HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 107 Autism
SPONSOR(S): Health Care Regulation Policy Committee; Coley
TIED BILLS: **IDEN./SIM. BILLS:** SB 214

	REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1)	Health Care Regulation Policy Committee	10 Y, 1 N, As CS	Guy	Calamas
2)	Government Operations Appropriations Committee		Delaney	Topp
3)	General Government Policy Council			
4)				
5)				

SUMMARY ANALYSIS

Committee Substitute for House Bill 107 requires screening for autism spectrum disorder (ASD) under certain conditions. If a minor's parent or legal guardian believes the minor exhibits symptoms of ASD, and reports the observation to a physician, then the physician shall perform ASD screening according to the American Academy of Pediatrics guidelines. If the physician determines that referral to a specialist for additional screening is medically necessary, then the physician shall refer the minor to an "appropriate specialist" for a determination if the minor meets diagnostic criteria for ASD. The bill defines "appropriate specialist" and provides a list of professionals who meet the definition.

The bill provides an exemption for physicians providing emergency services and care under s. 395.1041, F.S.

The bill expands the insurance coverage mandate in s. 627.6686, F.S., and s. 641.31098, F.S., to include cerebral palsy and Down syndrome. The bill requires insurers and plans to cover "direct patient access" to an appropriate specialist for a minimum of three visits per policy year for screening, evaluation or diagnosis of ASD, cerebral palsy, or Down syndrome. The bill defines "direct patient access" as the ability of a subscriber or the insured to obtain services from an in-network provider without getting a referral or other authorization prior to receiving services.

A consultant under contract with the Department of Management Services estimates that the bill will have a fiscal impact to the state group insurance program in the range of $6 to $12 million annually. In addition, there is an indeterminate fiscal impact on local governments (See Fiscal Analysis & Economic Impact Statement).

CS/HB 107 provides an effective date of July 1, 2010.

HOUSE PRINCIPLES

Members are encouraged to evaluate proposed legislation in light of the following guiding principles of the House of Representatives

- Balance the state budget.
- Create a legal and regulatory environment that fosters economic growth and job creation.
- Lower the tax burden on families and businesses.
- Reverse or restrain the growth of government.
- Promote public safety.
- Promote educational accountability, excellence, and choice.
- Foster respect for the family and for innocent human life.
- Protect Florida's natural beauty.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Autism Spectrum Disorder

Autism spectrum disorder (ASD) is the term for a number of pervasive developmental disorders including autistic disorder, Asperger's syndrome, and Rhett's syndrome.[1] Autism spectrum disorders range from a severe form, called autistic disorder, to a milder form, Asperger syndrome. If a child has symptoms of either of these disorders, but does not meet the specific criteria for either, the diagnosis is called pervasive developmental disorder not otherwise specified (PDD-NOS).[2] ASD is generally detected by age three, and the United States Centers for Disease Control and Prevention (CDC) estimates that ASD affects between two and six of every 1,000 children.[3]

Common characteristics shared by children with ASD are varying degrees of deficits in social interaction, verbal and nonverbal communication, and repetitive behaviors or interest. In addition, many children with ASD have some degree of mental impairment. According to the National Institute of Mental Health, the rate of autism diagnosis is increasing - possibly due a change in the criteria to diagnose and "increased recognition of the disorder by professionals and the public."[4] Currently, there is no determinative cause of autism.

ASD Screening and Referrals

The earlier a child is diagnosed with ASD, the more likely early intervention and treatment can assist the child with developmental gains and improved outcomes.[5] In evaluating a child, clinicians rely on behavioral characteristics to make a diagnosis. The diagnosis usually requires a two-stage process. The first phase is a screening which is used to determine if further evaluation is needed.[6] The second phase is a diagnostic evaluation which may be done by a multidisciplinary team that may include a

[1] National Institute of Mental Health, U.S. Department of Health and Human Services, *Autism Spectrum Disorders: Pervasive Developmental Disorders*, see http://www.nimh.nih.gov/health/publications/autism/index.shtml (last visited March 20, 2010).
[2] *Id*.
[3] *Id*.
[4] *Id*.
[5] *Id*.
[6] There are several screening instruments for ASD which may be used including but not limited to the Checklist of Autism in Toddlers (CHAT), the modified Checklist for Autism in Toddlers (M-CHAT), the Screening Tool for Autism in Two-Year-Olds (STAT), and the Social Communication Questionnaire (SCQ) for children 4 years of age and older.

psychologist, neurologist, psychiatrist, speech therapist, or other professionals who diagnose children with ASD.[7]

The American Academy of Pediatrics (Academy) has issued guidelines for the identification and evaluation of children with ASD. These guidelines also include resource materials and screening algorithms for pediatricians to use. In summary, the Academy encourages pediatricians to:[8]

- Conduct surveillance at every well-child visit. Be a good listener and recognize the early subtle red flags that indicate the possibility of an ASD. Be especially vigilant for younger siblings of a child who has already been diagnosed with an ASD.

- Screen at 18, and 24 months and any other time when parents raise a concern about a possible ASD. Although no screening tool is perfect, choose and become comfortable with at least 1 tool for each age group and use it consistently. Before 18 months of age, screening tools that target social and communication skills may be helpful in systematically looking for early signs of ASDs.

- If an ASD-specific screening result is negative but either the parents or the pediatrician remain somewhat concerned, then the pediatrician should schedule the child for an early, targeted clinic visit to address these persistent concerns.

- Act on a positive screening result or when a child demonstrates 2 or more risk factors. Do not take a "wait-and-see" approach. Depending on the age of the child, simultaneously refer for all 3: comprehensive ASD evaluation; early intervention/early childhood education services; and an audiologic evaluation. Do not wait for a definitive diagnosis of an ASD to refer for developmental services; early intervention can be beneficial even if it targets the child's unique deficits. The intervention strategy can be modified if needed when the child is determined to have an ASD.

The American Academy of Pediatrics recommends that initial screening be done by the pediatrician in the child's medical home.[9] The National Institute of Mental Health suggests the diagnostic valuation may be done by a multidisciplinary team that includes a psychologist, a neurologist, a psychiatrist, a speech therapist, or other professionals who diagnose children with ASD.[10]

Currently, physicians in Florida are not statutorily required to refer a minor patient to a specialist for ASD screening.

Treatment for autism uses applied behavior analysis to reduce inappropriate behavior and increase communication, learning, and appropriate social behavior.[11] Treatment for young children focuses on early communication and building social interaction skills. Some children may take medication in addition to social training.

Cerebral Palsy

Cerebral palsy is a term used to describe a number of neurological disorders that appear in infancy or early childhood and affect muscle coordination and movement.[12] It is caused by abnormalities in parts

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[7] National Institute of Mental Health, *supra* note 1.
[8] Chris Plauche Johnson, *Identification and Evaluation of Children with Autism Spectrum Disorders*, Pediatrics 120:5 1183-1215 (November 2007).
[9] American Academy of Pediatricians, The Medical Home and Early Intervention Programs, see http://www.medicalhomeinfo.org/health/Downloads/EIBrochureF.pdf (last visited March 20, 2010).
[10] National Institute of Mental Health, "The Diagnosis of Autism Spectrum Disorders," see http://www.nimh.nih.gov/health/publications/autism/the-diagnosis-of-autism-spectrum-disorders.shtml (last visited March 20, 2010).
[11] National Institute of Mental Health, "Treatment Options," see http://www.nimh.nih.gov/health/publications/autism/treatment-options.shtml (last visited March 20, 2010).
[12] National Institute of Neurological Disorders and Stroke, "NINDS Cerebral Palsy Information Page," see http://www.ninds.nih.gov/disorders/cerebral_palsy/cerebral_palsy.htm (last visited March 25, 2010).

of the brain that control muscle movements.[13] Symptoms can be mild to severe and usually appear before 3 years of age. Nationally, cerebral palsy occurs in 1 in 278 children.[14]

Cerebral palsy is diagnosed by examination of a child's physical and behavioral signs.[15] Then additional tests are performed to rule out other disorders that can cause movement problems.[16] The most common symptoms of cerebral palsy are: a lack of muscle coordination when performing voluntary movements (ataxia); stiff or tight muscles and exaggerated reflexes (spasticity); walking with one foot or leg dragging; walking on the toes, a crouched gait, or a "scissored" gait; and muscle tone that is either too stiff or too floppy.[17]

Cerebral palsy is incurable, but early intervention, physical and occupational therapy are suggested to manage the condition. Cerebral palsy does not worsen as the child ages.[18] Drugs and surgery are used to alleviate pain and manage muscle control.

Down Syndrome

Down syndrome is a set of mental and physical symptoms caused by the presence of an extra chromosome 21 (trisomy 21). The presence of this third chromosome 21 changes brain and body development.[19] The range of symptoms can be mild to severe and may cause limits on intellectual abilities and adaptive behaviors. People with Down syndrome may have slower motor development and lower to mid-range IQ.[20] Many people with Down syndrome experience hearing loss and are at a higher risk for heart conditions.[21] Down syndrome occurs in approximately 1 in 740 live births in the U.S.[22] In Florida, there were 162 Down syndrome live births in 2005, the most recent year for which statistics are available.[23]

Down syndrome is usually first diagnosed based on physical features present at birth. Physical features include: a flat facial profile; an upward slant to the eye; a short neck; and white spots on the iris of the eye (called Brushfield spots).[24] These and other physical characteristics may not all be present in every infant who is diagnosed with Down syndrome. The diagnosis is then confirmed by a blood test called a chromosomal karyotype.[25]

Down syndrome is incurable, but early intervention, speech and occupational therapy are suggested to manage the condition.[26]

Physician Licensure and Discipline

Physicians are licensed by the Department of Health (DOH) and are regulated by either the Florida Board of Medicine (Board), for allopathic physicians licensed under Chapter 458, F.S., or the Florida Board of Osteopathic Medicine (Board), for osteopathic physicians licensed under Chapter 459, F.S. There are currently 41,951 active, allopathic physicians and 3,886 active, osteopathic physicians licensed in Florida.[27]

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[13] *Id*.
[14] Centers for Disease Control and Prevention, "Data Show 1 in 303 Children Have Cerebral Palsy," see http://www.cdc.gov/Features/CerebralPalsy/ (last visited March 25, 2010).
[15] Mayo Clinic, "Cerebral Palsy," see http://www.mayoclinic.org/cerebral-palsy/ (last visited March 25, 2010).
[16] *Id*.
[17] National Institute of Neurological Disorders and Stroke, *supra* note 12.
[18] Mayo Clinic, *supra* note 15.
[19] National Institute of Child Health and Human Development, "Down Syndrome," see http://www.nichd.nih.gov/health/topics/down_syndrome.cfm (last visited March 25, 2010).
[20] *Id*.
[21] National Institute of Medicine, Genetics Home Reference, "Down Syndrome," see http://ghr.nlm.nih.gov/condition=downsyndrome (last visited March 25, 2010).
[22] *Id*.
[23] Florida Department of Health, "Environmental Public Health Tracking," see http://www.floridatracking.com/HealthTrackFL/report.aspx?IndNumber=1280&mes=11111 (last visited March 25, 2010).
[24] National Institutes of Medicine, *supra* note 14.
[25] National Institute of Child Health and Human Development, "Facts about Down Syndrome," see http://www.nichd.nih.gov/publications/pubs/downsyndrome.cfm#DownSyndrome (last visited March 25, 2010).
[26] National Institute of Child Health and Human Development, *supra* note 12.

Section 456.072, F.S., authorizes health care practitioner boards organized within the Florida Department of Health to regulate and discipline practitioners who do not comply with prevailing standards of care, state and federal law. Disciplinary measures for allopathic and osteopathic physicians include, but are not limited to: application denial; fines; compelled community service; practice restriction; temporary and emergency suspension; and licensure revocation.[28]

Health Insurance Mandates and Mandated Offerings

A health insurance mandate is a legal requirement that an insurance company or health plan cover services by particular health care providers, specific benefits, or specific patient groups. Florida currently has at least 52 mandates.[29] The Council for Affordable Health Insurance estimates that mandated benefits currently increase the cost of basic health coverage from a little less than 20 percent to perhaps 50 percent, depending on the number of mandates, the benefit design and the cost of the initial premium.[30] Each mandate adds to the cost of a plan's premiums, in a range of less than 1 percent to 10 percent, depending on the mandate.[31] Higher costs resulting from mandates are most likely to be experienced in the small group market since these are the plans that are subject to state regulations. The national average cost of insurance for a family is $13,375.[32]

Health Insurance Mandate Report

Section 624.215, F.S., requires that a report assessing the social and financial impact of any proposal for legislation that mandates health benefit coverage or mandates offering requirements must be submitted to AHCA and the legislative committee having jurisdictions. The report shall include:[33]

- Extent to which the treatment or service generally used by a significant portion of the population.
- Extent to which the insurance coverage generally available.
- If the insurance coverage is not generally available, extent to which the lack of coverage result in persons avoiding necessary health care treatment.
- If the coverage is not generally available, extent to which the lack of coverage result in unreasonable financial hardship.
- Level of public demand for the treatment or service.
- Level of public demand for insurance coverage of the treatment or service.
- Level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.
- Extent to which the coverage increase or decrease the cost of the treatment or service.
- Extent to which the coverage increase the appropriate uses of the treatment or service.
- Extent to which the mandated treatment or service be a substitute for a more expensive treatment or service.
- Extent to which the coverage increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.
- Impact of this coverage on the total cost of health care.

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[27] Florida Department of Health, *Division of Medical Quality Assurance Annual Report July 1, 2008 – June 30, 2009*.
[28] Rule 64B8-8.001, F.A.C., and 64B15-19.002, F.A.C.
[29] Office of Insurance Regulation list of state health insurance mandates (on file with Health Care Regulation Policy Committee); and Council for Affordable Health Insurance, *Health Insurance Mandates in the States 2009*, see http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2009.pdf. (last viewed March 20, 2010).
[30] Council for Affordable Health Insurance, *Health Insurance Mandates in the States 2009*, see http://www.cahi.org/cahi_contents/resources/pdf/HealthInsuranceMandates2009.pdf. (last viewed March 20, 2010).
[31] *Id*.
[32] Kaiser Family Foundation, *Employer Health Benefits 2009 Annual Survey*, see http://ehbs.kff.org/?CFID=20695941&CFTOKEN=84763322&jsessionid=6030bac21268c605c7863526585a397e6175 (last viewed March 20, 2010).
[33] s. 624.215(2), F.S.

Health Insurance Coverage for ASD, Cerebral Palsy and Down Syndrome

Currently, Florida law mandates certain health insurance coverage for ASD. Florida law does not mandate coverage for cerebral palsy or Down syndrome.

Chapter 627, F.S., relates to insurers and Chapter 641, F.S., relates to health maintenance organizations. Sections 627.6686 and 641.31098, F.S., define "autism spectrum disorder" to mean autistic disorder, Asperger's syndrome, and a PDD-NOS, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. These sections mandate health insurance coverage for autism spectrum disorder treatment for plans issued or renewed as of April 1, 2009.[34] An "eligible individual" is a person under 18 years old or an individual at least 18 years who is in high school and was diagnosed as having a developmental disability before reaching 9 years of age.[35] Section 627.6686(4)(b), F.S., and s. 641.31098(4)(b), F.S., provide a coverage cap of $36,000 annually and $200,000 in total lifetime benefits.

Together the aforementioned sections of Florida law are known as the "Steven A. Geller Autism Coverage Act." Passed during the 2008 Legislative Session, the bill also included the Window of Opportunity Act which required the Florida Office of Insurance Regulation to convene a workgroup of stakeholders by August 31, 2008, to negotiate a compact for a binding agreement among the participants relating to insurance coverage and access to services for persons with developmental disabilities.[36] The compact requirements are found in s. 624.916, F.S., which defines developmental disabilities to include cerebral palsy and Down syndrome. The law required the compact to include: coverage for specific therapies; policy-holder notification standards; and penalties for claims denial under specified circumstances.[37]

A compact was developed by the workgroup and adopted on December 17, 2008. The compact requires insurers and HMOs that sign onto the compact agreement to provide coverage for developmental disabilities as specified in the compact for all plans issued or renewed after January 1, 2010. As of February 15, 2010, the only compact signatory is Total Health Choices, Inc.[38]

All insurers and HMOs that did not sign the compact by April 1, 2009, are subject to the requirements of the Steven A. Gellar Autism Act.[39]

Effect of Proposed Changes

Committee Substitute for House Bill 107 creates s. 381.986, F.S., requiring screening for autism spectrum disorder under certain conditions. If a minor patient's parent or legal guardian believes the minor exhibits symptoms of ASD, and they report their observations to the physician, then the physician shall perform ASD screening according to the American Academy of Pediatrics guidelines. If the physician determines that referral to a specialist is medically necessary, then he shall refer the minor to an "appropriate specialist" for a determination if the minor meets diagnostic criteria for ASD.

If the physician determines that referral to a specialist is not medically necessary, then the physician shall inform the parent or legal guardian that they may self-refer to the Early Steps intervention program or other autism specialist.

The bill defines "appropriate specialist" as a qualified professional who is experienced in the evaluation of ASD and who has training in validated diagnostic tools, including a Florida-licensed:

- Psychologist;
- Psychiatrist;

[34] s. 627.6686(3), F.S., and s. 641.31098(3), F.S.
[35] s. 627.6686(2)(c), F.S., and s. 641.31098(2)(c), F.S.
[36] s. 624.916, F.S.
[37] s. 624.916(4), F.S.
[38] Office of Insurance Regulation, *2010 Developmental Disabilities Compact Annual Report* (February 15, 2010).
[39] s. 627.6686(10), F.S., and s. 641.31098(9), F.S.

- Neurologist;
- Developmental or behavioral pediatrician who specializes in child neurology; or
- Professional whose licensure is deemed appropriate by the Children's Medical Services Early Steps Program within the Department of Health.[40]

The bill provides an exemption from this requirement for physicians providing emergency services in care under s. 395.1041, F.S.[41]

The bill expands the insurance coverage mandate in s. 627.6686 and s. 641.31098, F.S., to include coverage for the developmental disabilities of cerebral palsy and Down syndrome. The bill defines:

- "Developmental disability" to mean a disorder or syndrome attributable to cerebral palsy or Down syndrome which manifests before 18 years old and constitutes a substantial handicap that can reasonably be expected to continue indefinitely.
- "Cerebral palsy" to mean a group of disabling symptoms of extended duration which results from damage to the developing brain that may occur before, during, or after birth and that result in the loss or impairment of control over voluntary muscles.
- "Down syndrome" to mean a disorder caused by the presence of an extra chromosome 21.

The bill requires "direct patient access" to an appropriate specialist for a minimum of three visits per policy year for screening, evaluation or diagnosis of ASD, cerebral palsy or Down syndrome. The bill defines "direct patient access" to mean the ability of a subscriber or the insured to obtain services from an in-network provider without getting a referral or other authorization prior to receiving services.

Health Insurance Mandate Report

The health insurance mandate report required by s. 624.215, F.S., was submitted by Zepp Strategic Partners.[42] The report relates to HB 107 as originally filed, not the CS/HB 107. Therefore, it only addresses the insurance mandate for ASD coverage and does not address the additional mandates for cerebral palsy and Down syndrome coverage created in the committee substitute. An updated insurance mandate report was not submitted to the House Health Care Regulation Policy Committee.

- **Extent to which the treatment or service generally used by a significant portion of the population.**[43]

Proponents cite to the screening guidelines of the American Academy of Pediatrics which recommends autism screening at 18 months and 24 months of age. However, proponents did not provide any documentation or statistics concerning the number of children in Florida who undergo screening or treatment.

- **Extent to which the insurance coverage is generally available.**[44]

Proponents suggest that less than 50 percent of children in Florida have insurance coverage. Proponents assert that a "significant number" of children are Medicaid recipients or have Healthy Kids coverage. According to the proponents, neither system covers autism screening. Proponents did not provide documentation for these assertions.

However, according to data provided by the University of Florida, only about 12 percent of Florida's children are uninsured. In addition, about 75 percent of Florida's uninsured children are currently

[40] The Florida Department of Health administers the Early Steps program under Children's Medical Services. "Early Steps is an early intervention system that offers services to infants and toddlers (birth to thirty-six months) with significant delays or a condition likely to result in a developmental delay." See http://www.doh.state.fl.us/AlternateSites/CMS-Kids/families/early_steps/early_steps.html (last visited March 20, 2010).
[41] This section requires hospitals with emergency departments to provide emergency services and care for persons with emergency medical conditions, regardless of ability to pay, and prohibits hospitals from transferring emergency patients except under certain, limited, conditions.
[42] The health insurance mandate report is on file with the Health Care Regulation Policy Committee.
[43] s. 624.215(2)(a), F.S.
[44] s. 624.215(2)(b), F.S.

eligible for government program-based coverage.[45] Of the insured children, about 58 percent are covered by private individual or employer-based coverage, and about 37 percent are covered by government programs.[46]

According to the Agency for Health Care Administration, the Medicaid Child Health Check-up program does not currently reimburse for a specific procedure code for screening for Autism or ASD. However, Medicaid's Early Intervention Services program (EIS) provides for the early identification of developmental delays or conditions. EIS reimburses for screenings, evaluations, and early intervention sessions for eligible children identified with a delay or suspected delay.[47]

- **Extent to which the lack of insurance coverage results in persons avoiding necessary health care treatment, if insurance coverage is not generally available.**[48]

The proponent provided no data to make a determination regarding children avoiding necessary health care treatment due to lack of insurance coverage.

- **Extent to which insurance coverage is generally not available and results in an unreasonable financial hardship.**[49]

According to the proponents, the average cost over a lifetime to treat ASD is $3.2 million.[50] Proponents suggest that early diagnosis and intervention can reduce this cost, but provide no data to support that assertion.

- **The level of public demand for the treatment or service.**[51]

Proponents cite to the Centers for Disease Control and Prevention for the statistic that 1 percent of children in Florida have ASD.[52] However, insufficient documentation was provided to determine the level of public demand.

- **The level of public demand for insurance coverage of the treatment or service.**[53]

The proponents provided no data on the level of public demand for insurance coverage of ASD screening, evaluation and diagnosis.

- **The level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.**[54]

Insufficient documentation was provided to determine the level of interest of collective bargaining agents in negotiating for the inclusion of this coverage in group contracts.

- **Extent to which the coverage would increase or decrease the cost of the treatment or service.**[55]

The proponents assert that the cost of ASD screening would be $10-20 per visit, but provide no data to support this assertion. Proponents suggest that 227,000 children may use the screening service for a

[45] "Health Insurance Coverage Among Children in Florida," Florida Health Insurance Study, Florida Center for Medicaid and the Uninsured, University of Florida (2005).
[46] *Id.*
[47] Agency for Health Care Administration 2010 Bill Analysis & Economic Impact Report, House Bill 107, on file with the House Health Regulation Policy Committee.
[48] s. 624.6686(2)(c), F.S.
[49] s. 624.215(2)(d), F.S.
[50] Michael Ganz, *Understanding Autism: From Basic Neuroscience to Treatment*, CRC Press (2006). House Health Care Regulation Policy Committee staff was not provided this source.
[51] s. 624.215(2)(e), F.S.
[52] House Health Care Regulation Policy Committee staff could not verify this statistic.
[53] S. 624.215(2)(f), F.S.
[54] s. 624.215(2)(g), F.S.
[55] s. 624.215(2)(h), F.S.

total cost of $3.3 million, but provide no documentation or data to support this projection. The proponents made no assertions as to the effect of increased coverage on the cost of the treatment or service.

- **Extent to which the coverage increase the appropriate uses of the treatment or service.**[56]

The proponents provided no data from which to make a determination regarding the increase the appropriate uses of the treatment or service.

- **Extent to which the mandated treatment or service be a substitute for a more expensive treatment or service.**[57]

The proponents suggest that while ASD screening is not a substitute for a more expensive treatment or service, the use of ASD screening will reduce the use of more expensive treatments over the patient's lifetime.

- **Extent to which the coverage increases or decreases the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.**[58]
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Insufficient documentation was provided to determine any increases or decreases in administrative expenses to insurance companies or premium and administrative expenses to policyholders. However, it is reasonable to expect that covering more services will result in higher premiums.

- **The impact of this coverage on the total cost of health care.**[59]

Proponents assert that ASD screening, evaluation and diagnosis coverage would significantly decrease the costs of health care for persons with ASD, but made no statements as to the impact on the total cost of health care.

CS/HB 107 provides an effective date of July 1, 2010.

B. SECTION DIRECTORY:

Section 1: Creates s. 381.986, F.S., relating to screening for autism spectrum disorder.
Section 2: Amends s. 627.6686, F.S., relating to coverage for individuals with autism spectrum disorder required; exception.
Section 3: Amends s. 641.31098, F.S., relating to coverage for individuals with developmental disabilities.
Section 4: Provides an effective date of July 1, 2010.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

[56] s. 624.215(2)(i), F.S.
[57] s. 624.215(2)(j), F.S.
[58] s. 624.215(2)(k), F.S.
[59] s. 624.215(2)(l), F.S.

2. Expenditures:

   According to a study requested by the Department of Management Services (DMS), there is an estimated recurring cost to the State Group Health Insurance Trust Fund for the expanded coverage requirements contained in the bill, specifically relating to cerebral palsy and Down syndrome.[60]

   Estimated increase in expenditures for the State Group Insurance Program:

FY 10-11	FY 11-12	FY 12-13
$6 – $12 million	$6.6 – $13.2 million	$7.4 - $14.7 million

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   Indeterminate impact.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Indeterminate economic impact.

D. FISCAL COMMENTS:

E. According to the Department of Health, Children's Medical Services and Early Steps programs may see an increase in the number of referrals for screening, which could result in an inability for Early Steps program to meet federally-mandated timelines for evaluation and service provision; however, the exact fiscal impact could not be determined at this time.[61]

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill appears to require counties or municipalities to take action requiring the expenditure of funds; therefore, the bill potentially falls under the purview of s. 18, art, VII of the State Constitution, which provides that cities and counties are not bound by general laws requiring them to spend funds unless certain provisions are met. First the legislature must determine the bill fulfills an important state interest, and one or more of the following conditions is met: approval by two-thirds of the membership of each house of the Legislature, or the expenditure is required to comply with a law that applies to all persons similarly situated.

   The law applies to all persons that are similarly situated; however, the bill does not contain a statement that the Legislature has determined that the bill fulfills an important state interest. Consideration should be given to amending such a statement on to the bill.

2. Other:

   None.

[60] Teleconference with Department of Management Services staff, March 26, 2010, and information contained in an April 24, 2010, letter from Buck Consultants to the Director of the Division of State Group Insurance (notes and letter on file with the Committee).
[61] Florida Department of Health, Bill Analysis, Economic Statement and Fiscal Note (September 22, 2009).

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill requires direct patient access for the screening for, evaluation of, or diagnosis of ASD or other developmental disability by an appropriate specialist as defined in s. 381.986, F.S. However, an appropriate specialist under that section is one who is experienced in the evaluation of ASD. It is unclear if an appropriate specialist trained in the evaluation of ASD will provide a cogent screening, evaluation, or diagnosis of cerebral palsy or Down syndrome.

IV. AMENDMENTS/COUNCIL OR COMMITTEE SUBSTITUTE CHANGES

On March 22, 2010, the House Health Care Regulation Policy Committee adopted a strike-all amendment to HB 107.

The strike-all amendment revises physician referral for ASD screening requirements to require pre-referral screening by the physician under the American Academy of Pediatrics guidelines. The physician must refer the patient to an appropriate specialist for ASD screening if the physician determines in his or her professional judgment that further ASD testing is medically necessary. If the physician determines that further ASD testing is not medically necessary, then the physician must inform the parent or legal guardian that they may self-refer to the Early Steps intervention program or other autism specialist.

The strike-all amendment expands the existing insurance coverage mandate in s. 627.6686 and s. 641.31098, F.S., to include cerebral palsy and Down syndrome. The insurance coverage mandate is expanded to require direct patient access for a minimum of three visits per policy year for the screening, evaluation or diagnosis of ASD, cerebral palsy or Down syndrome.