HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HSQS 12-03 Health Care Coverage Mandates
SPONSOR(S): Health & Human Services Quality Subcommittee; Wood
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health & Human Services Quality Subcommittee		Poche	Calamas

SUMMARY ANALYSIS

PCB HSQS 12-03 proposes the repeal of the following health insurance coverage mandates:

- Section 627.669, F.S., regarding substance and alcohol abuse treatment;
- Section 627.42395, F.S., regarding enteral nutrition;
- Section 627.668, F.S., regarding mental and nervous disorders;
- Section 641.31(24), F.S., regarding osteopathic hospitals;
- Sections 627.6686, F.S., and 641.31098, F.S., relating to autism and developmental disabilities;
- Section 627.4236, F.S., relating to bone marrow transplant procedures;
- Sections 627.64193, F.S., 627.66911, F.S., and 641.31(35), F.S., relating to cleft lip and cleft palate;
- Section 627.6617, F.S., relating to home health care;
- Sections 627.6403, F.S., and 627.6618, F.S., relating to payment to acupuncturists;
- Section 627.419(4), F.S., relating to chiropractic physicians;
- Sections 627.6407, F.S., 627.6619, F.S., and 641.31(37), F.S., relating to massage therapists;
- Section 627.419(4), F.S., relating to podiatrists; and
- Sections 627.6471(6), F.S., 627.6472(15), F.S., and 627.668, F.S., relating to mandated eligibility provisions for participation in a network by marriage and family therapists, professional counselors, psychologists, and psychiatric nurses.

The PCB amends several statutes to conform cross-references to the statutes proposed for repeal.

The PCB appears to have an indeterminate positive fiscal impact on state and local government.

The PCB provides an effective date of July 1, 2012.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Health Insurance Mandates and Mandated Offerings

A health insurance mandate is a legal requirement that an insurance company or health plan cover services by particular health care providers, specific benefits, or specific patient groups. Mandated offerings, on the other hand, do not mandate that certain benefits be provided. Rather, a mandated offering law can require that insurers offer an option for coverage for a particular benefit or specific patient groups, which may require a higher premium and which the insured is free to accept or reject. A mandated offering law in the context of mental health can require that insurers offer an option of coverage for mental illness, which may require a higher premium and which the insured is free to accept or reject or require that, if insurers offer mental illness coverage, the benefits must be equivalent to other types of benefits.

Florida currently has at least 59 mandates.[1] The Council for Affordable Health Insurance estimates that mandated benefits currently increase the cost of basic health coverage by a little less than 20 percent, but possibly higher depending on the number of mandates, the benefit design and the cost of the initial premium.[2] Each mandate adds to the cost of a plan's premiums, in a range of less than 1 percent to 10 percent, depending on the mandate.[3] Higher costs resulting from mandates are most likely to be experienced in the small group market since these are the plans that are subject to state regulations. The national average cost of insurance for a family of four is $15,073.[4]

Selected Florida Mandates

Podiatrists and Chiropractic Physicians

Section 627.419(3), F.S., requires any health insurance policy, health care services plan or other contract that covers services within the scope of practice of a podiatrist to provide for payment to a podiatrist who provides those services.[5]

Section 627.419(4), F.S., requires any health insurance policy, health care services plan or other contract that covers services within the scope of practice of a chiropractic physician to provide for payment to a chiropractic physician who provides those services.[6]

At least thirty-two other states have an insurance mandate requiring coverage of treatment by a podiatrist and at least forty three other states have an insurance mandate requiring coverage of treatment by a chiropractor.[7]

Bone Marrow Transplant Procedures

[1] *See* Florida House of Representatives, Health and Human Services Quality Subcommittee, *Meeting Packet for November 15, 2011*, pages 7-9 (available at http://myfloridahouse.gov/Sections/Documents/publications.aspx?CommitteeId=2612&PublicationType=Committees&DocumentType=Meeting Packets&Session=2012&SessionId=70); *but see also* Council for Affordable Health Insurance , *Health Insurance Mandates in the States 2010- Table 1: Total Mandates by State*, page 3 (on file with Health and Human Services Quality Subcommittee).
[2] *Id.* at page 7.
[3] *Id.* at pages 4-6.
[4] Kaiser Family Foundation, *Employer Health Benefits 2011 Annual Survey- Summary of Findings*, page 1, available at: http://ehbs.kff.org/pdf/8226.pdf (last viewed January 26, 2012).
[5] The scope of practice of a podiatrist is governed by chapter 461, F.S.
[6] The scope of practice of a chiropractic physician is governed by chapter 460, F.S.
[7] *See supra* at FN 1, Council for Affordable Health Insurance, *Health Insurance Mandates in the States 2010*, at page 6.

A bone marrow transplant is a procedure to replace damaged or destroyed bone marrow with healthy bone marrow stem cells. Bone marrow is the soft, fatty tissue located on the inside of bones. Stem cells are immature cells in the bone marrow that give rise to all blood cells.[8] There are three kinds of bone marrow transplants:

- **Autologous bone marrow transplant**- Stem cells are removed from an individual before he or she receives high-dose chemotherapy or radiation treatment. After these treatments are done, the stems cells are put back in the body. This is also referred to as a "rescue" transplant.
- **Allogeneic bone marrow transplant**- Stem cells are removed from another person, called a donor. Most times, the donor must have the same genetic makeup as the patient, so that the blood is a "match". Special blood tests are done to determine if a donor is a good match. A brother or sister is most likely to be a good match. However, sometimes parents, children, and other relatives may be also be good matches. Donors who are not related to the patient may be found through national bone marrow registries.
- **Umbilical cord blood transplant**- Stem cells are removed from a newborn baby's umbilical cord immediately after being born. The stem cells are stored until they are needed for a transplant. Umbilical cord blood cells are so immature, there is less of a concern that they will not match.[9]

Minor surgery may be needed to collect bone marrow and stem cells from a donor. This is called a bone marrow harvest. The surgery is done under general anesthesia, which means the donor will be asleep and pain-free during the procedure. The bone marrow is removed from the hip bones.[10]

Section 627.4236, F.S., prohibits an insurer or HMO from excluding coverage for bone marrow transplant procedures, recommended by a referring physician and treating physician, on the basis of a policy exclusion for experimental, clinical investigative, educational or similar procedures in a policy or contract that covers cancer.[11] The use of the recommended bone marrow transplant procedure must be accepted within the appropriate oncological specialty and not experimental in nature, pursuant to rules established by the Agency for Health Care Administration (AHCA).[12]

Eight other states mandate insurance coverage for bone marrow transplants.[13]

Enteral Nutrition

Section 627.42395, F.S., requires any health insurance policy or group health insurance plan to offer coverage for nutrient and food supplements prescribed by a physician as medically necessary to treat inherited metabolic diseases or congenital defects that cause malabsorption. These supplements, known as enteral nutrition, are introduced to the body through one or more tube feeding options as a result of the symptoms of metabolic disease or congenital defects which prevent a person from eating or swallowing properly.[14] Coverage is required for modified, low protein food products up to $2,500 annually for any insured individual through the age of 24.[15]

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[8] The New York Times, Health Guide, *Bone Marrow Transplant*, available at http://health.nytimes.com/health/guides/surgery/bone-marrow-transplant/overview.html (last viewed on January 27, 2012).
[9] Bishop MR, Pavletic SZ. *Hematopoietic stem cell transplantation*. In: Abeloff MD, Armitage JO, Niederhuber JE, Kastan MB, McKena WG, eds. *Clinical Oncology* . 4th ed. Philadelphia, Pa: Elsevier Churchill Livingstone; 2008:chap 32.
[10] Vose JM, Pavletic SZ. *Hematopoietic stem cell transplantation*. In: Goldman L, Ausiello D. Cecil, *Medicine* . 23rd ed., Philadelphia, Pa: Saunders Elsevier; 2007:chap 184.
[11] S. 627.4236(2), F.S.
[12] *Id.*; *see also* s. 627.4236(3)(a), F.S.; Rule 59B-12.001, F.A.C. contains the bone marrow transplant procedures that are determined to be accepted and appropriate procedures.
[13] *See supra* at FN 1, page 4.
[14] American Society for Parenteral and Enteral Nutrition (ASPEN), *What is Enteral Nutrition?*, available at http://www.nutritioncare.org/wcontent.aspx?id=266.
[15] S. 627.42395, F.S.

Acupuncturists

The term "acupuncture" describes a family of procedures involving the stimulation of anatomical points on the body using a variety of techniques. The acupuncture technique that has been most often studied scientifically involves penetrating the skin with thin, solid, metallic needles that are manipulated by the hands or by electrical stimulation.[16]

The report from a Consensus Development Conference on Acupuncture held at the National Institutes of Health (NIH) in 1997 stated that acupuncture is being "widely" practiced—by thousands of physicians, dentists, acupuncturists, and other practitioners—for relief or prevention of pain and for various other health conditions.[17] According to the 2007 National Health Interview Survey, which included a comprehensive survey of CAM use by Americans, an estimated 3.1 million U.S. adults and 150,000 children had used acupuncture in the previous year. Between the 2002 and 2007 NHIS, acupuncture use among adults increased by approximately 1 million people.[18]

Research has shown that acupuncture reduces nausea and vomiting after surgery and chemotherapy, can relieve pain. Researchers do not fully understand how acupuncture works; it might aid the activity of the body's pain-killing chemicals and affect how the body releases chemicals that regulate blood pressure and flow.[19]

Section 627.6403, F.S., and s. 627.6618, F.S., require any individual health insurance policy that covers acupuncture to pay for the services of a licensed acupuncturist[20] to the same extent and degree as the services of a licensed physician.

At least eleven other states have an insurance mandate requiring payment of services provided by an acupuncturist.[21]

Massage Therapists

Section 627.6407, F.S., s. 627.6619, F.S., and s. 641.31(37), F.S., require any individual health insurance policy that covers massage to cover the services of a licensed massage therapist[22] if the massage is prescribed by a licensed physician as medically necessary and the prescription specifies the number of treatments.

Cleft Lip and Cleft Palate

Cleft lip and cleft palate are the two most common forms of orofacial clefts found in Florida.[23] These types of clefts occur when the structures of the mouth fail to form properly. This typically occurs early in fetal development between four and ten weeks after conception. Cleft lip and palate may occur separately or together. A cleft lip involves the space between the upper lip and the nostrils. Clefts of the palate may occur in the front of the palate, which involves underlying bone, or in the back area involving soft tissue. Infants born with a cleft typically undergo surgery and receive speech therapy and

[16] National Institutes of Health, National Center for Complementary and Alternative Medicine, *Acupuncture: An Introduction*, NCCAM Pub. No. D404, December 2007 (updated August 2011), available at http://nccam.nih.gov/health/acupuncture/introduction.htm (last viewed on January 27, 2012).
[17] *Id.*
[18] *Id.*
[19] National Institutes of Health, U.S. National Library of Medicine, MedlinePlus, *Acupuncture*, available at http://www.nlm.nih.gov/medlineplus/acupuncture.html (last viewed on January 27, 2012).
[20] Chapter 457, F.S., governs the licensing of acupuncturists in Florida; *see also* Chapter 64B1-4, F.A.C.
[21] *See supra* at FN 1, page 5.
[22] Massage therapists are governed by chapter 480, F.S. and chapters 64B7-24 through -33, F.A.C.
[23] Florida Department of Health, Bureau of Environmental Public Health, Florida Birth Defects Registry, *Orofacial Clefts*, available at: http://www.fbdr.org/2005/birthdefects/cleft.asp (last viewed on January 26, 2012).

orthodontic care. From 1998 through 2007, Florida saw 2,909 cases of cleft lip or cleft palate, an average of 291 cases per year during that time period.[24]

Section 627.64193, F.S., s. 627.66911, F.S., and s. 641.31(35), F.S., require a health insurance policy or HMO contract that provides coverage for a child under the age of 18 to cover treatment of cleft lip and cleft palate for the child. Treatment must include medical, dental and speech therapy, audiology, and nutrition services if determined to be medically necessary and consequent to the treatment of cleft lip or cleft palate. This coverage mandate does not apply to specified-accident, specified-disease, hospital indemnity, limited benefit disability income, or long-term care insurance policies.

Sixteen other states mandate insurance coverage for cleft lip and cleft palate.[25]

Mandated Eligibility Criteria for Participation in a Provider Network

Section 627.6471(6), F.S., and s. 627.6472(15), F.S., require an insurer, where psychotherapeutic services are covered by the policy, to provide eligibility criteria for allopathic and osteopathic physicians, psychologists[26], marriage and family therapists and mental health counselors[27], and psychiatric advanced registered nurse practitioners[28] to be added to the provider network.

At least forty-three other states have some form of insurance mandate related to psychologists.[29] At least sixteen other states have some form of insurance mandate related to marriage and family therapists.[30] At least sixteen other states have some form of insurance mandate related to professional counselors.[31] At least seventeen other states have some form of insurance mandate related to psychiatric nurses.[32]

Home Health Care

Home health care covers a wide range of services, including occupational and physical therapy, speech therapy, and skilled nursing. It may involve helping the elderly with activities of daily living such as bathing, dressing, and eating. Home health care may also include assistance with cooking, cleaning, other housekeeping jobs, and monitoring one's daily regimen of prescription and over-the-counter medications.[33]

Section 627.6617, F.S., requires any group health insurance policy to provide coverage for home health care performed by a home health care agency licensed under part III of chapter 400, F.S. The home health care provided can range from basic assistance with activities of daily living by a home health aide to skilled nursing care provided by a registered nurse. Coverage in the amount of at least $1,000 must be provided annually for home health care prescribed by a physician and provided by a licensed agency.

Nineteen other states mandate insurance coverage for home health care.[34]

Mental Health Parity and Addiction Equity Act

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[24] Florida Department of Health, Bureau of Environmental Public Health, Florida Birth Defects Registry, *Orofacial Cleft Defects in Florida, 1998-2007*, available at: http://www.fbdr.org/gfx/data/cleft_table.jpg (last viewed on January 26, 2012).
[25] *See supra* at FN 13.
[26] Chapter 490, F.S., governs the licensing of psychologists in Florida.
[27] Chapter 491, F.S., governs the licensing of marriage and family therapists and mental health counselors in Florida.
[28] Psychiatric advanced registered nurse practitioners are licensed pursuant to s. 464.012, F.S..
[29] *See supra* at FN 1, page 6.
[30] *Id.*
[31] *Id.*
[32] *Id.*
[33] U.S. Department of Health and Human Services, Administration on Aging, Eldercare Locator, *What is Home Health Care?*, available at http://www.eldercare.gov/Eldercare.NET/Public/Resources/Factsheets/Home_Health_Care.aspx (last viewed on January 27, 2012).
[34] *See supra* at FN 13.

In 2010, an estimated 45.9 million adults aged 18 or older in the United States had any mental illness[35] in the past year.[36] This represents 20.0 percent of all adults in this country.[37] These estimates were stable between 2009 (45.1 million, 19.9 percent) and 2010.[38] In 2010, there were an estimated 11.4 million adults aged 18 or older in the United States with serious mental illness[39] in the past year.[40] This represented 5.0 percent of all adults in this country in 2010.[41] These estimates of adults with serious mental illness in 2010 were similar to those in 2009 (11.0 million, 4.8 percent).[42]

On October 2, 2008, President George W. Bush signed into law H.R. 1424, which contains the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (the Act). The Act applies to employer-sponsored ERISA group health plans and large group health insurance plans. The Act will preempt all state laws that apply to the same group health insurance policies (large group plans) while allowing for state laws that expand upon the federal mandate. Any state parity legislation regarding group health insurance will only apply to small group health insurance (2-50 employees) and large group health insurance to the extent that the state act expands the benefits provided under the Act.

Pursuant to the Act, a group health plan that provides medical and surgical benefits and offers benefits for the treatment of mental health conditions or substance abuse must apply financial requirements and treatment limitations to mental health disorders and substance abuse that are no more restrictive than those predominantly applied to medical and surgical benefits under the policy. Parity with regard to financial requirements includes deductibles, copayments, coinsurance, and out-of-pocket expenses, but not annual and lifetime limits. Parity with regard to treatment limitations includes limits on treatment frequency, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. Annual and lifetime coverage limits for mental health benefits must be equivalent to the limits on substantially all medical and surgical benefits; if no limit is applied to medical and surgical benefits then a limit may not be applied to mental health benefits. Additionally, out-of-network benefits for mental health and substance abuse treatment must be provided on par with out-of-network medical and surgical benefits.

The Act does not specify a set of mental health benefits that must be provided. Instead, the Act requires that benefits for mental health and substance abuse be defined under the terms of the health care plan, in accordance with applicable state and federal law. As discussed above, current Florida law requires an offer of coverage for mental and nervous disorders as defined by the standard nomenclature of the American Psychiatric Association (APA) subject to the right of the applicant for a group policy or contract to select any alternative benefits or level of benefits as may be offered. Thus, insurers must offer a policy covering all conditions defined by the APA, but may also offer policies that provide benefits for a greater or lesser number of conditions, so long as the benefits are provided in accordance with the minimum limits contained in statute.

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[35] "Any mental illness" is defined as currently or at any time in the past year having had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association [APA], 1994). Adults who had a diagnosable mental, behavioral, or emotional disorder in the past year, regardless of their level of functional impairment, were defined as having any mental illness; *see* Substance Abuse and Mental Health Services Administration (SAMHSA), *Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-42, HHS Publication No. (SMA) 11-4667. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012. Available at http://www.samhsa.gov/data/NSDUH/2k10MH_Findings/2k10MHResults.htm#1.1 (last viewed on January 27, 2012).

[36] *Id.*

[37] *Id.*

[38] *Id.*

[39] SAMHSA defined serious mental illness as persons aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within DSM-IV (APA, 1994) that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities; *see supra* at FN 28.

[40] *Id.*

[41] *Id.*

[42] *Id.*

It appears that under the Act, in Florida, a large group health plan must offer a coverage plan providing coverage for mental and nervous disorders as defined by the standard nomenclature of the APA and that meets the requirements of the federal parity law. Alternative coverage plans may also be offered pursuant to Florida law, but such coverage would have to provide benefits in conformity with the federal parity mandate.

The Act exempts employers that have an average of between two and 50 employees (small groups). The Act also exempts health plans if application of parity for benefits results in a 2 percent or greater increase in total plan costs for the first year parity is applied, and an increase of 1 percent or greater in subsequent plan years. To qualify for an exemption, the determination that plan costs exceed the applicable percentage must be made in a written report by a qualified and licensed actuary that is a member in good standing of the American Academy of Actuaries. If an insurer or group health plan claims an exemption it must notify federal and state regulators, as well as plan participants and beneficiaries. Federal and state regulators both are authorized to conduct an audit of the books, records, and actuarial reports of a group health plan or insurer claiming an exemption

Many studies have examined the effect of mental health parity laws on the cost of health care coverage, with varying results. Recognizing these differing results, the Substance Abuse and Mental Health Services Administration (SAMHSA) within the United States Department of Health and Human Services designed a study to analyze the costs of parity.[43] At the time of the study most states had parity laws that were limited to serious mental illnesses and did not include substance abuse, small plans, or government employees. The study found that these types of plans with tightly managed care have a small effect on premiums; however, plans with full parity for mental health and substance abuse increased premiums by an average of 3.6 percent.[44]

Section 627.668, F.S., regulates the provision of mental and nervous disorder services by insurers, (HMOs), and nonprofit hospital and medical service plan corporations providing group health insurance or prepaid health care. Specifically, these entities must make mental and nervous disorder services available to a policyholder for an additional premium. Florida's law is a mandated offering law. Similarly, the Act does not require insurers, HMOs, or other providers of health insurance to provide coverage for mental and nervous disorder services. If a health insurance plan or contract offer these services, the Act requires coverage to be equal to the coverage provided for medical treatment and services. The Act is a mandated parity law.

Forty-one other states have a general mental health insurance mandate and forty seven other states have some form of mental health parity mandate.[45]

Autism

Autism spectrum disorder (ASD) refers to any of a group of developmental disorders (such as autism and Asperger's syndrome) marked by impairments in the ability to communicate and interact socially and by the presence of repetitive behaviors or restricted interests.[46] The Centers for Disease Control estimates that 1 in every 110 children in the United States has ASD.[47] Individuals with an ASD had average medical expenditures that exceeded those without an ASD by $4,110–$6,200 per year.[48]

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[43] Merrile Sing, et al, *The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits*, DHHS Publication No. MC99-80 (1998), Substance Abuse and Mental Health Services Administration, available at http://mentalhealth.about.com/library/mc/bltyexsm.htm (last viewed on January 27, 2012).
[44] *Id.*
[45] *See supra* at FN 21.
[46] *See* www.merriam-webster.com/dictionary/autism%20spectrum%20disorder (last viewed January 26, 2012).
[47] Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, *Autism Spectrum Disorders (ASDs)-Data and Statistics-Prevalence*, available at http://www.cdc.gov/ncbddd/autism/data.html#prevalence (last viewed January 26, 2012).
[48] Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, *Autism Spectrum Disorders (ASDs)-Data and Statistics-Economic Costs*, available at http://www.cdc.gov/ncbddd/autism/data.html#economic (last viewed January 26, 2012).

Recent studies have estimated that the lifetime cost to care for an individual with an ASD is $3.2 million.[49]

Section 627.6686, F.S., and section 641.31098, F.S. (applying to HMOs) requires coverage for well-baby and well-child screening for diagnosis of autism spectrum disorder.[50] Both statutes also require coverage for treatment of autism spectrum disorder through speech, occupational, and physical therapy and behavior therapy analysis.[51] The amount of coverage for screening and treatment is limited to $36,000 per year, with a lifetime maximum coverage limit of $200,000.[52]

At least twenty-seven other states have an insurance mandate for coverage of screening for and treatment of ASD.[53] Of those, Arkansas, Rhode Island, and West Virginia enacted an ASD mandate in 2011.[54]

Substance and Alcohol Abuse Treatment

Section 627.669, F.S., requires group health insurance plans and HMOs to offer coverage for treatment of substance abuse.[55] Coverage must provide a minimum lifetime benefit of $2,000.[56] Also, coverage must provide for a maximum of 44 out-patient treatment visits, with a maximum "per visit" benefit of $35.[57]

At least forty-five other states have some form of insurance mandate to provide coverage for treatment of alcoholism and substance abuse, and at least thirty-three other states have some form of insurance mandate to provide treatment of drug abuse.[58]

Osteopathic Hospitals

Section 641.31(24), F.S., requires HMO contracts that provide for in-patient and out-patient treatment at an allopathic hospital to provide the option for similar treatment at an osteopathic hospital, when those services are available in the HMO service area. According to AHCA, there are no osteopathic hospitals in Florida.[59]

Effect of Proposed Changes

PCB HSQS 12-03 proposes the repeal of the preceding mandates. The PCB also makes conforming changes to the statutory provisions included in sections 18 through 26 to reflect the repeal of the preceding mandates.

B. SECTION DIRECTORY:

Section 1: Amends s. 627.419, F.S., relating to construction of policies;
Section 2: Repeals s. 627.4236, F.S., relating to coverage for bone marrow transplant procedures;
Section 3: Repeals s. 627.42395, F.S., relating to coverage for certain prescription and nonprescription enteral formulas;

[49] *Id.*
[50] S. 627.6686(3)(a), F.S., and s. 641.31098(3)(a), F.S.
[51] S. 627.6686(3)(b), F.S., and s. 641.31098(3)(b), F.S.
[52] S. 627.6686(4)(b), F.S., and s. 641.31098(4)(b), F.S.
[53] *See supra* at FN 13.
[54] National Conference of State Legislatures, *2011 Health Insurance Reform Enacted State Laws Related to the Affordable Care Act*, available at http://www.ncsl.org/issues-research/health/2011-health-insurance-reform-enacted-state-laws-re.aspx (last viewed on January 27, 2012).
[55] S. 627.669(1), F.S.
[56] S. 627.669(2)(b)2., F.S.
[57] S. 627.669(2)(b)3. and 4., F.S.
[58] *See supra* at FN 13.
[59] Email correspondence from AHCA legislative affairs staff to Health and Human Services Quality Subcommittee staff dated January 26, 2012 (on file with the Subcommittee).

Section 4: Repeals s. 627.6403, F.S., relating to payment of acupuncture benefits to certified acupuncturists;
Section 5: Repeals s. 627.6407, F.S., relating to massage;
Section 6: Repeals s. 627.64193, F.S., relating to required coverage for cleft lip and cleft palate;
Section 7: Amends s. 627.6471, F.S., relating to contracts for reduced rates of payment; limitations; coinsurance and deductibles;
Section 8: Amends s. 627.6472, F.S., relating to exclusive provider organizations;
Section 9: Repeals s. 627.6617, F.S., relating to coverage for home health care services;
Section 10: Repeals s. 627.6618, F.S., relating to payment of acupuncture benefits to certified acupuncturists;
Section 11: Repeals s. 627.6619, F.S., relating to massage;
Section 12: Repeals 627.668, F.S., relating to optional coverage for mental and nervous disorders required; exception;
Section 13: Repeals s. 627.6686, F.S., relating to coverage for individuals with autism spectrum disorder required; exception;
Section 14: Repeals s. 627.669, F.S., relating to optional coverage required for substance abuse impaired persons; exception;
Section 15: Repeals s. 627.66911, F.S., relating to required coverage for cleft lip and cleft palate;
Section 16: Amends s. 641.31, F.S., relating to health maintenance contracts;
Section 17: Repeals s. 641.31098, F.S., relating to coverage for individuals with developmental disabilities;
Section 18: Amends s. 409.815, F.S., relating to health benefits coverage; limitations;
Section 19: Amends s. 409.906, F.S., relating to optional Medicaid coverage;
Section 20: Amends s. 624.916, F.S., relating to developmental disabilities compact;
Section 21: Amends s. 627.6472, F.S., relating to exclusive provider organizations;
Section 22: Amends s. 627.6515, F.S., relating to out-of-state-groups;
Section 23: Amends s. 627.6675, F.S., relating to conversion on termination of eligibility;
Section 24: Amends s. 627.6699, F.S., relating to Employee Health Care Access Act;
Section 25: Amends s. 641.2018, F.S., relating to limited coverage for home health care authorized;
Section 26: Amends s. 1002.66, F.S., relating to specialized instructional services for children with disabilities; and
Section 27: Provides an effective date of July 1, 2012.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The Division of State Group Insurance may realize a reduction in health insurance costs statewide as both PPO plans and HMO plans lower premiums in response to the removal of several coverage mandates and mandated offerings of coverage, assuming the Division chooses not continue purchasing coverage for those benefits and assuming that insurers adjust their rates.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

Local governments, as employers, may realize reduction in health insurance costs as health insurance plans and HMOs lower premiums in response to the removal of several coverage mandates and mandated offerings of coverage, assuming local governments choose not to continue purchasing coverage for those benefits and assuming that insurers adjust their rates.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Employers, employees, and individual insureds may realize a reduction in premiums due to the elimination of coverage mandates, assuming they choose to continue purchasing coverage for those benefits, and assuming insurers adjust their rates.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditures of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES