Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate House

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Representatives Benson, H. Gibson, Baxley, Galvano, Kendrick, Garcia, Negron, and Bean offered the following:

Amendment (with title amendment)

Between line(s) 116 and 117, insert:

Section 4. 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 subsection (2) ~~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) In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

(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 5. 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:

(a) A copy of the applicant's articles of incorporation or other organizing documents, including all amendments.

(b) A copy of the applicant's bylaws.

(c) A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire 10 percent or more of the voting securities of the applicant. Such listing must fully disclose the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant's affairs and the discount medical plan organization, including any possible conflicts of interest.

(d) A complete biographical statement, on forms prescribed by the commission, an independent investigation report, and a

set of fingerprints, as provided in chapter 624, with respect to each individual identified under paragraph (c).

(e) A statement generally describing the applicant, its facilities and personnel, and the medical services to be offered.

(f) A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of medical services to members.

(g) A copy of the form of any contract made or arrangement to be made between the applicant and any person listed in paragraph (c).

(h) A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function, including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of health services to members.

~~(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 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.~~

(i)~~(j)~~ A description of the proposed method of marketing.

(j) ~~(k)~~ A description of the subscriber complaint procedures to be established and maintained.

(k) ~~(l)~~ The fee for issuance of a license.

(l) ~~(m)~~ Such other information as the commission or office may reasonably require to make the determinations required by this part.

Section 6. 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 7. 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, except for hospital services, including, but not limited to, waiting periods and notification periods; or

(d) Pay providers any fees for medical services.

Section 8. Subsections (1), (3), and (4) of section 636.216, Florida Statutes, are 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.

(3) All forms used, including the written agreement pursuant to subsection (2), must first be filed with ~~and approved by~~ the office. Every form filed shall be identified by a unique form number placed in the lower left corner of each form.

(4) A charge ~~or form~~ is considered approved on the 60th day after its date of filing unless it has been previously disapproved by the office. ~~The office shall disapprove any form that does not meet the requirements of this part or that is unreasonable, discriminatory, misleading, or unfair.~~ If such filing is ~~filings are~~ disapproved, the office shall notify the discount medical plan organization and shall specify in the notice the reasons for disapproval.

Section 9. 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 10. 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 11. Section 636.230, Florida Statutes, is repealed.

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

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Remove line 15 and insert:

under group health insurance policies; amending s. 627.668, F.S.; revising the benefit level for treatment of mental and nervous disorders; amending s. 636.204, F.S.; revising license application provisions for discount medical plan organizations; 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 exception to review 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; repealing s. 636.230, F.S., relating to the bundling of discount medical plans with other products; amending s. 641.31,