By Senator Rouson

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1 A bill to be entitled
2 An act relating to insurance coverage parity for
3 mental, nervous, and substance use disorders; amending
4 s. 409.967, F.S.; requiring Medicaid managed care
5 plans to submit an annual report to the Agency for
6 Health Care Administration relating to parity between
7 mental or nervous disorder and substance use disorder
8 benefits and medical and surgical benefits; specifying
9 required information in the report; amending s.
10 627.6675, F.S.; conforming a provision to changes made
11 by the act; transferring, renumbering, and amending s.
12 627.668, F.S.; requiring certain entities transacting
13 individual or group health insurance or providing
14 prepaid health care to comply with specified federal
15 provisions that prohibit the imposition of less
16 favorable benefit limitations on mental or nervous
17 disorder and substance use disorder benefits than on
18 medical and surgical benefits; deleting provisions
19 relating to optional coverage for mental and nervous
20 disorders by such entities; revising the standard for
21 defining substance use disorders; requiring such
22 entities to submit an annual report relating to parity
23 between mental or nervous disorder and substance use
24 disorder benefits and medical and surgical benefits to
25 the Office of Insurance Regulation; specifying
26 required information in the report; requiring the
27 office to implement and enforce certain federal laws
28 in a specified manner; requiring the office to issue a
29 specified annual report to the Legislature; specifying

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30 requirements for writing and publicly posting the
31 report; repealing s. 627.669, F.S., relating to
32 optional coverage required for substance abuse
33 impaired persons; providing an 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 or*
45 *nervous disorder and substance use disorder benefits.*—Every
46 managed care plan shall submit an annual report to the agency,
47 on or before July 1 of each year, which contains all of the
48 following information:
49 1. A description of the process used to develop or select
50 the medical necessity criteria for:
51 a. Mental or nervous disorder benefits;
52 b. Substance use disorder benefits; and
53 c. Medical and surgical benefits.
54 2. Identification of all nonquantitative treatment
55 limitations (NQTLs) applied to both mental or nervous disorder
56 and substance use disorder benefits and medical and surgical
57 benefits. Within any classification of benefits, there may not
58 be separate NQTLs that apply to mental or nervous disorder and

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59 substance use disorder benefits but do not apply to medical and
60 surgical benefits.
61 3. The results of an analysis demonstrating that for the
62 medical necessity criteria described in subparagraph 1. and for
63 each NQTL identified in subparagraph 2., as written and in
64 operation, the processes, strategies, evidentiary standards, or
65 other factors used to apply the criteria and NQTLs to mental or
66 nervous disorder and substance use disorder benefits are
67 comparable to, and are applied no more stringently than, the
68 processes, strategies, evidentiary standards, or other factors
69 used to apply the criteria and NQTLs, as written and in
70 operation, to medical and surgical benefits. At a minimum, the
71 results of the analysis must:
72 a. Identify the factors used to determine that an NQTL will
73 apply to a benefit, including factors that were considered but
74 rejected;
75 b. Identify and define the specific evidentiary standards
76 used to define the factors and any other evidentiary standards
77 relied upon in designing each NQTL;
78 c. Identify and describe the methods and analyses used,
79 including the results of the analyses, to determine that the
80 processes and strategies used to design each NQTL, as written,
81 for mental or nervous disorder and substance use disorder
82 benefits are comparable to, and are applied no more stringently
83 than, the processes and strategies used to design each NQTL, as
84 written, for medical and surgical benefits;
85 d. Identify and describe the methods and analyses used,
86 including the results of the analyses, to determine that the
87 processes and strategies used to apply each NQTL, in operation,

88 for mental or nervous disorder and substance use disorder
89 benefits are comparable to, and are applied no more stringently
90 than, the processes or strategies used to apply each NQTL, in
91 operation, for medical and surgical benefits; and
92 e. Disclose the specific findings and conclusions the
93 managed care plan reached in its analyses which indicate that
94 the managed care plan is in compliance with this section, the
95 federal Paul Wellstone and Pete Domenici Mental Health Parity
96 and Addiction Equity Act of 2008 (MHPAEA), and any federal
97 guidance or regulations relating to MHPAEA, including, but not
98 limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45
99 C.F.R. s. 156.115(a)(3).
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,

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 and nervous
135 disorder and substance use disorder benefits; reporting
136 requirements ~~Optional coverage for mental and nervous disorders~~
137 ~~required; exception~~.—
138 (1) Every insurer, health maintenance organization, and
139 nonprofit hospital and medical service plan corporation
140 transacting individual or group health insurance or providing
141 prepaid health care in this state must comply with the federal
142 Paul Wellstone and Pete Domenici Mental Health Parity and
143 Addiction Equity Act of 2008 (MHPAEA) and any federal guidance
144 or regulations relating to MHPAEA, including, but not limited
145 to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s.

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146 156.115(a)(3); and must provide ~~shall make available to the~~
147 ~~policyholder as part of the application, for an appropriate~~
148 ~~additional premium under a group hospital and medical expense-~~
149 ~~incurred insurance policy, under a group prepaid health care~~
150 ~~contract, and under a group hospital and medical service plan~~
151 ~~contract,~~ the benefits or level of benefits specified in
152 subsection (2) for the necessary care and treatment of mental
153 and nervous disorders, including substance use disorders, as
154 defined in the Diagnostic and Statistical Manual of Mental
155 Disorders, Fifth Edition, published by ~~standard nomenclature of~~
156 the American Psychiatric Association~~, subject to the right of~~
157 ~~the applicant for a group policy or contract to select any~~
158 ~~alternative benefits or level of benefits as may be offered by~~
159 ~~the insurer, health maintenance organization, or service plan~~
160 ~~corporation provided that, if alternate inpatient, outpatient,~~
161 ~~or partial hospitalization benefits are selected, such benefits~~
162 ~~shall not be less than the level of benefits required under~~
163 ~~paragraph (2)(a), paragraph (2)(b), or paragraph (2)(c),~~
164 ~~respectively~~.
165 (2) Under individual or group policies or contracts,
166 inpatient hospital benefits, partial hospitalization benefits,
167 and outpatient benefits consisting of durational limits, dollar
168 amounts, deductibles, and coinsurance factors may ~~shall~~ not be
169 less favorable than for physical illness, in accordance with 45
170 C.F.R. s. 146.136(c)(2) and (3) ~~generally, except that:~~
171 ~~(a) Inpatient benefits may be limited to not less than 30~~
172 ~~days per benefit year as defined in the policy or contract~~. ~~If~~
173 ~~inpatient hospital benefits are provided beyond 30 days per~~
174 ~~benefit year, the durational limits, dollar amounts, and~~

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175 ~~coinsurance factors thereto need not be the same as applicable~~
176 ~~to physical illness generally.~~
177 ~~(b) Outpatient benefits may be limited to $1,000 for~~
178 ~~consultations with a licensed physician, a psychologist licensed~~
179 ~~pursuant to chapter 490, a mental health counselor licensed~~
180 ~~pursuant to chapter 491, a marriage and family therapist~~
181 ~~licensed pursuant to chapter 491, and a clinical social worker~~
182 ~~licensed pursuant to chapter 491. If benefits are provided~~
183 ~~beyond the $1,000 per benefit year, the durational limits,~~
184 ~~dollar amounts, and coinsurance factors thereof need not be the~~
185 ~~same as applicable to physical illness generally.~~
186 ~~(c) Partial hospitalization benefits shall be provided~~
187 ~~under the direction of a licensed physician. For purposes of~~
188 ~~this part, the term "partial hospitalization services" is~~
189 ~~defined as those services offered by a program that is~~
190 ~~accredited by an accrediting organization whose standards~~
191 ~~incorporate comparable regulations required by this state.~~
192 ~~Alcohol rehabilitation programs accredited by an accrediting~~
193 ~~organization whose standards incorporate comparable regulations~~
194 ~~required by this state or approved by the state and licensed~~
195 ~~drug abuse rehabilitation programs shall also be qualified~~
196 ~~providers under this section. In a given benefit year, if~~
197 ~~partial hospitalization services or a combination of inpatient~~
198 ~~and partial hospitalization are used, the total benefits paid~~
199 ~~for all such services may not exceed the cost of 30 days after~~
200 ~~inpatient hospitalization for psychiatric services, including~~
201 ~~physician fees, which prevail in the community in which the~~
202 ~~partial hospitalization services are rendered. If partial~~
203 ~~hospitalization services benefits are provided beyond the limits~~

204 ~~set forth in this paragraph, the durational limits, dollar~~
205 ~~amounts, and coinsurance factors thereof need not be the same as~~
206 ~~those applicable to physical illness generally.~~
207 (3) Insurers must maintain strict confidentiality regarding
208 psychiatric and psychotherapeutic records submitted to an
209 insurer for the purpose of reviewing a claim for benefits
210 payable under this section. These records submitted to an
211 insurer are subject to the limitations of s. 456.057, relating
212 to the furnishing of patient records.
213 (4) Every insurer, health maintenance organization, and
214 nonprofit hospital and medical service plan corporation
215 transacting individual or group health insurance or providing
216 prepaid health care in this state shall submit an annual report
217 to the office, on or before July 1 of each year, which contains
218 all of the following information:
219 (a) A description of the process used to develop or select
220 the medical necessity criteria for:
221 1. Mental or nervous disorder benefits;
222 2. Substance use disorder benefits; and
223 3. Medical and surgical benefits.
224 (b) Identification of all nonquantitative treatment
225 limitations (NQTLs) applied to both mental or nervous disorder
226 and substance use disorder benefits and medical and surgical
227 benefits. Within any classification of benefits, there may not
228 be separate NQTLs that apply to mental or nervous disorder and
229 substance use disorder benefits but do not apply to medical and
230 surgical benefits.
231 (c) The results of an analysis demonstrating that for the
232 medical necessity criteria described in paragraph (a) and for

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233 each NQTL identified in paragraph (b), as written and in
234 operation, the processes, strategies, evidentiary standards, or
235 other factors used to apply the criteria and NQTLs to mental or
236 nervous disorder and substance use disorder benefits are
237 comparable to, and are applied no more stringently than, the
238 processes, strategies, evidentiary standards, or other factors
239 used to apply the criteria and NQTLs, as written and in
240 operation, to medical and surgical benefits. At a minimum, the
241 results of the analysis must:
242 1. Identify the factors used to determine that an NQTL will
243 apply to a benefit, including factors that were considered but
244 rejected;
245 2. Identify and define the specific evidentiary standards
246 used to define the factors and any other evidentiary standards
247 relied upon in designing each NQTL;
248 3. Identify and describe the methods and analyses used,
249 including the results of the analyses, to determine that the
250 processes and strategies used to design each NQTL, as written,
251 for mental or nervous disorder and substance use disorder
252 benefits are comparable to, and are applied no more stringently
253 than, the processes and strategies used to design each NQTL, as
254 written, for medical and surgical benefits;
255 4. Identify and describe the methods and analyses used,
256 including the results of the analyses, to determine that the
257 processes and strategies used to apply each NQTL, in operation,
258 for mental or nervous disorder and substance use disorder
259 benefits are comparable to, and are applied no more stringently
260 than, the processes or strategies used to apply each NQTL, in
261 operation, for medical and surgical benefits; and

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262 5. Disclose the specific findings and conclusions the
263 insurer, health maintenance organization, or nonprofit hospital
264 and medical service plan corporation reached in its analyses
265 which indicate that the insurer, health maintenance
266 organization, or nonprofit hospital and medical service plan
267 corporation is in compliance with this section, MHPAEA, and any
268 regulations relating to MHPAEA, including, but not limited to,
269 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s.
270 156.115(a)(3).
271 (5) The office shall implement and enforce applicable
272 provisions of MHPAEA and federal guidance or regulations
273 relating to MHPAEA, including, but not limited to, 45 C.F.R. s.
274 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3),
275 and this section. This implementation and enforcement includes:
276 (a) Ensuring compliance by each insurer, health maintenance
277 organization, and nonprofit hospital and medical service plan
278 corporation transacting individual or group health insurance or
279 providing prepaid health care in this state.
280 (b) Detecting violations by any insurer, health maintenance
281 organization, or nonprofit hospital and medical service plan
282 corporation transacting individual or group health insurance or
283 providing prepaid health care in this state.
284 (c) Accepting, evaluating, and responding to complaints
285 regarding potential violations.
286 (d) Reviewing information from consumer complaints for
287 possible parity violations regarding mental or nervous disorder
288 and substance use disorder coverage.
289 (e) Performing parity compliance market conduct
290 examinations, which include, but are not limited to, reviews of

291 medical management practices, network adequacy, reimbursement
292 rates, prior authorizations, and geographic restrictions of
293 insurers, health maintenance organizations, and nonprofit
294 hospital and medical service plan corporations transacting
295 individual or group health insurance or providing prepaid health
296 care in this state.
297 (6) No later than December 31 of each year, the office
298 shall issue a report to the Legislature which describes the
299 methodology the office is using to check for compliance with
300 MHPAEA; any federal guidance or regulations that relate to
301 MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45
302 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3); and this
303 section. The report must be written in nontechnical and readily
304 understandable language and must be made available to the public
305 by posting the report on the office's website and by other means
306 the office finds appropriate.
307 Section 4. Section 627.669, Florida Statutes, is repealed.
308 Section 5. This act shall take effect July 1, 2021.

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