

Committee Substitute for Committee Substitute for  
Committee Substitute for Senate Bill No. 2654

An act relating to children with disabilities; amending s. 409.906, F.S.; creating the "Window of Opportunity Act"; authorizing the Agency for Health Care Administration to seek federal approval through a state plan amendment to provide home and community-based services for autism spectrum disorder and other developmental disabilities; specifying eligibility criteria; specifying limitations on provision of benefits; requiring reports to the Legislature; requiring legislative approval for implementation of certain provisions; creating s. 624.916, F.S.; creating the "Steven A. Geller Autism Coverage Act"; directing the Office of Insurance Regulation to establish a workgroup to develop and execute a compact relating to coverage for insured persons with developmental disabilities; providing for membership of the workgroup; requiring the workgroup to convene within a specified period of time; directing the office to establish a consumer advisory workgroup and providing purpose thereof; requiring the compact to contain specified components; requiring reports to the Governor and the Legislature; creating s. 627.6686, F.S.; providing health insurance coverage for individuals with autism spectrum disorder; providing definitions; providing coverage for certain screening to diagnose and treat autism spectrum disorder; providing limitations on coverage; providing for eligibility standards for benefits and coverage; prohibiting insurers from denying coverage under certain circumstances; specifying required elements of a treatment plan; providing, beginning January 1, 2011, that the maximum benefit shall be adjusted annually; clarifying that the section may not be construed as limiting benefits and coverage otherwise available to an insured under a health insurance plan; prohibiting the Office of Insurance Regulation from enforcing certain provisions against insurers that are signatories to the developmental disabilities compact by a specified date; creating s. 641.31098, F.S.; providing coverage under a health maintenance contract for individuals with autism spectrum disorder; providing definitions; providing coverage for certain screening to diagnose and treat autism spectrum disorder; providing limitations on coverage; providing for eligibility standards for benefits and coverage; prohibiting health maintenance organizations from denying coverage under certain circumstances; specifying required elements of a treatment plan; providing, beginning January 1, 2011, that the maximum benefit shall be adjusted annually; prohibiting the Office of Insurance Regulation from enforcing certain provisions against health maintenance organizations that are signatories to the developmental disabilities compact by a specified date; providing an effective date.

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

Section 1. Subsection (26) is added to section 409.906, Florida Statutes, to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(26) HOME AND COMMUNITY-BASED SERVICES FOR AUTISM SPECTRUM DISORDER AND OTHER DEVELOPMENTAL DISABILITIES.—The agency is authorized to seek federal approval through a Medicaid waiver or a state plan amendment for the provision of occupational therapy, speech therapy, physical therapy, behavior analysis, and behavior assistant services to individuals who are 5 years of age and under and have a diagnosed developmental disability as defined in s. 393.063, autism spectrum disorder as defined in s. 627.6686, or Down syndrome, a genetic disorder caused by the presence of extra chromosomal material on chromosome 21. Causes of the syndrome may include Trisomy 21, Mosaicism, Robertsonian Translocation, and other duplications of a portion of chromosome 21. Coverage for such services shall be limited to \$36,000 annually and may not exceed \$108,000 in total lifetime benefits. The agency shall submit an annual report beginning on January 1, 2009, to the President of the Senate, the Speaker of the House of Representatives, and the relevant committees of the Senate and the House of Representatives regarding progress on obtaining federal approval and recommendations for the implementation of these home and community-based services. The agency may not implement this subsection without prior legislative approval.

Section 2. Section 624.916, Florida Statutes, is created to read:

624.916 Developmental disabilities compact.—

(1) This section may be cited as the "Window of Opportunity Act."

(2) The Office of Insurance Regulation shall convene a workgroup by August 31, 2008, for the purpose of negotiating a compact that includes a binding agreement among the participants relating to insurance and access to services for persons with developmental disabilities. The workgroup shall consist of the following:

- (a) Representatives of all health insurers licensed under this chapter.
- (b) Representatives of all health maintenance organizations licensed under part I of chapter 641.
- (c) Representatives of employers with self-insured health benefit plans.
- (d) Two designees of the Governor, one of whom must be a consumer advocate.
- (e) A designee of the President of the Senate.
- (f) A designee of the Speaker of the House of Representatives.
- (3) The Office of Insurance Regulation shall convene a consumer advisory workgroup for the purpose of providing a forum for comment on the compact negotiated in subsection (2). The office shall convene the workgroup prior to finalization of the compact.
- (4) The agreement shall include the following components:
- (a) A requirement that each signatory to the agreement increase coverage for behavior analysis and behavior assistant services as defined in s. 409.815(2)(r) and speech therapy, physical therapy, and occupational therapy when medically necessary due to the presence of a developmental disability.
- (b) Procedures for clear and specific notice to policyholders identifying the amount, scope, and conditions under which coverage is provided for behavior analysis and behavior assistant services as defined in s. 409.815(2)(r) and speech therapy, physical therapy, and occupational therapy when medically necessary due to the presence of a developmental disability.
- (c) Penalties for documented cases of denial of claims for medically necessary services due to the presence of a developmental disability.
- (d) Proposals for new product lines that may be offered in conjunction with traditional health insurance and provide a more appropriate means of spreading risk, financing costs, and accessing favorable prices.
- (5) Upon completion of the negotiations for the compact, the office shall report the results to the Governor, the President of the Senate, and the Speaker of the House of Representatives.
- (6) Beginning February 15, 2009, and continuing annually thereafter, the Office of Insurance Regulation shall provide a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives regarding the implementation of the agreement negotiated under this section. The report shall include:
- (a) The signatories to the agreement.
- (b) An analysis of the coverage provided under the agreement in comparison to the coverage required under ss. 627.6686 and 641.31098.

(c) An analysis of the compliance with the agreement by the signatories, including documented cases of claims denied in violation of the agreement.

(7) The Office of Insurance Regulation shall continue to monitor participation, compliance, and effectiveness of the agreement and report its findings at least annually.

(8) As used in this section, the term “developmental disabilities” includes:

(a) The term as defined in s. 393.063;

(b) Down syndrome, a genetic disorder caused by the presence of extra chromosomal material on chromosome 21. Causes of the syndrome may include Trisomy 21, Mosaicism, Robertsonian Translocation, and other duplications of a portion of chromosome 21; and

(c) Autism spectrum disorder, as defined in s. 627.6686.

Section 3. Section 627.6686, Florida Statutes, is created to read:

627.6686 Coverage for individuals with autism spectrum disorder required; exception.—

(1) This section and section 641.31098, may be cited as the “Steven A. Geller Autism Coverage Act.”

(2) As used in this section, the term:

(a) “Applied behavior analysis” means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

(b) “Autism spectrum disorder” means any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

1. Autistic disorder.

2. Asperger’s syndrome.

3. Pervasive developmental disorder not otherwise specified.

(c) “Eligible individual” means an individual under 18 years of age or an individual 18 years of age or older who is in high school who has been diagnosed as having a developmental disability at 8 years of age or younger.

(d) “Health insurance plan” means a group health insurance policy or group health benefit plan offered by an insurer which includes the state group insurance program provided under s. 110.123. The term does not include any health insurance plan offered in the individual market, any

health insurance plan that is individually underwritten, or any health insurance plan provided to a small employer.

(e) “Insurer” means an insurer providing health insurance coverage, which is licensed to engage in the business of insurance in this state and is subject to insurance regulation.

(3) A health insurance plan issued or renewed on or after April 1, 2009, shall provide coverage to an eligible individual for:

(a) Well-baby and well-child screening for diagnosing the presence of autism spectrum disorder.

(b) Treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy, and applied behavior analysis. Applied behavior analysis services shall be provided by an individual certified pursuant to s. 393.17 or an individual licensed under chapter 490 or chapter 491.

(4) The coverage required pursuant to subsection (3) is subject to the following requirements:

(a) Coverage shall be limited to treatment that is prescribed by the insured’s treating physician in accordance with a treatment plan.

(b) Coverage for the services described in subsection (3) shall be limited to \$36,000 annually and may not exceed \$200,000 in total lifetime benefits.

(c) Coverage may not be denied on the basis that provided services are habilitative in nature.

(d) Coverage may be subject to other general exclusions and limitations of the insurer’s policy or plan, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, and utilization review of health care services, including the review of medical necessity, case management, and other managed care provisions.

(5) The coverage required pursuant to subsection (3) may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illnesses that are generally covered under the health insurance plan, except as otherwise provided in subsection (4).

(6) An insurer may not deny or refuse to issue coverage for medically necessary services, refuse to contract with, or refuse to renew or reissue or otherwise terminate or restrict coverage for an individual because the individual is diagnosed as having a developmental disability.

(7) The treatment plan required pursuant to subsection (4) shall include all elements necessary for the health insurance plan to appropriately pay claims. These elements include, but are not limited to, a diagnosis, the proposed treatment by type, the frequency and duration of treatment, the

anticipated outcomes stated as goals, the frequency with which the treatment plan will be updated, and the signature of the treating physician.

(8) Beginning January 1, 2011, the maximum benefit under paragraph (4)(b) shall be adjusted annually on January 1 of each calendar year to reflect any change from the previous year in the medical component of the then current Consumer Price Index for all urban consumers, published by the Bureau of Labor Statistics of the United States Department of Labor.

(9) This section may not be construed as limiting benefits and coverage otherwise available to an insured under a health insurance plan.

(10) The Office of Insurance Regulation may not enforce this section against an insurer that is a signatory no later than April 1, 2009, to the developmental disabilities compact established under s. 624.916. The Office of Insurance Regulation shall enforce this section against an insurer that is a signatory to the compact established under s. 624.916 if the insurer has not complied with the terms of the compact for all health insurance plans by April 1, 2010.

Section 4. Section 641.31098, Florida Statutes, is created to read:

641.31098 Coverage for individuals with developmental disabilities.—

(1) This section and section 627.6686, may be cited as the “Steven A. Geller Autism Coverage Act.”

(2) As used in this section, the term:

(a) “Applied behavior analysis” means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

(b) “Autism spectrum disorder” means any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

1. Autistic disorder.
2. Asperger’s syndrome.
3. Pervasive developmental disorder not otherwise specified.

(b) “Eligible individual” means an individual under 18 years of age or an individual 18 years of age or older who is in high school who has been diagnosed as having a developmental disability at 8 years of age or younger.

(c) “Health maintenance contract” means a group health maintenance contract offered by a health maintenance organization. This term does not include a health maintenance contract offered in the individual market, a health maintenance contract that is individually underwritten, or a health maintenance contract provided to a small employer.

(3) A health maintenance contract issued or renewed on or after April 1, 2009, shall provide coverage to an eligible individual for:

(a) Well-baby and well-child screening for diagnosing the presence of autism spectrum disorder.

(b) Treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy, and applied behavior analysis services. Applied behavior analysis services shall be provided by an individual certified pursuant to s. 393.17 or an individual licensed under chapter 490 or chapter 491.

(4) The coverage required pursuant to subsection (3) is subject to the following requirements:

(a) Coverage shall be limited to treatment that is prescribed by the subscriber's treating physician in accordance with a treatment plan.

(b) Coverage for the services described in subsection (3) shall be limited to \$36,000 annually and may not exceed \$200,000 in total benefits.

(c) Coverage may not be denied on the basis that provided services are habilitative in nature.

(d) Coverage may be subject to general exclusions and limitations of the subscriber's contract, including, but not limited to, coordination of benefits, participating provider requirements, and utilization review of health care services, including the review of medical necessity, case management, and other managed care provisions.

(5) The coverage required pursuant to subsection (3) may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to a subscriber than the dollar limits, deductibles, or coinsurance provisions that apply to physical illnesses that are generally covered under the subscriber's contract, except as otherwise provided in subsection (3).

(6) A health maintenance organization may not deny or refuse to issue coverage for medically necessary services, refuse to contract with, or refuse to renew or reissue or otherwise terminate or restrict coverage for an individual solely because the individual is diagnosed as having a developmental disability.

(7) The treatment plan required pursuant to subsection (4) shall include, but is not limited to, a diagnosis, the proposed treatment by type, the frequency and duration of treatment, the anticipated outcomes stated as goals, the frequency with which the treatment plan will be updated, and the signature of the treating physician.

(8) Beginning January 1, 2011, the maximum benefit under paragraph (4)(b) shall be adjusted annually on January 1 of each calendar year to reflect any change from the previous year in the medical component of the then current Consumer Price Index for all urban consumers, published by the Bureau of Labor Statistics of the United States Department of Labor.

(9) The Office of Insurance Regulation may not enforce this section against a health maintenance organization that is a signatory no later than April 1, 2009, to the developmental disabilities compact established under s. 624.916. The Office of Insurance Regulation shall enforce this section against a health maintenance organization that is a signatory to the compact established under s. 624.916 if the health maintenance organization has not complied with the terms of the compact for all health maintenance contracts by April 1, 2010.

Section 5. This act shall take effect July 1, 2008.

Approved by the Governor May 20, 2008.

Filed in Office Secretary of State May 20, 2008.