A bill to be entitled

An act relating to coverage for mental, nervous, and substance-related disorders; amending s. 627.668, F.S.; revising requirements for optional coverage for mental, nervous, and substance-related disorders; revising certain benefits limitations; providing an options application requirement; repealing s. 627.669, F.S., relating to optional coverage required for substance abuse impaired persons; amending s. 627.6675, F.S.; conforming a cross-reference; 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, and substance-related 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 all diagnostic categories of mental health and substance-related disorders listed in the most recent edition of the Diagnostic

and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, and as listed in the mental and behavioral disorders section of the current International Classification of Diseases, to include schizophrenia, schizophreniform disorders, schizo-affective disorders, paranoid and other psychotic disorders, bipolar disorders, panic disorders, obsessive-compulsive disorders, major depressive disorders, anxiety disorders, mood disorders, pervasive development disorders or autism, depression in childhood and adolescence, personality disorders, paraphilias, attention deficit and disruptive behavior disorders, tic disorders, eating disorders including bulimia and anorexia, substance-related disorders, Asperger's disorder, intermittent explosive disorder, posttraumatic stress disorder, psychosis not otherwise specified (NOS) when diagnosed in a child under 17 years of age, Rett's disorder, Tourette's disorder, delirium, and dementia ~~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 ~~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 may not be more restrictive than the treatment limitations and cost-sharing requirements under the plan that are applicable to other disease, illnesses, and medical conditions. ~~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 2. Section 627.669, Florida Statutes, is repealed.

Section 3. Paragraph (b) of subsection (8) of section 627.6675, Florida Statutes, is amended to read:

627.6675 Conversion on termination of eligibility.--Subject to all of the provisions of this section,

a group policy delivered or issued for delivery in this state by an insurer or nonprofit health care services plan that provides, on an expense-incurred basis, hospital, surgical, or major medical expense insurance, or any combination of these coverages, shall provide that an employee or member whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy, and under any group policy providing similar benefits that the terminated group policy replaced, for at least 3 months immediately prior to termination, shall be entitled to have issued to him or her by the insurer a policy or certificate of health insurance, referred to in this section as a "converted policy." A group insurer may meet the requirements of this section by contracting with another insurer, authorized in this state, to issue an individual converted policy, which policy has been approved by the office under s. 627.410. An employee or member shall not be entitled to a converted policy if termination of his or her insurance under the group policy occurred because he or she failed to pay any required contribution, or because any discontinued group coverage was replaced by similar group coverage within 31 days after discontinuance.

(8) BENEFITS OFFERED.--

(b) An insurer shall offer the benefits specified in s. 627.668 ~~and the benefits specified in s. 627.669~~ if those benefits were provided in the group plan.

Section 4. This act shall take effect January 1, 2009.