By the Committee on Banking and Insurance; and Senator Rouson

597-02932-18 20181422c1

A bill to be entitled

An act relating to insurance coverage parity for mental health and substance use disorders; amending s. 409.967, F.S.; requiring contracts between the Agency for Health Care Administration and certain managed care plans to require the plans to submit a specified annual report to the agency relating to parity between mental health and substance use disorder benefits and medical and surgical benefits; amending s. 627.6675, F.S.; conforming a provision to changes made by the act; transferring, renumbering, and amending s. 627.668, F.S.; deleting certain provisions that require insurers, health maintenance organizations, and nonprofit hospital and medical service plan organizations transacting group health insurance or providing prepaid health care to offer specified optional coverage for mental and nervous disorders; requiring such entities transacting individual or group health insurance or providing prepaid health care to comply with specified provisions prohibiting the imposition of less favorable benefit limitations on mental health and substance use disorder benefits than on medical and surgical benefits; revising the standard for defining substance use disorders; requiring such entities to submit a specified annual report relating to parity between such benefits to the Office of Insurance Regulation; requiring the office to implement and enforce specified federal provisions, guidance, and regulations; specifying actions the

office must take relating to such implementation and enforcement; requiring the office to issue a specified annual report to the Legislature; repealing s. 627.669, F.S., relating to optional coverage required for substance abuse impaired persons; providing an effective date.

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

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

409.967 Managed care plan accountability.—

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

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

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

a. Mental or nervous disorder benefits;

b. Substance use disorder benefits; and

c. Medical and surgical benefits.

2. Identification of all nonquantitative treatment limitations (NQTLs) applied to both mental or nervous disorder and substance use disorder benefits and medical and surgical benefits. Within any classification of benefits, there may not

be separate NQTLs that apply to mental or nervous disorder and substance use disorder benefits but do not apply to medical and surgical benefits.

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

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

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

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

d. Identify and describe the methods and analyses used, including the results of the analyses, to determine that

processes and strategies used to apply each NQTL, in operation, for mental or nervous disorder and substance use disorder benefits are comparable to, and no more stringently applied than, the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits; and

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

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

627.6675 Conversion on termination of eligibility.—Subject to all of the provisions of this section, a group policy delivered or issued for delivery in this state by an insurer or nonprofit health care services plan that provides, on an expense-incurred basis, hospital, surgical, or major medical expense insurance, or any combination of these coverages, shall provide that an employee or member whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy, and under any group policy providing similar benefits that the terminated group policy replaced, for at least 3 months immediately prior to

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

(8) BENEFITS OFFERED.—

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

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

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

(1) Every insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation transacting individual or group health insurance or providing prepaid health care in this state must comply with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and any regulations relating to MHPAEA, including, but not limited to, 45 C.F.R. s.

146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3); and must provide ~~shall make available to the policyholder as part of the application, for an appropriate additional premium under a group hospital and medical expense-incurred insurance policy, under a group prepaid health care contract, and under a group hospital and medical service plan contract,~~ the benefits or level of benefits specified in subsection (2) for the necessary care and treatment of mental and nervous disorders, including substance use disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by ~~standard nomenclature of~~ the American Psychiatric Association~~, subject to the right of the applicant for a group policy or contract to select any alternative benefits or level of benefits as may be offered by the insurer, health maintenance organization, or service plan corporation provided that, if alternate inpatient, outpatient, or partial hospitalization benefits are selected, such benefits shall not be less than the level of benefits required under paragraph (2)(a), paragraph (2)(b), or paragraph (2)(c), respectively~~.

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

~~(a) Inpatient benefits may be limited to not less than 30 days per benefit year as defined in the policy or contract~~. ~~If inpatient hospital benefits are provided beyond 30 days per benefit year, the durational limits, dollar amounts, and~~

~~coinsurance factors thereto need not be the same as applicable to physical illness generally.~~

~~(b) Outpatient benefits may be limited to $1,000 for consultations with a licensed physician, a psychologist licensed pursuant to chapter 490, a mental health counselor licensed pursuant to chapter 491, a marriage and family therapist licensed pursuant to chapter 491, and a clinical social worker licensed pursuant to chapter 491. If benefits are provided beyond the $1,000 per benefit year, the durational limits, dollar amounts, and coinsurance factors thereof need not be the same as applicable to physical illness generally.~~

~~(c) Partial hospitalization benefits shall be provided under the direction of a licensed physician. For purposes of this part, the term "partial hospitalization services" is defined as those services offered by a program that is accredited by an accrediting organization whose standards incorporate comparable regulations required by this state. Alcohol rehabilitation programs accredited by an accrediting organization whose standards incorporate comparable regulations required by this state or approved by the state and licensed drug abuse rehabilitation programs shall also be qualified providers under this section. In a given benefit year, if partial hospitalization services or a combination of inpatient and partial hospitalization are used, the total benefits paid for all such services may not exceed the cost of 30 days after inpatient hospitalization for psychiatric services, including physician fees, which prevail in the community in which the partial hospitalization services are rendered. If partial hospitalization services benefits are provided beyond the limits~~

~~set forth in this paragraph, the durational limits, dollar amounts, and coinsurance factors thereof need not be the same as those applicable to physical illness generally.~~

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

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

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

1. Mental or nervous disorder benefits;

2. Substance use disorder benefits; and

3. Medical and surgical benefits.

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

(c) The results of an analysis demonstrating that for the medical necessity criteria described in paragraph (a) and for

each NQTL identified in paragraph (b), as written and in operation, the processes, strategies, evidentiary standards, or other factors used to apply the criteria and NQTLs to mental or nervous disorder and substance use disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to apply the criteria and NQTLs, as written and in operation, to medical and surgical benefits. At a minimum, the results of the analysis must:

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

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

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

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

5. Disclose the specific findings and conclusions reached by the insurer, health maintenance organization, or nonprofit hospital and medical service plan corporation that the results of the analyses indicate that the insurer, health maintenance organization, or nonprofit hospital and medical service plan corporation is in compliance with this section; MHPAEA; and any regulations relating to MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3).

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

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

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

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

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

(e) Performing parity compliance market conduct examinations, which include, but are not limited to, reviews of

medical management practices, network adequacy, reimbursement rates, prior authorizations, and geographic restrictions of insurers, health maintenance organizations, and nonprofit hospital and medical service plan corporations transacting individual or group health insurance or providing prepaid health care in this state.

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

Section 4. Section 627.669, Florida Statutes, is repealed.

Section 5. This act shall take effect July 1, 2018.