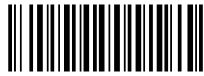 243598

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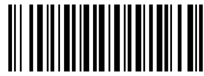
Proposed Committee Substitute by the Committee on Appropriations
(Appropriations Subcommittee on Health and Human Services)

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; amending s. 627.6675,
10 F.S.; conforming a provision to changes made by the
11 act; transferring, renumbering, and amending s.
12 627.668, F.S.; deleting certain provisions that
13 require insurers, health maintenance organizations,
14 and nonprofit hospital and medical service plan
15 organizations transacting group health insurance or
16 providing prepaid health care to offer specified
17 optional coverage for mental and nervous disorders;
18 requiring such entities transacting individual or
19 group health insurance or providing prepaid health
20 care to comply with specified provisions prohibiting
21 the imposition of less favorable benefit limitations
22 on mental health and substance use disorder benefits
23 than on medical and surgical benefits; revising the
24 standard for defining substance use disorders;
25 requiring such entities to submit a specified annual
26 report relating to parity between such benefits to the
27 Office of Insurance Regulation; requiring the office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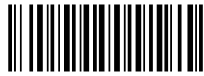
28 to implement and enforce specified federal provisions,
29 guidance, and regulations; specifying actions the
30 office must take relating to such implementation and
31 enforcement; requiring the office to issue a specified
32 annual report to the Legislature; repealing s.
33 627.669, F.S., relating to optional coverage required
34 for substance abuse impaired persons; providing an
35 appropriation; providing an effective date.
36
37 Be It Enacted by the Legislature of the State of Florida:
38
39 Section 1. Paragraph (p) is added to subsection (2) of
40 section 409.967, Florida Statutes, to read:
41 409.967 Managed care plan accountability.—
42 (2) The agency shall establish such contract requirements
43 as are necessary for the operation of the statewide managed care
44 program. In addition to any other provisions the agency may deem
45 necessary, the contract must require:
46 (p) *Annual reporting relating to parity in mental health*
47 *and substance use disorder benefits.*—Every managed care plan
48 shall submit an annual report to the agency, on or before July
49 1, which contains all of the following information:
50 1. A description of the process used to develop or select
51 the medical necessity criteria for:
52 a. Mental or nervous disorder benefits;
53 b. Substance use disorder benefits; and
54 c. Medical and surgical benefits.
55 2. Identification of all nonquantitative treatment
56 limitations (NQTLs) applied to both mental or nervous disorder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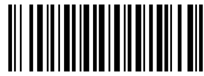
57 and substance use disorder benefits and medical and surgical
58 benefits. Within any classification of benefits, there may not
59 be separate NQTLs that apply to mental or nervous disorder and
60 substance use disorder benefits but do not apply to medical and
61 surgical benefits.
62 3. The results of an analysis demonstrating that for the
63 medical necessity criteria described in subparagraph 1. and for
64 each NQTL identified in subparagraph 2., as written and in
65 operation, the processes, strategies, evidentiary standards, or
66 other factors used to apply the criteria and NQTLs to mental or
67 nervous disorder and substance use disorder benefits are
68 comparable to, and are applied no more stringently than, the
69 processes, strategies, evidentiary standards, or other factors
70 used to apply the criteria and NQTLs, as written and in
71 operation, to medical and surgical benefits. At a minimum, the
72 results of the analysis must:
73 a. Identify the factors used to determine that an NQTL will
74 apply to a benefit, including factors that were considered but
75 rejected;
76 b. Identify and define the specific evidentiary standards
77 used to define the factors and any other evidentiary standards
78 relied upon in designing each NQTL;
79 c. Identify and describe the methods and analyses used,
80 including the results of the analyses, to determine that the
81 processes and strategies used to design each NQTL, as written,
82 for mental or nervous disorder and substance use disorder
83 benefits are comparable to, and no more stringently applied
84 than, the processes and strategies used to design each NQTL, as
85 written, for medical and surgical benefits;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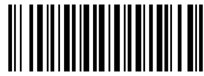
86 d. Identify and describe the methods and analyses used,
87 including the results of the analyses, to determine that
88 processes and strategies used to apply each NQTL, in operation,
89 for mental or nervous disorder and substance use disorder
90 benefits are comparable to, and no more stringently applied
91 than, the processes or strategies used to apply each NQTL, in
92 operation, for medical and surgical benefits; and
93 e. Disclose the specific findings and conclusions reached
94 by the managed care plan that the results of the analyses
95 indicate that the insurer, health maintenance organization, or
96 nonprofit hospital and medical service plan corporation is in
97 compliance with this section, the federal Paul Wellstone and
98 Pete Domenici Mental Health Parity and Addiction Equity Act of
99 2008 (MHPAEA), and any federal guidance or regulations relating
100 to MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136,
101 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3).
102 Section 2. Paragraph (b) of subsection (8) of section
103 627.6675, Florida Statutes, is amended to read:
104 627.6675 Conversion on termination of eligibility.—Subject
105 to all of the provisions of this section, a group policy
106 delivered or issued for delivery in this state by an insurer or
107 nonprofit health care services plan that provides, on an
108 expense-incurred basis, hospital, surgical, or major medical
109 expense insurance, or any combination of these coverages, shall
110 provide that an employee or member whose insurance under the
111 group policy has been terminated for any reason, including
112 discontinuance of the group policy in its entirety or with
113 respect to an insured class, and who has been continuously
114 insured under the group policy, and under any group policy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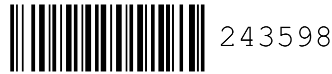
115 providing similar benefits that the terminated group policy
116 replaced, for at least 3 months immediately prior to
117 termination, shall be entitled to have issued to him or her by
118 the insurer a policy or certificate of health insurance,
119 referred to in this section as a “converted policy.” A group
120 insurer may meet the requirements of this section by contracting
121 with another insurer, authorized in this state, to issue an
122 individual converted policy, which policy has been approved by
123 the office under s. 627.410. An employee or member shall not be
124 entitled to a converted policy if termination of his or her
125 insurance under the group policy occurred because he or she
126 failed to pay any required contribution, or because any
127 discontinued group coverage was replaced by similar group
128 coverage within 31 days after discontinuance.
129 (8) BENEFITS OFFERED.—
130 (b) An insurer shall offer the benefits specified in s.
131 627.4193 ~~s. 627.668 and the benefits specified in s. 627.669~~ if
132 those benefits were provided in the group plan.
133 Section 3. Section 627.668, Florida Statutes, is
134 transferred, renumbered as section 627.4193, Florida Statutes,
135 and amended, to read:
136 627.4193 ~~627.668~~ Requirements for mental health and
137 substance use disorder benefits; reporting requirements ~~Optional~~
138 ~~coverage for mental and nervous disorders required; exception~~.—
139 (1) Every insurer, health maintenance organization, and
140 nonprofit hospital and medical service plan corporation
141 transacting individual or group health insurance or providing
142 prepaid health care in this state must comply with the federal
143 Paul Wellstone and Pete Domenici Mental Health Parity and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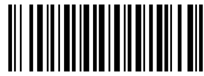
144 Addiction Equity Act of 2008 (MHPAEA) and any regulations
145 relating to MHPAEA, including, but not limited to, 45 C.F.R. s.
146 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3);
147 and must provide ~~shall make available to the policyholder as~~
148 ~~part of the application, for an appropriate additional premium~~
149 ~~under a group hospital and medical expense-incurred insurance~~
150 ~~policy, under a group prepaid health care contract, and under a~~
151 ~~group hospital and medical service plan contract,~~ the benefits
152 or level of benefits specified in subsection (2) for the
153 necessary care and treatment of mental and nervous disorders,
154 including substance use disorders, as defined in the Diagnostic
155 and Statistical Manual of Mental Disorders, Fifth Edition,
156 published by ~~standard nomenclature of~~ the American Psychiatric
157 Association~~, subject to the right of the applicant for a group~~
158 ~~policy or contract to select any alternative benefits or level~~
159 ~~of benefits as may be offered by the insurer, health maintenance~~
160 ~~organization, or service plan corporation provided that, if~~
161 ~~alternate inpatient, outpatient, or partial hospitalization~~
162 ~~benefits are selected, such benefits shall not be less than the~~
163 ~~level of benefits required under paragraph (2)(a), paragraph~~
164 ~~(2)(b), or paragraph (2)(c), 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~~



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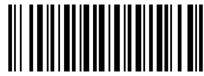
173 inpatient hospital benefits are provided beyond 30 days per
174 benefit year, the durational limits, dollar amounts, and
175 coinsurance factors thereto need not be the same as applicable
176 to physical illness generally.
177 (b) Outpatient benefits may be limited to $1,000 for
178 consultations 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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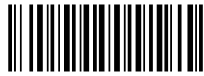
202 ~~partial hospitalization services are rendered. If partial~~
203 ~~hospitalization services benefits are provided beyond the limits~~
204 ~~set forth in this paragraph, the durational limits, dollar~~
205 ~~amounts, and coinsurance factors thereof need not be the same as~~
206 ~~those applicable 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, which contains all of the
218 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.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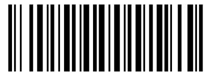
231 (c) The results of an analysis demonstrating that for the
232 medical necessity criteria described in paragraph (a) and for
233 each NQTL identified in paragraph (b), as written and in
234 operation, the processes, strategies, evidentiary standards, or
235 other factors used to apply the criteria 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 no more stringently applied
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
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 no more stringently applied than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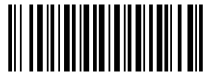
260 the processes or strategies used to apply each NQTL, in
261 operation, for medical and surgical benefits; and
262 5. Disclose the specific findings and conclusions reached
263 by the insurer, health maintenance organization, or nonprofit
264 hospital and medical service plan corporation that the results
265 of the analyses 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, which 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, from consumer complaints, for possible
287 parity violations regarding mental or nervous disorder and
288 substance use disorder coverage.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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. For the 2018-2019 fiscal year, the sum of
309 $69,414 in recurring funds is appropriated from the Insurance
310 Regulatory Trust Fund to the Office of Insurance Regulation, and
311 one full-time equivalent position with salary rate of 47,858 is
312 authorized, for the purpose of implementing s. 627.4193, Florida
313 Statutes.
314 Section 6. This act shall take effect July 1, 2018.