A bill to be entitled

An act relating to health care coverage mandates; amending s. 627.419, F.S.; deleting provisions providing that certain health insurance policies, health care services plans, or other contracts be construed to require payment to podiatrists and chiropractors for services within their scope of practice; repealing s. 627.4236, F.S., relating to required coverage for bone marrow transplant procedures under certain circumstances; repealing s. 627.6403, F.S., relating to payment of acupuncture benefits to certified acupuncturists; repealing s. 627.6407, F.S.; deleting a requirement that health insurance policies that cover massage must also cover the services of a person licensed to practice massage pursuant to ch. 480, F.S., under certain circumstances; amending ss. 627.6471 and 627.6472, F.S.; conforming cross-references to changes made by the act; deleting provisions relating to mandated eligibility for participation in provider networks by therapists, counselors, psychologists, and certain psychiatric nurses; repealing s. 627.6617, F.S., relating to required coverage for home health care services under certain circumstances; repealing s. 627.6618, F.S., relating to coverage by group health insurance policies for acupuncture benefits and payment to certified acupuncturists; repealing s. 627.6619, F.S.; deleting a requirement that health

insurance policies covering massage also cover the services of a person licensed to practice massage under certain circumstances; repealing s. 627.668, F.S., relating to requirements that optional coverage for mental and nervous disorders be made available under certain circumstances; repealing s. 627.6686, F.S., relating to required coverage for individuals with autism spectrum disorder under certain circumstances; repealing s. 627.66911, F.S., relating to required coverage for cleft lip and cleft palate treatment under certain circumstance; amending s. 641.31, F.S.; deleting provisions relating to payment for treatment at an osteopathic hospital under certain circumstances, required coverage for cleft lip and cleft palate treatment, and payment for services provided by a massage therapist; amending ss. 383.145, 409.815, 409.906, 624.916, 627.401, 627.6515, 627.6675, 627.6699, 641.2018, 641.31098, and 1002.66, F.S.; conforming cross-references to changes made by the act; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsections (5) through (9) of section 627.419, Florida Statutes, are renumbered as subsections (4) through (8), respectively, and subsections (3) and (4) of that section are amended to read:

627.419 Construction of policies.—

(3) Notwithstanding any other provision of law, when any health insurance policy, health care services plan, or other contract provides for the payment for procedures specified in the policy or contract which are within the scope of an optometrist's ~~or podiatric physician's~~ professional license, such policy shall be construed to include payment to an optometrist ~~or podiatric physician~~ who performs such procedures. ~~In the case of podiatric services, such payments shall be made in accordance with the coverage now provided for medical and surgical benefits.~~

~~(4) Notwithstanding any other provision of law, when any health insurance policy, health care services plan, or other contract provides for the payment for medical expense benefits or procedures, such policy, plan, or contract shall be construed to include payment to a chiropractic physician who provides the medical service benefits or procedures which are within the scope of a chiropractic physician's license. Any limitation or condition placed upon payment to, or upon services, diagnosis, or treatment by, any licensed physician shall apply equally to all licensed physicians without unfair discrimination to the usual and customary treatment procedures of any class of physicians.~~

Section 2. Section 627.4236, Florida Statutes, is repealed.

Section 3. Section 627.6403, Florida Statutes, is repealed.

Section 4. Section 627.6407, Florida Statutes, is repealed.

Section 5. Paragraph (b) of subsection (1) and subsections (5) and (6) of section 627.6471, Florida Statutes, are amended to read:

627.6471 Contracts for reduced rates of payment; limitations; coinsurance and deductibles.—

(1) As used in this section:

(b) "Preferred provider" means any licensed health care provider with which the insurer has directly or indirectly contracted for an alternative or a reduced rate of payment, which shall include any health care provider listed in s. 627.419(3) ~~and (4)~~ and shall provide reasonable access to such health care provider ~~providers~~.

(5) Any policy issued under this section which does not provide direct patient access to a dermatologist must conform to the requirements of s. 627.6472(15) ~~627.6472(16)~~. This subsection shall not be construed to affect the amount the insured or patient must pay as a deductible or coinsurance amount authorized under this section.

~~(6) If psychotherapeutic services are covered by a policy issued by the insurer, the insurer shall provide eligibility criteria for each group of health care providers licensed under chapter 458, chapter 459, chapter 490, or chapter 491, which include psychotherapy within the scope of their practice as provided by law, or for any person who is certified as an advanced registered nurse practitioner in psychiatric mental health under s. 464.012. When psychotherapeutic services are covered, eligibility criteria shall be established by the insurer to be included in the insurer's criteria for selection~~

~~of network providers. The insurer may not discriminate against a health care provider by excluding such practitioner from its provider network solely on the basis of the practitioner's license.~~

Section 6. Subsections (16) through (18) of section 627.6472, Florida Statutes, are renumbered as subsections (15) through (17), respectively, and paragraph (c) of subsection (1) and subsection (15) of that section are amended to read:

627.6472 Exclusive provider organizations.—

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

(c) "Exclusive provider" means a provider of health care, or a group of providers of health care, that has entered into a written agreement with the insurer to provide benefits under a health insurance policy issued under this section, which agreement shall include any health care provider listed in s. 627.419(3) ~~and (4)~~ and shall provide reasonable access to such health care provider ~~providers~~.

~~(15) If psychotherapeutic services are covered by a policy issued by the insurer, the insurer shall provide eligibility criteria for all groups of health care providers licensed under chapter 458, chapter 459, chapter 490, or chapter 491, which include psychotherapy within the scope of their practice as provided by law, or for any person who is certified as an advanced registered nurse practitioner in psychiatric mental health under s. 464.012. When psychotherapeutic services are covered, eligibility criteria shall be established by the insurer to be included in the insurer's criteria for selection of network providers. The insurer may not discriminate against a~~

~~health care provider by excluding such practitioner from its provider network solely on the basis of the practitioner's license.~~

Section 7. Section 627.6617, Florida Statutes, is repealed.

Section 8. Section 627.6618, Florida Statutes, is repealed.

Section 9. Section 627.6619, Florida Statutes, is repealed.

Section 10. Section 627.668, Florida Statutes, is repealed.

Section 11. Section 627.6686, Florida Statutes, is repealed.

Section 12. Section 627.66911, Florida Statutes, is repealed.

Section 13. Subsections (25) through (34) of section 641.31, Florida Statutes, are renumbered as subsections (24) through (33), respectively, subsection (36) of that section is renumbered as subsection (34), subsections (38) through (43) of that section are renumbered as subsections (35) through (40), respectively, and subsections (24), (35), and (37) of that section are amended to read:

641.31 Health maintenance contracts.—

~~(24) Each health maintenance organization that provides for inpatient and outpatient services by allopathic hospitals shall provide as an option of the subscriber similar inpatient and outpatient services by hospitals accredited by the American Osteopathic Association when such services are available in the~~

~~same service area of the HMO and the osteopathic hospital agrees to provide the services as specified herein. As a condition precedent to providing osteopathic inpatient and outpatient services through an osteopathic hospital that has not entered into a written contract with the HMO, the HMO may require the subscriber or any other person receiving osteopathic services to release the HMO from any liability arising from any act of omission or commission constituting malpractice in the delivery of osteopathic care from that hospital. The osteopathic hospital providing the inpatient and outpatient services for the HMO shall charge rates that do not exceed the osteopathic hospital's usual and customary rates less the average discount provided by allopathic hospitals providing the HMO services in the same service area of the HMO.~~

~~(35) A health maintenance contract that covers a child under the age of 18 must provide coverage for treatment of cleft lip and cleft palate for the child. The coverage must include medical, dental, speech therapy, audiology, and nutrition services only if such services are prescribed by the primary care physician or physician to whom the child is referred and such physician certifies that such services are medically necessary and consequent to treatment of the cleft lip or cleft palate. The coverage required by this section is subject to terms and conditions applicable to other benefits.~~

~~(37) All health maintenance contracts that provide coverage for massage must also cover the services of persons licensed to practice massage pursuant to chapter 480 if the massage is prescribed by a contracted physician licensed under~~

~~chapter 458, chapter 459, chapter 460, or chapter 461 as medically necessary and the prescription specifies the number of treatments. Such massage services are subject to the same terms, conditions, and limitations as those of other covered services.~~

Section 14. Paragraph (j) of subsection (3) of section 383.145, Florida Statutes, is amended to read:

383.145 Newborn and infant hearing screening.—

(3) REQUIREMENTS FOR SCREENING OF NEWBORNS; INSURANCE COVERAGE; REFERRAL FOR ONGOING SERVICES.—

(j) The initial procedure for screening the hearing of the newborn or infant and any medically necessary followup reevaluations leading to diagnosis shall be a covered benefit, reimbursable under Medicaid as an expense compensated supplemental to the per diem rate for Medicaid patients enrolled in MediPass or Medicaid patients covered by a fee for service program. For Medicaid patients enrolled in HMOs, providers shall be reimbursed directly by the Medicaid Program Office at the Medicaid rate. This service may not be considered a covered service for the purposes of establishing the payment rate for Medicaid HMOs. All health insurance policies and health maintenance organizations as provided under ss. 627.6416, 627.6579, and 641.31(29) ~~641.31(30)~~, except for supplemental policies that only provide coverage for specific diseases, hospital indemnity, or Medicare supplement, or to the supplemental polices, shall compensate providers for the covered benefit at the contracted rate. Nonhospital-based providers shall be eligible to bill Medicaid for the professional and technical component of each procedure code.

Section 15. Paragraph (e) of subsection (2) of section 409.815, Florida Statutes, is amended to read:

409.815 Health benefits coverage; limitations.—

(2) BENCHMARK BENEFITS.—In order for health benefits coverage to qualify for premium assistance payments for an eligible child under ss. 409.810-409.821, the health benefits coverage, except for coverage under Medicaid and Medikids, must include the following minimum benefits, as medically necessary.

(e) Organ transplantation services.—Covered services include pretransplant, transplant, and postdischarge services and treatment of complications after transplantation for transplants deemed necessary and appropriate within the guidelines set by the Organ Transplant Advisory Council under s. 765.53 ~~or the Bone Marrow Transplant Advisory Panel under s. 627.4236~~.

Section 16. Subsection (26) of section 409.906, Florida Statutes, is amended 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. 393.063, autism spectrum disorder ~~as defined in s. 627.6686~~, or 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. Coverage for such services shall be limited to $36,000 annually and may not exceed $108,000 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 17. Paragraph (b) of subsection (6) and paragraph (c) of subsection (8) of section 624.916, Florida Statutes, are amended to read:

624.916 Developmental disabilities compact.—

(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:

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

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

(c) Autism spectrum disorder~~, as defined in s. 627.6686~~.

Section 18. Subsection (5) of section 627.401, Florida Statutes, is amended to read:

627.401 Scope of this part.—No provision of this part of this chapter applies to:

(5) Credit life or credit disability insurance, except ss. 627.419(4) ~~627.419(5)~~ and 627.428.

Section 19. Paragraph (c) of subsection (2) of section 627.6515, Florida Statutes, is amended to read:

627.6515 Out-of-state groups.—

(2) Except as otherwise provided in this part, this part does not apply to a group health insurance policy issued or delivered outside this state under which a resident of this state is provided coverage if:

(c) The policy provides the benefits specified in ss. 627.419, 627.6574, 627.6575, 627.6579, 627.6612, 627.66121, 627.66122, 627.6613, 627.667, 627.6675, and 627.6691, ~~and 627.66911,~~ and complies with the requirements of s. 627.66996.

Section 20. Paragraph (b) of subsection (8) of section 627.6675, Florida Statutes, is amended to read:

627.6675 Conversion on termination of eligibility.—Subject to all of the provisions of this section, a group policy delivered or issued for delivery in this state by an insurer or nonprofit health care services plan that provides, on an expense-incurred basis, hospital, surgical, or major medical expense insurance, or any combination of these coverages, shall provide that an employee or member whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy, and under any group policy providing similar benefits that the terminated group policy replaced, for at least 3 months immediately prior to termination, shall be entitled to have issued to him or her by the insurer a policy or certificate of health insurance, referred to in this section as a "converted policy." A group insurer may meet the requirements of this section by contracting

with another insurer, authorized in this state, to issue an individual converted policy, which policy has been approved by the office under s. 627.410. An employee or member shall not be entitled to a converted policy if termination of his or her insurance under the group policy occurred because he or she failed to pay any required contribution, or because any discontinued group coverage was replaced by similar group coverage within 31 days after discontinuance.

(8) BENEFITS OFFERED.—

(b) An insurer shall offer the benefits specified ~~in s. 627.668 and the benefits specified~~ in s. 627.669 if those benefits were provided in the group plan.

Section 21. Paragraph (b) of subsection (12) of section 627.6699, Florida Statutes, is amended to read:

627.6699 Employee Health Care Access Act.—

(12) STANDARD, BASIC, HIGH DEDUCTIBLE, AND LIMITED HEALTH BENEFIT PLANS.—

(b)1. Each small employer carrier issuing new health benefit plans shall offer to any small employer, upon request, a standard health benefit plan, a basic health benefit plan, and a high deductible plan that meets the requirements of a health savings account plan as defined by federal law or a health reimbursement arrangement as authorized by the Internal Revenue Service, that meet the criteria set forth in this section.

2. For purposes of this subsection, the terms "standard health benefit plan," "basic health benefit plan," and "high deductible plan" mean policies or contracts that a small employer carrier offers to eligible small employers that

contain:

a. An exclusion for services that are not medically necessary or that are not covered preventive health services; and

b. A procedure for preauthorization by the small employer carrier, or its designees.

3. A small employer carrier may include the following managed care provisions in the policy or contract to control costs:

a. A preferred provider arrangement or exclusive provider organization or any combination thereof, in which a small employer carrier enters into a written agreement with the provider to provide services at specified levels of reimbursement or to provide reimbursement to specified providers. Any such written agreement between a provider and a small employer carrier must contain a provision under which the parties agree that the insured individual or covered member has no obligation to make payment for any medical service rendered by the provider which is determined not to be medically necessary. A carrier may use preferred provider arrangements or exclusive provider arrangements to the same extent as allowed in group products that are not issued to small employers.

b. A procedure for utilization review by the small employer carrier or its designees.

This subparagraph does not prohibit a small employer carrier from including in its policy or contract additional managed care and cost containment provisions, subject to the approval of the

office, which have potential for controlling costs in a manner that does not result in inequitable treatment of insureds or subscribers. The carrier may use such provisions to the same extent as authorized for group products that are not issued to small employers.

4. The standard health benefit plan shall include:

a. Coverage for inpatient hospitalization;

b. Coverage for outpatient services;

c. Coverage for newborn children pursuant to s. 627.6575;

d. Coverage for child care supervision services pursuant to s. 627.6579;

e. Coverage for adopted children upon placement in the residence pursuant to s. 627.6578;

f. Coverage for mammograms pursuant to s. 627.6613;

g. Coverage for handicapped children pursuant to s. 627.6615;

h. Emergency or urgent care out of the geographic service area; and

i. Coverage for services provided by a hospice licensed under s. 400.602 in cases where such coverage would be the most appropriate and the most cost-effective method for treating a covered illness.

5. The standard health benefit plan and the basic health benefit plan may include a schedule of benefit limitations for specified services and procedures. If the committee develops such a schedule of benefits limitation for the standard health benefit plan or the basic health benefit plan, a small employer carrier offering the plan must offer the employer an option for

increasing the benefit schedule amounts by 4 percent annually.

6. The basic health benefit plan shall include all of the benefits specified in subparagraph 4.; however, the basic health benefit plan shall place additional restrictions on the benefits and utilization and may also impose additional cost containment measures.

7. Sections 627.419(2) and~~,~~ (3), ~~and (4),~~ 627.6574, 627.6612, 627.66121, 627.66122, and 627.6616~~, 627.6618, 627.668, and 627.66911~~ apply to the standard health benefit plan and to the basic health benefit plan. However, notwithstanding said provisions, the plans may specify limits on the number of authorized treatments, if such limits are reasonable and do not discriminate against any type of provider.

8. The high deductible plan associated with a health savings account or a health reimbursement arrangement shall include all the benefits specified in subparagraph 4.

9. Each small employer carrier that provides for inpatient and outpatient services by allopathic hospitals may provide as an option of the insured similar inpatient and outpatient services by hospitals accredited by the American Osteopathic Association when such services are available and the osteopathic hospital agrees to provide the service.

Section 22. Subsection (1) of section 641.2018, Florida Statutes, is amended to read:

641.2018 Limited coverage for home health care authorized.—

(1) Notwithstanding other provisions of this chapter, a health maintenance organization may issue a contract that limits

coverage to home health care services only. The organization and the contract shall be subject to all of the requirements of this part that do not require or otherwise apply to specific benefits other than home care services. To this extent, all of the requirements of this part apply to any organization or contract that limits coverage to home care services, except the requirements for providing comprehensive health care services as provided in ss. 641.19(4), (11), and (12), and 641.31(1), except ss. 641.31(9), (12), (17), (18), (19), (20), and (21)~~, and (24)~~ and 641.31095.

Section 23. Subsection (1) of section 641.31098, Florida Statutes, is amended to read:

641.31098 Coverage for individuals with developmental disabilities.—

(1) This section ~~and s. 627.6686~~ may be cited as the "Steven A. Geller Autism Coverage Act."

Section 24. Paragraph (a) of subsection (2) of section 1002.66, Florida Statutes, is amended to read:

1002.66 Specialized instructional services for children with disabilities.—

(2) The parent of a child who is eligible for the prekindergarten program for children with disabilities may select one or more specialized instructional services that are consistent with the child's individual educational plan. These specialized instructional services may include, but are not limited to:

(a) Applied behavior analysis as defined in s. ~~ss. 627.6686 and~~ 641.31098.

Section 25. This act shall take effect July 1, 2012.