By Senator Ring

29-00057-14 2014174__

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

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30 Academy of Pediatrics. If the physician determines that referral
31 to a specialist is medically necessary, the physician shall
32 refer the minor to an appropriate specialist to determine
33 whether the minor meets diagnostic criteria for autism spectrum
34 disorder. If the physician determines that referral to a
35 specialist is not medically necessary, the physician shall
36 inform the parent or legal guardian that he or she may directly
37 access screening for, or evaluation or diagnosis of, autism
38 spectrum disorder for the minor from the Early Steps program or
39 another appropriate specialist in autism without a referral for
40 at least three visits per policy year. This section does not
41 apply to a physician providing care under s. 395.1041.
42 (2) As used in this section, the term "appropriate
43 specialist" means a qualified professional licensed in this
44 state who is experienced in the evaluation of autism spectrum
45 disorder and has training in validated diagnostic tools. The
46 term includes, but is not limited to:
47 (a) A psychologist;
48 (b) A psychiatrist;
49 (c) A neurologist; or
50 (d) A developmental or behavioral pediatrician.
51 Section 2. Section 627.6686, Florida Statutes, is amended
52 to read:
53 627.6686 Coverage for individuals with autism spectrum
54 disorder required; exception.—
55 (1) This section and s. 641.31098 may be cited as the
56 "Steven A. Geller Autism Coverage Act."
57 (2) As used in this section, the term:
58 (a) "Applied behavior analysis" means the design,

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

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88 insurance coverage~~,~~ which is licensed to engage in the business
89 of insurance in this state and is subject to insurance
90 regulation.
91 (3) A health insurance plan issued or renewed on or after
92 January 1, 2015, must ~~April 1, 2009, shall~~ provide coverage to
93 an eligible individual for:
94 (a) Direct patient access to an appropriate specialist, as
95 defined in s. 381.986, for a minimum of three visits per policy
96 year for screening for, or evaluation or diagnosis of, autism
97 spectrum disorder.
98 (b)~~(a)~~ Well-baby and well-child screening for diagnosing
99 the presence of autism spectrum disorder.
100 (c)~~(b)~~ Treatment of autism spectrum disorder through speech
101 therapy, occupational therapy, physical therapy, and applied
102 behavior analysis. Applied behavior analysis services must ~~shall~~
103 be provided by an individual certified pursuant to s. 393.17 or
104 an individual licensed under chapter 490 or chapter 491.
105 (4) The coverage required pursuant to subsection (3) is
106 subject to the following requirements:
107 (a) Except as provided in paragraph (3)(a), coverage must
108 ~~shall~~ be limited to treatment that is prescribed by the
109 insured's treating physician in accordance with a treatment
110 plan.
111 (b) Coverage for the services described in subsection (3)
112 must ~~shall~~ be limited to $36,000 annually and may not exceed
113 $200,000 in total lifetime benefits.
114 (c) Coverage may not be denied on the basis that provided
115 services are habilitative in nature.
116 (d) Coverage may be subject to other general exclusions and

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

146 for All Urban Consumers, published by the Bureau of Labor
147 Statistics of the United States Department of Labor.
148 (9) This section does ~~may~~ not limit ~~be construed as~~
149 ~~limiting~~ benefits and coverage otherwise available to an insured
150 under a health insurance plan.
151 Section 3. Section 641.31098, Florida Statutes, is amended
152 to read:
153 641.31098 Coverage for individuals with developmental
154 disabilities.—
155 (1) This section and s. 627.6686 may be cited as the
156 "Steven A. Geller Autism Coverage Act."
157 (2) As used in this section, the term:
158 (a) "Applied behavior analysis" means the design,
159 implementation, and evaluation of environmental modifications,
160 using behavioral stimuli and consequences, to produce socially
161 significant improvement in human behavior, including, but not
162 limited to, the use of direct observation, measurement, and
163 functional analysis of the relations between environment and
164 behavior.
165 (b) "Autism spectrum disorder" means any of the following
166 disorders as defined in the most recent edition of the
167 Diagnostic and Statistical Manual of Mental Disorders of the
168 American Psychiatric Association:
169 1. Autistic disorder.
170 2. Asperger's syndrome.
171 3. Pervasive developmental disorder not otherwise
172 specified.
173 (c) "Direct patient access" means the ability of an insured
174 to obtain services from an in-network provider without a

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175 referral or other authorization before receiving services.
176 (d) ~~(c)~~ "Eligible individual" means an individual under 18
177 years of age or an individual 18 years of age or older who is in
178 high school who has been diagnosed as having a developmental
179 disability at 8 years of age or younger.
180 (e) ~~(d)~~ "Health maintenance contract" means a group health
181 maintenance contract offered by a health maintenance
182 organization. This term does not include a health maintenance
183 contract offered in the individual market, a health maintenance
184 contract that is individually underwritten, or a health
185 maintenance contract provided to a small employer.
186 (3) A health maintenance contract issued or renewed on or
187 after January 1, 2015, must ~~April 1, 2009, shall~~ provide
188 coverage to an eligible individual for:
189 (a) Direct patient access to an appropriate specialist, as
190 defined in s. 381.986, for a minimum of three visits per policy
191 year for screening for, or evaluation or diagnosis of, autism
192 spectrum disorder.
193 (b) ~~(a)~~ Well-baby and well-child screening for diagnosing
194 the presence of autism spectrum disorder.
195 (c) ~~(b)~~ Treatment of autism spectrum disorder through speech
196 therapy, occupational therapy, physical therapy, and applied
197 behavior analysis services. Applied behavior analysis services
198 must ~~shall~~ be provided by an individual certified pursuant to s.
199 393.17 or an individual licensed under chapter 490 or chapter
200 491.
201 (4) The coverage required pursuant to subsection (3) is
202 subject to the following requirements:
203 (a) Except as provided in paragraph (3)(a), coverage must

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

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233 the proposed treatment by type, the frequency and duration of
234 treatment, the anticipated outcomes stated as goals, the
235 frequency with which the treatment plan will be updated, and the
236 signature of the treating physician.
237 (8) ~~Beginning January 1, 2011,~~ The maximum benefit under
238 paragraph (4)(b) shall be adjusted annually on January 1 of each
239 calendar year to reflect any change from the previous year in
240 the medical component of the then current Consumer Price Index
241 for All Urban Consumers, published by the Bureau of Labor
242 Statistics of the United States Department of Labor.
243 Section 4. This act shall take effect July 1, 2014.