Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate House

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Representative(s) Kendrick offered the following:

Amendment (with title amendment)

Between line(s) 200 and 201, insert:

Section 5. Effective July 1, 2007, and applicable to any policy issued, written, or renewed on or after such date, 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 group health insurance or providing prepaid health care in this state shall 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, 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 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 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 accredited by the Joint Commission on Accreditation of Hospitals (JCAH) or in compliance with equivalent standards. Alcohol rehabilitation programs accredited by the Joint Commission on Accreditation of Hospitals or approved by the state and licensed drug abuse rehabilitation programs shall also be qualified providers under this section. In any benefit year, if partial hospitalization services or a combination of inpatient and partial hospitalization are utilized, the total benefits paid for all such services shall not exceed the cost of 30 days of 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)(a) Every insurer and health maintenance organization transacting group health insurance or providing prepaid health care in this state shall make available to the policyholder, for an appropriate additional premium, as part of the application for a group hospital and medical expense-incurred insurance policy, a group prepaid health care contract, or a group health maintenance organization contract, coverage for the treatment of

serious mental illness, which treatment is determined to be medically necessary.

(b) Under group policies or contracts, inpatient hospital benefits, partial hospitalization benefits, and outpatient benefits, consisting of durational limits, dollar amounts, deductibles, and coinsurance factors, must be the same for serious mental illness as for physical illness generally. Notwithstanding the provisions of this subsection, an insurer or health maintenance organization may limit inpatient coverage to 45 days per year and may limit outpatient coverage to 60 visits per year.

(c) This subsection does not apply to any group health plan, or group health insurance covered in connection with a group health plan, for any plan year of a small employer as defined in s. 627.6699.

(d) As used in this subsection, the term "serious mental illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the most current edition of the Diagnostic and Statistical Manual: schizophrenia, schizoaffective disorder, panic disorder, bipolar affective disorder, major depressive disorder, and specific obsessive-compulsive disorder.

(e) Notwithstanding any other provisions of this section, chapter 641, s. 627.6471, or s. 627.6472, an insurer or health maintenance organization may require that the covered services required by this section be provided by an exclusive provider of health care, or a group of exclusive providers of health care, which has entered into a written agreement with the insurer or health maintenance organization to provide benefits under this

section. The insurer or health maintenance organization may make the payment of such benefits, in whole or in part, contingent upon the use of such exclusive providers.

(f) The insurer or health maintenance organization may directly or indirectly enter into a capitation contract with an exclusive provider of health care or a group of exclusive providers of health care to provide benefits under this section. In providing the benefits under this section, the insurer or health maintenance organization may impose other appropriate financial incentives, peer review, and utilization requirements to reduce service costs and utilization without compromising quality of care.

(g) This subsection does not apply with respect to a group health plan or health insurance coverage offered in connection with a group health plan if the application of this subsection to a plan or coverage results in an increase in the cost under the plan or coverage of more than 2 percent, as determined and certified by an insurer's or health maintenance organization's actuary.

(4) ~~(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, relating to the furnishing of patient records.

======= T I T L E A M E N D M E N T =======

Remove line(s) 23 and insert:

insurers to implement such requirements; amending s. 627.668, F.S.; revising provisions relating to required optional coverage for mental and nervous disorders; providing additional requirements; specifying nonapplication; providing a definition; authorizing insurers and health maintenance organizations to require certain services to be provided by certain exclusive providers; providing for a payment of benefits contingency; authorizing insures and health maintenance organizations to enter into capitation contracts with exclusive providers for certain purposes; specifying nonapplication to certain health plans or health insurance coverages; amending s.