By the Committee on Health Care Services and Representatives Mackey, Heyman, Murman, Frankel, Argenziano, Wasserman Schultz, Peaden, Fasano, Culp, Brown, Sanderson, Jacobs, Fischer, Dennis, Dawson-White, Diaz de la Portilla, (Additional Sponsors on Last Printed Page)

A bill to be entitled

An act relating to mastectomies; amending ss. 627.6417, 627.651, 627.6515, 627.6612, and 627.6699, F.S.; requiring certain health insurance policies to provide certain coverage for hospital stays for mastectomies; requiring such coverage to provide postsurgical care; requiring coverage for reconstructive breast surgery for certain purposes; amending s. 641.31, F.S.; requiring certain health maintenance contracts to provide certain coverage for hospital stays for mastectomies; requiring such contracts to provide postsurgical care; requiring coverage for reconstructive surgery for certain purposes; creating ss. 627.64175, 627.6614, and 641.30198, F.S.; providing requirements and prohibitions for insurers and health maintenance organizations relating to breast cancer coverage; providing a description of 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) A health insurance policy that is issued, amended, delivered, or renewed in this state that provides coverage on an expense-incurred basis shall provide hospital, medical, or

surgical coverage for mastectomies to the same extent that such coverage is provided for illness or disease under the policy, and may not limit inpatient hospital coverage for mastectomies to any time period that is less than that determined by the treating surgical, gynecological, or oncological care provider to be medically necessary, in accordance with prevailing medical standards and consistent with the guidelines for surgical, gynecological, and oncological care.

(2) Any health insurance policy that provides coverage for mastectomies under subsection (1) must also provide coverage for outpatient postsurgical mastectomy followup care. Such care must be comparable to inpatient hospital postsurgical care and must include assessment of the patient's condition in keeping with prevailing medical standards by a licensed health care professional qualified to provide postsurgical mastectomy care, and may be provided at the hospital, outpatient center, treating physician's office, or in the patient's home. This subsection does not apply to a hospital and surgical policy that primarily provides coverage only for hospital inpatient expenses except that outpatient postsurgical care must be covered to the same extent that the policy would have covered inpatient postsurgical care.

(3)~~(1)~~ Any ~~An accident or~~ health insurance policy ~~issued, amended, delivered, or renewed in this state~~ that provides coverage for mastectomies under subsection (1)must also provide ~~make available to the policyholder, as part of the application,~~coverage for ~~the initial~~ prosthetic devices ~~device~~ and reconstructive surgery incident to the mastectomy. Breast reconstructive surgery means surgery to reestablish symmetry between the two breasts and includes augmentation

mammoplasty, reduction mammoplasty, and mastoplexy. Such surgery shall be in a manner chosen by the treating physician, consistent with prevailing medical standards, and in consultation with the patient if the patient chooses such surgery.~~The insurer may charge an appropriate additional premium for the coverage required by this subsection.~~ The coverage for prosthetic devices and 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 the policy ~~other benefits~~. ~~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.~~

(4)~~(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. The term includes prophylactic mastectomies and lymph node dissections that are determined to be medically necessary.

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

(a) Deny to an insured continued eligibility 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 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.

(6) 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.

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

Section 2. Section 627.64175, Florida Statutes, is created to read:

627.64175 Requirements with respect to breast cancer.--

(1) An insurer may not refuse to provide coverage for an applicant for health insurance due to breast cancer if the applicant has remained free from breast cancer for at least 5 years prior to the applicant's request for health insurance coverage.

(2) An insurer may not exclude coverage under a health insurance policy for breast cancer if the applicant has remained free from breast cancer for at least 2 years prior to the applicant's request for health insurance coverage. The

department shall report to the Legislature by October 1, 1999, the cost in terms of premium increases and the number of additional persons covered as a result of this section.

(3) 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 shall not be considered as 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 followup care.

Section 3. 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, 627.6614,627.6615, 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 4. Paragraph (c) of 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:

(c) The policy provides the benefits specified in ss. 627.419, 627.6417, 627.64175,627.6574, 627.6575, 627.6579, 627.6613, 627.667, 627.6675, and 627.6691.

Section 5. Section 627.6612, Florida Statutes, is amended to read:

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

(1) A group, blanket, or franchise health insurance policy that is issued, amended, delivered, or renewed in this state that provides coverage on an expense-incurred basis shall provide hospital, medical, or surgical coverage for mastectomies to the same extent that hospital, medical, or surgical coverage is provided for illness or disease under the policy, and may not limit inpatient hospital coverage for mastectomies to any time period that is less than that determined by the treating surgical, gynecological, or oncological care provider to be medically necessary, in accordance with prevailing medical standards and consistent with the guidelines for surgical, gynecological, and oncological care.

(2) Any group, blanket, or franchise health insurance policy that provides coverage for mastectomies under subsection (1) must also provide coverage for outpatient postsurgical mastectomy followup care. Such care must be comparable to inpatient hospital postsurgical care and must include assessment of the patient's condition in keeping with prevailing medical standards by a licensed health care professional qualified to provide postsurgical mastectomy care, and may be provided at the hospital, outpatient center, treating physician's office, or in the patient's home.

(3)~~(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 under subsection (1)must also provide ~~make available to the policyholder~~ coverage for ~~the initial~~ prosthetic devices ~~device~~ and reconstructive surgery incident to the mastectomy. Breast reconstructive surgery means surgery to reestablish symmetry between the two breasts and includes augmentation mammoplasty, reduction mammoplasty, and mastoplexy. Such surgery shall be in a manner chosen by the treating physician, consistent with prevailing medical standards, and in consultation with the patient if the patient chooses such surgery.~~The insurer may charge an appropriate additional premium for the coverage required by this subsection.~~ The coverage for prosthetic devices and 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 the policy ~~other benefits~~. ~~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.~~

(4)~~(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. The term includes prophylactic mastectomies and lymph node dissections that are determined to be medically necessary.

(5) 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 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.

(6) 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.

Section 6. Section 627.6614, Florida Statutes, is created to read:

627.6614 Requirements with respect to breast cancer.--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 shall not be considered as 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 followup care.

Section 7. Paragraph (b) of 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.--

(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, 627.6614,627.6616, 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.

Section 8. Subsection (29) is added to section 641.31, Florida Statutes, 1996 Supplement, to read:

641.31 Health maintenance contracts.--

(29)(a) 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 network or plan physician. The term includes prophylactic mastectomies and lymph node dissections that are determined to be medically necessary.

(b) Every health maintenance contract issued, amended, delivered, or renewed in this state shall provide hospital, medical, and surgical coverage for mastectomies to the same extent that such coverage is provided for illness or disease under the contract, and may not limit inpatient hospital coverage for mastectomies to any time period that is less than that determined by the treating surgical, gynecological, or oncological care provider to be medically necessary, in accordance with prevailing medical standards and consistent with the guidelines for surgical, gynecological, and oncological care.

(c) Any health maintenance contract that provides coverage for mastectomies under paragraph (b) must also provide outpatient postsurgical mastectomy followup care. Such care must be comparable to inpatient hospital postsurgical care and must include assessment of the patient's condition in keeping with prevailing medical standards by a licensed health care professional qualified to provide postsurgical mastectomy care, and may be provided at the

hospital, outpatient center, treating physician's office, or in the patient's home.

(d) Any health maintenance contract that provides coverage for mastectomies under paragraph (b) must also provide coverage for prosthetic devices and reconstructive surgery incident to the mastectomy. Breast reconstructive surgery means surgery to reestablish symmetry between the two breasts and includes augmentation mammoplasty, reduction mammoplasty, and mastoplexy. Such surgery shall be in a manner chosen by the treating physician, consistent with prevailing medical standards, and in consultation with the patient if the patient chooses such surgery. The coverage for prosthetic devices and reconstructive surgery shall be subject to any copayments under the contract.

(e) A health maintenance contract subject to this subsection may not:

1. Deny to a covered person continued eligibility 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 an insured 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.

(f) 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 providers, and does not prohibit appropriate utilization review or case management by the health maintenance organization.

Section 9. Section 641.30198, Florida Statutes, is created to read:

641.30198 Requirements with respect to breast cancer.--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 shall not be considered as 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 followup care.

Section 10. The provisions of this act fulfill an important state interest in that they promote the relief and alleviation of health and medical problems that affect residents of this state who have been stricken with breast cancer. The act, in prohibiting limitations on inpatient hospital coverage for mastectomies and requiring more comprehensive insurance coverage for breast cancer treatment, should insure the provision of appropriate and cost-effective medical treatment.

Section 11. This act shall take effect October 1, 1997.

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ADDITIONAL SPONSORS

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