CHAPTER 97-48

Committee Substitute for Senate Bill Nos. 530 and 848

An act relating to breast cancer treatment; amending s. 627.6417, F.S.; requiring certain health insurance policies to provide coverage for breast reconstructive surgery and prosthetic devices; creating s. 627.64171, F.S.; providing for length of stay and followup care for persons who have a mastectomy; prohibiting certain acts by insurers; providing that the act does not require a hospital stay; providing for cost-sharing; limiting the application of the law; providing exceptions; creating s. 627.64172, F.S.; providing requirements with respect to followup care; providing for a determination of a preexisting condition; amending s. 627.6419, F.S.; including insureds who have been free from breast cancer for a period of time in the coverage requirements; prohibiting an insurer from denying, canceling, or failing to renew a health or accident insurance policy or exclude coverage or benefits under certain conditions; amending s. 627.651, F.S.; applying certain requirements for group coverage to multiple-employer welfare arrangements; amending s. 627.6515, F.S.; applying certain requirements for group coverage to out-of-state groups; amending s. 627.6612, F.S.; requiring certain health insurance policies to provide coverage for breast reconstructive surgery and prosthetic devices; creating s. 627.66121, F.S.; providing for length of stay and followup care for persons who have a mastectomy; prohibiting certain acts by insurers; providing that the act does not require a hospital stay; providing for cost-sharing; limiting the application of the law; providing exceptions; creating s. 627.66122, F.S.; providing requirements with respect to followup care; providing for a determination of a preexisting condition; amending s. 627.6699, F.S.; applying certain requirements for group coverage to coverage for small employers; creating s. 641.31096, F.S.; providing requirements with respect to followup care; providing for a determination of a preexisting condition; amending s. 641.31, F.S.; providing for length of stay and followup care for persons who have a mastectomy; prohibiting certain acts by health maintenance organizations; providing that the act does not require a hospital stay; providing for cost-sharing; limiting the application of the law; providing exceptions; requiring health maintenance organization contracts to provide coverage for breast reconstructive surgery and prosthetic devices; providing a statement that the act fulfills an important state interest; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 627.6417, Florida Statutes, is amended to read:

627.6417 ~~Optional~~ Coverage for surgical procedures and devices incident to mastectomy.—

(1) Any ~~An accident or~~ health insurance policy ~~issued, amended, delivered, or renewed in this state~~ that provides coverage for mastectomies must also provide ~~make available to the policyholder, as part of the application,~~ coverage for ~~the initial~~ prosthetic devices ~~device~~ and breast reconstructive surgery incident to the mastectomy. The insurer may charge an appropriate additional premium for the coverage required by this subsection. The coverage for prosthetic devices and breast reconstructive surgery shall be ~~is~~ subject to any ~~the~~ deductible and coinsurance conditions ~~applied to the mastectomy,~~ and all other terms and conditions applicable to other benefits. Breast reconstructive surgery must be in a manner chosen by the treating physician, consistent with prevailing medical standards, and in consultation with the patient. ~~If a mastectomy is performed and there is no evidence of malignancy, the coverage may be limited to the provision of the initial prosthetic device and reconstructive surgery within 2 years after the date of the mastectomy.~~

(2) As used in this section, the term "mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician, and the term "breast reconstructive surgery" means surgery to reestablish symmetry between the two breasts.

(3) This section does not apply to disability income, specified disease other than cancer, or hospital indemnity policies.

Section 2. Section 627.64171, Florida Statutes, is created to read:

627.64171 Coverage for length of stay and outpatient postsurgical care.—

(1) Any health insurance policy that is issued, amended, delivered, or renewed in this state which provides coverage for breast cancer treatment may not limit inpatient hospital coverage for mastectomies to any period that is less than that determined by the treating physician to be medically necessary in accordance with prevailing medical standards and after consultation with the insured patient.

(2) Any health insurance policy that provides coverage for mastectomies under subsection (1) must also provide coverage for outpatient postsurgical followup care in keeping with prevailing medical standards by a licensed health care professional qualified to provide postsurgical mastectomy care. The treating physician, after consultation with the insured patient, may choose that the outpatient care be provided at the most medically appropriate setting, which may include the hospital, treating physician's office, outpatient center, or home of the insured patient.

(3) An insurer subject to subsection (1) may not:

(a) Deny to an insured eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the policy for the purpose of avoiding the requirements of this section;

(b) Provide monetary payments or rebates to an insured patient to accept less than the minimum protections available under this section;

(c) Penalize or otherwise reduce or limit the reimbursement of an attending provider solely because the attending provider provided care to an insured patient under this section;

(d) Provide incentives, monetary or otherwise, to an attending provider solely to induce the provider to provide care to an insured patient in a manner inconsistent with this section; or

(e) Subject to the other provisions of this section, restrict benefits for any portion of a period within a hospital length of stay or outpatient care as required by this section in a manner that is less than favorable than the benefits provided for any preceding portion of such stay.

(4)(a) This section does not require an insured patient to have the mastectomy in the hospital or stay in the hospital for a fixed period of time following the mastectomy.

(b) This section does not prevent a policy from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits under this section, except that such cost-sharing may not exceed cost-sharing with other benefits.

(5) Except as provided in subsection (3), this section does not affect any agreement between an insurer and a hospital or other health care provider with respect to reimbursement for health care services provided, rate negotiations with providers, or capitation of providers, and does not prohibit appropriate utilization review or case management by the insurer.

(6) This section does not apply to disability income, specified diseases other than cancer, or hospital indemnity policies.

(7) As used in this section, the term "mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.

Section 3. Section 627.64172, Florida Statutes, is created to read:

627.64172 Requirements with respect to breast cancer and routine followup care.—Routine followup care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care, or treatment for purposes of determining preexisting conditions, unless evidence of breast cancer is found during or as a result of the followup care.

Section 4. Section 627.6419, Florida Statutes, is amended to read:

627.6419 Requirements with respect to breast cancer ~~fibrocystic conditions~~.—

(1) An insurer may not deny the issuance or renewal of, or cancel, a policy of accident insurance or health insurance, nor include any exception or exclusion of benefits in a policy~~,~~ solely because the insured has been diagnosed as having a fibrocystic condition or a nonmalignant lesion that demonstrates a predisposition, unless the condition is diagnosed through a breast

biopsy that demonstrates an increased disposition to developing breast cancer.

(2) An insurer may not deny the issuance or renewal of, or cancel, a policy of accident insurance or health insurance, nor include any exception or exclusion of benefits in a policy solely due to breast cancer, if the insured has been free from breast cancer for more than 2 years before the applicant's request for health insurance coverage.

(3) This section also applies to a policy of group, blanket, or franchise accident or health insurance and to a contract or evidence of coverage issued by a health maintenance organization.

Section 5. Subsection (4) of section 627.651, Florida Statutes, is amended to read:

627.651 Group contracts and plans of self-insurance must meet group requirements.—

(4) This section does not apply to any plan which is established or maintained by an individual employer in accordance with the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, or to a multiple-employer welfare arrangement as defined in s. 624.437(1), except that a multiple-employer welfare arrangement shall comply with ss. 627.419, 627.657, 627.6575, 627.6576, 627.6578, 627.6579, 627.6612, 627.66121, 627.66122, 627.6615, 627.6616, and 627.662(6). This subsection does not allow an authorized insurer to issue a group health insurance policy or certificate which does not comply with this part.

Section 6. Subsection (2) of section 627.6515, Florida Statutes, 1996 Supplement, is amended to read:

627.6515 Out-of-state groups.—

(2) This part does not apply to a group health insurance policy issued or delivered outside this state under which a resident of this state is provided coverage if:

(a) The policy is issued to an employee group the composition of which is substantially as described in s. 627.653; a labor union group or association group the composition of which is substantially as described in s. 627.654; an additional group the composition of which is substantially as described in s. 627.656; a group insured under a blanket health policy when the composition of the group is substantially in compliance with s. 627.659; a group insured under a franchise health policy when the composition of the group is substantially in compliance with s. 627.663; an association group to cover persons associated in any other common group, which common group is formed primarily for purposes other than providing insurance; a group that is established primarily for the purpose of providing group insurance, provided the benefits are reasonable in relation to the premiums charged thereunder and the issuance of the group policy has resulted, or will result, in economies of administration; or a group of insurance agents of an insurer, which insurer is the policyholder;

(b) Certificates evidencing coverage under the policy are issued to residents of this state and contain in contrasting color and not less than 10-point type the following statement: "The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida"; and

(c) The policy provides the benefits specified in ss. 627.419, 627.6574, 627.6575, 627.6579, 627.6612, 627.66121, 627.66122, 627.6613, 627.667, 627.6675, and 627.6691.

Section 7. Section 627.6612, Florida Statutes, is amended to read:

627.6612 ~~Optional~~ Coverage for surgical procedures and devices incident to mastectomy.—

(1) Any ~~A~~ group, blanket, or franchise accident or health insurance policy ~~issued, amended, delivered, or renewed in this state~~ that provides coverage for mastectomies must also provide ~~make available to the policyholder~~ coverage for ~~the initial~~ prosthetic devices ~~device~~ and breast reconstructive surgery incident to the mastectomy. The insurer may charge an appropriate additional premium for the coverage required by this subsection. The coverage for prosthetic devices and breast reconstructive surgery shall be ~~is~~ subject to any ~~the~~ deductible and coinsurance conditions ~~applied to the mastectomy~~, and all other terms and conditions applicable to other benefits. Breast reconstructive surgery must be in a manner chosen by the treating physician under contract with the health maintenance organization, consistent with prevailing medical standards, and in consultation with the patient. ~~If a mastectomy is performed and there is no evidence of malignancy, the coverage may be limited to the provision of the initial prosthetic device and reconstructive surgery to within 2 years after the date of the mastectomy.~~

(2) As used in this section, the term "mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician, and the term "breast reconstructive surgery" means surgery to reestablish symmetry between the two breasts.

Section 8. Section 627.66121, Florida Statutes, is created to read:

627.66121 Coverage for length of stay and outpatient post surgical care.—

(1) Any group, blanket, or franchise accident or health insurance policy that is issued, amended, delivered, or renewed in this state which provides coverage for breast cancer treatment may not limit inpatient hospital coverage for mastectomies to any period that is less than that determined by the treating physician to be medically necessary in accordance with prevailing medical standards and after consultation with the insured patient.

(2) Any group, blanket, or franchise accident or health insurance policy that provides coverage for mastectomies under subsection (1) must also provide coverage for outpatient postsurgical followup care in keeping with prevailing medical standards by a licensed health care professional qualified to provide postsurgical mastectomy care. The treating physician, after consultation with the insured patient, may choose that the outpatient care be

provided at the most medically appropriate setting, which may include the hospital, treating physician's office, outpatient center, or home of the insured patient.

(3) An insurer subject to subsection (1) may not:

(a) Deny to an insured eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the policy for the purpose of avoiding the requirements of this section;

(b) Provide monetary payments or rebates to an insured patient to accept less than the minimum protections available under this section;

(c) Penalize or otherwise reduce or limit the reimbursement of an attending provider solely because the attending provider provided care to an insured patient under this section;

(d) Provide incentives, monetary or otherwise, to an attending provider solely to induce the provider to provide care to an insured patient in a manner inconsistent with this section; or

(e) Subject to the other provisions of this section, restrict benefits for any portion of a period within a hospital length of stay or outpatient care as required by this section in a manner that is less than favorable than the benefits provided for any preceding portion of such stay.

(4)(a) This section does not require an insured patient to have the mastectomy in the hospital or stay in the hospital for a fixed period of time following the mastectomy.

(b) This section does not prevent a policy from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits under this section, except that such cost-sharing may not exceed cost-sharing with other benefits.

(5) Except as provided in subsection (3), this section does not affect any agreement between an insurer and a hospital or other health care provider with respect to reimbursement for health care services provided, rate negotiations with providers, or capitation of providers and does not prohibit appropriate utilization review or case management by the insurer.

(6) This section does not apply to disability income, specified diseases other than cancer, or hospital indemnity policies.

(7) As used in this section, the term "mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.

Section 9. Section 627.66122, Florida Statutes, is created to read:

627.66122 Requirements with respect to breast cancer and routine followup care.—Routine followup care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of

breast cancer does not constitute medical advice, diagnosis, care, or treatment for purposes of determining preexisting conditions unless evidence of breast cancer is found during or as a result of the followup care.

Section 10. Subsection (12) of section 627.6699, Florida Statutes, 1996 Supplement, is amended to read:

627.6699 Employee Health Care Access Act.—

(12) STANDARD, BASIC, AND LIMITED HEALTH BENEFIT PLANS.—

(a)1. By May 15, 1993, the commissioner shall appoint a health benefit plan committee composed of four representatives of carriers which shall include at least two representatives of HMOs, at least one of which is a staff model HMO, two representatives of agents, four representatives of small employers, and one employee of a small employer. The carrier members shall be selected from a list of individuals recommended by the board. The commissioner may require the board to submit additional recommendations of individuals for appointment. As alliances are established under s. 408.702, each alliance shall also appoint an additional member to the committee.

2. The committee shall develop changes to the form and level of coverages for the standard health benefit plan and the basic health benefit plan, and shall submit the forms, and levels of coverages to the department by September 30, 1993. The department must approve such forms and levels of coverages by November 30, 1993, and may return the submissions to the committee for modification on a schedule that allows the department to grant final approval by November 30, 1993.

3. The plans shall comply with all of the requirements of this subsection.

4. The plans must be filed with and approved by the department prior to issuance or delivery by any small employer carrier.

5. After approval of the revised health benefit plans, if the department determines that modifications to a plan might be appropriate, the commissioner shall appoint a new health benefit plan committee in the manner provided in subparagraph 1. to submit recommended modifications to the department for approval.

(b)1. Each small employer carrier issuing new health benefit plans shall offer to any small employer, upon request, a standard health benefit plan and a basic health benefit plan that meets the criteria set forth in this section.

2. For purposes of this subsection, the terms “standard health benefit plan” and “basic health benefit plan” mean policies or contracts that a small employer carrier offers to eligible small employers that contain:

a. An exclusion for services that are not medically necessary or that are not covered preventive health services; and

b. A procedure for preauthorization by the small employer carrier, or its designees.

3. A small employer carrier may include the following managed care provisions in the policy or contract to control costs:

a. A preferred provider arrangement or exclusive provider organization or any combination thereof, in which a small employer carrier enters into a written agreement with the provider to provide services at specified levels of reimbursement or to provide reimbursement to specified providers. Any such written agreement between a provider and a small employer carrier must contain a provision under which the parties agree that the insured individual or covered member has no obligation to make payment for any medical service rendered by the provider which is determined not to be medically necessary. A carrier may use preferred provider arrangements or exclusive provider arrangements to the same extent as allowed in group products that are not issued to small employers.

b. A procedure for utilization review by the small employer carrier or its designees.

This subparagraph does not prohibit a small employer carrier from including in its policy or contract additional managed care and cost containment provisions, subject to the approval of the department, which have potential for controlling costs in a manner that does not result in inequitable treatment of insureds or subscribers. The carrier may use such provisions to the same extent as authorized for group products that are not issued to small employers.

4. The standard health benefit plan shall include:

a. Coverage for inpatient hospitalization;

b. Coverage for outpatient services;

c. Coverage for newborn children pursuant to s. 627.6575;

d. Coverage for child care supervision services pursuant to s. 627.6579;

e. Coverage for adopted children upon placement in the residence pursuant to s. 627.6578;

f. Coverage for mammograms pursuant to s. 627.6613;

g. Coverage for handicapped children pursuant to s. 627.6615;

h. Emergency or urgent care out of the geographic service area; and

i. Coverage for services provided by a hospice licensed under s. 400.602 in cases where such coverage would be the most appropriate and the most cost-effective method for treating a covered illness.

5. The standard health benefit plan and the basic health benefit plan may include a schedule of benefit limitations for specified services and

procedures. If the committee develops such a schedule of benefits limitation for the standard health benefit plan or the basic health benefit plan, a small employer carrier offering the plan must offer the employer an option for increasing the benefit schedule amounts by 4 percent annually.

6. The basic health benefit plan shall include all of the benefits specified in subparagraph 4.; however, the basic health benefit plan shall place additional restrictions on the benefits and utilization and may also impose additional cost containment measures.

7. Sections 627.419(2), (3), and (4), 627.6574, 627.6612, 627.66121, 627.66122, 627.6616, 627.6618, and 627.668 apply to the standard health benefit plan and to the basic health benefit plan. However, notwithstanding said provisions, the plans may specify limits on the number of authorized treatments, if such limits are reasonable and do not discriminate against any type of provider.

8. Each small employer carrier that provides for inpatient and outpatient services by allopathic hospitals may provide as an option of the insured similar inpatient and outpatient services by hospitals accredited by the American Osteopathic Association when such services are available and the osteopathic hospital agrees to provide the service.

(c) If a small employer rejects, in writing, the standard health benefit plan and the basic health benefit plan, the small employer carrier may offer the small employer a limited benefit policy or contract.

(d)1. Upon offering coverage under a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract for any small employer, the small employer carrier shall provide such employer group with a written statement that contains, at a minimum:

a. An explanation of those mandated benefits and providers that are not covered by the policy or contract;

b. An explanation of the managed care and cost control features of the policy or contract, along with all appropriate mailing addresses and telephone numbers to be used by insureds in seeking information or authorization; and

c. An explanation of the primary and preventive care features of the policy or contract.

Such disclosure statement must be presented in a clear and understandable form and format and must be separate from the policy or certificate or evidence of coverage provided to the employer group.

2. Before a small employer carrier issues a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract, it must obtain from the prospective policyholder a signed written statement in which the prospective policyholder:

a. Certifies as to eligibility for coverage under the standard health benefit plan, basic health benefit plan, or limited benefit policy or contract;

b. Acknowledges the limited nature of the coverage and an understanding of the managed care and cost control features of the policy or contract;

c. Acknowledges that if misrepresentations are made regarding eligibility for coverage under a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract, the person making such misrepresentations forfeits coverage provided by the policy or contract; and

d. If a limited plan is requested, acknowledges that the prospective policyholder had been offered, at the time of application for the insurance policy or contract, the opportunity to purchase any health benefit plan offered by the carrier and that the prospective policyholder had rejected that coverage.

A copy of such written statement shall be provided to the prospective policyholder no later than at the time of delivery of the policy or contract, and the original of such written statement shall be retained in the files of the small employer carrier for the period of time that the policy or contract remains in effect or for 5 years, whichever period is longer.

3. Any material statement made by an applicant for coverage under a health benefit plan which falsely certifies as to the applicant's eligibility for coverage serves as the basis for terminating coverage under the policy or contract.

4. Each marketing communication that is intended to be used in the marketing of a health benefit plan in this state must be submitted for review by the department prior to use and must contain the disclosures stated in this subsection.

(e)1. A small employer carrier may not use any policy, contract, form, or rate under this section, including applications, enrollment forms, policies, contracts, certificates, evidences of coverage, riders, amendments, endorsements, and disclosure forms, until the insurer has filed it with the department and the department has approved it under ss. 627.410, 627.4106, and 627.411.

2. A small employer carrier must file with the department by December 1, 1993, the standard and basic health benefit plan that it intends to initially use to comply with this subsection during calendar year 1994, together with the rates therefor, and the department must approve the submissions by January 1, 1994.

Section 11. Section 641.31096, Florida Statutes, is created to read:

641.31096 Requirements with respect to breast cancer and routine followup care.—Routine followup care to determine whether a breast cancer has recurred in a person who has been previously determined to be free of breast cancer does not constitute medical advice, diagnosis, care, or treatment for purposes of determining preexisting conditions unless evidence of breast cancer is found during or as a result of the followup care.

Section 12. Subsections (29) and (30) are added to section 641.31, Florida Statutes, 1996 Supplement, to read:

641.31 Health maintenance contracts.—

(29)(a) Health maintenance contracts that provide coverage, benefits, or services for breast cancer treatment may not limit inpatient hospital coverage for mastectomies to any period that is less than that determined by the treating physician under contract with the health maintenance organization to be medically necessary in accordance with prevailing medical standards and after consultation with the covered patient. Such contract must also provide coverage for outpatient postsurgical followup care in keeping with prevailing medical standards by a licensed health care professional under contract with the health maintenance organization qualified to provide postsurgical mastectomy care. The treating physician under contract with the health maintenance organization, after consultation with the covered patient, may choose that the outpatient care be provided at the most medically appropriate setting, which may include the hospital, treating physician's office, outpatient center, or home of the covered patient.

(b) A health maintenance organization subject to this subsection may not:

1. Deny to a covered person eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the contract for the purpose of avoiding the requirements of this subsection;

2. Provide monetary payments or rebates to a covered patient to accept less than the minimum protections available under this subsection;

3. Penalize or otherwise reduce or limit the reimbursement of an attending provider solely because the attending provider provided care to a covered patient under this subsection;

4. Provide incentives, monetary or otherwise, to an attending provider solely to induce the provider to provide care to a covered patient in a manner inconsistent with this subsection; or

5. Subject to the other provisions of this subsection, restrict benefits for any portion of a period within a hospital length of stay or outpatient care as required by this subsection in a manner that is less than favorable than the benefits provided for any preceding portion of such stay.

(c)1. This subsection does not require a covered patient to have the mastectomy in the hospital or stay in the hospital for a fixed period of time following the mastectomy.

2. This subsection does not prevent a contract from imposing deductibles, coinsurance, or other cost-sharing in relation to benefits pursuant to this subsection, except that such cost-sharing shall not exceed cost-sharing with other benefits.

(d) Except as provided in paragraph (b), this subsection does not affect any agreement between a health maintenance organization and a hospital or other health care provider with respect to reimbursement for health care services provided, rate negotiations with providers, or capitation of provid-

ers, and does not prohibit appropriate utilization review or case management by the health maintenance organization.

(e) As used in this subsection the term "mastectomy" means the removal of all or part of the breast for medically necessary reasons as determined by a licensed physician.

(30) A health maintenance contract that provides coverage for mastectomies must also provide coverage for prosthetic devices and breast reconstructive surgery incident to the mastectomy. As used in this subsection, the term "breast reconstructive surgery" means surgery to reestablish symmetry between the two breasts. Such surgery must be in a manner chosen by the treating physician under contract with the health maintenance organization, consistent with prevailing medical standards, and in consultation with the patient. The health maintenance organization may charge an appropriate additional premium for the coverage required by this subsection. The coverage for prosthetic devices and breast reconstructive surgery shall be subject to any deductible and coinsurance conditions.

Section 13. This act fulfills an important state interest.

Section 14. This act shall take effect October 1, 1997, and shall apply to policies and contracts issued or renewed after that date.

Approved by the Governor May 7, 1997.

Filed in Office Secretary of State May 7, 1997.