By the Committee on Banking and Insurance; and Senator Ring

597-03307-11 2011100c1

1 A bill to be entitled
2 An act relating to autism; creating s. 381.986, F.S.;
3 requiring that a physician refer a minor to an
4 appropriate specialist for screening for autism
5 spectrum disorder under certain circumstances;
6 defining the term "appropriate specialist"; amending
7 ss. 627.6686 and 641.31098, F.S.; defining the term
8 "direct patient access"; requiring that certain
9 insurers and health maintenance organizations provide
10 direct patient access to an appropriate specialist for
11 screening for or evaluation or diagnosis of autism
12 spectrum disorder; requiring certain insurance
13 policies and health maintenance organization contracts
14 to provide a minimum number of visits per year for
15 screening for or evaluation or diagnosis of autism
16 spectrum disorder; providing an effective date.
17
18 Be It Enacted by the Legislature of the State of Florida:
19
20 Section 1. Section 381.986, Florida Statutes, is created to
21 read:
22 381.986 Screening for autism spectrum disorder.—
23 (1) If the parent or legal guardian of a minor believes
24 that the minor exhibits symptoms of autism spectrum disorder,
25 the parent or legal guardian may report his or her observation
26 to a physician licensed under chapter 458 or chapter 459. The
27 physician shall perform screening in accordance with American
28 Academy of Pediatrics' guidelines. If the physician determines
29 that referral to a specialist is medically necessary, the

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30 physician shall refer the minor to an appropriate specialist to
31 determine whether the minor meets diagnostic criteria for autism
32 spectrum disorder. If the physician determines that referral to
33 a specialist is not medically necessary, the physician shall
34 inform the parent or legal guardian of the option for the parent
35 or guardian to refer the child to the Early Steps Program or
36 other specialist in autism. This section does not apply to a
37 physician providing care under s. 395.1041.
38 (2) As used in this section, the term "appropriate
39 specialist" means a qualified professional licensed in this
40 state who is experienced in the evaluation of autism spectrum
41 disorder and has training in validated diagnostic tools. The
42 term includes, but is not limited to:
43 (a) A psychologist;
44 (b) A psychiatrist;
45 (c) A neurologist; or
46 (d) A developmental or behavioral pediatrician.
47 Section 2. Section 627.6686, Florida Statutes, is amended
48 to read:
49 627.6686 Coverage for individuals with autism spectrum
50 disorder required; exception.—
51 (1) This section and s. 641.31098 may be cited as the
52 "Steven A. Geller Autism Coverage Act."
53 (2) As used in this section, the term:
54 (a) "Applied behavior analysis" means the design,
55 implementation, and evaluation of environmental modifications,
56 using behavioral stimuli and consequences, to produce socially
57 significant improvement in human behavior, including, but not
58 limited to, the use of direct observation, measurement, and

59 functional analysis of the relations between environment and
60 behavior.
61 (b) “Autism spectrum disorder” means any of the following
62 disorders as defined in the most recent edition of the
63 Diagnostic and Statistical Manual of Mental Disorders of the
64 American Psychiatric Association:
65 1. Autistic disorder.
66 2. Asperger’s syndrome.
67 3. Pervasive developmental disorder not otherwise
68 specified.
69 (c) “Direct patient access” means the ability of an insured
70 to obtain services from a contracted provider without a referral
71 or other authorization before receiving services.
72 (d) ~~(c)~~ “Eligible individual” means an individual under 18
73 years of age or an individual 18 years of age or older who is in
74 high school and who has been diagnosed as having a developmental
75 disability at 8 years of age or younger.
76 (e) ~~(d)~~ “Health insurance plan” means a group health
77 insurance policy or group health benefit plan offered by an
78 insurer which includes the state group insurance program
79 provided under s. 110.123. The term does not include a ~~any~~
80 health insurance plan offered in the individual market, a ~~any~~
81 health insurance plan that is individually underwritten, or a
82 ~~any~~ health insurance plan provided to a small employer.
83 (f) ~~(e)~~ “Insurer” means an insurer providing health
84 insurance coverage, which is licensed to engage in the business
85 of insurance in this state and is subject to insurance
86 regulation.
87 (3) A health insurance plan issued or renewed on or after

88 April 1, 2009, shall provide coverage to an eligible individual
89 for:
90 (a) Direct patient access to an appropriate specialist, as
91 defined in s. 381.986, for a minimum of three visits per policy
92 year for screening for or evaluation or diagnosis of autism
93 spectrum disorder.
94 (b) ~~(a)~~ Well-baby and well-child screening for diagnosing
95 the presence of autism spectrum disorder.
96 (c) ~~(b)~~ Treatment of autism spectrum disorder through speech
97 therapy, occupational therapy, physical therapy, and applied
98 behavior analysis. Applied behavior analysis services shall be
99 provided by an individual certified pursuant to s. 393.17 or an
100 individual licensed under chapter 490 or chapter 491.
101 (4) The coverage required pursuant to subsection (3) is
102 subject to the following requirements:
103 (a) Coverage shall be limited to treatment that is
104 prescribed by the insured's treating physician in accordance
105 with a treatment plan.
106 (b) Coverage for the services described in subsection (3)
107 shall be limited to $36,000 annually and may not exceed $200,000
108 in total lifetime benefits.
109 (c) Coverage may not be denied on the basis that provided
110 services are habilitative in nature.
111 (d) Coverage may be subject to other general exclusions and
112 limitations of the insurer's policy or plan, including, but not
113 limited to, coordination of benefits, participating provider
114 requirements, restrictions on services provided by family or
115 household members, and utilization review of health care
116 services, including the review of medical necessity, case

117 management, and other managed care provisions.
118 (5) The coverage required pursuant to subsection (3) may
119 not be subject to dollar limits, deductibles, or coinsurance
120 provisions that are less favorable to an insured than the dollar
121 limits, deductibles, or coinsurance provisions that apply to
122 physical illnesses that are generally covered under the health
123 insurance plan, except as otherwise provided in subsection (4).
124 (6) An insurer may not deny or refuse to issue coverage for
125 medically necessary services, refuse to contract with, or refuse
126 to renew or reissue or otherwise terminate or restrict coverage
127 for an individual because the individual is diagnosed as having
128 a developmental disability.
129 (7) The treatment plan required pursuant to subsection (4)
130 shall include all elements necessary for the health insurance
131 plan to appropriately pay claims. These elements include, but
132 are not limited to, a diagnosis, the proposed treatment by type,
133 the frequency and duration of treatment, the anticipated
134 outcomes stated as goals, the frequency with which the treatment
135 plan will be updated, and the signature of the treating
136 physician.
137 (8) Beginning January 1, 2011, the maximum benefit under
138 paragraph (4)(b) shall be adjusted annually on January 1 of each
139 calendar year to reflect any change from the previous year in
140 the medical component of the then current Consumer Price Index
141 for all urban consumers, published by the Bureau of Labor
142 Statistics of the United States Department of Labor.
143 (9) This section may not be construed as limiting benefits
144 and coverage otherwise available to an insured under a health
145 insurance plan.

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146 (10) The Office of Insurance Regulation may not enforce
147 this section against an insurer that is a signatory no later
148 than April 1, 2009, to the developmental disabilities compact
149 established under s. 624.916. The Office of Insurance Regulation
150 shall enforce this section against an insurer that is a
151 signatory to the compact established under s. 624.916 if the
152 insurer has not complied with the terms of the compact for all
153 health insurance plans by April 1, 2010.
154 Section 3. Section 641.31098, Florida Statutes, is amended
155 to read:
156 641.31098 Coverage for individuals with developmental
157 disabilities.—
158 (1) This section and s. 627.6686 may be cited as the
159 "Steven A. Geller Autism Coverage Act."
160 (2) As used in this section, the term:
161 (a) "Applied behavior analysis" means the design,
162 implementation, and evaluation of environmental modifications,
163 using behavioral stimuli and consequences, to produce socially
164 significant improvement in human behavior, including, but not
165 limited to, the use of direct observation, measurement, and
166 functional analysis of the relations between environment and
167 behavior.
168 (b) "Autism spectrum disorder" means any of the following
169 disorders as defined in the most recent edition of the
170 Diagnostic and Statistical Manual of Mental Disorders of the
171 American Psychiatric Association:
172 1. Autistic disorder.
173 2. Asperger's syndrome.
174 3. Pervasive developmental disorder not otherwise

175 specified.
176 (c) “Direct patient access” means the ability of an insured
177 to obtain services from an in-network provider without a
178 referral or other authorization before receiving services.
179 (d) ~~(c)~~ “Eligible individual” means an individual under 18
180 years of age or an individual 18 years of age or older who is in
181 high school and who has been diagnosed as having a developmental
182 disability at 8 years of age or younger.
183 (e) ~~(d)~~ “Health maintenance contract” means a group health
184 maintenance contract offered by a health maintenance
185 organization. The ~~This~~ term does not include a health
186 maintenance contract offered in the individual market, a health
187 maintenance contract that is individually underwritten, or a
188 health maintenance contract provided to a small employer.
189 (3) A health maintenance contract issued or renewed on or
190 after April 1, 2009, shall provide coverage to an eligible
191 individual for:
192 (a) Direct patient access to an appropriate specialist, as
193 defined in s. 381.986, for a minimum of three visits per policy
194 year for screening for or evaluation or diagnosis of autism
195 spectrum disorder.
196 (b) ~~(a)~~ Well-baby and well-child screening for diagnosing
197 the presence of autism spectrum disorder.
198 (c) ~~(b)~~ Treatment of autism spectrum disorder through speech
199 therapy, occupational therapy, physical therapy, and applied
200 behavior analysis services. Applied behavior analysis services
201 shall be provided by an individual certified pursuant to s.
202 393.17 or an individual licensed under chapter 490 or chapter
203 491.

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204 (4) The coverage required pursuant to subsection (3) is
205 subject to the following requirements:
206 (a) Coverage shall be limited to treatment that is
207 prescribed by the subscriber's treating physician in accordance
208 with a treatment plan.
209 (b) Coverage for the services described in subsection (3)
210 shall be limited to $36,000 annually and may not exceed $200,000
211 in total benefits.
212 (c) Coverage may not be denied on the basis that provided
213 services are habilitative in nature.
214 (d) Coverage may be subject to general exclusions and
215 limitations of the subscriber's contract, including, but not
216 limited to, coordination of benefits, participating provider
217 requirements, and utilization review of health care services,
218 including the review of medical necessity, case management, and
219 other managed care provisions.
220 (5) The coverage required pursuant to subsection (3) may
221 not be subject to dollar limits, deductibles, or coinsurance
222 provisions that are less favorable to a subscriber than the
223 dollar limits, deductibles, or coinsurance provisions that apply
224 to physical illnesses that are generally covered under the
225 subscriber's contract, except as otherwise provided in
226 subsection (3).
227 (6) A health maintenance organization may not deny or
228 refuse to issue coverage for medically necessary services,
229 refuse to contract with, or refuse to renew or reissue or
230 otherwise terminate or restrict coverage for an individual
231 solely because the individual is diagnosed as having a
232 developmental disability.

233 (7) The treatment plan required pursuant to subsection (4)
234 shall include, but is not limited to, a diagnosis, the proposed
235 treatment by type, the frequency and duration of treatment, the
236 anticipated outcomes stated as goals, the frequency with which
237 the treatment plan will be updated, and the signature of the
238 treating physician.
239 (8) Beginning January 1, 2011, the maximum benefit under
240 paragraph (4)(b) shall be adjusted annually on January 1 of each
241 calendar year to reflect any change from the previous year in
242 the medical component of the then current Consumer Price Index
243 for all urban consumers, published by the Bureau of Labor
244 Statistics of the United States Department of Labor.
245 (9) The Office of Insurance Regulation may not enforce this
246 section against a health maintenance organization that is a
247 signatory no later than April 1, 2009, to the developmental
248 disabilities compact established under s. 624.916. The Office of
249 Insurance Regulation shall enforce this section against a health
250 maintenance organization that is a signatory to the compact
251 established under s. 624.916 if the health maintenance
252 organization has not complied with the terms of the compact for
253 all health maintenance contracts by April 1, 2010.
254 Section 4. This act shall take effect July 1, 2011.