The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Governmental Oversight and Accountability Committee

BILL: CS/CS/CS/SB 214

INTRODUCER: Governmental Oversight and Accountability Committee, Banking and Insurance Committee, Health Regulation Committee, and Senator Ring

SUBJECT: Autism

DATE: April 6, 2010 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Bell	Wilson	HR	**Fav/CS**
2.	Johnson	Burgess	BI	**Fav/CS**
3.	Wilson	Wilson	GO	**Fav/CS**
4.			WPSC	
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE..... [X] Statement of Substantial Changes

B. AMENDMENTS........................ [ ] Technical amendments were recommended

[ ] Amendments were recommended

[ ] Significant amendments were recommended

I. Summary:

The Committee Substitute (CS) for SB 214 requires a physician to screen a minor for autism spectrum disorder (ASD) in accordance with the American Academy of Pediatrics' guidelines, when the parent or legal guardian of that minor believes the minor exhibits symptoms of ASD and notifies the physician. Based on a determination of medical necessity, the physician must refer the minor for additional ASD screening or inform the patient of other available ASD screening options.

The CS expands the current autism coverage mandate to include treatment for developmental disabilities. The term, "developmental disabilities," is defined to include "a disorder or syndrome attributable to cerebral palsy and Down syndrome…" The CS requires health insurers and health maintenance organizations (HMOs) to provide direct access to one appropriate specialist for the diagnosis of ASD or other developmental disability. The CS mandates health insurance policies and HMO contracts to provide at least three visits per policy year for the screening for, evaluation of, or diagnosis of ASD or other specified developmental disabilities.

The Division of State Group Insurance of the Department of Management Services estimates that the bill will have a fiscal impact on state government of $6-12 million for FY 2010-11, and thereafter. The impact on local governments is indeterminate at this time.

The CS creates s. 381.986, F.S., and amends ss. 627.6686 and 641.31098, of the Florida Statutes.

II. Present Situation:

What is Autism?

Autism is a term used to describe a group of complex developmental disabilities that many researchers believe are the result of a neurological disorder that affects the functioning of the brain. Individuals with autism often have problems communicating with others through spoken language and nonverbal communication. The early signs of autism usually appear in the form of developmental delays before a child turns 3 years old.[1]

Section 393.063(3), F.S., defines autism to mean: ". . . a pervasive, neurologically based developmental disability of extended duration which causes severe learning, communication, and behavior disorders with age of onset during infancy or childhood. Individuals with autism exhibit impairment in reciprocal social interaction, impairment in verbal and nonverbal communication and imaginative ability, and a markedly restricted repertoire of activities and interests."

The various forms of autism are referred to as the autism spectrum disorders (ASD), meaning that autism can be manifested in a wide variety of combinations, from mild to severe. Thus, many different behaviors can indicate that a person should be diagnosed as autistic. According to the National Institute of Mental Health (NIMH),[2] the pervasive developmental disorders, or ASDs, range from a severe form, called autistic disorder, to a milder form, Asperger's syndrome.[3] 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). Other rare, severe disorders that are included in the autism spectrum are Rett syndrome[4] and childhood disintegrative disorder.[5] The NIMH states that all children with an ASD demonstrate deficits in:

[1] Centers for Disease Control and Prevention website, Found at: <http://www.cdc.gov/ncbddd/autism/signs.html> (Last visited on March 5, 2010).

[2] Department of Health and Human Services, National Institute of Mental Health. *Autism Spectrum Disorders: Pervasive Developmental Disorders.* Printed 2004 Reprinted 2008. Found at: <http://www.nimh.nih.gov/health/publications/autism/nimhautismspectrum.pdf> (Last visited on March 5, 2010).

[3] The NIMH states that children with Asperger's syndrome are similar to high-functioning children with autism in that their language and intelligence remain intact. Like autistic children, persons with Asperger's syndrome have repetitive behaviors, severe social problems, and clumsy movements. The symptoms of Asperger's syndrome usually appear later in childhood than those of autism.

[4] The NIMH provides the following explanation of Rett syndrome: Rett syndrome is relatively rare, affecting almost exclusively females, one out of 10,000 to 15,000. After a period of normal development, sometime between 6 and 18 months, autism-like symptoms begin to appear. The little girl's mental and social development regresses—she no longer responds to her parents and pulls away from any social contact. If she has been talking, she stops; she cannot control her feet; she wrings her hands. Some of the problems associated with Rett syndrome can be treated. Physical, occupational, and speech therapy can help with problems of coordination, movement, and speech.

[5] The NIMH provides the following explanation of childhood disintegrative disorder: Very few children who have an ASD diagnosis meet the criteria for childhood disintegrative disorder (CDD). An estimate based on four surveys of ASD found

- *Social Interaction* – Most children with an ASD have difficulty learning to engage in everyday human interaction. Children with an ASD are also slower in understanding subtle social cues (nonverbal communication) and thus struggle to interpret what others are thinking and feeling. This causes them to often find social interaction confusing and frustrating. It is also common for people with an ASD to have difficulty controlling their emotions. Examples include episodes of disruptive behavior such as crying or verbal outbursts at inappropriate times or physical aggression. Autistics often can lose self control when exposed to a strange or overwhelming environment or when angry or frustrated.
- *Verbal and nonverbal communication* – Autistics have difficulty developing standard communication skills. Some children with an ASD remain mute, while others do not develop language until ages 5 to 9. Others use language in unusual ways or utilize sign language or pictures to communicate. The body language of autistics can be difficult to understand because it is not always consistent with the words they are saying. As they grow older, persons with an ASD often become more aware of their difficulties in communication, which can lead to anxiety or depression.
- *Repetitive behaviors or interests* – Children with an ASD often perform odd repetitive motions that set them apart from their peers. For example, some children and adults repeatedly flap their arms or walk on their toes while others freeze in position. Children with an ASD exhibit the need for consistency in their environment. Changes in daily routines—such as mealtimes, dressing, bathing, going to school at a certain time and by the same route—can cause autistics to become extremely disturbed. As children, they might spend hours lining up their toys in a certain way and if the toys are moved become upset. Additionally, autistics often form intense, obsessive preoccupations with certain objects or topics on which they focus much of their energy.

Another common difficulty is that children with an ASD often have unusual responses to sensory experiences, such as certain sounds or the way objects look.

The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, is the primary system used to classify and diagnose mental disorders. The 4th edition of the DSM was released in 1994. On February 10, 2010, the American Psychiatric Association released its draft criteria for the fifth edition of the DSM on its website, which is available for public comment until April 20, 2010.[6] The draft DSM-5 includes collapsing all autism related diagnoses into one single category, "autism spectrum disorder" that would incorporate autistic disorder, Asperger's syndrome, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified. The final DSM-5 is not scheduled for release until May 2013.

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fewer than two children per 100,000 with an ASD could be classified as having CDD. This suggests that CDD is a very rare form of ASD. It has a strong male preponderance. Symptoms may appear by age 2, but the average age of onset is between 3 and 4 years. Until this time, the child has age-appropriate skills in communication and social relationships. The long period of normal development before regression helps differentiate CDD from Rett syndrome. The loss of such skills as vocabulary is more dramatic in CDD than they are in classical autism. The diagnosis requires extensive and pronounced losses involving motor, language, and social skills. CDD is also accompanied by loss of bowel and bladder control and oftentimes seizures and a very low IQ.

[6] Proposed Draft Revisions to DSM Disorders and Criteria. Found at: <http://www.dsm5.org/Pages/Default.aspx> (Last visited on March 5, 2010).

Sections 627.6686(2)(b) and 641.31098(2)(b), F.S., define the term “autism spectrum disorder” as any of the following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association:

- Autistic disorder.
- Asperger’s syndrome.
- Pervasive developmental disorder not otherwise specified.

The law requires certain insurance coverage for diagnostic screening, intervention, and treatment of autism spectrum disorder for eligible individuals. The act defines an eligible individual as:

> . . .an individual under 18 years of age or an individual 18 years of age or older who is in high school who has been diagnosed as having a developmental disability at 8 years of age or younger.[7]

Diagnosis of Autism Spectrum Disorders

There is no medical test for ASDs. Instead, doctors look at behavioral symptoms to make a diagnosis. These symptoms may show up within the first few months of life or may appear at any time before the age of 3.[8]

According to the Centers for Disease Control and Prevention (CDC), research shows that the diagnosis of autism at age 2 can be reliable, valid, and stable. However, many children do not receive final diagnosis until they are much older. This delay in diagnosis may result in lost opportunities for specialized early intervention.[9]

The diagnosis of an ASD is a two-stage process. The first stage involves developmental screening during “well child” check-ups. These screening tests are used solely for identifying children with developmental disabilities. Additional screening may be needed if a child is at high risk[10] for an ASD or if the symptoms warrant it.[11]

The second stage of diagnosis is a comprehensive evaluation. If the initial screening tests indicate the possibility of an ASD, then further comprehensive testing is performed. Comprehensive testing is done by health care practitioners from multiple disciplines (psychologists, psychiatrists, neurologists, speech therapists, and other professions with

[7] ss. 627.6686(2)(c) and 641.31098(2)(c), F.S.

[8] Centers for Disease Control and Prevention website. Found at: <http://www.cdc.gov/ncbddd/autism/screening.html> (Last visited on March 5, 2010).

[9] Centers for Disease Control and Prevention website. Found at <http://www.cdc.gov/ncbddd/autism/screening.html> (Last visited on March 5, 2010).

[10] The CDC considers a child with a sibling or parent with an ASD to be at high risk.

[11] Centers for Disease Control and Prevention website, Found at <http://www.cdc.gov/ncbddd/autism/screening.html> (Last visited on March 5, 2010).

experience in diagnosing children with an ASD) who evaluate the child in depth and determine if there is a developmental disorder, and if so, render a diagnosis. This may include:[12]

- Clinical observations;
- Parent interviews;
- Developmental histories;
- Psychological testing;
- Speech and language assessments;
- The possibility of the use of one or more autism diagnostic scales; and
- The possibility of physical, neurological, and genetic testing.

According to the Agency for Health Care Administration (AHCA), it is currently at the physician's discretion to determine when a referral for an autism screening is appropriate.[13]

Treatment Approaches

Much of the scientific and clinical evidence indicates that early treatment of autism during preschool years (ages 3 to 5) often yields very positive results in mitigating the effects of ASDs. According to the National Institute of Neurological Disorders and Stroke (NINDS), therapies for autism are designed to remedy specific symptoms.[14] Educational and behavioral interventions are highly-structured and usually aimed at the development of skills such as language and social skills. Medication may be prescribed to reduce self-injurious behavior or other behavioral symptoms of autism. Early intervention is important for children because children learn most rapidly when they are very young. If begun early enough, such intervention has a chance of favorably influencing brain development. In a 2001 report, the Commission on Behavioral and Social Sciences and Education recommended that treatment "services begin as soon as a child is suspected of having an autistic spectrum disorder. Those services should include a minimum of 25 hours a week, 12 months a year, in which the child is engaged in systematically planned, and developmentally appropriate educational activity toward identified objectives."[15]

The Center for Autism and Related Disabilities provided the following information concerning the application of speech-language therapy, occupational therapy, and physical therapy for individuals with autism:

- *Speech-Language Therapy:* People with autism usually have delays in communication. Speech therapists look for a system of communication that will work for an individual with autism and may consider alternatives to the spoken word such as signing, typing, or a picture board with words.
- *Occupational Therapy:* Commonly, this therapy focuses on improving fine motor skills, such as brushing teeth, feeding, and writing, or sensory motor skills that include balance, awareness of body position, and touch.

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[12] Centers for Disease Control and Prevention website, Found at <http://www.cdc.gov/ncbddd/autism/screening.html> (Last visited on March 4, 2010).

[13] Agency for Health Care Administration 2010 Bill Analysis & Economic Impact Statement, Senate Bill 214 (on file with the Senate Committee on Health Regulation).

[14] National Institutes of Health, National Institute of Neurological Disorders and Stroke, Autism Information Page. Found at: <http://www.ninds.nih.gov/disorders/autism/autism.htm#Is_there_any_treatment> (Last visited on March 5, 2010).

[15] Commission on Behavioral and Social Sciences and Education, *Educating Children with Autism* 6, 2001. Found at: <http://www.nap.edu/openbook.php?record_id=10017&page=66> (Last visited on March 5, 2010).

- *Physical Therapy:* This therapy specializes in developing strength, coordination, and movement.

According to the NIMH, a number of treatment approaches have evolved in the decades since autism was first identified. These approaches include developmental, behaviorist, and nonstandard. Developmental approaches provide consistency and structure along with appropriate levels of stimulation. Behaviorist training approaches are based on rewarding individuals for a certain type of behavior. Dr. Ivar Lovaas pioneered the use of behaviorist methods for children with autism more than 25 years ago. Lovaas therapy involves time-intensive, highly structured, repetitive sequences in which a child is given a command and rewarded each time he responds correctly. Using this approach for up to 40 hours a week, some children may be brought to the point of near-normal behavior. Others are much less responsive to the treatment. However, some researchers and therapists believe that less intensive treatments, particularly those begun early in a child's life, may provide the same level of efficacy.

Health Insurance Coverage for Autism Spectrum Disorders in Florida

In 2008, the Legislature passed CS/CS/SB 2654, which included the *Steven A. Geller Autism Coverage Act* and the *Window of Opportunity Act*.[16]

The Window of Opportunity Act required the 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. The law required the compact to include coverage for behavioral analysis and behavior assistant services, speech therapy, physical therapy, and occupational therapy when medically necessary; policies and procedures for notifying policy holders of the amount, scope, and developmental disability conditions covered; penalties for documented cases of denial of claims for medically necessary services due to the presence of a developmental disability; and proposals for new product lines that may be offered in conjunction with traditional health insurance to provide a more appropriate means of spreading risk, financing costs, and accessing favorable prices.

In September 2008, the Office of Insurance Regulation convened the Developmental Disabilities Compact Workgroup to develop the compact required in law. A compact was developed by the workgroup and adopted on December 17, 2008.[17] Insurers and HMOs that sign onto the compact agreement must provide coverage for developmental disabilities as specified in the compact for all plans issued or renewed after January 1, 2010. The Office of Insurance Regulation reports that Total Health Choices, Incorporated is the only health insurer that has signed onto the autism compact.[18]

All insurers and HMOs that did not sign the Developmental Disabilities Compact Workgroup by April 1, 2009, are subject to the requirements of the Steven A. Gellar Autism Act. The Act requires insurers, including the state group insurance plan, to provide coverage for well-baby and

[16] Chapter 2008-30, Laws of Florida.
[17] Developmental Disabilities Compact. Found at: <http://www.floir.com/pdf/DDCProposal-A.pdf> (Last visited on March 5, 2010).
[18] Office of Insurance Regulation email correspondence, March 4, 2010.

child screening for diagnosing the presence of autism and to cover the treatment of autism through applied behavioral analysis and assistant services, physical therapy, speech therapy, and occupational therapy.[19] The autism disorders covered in the law are: autistic disorder, Asperger's syndrome, and pervasive developmental disorder not otherwise specified. The insurance coverage is limited to $36,000 annually with a $200,000 total lifetime benefit. Beginning January 1, 2011, the coverage maximum will increase with inflation.

Down Syndrome

Down syndrome is a set of mental and physical symptoms that result from having an extra copy of chromosome 21 or "trisomy 21." Down syndrome is the most frequent genetic cause of mild to moderate mental retardation and occurs in one out of 800 live births, in all races and economic groups. [20] In Florida, the number of children born with Down syndrome in 2005 was 309, 298 in 2004, 175 in 2003, 272 in 2002, and 262 in 2001.[21]

A newborn baby with Down syndrome often has physical features that the attending physician usually will recognize in the delivery room. Common features include: a flat facial profile, an upward slant to the eye, a short neck, abnormally shaped ears, white spots on the iris of the eye, and a single, deep transverse crease on the palm of the hand. However, a child with Down syndrome may not possess all of these features. Down syndrome diagnosis is confirmed by a chromosomal karyotype blood test.[22]

Hearing loss, congenital heart disease, hypothyroidism, and vision disorders are more prevalent among those with Down syndrome.[23] Children with Down syndrome may be developmentally delayed. A child with Down syndrome is often slow to turn over, sit, stand, and respond. Development of speech and language abilities may also take longer. There is limited information available about the effectiveness of early intervention programs for children with Down syndrome.[24]

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[19] ss. 627.6686 and 641.31098, F.S.

[20] National Institutes of Health, National Institute of Child Health and Human Development, Down Syndrome, Last Update: 08/15/2008. Found at: <http://www.nichd.nih.gov/publications/pubs/downsyndrome.cfm#DownSyndrome> (Last visited on March 10, 2010).

[21] Florida Department of Health, Environmental Public Health Tracking, Birth Defect, Trisomy 21. Found at: < http://www.floridatracking.com/HealthTrackFL/report.aspx?IndNumber=1280&mes=11111> (Last visited on March 10, 2010).

[22] National Institutes of Health, National Institute of Child Health and Human Development, A Diagnosis of Down Syndrome, Last Update: 08/15/2008. Found at: <http://www.nichd.nih.gov/publications/pubs/downsyndrome.cfm#ADiagnosis> (Last visited on March 10, 2010).

[23] National Institutes of Health, National Institute of Child Health and Human Development, Down Syndrome and Associated Medical Disorders, Last Update: 08/15/2008. Found at: <http://www.nichd.nih.gov/publications/pubs/downsyndrome.cfm#DownSyndromeAssociated> (Last visited on March 10, 2010).

[24] National Institutes of Health, National Institute of Child Health and Human Development, Early Intervention and Education, Last Update: 08/15/2008. Found at: <http://www.nichd.nih.gov/publications/pubs/downsyndrome.cfm#EarlyIntervention> (Last visited on March 10, 2010).

Cerebral Palsy

Cerebral palsy is a term used to refer to any one of a number of neurological disorders that appear in infancy or early childhood and permanently affect body movement and muscle coordination that does not worsen overtime. Cerebral palsy is caused by abnormalities in parts of the brain that control movements. Approximately 1 in 278 children are diagnosed with cerebral palsy.[25] The majority of children with cerebral palsy are born with it, although it may not be detected until months or years later. The early signs of cerebral palsy usually appear before a child reaches 3 of age.[26]
Children with cerebral palsy exhibit a wide variety of symptoms, including:[27]
- Lack of muscle coordination when performing voluntary movements;
- Stiff or tight muscles and exaggerated reflexes;
- Walking with one foot or leg dragging;
- Walking on the toes, a crouched gait, or a "scissored" gait;
- Variations in muscle tone, either too stiff or too floppy;
- Excessive drooling or difficulties swallowing or speaking;
- Shaking or random involuntary movements; and
- Difficulty with precise motions, such as writing or buttoning a shirt.

Cerebral palsy cannot be cured, but treatment can improve a child's abilities. The earlier treatment begins the better chance children have of overcoming development disabilities. Treatment for cerebral palsy may include: physical or occupational therapy; speech therapy; drugs to control seizures, relax muscle spasms, and alleviate pain; surgery to correct anatomical abnormalities; and wheelchairs or rolling walkers. Cerebral palsy does not always cause profound disabilities. While one child with severe cerebral palsy might be unable to walk and need extensive, lifelong care, another with mild cerebral palsy might be only slightly awkward and require no special assistance.[28]

State Group Health Insurance Program

Currently, the Preferred Provider Organization (PPO) Plan and the HMO plans include coverage for the diagnosis and limited medical treatment, including prescription drugs, of autism, Asperger's syndrome, and other pervasive developmental disorders. Members under the PPO Plan have direct access to in- and out-of-network providers without referral. Members under three of the five HMOs have direct access to in-network physician providers, including specialist providers. Two HMOs require a referral to most types of specialist network physician providers.

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[25] Centers for Disease Control and Prevention, Data Show 1 in 278 Children Have Cerebral Palsy. Found at: <http://www.cdc.gov/Features/CerebralPalsy/> (Last visited on March 10, 2010).
[26] National Institutes of Health, National Institute of Neurological Disorders and Stroke, What is Cerebral Palsy. Found at: <http://www.ninds.nih.gov/disorders/cerebral_palsy/cerebral_palsy.htm#What_is> (Last visited on March 10, 2010).
[27] National Institutes of Health, National Institute of Neurological Disorders and Stroke, Cerebral Palsy: Hope Through Research. Found at: <http://www.ninds.nih.gov/disorders/cerebral_palsy/detail_cerebral_palsy.htm> (Last visited on March 10, 2010).
[28] National Institutes of Health, National Institute of Neurological Disorders and Stroke, What is Cerebral Palsy. Found at: <http://www.ninds.nih.gov/disorders/cerebral_palsy/cerebral_palsy.htm#Is_there_any_treatment> (Last visited on March 10, 2010).

Beginning January 1, 2010, the State Group Health Insurance Program implemented the requirements of the Steven A. Geller Autism Coverage Act, which requires more comprehensive coverage for the screening, diagnosis and treatment of autism spectrum disorder. That law requires the State Group Insurance Plan to cover well-baby and child screening for diagnosing the presence of autism and to cover the treatment of autism through applied behavior analysis and assistant services, physical therapy, speech therapy and occupational therapy. The disorders covered by the legislation are autistic disorder, Asperger's syndrome and pervasive developmental disorder not otherwise specified. Children under age 18 or in high school are covered.

III. Effect of Proposed Changes:

The CS creates s. 381.986, F.S., to require a physician to screen a minor for ASD in accordance with the American Academy of Pediatrics' guidelines, when the parent or legal guardian of that minor believes the minor exhibits symptoms of ASD and notifies the physician. If the physician determines that a referral to a specialist is medically necessary, he or she must refer the minor to an appropriate specialist to determine whether the minor meets diagnostic criteria for ASD. If the physician determines that a referral to a specialist is not medically necessary, the physician must inform the parent or guardian that he or she can self-refer to the Early Steps Program or other autism specialist. The CS exempts physicians providing care in a hospital emergency department from this requirement.

An appropriate specialist is defined in the CS as a qualified professional who is experienced in the evaluation of autism spectrum disorder, is licensed in this state, and has training in validated diagnostic tools. The term includes, but is not limited to:

- A psychologist;
- A psychiatrist;
- A neurologist;
- A developmental or behavioral pediatrician; or
- A professional whose licensure is deemed appropriate by the Children's Medical Services Early Steps Program within the Department of Health.

The CS amends ss. 627.6686 and 641.31098, F.S., to mandate health insurers and HMOs to provide direct patient access to one appropriate specialist, defined in the CS in s. 381.986, F.S, for the screening for, evaluation of, or diagnosis of ASD or other developmental disability.

- Direct patient access is defined as the ability of a subscriber or insured to obtain services from an in-network provider without a referral or other authorization before receiving services.
- Developmental disability is defined as a disorder or syndrome attributable to cerebral palsy or Down syndrome.
  - Cerebral palsy is defined as 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 results in the loss or impairment of control over voluntary muscles.
  - Down syndrome means a disorder caused by the presence of an extra chromosome 21.

The CS provides that all health insurance policies and HMO contracts under ss. 627.6686 and 641.31098, F.S., must provide plan enrollees a minimum of three visits per policy year for the

screening for, evaluation of, or diagnosis of ASD or developmental disability. In addition, the CS requires health insurance policies and HMO contracts to cover the treatment of developmental disability (cerebral palsy and Down syndrome) through speech and occupational therapy and applied behavior analysis. The coverage is limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan; limited to $36,000 annually, not to exceed a $200,000 lifetime maximum, and cannot be denied on the basis that provided services are habilitative in nature.

The CS takes effect July 1, 2010, and applies to policies issued or renewed on or after that date.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

Inasmuch as this CS requires local governments to incur expenses to pay additional health insurance costs, the bill falls within 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 or to take an action which requires the expenditure of funds unless certain specified conditions are met. One condition that must be met is that the Legislature has determined that the law fulfills an important state interest. The bill does contain an express legislative determination to this effect. In addition, one of various other conditions must be met, including (among others), approval by a two-thirds vote of the membership of each house of the Legislature for passage; or that the expenditure is required to comply with a law that applies to all persons similarly situated, including the state and local government.

As discussed, *below*, the Department of Health in its Early Steps program determines whether a provider is qualified to provide professional services in the named disorders. In its table of definitions accompanying the program description the term "qualified" is defined to incorporate "other comparable requirements that apply to the area in which the person is providing early intervention services."[29] This statement references 34 CFR s. 303.22 which references that a person " . . . has met State approved or recognized certification, licensing, registration or other comparable requirements . . . ." There is no specific statutory authority under state law providing a range of credentialing authority for the department to make such determinations. Of the eighteen pages of definitions provided in this program, there is only one citation to an administrative rule. As these determinations reach outside of the agency they adopt the appearance of unadopted rules as they determine whether services can be provided or whether a provider meets unarticulated minimum standards of acceptability. A provider could challenge any adverse determination of qualification by asserting that the department did not have specific statutory authority to substantiate its decision-making.

[29] Department of Health, Children's Medical Services, *Early Steps Policy Definitions*, March 1, 2009; www.cms-kids.com/home/resources.

B. Public Records/Open Meetings Issues:

The provisions of this CS have no impact on public records or open meetings issues under the requirements of article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this CS have no impact on the trust fund restrictions under the requirements of article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

Insured participants will be responsible for co-insurance, deductibles, and other out-of-pocket expenses associated with this expanded coverage as provided in their contracts of insurance. The financial estimates, below, for state employees contemplate a financial impact that bundles professional and pharmaceutical services. The impact varies with the contract - PPO or HMO - and whether the participant has chosen a high deductible feature or not.

B. Private Sector Impact:

The bill will provide parents and guardians of minors with access to appropriate medical specialists for the screening, evaluation of, or diagnosis for autism spectrum disorder. Early identification, intervention, and treatment for ASDs often produce very positive results in mitigating the effects of the disorder.

The CS may increase the total number and cost of claims incurred by insurers and HMOs for evaluations because more minors may be referred for ASD screening.

The CS may increase the costs of large group health insurance and large group HMO coverage due to pent-up demand and increased utilization of the evaluation services, speech therapy, occupation therapy, and applied behavioral analysis. To the extent that private sector employers provide health insurance to their employees, the bill may cause health insurance costs to increase.

C. Government Sector Impact:

The Division of State Group Insurance within the Department of Management Services provided an estimated fiscal impact of the CS. The CS requires physicians licensed in this state to refer a minor suspected of having autism spectrum disorder to an appropriate specialist for screening at the request of the parent or legal guardian. The bill requires that the parent or legal guardian have direct access to an in-network specialist for screening and evaluation purposes with a minimum of three visits per policy year. These provisions may result in higher screening rates.

In 2008, the Legislature expanded the benefits under the State Group Insurance Plan to include therapies for autism with a $36,000 annual limit and a $200,000 lifetime limit. This CS expands benefit coverage for other developmental disabilities, which would include cerebral palsy and Down syndrome.

	FY 10-11	FY 11-12	FY 12-13
Expenditures			
Recurring*	$6-12 Million	$6.6-13.2 Million	$7.4-14.7 Million
Nonrecurring	$5,000**		

*Based on actuarial analysis conducted for the 2009 CS/CS/SB 308.
**Estimated cost to update the actuarial analysis, which might be required to support the Self-Insurance Estimating Conference, pursuant to s. 216.134, F.S.

The Department of Health, the Children's Medical Services program, and Early Steps program may see an increase in the number of referrals for screening that would result in additional program costs. The additional screening could result in an inability for the Early Steps program to meet federally-mandated timelines for evaluation and service provision for children who have autism spectrum disorders, other developmental services, or delay.[30]

The most recent estimates on the financial outlook for the state employee group trust fund contemplate a worsening negative cash flow with a deficit as early as the year 2011, as follows:

Financial Outlook[31]	FY 09-10	FY 10-11	FY 11-12	FY 12-13	FY 13-14
Beginning Cash Balance	206.2	170.8	23	0	0
Revenues	1766.1	1849.4	1832.3	1884.3	1902.2
Expenses	1801.5	1997.2	2212.4	2467.7	2751.0
Operating Gain/(Loss)	(35.4)	(147.8)	(380.1)	(583.4)	(848.8)
Ending Cash Balance	**170.8**	**23.0**	**(357.1)**	**(583.4)**	**(848.8)**

In March 2010 the Congress enacted HR 3590 and HR 4872 to expand the coverage and access to health insurance. Both acts contemplate a phased implementation schedule and later that same month the National Conference of State Legislatures (NCSL) provided a summary table of provisions in those acts which take effect in the near term, as follows:

[30] Department of Health 2010 Bill Analysis & Economic Impact Statement, Senate Bill 214 (on file with the Senate Committee on Health Regulation).
[31] Florida Department of Management Services, Division of State Group Insurance, *State Employees' Group Insurance Self-Insurance Trust Fund, Report on the Financial Outlook for the Fiscal Years Ending June 30, 2010 through June 30, 2014*, February 22, 2010.

Feature[32]	90 Days	6 Months	2010	2011
Pre-existing condition/children	X			
Lifetime limits prohibition		X		
Annual coverage limits removed		X		
Preventive care limits removed		X		
Early retirees reinsurance (55-64)	X			
Independent appeals process		X		
Minimum medical loss ratio				X
High risk pool	X			
Age 27 dependent coverage		X		
No salary discrimination on high wages		X		
Consumer assistance			X	
Small business tax credits			X	
Closure of Medicare RX "donut hole"			X	
Closure of Medicare co-pays				X
Community health centers			X	
Primary care doctor increase			X	
Voluntary long-term care				X

The first three items in the table are highlighted as they would affect plan participants with conditions defined in the bill relatively more directly. The annual and lifetime limitations now provided for the covered conditions in the state employee group plan would also be placed in jeopardy. Because the plan year runs on a calendar basis, the effect of these changes will be fully experienced beginning January 1, 2011.

VI. Technical Deficiencies:

Section 1 requires a physician to perform screening in accordance with the guidelines of the American Academy of Pediatrics, if the parent or legal guardian of a minor believes the minor exhibits symptoms of autism spectrum disorder. If the physician determines that referral to a specialist is medically necessary, he or she shall refer the minor to an appropriate specialist to determine whether the minor meets diagnostic criteria for autism spectrum disorder. The term, "appropriate specialist" is defined to mean a qualified professional with experience in the evaluation of autism, who has training in validated diagnostic tools, and includes, but is not limited to, a person who is licensed as: a psychologist; a psychiatrist; a neurologist; a developmental or behavioral pediatrician who specialized in child neurology; or a professional whose licensure is deemed appropriate by the Children's Medical Services Early Steps Program within the Department of Health. This section requires insurers and HMOs to reimburse for services rendered by "qualified professional" – a term not defined by reference to a statutory licensing statute or other statutory reference. The absence of definition could present a quality assurance concern for an insurer or HMO related to its responsibility to provide services using appropriately credentialed providers. As written, the proposed language is ambiguous and would require the insurer or HMO to determine if the qualified professional submitting a claim is an "appropriate specialist."

[32] National Conference of State Legislatures, *What states can expect from federal health care overhaul*, March 29, 2010; www.ncsl.org/documents/health/FactSheet_KeyProv.pdf.

Sections 2 and 3 define "direct patient access" as the ability of an insured to obtain services from an in-network provider without a referral or other authorization before receiving services. However, Sections 1, 2, and 3 appear to conflict. Section 1 provides that the parent or legal guardian "may" report his or her observation to a physician, and then the physician will refer the minor to an appropriate specialist. Sections 2 and 3, "direct patient access" provision gives the insured the ability to obtain services directly without a referral. These provisions appear inconsistent and could be revised for clarity.

The bill is entitled "An act relating to autism"; however, the scope of the bill also includes other types of conditions and disabilities.

VII. Related Issues:

Section 624.215, F.S., requires every person or organization seeking consideration of a legislative proposal mandating health coverage to submit to the Agency for Health Care Administration and the appropriate legislative committees having jurisdiction a report assessing the social and financial impacts of the proposed coverage. The Senate Committee on Health Regulation and the Committee on Banking and Insurance have not received a report analyzing the insurance mandate created in the CS.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Regulation on March 9, 2010:
Requires physicians to perform screening for ASD in accordance with American Academy of Pediatrics' guidelines;

- Requires physicians to inform the parent or legal guardian of a minor about the Early Steps intervention program or other autism specialist in certain situations;
- Expands the health insurance and HMO coverage requirements for ASD to include coverage for cerebral palsy and Down syndrome; and
- Removes conflicting language that referenced "eligible individuals."

CS by Banking and Insurance on March 24, 2010:

- Clarifies that direct patient access means access to one appropriate specialist for a minimum of three visits per policy year for the screening for, evaluation of, or diagnosis of autism spectrum disorder or other developmental disability;
- States that the Legislature finds that this act fulfils an important state interest;
- Provides technical, conforming changes; and
- Provides that the provisions of the bill would apply to policies issued or renewed on or after July 1, 2010.

CS by Governmental Oversight and Accountability on April 6, 2010:

- Provides more specificity in the need for affordable and accessible quality health care in the declaration of important state interest.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.