By Representative Peaden

A bill to be entitled

An act relating to mastectomies; amending ss. 627.6417, 627.6612, 627.6699, and 641.31, F.S.; requiring health insurance policies and contracts to provide coverage for mastectomies; prohibiting such policies and contracts from imposing certain limitations on coverage for hospital stays under certain circumstances; 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; amending ss. 627.651 and 627.6515, F.S.; conforming application provisions to include certain cross references; 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 mastectomy and surgical procedures and devices incident to mastectomy.--

(1) A health insurance policy that covers a resident of this state and that is issued, amended, delivered, or renewed in this state by an insurer that provides, on an expense-incurred basis, hospital, medical, or surgical expense insurance, or any combination of such coverages, shall provide coverage for mastectomies, including hospital, medical, or surgical care to the same extent that hospital, medical, or surgical coverage is provided for illness or disease under the

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

policy. The coverage, other than coverage for complications, shall include inpatient hospital coverage for at least 48 hours following the date of surgery.

(2) The insured shall have the option to be discharged earlier than the time period established in subsection (1). In such case, the coverage must include at least one home health care visit, which shall be in addition to, rather than in lieu of, any home health care coverage available under the policy and which may be requested by the insured within 72 hours after discharge from the hospital and shall be provided within 24 hours after such request. The home health care coverage shall be pursuant to the policy and subject to the provisions of this subsection and not subject to deductibles, coinsurance, or copayments.

(3)~~(1)~~ A ~~An accident or~~ health insurance policy issued, amended, delivered, or renewed in this state that provides coverage for mastectomies must also include ~~make available to the policyholder, as part of the application,~~ coverage for the initial prosthetic device and 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 reconstructive surgery is subject to the deductible and coinsurance conditions applied to the mastectomy, and all other terms and conditions applicable to 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.

(5)~~(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 cover 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 5 years prior to the applicant's request for health insurance coverage.

(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 the 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, 627.6574, 627.6575, 627.6579, 627.6612,627.6613, 627.6614,627.667, 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 covers a resident of this state and that is issued, amended, delivered, or renewed in this state that provides, on an expense-incurred basis, coverage for hospital, medical, or surgical expenses, or any combination of such expenses, shall provide coverage for mastectomies, including hospital, medical, or surgical care to the same extent that hospital, medical, or surgical coverage is provided for

illness or disease under the policy. The coverage, other than coverage for complications, shall include inpatient hospital coverage for at least 48 hours following the date of surgery.

(2) The certificateholder shall have the option to be discharged earlier than the time period established in subsection (1). In such case, the coverage must include at least one home health care visit, which shall be in addition to, rather than in lieu of, any home health care coverage available under the policy and which may be requested by the insured within 72 hours after discharge from the hospital and shall be provided within 24 hours after such request. The home health care coverage shall be pursuant to the policy and subject to the provisions of this subsection and not subject to deductibles, coinsurance, or copayments.

(3)~~(1)~~ 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 include ~~make available to the policyholder~~ coverage for the initial prosthetic device and 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 reconstructive surgery is subject to the deductible and coinsurance conditions applied to the mastectomy, and all other terms and conditions applicable to 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.

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

627.6614 Requirements with respect to breast cancer.--

(1) When an insurer is permitted to underwrite and selectively insure, the insurer:

(a) May not refuse to cover nor charge an unfairly discriminatory rate for an individual member applicant within a group which is applying for group, blanket, or franchise health insurance due to breast cancer if the individual member applicant has remained free from breast cancer for at least 5 years prior to the individual member applicant's request for health insurance coverage.

(b) May not exclude coverage under the group, blanket, or franchise health insurance policy for breast cancer if the individual member applicant has remained free from breast cancer for at least 5 years prior to the individual member applicant's request for health insurance coverage.

(2) 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 the followup care.

Section 7. Subsection (29) is added to section 641.31, Florida Statutes, 1996 Supplement, to read:

641.31 Health maintenance contracts.--

(29)(a) Every health maintenance contract issued, amended, delivered, or renewed in this state shall provide coverage for mastectomies, including hospital, medical, and surgical care to the same extent that hospital, medical, and surgical coverage is provided for illness or disease under the contract. The coverage, other than coverage for complications, shall include inpatient hospital coverage for at least 48 hours following the date of the surgery.

(b) The subscriber shall have the option to be discharged earlier than the time period established in paragraph (a). In such case, the coverage must include at least one home care visit, which shall be in addition to, rather than in lieu of, any home health care coverage available under the contract and which may be requested by the insured within 72 hours after discharge from the hospital and shall be provided within 24 hours after such request. The home health care coverage shall be pursuant to the contract and subject to the provisions of this subsection, and not subject to copayments.

(c) Every health maintenance contract must also provide coverage for the initial prosthetic device and reconstructive surgery incident to the mastectomy. The coverage for prosthetic devices and reconstructive surgery is subject to the deductible and copayment provisions applicable to the contract, and is also subject to all other terms and conditions applicable to other benefits.

(d) 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.

Section 8. Section 641.30198, Florida Statutes, is created to read:

641.30198 Requirements with respect to breast cancer.--

(1) A health maintenance organization may not refuse to cover nor charge an unfairly discriminatory rate to an applicant for health coverage 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 coverage.

(2) A health maintenance organization may not consider the condition as a preexisting condition under a health maintenance contract if the applicant has remained free from breast cancer for at least 5 years prior to the applicant's request for health coverage.

(3) Routine followup care to determine whether a breast cancer has recurred in a person who has been previously determined to be free from 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 the followup care.

Section 9. 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 a mastectomy and surgical procedures and devices incident to a mastectomy pursuant to s. 627.6612.

g.~~f.~~ Coverage for mammograms pursuant to s. 627.6613;

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

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

j.~~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, 627.6616, 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 10. This act shall take effect October 1, 1997.

****

HOUSE SUMMARY

Requires health insurance policies and health maintenance contracts to provide coverage for mastectomies. Provides for limited home health care after discharge from a hospital after a mastectomy. Prohibits insurers or health maintenance organizations from refusing to provide or exclude coverage for breast cancer under specified conditions. See bill for details.