By Senator \_\_\_\_\_\_

A bill to be entitled

An act relating to insurance coverage for mental and nervous disorders; amending S. 627.668, F.S.; providing that certain coverage for mental and nervous disorders is at parity with coverage for other medical care; providing that insurers submit certain information demonstrating compliance with parity; providing that the Office of Insurance Regulation implement parity; providing coverage specifications for medications used for the treatment of substance use disorders; providing an effective date.

Be it enacted by the Legislature of the state of Florida:

Section 1. Section 627.668, Florida Statutes, is amended to read:

627.668 Optional coverage for mental and nervous disorders required; exception.—

(1) Every insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation transacting individual or group health insurance or providing prepaid health care in this state shall comply with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and any regulations that relate to MHPAEA, including but not limited to 45 CFR 146.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3) and provide ~~make available to the policyholder as part of the application, for an appropriate additional premium under a group hospital and medical expense-incurred insurance policy, under a group prepaid health care contract, and under a group hospital and medical service plan contract,~~ the benefits or level of benefits specified in subsection (2) for the necessary care and treatment of mental and nervous disorders, including substance use disorders, as defined in the standard nomenclature of the American Psychiatric Association, ~~subject to the right of the applicant for a group policy or contract to select any alternative benefits or level of benefits as may be offered by the insurer, health maintenance organization, or service plan corporation provided that, if alternate inpatient, outpatient, or partial hospitalization benefits are selected, such benefits shall not be less than the level of benefits required under paragraph (2)(a), paragraph (2)(b), or paragraph (2)(c), respectively~~.

(2) Under individual or group policies or contracts, inpatient hospital benefits, partial hospitalization benefits, and outpatient benefits consisting of durational limits, dollar amounts, deductibles, and coinsurance factors shall not be less favorable than for physical illness, in accordance with 45 CFR 146.136(c)(2) and 45 CFR 146.136(c)(3) ~~generally, except that:~~

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

~~(b) Outpatient benefits may be limited to $1,000 for consultations with a licensed physician, a psychologist licensed pursuant to chapter 490, a mental health counselor licensed pursuant to chapter 491, a marriage and family therapist licensed pursuant to chapter 491, and a clinical social worker licensed pursuant to chapter 491. If benefits are provided beyond the $1,000 per benefit year, the durational limits, dollar amounts, and coinsurance factors thereof need not be the same as applicable to physical illness generally.~~

~~(c) Partial hospitalization benefits shall be provided under the direction of a licensed physician. For purposes of this part, the term “partial hospitalization services” is defined as those services offered by a program that is accredited by an accrediting organization whose standards incorporate comparable regulations required by this state. Alcohol rehabilitation programs accredited by an accrediting organization whose standards incorporate comparable regulations required by this state or approved by the state and licensed drug abuse rehabilitation programs shall also be qualified providers under this section. In a given benefit year, if partial hospitalization services or a combination of inpatient and partial hospitalization are used, the total benefits paid for all such services may not exceed the cost of 30 days after inpatient hospitalization for psychiatric services, including physician fees, which prevail in the community in which the partial hospitalization services are rendered. If partial hospitalization services benefits are provided beyond the limits set forth in this paragraph, the durational limits, dollar amounts, and coinsurance factors thereof need not be the same as those applicable to physical illness generally~~.

(3) Insurers must maintain strict confidentiality regarding psychiatric and psychotherapeutic records submitted to an insurer for the purpose of reviewing a claim for benefits payable under this section. These records submitted to an insurer are subject to the limitations of s. [456.057](http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0400-0499/0456/Sections/0456.057.html), relating to the furnishing of patient records.

(4) Every insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation transacting individual or group health insurance or providing prepaid health care in this state shall submit an annual report to the Office of Insurance Regulation on or before July 1 that contains the following information:

(a) A description of the process used to develop or select the medical necessity criteria for mental or nervous disorderbenefits*,* the process used to develop or select the medical necessity criteria for substance use disorder benefits,and the process used to develop or select the medical necessity criteria for medical and surgical benefits.

(b) Identification of all non-quantitative treatment limitations (NQTLs) that are applied to both mental or nervous disorder and substance use disorderbenefits and medical and surgical benefits; there may be no separate NQTLs that apply to mental or nervous disorder and substance use disorder benefits but do not apply to medical and surgical benefits within any classification of benefits.

(c) The results of an analysis that demonstrates that for the medical necessity criteria described in paragraph (a) and for each NQTL identified in paragraph (b), as written and in operation, the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and each NQTL to mental or nervous disorder and substance use disorder benefits are comparable to, and are applied no more stringently than the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and each NQTL, as written and in operation, to medical and surgical benefits; at a minimum, the results of the analysis shall:

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

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

3. Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each NQTL, as written, and the as written processes and strategies used to apply the NQTL to mental or nervous disorder and substance use disorder benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each NQTL, as written, and the as written processes and strategies used to apply the NQTL to medical and surgical benefits;

4. Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each NQTL, in operation, for mental or nervous disorder and substance use disorderbenefits are comparable to, and are applied no more stringently than, the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits;

5. Disclose the specific findings and conclusions reached by the insurer, health maintenance organization, or nonprofit hospital and medical service plan corporation that the results of the analyses above indicate that the insurer, health maintenance organization, or nonprofit hospital and medical service plan corporation is in compliance with this section and the Mental Health Parity and Addiction Equity Act of 2008 and any regulations that relate to MHPAEA, including but not limited to 45 CFR 146.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3) and any other relevant current or future regulations.

(5) The Office of Insurance Regulation shall implement and enforce applicable provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and federal guidance or regulations that relate to MHPAEA, including but not limited to 45 CFR 146.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3), and this section, which includes:

(a) Ensuring compliance by each insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation transacting individual or group health insurance or providing prepaid health care in this state.

(b) Detecting violations of the law by each insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation transacting individual or group health insurance or providing prepaid health care in this state.

(c) Accepting, evaluating, and responding to complaints regarding such potential violations.

(d) Reviewing for possible parity violations all consumer complaints regarding mental or nervous disorder and substance use disorder coverage.

(e) Performing parity compliance market conduct examinations of insurers, health maintenance organizations, and nonprofit hospital and medical service plan corporations transacting individual or group health insurance or providing prepaid health care in this state*,* including but not limited to reviews of medical management practices, network adequacy, reimbursement rates, prior authorizations, and geographic restrictions.

(6) Not later than December 31of each year, the Office of Insurance Regulation shall issue a report to the Legislature that describes the methodology the Office is using to check for compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and any and federal guidance or regulations that relate to MHPAEA, including but not limited to 45 CFR 146.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3), and this section. The report must be written in non-technical, readily understandable language and shall be made available to the public by, among such other means as the Office finds appropriate, posting the report on the Office’s Internet website.

(7) Each insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation that issues individual and group policies or contracts that provide prescription drug benefits for the treatment of substance use disorders shall not impose any prior authorization requirements on any prescription medication approved by the federal Food and Drug Administration (FDA) for the treatment of substance use disorders.

(8) Each insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation that issues individual and group policies or contracts that provide prescription drug benefits for the treatment of substance use disorders shall not impose any step therapy requirements before the insurer, health maintenance organization, or nonprofit hospital and medical service plan corporation will authorize coverage for a prescription medication approved by the FDA for the treatment of substance use disorders.

(9) Each insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation that issues individual and group policies or contracts that provide prescription drug benefits for the treatment of substance use disorders shall place all prescription medications approved by the FDA for the treatment of substance use disorders on the lowest tier of the drug formulary developed and maintained by the insurer, health maintenance organization, or nonprofit hospital and medical service plan corporation.

(10) Each insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation that issues individual and group policies or contracts that provide prescription drug benefits for the treatment of substance use disorders shall not exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services on the grounds that such medications and services were court ordered.

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

409.967 Managed Care Accountability.—

(2)

(p) Every managed care plan shall submit an annual report to the Agency for Health Care Administration on or before July 1 that contains the following information:

1. A description of the process used to develop or select the medical necessity criteria for mental or nervous disorderbenefits*,* the process used to develop or select the medical necessity criteria for substance use disorder benefits,and the process used to develop or select the medical necessity criteria for medical and surgical benefits.

2. Identification of all non-quantitative treatment limitations (NQTLs) that are applied to both mental or nervous disorder and substance use disorderbenefits and medical and surgical benefits; there may be no separate NQTLs that apply to mental or nervous disorder and substance use disorder benefits but do not apply to medical and surgical benefits within any classification of benefits.

3. The results of an analysis that demonstrates that for the medical necessity criteria described in subparagraph (1) and for each NQTL identified in subparagraph (2), as written and in operation, the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and each NQTL to mental or nervous disorder and substance use disorder benefits are comparable to, and are applied no more stringently than the processes, strategies, evidentiary standards, or other factors used to apply the medical necessity criteria and each NQTL, as written and in operation, to medical and surgical benefits; at a minimum, the results of the analysis shall:

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

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

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

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

e. Disclose the specific findings and conclusions reached by the managed care plan that the results of the analyses above indicate that the insurer, health maintenance organization, or nonprofit hospital and medical service plan corporation is in compliance with this section and the Mental Health Parity and Addiction Equity Act of 2008 and any federal guidance or regulations that relate to MHPAEA, including but not limited to 45 CFR 146.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3) and any other relevant current or future regulations.

Section 3. This act shall take effect July 1, 2019.