

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 cross-reference; transferring,  
11 renumbering, and amending s. 627.668, F.S.; deleting  
12 certain provisions that require insurers, health  
13 maintenance organizations, and nonprofit hospital and  
14 medical service plan organizations transacting group  
15 health insurance or providing prepaid health care to  
16 offer specified optional coverage for mental and  
17 nervous disorders; requiring such entities transacting  
18 individual or group health insurance or providing  
19 prepaid health care to comply with specified  
20 provisions prohibiting the imposition of less  
21 favorable benefit limitations on mental health and  
22 substance use disorder benefits than on medical and  
23 surgical benefits; requiring such entities to submit a  
24 specified annual report relating to parity between  
25 such benefits to the Office of Insurance Regulation;

26 requiring the office to implement and enforce  
 27 specified federal provisions, guidance, and  
 28 regulations; specifying actions the office must take  
 29 relating to such implementation and enforcement;  
 30 requiring the office to issue a specified annual  
 31 report to the Legislature; providing an effective  
 32 date.

33

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

35

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

38 409.967 Managed care plan accountability.—

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

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

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

49 a. Mental or nervous disorder benefits;

50 b. Substance use disorder benefits; and

51 c. Medical and surgical benefits.

52 2. Identification of all nonquantitative treatment  
53 limitations (NQTs) applied to both mental or nervous disorder  
54 and substance use disorder benefits and medical and surgical  
55 benefits. Within any classification of benefits, there may not  
56 be separate NQTs that apply to mental or nervous disorder and  
57 substance use disorder benefits but do not apply to medical and  
58 surgical benefits.

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

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

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

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

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

90 e. Disclose the specific findings and conclusions reached  
91 by the managed care plan that the results of the analyses  
92 indicate that the insurer, health maintenance organization, or  
93 nonprofit hospital and medical service plan corporation is in  
94 compliance with this section, the Paul Wellstone and Pete  
95 Domenici Mental Health Parity and Addiction Equity Act of 2008  
96 (MHPAEA); any 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); and any other relevant current or  
99 future regulations.

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 health and  
 135 substance use disorder benefits; reporting requirements ~~Optional~~  
 136 ~~coverage for mental and nervous disorders required; exception.—~~

137 (1) Every insurer, health maintenance organization, and  
 138 nonprofit hospital and medical service plan corporation  
 139 transacting individual or group health insurance or providing  
 140 prepaid health care in this state must comply with the Paul  
 141 Wellstone and Pete Domenici Mental Health Parity and Addiction  
 142 Equity Act of 2008 (MHPAEA) and any regulations relating to  
 143 MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45  
 144 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a) (3); and must  
 145 provide ~~shall make available to the policyholder as part of the~~  
 146 ~~application, for an appropriate additional premium under a group~~  
 147 ~~hospital and medical expense-incurred insurance policy, under a~~  
 148 ~~group prepaid health care contract, and under a group hospital~~  
 149 ~~and medical service plan contract,~~ the benefits or level of  
 150 benefits specified in subsection (2) for the necessary care and

151 treatment of mental and nervous disorders, including substance  
152 use disorders, as defined in the standard nomenclature of the  
153 American Psychiatric Association, ~~subject to the right of the~~  
154 ~~applicant for a group policy or contract to select any~~  
155 ~~alternative benefits or level of benefits as may be offered by~~  
156 ~~the insurer, health maintenance organization, or service plan~~  
157 ~~corporation provided that, if alternate inpatient, outpatient,~~  
158 ~~or partial hospitalization benefits are selected, such benefits~~  
159 ~~shall not be less than the level of benefits required under~~  
160 ~~paragraph (2) (a), paragraph (2) (b), or paragraph (2) (c),~~  
161 ~~respectively.~~

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

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

174 (b) ~~Outpatient benefits may be limited to \$1,000 for~~  
175 ~~consultations with a licensed physician, a psychologist licensed~~

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

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



201 ~~set forth in this paragraph, the durational limits, dollar~~  
202 ~~amounts, and coinsurance factors thereof need not be the same as~~  
203 ~~those applicable to physical illness generally.~~

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

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

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

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

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

226 substance use disorder benefits but do not apply to medical and  
227 surgical benefits.

228 (c) The results of an analysis demonstrating that for the  
229 medical necessity criteria described in paragraph (a) and for  
230 each NQTL identified in paragraph (b), as written and in  
231 operation, the processes, strategies, evidentiary standards, or  
232 other factors used to apply the criteria and NQTLs to mental or  
233 nervous disorder and substance use disorder benefits are  
234 comparable to, and are applied no more stringently than, the  
235 processes, strategies, evidentiary standards, or other factors  
236 used to apply the criteria and NQTLs, as written and in  
237 operation, to medical and surgical benefits. At a minimum, the  
238 results of the analysis must:

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

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

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

251 written, for medical and surgical benefits;

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

259 5. Disclose the specific findings and conclusions reached  
260 by the insurer, health maintenance organization, or nonprofit  
261 hospital and medical service plan corporation that the results  
262 of the analyses indicate that the insurer, health maintenance  
263 organization, or nonprofit hospital and medical service plan  
264 corporation is in compliance with this section; MHPAEA; any  
265 regulations relating to MHPAEA, including, but not limited to,  
266 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s.  
267 156.115(a) (3); and any other relevant current or future  
268 regulations.

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, which 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, from consumer complaints, for possible  
285 parity violations regarding mental or nervous disorder and  
286 substance use disorder coverage.

287 (e) Performing parity compliance market conduct  
288 examinations, which include, but is 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 regulations relating to MHPAEA, including, but not  
299 limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45  
300 C.F.R. s. 156.115(a) (3); and this section. The report must be

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301 written in nontechnical and readily understandable language and  
302 must be made available to the public by posting the report on  
303 the office's website and by other means the office finds  
304 appropriate.

305 Section 4. This act shall take effect July 1, 2018.