

By Senator Rouson

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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 Medicaid managed care plans  
5           to submit an annual report to the Agency for Health  
6           Care Administration relating to parity between mental  
7           health and substance use disorder benefits and medical  
8           and surgical benefits; specifying required information  
9           in the report; amending s. 627.6675, F.S.; conforming  
10          a provision to changes made by the act; transferring,  
11          renumbering, and amending s. 627.668, F.S.; requiring  
12          certain entities transacting individual or group  
13          health insurance or providing prepaid health care to  
14          comply with specified federal provisions that prohibit  
15          the imposition of less favorable benefit limitations  
16          on mental health and substance use disorder benefits  
17          than on medical and surgical benefits; deleting  
18          provisions relating to optional coverage for mental  
19          and nervous disorders by such entities; revising the  
20          standard for defining substance use disorders;  
21          requiring such entities to submit an annual report  
22          relating to parity between mental health and substance  
23          use disorder benefits and medical and surgical  
24          benefits to the Office of Insurance Regulation;  
25          specifying required information in the report;  
26          requiring the office to implement and enforce certain  
27          federal law in a specified manner; requiring the  
28          office to issue a specified annual report to the  
29          Legislature; providing requirements for writing and

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publicly posting the report; 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 (NQTs) 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 NQTs that apply to mental or nervous disorder and  
substance use disorder benefits but do not apply to medical and

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59 surgical benefits.

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

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

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

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

84 d. Identify and describe the methods and analyses used,  
85 including the results of the analyses, to determine that the  
86 processes and strategies used to apply each NQTL, in operation,  
87 for mental or nervous disorder and substance use disorder

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88 benefits are comparable to, and are applied no more stringently  
89 than, the processes or strategies used to apply each NQTL, in  
90 operation, for medical and surgical benefits; and

91 e. Disclose the specific findings and conclusions the  
92 managed care plan reached in its analyses which indicate that  
93 the managed care plan is in compliance with this section, the  
94 federal Paul Wellstone and Pete Domenici Mental Health Parity  
95 and Addiction Equity Act of 2008 (MHPAEA), and any federal  
96 guidance or regulations relating to MHPAEA, including, but not  
97 limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45  
98 C.F.R. s. 156.115(a)(3).

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

101 627.6675 Conversion on termination of eligibility.—Subject  
102 to all of the provisions of this section, a group policy  
103 delivered or issued for delivery in this state by an insurer or  
104 nonprofit health care services plan that provides, on an  
105 expense-incurred basis, hospital, surgical, or major medical  
106 expense insurance, or any combination of these coverages, shall  
107 provide that an employee or member whose insurance under the  
108 group policy has been terminated for any reason, including  
109 discontinuance of the group policy in its entirety or with  
110 respect to an insured class, and who has been continuously  
111 insured under the group policy, and under any group policy  
112 providing similar benefits that the terminated group policy  
113 replaced, for at least 3 months immediately prior to  
114 termination, shall be entitled to have issued to him or her by  
115 the insurer a policy or certificate of health insurance,  
116 referred to in this section as a “converted policy.” A group

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

126 (8) BENEFITS OFFERED.—

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

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

133 627.4193 ~~627.668~~ Requirements for mental health and  
134 substance use disorder benefits; reporting requirements ~~Optional~~  
135 ~~coverage for mental and nervous disorders required; exception.—~~

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

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

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

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

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

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

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204 ~~those applicable to physical illness generally.~~

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

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

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

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

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

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



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

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

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

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

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

260 5. Disclose the specific findings and conclusions the  
261 insurer, health maintenance organization, or nonprofit hospital

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

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. This implementation and enforcement 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 information from consumer complaints for  
285 possible parity violations regarding mental or nervous disorder  
286 and 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

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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. Section 627.669, Florida Statutes, is repealed.

306 Section 5. This act shall take effect July 1, 2020.