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 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; requiring the report to
10 contain certain information; amending s. 627.6675,
11 F.S.; conforming a provision to changes made by the
12 act; transferring, renumbering, and amending s.
13 627.668, F.S.; deleting certain provisions that
14 require insurers, health maintenance organizations,
15 and nonprofit hospital and medical service plan
16 organizations transacting group health insurance or
17 providing prepaid health care to offer specified
18 optional coverage for mental and nervous disorders;
19 requiring such entities transacting individual or
20 group health insurance or providing prepaid health
21 care to comply with specified provisions prohibiting
22 the imposition of less favorable benefit limitations
23 on mental health and substance use disorder benefits
24 than on medical and surgical benefits; revising the
25 standard for defining substance use disorders;
26 requiring such entities to submit a specified annual
27 report relating to parity between such benefits to the
28 Office of Insurance Regulation; requiring the report
29 to contain certain information; requiring the office

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30 to implement and enforce specified federal provisions,
31 guidance, and regulations; specifying actions the
32 office must take relating to such implementation and
33 enforcement; requiring the office to issue a specified
34 annual report to the Legislature; repealing s.
35 627.669, F.S., relating to optional coverage required
36 for substance abuse impaired persons; providing an
37 effective date.
38
39 Be It Enacted by the Legislature of the State of Florida:
40
41 Section 1. Paragraph (p) is added to subsection (2) of
42 section 409.967, Florida Statutes, to read:
43 409.967 Managed care plan accountability.—
44 (2) The agency shall establish such contract requirements
45 as are necessary for the operation of the statewide managed care
46 program. In addition to any other provisions the agency may deem
47 necessary, the contract must require:
48 (p) *Annual reporting relating to parity in mental health*
49 *and substance use disorder benefits.*—Every managed care plan
50 shall submit an annual report to the agency, on or before July
51 1, which contains all of the following information:
52 1. A description of the process used to develop or select
53 the medical necessity criteria for:
54 a. Mental or nervous disorder benefits;
55 b. Substance use disorder benefits; and
56 c. Medical and surgical benefits.
57 2. Identification of all nonquantitative treatment
58 limitations (NQTLs) applied to both mental or nervous disorder

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

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88 d. Identify and describe the methods and analyses used,
89 including the results of the analyses, to determine that the
90 processes and strategies used to apply each NQTL, in operation,
91 for mental or nervous disorder and substance use disorder
92 benefits are comparable to, and no more stringently applied
93 than, the processes or strategies used to apply each NQTL, in
94 operation, for medical and surgical benefits; and
95 e. Disclose the specific findings and conclusions reached
96 by the managed care plan that the results of the analyses
97 indicate that the insurer, health maintenance organization, or
98 nonprofit hospital and medical service plan corporation is in
99 compliance with this section, the federal Paul Wellstone and
100 Pete Domenici Mental Health Parity and Addiction Equity Act of
101 2008 (MHPAEA), and any federal guidance or regulations relating
102 to MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136,
103 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3).
104 Section 2. Paragraph (b) of subsection (8) of section
105 627.6675, Florida Statutes, is amended to read:
106 627.6675 Conversion on termination of eligibility.—Subject
107 to all of the provisions of this section, a group policy
108 delivered or issued for delivery in this state by an insurer or
109 nonprofit health care services plan that provides, on an
110 expense-incurred basis, hospital, surgical, or major medical
111 expense insurance, or any combination of these coverages, shall
112 provide that an employee or member whose insurance under the
113 group policy has been terminated for any reason, including
114 discontinuance of the group policy in its entirety or with
115 respect to an insured class, and who has been continuously
116 insured under the group policy, and under any group policy

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117 providing similar benefits that the terminated group policy
118 replaced, for at least 3 months immediately prior to
119 termination, shall be entitled to have issued to him or her by
120 the insurer a policy or certificate of health insurance,
121 referred to in this section as a “converted policy.” A group
122 insurer may meet the requirements of this section by contracting
123 with another insurer, authorized in this state, to issue an
124 individual converted policy, which policy has been approved by
125 the office under s. 627.410. An employee or member shall not be
126 entitled to a converted policy if termination of his or her
127 insurance under the group policy occurred because he or she
128 failed to pay any required contribution, or because any
129 discontinued group coverage was replaced by similar group
130 coverage within 31 days after discontinuance.
131 (8) BENEFITS OFFERED.—
132 (b) An insurer shall offer the benefits specified in s.
133 627.4193 ~~s. 627.668 and the benefits specified in s. 627.669~~ if
134 those benefits were provided in the group plan.
135 Section 3. Section 627.668, Florida Statutes, is
136 transferred, renumbered as section 627.4193, Florida Statutes,
137 and amended to read:
138 627.4193 ~~627.668~~ Requirements for mental health and
139 substance use disorder benefits; reporting requirements ~~Optional~~
140 ~~coverage for mental and nervous disorders required; exception~~.—
141 (1) Every insurer, health maintenance organization, and
142 nonprofit hospital and medical service plan corporation
143 transacting individual or group health insurance or providing
144 prepaid health care in this state must comply with the federal
145 Paul Wellstone and Pete Domenici Mental Health Parity and

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146 Addiction Equity Act of 2008 (MHPAEA) and any regulations
147 relating to MHPAEA, including, but not limited to, 45 C.F.R. s.
148 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3);
149 and must provide ~~shall make available to the policyholder as~~
150 ~~part of the application, for an appropriate additional premium~~
151 ~~under a group hospital and medical expense-incurred insurance~~
152 ~~policy, under a group prepaid health care contract, and under a~~
153 ~~group hospital and medical service plan contract,~~ the benefits
154 or level of benefits specified in subsection (2) for the
155 necessary care and treatment of mental and nervous disorders,
156 including substance use disorders, as defined in the Diagnostic
157 and Statistical Manual of Mental Disorders, Fifth Edition,
158 published by ~~standard nomenclature of~~ the American Psychiatric
159 Association~~, subject to the right of the applicant for a group~~
160 ~~policy or contract to select any alternative benefits or level~~
161 ~~of benefits as may be offered by the insurer, health maintenance~~
162 ~~organization, or service plan corporation provided that, if~~
163 ~~alternate inpatient, outpatient, or partial hospitalization~~
164 ~~benefits are selected, such benefits shall not be less than the~~
165 ~~level of benefits required under paragraph (2)(a), paragraph~~
166 ~~(2)(b), or paragraph (2)(c), respectively~~.
167 (2) Under individual or group policies or contracts,
168 inpatient hospital benefits, partial hospitalization benefits,
169 and outpatient benefits consisting of durational limits, dollar
170 amounts, deductibles, and coinsurance factors may ~~shall~~ not be
171 less favorable than for physical illness, in accordance with 45
172 C.F.R. s. 146.136(c)(2) and (3) ~~generally, except that:~~
173 ~~(a) Inpatient benefits may be limited to not less than 30~~
174 ~~days per benefit year as defined in the policy or contract~~. ~~If~~

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

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

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

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

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291 (e) Performing parity compliance market conduct
292 examinations, which include, but are not limited to, reviews of
293 medical management practices, network adequacy, reimbursement
294 rates, prior authorizations, and geographic restrictions of
295 insurers, health maintenance organizations, and nonprofit
296 hospital and medical service plan corporations transacting
297 individual or group health insurance or providing prepaid health
298 care in this state.
299 (6) No later than December 31 of each year, the office
300 shall issue a report to the Legislature which describes the
301 methodology the office is using to check for compliance with
302 MHPAEA; any federal guidance or regulations that relate to
303 MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45
304 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3); and this
305 section. The report must be written in nontechnical and readily
306 understandable language and must be made available to the public
307 by posting the report on the office’s website and by other means
308 the office finds appropriate.
309 Section 4. Section 627.669, Florida Statutes, is repealed.
310 Section 5. This act shall take effect July 1, 2019.