Amendment No.

CHAMBER ACTION

Senate House

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Representative Gardiner offered the following:

Amendment to Senate Amendment (697284) (with title amendment)

Remove lines 7-318 and insert:

Section 1. Subsection (7) of section 409.8132, Florida Statutes, is amended to read:

409.8132 Medikids program component.--

(7) ENROLLMENT.--Enrollment in the Medikids program component may occur at any time throughout the year. A child may not receive services under the Medikids program until the child is enrolled in a managed care plan or MediPass. Once determined eligible, an applicant may receive choice counseling and select a managed care plan or MediPass. The agency may initiate mandatory assignment for a Medikids applicant who has not chosen a managed care plan or MediPass provider after the applicant's

voluntary choice period ends; however, the agency shall ensure that family members are assigned to the same managed care plan or the same MediPass provider to the greatest extent possible, including situations in which some family members are enrolled in Medicaid and other family members are enrolled in a Title XXI-funded component of the Florida Kidcare program. An applicant may select MediPass under the Medikids program component only in counties that have fewer than two managed care plans available to serve Medicaid recipients and only if the federal Health Care Financing Administration determines that MediPass constitutes "health insurance coverage" as defined in Title XXI of the Social Security Act.

Section 2. Subsection (2) of section 409.8134, Florida Statutes, is amended to read:

409.8134 Program expenditure ceiling.--

(2) The Florida Kidcare program may conduct enrollment at any time throughout the year for the purpose of enrolling children eligible for all program components listed in s. 409.813 except Medicaid. The four Florida Kidcare administrators shall work together to ensure that the year-round enrollment period is announced statewide. Eligible children shall be enrolled on a first-come, first-served basis using the date the enrollment application is received. Enrollment shall immediately cease when the expenditure ceiling is reached. Year-round enrollment shall only be held if the Social Services Estimating Conference determines that sufficient federal and state funds will be available to finance the increased enrollment ~~through federal fiscal year 2007~~. Any individual who is not enrolled

must reapply by submitting a new application. The application for the Florida Kidcare program shall be valid for a period of 120 days after the date it was received. At the end of the 120-day period, if the applicant has not been enrolled in the program, the application shall be invalid and the applicant shall be notified of the action. The applicant may reactivate ~~resubmit~~ the application after notification of the action taken by the program. Except for the Medicaid program, whenever the Social Services Estimating Conference determines that there are presently, or will be by the end of the current fiscal year, insufficient funds to finance the current or projected enrollment in the Florida Kidcare program, all additional enrollment must cease and additional enrollment may not resume until sufficient funds are available to finance such enrollment.

Section 3. Paragraphs (c) and (f) of subsection (4) and subsections (5), (7), and (8) of section 409.814, Florida Statutes, are amended to read:

409.814 Eligibility.--A child who has not reached 19 years of age whose family income is equal to or below 200 percent of the federal poverty level is eligible for the Florida Kidcare program as provided in this section. For enrollment in the Children's Medical Services Network, a complete application includes the medical or behavioral health screening. If, subsequently, an individual is determined to be ineligible for coverage, he or she must immediately be disenrolled from the respective Florida Kidcare program component.

(4) The following children are not eligible to receive premium assistance for health benefits coverage under the

Florida Kidcare program, except under Medicaid if the child would have been eligible for Medicaid under s. 409.903 or s. 409.904 as of June 1, 1997:

(c) A child who is seeking premium assistance for the Florida Kidcare program through employer-sponsored group coverage, if the child has been covered by the same employer's group coverage during the 90 days ~~6 months~~ prior to the family's submitting an application for determination of eligibility under the program.

(f) A child who has had his or her coverage in an employer-sponsored or private health benefit plan voluntarily canceled in the last 90 days ~~6 months~~, except those children who were on the waiting list prior to March 12, 2004, or whose coverage was voluntarily canceled for good cause, including, but not limited to, the following circumstances:

1. The cost of participation in an employer-sponsored or private health benefit plan is greater than 5 percent of the family's income;

2. The parent lost a job that provided an employer-sponsored health benefit plan for children;

3. The parent with health benefits coverage for the child is deceased;

4. The employer of the parent canceled health benefits coverage for children;

5. The child's health benefits coverage ended because the child reached the maximum lifetime coverage amount;

6. The child has exhausted coverage under a COBRA continuation provision; or

7. A situation involving domestic violence led to the loss of coverage.

(5) A child whose family income is above 200 percent of the federal poverty level or a child who is excluded under the provisions of subsection (4) may participate in the Medikids program as provided in s. 409.8132 or, if the child is ineligible for Medikids by reason of age, in the Florida Healthy Kids program as provided in s. 624.91, subject to the following provisions:

(a) The family is not eligible for premium assistance payments and must pay the full cost of the premium, including any administrative costs.

~~(b) The agency is authorized to place limits on enrollment in Medikids by these children in order to avoid adverse selection. The number of children participating in Medikids whose family income exceeds 200 percent of the federal poverty level must not exceed 10 percent of total enrollees in the Medikids program.~~

(b) ~~(c)~~ The board of directors of the Florida Healthy Kids Corporation ~~is authorized to place limits on enrollment of these children in order to avoid adverse selection. In addition, the board~~ is authorized to offer a reduced benefit package to these children in order to limit program costs for such families. ~~The number of children participating in the Florida Healthy Kids program whose family income exceeds 200 percent of the federal poverty level must not exceed 10 percent of total enrollees in the Florida Healthy Kids program.~~

(7) When determining or reviewing a child's eligibility under the Florida Kidcare program, the applicant shall be provided with reasonable notice of changes in eligibility which may affect enrollment in one or more of the program components. When a transition from one program component to another is authorized, there shall be cooperation between the program components, ~~and~~ the affected family, the child's health insurance plan, and the child's health care providers to promote ~~which promotes~~ continuity of health care coverage. If a child is determined ineligible for Medicaid or Medikids, the agency, in coordination with the department, shall notify that child's Medicaid managed care plan or MediPass provider of such determination before the child's eligibility is scheduled to be terminated so that the Medicaid managed care plan or MediPass provider can assist the child's family in applying for Florida Kidcare program coverage. Any authorized transfers must be managed within the program's overall appropriated or authorized levels of funding. Each component of the program shall establish a reserve to ensure that transfers between components will be accomplished within current year appropriations. These reserves shall be reviewed by each convening of the Social Services Estimating Conference to determine the adequacy of such reserves to meet actual experience.

(8) In determining the eligibility of a child for the Florida Kidcare program, an assets test is not required. The information required under this section from each applicant shall be obtained electronically to the extent possible. If such information cannot be obtained electronically, the ~~Each~~

applicant shall provide written documentation during the application process and the redetermination process, including, but not limited to, the following:

(a) Proof of family income, which must include a copy of the applicant's most recent federal income tax return. In the absence of a federal income tax return, an applicant may submit wages and earnings statements (pay stubs), W-2 forms, or other appropriate documents.

(b) A statement from all family members that:

1. Their employer does not sponsor a health benefit plan for employees; or

2. The potential enrollee is not covered by the employer-sponsored health benefit plan because the potential enrollee is not eligible for coverage, or, if the potential enrollee is eligible but not covered, a statement of the cost to enroll the potential enrollee in the employer-sponsored health benefit plan.

<u>An individual who applies for coverage under the Florida Kidcare program and who pays the full cost of the premium is exempt from the requirements of this subsection.</u>

Section 4. Paragraph (b) of subsection (1) of section 409.818, Florida Statutes, is amended to read:

409.818 Administration.--In order to implement ss. 409.810-409.820, the following agencies shall have the following duties:

(1) The Department of Children and Family Services shall:

(b) Establish and maintain the eligibility determination process under the program except as specified in subsection (5). The department shall directly, or through the services of a contracted third-party administrator, establish and maintain a process for determining eligibility of children for coverage under the program. The eligibility determination process must be used solely for determining eligibility of applicants for health benefits coverage under the program. The eligibility determination process must include an initial determination of eligibility for any coverage offered under the program, as well as a redetermination or reverification of eligibility each subsequent 12 ~~6~~ months. Effective January 1, 1999, a child who has not attained the age of 5 and who has been determined eligible for the Medicaid program is eligible for coverage for 12 months without a redetermination or reverification of eligibility. In conducting an eligibility determination, the department shall determine if the child has special health care needs. The department, in consultation with the Agency for Health Care Administration and the Florida Healthy Kids Corporation, shall develop procedures for redetermining eligibility which enable a family to easily update any change in circumstances which could affect eligibility. The department may accept changes in a family's status as reported to the department by the Florida Healthy Kids Corporation without requiring a new application from the family. Redetermination of a child's eligibility for Medicaid may not be linked to a child's eligibility determination for other programs.

Section 5. Subsection (26) is added to section 409.906, Florida Statutes, to read:

409.906 Optional Medicaid services.--Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(26) HOME AND COMMUNITY-BASED SERVICES for AUTISM SPECTRUM DISORDER AND OTHER DEVELOPMENTAL DISABILITIES.--The agency is authorized to seek federal approval through a Medicaid waiver or a state plan amendment for the provision of occupational

therapy, speech therapy, physical therapy, behavior analysis, and behavior assistant services to individuals who are 5 years of age and under and have a diagnosed developmental disability as defined in s. 624.916. These services shall be provided for producing and maintaining improvements in communication, human behavior, and skill acquisition, including the the reduction of problematic behavior. Coverage for such services shall be limited to $36,000 annually and may not exceed $200,000 in total lifetime benefits. The agency shall submit an annual report beginning on January 1, 2009, to the President of the Senate, the Speaker of the House of Representatives, and the relevant committees of the Senate and the House of Representatives regarding progress on obtaining federal approval and recommendations for the implementation of these home and community-based services. The agency may not implement this subsection without prior legislative approval.

Section 6. Paragraph (b) of subsection (5) of section 624.91, Florida Statutes, are amended to read:

624.91 The Florida Healthy Kids Corporation Act.--

(5) CORPORATION AUTHORIZATION, DUTIES, POWERS.--

(b) The Florida Healthy Kids Corporation shall:

1. Arrange for the collection of any family, local contributions, or employer payment or premium, in an amount to be determined by the board of directors, to provide for payment of premiums for comprehensive insurance coverage and for the actual or estimated administrative expenses.

2. Arrange for the collection of any voluntary contributions to provide for payment of premiums for children

who are not eligible for medical assistance under Title XXI of the Social Security Act.

3. Subject to the provisions of s. 409.8134, accept voluntary supplemental local match contributions that comply with the requirements of Title XXI of the Social Security Act for the purpose of providing additional coverage in contributing counties under Title XXI.

4. Establish the administrative and accounting procedures for the operation of the corporation.

5. Establish, with consultation from appropriate professional organizations, standards for preventive health services and providers and comprehensive insurance benefits appropriate to children, provided that such standards for rural areas shall not limit primary care providers to board-certified pediatricians.

6. Determine eligibility for children seeking to participate in the Title XXI-funded components of the Florida Kidcare program consistent with the requirements specified in s. 409.814, as well as the non-Title-XXI-eligible children as provided in subsection (3).

7. Establish procedures under which providers of local match to, applicants to and participants in the program may have grievances reviewed by an impartial body and reported to the board of directors of the corporation.

8. Establish participation criteria and, if appropriate, contract with an authorized insurer, health maintenance organization, or third-party administrator to provide administrative services to the corporation.

9. Establish enrollment criteria which shall include penalties or waiting periods of not fewer than 60 days for reinstatement of coverage upon voluntary cancellation for nonpayment of family premiums.

10. Contract with authorized insurers or any provider of health care services, meeting standards established by the corporation, for the provision of comprehensive insurance coverage to participants. Such standards shall include criteria under which the corporation may contract with more than one provider of health care services in program sites. Health plans shall be selected through a competitive bid process. The Florida Healthy Kids Corporation shall purchase goods and services in the most cost-effective manner consistent with the delivery of quality medical care. The maximum administrative cost for a Florida Healthy Kids Corporation contract shall be 15 percent. For health care contracts, the minimum medical loss ratio for a Florida Healthy Kids Corporation contract shall be 85 percent. For dental contracts, the remaining compensation to be paid to the authorized insurer or provider under a Florida Healthy Kids Corporation contract shall be no less than an amount which is 85 percent of premium; to the extent any contract provision does not provide for this minimum compensation, this section shall prevail. The health plan selection criteria and scoring system, and the scoring results, shall be available upon request for inspection after the bids have been awarded.

11. Establish disenrollment criteria in the event local matching funds are insufficient to cover enrollments.

12. Develop and implement a plan to publicize the Florida Kidcare program ~~Healthy Kids Corporation~~, the eligibility requirements of the program, and the procedures for enrollment in the program and to maintain public awareness of the corporation and the program. Health care and dental health plans participating in the program may develop and distribute marketing and other promotional materials and participate in activities, such as health fairs and public events, as approved by the corporation. Health care and dental health plans may also contact their current and former enrollees to encourage continued participation in the program and assist the enrollee in transferring from a Title XIX-funded plan to a Title XXI-funded plan.

13. Establish an assignment process for Florida Healthy Kids program enrollees to ensure that family members are assigned to the same managed care plan to the greatest extent possible, including situations in which some family members are enrolled in a Medicaid managed care plan and other family members are enrolled in a Florida Healthy Kids plan. The Agency for Health Care Administration shall consult with the corporation to implement this subparagraph.

14.~~13.~~ Secure staff necessary to properly administer the corporation. Staff costs shall be funded from state and local matching funds and such other private or public funds as become available. The board of directors shall determine the number of staff members necessary to administer the corporation.

15.~~14.~~ Provide a report annually to the Governor, Chief Financial Officer, Commissioner of Education, Senate President,

Speaker of the House of Representatives, and Minority Leaders of the Senate and the House of Representatives.

16.~~15.~~ Establish benefit packages which conform to the provisions of the Florida Kidcare program, as created in ss. 409.810-409.820.

Section 7. Section 624.916, Florida Statutes, is created to read:

624.916 Developmental disabilities compact.--

(1) This section may be cited as the "Window of Opportunity Act."

(2) The Office of Insurance Regulation shall convene a workgroup by August 31, 2008, for the purpose of negotiating a compact that includes a binding agreement among the participants relating to insurance and access to services for persons with developmental disabilities. The workgroup shall consist of the following:

(a) Representatives of all health insurers licensed under this chapter.

(b) Representatives of all health maintenance organizations licensed under part I of chapter 641.

(c) Representatives of employers with self-insured health benefit plans.

(d) Two designees of the Governor, one of whom must be a consumer advocate.

(e) A designee of the President of the Senate.

(f) A designee of the Speaker of the House of Representatives.

(3) The Office of Insurance Regulation shall convene a consumer advisory workgroup for the purpose of providing a forum for comment on the compact negotiated in subsection (2). The office shall convene the workgroup prior to finalization of the compact.

(4) The agreement shall include the following components:

(a) A requirement that each signatory to the agreement increase coverage for behavior analysis and behavior assistant services and speech therapy, physical therapy, and occupational therapy due to the presence of a developmental disability for producing and maintaining improvements in communication, human behavior, and skill acquisition, including the the reduction of problematic behavior.

(b) Procedures for clear and specific notice to policyholders identifying the amount, scope, and conditions under which coverage is provided for behavior analysis and behavior assistant services and speech therapy, physical therapy, and occupational therapy when medically necessary due to the presence of a developmental disability.

(c) Penalties for documented cases of denial of claims for medically necessary services due to the presence of a developmental disability.

(d) Proposals for new product lines that may be offered in conjunction with traditional health insurance and provide a more appropriate means of spreading risk, financing costs, and accessing favorable prices.

(5) Upon completion of the negotiations for the compact, the office shall report the results to the Governor, the

President of the Senate, and the Speaker of the House of Representatives.

(6) Beginning February 15, 2009, and continuing annually thereafter, the Office of Insurance Regulation shall provide a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives regarding the implementation of the agreement negotiated under this section. The report shall include:

(a) The signatories to the agreement.

(b) An analysis of the coverage provided under the agreement in comparison to the coverage required under ss. 627.6686 and 641.31098.

(c) An analysis of the compliance with the agreement by the signatories, including documented cases of claims denied in violation of the agreement.

(7) The Office of Insurance Regulation shall continue to monitor participation, compliance, and effectiveness of the agreement and report its findings at least annually.

(8) As used in this section, the term "developmental disabilities" includes:

(a) The term as defined in s. 393.063;

(b) Down syndrome, a genetic disorder caused by the presence of extra chromosomal material on chromosome 21. Causes of the syndrome may include Trisomy 21, Mosaicism, Robertsonian Translocation, and other duplications of a portion of chromosome 21; and

(c) Autism spectrum disorder means 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:

1. Autistic disorder.

2. Asperger's syndrome.

3. Pervasive developmental disorder not otherwise specified.

Section 8. Section 627.6686, Florida Statutes, is created to read:

627.6686 Coverage for individuals with developmental disabilities required; exception.--

(1) This section and section 641.31098, may be cited as the "Steven A. Geller Developmental Disabilities Coverage Act."

(2) As used in this section, the term:

(a) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

(b) "Developmental disabilities" means the term as defined in s. 624.916.

(c) "Eligible individual" means 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.

(d) "Health insurance plan" means a group health insurance policy or group health benefit plan offered by an insurer which

includes the state group insurance program provided under s. 110.123. The term does not include any health insurance plan offered in the individual market, any health insurance plan that is individually underwritten, or any health insurance plan provided to a small employer.

(e) "Insurer" means an insurer providing health insurance coverage, which is licensed to engage in the business of insurance in this state and is subject to insurance regulation.

(3) A health insurance plan issued or renewed on or after April 1, 2009, shall provide coverage to an eligible individual for:

(a) Well-baby and well-child screening for diagnosing the presence of a developmental disability .

(b) Treatment of a developmental disability through speech therapy, occupational therapy, physical therapy, and applied behavior analysis to produce and maintain improvements in communication, human behavior, and skill acquisition, including the the reduction of problematic behavior. Applied behavior analysis services shall be provided by an individual certified pursuant to s. 393.17 or an individual licensed under chapter 490 or chapter 491.

(4) The coverage required pursuant to subsection (3) is subject to the following requirements:

(a) Coverage shall be limited to treatment that is prescribed by the insured's treating physician in accordance with a treatment plan.

(b) Coverage for the services described in subsection (3) shall be limited to $36,000 annually and may not exceed $200,000 in total lifetime benefits.

(c) Coverage may not be denied on the basis that provided services are habilitative in nature.

(d) Coverage may be subject to other general exclusions and limitations of the insurer's policy or plan, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, and utilization review of health care services, including the review of medical necessity, case management, and other managed care provisions.

(5) The coverage required pursuant to subsection (3) may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to physical illnesses that are generally covered under the health insurance plan, except as otherwise provided in subsection (4).

(6) An insurer may not deny or refuse to issue coverage for medically necessary services, refuse to contract with, or refuse to renew or reissue or otherwise terminate or restrict coverage for an individual because the individual is diagnosed as having a developmental disability.

(7) The treatment plan required pursuant to subsection (4) shall include all elements necessary for the health insurance plan to appropriately pay claims. These elements include, but are not limited to, a diagnosis, the proposed treatment by type, the frequency and duration of treatment, the anticipated

outcomes stated as goals, the frequency with which the treatment plan will be updated, and the signature of the treating physician.

(8) Beginning January 1, 2011, the maximum benefit under paragraph (4)(b) shall be adjusted annually on January 1 of each calendar year to reflect any change from the previous year in the medical component of the then current Consumer Price Index for all urban consumers, published by the Bureau of Labor Statistics of the United States Department of Labor.

(9) This section may not be construed as limiting benefits and coverage otherwise available to an insured under a health insurance plan.

(10) The Office of Insurance Regulation may not enforce this section against an insurer that is a signatory no later than April 1, 2009, to the developmental disabilities compact established under s. 624.916. The Office of Insurance Regulation shall enforce this section against an insurer that is a signatory to the compact established under s. 624.916 if the insurer has not complied with the terms of the compact for all health insurance plans by April 1, 2010.

Section 9. Section 641.31098, Florida Statutes, is created to read:

641.31098 Coverage for individuals with developmental disabilities.--

(1) This section and section 627.6686, may be cited as the "Steven A. Geller Developmental Disabilities Coverage Act."

(2) As used in this section, the term:

(a) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including, but not limited to, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

(b) "Developmental disabilities" means the term as defined in s. 624.916.

(c) "Eligible individual" means 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.

(d) "Health maintenance contract" means a group health maintenance contract offered by a health maintenance organization. This term does not include a health maintenance contract offered in the individual market, a health maintenance contract that is individually underwritten, or a health maintenance contract provided to a small employer.

(3) A health maintenance contract issued or renewed on or after April 1, 2009, shall provide coverage to an eligible individual for:

(a) Well-baby and well-child screening for diagnosing the presence of a developmental disability .

(b) Treatment of a developmental disability through speech therapy, occupational therapy, physical therapy, and applied behavior analysis services to produce and maintain improvements in communication, human behavior, and skill

acquisition, including the the reduction of problematic behavior. Applied behavior analysis services shall be provided by an individual certified pursuant to s. 393.17 or an individual licensed under chapter 490 or chapter 491.

(4) The coverage required pursuant to subsection (3) is subject to the following requirements:

(a) Coverage shall be limited to treatment that is prescribed by the subscriber's treating physician in accordance with a treatment plan.

(b) Coverage for the services described in subsection (3) shall be limited to $36,000 annually and may not exceed $200,000 in total benefits.

(c) Coverage may not be denied on the basis that provided services are habilitative in nature.

(d) Coverage may be subject to general exclusions and limitations of the subscriber's contract, including, but not limited to, coordination of benefits, participating provider requirements, and utilization review of health care services, including the review of medical necessity, case management, and other managed care provisions.

(5) The coverage required pursuant to subsection (3) may not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to a subscriber than the dollar limits, deductibles, or coinsurance provisions that apply to physical illnesses that are generally covered under the subscriber's contract, except as otherwise provided in subsection (4).

(6) A health maintenance organization may not deny or refuse to issue coverage for medically necessary services, refuse to contract with, or refuse to renew or reissue or otherwise terminate or restrict coverage for an individual solely because the individual is diagnosed as having a developmental disability.

(7) The treatment plan required pursuant to subsection (4) shall include, but is not limited to, a diagnosis, the proposed treatment by type, the frequency and duration of treatment, the anticipated outcomes stated as goals, the frequency with which the treatment plan will be updated, and the signature of the treating physician.

(8) Beginning January 1, 2011, the maximum benefit under paragraph (4)(b) shall be adjusted annually on January 1 of each calendar year to reflect any change from the previous year in the medical component of the then current Consumer Price Index for all urban consumers, published by the Bureau of Labor Statistics of the United States Department of Labor.

(9) The Office of Insurance Regulation may not enforce this section against a health maintenance organization that is a signatory no later than April 1, 2009, to the developmental disabilities compact established under s. 624.916. The Office of Insurance Regulation shall enforce this section against a health maintenance organization that is a signatory to the compact established under s. 624.916 if the health maintenance organization has not complied with the terms of the compact for all health maintenance contracts by April 1, 2010.

Section 5. This act shall take effect July 1, 2008.

Amendment No.

T I T L E A M E N D M E N T

Remove lines 325-374 and insert:

amending s. 409.8132, F.S.; revising provisions relating to enrollment in the Medikids program component of Florida Kidcare; providing for the Agency for Health Care Administration to assign family members to the same managed care plan or Medicaid provider, under certain circumstances; amending s. 409.8134, F.S.; providing limitations on year-round enrollment for premium assistance; amending s. 409.814, F.S.; revising conditions for eligibility for premium assistance for the Florida Kidcare Program; providing limitations on enrollment in the Medikids program after January 1, 2009; providing for enrollment of new applicants in the Florida Healthy Kids program; revising duties of the board of directors of the Florida Healthy Kids Corporation regarding enrollment limitations; providing for notification to certain managed care plans or MediPass providers prior to termination of a child's eligibility for Florida Kidcare; providing for certain information relating to eligibility to be obtained electronically; providing an exemption from certain requirements for individuals who pay the full cost of the Florida Kidcare premium; amending s. 409.815, F.S.; revising provisions relating to health benefits coverage for specified services to include habilitative and behavior analysis services; providing definitions; limiting the lifetime

maximum of health benefits coverage for certain services; amending s. 409.818, F.S.; revising timeframe for redetermination or reverification of eligibility for Florida Kidcare; amending s. 409.906, F.S.; creating the "Window of Opportunity Act"; authorizing the Agency for Health Care Administration to seek federal approval through a state plan amendment to provide home and community-based services for autism spectrum disorder and other development disabilities; specifying eligibility criteria; specifying limitations on provision of benefits; requiring reports to the Legislature; requiring legislative approval for implementation of certain provisions; amending s. 409.91, F.S.; revising duties of the Florida Healthy Kids Corporation; creating s. 624.916, F.S.; creating the "Window of Opportunity Act"; directing the Office of Insurance Regulation to establish a workgroup to develop and execute a compact relating to coverage for insured persons with development disabilities; providing for membership of the workgroup; requiring the workgroup to convene within a specified period of time; directing the office to establish a consumer advisory workgroup and providing purpose thereof; requiring the compact to contain specified components; requiring reports to the Governor and the Legislature; creating s. 627.6686, F.S.; creating the Steven A. Geller Autism Coverage Act"; providing health insurance coverage for individuals with autism spectrum disorder; providing definitions; providing coverage for certain screening to diagnose and treat autism spectrum disorder; providing limitations on coverage; providing for eligibility standards for benefits and coverage; prohibiting insurers from

denying coverage under certain circumstances; specifying required elements of a treatment plan; providing, beginning January 1, 2011, that the maximum benefit shall be adjusted annually; clarifying that the section may not be construed as limiting benefits and coverage otherwise available to an insured under a health insurance plan; prohibiting the Office of Insurance Regulation from enforcing certain provisions against insurers that are signatories to the developmental disabilities compact by a specified date; creating s. 641.31098, F.S.; providing coverage under a health maintenance contract for individuals with autism spectrum disorder; providing definitions; providing coverage for certain screening to diagnose and treat autism spectrum disorder; providing limitations on coverage; providing for eligibility standards for benefits and coverage; prohibiting health maintenance organizations from denying coverage under certain circumstances; specifying required elements of a treatment plan; providing, beginning January 1, 2011, that the maximum benefit shall be adjusted annually; prohibiting the Office of Insurance Regulation from enforcing certain provisions against health maintenance organizations that are signatories to the developmental disabilities compact by a specified date; providing an effective date.