Federal Mental Health Coverage 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 health plans.

In 2008, Congress passed the Mental Health Parity and Addiction Equity Act20 (MHPAEA), which generally applies to large group health plans. 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. Like the MHPA, the MHPAEA does not require large groups to provide benefits for mental health or substance use disorders. Rather, the Act requires large group plans electing to provide mental health and substance abuse benefits to provide those benefits in a manner that is no less generous than coverage for other medical benefits. The MHPAEA also 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.

In 2010, the Patient Protection and Affordable Care Act25 (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, 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.

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. 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.

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

State (Florida) 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.

All health insurance policies issued in Florida, with the exception of certain self-insured policies, 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.

The OIR reviews health insurance policies and contracts for compliance with the MHPAEA.35 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.

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.

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

The Florida Division of Consumer Services may be contacted via their web site at https://www.fdacs.gov/Divisions-Offices/Consumer-Services . Further contact information includes:

Rick Kimsey, Consumer Services Director, Phone Number: (850) 410-3800
CSWebmaster@FDACS.gov

FDACS-Division of Consumer Services
1-800-HELP-FLA (435-7352)
1-800-FL-AYUDA (352-9832) en Español

FDACS-Division of Consumer Services
P.O. Box 6700
Tallahassee, FL 32399-6700

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 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 publicly available on the CMS website. 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.