A bill to be entitled

An act relating to autism; creating s. 381.986, F.S.; requiring a physician, to whom a parent or legal guardian reports observing symptoms of autism exhibited by a minor child, to refer the minor to an appropriate specialist for screening for autism spectrum disorder under certain circumstances; defining the term "appropriate specialist"; amending ss. 627.6686 and 641.31098, F.S.; defining the term "direct patient access"; requiring that certain insurers and health maintenance organizations provide direct patient access to an appropriate specialist for screening for or evaluation or diagnosis of autism spectrum disorder; requiring that certain insurance policies and health maintenance organization contracts provide a minimum number of visits per year for screening for or evaluation or diagnosis of autism spectrum disorder; providing an effective date.

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

Section 1. Section 381.986, Florida Statutes, is created to read:

381.986 Screening for autism spectrum disorder.—

(1) If the parent or legal guardian of a minor believes that the minor exhibits symptoms of autism spectrum disorder and

reports his or her observation to a physician licensed under chapter 458 or chapter 459, the physician shall perform screening in accordance with the guidelines of the American Academy of Pediatrics. If the physician determines that referral to a specialist is medically necessary, the physician shall refer the minor to an appropriate specialist to determine whether the minor meets diagnostic criteria for autism spectrum disorder. If the physician determines that referral to a specialist is not medically necessary, the physician shall inform the parent or legal guardian that he or she may directly access screening for, or evaluation or diagnosis of, autism spectrum disorder for the minor from the Early Steps program or another appropriate specialist in autism without a referral for at least three visits per policy year. This section does not apply to a physician providing care under s. 395.1041.

(2) As used in this section, the term "appropriate specialist" means a qualified professional licensed in this state who is experienced in the evaluation of autism spectrum disorder and has training in validated diagnostic tools. The term includes, but is not limited to:

(a) A psychologist;

(b) A psychiatrist;

(c) A neurologist; or

(d) A developmental or behavioral pediatrician.

Section 2. Section 627.6686, Florida Statutes, is amended to read:

627.6686 Coverage for individuals with autism spectrum disorder required; exception.—

(1) This section and s. 641.31098 may be cited as the "Steven A. Geller Autism 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) "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.

(c) "Direct patient access" means the ability of an insured to obtain services from a contracted provider without a referral or other authorization before receiving services.

(d) ~~(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.

(e) ~~(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.

(f) ~~(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 January 1, 2015, must ~~April 1, 2009, shall~~ provide coverage to an eligible individual for:

(a) Direct patient access to an appropriate specialist, as defined in s. 381.986, for a minimum of three visits per policy year for screening for, or evaluation or diagnosis of, autism spectrum disorder.

(b) ~~(a)~~ Well-baby and well-child screening for diagnosing the presence of autism spectrum disorder.

(c) ~~(b)~~ Treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy, and applied behavior analysis. Applied behavior analysis services must ~~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) Except as provided in paragraph (3)(a), coverage must ~~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) must ~~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) must ~~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 does ~~may~~ not limit ~~be construed as limiting~~ benefits and coverage otherwise available to an insured under a health insurance plan.

Section 3. 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."

(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) "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.

(c) "Direct patient access" means the ability of an insured to obtain services from an in-network provider without a referral or other authorization before receiving services.

(d) ~~(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.

(e) ~~(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 January 1, 2015, must ~~April 1, 2009, shall~~ provide coverage to an eligible individual for:

(a) Direct patient access to an appropriate specialist, as defined in s. 381.986, for a minimum of three visits per policy year for screening for, or evaluation or diagnosis of, autism spectrum disorder.

(b) ~~(a)~~ Well-baby and well-child screening for diagnosing the presence of autism spectrum disorder.

(c) ~~(b)~~ Treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy, and applied behavior analysis services. Applied behavior analysis services must ~~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) Except as provided in paragraph (3)(a), coverage must ~~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)

must ~~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 (3).

(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) must ~~shall~~ include, but need ~~is~~ not be 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.

Section 4. This act shall take effect July 1, 2014.