

By Senator Rouson

19-01110-18

20181422__

1 A bill to be entitled
2 An act relating to insurance coverage parity for
3 mental health and substance use disorders; amending s.
4 409.967, F.S.; requiring contracts between the Agency
5 for Health Care Administration and certain managed
6 care plans to require the plans to submit a specified
7 annual report to the agency relating to parity between
8 mental health and substance use disorder benefits and
9 medical and surgical benefits; amending s. 627.6675,
10 F.S.; conforming a cross-reference; transferring,
11 renumbering, and amending s. 627.668, F.S.; deleting
12 certain provisions that require insurers, health
13 maintenance organizations, and nonprofit hospital and
14 medical service plan organizations transacting group
15 health insurance or providing prepaid health care to
16 offer specified optional coverage for mental and
17 nervous disorders; requiring such entities transacting
18 individual or group health insurance or providing
19 prepaid health care to comply with specified
20 provisions prohibiting the imposition of less
21 favorable benefit limitations on mental health and
22 substance use disorder benefits than on medical and
23 surgical benefits; requiring such entities to submit a
24 specified annual report relating to parity between
25 such benefits to the Office of Insurance Regulation;
26 requiring the office to implement and enforce
27 specified federal provisions, guidance, and
28 regulations; specifying actions the office must take
29 relating to such implementation and enforcement;

19-01110-18

20181422__

30 requiring the office to issue a specified annual
31 report to the Legislature; providing an effective
32 date.

33
34 Be It Enacted by the Legislature of the State of Florida:

35
36 Section 1. Paragraph (p) is added to subsection (2) of
37 section 409.967, Florida Statutes, to read:

38 409.967 Managed care plan accountability.—

39 (2) The agency shall establish such contract requirements
40 as are necessary for the operation of the statewide managed care
41 program. In addition to any other provisions the agency may deem
42 necessary, the contract must require:

43 (p) Annual reporting relating to parity in mental health
44 and substance use disorder benefits.—Every managed care plan
45 shall submit an annual report to the agency, on or before July
46 1, which contains all of the following information:

47 1. A description of the process used to develop or select
48 the medical necessity criteria for:

49 a. Mental or nervous disorder benefits;

50 b. Substance use disorder benefits; and

51 c. Medical and surgical benefits.

52 2. Identification of all nonquantitative treatment
53 limitations (NQTLs) applied to both mental or nervous disorder
54 and substance use disorder benefits and medical and surgical
55 benefits. Within any classification of benefits, there may not
56 be separate NQTLs that apply to mental or nervous disorder and
57 substance use disorder benefits but do not apply to medical and
58 surgical benefits.

19-01110-18

20181422__

59 3. The results of an analysis demonstrating that for the
60 medical necessity criteria described in subparagraph 1. and for
61 each NQTL identified in subparagraph 2., as written and in
62 operation, the processes, strategies, evidentiary standards, or
63 other factors used to apply the criteria and NQTLs to mental or
64 nervous disorder and substance use disorder benefits are
65 comparable to, and are applied no more stringently than, the
66 processes, strategies, evidentiary standards, or other factors
67 used to apply the criteria and NQTLs, as written and in
68 operation, to medical and surgical benefits. At a minimum, the
69 results of the analysis must:

70 a. Identify the factors used to determine that an NQTL will
71 apply to a benefit, including factors that were considered but
72 rejected;

73 b. Identify and define the specific evidentiary standards
74 used to define the factors and any other evidentiary standards
75 relied upon in designing each NQTL;

76 c. Identify and describe the methods and analyses used,
77 including the results of the analyses, to determine that the
78 processes and strategies used to design each NQTL, as written,
79 for mental or nervous disorder and substance use disorder
80 benefits are comparable to, and no more stringently applied
81 than, the processes and strategies used to design each NQTL, as
82 written, for medical and surgical benefits;

83 d. Identify and describe the methods and analyses used,
84 including the results of the analyses, to determine that
85 processes and strategies used to apply each NQTL, in operation,
86 for mental or nervous disorder and substance use disorder
87 benefits are comparable to, and no more stringently applied

19-01110-18

20181422__

88 than, the processes or strategies used to apply each NQTL, in
89 operation, for medical and surgical benefits; and

90 e. Disclose the specific findings and conclusions reached
91 by the managed care plan that the results of the analyses
92 indicate that the insurer, health maintenance organization, or
93 nonprofit hospital and medical service plan corporation is in
94 compliance with this section, the federal Paul Wellstone and
95 Pete Domenici Mental Health Parity and Addiction Equity Act of
96 2008 (MHPAEA); any federal guidance or regulations relating to
97 MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45
98 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a) (3); and any other
99 relevant current or future regulations.

100 Section 2. Paragraph (b) of subsection (8) of section
101 627.6675, Florida Statutes, is amended to read:

102 627.6675 Conversion on termination of eligibility.—Subject
103 to all of the provisions of this section, a group policy
104 delivered or issued for delivery in this state by an insurer or
105 nonprofit health care services plan that provides, on an
106 expense-incurred basis, hospital, surgical, or major medical
107 expense insurance, or any combination of these coverages, shall
108 provide that an employee or member whose insurance under the
109 group policy has been terminated for any reason, including
110 discontinuance of the group policy in its entirety or with
111 respect to an insured class, and who has been continuously
112 insured under the group policy, and under any group policy
113 providing similar benefits that the terminated group policy
114 replaced, for at least 3 months immediately prior to
115 termination, shall be entitled to have issued to him or her by
116 the insurer a policy or certificate of health insurance,

19-01110-18

20181422__

117 referred to in this section as a "converted policy." A group
 118 insurer may meet the requirements of this section by contracting
 119 with another insurer, authorized in this state, to issue an
 120 individual converted policy, which policy has been approved by
 121 the office under s. 627.410. An employee or member shall not be
 122 entitled to a converted policy if termination of his or her
 123 insurance under the group policy occurred because he or she
 124 failed to pay any required contribution, or because any
 125 discontinued group coverage was replaced by similar group
 126 coverage within 31 days after discontinuance.

127 (8) BENEFITS OFFERED.—

128 (b) An insurer shall offer the benefits specified in s.
 129 627.4193 ~~s. 627.668~~ and the benefits specified in s. 627.669 if
 130 those benefits were provided in the group plan.

131 Section 3. Section 627.668, Florida Statutes, is
 132 transferred, renumbered as section 627.4193, Florida Statutes,
 133 and amended, to read:

134 627.4193 ~~627.668~~ Requirements for mental health and
 135 substance use disorder benefits; reporting requirements ~~Optional~~
 136 ~~coverage for mental and nervous disorders required; exception.—~~

137 (1) Every insurer, health maintenance organization, and
 138 nonprofit hospital and medical service plan corporation
 139 transacting individual or group health insurance or providing
 140 prepaid health care in this state must comply with the federal
 141 Paul Wellstone and Pete Domenici Mental Health Parity and
 142 Addiction Equity Act of 2008 (MHPAEA) and any regulations
 143 relating to MHPAEA, including, but not limited to, 45 C.F.R. s.
 144 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a) (3);
 145 and must provide ~~shall make available to the policyholder as~~

19-01110-18

20181422__

146 ~~part of the application, for an appropriate additional premium~~
147 ~~under a group hospital and medical expense incurred insurance~~
148 ~~policy, under a group prepaid health care contract, and under a~~
149 ~~group hospital and medical service plan contract, the benefits~~
150 or level of benefits specified in subsection (2) for the
151 necessary care and treatment of mental and nervous disorders,
152 including substance use disorders, as defined in the standard
153 nomenclature of the American Psychiatric Association, ~~subject to~~
154 ~~the right of the applicant for a group policy or contract to~~
155 ~~select any alternative benefits or level of benefits as may be~~
156 ~~offered by the insurer, health maintenance organization, or~~
157 ~~service plan corporation provided that, if alternate inpatient,~~
158 ~~outpatient, or partial hospitalization benefits are selected,~~
159 ~~such benefits shall not be less than the level of benefits~~
160 ~~required under paragraph (2) (a), paragraph (2) (b), or paragraph~~
161 ~~(2) (c), respectively.~~

162 (2) Under individual or group policies or contracts,
163 inpatient hospital benefits, partial hospitalization benefits,
164 and outpatient benefits consisting of durational limits, dollar
165 amounts, deductibles, and coinsurance factors may ~~shall~~ not be
166 less favorable than for physical illness, in accordance with 45
167 C.F.R. s. 146.136(c) (2) and (3) ~~generally, except that:~~

168 ~~(a) Inpatient benefits may be limited to not less than 30~~
169 ~~days per benefit year as defined in the policy or contract. If~~
170 ~~inpatient hospital benefits are provided beyond 30 days per~~
171 ~~benefit year, the durational limits, dollar amounts, and~~
172 ~~coinsurance factors thereto need not be the same as applicable~~
173 ~~to physical illness generally.~~

174 ~~(b) Outpatient benefits may be limited to \$1,000 for~~

19-01110-18

20181422__

175 ~~consultations with a licensed physician, a psychologist licensed~~
176 ~~pursuant to chapter 490, a mental health counselor licensed~~
177 ~~pursuant to chapter 491, a marriage and family therapist~~
178 ~~licensed pursuant to chapter 491, and a clinical social worker~~
179 ~~licensed pursuant to chapter 491. If benefits are provided~~
180 ~~beyond the \$1,000 per benefit year, the durational limits,~~
181 ~~dollar amounts, and coinsurance factors thereof need not be the~~
182 ~~same as applicable to physical illness generally.~~

183 ~~(c) Partial hospitalization benefits shall be provided~~
184 ~~under the direction of a licensed physician. For purposes of~~
185 ~~this part, the term "partial hospitalization services" is~~
186 ~~defined as those services offered by a program that is~~
187 ~~accredited by an accrediting organization whose standards~~
188 ~~incorporate comparable regulations required by this state.~~
189 ~~Alcohol rehabilitation programs accredited by an accrediting~~
190 ~~organization whose standards incorporate comparable regulations~~
191 ~~required by this state or approved by the state and licensed~~
192 ~~drug abuse rehabilitation programs shall also be qualified~~
193 ~~providers under this section. In a given benefit year, if~~
194 ~~partial hospitalization services or a combination of inpatient~~
195 ~~and partial hospitalization are used, the total benefits paid~~
196 ~~for all such services may not exceed the cost of 30 days after~~
197 ~~inpatient hospitalization for psychiatric services, including~~
198 ~~physician fees, which prevail in the community in which the~~
199 ~~partial hospitalization services are rendered. If partial~~
200 ~~hospitalization services benefits are provided beyond the limits~~
201 ~~set forth in this paragraph, the durational limits, dollar~~
202 ~~amounts, and coinsurance factors thereof need not be the same as~~
203 ~~those applicable to physical illness generally.~~

19-01110-18

20181422__

204 (3) Insurers must maintain strict confidentiality regarding
205 psychiatric and psychotherapeutic records submitted to an
206 insurer for the purpose of reviewing a claim for benefits
207 payable under this section. These records submitted to an
208 insurer are subject to the limitations of s. 456.057, relating
209 to the furnishing of patient records.

210 (4) Every insurer, health maintenance organization, and
211 nonprofit hospital and medical service plan corporation
212 transacting individual or group health insurance or providing
213 prepaid health care in this state shall submit an annual report
214 to the office, on or before July 1, which contains all of the
215 following information:

216 (a) A description of the process used to develop or select
217 the medical necessity criteria for:

- 218 1. Mental or nervous disorder benefits;
- 219 2. Substance use disorder benefits; and
- 220 3. Medical and surgical benefits.

221 (b) Identification of all nonquantitative treatment
222 limitations (NQTs) applied to both mental or nervous disorder
223 and substance use disorder benefits and medical and surgical
224 benefits. Within any classification of benefits, there may not
225 be separate NQTs that apply to mental or nervous disorder and
226 substance use disorder benefits but do not apply to medical and
227 surgical benefits.

228 (c) The results of an analysis demonstrating that for the
229 medical necessity criteria described in paragraph (a) and for
230 each NQTL identified in paragraph (b), as written and in
231 operation, the processes, strategies, evidentiary standards, or
232 other factors used to apply the criteria and NQTLs to mental or

19-01110-18

20181422__

233 nervous disorder and substance use disorder benefits are
234 comparable to, and are applied no more stringently than, the
235 processes, strategies, evidentiary standards, or other factors
236 used to apply the criteria and NQTLs, as written and in
237 operation, to medical and surgical benefits. At a minimum, the
238 results of the analysis must:

239 1. Identify the factors used to determine that an NQTL will
240 apply to a benefit, including factors that were considered but
241 rejected;

242 2. Identify and define the specific evidentiary standards
243 used to define the factors and any other evidentiary standards
244 relied upon in designing each NQTL;

245 3. Identify and describe the methods and analyses used,
246 including the results of the analyses, to determine that the
247 processes and strategies used to design each NQTL, as written,
248 for mental or nervous disorder and substance use disorder
249 benefits are comparable to, and no more stringently applied
250 than, the processes and strategies used to design each NQTL, as
251 written, for medical and surgical benefits;

252 4. Identify and describe the methods and analyses used,
253 including the results of the analyses, to determine that
254 processes and strategies used to apply each NQTL, in operation,
255 for mental or nervous disorder and substance use disorder
256 benefits are comparable to and no more stringently applied than
257 the processes or strategies used to apply each NQTL, in
258 operation, for medical and surgical benefits; and

259 5. Disclose the specific findings and conclusions reached
260 by the insurer, health maintenance organization, or nonprofit
261 hospital and medical service plan corporation that the results

19-01110-18

20181422__

262 of the analyses indicate that the insurer, health maintenance
263 organization, or nonprofit hospital and medical service plan
264 corporation is in compliance with this section; MHPAEA; any
265 regulations relating to MHPAEA, including, but not limited to,
266 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s.
267 156.115(a) (3); and any other relevant current or future
268 regulations.

269 (5) The office shall implement and enforce applicable
270 provisions of MHPAEA and federal guidance or regulations
271 relating to MHPAEA, including, but not limited to, 45 C.F.R. s.
272 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a) (3),
273 and this section, which includes:

274 (a) Ensuring compliance by each insurer, health maintenance
275 organization, and nonprofit hospital and medical service plan
276 corporation transacting individual or group health insurance or
277 providing prepaid health care in this state.

278 (b) Detecting violations by any insurer, health maintenance
279 organization, or nonprofit hospital and medical service plan
280 corporation transacting individual or group health insurance or
281 providing prepaid health care in this state.

282 (c) Accepting, evaluating, and responding to complaints
283 regarding potential violations.

284 (d) Reviewing, from consumer complaints, for possible
285 parity violations regarding mental or nervous disorder and
286 substance use disorder coverage.

287 (e) Performing parity compliance market conduct
288 examinations, which include, but are not limited to, reviews of
289 medical management practices, network adequacy, reimbursement
290 rates, prior authorizations, and geographic restrictions of

19-01110-18

20181422__

291 insurers, health maintenance organizations, and nonprofit
292 hospital and medical service plan corporations transacting
293 individual or group health insurance or providing prepaid health
294 care in this state.

295 (6) No later than December 31 of each year, the office
296 shall issue a report to the Legislature which describes the
297 methodology the office is using to check for compliance with
298 MHPAEA; any federal guidance or regulations that relate to
299 MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45
300 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3); and this
301 section. The report must be written in nontechnical and readily
302 understandable language and must be made available to the public
303 by posting the report on the office's website and by other means
304 the office finds appropriate.

305 Section 4. This act shall take effect July 1, 2018.