By Senator Ring

29-00062-16 2016144__

1 A bill to be entitled
2 An act relating to autism; creating s. 381.988, F.S.;
3 requiring a physician, to whom the parent or legal
4 guardian of a minor reports observing symptoms of
5 autism exhibited by the minor, to refer the minor to
6 an appropriate specialist for screening for autism
7 spectrum disorder under certain circumstances;
8 authorizing the parent or legal guardian to have
9 direct access to screening for, or evaluation or
10 diagnosis of, autism spectrum disorder for a minor
11 from the Early Steps program or another appropriate
12 specialist in autism under certain circumstances;
13 defining the term "appropriate specialist"; amending
14 ss. 627.6686 and 641.31098, F.S.; defining the term
15 "direct patient access"; requiring that certain
16 insurers and health maintenance organizations provide
17 direct patient access for a minimum number of visits
18 to an appropriate specialist for screening for, or
19 evaluation or diagnosis of, autism spectrum disorder;
20 providing effective dates.
21
22 Be It Enacted by the Legislature of the State of Florida:
23
24 Section 1. Section 381.988, Florida Statutes, is created to
25 read:
26 381.988 Screening for autism spectrum disorder.—
27 (1) If the parent or legal guardian of a minor believes
28 that the minor exhibits symptoms of autism spectrum disorder and
29 reports his or her observation to a physician licensed under

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30 chapter 458 or chapter 459, the physician shall screen the minor
31 in accordance with the guidelines of the American Academy of
32 Pediatrics. If the physician determines that referral to a
33 specialist is medically necessary, the physician shall refer the
34 minor to an appropriate specialist to determine whether the
35 minor meets diagnostic criteria for autism spectrum disorder. If
36 the physician determines that referral to a specialist is not
37 medically necessary, the physician shall inform the parent or
38 legal guardian that the parent or legal guardian may have direct
39 access to screening for, or evaluation or diagnosis of, autism
40 spectrum disorder for the minor from the Early Steps program or
41 another appropriate specialist in autism without a referral for
42 at least three visits per policy year. This section does not
43 apply to a physician providing care under s. 395.1041.
44 (2) As used in this section, the term "appropriate
45 specialist" means a qualified professional licensed in this
46 state who is experienced in the evaluation of autism spectrum
47 disorder and has training in validated diagnostic tools. The
48 term includes, but is not limited to:
49 (a) A psychologist;
50 (b) A psychiatrist;
51 (c) A neurologist; or
52 (d) A developmental or behavioral pediatrician.
53 Section 2. Effective January 1, 2017, section 627.6686,
54 Florida Statutes, is amended to read:
55 627.6686 Coverage for individuals with autism spectrum
56 disorder required; exception.—
57 (1) This section and s. 641.31098 may be cited as the
58 "Steven A. Geller Autism Coverage Act."

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59 (2) As used in this section, the term:
60 (a) “Applied behavior analysis” means the design,
61 implementation, and evaluation of environmental modifications,
62 using behavioral stimuli and consequences, to produce socially
63 significant improvement in human behavior, including, but not
64 limited to, the use of direct observation, measurement, and
65 functional analysis of the relations between environment and
66 behavior.
67 (b) “Autism spectrum disorder” means any of the following
68 disorders as defined in the most recent edition of the
69 Diagnostic and Statistical Manual of Mental Disorders of the
70 American Psychiatric Association:
71 1. Autistic disorder.
72 2. Asperger’s syndrome.
73 3. Pervasive developmental disorder not otherwise
74 specified.
75 (c) “Direct patient access” means the ability of an insured
76 to obtain services from a contracted provider without a referral
77 or other authorization before receiving services.
78 (d) ~~(c)~~ “Eligible individual” means an individual younger
79 than ~~under~~ 18 years of age or an individual 18 years of age or
80 older who is in high school who has been diagnosed as having a
81 developmental disability at 8 years of age or younger.
82 (e) ~~(d)~~ “Health insurance plan” means a group health
83 insurance policy or group health benefit plan offered by an
84 insurer which includes the state group insurance program
85 provided under s. 110.123. The term does not include any health
86 insurance plan offered in the individual market, any health
87 insurance plan that is individually underwritten, or any health

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88 insurance plan provided to a small employer.
89 <u>(f)</u>~~(e)~~ “Insurer” means an insurer providing health
90 insurance coverage~~,~~ which is licensed to engage in the business
91 of insurance in this state and is subject to insurance
92 regulation.
93 (3) A health insurance plan issued or renewed on or after
94 <u>January 1, 2017, must</u> ~~April 1, 2009, shall~~ provide coverage to
95 an eligible individual for:
96 <u>(a) Direct patient access to an appropriate specialist, as</u>
97 <u>defined in s. 381.988, for a minimum of three visits per policy</u>
98 <u>year for screening for, or evaluation or diagnosis of, autism</u>
99 <u>spectrum disorder.</u>
100 <u>(b)</u>~~(a)~~ Well-baby and well-child screening for diagnosing
101 the presence of autism spectrum disorder.
102 <u>(c)</u>~~(b)~~ Treatment of autism spectrum disorder through speech
103 therapy, occupational therapy, physical therapy, and applied
104 behavior analysis. Applied behavior analysis services <u>must</u> ~~shall~~
105 be provided by an individual certified pursuant to s. 393.17 or
106 an individual licensed under chapter 490 or chapter 491.
107 (4) The coverage required pursuant to subsection (3) is
108 subject to the following requirements:
109 (a) <u>Except as provided in paragraph (3)(a),</u> coverage <u>is</u>
110 ~~shall be~~ limited to treatment that is prescribed by the
111 insured’s treating physician in accordance with a treatment
112 plan.
113 (b) Coverage for the services described in subsection (3)
114 <u>is</u> ~~shall be~~ limited to $36,000 annually and may not exceed
115 $200,000 in total lifetime benefits.
116 (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 under ~~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 for an individual because the individual is diagnosed as having a developmental disability, and may not refuse to contract with such an individual~~,~~ or refuse to renew or reissue or otherwise terminate or restrict coverage for such 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.

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146 (8) The maximum benefit under paragraph (4)(b) shall be
147 adjusted annually on January 1 of each calendar year to reflect
148 any change from the previous year in the medical component of
149 the then current Consumer Price Index for All Urban Consumers,
150 published by the Bureau of Labor Statistics of the United States
151 Department of Labor.
152 (9) This section does ~~may~~ not limit ~~be construed as~~
153 ~~limiting~~ benefits and coverage otherwise available to an insured
154 under a health insurance plan.
155 Section 3. Effective January 1, 2017, section 641.31098,
156 Florida Statutes, is amended to read:
157 641.31098 Coverage for individuals with developmental
158 disabilities.—
159 (1) This section and s. 627.6686 may be cited as the
160 "Steven A. Geller Autism Coverage Act."
161 (2) As used in this section, the term:
162 (a) "Applied behavior analysis" means the design,
163 implementation, and evaluation of environmental modifications,
164 using behavioral stimuli and consequences, to produce socially
165 significant improvement in human behavior, including, but not
166 limited to, the use of direct observation, measurement, and
167 functional analysis of the relations between environment and
168 behavior.
169 (b) "Autism spectrum disorder" means any of the following
170 disorders as defined in the most recent edition of the
171 Diagnostic and Statistical Manual of Mental Disorders of the
172 American Psychiatric Association:
173 1. Autistic disorder.
174 2. Asperger's syndrome.

175 3. Pervasive developmental disorder not otherwise
176 specified.
177 (c) “Direct patient access” means the ability of an insured
178 to obtain services from an in-network provider without a
179 referral or other authorization before receiving services.
180 (d) ~~(c)~~ “Eligible individual” means an individual younger
181 than ~~under~~ 18 years of age or an individual 18 years of age or
182 older who is in high school who has been diagnosed as having a
183 developmental disability at 8 years of age or younger.
184 (e) ~~(d)~~ “Health maintenance contract” means a group health
185 maintenance contract offered by a health maintenance
186 organization. This term does not include a health maintenance
187 contract offered in the individual market, a health maintenance
188 contract that is individually underwritten, or a health
189 maintenance contract provided to a small employer.
190 (3) A health maintenance contract issued or renewed on or
191 after January 1, 2017, must ~~April 1, 2009, shall~~ provide
192 coverage to an eligible individual for:
193 (a) Direct patient access to an appropriate specialist, as
194 defined in s. 381.988, for a minimum of three visits per policy
195 year for screening for, or evaluation or diagnosis of, autism
196 spectrum disorder.
197 (b) ~~(a)~~ Well-baby and well-child screening for diagnosing
198 the presence of autism spectrum disorder.
199 (c) ~~(b)~~ Treatment of autism spectrum disorder through speech
200 therapy, occupational therapy, physical therapy, and applied
201 behavior analysis services. Applied behavior analysis services
202 must ~~shall~~ be provided by an individual certified pursuant to s.
203 393.17 or an individual licensed under chapter 490 or chapter

204 491.
205 (4) The coverage required pursuant to subsection (3) is
206 subject to the following requirements:
207 (a) Except as provided in paragraph (3)(a), coverage is
208 ~~shall be~~ limited to treatment that is prescribed by the
209 subscriber's treating physician in accordance with a treatment
210 plan.
211 (b) Coverage for the services described in subsection (3)
212 is ~~shall be~~ limited to $36,000 annually and may not exceed
213 $200,000 in total benefits.
214 (c) Coverage may not be denied on the basis that provided
215 services are habilitative in nature.
216 (d) Coverage may be subject to general exclusions and
217 limitations of the subscriber's contract, including, but not
218 limited to, coordination of benefits, participating provider
219 requirements, and utilization review of health care services,
220 including the review of medical necessity, case management, and
221 other managed care provisions.
222 (5) The coverage required pursuant to subsection (3) may
223 not be subject to dollar limits, deductibles, or coinsurance
224 provisions that are less favorable to a subscriber than the
225 dollar limits, deductibles, or coinsurance provisions that apply
226 to physical illnesses that are generally covered under the
227 subscriber's contract, except as otherwise provided in
228 subsection (3).
229 (6) A health maintenance organization may not deny or
230 refuse to issue coverage for medically necessary services for an
231 individual solely because the individual is diagnosed as having
232 a developmental disability, and may not refuse to contract with

233 such an individual~~,~~ or refuse to renew or reissue or otherwise
234 terminate or restrict coverage for such an individual ~~solely~~
235 ~~because the individual is diagnosed as having a developmental~~
236 ~~disability~~.
237 (7) The treatment plan required pursuant to subsection (4)
238 must ~~shall~~ include, but need ~~is~~ not be limited to, a diagnosis,
239 the proposed treatment by type, the frequency and duration of
240 treatment, the anticipated outcomes stated as goals, the
241 frequency with which the treatment plan will be updated, and the
242 signature of the treating physician.
243 (8) The maximum benefit under paragraph (4)(b) shall be
244 adjusted annually on January 1 of each calendar year to reflect
245 any change from the previous year in the medical component of
246 the then current Consumer Price Index for All Urban Consumers,
247 published by the Bureau of Labor Statistics of the United States
248 Department of Labor.
249 Section 4. Except as otherwise expressly provided in this
250 act, this act shall take effect July 1, 2016.