

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; requiring the report to  
10 contain certain information; amending s. 627.6675,  
11 F.S.; conforming a provision to changes made by the  
12 act; transferring, renumbering, and amending s.  
13 627.668, F.S.; deleting certain provisions that  
14 require insurers, health maintenance organizations,  
15 and nonprofit hospital and medical service plan  
16 organizations transacting group health insurance or  
17 providing prepaid health care to offer specified  
18 optional coverage for mental and nervous disorders;  
19 requiring such entities transacting individual or  
20 group health insurance or providing prepaid health  
21 care to comply with specified provisions prohibiting  
22 the imposition of less favorable benefit limitations  
23 on mental health and substance use disorder benefits  
24 than on medical and surgical benefits; revising the  
25 standard for defining substance use disorders;

26 requiring such entities to submit a specified annual  
27 report relating to parity between such benefits to the  
28 Office of Insurance Regulation; requiring the report  
29 to contain certain information; requiring the office  
30 to implement and enforce specified federal provisions,  
31 guidance, and regulations; specifying actions the  
32 office must take relating to such implementation and  
33 enforcement; requiring the office to issue a specified  
34 annual report to the Legislature; repealing s.  
35 627.669, F.S., relating to optional coverage required  
36 for substance abuse impaired persons; providing an  
37 effective date.

38  
39 Be It Enacted by the Legislature of the State of Florida:

40  
41 Section 1. Paragraph (p) is added to subsection (2) of  
42 section 409.967, Florida Statutes, to read:

43 409.967 Managed care plan accountability.—

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

48 (p) Annual reporting relating to parity in mental health  
49 and substance use disorder benefits.—Every managed care plan  
50 shall submit an annual report to the agency, on or before July

51 1, which contains all of the following information:

52 1. A description of the process used to develop or select

53 the medical necessity criteria for:

54 a. Mental or nervous disorder benefits;

55 b. Substance use disorder benefits; and

56 c. Medical and surgical benefits.

57 2. Identification of all nonquantitative treatment

58 limitations (NQTLs) applied to both mental or nervous disorder

59 and substance use disorder benefits and medical and surgical

60 benefits. Within any classification of benefits, there may not

61 be separate NQTLs that apply to mental or nervous disorder and

62 substance use disorder benefits but do not apply to medical and

63 surgical benefits.

64 3. The results of an analysis demonstrating that for the

65 medical necessity criteria described in subparagraph 1. and for

66 each NQTL identified in subparagraph 2., as written and in

67 operation, the processes, strategies, evidentiary standards, or

68 other factors used to apply the criteria and NQTLs to mental or

69 nervous disorder and substance use disorder benefits are

70 comparable to, and are applied no more stringently than, the

71 processes, strategies, evidentiary standards, or other factors

72 used to apply the criteria and NQTLs, as written and in

73 operation, to medical and surgical benefits. At a minimum, the

74 results of the analysis must:

75 a. Identify the factors used to determine that an NQTL

76 will apply to a benefit, including factors that were considered  
77 but rejected;

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

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

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

95 e. Disclose the specific findings and conclusions reached  
96 by the managed care plan that the results of the analyses  
97 indicate that the insurer, health maintenance organization, or  
98 nonprofit hospital and medical service plan corporation is in  
99 compliance with this section, the federal Paul Wellstone and  
100 Pete Domenici Mental Health Parity and Addiction Equity Act of

101 2008 (MHPAEA), and any federal guidance or regulations relating  
102 to MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136,  
103 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3).

104 Section 2. Paragraph (b) of subsection (8) of section  
105 627.6675, Florida Statutes, is amended to read:

106 627.6675 Conversion on termination of eligibility.—Subject  
107 to all of the provisions of this section, a group policy  
108 delivered or issued for delivery in this state by an insurer or  
109 nonprofit health care services plan that provides, on an  
110 expense-incurred basis, hospital, surgical, or major medical  
111 expense insurance, or any combination of these coverages, shall  
112 provide that an employee or member whose insurance under the  
113 group policy has been terminated for any reason, including  
114 discontinuance of the group policy in its entirety or with  
115 respect to an insured class, and who has been continuously  
116 insured under the group policy, and under any group policy  
117 providing similar benefits that the terminated group policy  
118 replaced, for at least 3 months immediately prior to  
119 termination, shall be entitled to have issued to him or her by  
120 the insurer a policy or certificate of health insurance,  
121 referred to in this section as a "converted policy." A group  
122 insurer may meet the requirements of this section by contracting  
123 with another insurer, authorized in this state, to issue an  
124 individual converted policy, which policy has been approved by  
125 the office under s. 627.410. An employee or member shall not be

126 entitled to a converted policy if termination of his or her  
127 insurance under the group policy occurred because he or she  
128 failed to pay any required contribution, or because any  
129 discontinued group coverage was replaced by similar group  
130 coverage within 31 days after discontinuance.

131 (8) BENEFITS OFFERED.—

132 (b) An insurer shall offer the benefits specified in s.  
133 627.4193 ~~s. 627.668~~ and the benefits specified in ~~s. 627.669~~ if  
134 those benefits were provided in the group plan.

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

138 627.4193 ~~627.668~~ Requirements for mental health and  
139 substance use disorder benefits; reporting requirements ~~Optional~~  
140 ~~coverage for mental and nervous disorders required; exception.—~~

141 (1) Every insurer, health maintenance organization, and  
142 nonprofit hospital and medical service plan corporation  
143 transacting individual or group health insurance or providing  
144 prepaid health care in this state must comply with the federal  
145 Paul Wellstone and Pete Domenici Mental Health Parity and  
146 Addiction Equity Act of 2008 (MHPAEA) and any federal guidance  
147 or regulations relating to MHPAEA, including, but not limited  
148 to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s.  
149 156.115(a) (3); and must provide ~~shall make available to the~~  
150 ~~policyholder as part of the application, for an appropriate~~

151 ~~additional premium under a group hospital and medical expense-~~  
152 ~~incurred insurance policy, under a group prepaid health care~~  
153 ~~contract, and under a group hospital and medical service plan~~  
154 ~~contract,~~ the benefits or level of benefits specified in  
155 subsection (2) for the necessary care and treatment of mental  
156 and nervous disorders, including substance use disorders, as  
157 defined in the Diagnostic and Statistical Manual of Mental  
158 Disorders, Fifth Edition, published by standard nomenclature of  
159 ~~the American Psychiatric Association, subject to the right of~~  
160 ~~the applicant for a group policy or contract to select any~~  
161 ~~alternative benefits or level of benefits as may be offered by~~  
162 ~~the insurer, health maintenance organization, or service plan~~  
163 ~~corporation provided that, if alternate inpatient, outpatient,~~  
164 ~~or partial hospitalization benefits are selected, such benefits~~  
165 ~~shall not be less than the level of benefits required under~~  
166 ~~paragraph (2) (a), paragraph (2) (b), or paragraph (2) (c),~~  
167 ~~respectively.~~

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

174 ~~(a) Inpatient benefits may be limited to not less than 30~~  
175 ~~days per benefit year as defined in the policy or contract. If~~

176 ~~inpatient hospital benefits are provided beyond 30 days per~~  
177 ~~benefit year, the durational limits, dollar amounts, and~~  
178 ~~coinsurance factors thereto need not be the same as applicable~~  
179 ~~to physical illness generally.~~

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

189 ~~(c) Partial hospitalization benefits shall be provided~~  
190 ~~under the direction of a licensed physician. For purposes of~~  
191 ~~this part, the term "partial hospitalization services" is~~  
192 ~~defined as those services offered by a program that is~~  
193 ~~accredited by an accrediting organization whose standards~~  
194 ~~incorporate comparable regulations required by this state.~~  
195 ~~Alcohol rehabilitation programs accredited by an accrediting~~  
196 ~~organization whose standards incorporate comparable regulations~~  
197 ~~required by this state or approved by the state and licensed~~  
198 ~~drug abuse rehabilitation programs shall also be qualified~~  
199 ~~providers under this section. In a given benefit year, if~~  
200 ~~partial hospitalization services or a combination of inpatient~~

201 ~~and partial hospitalization are used, the total benefits paid~~  
202 ~~for all such services may not exceed the cost of 30 days after~~  
203 ~~inpatient hospitalization for psychiatric services, including~~  
204 ~~physician fees, which prevail in the community in which the~~  
205 ~~partial hospitalization services are rendered. If partial~~  
206 ~~hospitalization services benefits are provided beyond the limits~~  
207 ~~set forth in this paragraph, the durational limits, dollar~~  
208 ~~amounts, and coinsurance factors thereof need not be the same as~~  
209 ~~those applicable to physical illness generally.~~

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

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

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

- 224 1. Mental or nervous disorder benefits;  
225 2. Substance use disorder benefits; and

226 3. Medical and surgical benefits.

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

234 (c) The results of an analysis demonstrating that for the  
235 medical necessity criteria described in paragraph (a) and for  
236 each NQT identified in paragraph (b), as written and in  
237 operation, the processes, strategies, evidentiary standards, or  
238 other factors used to apply the criteria and NQTs to mental or  
239 nervous disorder and substance use disorder benefits are  
240 comparable to, and are applied no more stringently than, the  
241 processes, strategies, evidentiary standards, or other factors  
242 used to apply the criteria and NQTs, as written and in  
243 operation, to medical and surgical benefits. At a minimum, the  
244 results of the analysis must:

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

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

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

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

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

274 (5) The office shall implement and enforce applicable  
275 provisions of MHPAEA and federal guidance or regulations

276 relating to MHPAEA, including, but not limited to, 45 C.F.R. s.  
277 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3),  
278 and this section, which includes:

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

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

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

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

292 (e) Performing parity compliance market conduct  
293 examinations that include, but are not limited to, reviews of  
294 medical management practices, network adequacy, reimbursement  
295 rates, prior authorizations, and geographic restrictions of  
296 insurers, health maintenance organizations, and nonprofit  
297 hospital and medical service plan corporations transacting  
298 individual or group health insurance or providing prepaid health  
299 care in this state.

300 (6) No later than December 31 of each year, the office

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301 shall issue a report to the Legislature which describes the  
302 methodology the office is using to check for compliance with  
303 MHPAEA; any federal guidance or regulations that relate to  
304 MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45  
305 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3); and this  
306 section. The report must be written in nontechnical and readily  
307 understandable language and must be made available to the public  
308 by posting the report on the office's website and by other means  
309 the office finds appropriate.

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

311 Section 5. This act shall take effect July 1, 2019.