

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
 30 publicly posting the report; repealing s. 627.669,
 31 F.S., relating to optional coverage required for
 32 substance abuse impaired persons; providing an
 33 effective date.

34

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

36

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

39 409.967 Managed care plan accountability.—

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

44 (p) Annual reporting relating to parity in mental health
 45 and substance use disorder benefits.—Every managed care plan
 46 shall submit an annual report to the agency, on or before July
 47 1, which contains all of the following information:

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

50 a. Mental or nervous disorder benefits;

51 b. Substance use disorder benefits; and

52 c. Medical and surgical benefits.

53 2. Identification of all nonquantitative treatment
54 limitations (NQTs) applied to both mental or nervous disorder
55 and substance use disorder benefits and medical and surgical
56 benefits. Within any classification of benefits, there may not
57 be separate NQTs that apply to mental or nervous disorder and
58 substance use disorder benefits but do not apply to medical and
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 NQT 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 NQTs 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 NQTs, 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 NQT
72 will apply to a benefit, including factors that were considered
73 but 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
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
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~~
 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.~~

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

205 (3) Insurers must maintain strict confidentiality
206 regarding psychiatric and psychotherapeutic records submitted to
207 an 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
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
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
275 maintenance organization, and nonprofit hospital and medical

276 service plan corporation transacting individual or group health
277 insurance or providing prepaid health care in this state.

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

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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.