for Health Care Administration

The AHCA is charged with ensuring that plans participating in the MMA program are compliant with federal parity regulations. 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

²⁹ *Id.*

³⁰ S. 20.121(3)(a)1., F.S. The OIR's commissioner is the agency head for purposes of final agency action, and its rulemaking body is the Financial Services Commission (the Governor and the Cabinet). The Florida Insurance Code includes chapters 624-632, 634, 635, 636, 641, 642, 648, and 651, F.S.

³¹ 29 U.S.C. 18 § 1001 et seq. ERISA regulates certain self-insured plans, which represent approximately 50 percent of the insureds in Florida. These plans cannot be regulated by state law.

³² S. 627.413(1)(d), F.S.

³³ S. 624.26, F.S.

³⁴ *Id.*

³⁵ S. 20.121(2)(h), F.S.

³⁶ S. 624.26, F.S.

their credentialing, authorization, contracting, provider reimbursement, standards for accessing out-of-network providers, or other practices.³⁷ 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.³⁸ The AHCA 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 AHCA by the MCOs of complaint, grievance, and appeals reporting.

Effect of Proposed Changes

The bill establishes new communication duties for health insurers and HMOs, while creating reporting requirements for the DFS.

The bill requires health insurers and HMOs to provide written notice on an annual basis to covered individuals outlining the federal and state requirements for coverage of behavioral health care services. In addition, the notice must include the statewide toll-free telephone number established by the Division of Consumer Services at the DFS for reporting complaints related to the availability, affordability, and adequacy of behavioral health care services. Health insurers and HMOs must also make this information available on their websites.

The bill also requires the DFS to provide a report to the Governor and the Legislature by January 31, 2022, on the complaints received by the Division of Consumer Services regarding access to and affordability of behavioral health care services. At a minimum, the report must indicate the number of complaints received, the nature of such complaints, the disposition of the complaints, and any recommendations to the Legislature for improving the access to and affordability of behavioral health care services. The bill also requires that DFS make available on its website information about behavioral health care benefits for individual and group policies and contracts.

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

B. SECTION DIRECTORY:

Section 1: Creates s. 624.36, F.S., relating to coverage of and access to behavioral health care services; complaints; reporting.

Section 2: Creates s. 627.4215, F.S., relating to disclosures to policyholders; coverage of behavioral health care services.

Section 3: Creates s. 641.31085, F.S., relating to disclosures to subscribers; coverage of behavioral health care services.

Section 4: Provides an effective date of October 1, 2021.

³⁷ Agency for Health Care Administration, *2018-2023 Model Health Plan Contract: Exhibit II-A – Managed Medical Assistance Program*, October 1, 2020, https://ahca.myflorida.com/medicaid/statewide_mc/model_health_FY18-23.shtml (last accessed February 23, 2021).

³⁸ See CMS, *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Program*, (Jan. 17, 2017), <https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf> (last accessed February 25, 2021).

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 10, 2021, the Insurance & Banking Subcommittee considered the bill, adopted one amendment, and reported the bill favorably as a committee substitute. The amendment made the following changes to the bill:

- Removed language providing that the DFS, in collaboration with the AHCA, shall establish a system to track and monitor complaints.
- Provided greater details on the information that the DFS's report to the Governor and Legislature must include, extended the deadline for submitting the report, and added a requirement that the DFS include

information on its website about certain behavioral health care benefits for individual and group policies and contracts.

- Added a requirement that health insurers and HMOs disclose information about federal and state requirements for coverage of behavioral health care service on their websites.
- Changed the effective date of the bill from July 1, 2021 to October 1, 2021.

The analysis is drafted to the committee substitute as passed by the Insurance & Banking Subcommittee.