Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate House

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Representative(s) Benson, H. Gibson, Baxley, Galvano, Kendrick, Garcia, Negron, and Bean offered the following:

Substitute Amendment for Amendment (446541) (with title amendment)

Remove line 250 and insert:

Section 11. 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.

Section 12. Paragraph (i) of subsection (2) of section 636.204, Florida Statutes, is amended to read:

636.204 License required.--

(2) An application for a license to operate as a discount medical plan organization must be filed with the office on a form prescribed by the commission. Such application must be sworn to by an officer or authorized representative of the applicant and be accompanied by the following, if applicable:

(i) A copy of the applicant's most recent financial statements audited by an independent certified public accountant. An applicant that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the subsidiary may submit ~~petition the office to accept~~, in lieu of the audited financial statement of the applicant, the audited financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the applicant required by this part will be met by the parent entity.

Section 13. Subsection (1) of section 636.206, Florida Statutes, is amended to read:

636.206 Examinations and investigations.--

(1) The office may examine or investigate the business and affairs of any discount medical plan organization if the commissioner has reason to believe that the discount medical plan organization is not complying with the requirements of this act. The office may order any discount medical plan organization or applicant to produce any records, books, files, advertising and solicitation materials, or other information and may take

statements under oath to determine whether the discount medical plan organization or applicant is in violation of the law or is acting contrary to the public interest. The expenses incurred in conducting any examination or investigation must be paid by the discount medical plan organization or applicant. Examinations and investigations must be conducted as provided in chapter 624.

Section 14. Subsection (1) of section 636.210, Florida Statutes, is amended to read:

636.210 Prohibited activities of a discount medical plan organization.--

(1) A discount medical plan organization may not:

(a) Use in its advertisements, marketing material, brochures, and discount cards the term "insurance" except as otherwise provided in this part or as a disclaimer of any relationship between discount medical plan organization benefits and insurance;

(b) Use in its advertisements, marketing material, brochures, and discount cards the terms "health plan," "coverage," "copay," "copayments," "preexisting conditions," "guaranteed issue," "premium," "PPO," "preferred provider organization," or other terms in a manner that could reasonably mislead a person into believing the discount medical plan was health insurance;

(c) Have restrictions on free access to plan providers, <u>except for hospital services,</u> including, but not limited to, waiting periods and notification periods; or

(d) Pay providers any fees for medical services.

Section 15. Subsection (1) of section 636.216, Florida Statutes, is amended to read:

636.216 Charge or form filings.--

(1) All charges to members must be filed with the office. ~~and~~ Any charge to members greater than $30 per month or $360 per year for access to healthcare services, other than those provided by physicians licensed under chapters 458 and 459 or by hospitals licensed under chapter 395, must be approved by the office before the charges can be used. Any charge to members greater than $60 dollars per month or $720 per year for healthcare services that include services provided by physicians licensed under chapter 458 and 459 or by hospitals licensed under chapter 395 must be approved by the office before the charges can be used. The discount medical plan organization has the burden of proof that the charges bear a reasonable relation to the benefits received by the member.

Section 16. Subsection (2) of section 636.218, Florida Statutes, is amended to read:

636.218 Annual reports.--

(2) Such reports must be on forms prescribed by the commission and must include:

~~(a) Audited financial statements prepared in accordance with generally accepted accounting principles certified by an independent certified public accountant, including the organization's balance sheet, income statement, and statement of changes in cash flow for the preceding year. An organization that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the organization may petition the office to accept, in lieu of the audited financial statement of the organization, the audited~~

~~financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the organization required by this part will be met by the parent entity.~~

(a) ~~(b)~~ If different from the initial application or the last annual report, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements between such persons and the discount medical plan organization, including any possible conflicts of interest.

(b) ~~(c)~~ The number of discount medical plan members in the state.

(c) ~~(d)~~ Such other information relating to the performance of the discount medical plan organization as is reasonably required by the commission or office.

Section 17. Subsection (1) of section 636.220, Florida Statutes, is amended to read:

636.220 Minimum capital requirements.--

(1) Each discount medical plan organization must at all times maintain a net worth of at least $150,000 and each discount medical plan organization shall certify in writing under oath at licensure and annually that the minimum capitalization requirements of this part are satisfied.

Section 18. Section 636.230, Florida Statutes, is amended to read:

636.230 Bundling discount medical plans with insurance ~~other~~ products.--When a marketer or discount medical plan organization sells a discount medical plan together with any

insurance ~~other~~ product, the fees for the discount medical plan must be provided in writing to the member if the fees exceed $30 per month for access to healthcare services other than those provided by physicians licensed under chapter 458 or chapter 459 or by hospitals licensed under chapter 395 or $60 dollars per month for healthcare services which include services provided by physicians licensed under chapter 458 or chapter 459 or by hospitals licensed under chapter 395.

Section 19. Except as otherwise expressly provided in this act, this act shall take effect January 1, 2007,

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

Remove line 21, and insert:

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. 636.204, F.S.; revising a license application provision for discount medical plan organizations relating to submittal of financial statements;; amending s. 636.206, F.S.; revising examination and investigative authority; amending s. 636.210, F.S.; providing an exception to prohibited activities; amending s. 636.216, F.S.; providing provisions

relating to office approval of certain charges to members of the plan; amending s. 636.218, F.S.; removing certain information from the annual report; amending s. 636.220, F.S.; revising certain minimum capital requirements of discount medical plan organizations; amending s. 636.230, F.S.; revising provisions relating to the bundling of discount medical plans with insurance products; providing application; providing effective dates.