# Health & Human Services Committee

**Thursday, March 19, 2015**
**9:00 AM - 11:00 AM**
**Morris Hall**

**Steve Crisafulli**
**Speaker**

**Jason Brodeur**
**Chair**

# Committee Meeting Notice

## HOUSE OF REPRESENTATIVES

### Health & Human Services Committee

**Start Date and Time:** Thursday, March 19, 2015 09:00 am

**End Date and Time:** Thursday, March 19, 2015 11:00 am

**Location:** Morris Hall (17 HOB)

**Duration:** 2.00 hrs

**Consideration of the following bill(s):**

HB 235 Restitution by Eagle
CS/HB 279 Pharmacy by Health Innovation Subcommittee, Pigman
CS/CS/HB 437 Guardians for Dependent Children who are Developmentally Disabled or Incapacitated by Civil Justice Subcommittee, Children, Families & Seniors Subcommittee, Adkins
HB 441 Home Health Agencies by Rodrigues, R.
CS/HB 655 Clinical Laboratories by Health Quality Subcommittee, Roberson, K.
CS/HB 751 Emergency Treatment for Opioid Overdose by Civil Justice Subcommittee, Gonzalez, Renuart
HB 4017 Pain-Management Clinics by Spano

**Consideration of the following proposed committee bill(s):**

PCB HHSC 15-02 -- State Group Insurance Program
PCB HHSC 15-03 -- Conscience Protection for Private Child-Placing Agencies

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members is 6:00 p.m., Wednesday, March 18, 2015.

By request of the chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Wednesday, March 18, 2015.

**NOTICE FINALIZED on 03/17/2015 16:09 by Iseminger.Bobbye**

HB 235

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 235 Restitution
**SPONSOR(S):** Eagle
**TIED BILLS:** None **IDEN./SIM. BILLS:** SB 312

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Criminal Justice Subcommittee | 13 Y, 0 N | Cox | Cunningham |
| 2) Health & Human Services Committee | | Guzzo | Calamas |
| 3) Justice Appropriations Subcommittee | | | |
| 4) Judiciary Committee | | | |

## SUMMARY ANALYSIS


Section 985.437, F.S., authorizes a court with jurisdiction over a child that has been adjudicated delinquent to order the child to pay restitution to the victim for any damage or loss caused by the child's offense in a reasonable amount or manner. Restitution may be satisfied by monetary payments, with a promissory note cosigned by the child's parent or guardian, or by performing community service. A parent or guardian may be absolved of liability for restitution in their child's criminal case if the court makes a finding that the parent or guardian has made "diligent and good faith efforts to prevent the child from engaging in delinquent acts."

The bill amends s. 985.437, F.S., to *require*, rather than authorize, the court to order a child *and* the child's parent or legal guardian to pay restitution in cases where court has determined that restitution is appropriate. The bill further amends s. 985.437, F.S., to:

- Authorize the court to set up a payment plan if the child and the child's parents or legal guardians are unable to pay the restitution in one lump-sum payment;
- Absolve a parent or guardian of any liability for restitution if, after a hearing:
  - The court finds that it is the child's first referral *and* the parent or guardian has made diligent and good faith efforts to prevent the child from engaging in delinquent acts; *or*
  - If the victim entitled to the restitution is that child's parent or guardian;
- Authorize the court to order both of the child's parents or guardians liable for such child's restitution, regardless of whether one parent has sole parental responsibility for the child; and
- Specify that the Department of Children and Families, a foster parent, or the community-based care lead agency supervising the placement of a child while under contract with the department is not considered a guardian responsible for restitution for the delinquent acts of a child who is found to be dependent.

The bill makes conforming changes to s. 985.35, F.S., and amends s. 985.513, F.S., to remove duplicative language relating to the court's authority to order a parent or guardian to be responsible for the child's restitution.

To the extent that the bill increases the number and/or length of restitution hearings, which must be conducted by the court prior to entering an order of restitution, it could create an insignificant increased workload on the courts.

The bill provides an effective date of July 1, 2015.

# FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

### A. EFFECT OF PROPOSED CHANGES:

**Background**

Restitution in Juvenile Criminal Cases

Currently, s. 985.437, F.S., authorizes, but does not require, a court with jurisdiction over a child that has been adjudicated delinquent to order the child to pay restitution to the victim for *any* damage[1] or loss caused by the child's offense[2] in a reasonable amount or manner.[3] Similarly, s. 985.35, F.S., authorizes the court to place a child found to have committed a violation of law in a probation program.[4] The probation program may include restitution in money or in kind.[5] The court determines the amount or manner of restitution that is reasonable.[6]

To enter an order of restitution, a trial court must first conduct a restitution hearing addressing the child's ability to pay and the amount of restitution to which the victim is entitled.[7] A restitution hearing is not required if the child previously entered into an agreement to pay[8] or has waived his or her right to attend a restitution hearing.[9] When restitution is ordered by the court, the amount of restitution may not exceed an amount the child or the parent or guardian could reasonably be expected to pay.[10]

Restitution may be satisfied by monetary payments, with a promissory note cosigned by the child's parent or guardian, or by performing community service.[11] However, a parent or guardian may be absolved of any liability for restitution if, after a hearing, the court finds that the parent or guardian has made "diligent and good faith efforts to prevent the child from engaging in delinquent acts."[12]

The clerk of the circuit court receives and dispenses restitution payments, and must notify the court if restitution is not made. The court may retain jurisdiction over a child and the child's parent or legal guardian whom the court has ordered to pay restitution until the restitution order is satisfied or until the court orders otherwise.[13]

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[1] "Any damage" has been interpreted by Florida's courts to include damage for pain and suffering. *C.W. v. State*, 655 So.2d 87 (Fla. 1995).

[2] The damage or loss must be directly or indirectly related to the child's offense or criminal episode. *L.R.L. v. State*, 9 So.3d 714 (Fla. 2d DCA 2009).

[3] If restitution is ordered, it becomes a condition of probation, or if the child is committed to a residential commitment program, part of community-based sanctions upon release from the program. Section 985.437(1), F.S.

[4] Section 985.35(4) and (5), F.S.

[5] Section 985.35(4)(a), F.S.

[6] Section 985.437(2), F.S.

[7] *J.G. v. State*, 978 So.2d 270 (Fla. 4th DCA 2008). If a court intends to establish an amount of restitution based solely on evidence adduced at a hearing of a charge of delinquency, the juvenile must be given notice.

[8] *T.P.H. v. State*, 739 So.2d 1180 (Fla. 4th DCA 1999).

[9] *T.L. v. State*, 967 So.2d 421 (Fla. 1st DCA 2007).

[10] Section 985.437(2), F.S.

[11] Section 985.437(2), F.S. Similar to the process for juveniles, a parent or guardian cannot be ordered to pay restitution arising from offenses committed by their minor child, without the court providing the parent with meaningful notice and an opportunity to be heard, or without making a determination of the parents' ability to do so. *See S.B.L. v. State*, 737 So.2d 1131 (Fla. 1st DCA 1999); *A.T. v. State*, 706 So.2d 109 (Fla. 2d DCA 1998); and *M.H. v. State*, 698 So.2d 395 (Fla. 4th DCA 1997).

[12] Section 985.437(4), F.S.

[13] Section 985.437(5), F.S.

Court's Powers over a Juvenile Offender's Parent or Guardian

Section 985.513, F.S., authorizes, but does not require, a court that has jurisdiction over a child that has been adjudicated delinquent to order the parents or guardians of such child to perform community service and participate in family counseling. The statute also authorizes the court to:

- Order the parent or guardian to make restitution in money or in kind for any damage or loss caused by the child's offense; and
- Require the child's parent or legal guardian to be responsible for any restitution ordered against the child, as provided under s. 985.437, F.S.[14]

Current law does not specifically exempt the Department of Children and Families, a foster parent, or a community-based care organization supervising a dependent child from paying restitution when a court requires the child's parent or legal guardian to be responsible for restitution ordered against the child.

Failing to Pay Restitution Order

Section 985.0301(h), F.S., states that the terms of restitution orders in juvenile criminal cases are subject to s. 775.089, F.S. Section 775.089, F.S., provides that a restitution order may be enforced in the same manner as a judgment in a civil lien. Thus, if a child or parent fails to pay court-ordered restitution, a civil lien may be placed upon the parent or child's real property.[15] The court may transfer a restitution order to a collection court or a private collection agency to collect unpaid restitution.[16]

**Effect of Proposed Changes**

The bill amends s. 985.437, F.S., to *require*, rather than authorize, the court to order a child *and* the child's parent or legal guardian to pay restitution in cases where court has determined that restitution is appropriate. The bill further amends s. 985.437, F.S., to authorize the court to set up a payment plan if the child and the child's parents or legal guardians are unable to pay the restitution in one lump-sum payment. The payment plan must reflect the ability of a child and the child's parent or legal guardian to pay the restitution amount.

The bill absolves a parent or guardian of any liability for restitution if, after a hearing:

- The court finds that it is the child's first referral *and* the parent or guardian has made diligent and good faith efforts to prevent the child from engaging in delinquent acts; *or*
- The victim entitled to the restitution is the child's parent or guardian.

The bill authorizes the court to order both of the child's parents or guardians liable for such child's restitution, regardless of whether one parent has sole parental responsibility for the child.

The bill specifies that the Department of Children and Families, which includes a foster parent or community-based care lead agency, is not considered a guardian responsible for restitution for the delinquent acts of a child who is found to be dependent, as defined in s. 39.01(15), F.S.

The bill makes conforming changes to s. 985.35, F.S., and amends s. 985.513, F.S., to remove duplicative language relating to the court's authority to order a parent or guardian to be responsible for the child's restitution.

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[14] Section 985.513(1)(b), F.S.
[15] Section 775.089(5), F.S.
[16] Section 985.045, F.S., also states that this is allowed in a case where the circuit court has retained jurisdiction over the child and the child's parent or legal guardian.

B. SECTION DIRECTORY:

**Section 1:** Amends s. 985.35, F.S., relating to adjudicatory hearings; withheld adjudications; orders of adjudication.
**Section 2:** Amends s. 985.437, F.S., relating to restitution.
**Section 3:** Amends s. 985.513, F.S., relating to powers of the court over parent or guardian at disposition.
**Section 4:** Provides an effective date of July 1, 2015.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill does not appear to have any impact on state revenues.

2. Expenditures:

   The bill amends s. 985.437, F.S., to require, rather than authorize, the court to order a child and the child's parent or legal guardian to pay restitution in cases where court has determined that restitution is appropriate. To enter an order of restitution, the court must conduct a restitution hearing. To the extent that the bill increases the number and/or length of restitution hearings, it may result in a workload increase for the court system.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   The bill does not appear to have any fiscal impact on local government revenues.

2. Expenditures:

   The bill does not appear to have any fiscal impact on local government expenditures.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Parents and legal guardians of children that have been adjudicated delinquent will be liable for restitution in money or in kind for damages caused by the child's offense. Therefore, a victim of a child's offense may be more likely to receive restitution.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill appears to be exempt from the requirements of Article VII, Section 18 of the Florida Constitution because it is a criminal law.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill does not appear to create a need for rulemaking or rulemaking authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to restitution for juvenile offenses;
3 amending s. 985.35, F.S.; conforming provisions to
4 changes made by the act; amending s. 985.437, F.S.;
5 requiring a child's parent or guardian, in addition to
6 the child, to make restitution for damage or loss
7 caused by the child's offense; providing for payment
8 plans in certain circumstances; authorizing the parent
9 or guardian to be absolved of liability for
10 restitution in certain circumstances; authorizing the
11 court to order both parents or guardians liable for
12 the child's restitution regardless of one parent or
13 guardian having sole parental responsibility;
14 specifying that the Department of Children and
15 Families, foster parents, and specified agencies
16 contracted with the department are not guardians for
17 purposes of restitution; amending s. 985.513, F.S.;
18 removing duplicative provisions authorizing the court
19 to require a parent or guardian to be responsible for
20 any restitution ordered against the child; providing
21 an effective date.
22
23 Be It Enacted by the Legislature of the State of Florida:
24
25 Section 1. Paragraph (a) of subsection (4) of section
26 985.35, Florida Statutes, is amended to read:

27 985.35 Adjudicatory hearings; withheld adjudications;
28 orders of adjudication.—
29 (4) If the court finds that the child named in the
30 petition has committed a delinquent act or violation of law, it
31 may, in its discretion, enter an order stating the facts upon
32 which its finding is based but withholding adjudication of
33 delinquency.
34 (a) Upon withholding adjudication of delinquency, the
35 court may place the child in a probation program under the
36 supervision of the department or under the supervision of any
37 other person or agency specifically authorized and appointed by
38 the court. The court may, as a condition of the program, impose
39 as a penalty component restitution in money or in kind to be
40 made by the child and the child's parent or guardian as provided
41 in s. 985.437, community service, a curfew, urine monitoring,
42 revocation or suspension of the driver license of the child, or
43 other nonresidential punishment appropriate to the offense, and
44 may impose as a rehabilitative component a requirement of
45 participation in substance abuse treatment, or school or other
46 educational program attendance.
47 Section 2. Subsection (5) of section 985.437, Florida
48 Statutes, is renumbered as subsection (7), subsections (1), (2),
49 and (4) are amended, and new subsections (5) and (6) are added
50 to that section, to read:
51 985.437 Restitution.—
52 (1) Regardless of whether adjudication is imposed or

53 withheld, the court that has jurisdiction over a ~~an adjudicated~~
54 ~~delinquent~~ child may, by an order stating the facts upon which a
55 determination of a sanction and rehabilitative program was made
56 at the disposition hearing, order the child and the child's
57 parent or guardian to make restitution in the manner provided in
58 this section. This order shall be part of the child's probation
59 program to be implemented by the department or, in the case of a
60 committed child, as part of the community-based sanctions
61 ordered by the court at the disposition hearing or before the
62 child's release from commitment.
63 (2) If the court orders restitution, the court shall ~~may~~
64 order the child and the child's parent or guardian to make
65 restitution in money, through a promissory note ~~cosigned by the~~
66 ~~child's parent or guardian~~, or in kind for any damage or loss
67 caused by the child's offense in a reasonable amount or manner
68 to be determined by the court. When restitution is ordered by
69 the court, the amount of restitution may not exceed an amount
70 the child and the parent or guardian could reasonably be
71 expected to pay or make. If the child and the child's parent or
72 guardian are unable to pay the restitution in one lump-sum
73 payment, the court may set up a payment plan that reflects their
74 ability to pay the restitution amount.
75 (4) The parent or guardian may be absolved of liability
76 for restitution under this section if:
77 (a) After a hearing, the court finds that it is the
78 child's first referral to the delinquency system and ~~A finding~~



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

79 ~~by the court, after a hearing,~~ that the parent or guardian has
80 made diligent and good faith efforts to prevent the child from
81 engaging in delinquent acts; or
82 (b) The victim entitled to restitution as a result of
83 damage or loss caused by the child's offense is that child's
84 ~~absolves the~~ parent or guardian ~~of liability for restitution~~
85 ~~under this section~~.
86 (5) The court may order both parents or guardians liable
87 for restitution associated with the child's care regardless of
88 whether one parent or guardian has sole parental responsibility.
89 (6) For purposes of this section, the Department of
90 Children and Families, a foster parent with whom the child is
91 placed, or the community-based care lead agency supervising the
92 placement of the child pursuant to a contract with the
93 Department of Children and Families is not considered a guardian
94 responsible for restitution for the delinquent acts of a child
95 who is found to be dependent as defined in s. 39.01(15).
96 Section 3. Subsection (1) of section 985.513, Florida
97 Statutes, is amended to read:
98 985.513 Powers of the court over parent or guardian at
99 disposition.—
100 (1) The court that has jurisdiction over an adjudicated
101 delinquent child may, by an order stating the facts upon which a
102 determination of a sanction and rehabilitative program was made
103 at the disposition hearing,~~:~~
104 ~~(a)~~ order the child's parent or guardian, together with

105 the child, to render community service in a public service
106 program or to participate in a community work project. In
107 addition to the sanctions imposed on the child, the court may
108 order the child's parent or guardian to perform community
109 service if the court finds that the parent or guardian did not
110 make a diligent and good faith effort to prevent the child from
111 engaging in delinquent acts.
112 ~~(b) Order the parent or guardian to make restitution in~~
113 ~~money or in kind for any damage or loss caused by the child's~~
114 ~~offense. The court may also require the child's parent or legal~~
115 ~~guardian to be responsible for any restitution ordered against~~
116 ~~the child, as provided under s. 985.437. The court shall~~
117 ~~determine a reasonable amount or manner of restitution, and~~
118 ~~payment shall be made to the clerk of the circuit court as~~
119 ~~provided in s. 985.437.~~ The court may retain jurisdiction, as
120 provided under s. 985.0301, over the child and the child's
121 parent or legal guardian whom the court has ordered to pay
122 restitution until the restitution order is satisfied or the
123 court orders otherwise.
124 Section 4. This act shall take effect July 1, 2015.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

| | |
|---|---|
| ADOPTED | ___ (Y/N) |
| ADOPTED AS AMENDED | ___ (Y/N) |
| ADOPTED W/O OBJECTION | ___ (Y/N) |
| FAILED TO ADOPT | ___ (Y/N) |
| WITHDRAWN | ___ (Y/N) |
| OTHER | ______ |

1 Committee/Subcommittee hearing bill: Health & Human Services
2 Committee
3 Representative Eagle offered the following:
4
5 **Amendment (with title amendment)**
6 Remove lines 86-93 and insert:
7 (5) The court may only order restitution to be paid by the
8 parents or guardians who have current custody and parental
9 responsibility.
10 (6) For purposes of this section, the Department of
11 Children and Families, a foster parent with whom the child is
12 placed, the community-based care lead agency supervising the
13 placement of the child pursuant to a contract with the
14 Department of Children and Families, or a facility registered
15 under s. 409.176 is not considered a guardian
16
17 -----------------------------------------------------

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

19 Remove lines 11-17 and insert:

20 court to order restitution to be paid only by the parents or
21 guardians who have current custody and parental responsibility
22 of the child; specifying that the Department of Children and
23 Families, foster parents, a facility registered under s.
24 409.176, and specified agencies contracted with the department
25 are not guardians for purposes of restitution; amending s.
26 985.513, F.S.;

CS/HB 279

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 279 Pharmacy
**SPONSOR(S):** Health Innovation Subcommittee; Pigman
**TIED BILLS:** **IDEN./SIM. BILLS:**

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Health Innovation Subcommittee | 11 Y, 1 N, As CS | Castagna | Poche |
| 2) Health & Human Services Committee | | Castagna | Calamas |

### SUMMARY ANALYSIS


Section 465.189, F.S., authorizes pharmacists to administer the influenza, pneumococcal, meningococcal, and shingles vaccines to adults within an established protocol with a supervising physician. Before administering a vaccine, a pharmacist must apply to the Board of Pharmacy (Board), under the Department of Health's (DOH) Division of Medical Quality Assurance, for immunization certification and pay a $55 fee. To obtain certification, a pharmacist must demonstrate that he or she has successfully completed a Board-approved 20-hour vaccine administration certification program regarding the safe and effective administration of vaccines.

HB 279 adds the following vaccines to the list of vaccines a certified pharmacist may provide:

- Vaccines listed in the Centers for Disease Control and Prevention's (CDC) Adult Immunization Schedule (Schedule);
- Vaccines listed in the CDC's Health Information for International Travel; and
- Vaccines approved by the Board in response to a state of emergency declared by the Governor.

The bill authorizes pharmacy interns to administer vaccines upon completion of a 20-hour Board-approved vaccine administration certification program and payment of a $55 fee. A pharmacy intern who is authorized to administer vaccines must be under the supervision of a pharmacist who is certified to administer vaccines.

The bill will generate an estimated positive fiscal impact of $239,034 in new fee revenue to DOH for the first biennium. A portion of the fees will be used for costs associated with administering the intern vaccine administration certification program. Therefore, it is expected to be a positive fiscal impact to the Department of Health.

The bill provides an effective date of July 1, 2015.



**This document does not reflect the intent or official position of the bill sponsor or House of Representatives.**

# FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Current situation**

Department of Health – Division of Medical Quality Assurance

The Department of Health's (DOH) Division of Medical Quality Assurance (MQA) regulates health care practitioners to ensure the health, safety and welfare of the public. There are 22 boards and 8 councils under the MQA, and the MQA licenses 7 types of facilities and 200-plus occupations in more than 40 health care professions.[1] MQA is responsible for the licensure of health care practitioners and facilities, the enforcement of law and rules governing practitioners and facilities, and providing information and data to the public.[2]

A professional board is a statutory entity within the MQA authorized to exercise regulatory or rulemaking authority over practitioners.[3] A board is responsible for approving or denying applications for licensure and making disciplinary decisions on whether a health care practitioner is acting within the authority of the applicable practice act. Practice acts are the legal authority in state statute that grants a profession the authority to provide services to the public. The range of disciplinary actions taken by a board includes citations, suspensions, reprimands, probations, and revocations.

Pharmacy Practice in Florida

Chapter 465, F.S., governs the practice of pharmacy in Florida. The Board of Pharmacy (Board) is authorized to adopt rules to implement the provisions of the Florida Pharmacy Act.[4]

Section 465.003(13), F.S., defines the "practice of the profession of pharmacy" to include:

- Compounding, dispensing, and consulting concerning contents, therapeutic values, and uses of any medicinal drug;
- Consulting concerning therapeutic values and interactions of patent and proprietary preparations, whether pursuant to prescriptions or in the absence and entirely independent of such prescriptions or orders;
- Any other act, service, operation, research, or transaction incidental to any authorized acts involving or employing the practice or science of the pharmaceutical profession, study, or training; and
- Transmitting information from persons authorized to prescribe medicinal drugs to their patients.

To become a licensed pharmacist, a person must submit:

- An application form and the required fees to DOH;
- Satisfactory proof that the applicant:
  - Is at least 18 years of age;
  - Received a degree from an accredited school or college of pharmacy; or
  - Graduated from a 4-year undergraduate pharmacy program of a school or college of pharmacy located outside the United States, has demonstrated proficiency in English, has passed the Foreign Pharmacy Graduate Equivalency Examination, and

[1] Florida Department of Health, *Florida Health Source*, available at http://www.flhealthsource.gov/ (last visited February 20, 2015).
[2] Id.
[3] S. 456.001, F.S.
[4] S. 465.005, F.S.

- Has completed a minimum of 500 hours in a supervised work activity program within Florida under the supervision of a pharmacist licensed by the DOH;
- Satisfactory proof that the applicant has completed an internship program, which must not exceed 2,080 hours; and
- Proof of successful completion of the licensure examination.[5]

A pharmacist license is renewed every two years by submitting an application, paying a $205 renewal fee, [6,7] and submitting proof of completion of at least 30 hours of continuing professional pharmaceutical education during the two years prior to application for renewal.[8] If a pharmacist is certified to administer vaccines, 3 completed continuing education hours must cover the safe and effective administration of vaccines and epinephrine autoinjection.[9]

*Pharmacy Interns*

To become a pharmacy intern, a person must be certified by the Board as enrolled in an intern program at an accredited school or college of pharmacy or as a graduate of an accredited school or college of pharmacy and not yet licensed as a pharmacist in Florida.[10] The Board's rules outline the registration process for pharmacy interns and the internship program requirements for U.S. pharmacy students or graduates and foreign pharmacy graduates.[11] There were 10,319 registered pharmacy interns in 2014.[12]

A pharmacist is responsible for any delegated act performed by a registered pharmacy intern employed or supervised by the pharmacist.[13]

*Pharmacist Vaccine Administration*

A pharmacist may become certified to administer the influenza, pneumococcal, meningococcal, and shingles vaccines to adults within an established protocol under a licensed supervising physician. A pharmacist is permitted to administer epinephrine to treat any allergic reaction resulting from a vaccine. The protocol between the pharmacist and the supervising physician dictates which types of patients to whom the pharmacist may administer allowable vaccines.[14] The terms, scope, and conditions set forth in the protocol must be appropriate to the pharmacist's training and certification. A supervising physician must review the administration of vaccines by the pharmacist.[15] A pharmacist is required to provide the Board a copy of the protocol.[16]

To be certified to administer vaccines, a pharmacist must successfully complete a Board-approved vaccine administration certification program. The certification program requires pharmacists to submit an application, pay a $55 fee to the Board, and complete 20 hours of Board-approved continuing education classes.[17] The continuing education classes must cover:

- Mechanisms of action for vaccines, contraindications, drug interactions, and monitoring after vaccine administration;
- Immunization schedules;

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[5] S. 465.007, F.S.
[6] Florida Board of Pharmacy, *Pharmacist*, available at http://floridaspharmacy.gov/renewals/pharmacist/ (last visited March 7, 2015).
[7] S. 465.008(1), F.S.
[8] S. 465.009, F.S.
[9] S. 465.009(6)(a), F.S.
[10] S. 465.013, F.S.
[11] Rule 64B16-26.2032, F.A.C. (U.S. pharmacy students/graduates); Rule 64B16-26.2033, F.A.C. (foreign pharmacy graduates).
[12] Florida Dep't of Health, *2015 Agency Legislative Bill Analysis HB 279,* February 9, 2015 (on file with committee staff).
[13] Rule 64B16-27.430, F.A.C.
[14] S. 465.189(7), F.S.
[15] Id.
[16] Id.
[17] Rule 64B16-26.1031, F.A.C.

- Immunization screening questions, provision of risk/benefit information, informed consent, recordkeeping, and electronic reporting into the statewide immunization registry maintained by DOH;
- Vaccine storage and handling;
- Bio-hazardous waste disposal and sterile technique;
- Entering, negotiating, and performing pursuant to physician oversight protocols;
- Community immunization resources and programs;
- Identifying, managing and responding to adverse incidents including but not limited to potential allergic reactions associated with vaccine administration;
- Procedures and policies for reporting adverse incidents to the Vaccine Adverse Event Reporting System;
- Reimbursement procedures and vaccine coverage by federal, state, and local governmental jurisdictions and private third party payers;
- Administration techniques;
- Administration of epinephrine using an autoinjector delivery system;
- Current CDC immunization guidelines and recommendations for influenza, pneumococcal, meningococcal, and shingles vaccinations;
- Review of the current law permitting a pharmacist to administer vaccinations and epinephrine; and
- CPR training.[18]

A pharmacist must also pass an examination and demonstrate vaccine administration technique.[19]

Pharmacists who are certified to administer vaccines must also maintain at least $200,000 of professional liability insurance.[20] A certified pharmacist is required to report all administered vaccinations to the state registry of immunization information, Florida SHOTS.[21] Approximately 11,323, or 37 percent, of active licensed pharmacists in Florida are certified to administer vaccines.[22]

Currently, pharmacy interns are not authorized to administer vaccines.

<u>Other State Laws on Pharmacist Vaccination</u>

All 50 states have laws authorizing pharmacists to administer vaccines to adults.[23] Forty two states authorize pharmacists to administer all Centers for Disease Control and Prevention (CDC) recommended vaccines.[24,25] Eight states, including Florida, limit pharmacists' vaccination authority to only a few CDC recommended vaccines. In addition, 39 states and U.S. territories allow pharmacy interns to administer vaccines under the supervision of a pharmacist.[26]

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[18] Id.
[19] Id.
[20] S. 465.189(3), F.S.
[21] Florida SHOTS is a statewide centralized online immunization registry that assists health-care providers and schools in keeping track of immunization records administered by the Florida Dep't of Health. Florida Shots, *Florida SHOTS Facts,* available at http://www.flshots.com/what/ (last visited March 4, 2015).
[22] Supra at FN 12.
[23] Id.
[24] Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, District of Columbia, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Massachusetts, Maryland, Maine, Michigan, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, and Wisconsin allow pharmacists to administer any CDC recommended vaccine. American Pharmacists Association, *Pharmacist Administered Vaccines,* available at http://www.pharmacist.com/types-vaccines-pharmacists-are-authorized-administer (last visited March 3, 2015).
[25] Association of State and Territorial Health Officials, *2013 State Immunization Legislation Summary,* available at http://www.astho.org/Programs/Immunization/Legislative-Tracking/ (last visited March 3, 2015).
[26] Supra at FN 26.

Pharmacists are typically required to complete specific certification or training in the administration of vaccines prior to authorization. Depending on patient age and vaccine type, most states require pharmacists to have formal permission to administer certain vaccines.[27] Some states require a patient-specific prescription, a protocol with a supervising physician or public health official, or both, before a pharmacist can administer certain vaccinations.[28]

CDC Immunization Recommendations

*Advisory Committee on Immunization Practices*

Since 1964, the Advisory Committee on Immunization Practices (ACIP) has provided guidance on immunization policy to the CDC. ACIP members are selected by the Secretary of the U.S. Department of Health and Human Services and have expertise in fields such as vaccinology, immunology, pediatrics, internal medicine, and infectious disease. ACIP guidance includes scheduling of vaccine doses, specific risk groups for whom vaccinations are recommended, and vaccine contraindications and precautions. [29]

*Adult Immunization Schedule*

ACIP annually issues the Adult Immunization Schedule (Schedule) which is the official federal guideline for the use of vaccines in the United States.[30] The Schedule provides a summary of ACIP [31] recommendations for vaccines routinely administered to adults and ensures current vaccination practices for specific indications such as age, immunosuppressant medical conditions, pregnancy, and chronic diseases.

Although some vaccines listed on the Schedule have been recommended since the 1940s, the official, annually endorsed Schedule was not introduced until 1995.[32] The Schedule has been continuously updated as more vaccines are developed. The current version of the Schedule, issued February 2015, includes the following vaccines: [33]

- Influenza;
- Tetanus, diphtheria, pertussis (Td/Tdap), a combination vaccine, which prevents disease complications such as: [34]
    - Whooping cough, a highly contagious infection that can lead to pneumonia;
    - Lockjaw and muscle spasms; and
    - Breathing problems;
- Varicella, which prevents chickenpox;[35]
- Human Papillomavirus (for females and males), which prevents cervical cancer in women;
- Zoster, which prevents shingles;[36]

[27] Association of State and Territorial Health Officials, *Pharmacy Legal Toolkit,* available at http://www.astho.org/infectious-disease/pharmacy-legal-toolkit/.(last visited March 2, 2015).
[28] Id.
[29] Centers for Disease Control and Prevention, *Structure, Role, and Procedures of the ACIP,* available at http://www.cdc.gov/vaccines/acip/committee/structure-role.html (last visited March 5, 2015).
[30] Immunization Action Coalition, *Vaccine Policy and Licensing,* available at http://www.immunize.org/vacpolicy/ (last visited February 13, 2015).
[31] The Schedule is also endorsed by the American Academy of Family Physicians, The American College of Physicians, American College of Obstetricians and Gynecologists and American College of Nurse-Midwives.
[32] College of Physicians of Philadelphia, *The History of Vaccines, The Development of the Immunization Schedule,* available at http://www.historyofvaccines.org/content/articles/development-immunization-schedule (last visited February 13, 2015).
[33] Centers for Disease Control and Prevention, *Adult Immunization Schedules*, available at http://www.cdc.gov/vaccines/schedules/hcp/adult.html (last visited March 4, 2015).
[34] There are 4 combination vaccines used to prevent diphtheria, tetanus, and pertussis. DTap and DT are given to children under 7 and Tdap and Td are given to older children and adults. Centers for Disease Control and Prevention, *Tetanus (Lockjaw) Vaccination,* available at http://www.cdc.gov/vaccines/vpd-vac/tetanus/ (last visited March 4, 2015).
[35] Varicella vaccines are recommended for adults who have never had chickenpox or shingles. Supra at FN 33.

- Measles, Mumps, and Rubella (MMR), a combination vaccine, which prevents viral infections;[37]
- Pneumococcal,[38] which prevents pneumococcal bacterial disease and resulting complications such as:
  - Pneumonia, which causes inflammation in the lungs; and
  - Bacteremia, which causes bacteria to enter the blood stream;
- Meningococcal, which prevents meningococcal bacterial disease and resulting complications such as meningitis;
- Hepatitis A and Hepatitis B;[39] and
- Haemophilus influenza type b (Hib).[40]

New vaccines are considered for addition to the schedule after licensure by the United States Food and Drug Administration. Not all newly licensed vaccines are added to the Schedule. Some licensed vaccines are only recommended for people who are traveling to areas where other vaccine preventable diseases, such as typhoid fever, occur.[41]

*CDC Health Information for International Travel*

CDC's Health Information for International Travel, commonly called the Yellow Book (Book), is published biannually by the CDC as a reference for those who advise international travelers about health risks.[42] The Book includes a complete catalog of travel-related diseases, up-to-date vaccine and booster recommendations, and destination specific environmental health information. The Book also includes advice on preventing and treating common travel-related ailments and tips for individuals traveling with special needs.[43] A team of approximately 200 experts update the Book to provide the latest CDC recommendations.[44]

Vaccinations are recommended by the CDC to protect international travelers from illness and prevent the importation of infectious diseases across international borders. The Book recommends that persons traveling internationally should be up to date on all CDC recommended vaccines.[45] The Book includes an immunization schedule that recommends additional vaccines that are not listed in the Schedule, including yellow fever, rotavirus, and polio vaccines.[46] The specific vaccinations recommended depend on the traveler's destination and other factors. Some of the most common vaccinations considered for travelers include hepatitis A, hepatitis B, meningococcal, polio (adult booster), rabies, typhoid fever, and yellow fever.[47]

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[36] A single dose of zoster vaccine is recommended for adults aged 60 years or older regardless of whether they report a prior episode of zoster (shingles). Id.
[37] Children are the primary recipients of the MMR vaccine, but it is also recommended for adults, born after 1956, who have not been previously vaccinated as these diseases can cause serious health complications. Id.
[38] Two types of pneumococcal vaccines are recommended by the CDC for adults aged 65 and older, the pneuomoccocal13-valent conjugate and the pneumococcal polysaccharide vaccines. Id.
[39] Hepatitis A causes an acute, treatable infection while Hepatitis B can cause chronic and serious health complications such as cirrhosis, liver cancer, and death. A combination vaccine is available for Hepatitis A and B. Centers for Disease Control and Prevention, *Hepatitis A FAQs for the Public*, available at http://www.cdc.gov/hepatitis/A/aFAQ.htm#overview (last visited March 4, 2015).
[40] The Meningococcal vaccine, along with Hepatitis A and B, pneumococcal, and Hib are recommended for subgroups of the adult population based on pre-existing medical conditions, occupation, or lifestyle. Supra at FN 33.
[41] Supra at FN 32.
[42] Centers for Disease Control and Prevention. *CDC Health Information for International Travel 2014* (online version). New York: Oxford University Press; 2014. available at http://wwwnc.cdc.gov/travel/yellowbook/2014/table-of-contents (last visited March 4, 2015).
[43] Centers for Disease Control and Prevention, *CDC Releases 2014 Edition of the "Yellow Book"* available at http://www.cdc.gov/media/releases/2013/p0806-2014-yellow-book.html (last visited March 4, 2015).
[44] Id.
[45] Supra at FN 42, ch. 2.
[46] Id. at ch. 2, Table 2-04.
[47] Id. At ch. 4.

State of Emergency

The scope of practice of certain regulated healthcare practitioners may be modified for emergency situations to meet the increased demand for services.[48] The legal authorities and mechanisms for modifying health care scope of practice for a state of emergency vary among states. Various states have permanently authorized modified scopes of practice during emergencies for pharmacists and other health care practitioners, either by statute or regulation. In this instance, these provisions may be activated by an emergency declaration by a governor, state health officer, or other authorized officials.[49]

In Florida, s. 252.36, F.S., describes the powers of the Governor in a state of emergency. In the event an emergency or disaster is beyond local control, the Governor may assume direct operational control over all or any part of the emergency management functions within the state.[50] The Governor is authorized to delegate such powers as he or she may deem prudent.[51] A state of emergency must be declared by executive order or proclamation by the Governor when an emergency or disaster has occurred or the threat of occurrence is imminent.[52]

**Effect of Proposed Changes**

HB 279 amends s. 465.189, F.S., to authorize licensed pharmacists and registered pharmacy interns, who are certified with the Board to administer vaccines, to administer those vaccines:

- Listed in the CDC's Adult Immunization Schedule;
- Recommended in the CDC's Health Information for International Travel; and
- Approved by the Board in response to a state of emergency declared by the Governor.

A registered pharmacy intern who is authorized to administer vaccinations must be under the supervision of a pharmacist who is certified to administer vaccines.

The bill requires a pharmacy intern to meet the same vaccine administration certification requirements as a pharmacist. To be certified, a pharmacy intern must complete 20 hours of coursework approved by the Board concerning the safe and effective administration of the vaccines listed in the bill and pay a fee of $55.

In addition to the vaccines that pharmacists are currently authorized to administer in s. 465.189, F.S., the inclusion of the CDC's official immunization recommendations in s. 465.189, F.S., also authorizes:

- Measles, mumps, rubella (MMR);
- Tetanus, diphtheria, pertussis (Td/Tdap);
- Varicella;
- Human Papillomavirus (HPV);
- Hepatitis A;
- Hepatitis B;
- Haemophilus influenza type b (Hib); and
- Vaccines recommended for international travel such as yellow fever and typhoid fever.

The bill provides an effective date of July 1, 2015.

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[48] Association of State and Territorial Health Officials, *Scope of Practice Issues in Public Health Emergencies,* available at http://www.astho.org/Programs/Preparedness/Public-Health-Emergency-Law/Scope-of-Practice-Toolkit/Scope-of-Practice-Issues-in-Public-Health-Emergencies-Fact-Sheet/ (last viewed March 4, 2015).
[49] Id.
[50] S. 252.36(1)(a), F.S
[51] Id.
[52] S. 252.36(1)(b), F.S

B. SECTION DIRECTORY:

**Section 1:** Amends s. 465.189, F.S., relating to administration of vaccines and epinephrine autoinjection.

**Section 2:** Provides an effective date of July 1, 2015.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Based on Fiscal Year 2013-14 data, there are 30,636 pharmacists registered by the Board, and 11,323, or 37 percent, are currently certified to administer vaccines. There are 10,914 registered pharmacy interns. It is assumed that 4,038 (10,914 X 37 percent) of the current registered pharmacy interns will apply for certification to administer vaccines. There were 1,855 applications seeking intern registration in the Fiscal Year 2013-14. It is assumed that 686 (1,855 x 37 percent) pharmacy interns will apply for vaccine administration certification.

   Revenues collected from the $55 certification fee are calculated based on an estimated 4,724 (4,038 current registered interns + 686 newly registered interns) applications for certification totaling $259,820 (4,724 x $55). The fees collected are subject to the 8 percent general revenue surcharge and $20,786 ($259,820 x .08) is deducted from the estimated amounts to be collected by DOH to be deposited in the General Revenue Fund. The total estimated revenue for the DOH for first biennium is $239,034 ($259,820 - $20,786).[53]

2. Expenditures:

   The bill will cause the DOH to experience a recurring increase in workload, associated with processing applications for vaccine certification for pharmacy interns, which can be absorbed within current resources.

   DOH will incur a non-recurring increase in workload, associated with updating the Licensing and Enforcement Information Database System, modifying the pharmacy intern application, updating the Pharmacy website, and rulemaking. This can be absorbed within current resources.

   DOH may experience an increase in workload costs associated with the receipt and processing of certification applications for registered pharmacy interns. The processing cost per application is $7.69. It is estimated that 4,724 applicants for certification will be submitted for processing equating to a cost of $36,328.[54]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Pharmacies that opt to allow pharmacists and pharmacy interns to administer the vaccinations may see an increase in customers seeking vaccinations.

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[53] Supra at FN 12

[54] Id.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill gives the DOH rulemaking authority to authorize additional immunizations or vaccines as they are added to the CDC Adult Immunization Schedule and to approve immunizations in response to a state of emergency declared by the Governor.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 10, 2015, the Health Innovation Subcommittee adopted an amendment and reported the bill favorable as a committee substitute. The amendment specified that pharmacy interns who are authorized to administer vaccines must be under the supervision of a pharmacist who is certified to administer vaccines. The amendment also changed the referenced CDC Adult Immunization Schedule to the February 1, 2015, version. This analysis is drafted to the committee substitute.

1 A bill to be entitled
2 An act relating to pharmacy; amending s. 465.189,
3 F.S.; authorizing a registered intern under the
4 supervision of a pharmacist to administer specified
5 vaccines to an adult; revising which vaccines may be
6 administered by a pharmacist or registered intern
7 under the supervision of a pharmacist; requiring a
8 registered intern seeking to administer vaccines to be
9 certified to administer such vaccines and to complete
10 a minimum amount of coursework; providing an effective
11 date.
12
13 Be It Enacted by the Legislature of the State of Florida:
14
15 Section 1. Subsections (1) and (6) of section 465.189,
16 Florida Statutes, are amended to read:
17 465.189 Administration of vaccines and epinephrine
18 autoinjection.—
19 (1) In accordance with guidelines of the Centers for
20 Disease Control and Prevention for each recommended immunization
21 or vaccine, a pharmacist, or a registered intern under the
22 supervision of a pharmacist who is certified under subsection
23 (6), may administer the following vaccines to an adult within
24 the framework of an established protocol under a supervising
25 physician licensed under chapter 458 or chapter 459:
26 (a) Immunizations or vaccines listed in the Adult

27 Immunization Schedule as of February 1, 2015, by the United
28 States Centers for Disease Control and Prevention. The board may
29 authorize, by rule, additional immunizations or vaccines as they
30 are added to the Adult Immunization Schedule I~~nfluenza vaccine~~.
31 (b) Immunizations or vaccines recommended by the United
32 States Centers for Disease Control and Prevention for
33 international travel as of July 1, 2015. The board may
34 authorize, by rule, additional immunizations or vaccines as they
35 are recommended by the United States Centers for Disease Control
36 and Prevention for international travel ~~Pneumococcal vaccine~~.
37 (c) Immunizations or vaccines approved by the board in
38 response to a state of emergency declared by the Governor
39 pursuant to s. 252.36 ~~Meningococcal vaccine~~.
40 ~~(d) Shingles vaccine.~~
41 (6) Any pharmacist or registered intern seeking to
42 administer vaccines to adults under this section must be
43 certified to administer such vaccines pursuant to a
44 certification program approved by the Board of Pharmacy in
45 consultation with the Board of Medicine and the Board of
46 Osteopathic Medicine. The certification program shall, at a
47 minimum, require that the pharmacist attend at least 20 hours of
48 continuing education classes approved by the board and the
49 registered intern complete at least 20 hours of coursework
50 approved by the board. The program shall have a curriculum of
51 instruction concerning the safe and effective administration of
52 such vaccines, including, but not limited to, potential allergic

53 reactions to such vaccines.

54 Section 2. This act shall take effect July 1, 2015.

CS/CS/HB 437

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/CS/HB 437 Guardians for Dependent Children who are Developmentally Disabled or Incapacitated
**SPONSOR(S):** Civil Justice Subcommittee; Children, Families & Seniors Subcommittee; Adkins and others
**TIED BILLS:** None **IDEN./SIM. BILLS:** CS/SB 496

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Children, Families & Seniors Subcommittee | 11 Y, 0 N, As CS | Tuszynski | Brazzell |
| 2) Civil Justice Subcommittee | 13 Y, 0 N, As CS | Malcolm | Bond |
| 3) Health & Human Services Committee | | Tuszynski | Calamas |

## SUMMARY ANALYSIS


The bill creates a framework for identifying and appointing guardian advocates, limited guardians, and plenary guardians for developmentally disabled children who may require decision-making assistance beyond their 18th birthday. It also authorizes guardianship courts to exercise jurisdiction over dependent children nearing their 18th birthday to appoint guardian advocates, limited guardians, and plenary guardians. The bill:

- Requires the court to conduct an annual review of the continued necessity of a guardianship for young adults in extended foster care who already have a guardian advocate or guardian;
- Requires the Department of Children and Families (DCF) to develop an updated case plan for any child who may require the assistance of a guardian advocate, limited guardian, or plenary guardian;
- Requires that upon a judge's finding that no less restrictive decision-making assistance will meet the child's needs:
  - DCF must complete a report and identify individuals who are willing to serve as a guardian advocate or as a plenary or limited guardian; and
  - Proceedings for the appointment of a guardian advocate, plenary guardian, or limited guardian may be initiated in a separate proceeding in guardianship court within 180 days of the child's $17^{th}$ birthday.
- Requires that a minor who is 17 and one-half years of age and is subject to guardianship proceedings must receive all the due process rights of an adult; and
- Allows the child's parents to remain the child's natural guardians unless the parents' rights have been terminated or the dependency or guardianship court determines it is not in the child's best interest.

The bill does not appear to have a fiscal impact on state or local government.

The bill provides an effective date of July 1, 2015.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Present Situation**

Guardianships

There is a wide range of options to provide decision-making assistance to people with developmental disabilities or other incapacity that are not as restrictive as guardianships.[1] Examples include a power of attorney to officially act for the owner of a bank account;[2] general powers of attorney;[3] durable powers of attorney;[4] representative payee of benefits; advance directives; medical proxies; trusts; and guardian advocates (a less restrictive form of guardianship that does not require an adjudication of incapacity).[5] Guardianships that place decision-making authority for property and person with another individual require an examining committee to determine that the alleged incapacitated adult lacks decision-making capacity and requires an adjudication of incapacity by a judge.[6] This form of guardianship is considered the most restrictive and generally a last resort because it removes fundamental and civil rights of an individual to make decisions concerning his or her property and, in the most restrictive cases, his or her own care.[7] The level of decision-making assistance should not be more restrictive than required for that particular individual's needs and capacity.

*Guardianships for Children with Developmental Disabilities*

When a minor[8] with developmental disabilities or some level of incapacity ages out of the dependency system, there is a gap between the time he or she turns 18 years of age and the time a guardian advocate, limited guardian, or plenary guardian is appointed.[9] This creates a period in which the individual who may be in need of a guardian is considered an adult (*sui juris*, or "of one's own right")[10] but is likely unable to adequately make decisions for himself or herself. Two separate issues create this gap: first, the lack of a procedure within the dependency system to identify adults willing to serve as guardians or guardian advocates for these minors as they reach 18 years of age; and second, a jurisdictional issue in which probate courts will only exercise jurisdiction and begin guardianship proceedings after the child reaches 18 years of age. The latter is because there is a distinction in current law between adult guardianships and guardianships for minors. This distinction is the most significant barrier to obtaining guardians for minors who need them when they turn 18.[11]

For adult guardianships, current law requires an adjudication of incapacity based on the recommendation of an examining committee, the appointment of an attorney to represent the adult, and that the adult be present at the hearing before appointing a guardian.[12] For a guardianship of a minor, an adjudication of incapacity, an attorney's appointment, and the minor's presence at the hearing are

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[1] *Lighting the Way to Guardianship and Other Decision-Making Alternatives: A Manual for Individuals and Families*, 2010, Florida Developmental Disabilities Council, Inc.
[2] Ch. 709, F.S.
[3] Id.
[4] Id.
[5] S. 744.3085, F.S.
[6] S. 744.331, F.S.
[7] Supra. at FN 1.
[8] Any person who has not attained the age of 18 years, s. 1.01(13), F.S.
[9] Email from Alan Abramowitz, Executive Director of the Statewide Guardian ad Litem Program, on November 7, 2014; on file with Children, Families & Seniors Subcommittee staff.
[10] S. 743.07(1), F.S.
[11] Supra. at FN 9.
[12] S.744.331, F.S.

not required.[13] The waiver of these due process protections for minors is because the minor is not *sui juris*, and the guardianship of a minor terminates by law upon reaching age 18.

While both the dependency and probate courts are circuit courts in the state with general jurisdiction, each operates under different rules of procedure and areas of statute. Dependency courts work primarily within ch. 39, F.S., handling cases that deal with the abandonment, abuse, and neglect of children, whereas probate court works primarily with chs. 731 through 735, 744, and 747, F.S., dealing with wills, trusts, estates, guardianships, conservatorships, and other property and succession matters.

Under current law, probate courts will not entertain a petition for an adult guardianship for a minor. According to the Guardian ad Litem program, based on their discussions with the judiciary and probate practitioners, without amending current law it is unlikely that probate courts will engage in providing adult guardianships to minors in anticipation of the minor turning 18.[14] Currently, for those minors who have been identified as needing a guardianship as an adult, DCF recruits pro bono attorneys with the requisite experience to file a guardianship petition once they turn 18.

**Effect of Proposed Changes:**

The bill creates a procedure for DCF and circuit courts regarding those children within the dependency system that have been identified as possibly requiring some form of legal guardianship when they reach 18 years of age.

The bill amends s. 39.701, F.S., to require DCF to create an updated case plan for any child that meets the requirements for the appointment of a guardian or guardian advocate. The updated case plan must be based on a face-to-face conference with the child and, if appropriate, the child's attorney, any court-appointed guardian ad litem, the temporary custodian of the child, and the parent, if the parent's rights have not been terminated.

If the court determines at the first judicial review hearing after the child's 17th birthday that there is a good faith basis to believe that the child qualifies for appointment of a guardian advocate, limited guardian, or plenary guardian, and that no less restrictive decision-making assistance will meet the child's needs, then:

1) DCF must complete a multidisciplinary report, which must include a psychosocial evaluation if one has not been completed within the previous two years.
2) DCF must identify individuals who are willing to serve as the guardian advocate, plenary guardian, or limited guardian. The child's parents may not be considered unless the court enters a written order finding such an appointment is in the child's best interest; and
3) Guardianship proceedings may be initiated within 180 days after the child's 17th birthday. The bill encourages the use of pro bono representation to initiate the guardianship proceedings.

In the event that another interested party, such as a pro bono attorney, initiates guardianship proceedings, the bill requires DCF to provide all necessary documentation and information to the petitioner within 45 days after the first judicial review hearing after the child's 17th birthday.

The bill also provides that the guardianship proceedings must be conducted in separate proceedings in the guardianship court, not the dependency court.

The bill amends s. 393.12, F.S., to authorize the guardianship court to take jurisdiction of a minor who is the subject of a ch. 39, F.S., proceeding and initiate guardianship proceedings once the minor reaches the age of 17 years and 6 months or anytime thereafter. The minor must be provided the same due process rights as an adult.

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[13] SS. 744.3021 and 744.342, F.S.

[14] Supra. at FN 9.

The bill amends s. 744.301, F.S., to provide that if a parent's rights have been terminated, the parent is not the natural guardian of the minor. If the minor is the subject of a ch. 39, F.S., dependency proceeding, the parents retain their rights as natural guardians unless the dependency or guardianship court finds that it is not in the child's best interest.

The bill amends s. 744.3021, F.S., requiring that minors who are the subject of a ch. 39, F.S., dependency proceeding and aged 17 years and 6 months be given the same due process rights as an adult. It also requires the order of adjudication of incapacity and the letters of limited or plenary guardianship to issue upon the minor's 18th birthday or as soon thereafter as possible.

The bill amends s. 39.6251, F.S., to require annual reviews of the continued necessity of a guardianship for a young adult[15] in extended foster care for whom a guardian advocate or guardian has already been appointed. The review must also address whether restoration of guardianship proceedings are needed when the young adult reaches 22 years of age.

B. SECTION DIRECTORY:

**Section 1:** Amends s. 39.6251, F.S., relating to annual review.
**Section 2:** Amends s. 39.701, F.S., relating to judicial review.
**Section 3:** Amends s. 393.12, F.S., relating to capacity; appointment of guardian advocate.
**Section 4:** Amends s. 744.301, F.S., relating to natural guardians.
**Section 5:** Amends s. 744.3021, F.S., relating to guardians of minors.
**Section 6:** Provides for an effective date of July 1, 2015.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

[15] "Young adult" is defined as " an individual who has attained 18 years of age but who has not attained 21 years of age." S. 39.6251(1), F.S.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 17, 2015, the Children, Families & Seniors Subcommittee adopted a strike-all amendment. The amendment made the following changes:

- Amended s. 39.6251, F.S., to require annual review of the continued necessity of guardianship for a young adult in extended foster care already appointed a guardian advocate or guardian.
- Changed language to incorporate the requirements of ch. 744, F.S., and s. 393.12, F.S., to determine any child that may require the appointment of a guardian advocate or guardian, removing the language specifying, "developmentally disabled or incapacitated."
- Added language requiring a court to determine a good-faith basis for requesting appointment of a guardian advocate or guardian as well as a determination that no less restrictive decision-making assistance will meet the child's needs.
- Removed language requiring the DCF to initiate guardianship proceedings in probate court.

The bill was reported favorably as a committee substitute.

On March 4, 2015, the Civil Justice Subcommittee adopted one amendment and reported the bill favorably as a committee substitute. The amendment:

- Specifies that the proceedings seeking appointment of a guardian advocate or guardian be conducted separately from any other proceeding;
- Removes references to local rules of judicial administration and the Florida Probate Rules;
- Removes the requirement that guardianship proceedings be initiated if the court determines that that the child qualifies for appointment of a guardian advocate, limited guardian, or plenary guardian and that no less restrictive decision-making assistance will meet the child's needs;
- Encourages the use of pro bono representation to initiate guardianship proceedings; and
- Requires guardian advocate and guardianship proceedings be conducted in guardianship court rather than probate court.

This analysis is drafted to the committee substitute as passed by the Civil Justice Subcommittee.

1 A bill to be entitled
2 An act relating to guardians for dependent children
3 who are developmentally disabled or incapacitated;
4 amending s. 39.6251, F.S.; requiring the continued
5 review of the necessity of guardianships for young
6 adults; amending s. 39.701, F.S.; requiring an updated
7 case plan developed in a face-to-face conference with
8 the child, if appropriate, and other specified
9 persons; providing requirements for the Department of
10 Children and Families when a court determines that
11 there is a good faith basis to appoint a guardian
12 advocate, limited guardian, or plenary guardian for
13 the child and that no less restrictive decisionmaking
14 assistance will meet the child's needs; requiring the
15 department to provide specified information if another
16 interested party or participant initiates proceedings
17 for the appointment of a guardian advocate, plenary
18 guardian, or limited guardian for the child; requiring
19 that proceedings seeking appointment of a guardian
20 advocate or a determination of incapacity and the
21 appointment of a guardian be conducted in a separate
22 proceeding in guardianship court; amending s. 393.12,
23 F.S.; providing that the guardianship court has
24 jurisdiction over proceedings for appointment of a
25 guardian advocate if petitions are filed for certain
26 minors who are subject to chapter 39, F.S.,

27 proceedings if such minors have attained a specified
28 age; providing that such minor has the same due
29 process rights as certain adults; providing
30 requirements for when an order appointing a guardian
31 advocate must be issued; providing that proceedings
32 seeking appointment of a guardian advocate for certain
33 minors be conducted separately from any other
34 proceeding; amending s. 744.301, F.S.; providing that
35 if a child is subject to proceedings under chapter 39,
36 F.S., the parents may act as natural guardians unless
37 the court finds that it is not in the child's best
38 interests or their parental rights have been
39 terminated; amending s. 744.3021, F.S.; requiring the
40 guardianship court to initiate proceedings for
41 appointment of guardians for certain minors who are
42 subject to chapter 39, F.S., proceedings if petitions
43 are filed and if such minors have reached a specified
44 age; providing that such minor has the same due
45 process rights as certain adults; providing
46 requirements for when an order of adjudication and
47 letters of limited or plenary guardianship must be
48 issued; providing that proceedings seeking appointment
49 of a guardian advocate for certain minors be conducted
50 separately from any other proceeding; providing an
51 effective date.
52

53 Be It Enacted by the Legislature of the State of Florida:
54
55 Section 1. Subsection (8) of section 39.6251, Florida
56 Statutes, is amended to read:
57 39.6251 Continuing care for young adults.—
58 (8) During the time that a young adult is in care, the
59 court shall maintain jurisdiction to ensure that the department
60 and the lead agencies are providing services and coordinate
61 with, and maintain oversight of, other agencies involved in
62 implementing the young adult's case plan, individual education
63 plan, and transition plan. The court shall review the status of
64 the young adult at least every 6 months and hold a permanency
65 review hearing at least annually. <u>If the young adult is</u>
66 <u>appointed a guardian under chapter 744 or a guardian advocate</u>
67 <u>under s. 393.12, at the permanency review hearing the court</u>
68 <u>shall review the necessity of continuing the guardianship and</u>
69 <u>whether restoration of guardianship proceedings are needed when</u>
70 <u>the young adult reaches 22 years of age.</u> The court may appoint a
71 guardian ad litem or continue the appointment of a guardian ad
72 litem with the young adult's consent. The young adult or any
73 other party to the dependency case may request an additional
74 hearing or review.
75 Section 2. Paragraphs (b) and (c) of subsection (3) of
76 section 39.701, Florida Statutes, are amended to read:
77 39.701 Judicial review.—
78 (3) REVIEW HEARINGS FOR CHILDREN 17 YEARS OF AGE.—

79 (b) At the first judicial review hearing held subsequent
80 to the child's 17th birthday, the department shall provide the
81 court with an updated case plan that includes specific
82 information related to the independent living skills that the
83 child has acquired since the child's 13th birthday, or since the
84 date the child came into foster care, whichever came later.
85 1. For any child that may meet the requirements for
86 appointment of a guardian pursuant to chapter 744, or a guardian
87 advocate pursuant to s. 393.12, the updated case plan must be
88 developed in a face-to-face conference with the child, if
89 appropriate; the child's attorney; any court-appointed guardian
90 ad litem; the temporary custodian of the child; and the parent,
91 if the parent's rights have not been terminated.
92 2. At the judicial review hearing, if the court determines
93 pursuant to chapter 744 that there is a good faith basis to
94 believe that the child qualifies for appointment of a guardian
95 advocate, limited guardian, or plenary guardian for the child
96 and that no less restrictive decisionmaking assistance will meet
97 the child's needs:
98 a. The department shall complete a multidisciplinary
99 report which must include, but is not limited to, a psychosocial
100 evaluation and educational report if such a report has not been
101 completed within the previous 2 years.
102 b. The department shall identify one or more individuals
103 who are willing to serve as the guardian advocate pursuant to s.
104 393.12 or as the plenary or limited guardian pursuant to chapter

105 744. Any other interested parties or participants may make
106 efforts to identify such a guardian advocate, limited guardian,
107 or plenary guardian. The child's biological or adoptive family
108 members, including the child's parents if the parents' rights
109 have not been terminated, may not be considered for service as
110 the plenary or limited guardian unless the court enters a
111 written order finding that such an appointment is in the child's
112 best interests.
113 c. Proceedings may be initiated within 180 days after the
114 child's 17th birthday for the appointment of a guardian
115 advocate, plenary guardian, or limited guardian for the child in
116 a separate proceeding in the court division with jurisdiction
117 over guardianship matters and pursuant to chapter 744. The
118 Legislature encourages the use of pro bono representation to
119 initiate proceedings under this section.
120 3. In the event another interested party or participant
121 initiates proceedings for the appointment of a guardian
122 advocate, plenary guardian, or limited guardian for the child,
123 the department shall provide all necessary documentation and
124 information to the petitioner to complete a petition under s.
125 393.12 or chapter 744 within 45 days after the first judicial
126 review hearing after the child's 17th birthday.
127 4. Any proceedings seeking appointment of a guardian
128 advocate or a determination of incapacity and the appointment of
129 a guardian must be conducted in a separate proceeding in the
130 court division with jurisdiction over guardianship matters and

131 pursuant to chapter 744.
132 (c) If the court finds at the judicial review hearing that
133 the department has not met its obligations to the child as
134 stated in this part, in the written case plan, or in the
135 provision of independent living services, the court may issue an
136 order directing the department to show cause as to why it has
137 not done so. If the department cannot justify its noncompliance,
138 the court may give the department 30 days within which to
139 comply. If the department fails to comply within 30 days, the
140 court may hold the department in contempt.
141 Section 3. Paragraph (c) is added to subsection (2) of
142 section 393.12, Florida Statutes, to read:
143 393.12 Capacity; appointment of guardian advocate.—
144 (2) APPOINTMENT OF A GUARDIAN ADVOCATE.—
145 (c) If a petition is filed pursuant to this section
146 requesting appointment of a guardian advocate for a minor who is
147 the subject of any proceeding under chapter 39, the court
148 division with jurisdiction over guardianship matters has
149 jurisdiction over the proceedings pursuant to this section when
150 the minor reaches the age of 17 years and 6 months or anytime
151 thereafter. The minor shall be provided all the due process
152 rights conferred upon an alleged developmentally disabled adult
153 pursuant to this chapter. The order of appointment of a guardian
154 advocate under this section shall issue upon the minor's 18th
155 birthday or as soon thereafter as possible. Any proceeding
156 pursuant to this paragraph shall be conducted separately from

157 any other proceeding.
158 Section 4. Subsection (1) of section 744.301, Florida
159 Statutes, is amended to read:
160 744.301 Natural guardians.—
161 (1) The parents jointly are the natural guardians of their
162 own children and of their adopted children, during minority,
163 unless the parents' parental rights have been terminated
164 pursuant to chapter 39. If a child is the subject of any
165 proceeding under chapter 39, the parents may act as natural
166 guardians under this section unless the court division with
167 jurisdiction over guardianship matters finds that it is not in
168 the child's best interests. If one parent dies, the surviving
169 parent remains the sole natural guardian even if he or she
170 remarries. If the marriage between the parents is dissolved, the
171 natural guardianship belongs to the parent to whom sole parental
172 responsibility has been granted, or if the parents have been
173 granted shared parental responsibility, both continue as natural
174 guardians. If the marriage is dissolved and neither parent is
175 given parental responsibility for the child, neither may act as
176 natural guardian of the child. The mother of a child born out of
177 wedlock is the natural guardian of the child and is entitled to
178 primary residential care and custody of the child unless the
179 court enters an order stating otherwise.
180 Section 5. Subsection (1) of section 744.3021, Florida
181 Statutes, is amended, and subsection (4) is added to that
182 section, to read:

183 744.3021 Guardians of minors.—
184 (1) Except as provided in subsection (4), upon petition of
185 a parent, brother, sister, next of kin, or other person
186 interested in the welfare of a minor, a guardian for a minor may
187 be appointed by the court without the necessity of adjudication
188 pursuant to s. 744.331. A guardian appointed for a minor,
189 whether of the person or property, has the authority of a
190 plenary guardian.
191 (4) If a petition is filed pursuant to this section
192 requesting appointment of a guardian for a minor who is the
193 subject of any proceeding under chapter 39 and who is aged 17
194 years and 6 months or older, the court division with
195 jurisdiction over guardianship matters has jurisdiction over the
196 proceedings under s. 744.331. The alleged incapacitated minor
197 under this subsection shall be provided all the due process
198 rights conferred upon an alleged incapacitated adult pursuant to
199 this chapter and applicable court rules. The order of
200 adjudication under s. 744.331 and the letters of limited or
201 plenary guardianship may issue upon the minor's 18th birthday or
202 as soon thereafter as possible. Any proceeding pursuant to this
203 subsection shall be conducted separately from any other
204 proceeding.
205 Section 6. This act shall take effect July 1, 2015.

HB 441

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 441 Home Health Agencies
**SPONSOR(S):** Rodrigues
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 816

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Health Innovation Subcommittee | 13 Y, 0 N | Guzzo | Poche |
| 2) Health Care Appropriations Subcommittee | 12 Y, 0 N | Clark | Pridgeon |
| 3) Health & Human Services Committee | | Guzzo | Calamas |

### SUMMARY ANALYSIS


A home health agency (HHA) is an organization that provides home health services and staffing services. Home health services provided by an HHA include health and medical services and medical equipment provided to an individual in his or her home, such as nursing care, physical and occupational therapy, and home health aide services. HHAs are regulated by the Agency for Health Care Administration (AHCA) pursuant to part III of chapter 400, F.S.

An HHA that is a Medicare or Medicaid provider, or shares a common controlling interest with a provider that is a Medicare or Medicaid provider, must submit a quarterly report to AHCA, within 15 days after the end of each calendar quarter. The report must include:

- The number of insulin dependent diabetic patients receiving insulin-injection services from the HHA;
- The number of patients receiving home health services from the HHA while also receiving hospice services;
- The number of patients receiving home health services; and
- The name and license number of each nurse who received remuneration from the HHA in excess of $25,000 during the calendar quarter.

An HHA that submits the report late is fined $200 per day until AHCA receives the report, but the total fine imposed may not exceed $5,000 per quarter.

HB 441 removes the quarterly reporting requirement, and associated fines for late submittal of the report, for HHAs. Instead, the bill requires all HHAs to submit the number of patients receiving home health services to AHCA during the licensure renewal process.

The bill has an indeterminate negative fiscal impact on state government as there will be a reduction in revenues resulting from the elimination of associated fines; however, prior fine collections have been minimal, therefore the impact is not expected to be significant. Regulatory operation costs are covered by licensure fees.

The bill provides an effective date of July 1, 2015.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

Home Health Agencies

A home health agency (HHA) is an organization that provides home health services and staffing services.[1] Home health services provided by an HHA include health and medical services, such as nursing care, physical and occupational therapy, home health aide services, and medical equipment provided to an individual in his or her home.[2] HHAs are regulated by the Agency for Health Care Administration (AHCA) pursuant to part III of chapter 400, F.S.

Current law[3] requires HHAs that are Medicare or Medicaid providers, or share a common controlling interest with a provider that is a Medicare or Medicaid provider, to submit a quarterly report to AHCA, within 15 days after the end of each calendar quarter. The report must include:

- The number of insulin dependent diabetic patients receiving insulin-injection services from the HHA;
- The number of patients receiving home health services from the HHA while also receiving hospice services;
- The number of patients receiving home health services; and
- The name and license number of each nurse who received remuneration from the HHA in excess of $25,000 during the calendar quarter.

An HHA is exempt from submitting the report if it is not a Medicare or Medicaid provider or does not share a controlling interest with a provider that is a Medicare or Medicaid provider.

Fines for Late or Non-Reporting of Quarterly Report

In 2008, the Legislature authorized AHCA to impose a fine against an HHA that commits certain fraudulent acts.[4] The legislation also required HHAs to submit a quarterly report to AHCA to assist in identifying possible fraudulent activity and authorized AHCA to impose a fine of $5,000 for late or non-reporting. In 2013, the Legislature reduced the mandatory fine amount for late or non-reporting of the quarterly report from $5,000 to $200 per day, up to a maximum of $5,000 per quarter.[5]

Since July 1, 2008, $8,317,650 in fines has been assessed against HHAs.[6] The amount of fines has decreased annually since July 1, 2013, when the law was changed to reduce the amount of the fine.[7] The following table provides an overview of the HHA reporting fines assessed and collected by AHCA annually, since 2008.[8]

---

[1] S. 400.462(12), F.S.
[2] S. 400.462(14), F.S.
[3] S. 400.474(7), F.S.
[4] Ch. 2008-246, Laws of Fla.
[5] Ch. 2013-133, Laws of Fla.
[6] Florida Agency for Health Care Administration, 2015 *Agency Legislative Bill Analysis for HB 441,* page 2 (on file with Health Innovation Subcommittee staff).
[7] Id.
[8] Id.

| Fiscal Year | Fines Assessed | Fines Collected |
|---|---|---|
| FY 2008-09 | $485,5000 | $375,000 |
| FY 2009-10 | $2,921,100 | $2,254,533 |
| FY 2010-11 | $1,945,750 | $1,298,250 |
| FY 2011-12 | $927,750 | $711,750 |
| FY 2012-13 | $925,000 | $603,000 |
| FY 2013-14 | $723,250 | $263,375 |
| FY 2014-15 | $389,300 | $129,200 |
| **Total** | **$8,317,650** | **$5,635,108** |

**Effect of Proposed Changes**

The bill removes the quarterly reporting requirement, and associated fine provisions for late reporting, for HHAs that are Medicare or Medicaid providers. Instead, the bill requires all HHAs to submit the number of patients receiving home health services to AHCA during the licensure renewal process.

B. SECTION DIRECTORY:

**Section 1:** Amends s. 400.474, F.S., relating to administrative penalties for home health agencies.
**Section 2:** Provides an effective date of July 1, 2015.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill removes an HHA quarterly reporting requirement and the fines associated with the failure to timely file the report. As a result, there will be a reduction of fine revenues. Although the amount of fines collected for failure to timely file the quarterly report required by s. 400.474(7), F.S., has dropped significantly each year since FY 2009-10, the impact of the elimination of quarterly report fine revenue is indeterminate. Fines and licensure fees are deposited in the Agency's Health Care Trust fund and licensure fees are used to support the regulatory operations.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

HHAs may realize a reduction of administrative costs associated with submitting information to AHCA every two years instead of every quarter. Also, HHAs will no longer be fined for late filing of the report under s. 400.474(7), F.S.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rule making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to home health agencies; amending s. 400.474, F.S.; revising the information that a home health agency is required to submit to the Agency for Health Care Administration for license renewal; removing requirement that a home health agency submit quarterly reports; providing an effective date.

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

Section 1. Subsection (7) of section 400.474, Florida Statutes, is amended to read:

400.474 Administrative penalties.—

(7) A home health agency shall submit to the agency, with each license renewal application, the number of patients who receive home health services from the home health agency on the day that the license renewal application is filed~~, within 15 days after the end of each calendar quarter, a written report that includes the following data as they existed on the last day of the quarter:~~

~~(a) The number of insulin-dependent diabetic patients who receive insulin-injection services from the home health agency~~.

~~(b) The number of patients who receive both home health services from the home health agency and hospice services.~~

~~(c) The number of patients who receive home health services from the home health agency.~~

27 ~~(d) The name and license number of each nurse whose~~
28 ~~primary job responsibility is to provide home health services to~~
29 ~~patients and who received remuneration from the home health~~
30 ~~agency in excess of $25,000 during the calendar quarter.~~
31
32 ~~If the home health agency fails to submit the written quarterly~~
33 ~~report within 15 days after the end of each calendar quarter,~~
34 ~~the Agency for Health Care Administration shall impose a fine~~
35 ~~against the home health agency in the amount of $200 per day~~
36 ~~until the Agency for Health Care Administration receives the~~
37 ~~report, except that the total fine imposed pursuant to this~~
38 ~~subsection may not exceed $5,000 per quarter. A home health~~
39 ~~agency is exempt from submission of the report and the~~
40 ~~imposition of the fine if it is not a Medicaid or Medicare~~
41 ~~provider or if it does not share a controlling interest with a~~
42 ~~licensee, as defined in s. 408.803, which bills the Florida~~
43 ~~Medicaid program or the Medicare program.~~
44 Section 2. This act shall take effect July 1, 2015.



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

CS/HB 655

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 655 Clinical Laboratories
**SPONSOR(S):** Health Quality Subcommittee; Roberson
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 738

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Health Quality Subcommittee | 9 Y, 0 N, As CS | Guzzo | O'Callaghan |
| 2) Health & Human Services Committee | | Guzzo | Calamas |


## SUMMARY ANALYSIS

A clinical laboratory is a location in which body fluids or tissues are analyzed for purposes of the diagnosis, assessment, or prevention of a medical condition. Clinical laboratories may be free-standing facilities, may be part of a hospital, or may be part of a private practitioner's office. Current law authorizes physicians, chiropractors, podiatrists, naturopaths, optometrists, and dentists to operate their own clinical laboratories, called "exclusive use" laboratories, to exclusively diagnose and treat their own patients.

Clinical laboratories are required to accept and examine human specimens submitted by certain practitioners if the specimen and test are typically performed by the lab.

A clinical laboratory may only refuse a specimen based upon a history of nonpayment for services by a practitioner. Clinical laboratories are prohibited from charging different prices for tests based upon the chapter under which a practitioner is licensed.

The bill requires a clinical laboratory to make its services available to specified licensed health care practitioners, instead of requiring the laboratory to accept a human specimen from such practitioners. The bill also deletes a provision in current law that only authorizes a clinical laboratory to refuse a specimen if there has been a history of nonpayment.

The bill does not appear to have a fiscal impact on state or local government.

The bill provides that the act will take effect upon becoming a law.



**This document does not reflect the intent or official position of the bill sponsor or House of Representatives.**

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

Clinical Laboratories

*Licensure*

A clinical laboratory is a location in which body fluids or tissues are analyzed for purposes of the diagnosis, assessment, or prevention of a medical condition.[1] Clinical laboratories are licensed and regulated by the Agency for Health Care Administration (AHCA), pursuant to part I of chapter 483, F.S., and Rule 59A-7, F.A.C. Clinical laboratories may be free-standing facilities, may be part of a hospital, or may be part of a private practitioner's office.[2] A clinical laboratory license may only be issued to a laboratory to perform procedures and tests that are within the specialties or subspecialties in which the laboratory personnel are qualified to perform.[3] There are 3,761 actively licensed clinical laboratories in Florida.[4] Certain clinical laboratories are exempt from licensure, including clinical laboratories:

- Operated by the federal government;
- Operated and maintained exclusively for research and teaching purposes that do not involve patient or public health services; and
- Performing only "waived tests".[5]

*Acceptance, Collection, Identification, and Examination of Specimens*

A clinical laboratory may only examine human specimens at the request of a licensed practitioner.[6] Section 483.181(5), F.S., requires clinical laboratories to accept and examine human specimens submitted by certain practitioners if the specimen and test are typically performed by the laboratory. Specifically, clinical laboratories must accept and examine specimens submitted by a:

- Physician;
- Chiropractor;
- Podiatrist;
- Naturopath;
- Optometrist;
- Dentist; or an
- Advanced registered nurse practitioner.[7]

A clinical laboratory may only refuse a specimen based upon a history of nonpayment for services by a practitioner. Clinical laboratories are prohibited from charging different prices for tests based upon the chapter under which a practitioner is licensed.

Current law authorizes physicians, chiropractors, podiatrists, naturopaths, optometrists, and dentists to operate their own clinical laboratories, called "exclusive use" laboratories, to exclusively diagnose and

[1] S. 483.041(2), F.S.
[2] Id.
[3] S. 483.091, F.S.
[4] AHCA, Florida Health Finder.gov, Facility/Provider Search Results, available at http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (search conducted March 10, 2015).
[5] S. 483.031, F.S. Examples of waived tests include dip stick urinalysis or tablet reagent urinalysis, fecal occult blood, urine pregnancy tests, erythrocyte sedimentation rate, and blood glucose tests.
[6] S. 483.181(1), F.S.
[7] S. 483.181(5), F.S.

treat their own patients.[8] This, however, does not preclude the exclusive use laboratories from also being required to accept and examine all specimens submitted by certain practitioners pursuant to s. 483.181(5), F.S.

*Administrative Fines and Criminal Penalties*

A clinical laboratory is subject to a fine, not to exceed $1,000, to be imposed by AHCA for each violation of any provision of part I of chapter 483, F.S.[9] The AHCA must consider certain factors in determining the penalty for a violation, including:

- The severity of the violation, including the probability that death or serious harm to the health or safety of any person could occur as a result of the violation;
- Actions taken by the licensee to correct the violation or to remedy complaints; and
- The financial benefit to the licensee of committing or continuing the violation.[10]

In addition to the imposition of fines, an individual may be subject to criminal penalties for a violation of any provision of part I of chapter 483, F.S.[11] The AHCA must refer an individual who commits a violation to the local law enforcement agency and the individual may be subject to a misdemeanor of the second degree, punishable as provided in ss. 775.082 and 775.083, F.S.[12] Additionally, AHCA may issue and deliver a notice to cease and desist from such act and may impose, by citation, an administrative penalty not to exceed $5,000 per act.[13] Each day that unlicensed activity continues after issuance of a notice to cease and desist constitutes a separate act.[14]

An application for licensure or re-licensure as a clinical laboratory may be denied or revoked by AHCA for any violation of part I of chapter 483, F.S.[15]

**Effect of Proposed Changes**

The bill requires a clinical laboratory to make its services available to specified licensed health care practitioners, instead of requiring the laboratory to accept a human specimen from such practitioners. Specifically, a clinical laboratory must make its services available to a:

- Physician;
- Chiropractor;
- Podiatrist;
- Naturopath;
- Optometrist;
- Dentist; or an
- Advanced registered nurse practitioner.

A clinical laboratory may still be subject to fines, criminal penalties and licensure denial or revocation for a violation of this provision or any provision of part I of chapter 483, F.S.

The bill also deletes a provision in current law that only authorizes a clinical laboratory to refuse a specimen if there has been a history of nonpayment.

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[8] S. 483.035(1), F.S.
[9] S. 483.221(1), F.S.
[10] Id.
[11] S. 483.23(1)(a) and (b), F.S.
[12] Id.
[13] Id.
[14] Id.
[15] S. 408.815(1)(c), F.S.

B. SECTION DIRECTORY:

**Section 1:** Amends s. 483.181, F.S., relating to acceptance, collection, identification, and examination of specimens.
**Section 2:** Provides that the act shall take effect upon becoming a law.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

No additional rulemaking authority is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 12, 2015, the Health Quality Subcommittee adopted an amendment to the bill and reported the bill favorably as a committee substitute. The amendment:

- Requires clinical laboratories to make their services available to certain practitioners.
- Deletes a provision in current law that only authorizes a clinical laboratory to refuse a specimen if there has been a history of nonpayment.

The bill was reported favorably as a committee substitute. The analysis is drafted to the committee substitute.

1 A bill to be entitled
2 An act relating to clinical laboratories; amending s.
3 483.181, F.S.; requiring clinical laboratories to make
4 their services available to specified licensed
5 practitioners; prohibiting such a clinical laboratory
6 from charging different prices for its services based
7 upon the chapter under which a practitioner is
8 licensed; providing an effective date.
9
10 Be It Enacted by the Legislature of the State of Florida:
11
12 Section 1. Subsection (5) of section 483.181, Florida
13 Statutes, is amended to read:
14 483.181 Acceptance, collection, identification, and
15 examination of specimens.—
16 (5) A clinical laboratory licensed under this part must
17 make its services available to ~~accept a human specimen submitted~~
18 ~~for examination by~~ a practitioner licensed under chapter 458,
19 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,
20 s. 464.012, or chapter 466~~, if the specimen and test are the~~
21 ~~type performed by the clinical laboratory. A clinical laboratory~~
22 ~~may only refuse a specimen based upon a history of nonpayment~~
23 ~~for services by the practitioner~~. A clinical laboratory shall
24 not charge different prices for its services ~~tests~~ based upon
25 the chapter under which a practitioner ~~submitting a specimen for~~
26 ~~testing~~ is licensed.

27 Section 2. This act shall take effect upon becoming a law.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ___

1 Committee/Subcommittee hearing bill: Health & Human Services
2 Committee
3 Representative Roberson, K. offered the following:
4
5 **Amendment (with title amendment)**
6 Remove everything after the enacting clause and insert:
7 Section 1. Subsection (7) of section 483.041, Florida
8 Statutes, is amended to read:
9 483.041 Definitions.—As used in this part, the term:
10 (7) "Licensed practitioner" means a physician licensed
11 under chapter 458, chapter 459, chapter 460, or chapter 461; a
12 certified optometrist licensed under chapter 463; a dentist
13 licensed under chapter 466; a person licensed under chapter 462;
14 a consultant pharmacist or doctor of pharmacy licensed under
15 chapter 465; or an advanced registered nurse practitioner
16 licensed under part I of chapter 464; or a duly licensed
17 practitioner from another state licensed under similar statutes

18 who orders examinations on materials or specimens for
19 nonresidents of the State of Florida, but who reside in the same
20 state as the requesting licensed practitioner.
21 Section 2. Subsection (5) of section 483.181, Florida
22 Statutes, is amended to read:
23 483.181 Acceptance, collection, identification, and
24 examination of specimens.—
25 (5) A clinical laboratory licensed under this part must
26 make its services available to ~~accept a human specimen submitted~~
27 ~~for examination by~~ a practitioner licensed under chapter 458,
28 chapter 459, chapter 460, chapter 461, chapter 462, chapter 463,
29 s. 464.012, ~~or~~ chapter 466, or a consultant pharmacist or doctor
30 of pharmacy licensed under chapter 465 ~~if the specimen and test~~
31 ~~are the type performed by the clinical laboratory. A clinical~~
32 ~~laboratory may only refuse a specimen based upon a history of~~
33 ~~nonpayment for services by the practitioner~~. A clinical
34 laboratory shall not charge different prices for its services
35 ~~tests~~ based upon the chapter under which a practitioner
36 ~~submitting a specimen for testing~~ is licensed.
37 Section 3. This act shall take effect upon becoming a law.
38
39 -----------------------------------------------------
40 **T I T L E A M E N D M E N T**
41 Remove everything before the enacting clause and insert:
42 An act relating to clinical laboratories; amending s. 483.041,
43 F.S.; adding a consultant pharmacist or doctor of pharmacy

44 licensed under chapter 465, F.S., to the definition of licensed
45 practitioner; amending s. 483.181, F.S.; requiring clinical
46 laboratories to make their services available to specified
47 licensed practitioners; prohibiting such a clinical laboratory
48 from charging different prices for its services based upon the
49 chapter under which a practitioner is licensed; providing an
50 effective date.

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 751 Emergency Treatment for Opioid Overdose
**SPONSOR(S):** Civil Justice Subcommittee; Gonzalez; Renuart and others
**TIED BILLS:** None **IDEN./SIM. BILLS:** CS/SB 758

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Health Quality Subcommittee | 12 Y, 0 N | McElroy | O'Callaghan |
| 2) Civil Justice Subcommittee | 13 Y, 0 N, As CS | Bond | Bond |
| 3) Health & Human Services Committee | | McElroy | Calamas |

## SUMMARY ANALYSIS


Deaths from drug overdose have steadily increased over the past few decades and are the leading cause of accidental death in the United States. The vast majority of these deaths involved an overdose related to opioid analgesics, which are narcotic pain relievers derived from the opium poppy, or its synthetic analogues. Opioid antagonists have proven successful in reversing some opioid-related drug overdoses when administered in a timely manner.

CS/HB 751 creates the Emergency Treatment and Recovery Act. Patients and caregivers are authorized to store and possess emergency opioid antagonists. The bill authorizes patients and caregivers to administer an emergency opioid antagonist to a person believed in good faith to be experiencing an opioid overdose, regardless of whether that person has a prescription for an emergency opioid antagonist. This authorization only applies in an emergency situation when a physician is not immediately available. The bill authorizes healthcare practitioners to prescribe, and pharmacists to dispense, emergency opioid antagonists to patients and caregivers for this purpose.

The bill authorizes emergency responders to possess, store and administer emergency opioid antagonists.

The bill grants civil liability protections under the Good Samaritan Act for all individuals who administer emergency opioid antagonists in emergency situations. The bill also grants healthcare practitioners and pharmacists immunity from civil and criminal liability and professional discipline, related to prescribing and dispensing an opioid antagonist. The immunities provided by the bill do not limit any existing statutory immunities which are otherwise applicable.

The bill does not appear to have a fiscal impact on state or local government.

The bill takes effect upon becoming a law.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

### A. EFFECT OF PROPOSED CHANGES:

Opioids

The drug overdose death rate has more than doubled from 1999 through 2013 and has now become the leading cause of accidental deaths in the United States. [1] In 2013, there were 43,982 drug overdose deaths in the United States of which 22,767 (51.8%) were related to pharmaceuticals. [2] The majority of the pharmaceutical related deaths, 16,235 (71.3%), involved opioid analgesic drugs (opioids).[3]

Opioids are psychoactive substances derived from the opium poppy, or their synthetic analogues.[4] They are commonly used as pain relievers to treat acute and chronic pain. An individual experiences pain as a result of a series of electrical and chemical exchanges among his or her peripheral nerves, spinal cord and brain.[5] Opioid receptors occur naturally and are distributed widely throughout the central nervous system and in peripheral sensory and autonomic nerves. [6] When an individual experiences pain the body releases hormones, such as endorphins, which bind with targeted opioid receptors.[7] This disrupts the transmission of pain signals through the central nervous system and reduces the perception of pain.[8] Opioids function in the same way by binding to specific opioid receptors in the brain, spinal cord and gastrointestinal tract, thereby reducing the perception of pain.[9] Opioids include[10]:

- Buprenorphine (Subutex, Suboxone)
- Codeine
- Fentanyl (Duragesic, Fentora)
- Heroin
- Hydrocodone (Vicodin, Lortab, Norco)
- Hydromorphone (Dilaudid, Exalgo)
- Meperidine
- Methadone
- Morphine
- Oxycodone (OxyContin, Percodan, Percocet)
- Oxymorphone
- Tramadol

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[1] More deaths occur each year due to drug overdose than deaths caused by motor vehicle crashes. *Prescription Drug Overdose in the United States: Fact Sheet*, Centers for Disease Control and Prevention. http://www.cdc.gov/homeandrecreationalsafety/overdose/facts.html (last visited 2/27/15).
[2] *Prescription Drug Overdose in the United States: Fact Sheet*, Centers for Disease Control and Prevention. http://www.cdc.gov/homeandrecreationalsafety/overdose/facts.html (last visited 2/27/15).
[3] Id.
[4] *Information Sheet on Opioid Overdose*, World Health Organization, November 2014. http://www.who.int/substance_abuse/information-sheet/en/ (last visited 2/27/15).
[5] Mayo Clinic Health Library, http://www.riversideonline.com/health_reference/Nervous-System/PN00017.cfm (lasted visited).
[6] *Imaging of Opioid Receptors in the Central Nervous System,* Gjermund Henriksen, Frode Willoch; Brain (2008) 131 (5): 1171-1196.
[7] Id.
[8] Id.
[9] *SAMHSA Opioid Overdose Toolkit: Facts for Community Members*, Department of Health and Human Services- Substance Abuse and Mental Health Services Administration.
[10] *Drugs Identified in Deceased Persons by Florida Medical Examiners 2012 Report,* Florida Department of Law Enforcement, September 2013.

Opioids are commonly abused, with an estimated 15 million people worldwide suffering from opioid dependence.[11] Opioids can create a euphoric feeling because they affect the regions of the brain involved with pleasure and reward which can lead to abuse.[12] Continued use of these drugs can lead to the development of tolerance and psychological and physical dependence.[13] This dependence is characterized by a strong desire to take opioids, impaired control over opioid use, persistent opioid use despite harmful consequences, a higher priority given to opioid use than to other activities and obligations, and a physical withdrawal reaction when opioids are discontinued.[14]

An overabundance of opioids in the body can lead to a fatal overdose. In addition to their presence in major pain pathways, opioid receptors are also located in the respiratory control centers of the brain.[15] Opioids disrupt the transmission of signals for respiration in the identical manner that they disrupt the transmission of pain signals (figure 1). This leads to a reduction, and potentially cessation, of an individual's respiration. Oxygen starvation will eventually stop vital organs like the heart, then the brain, and can lead to unconsciousness, coma, and possibly death.[16] Within 3-5 minutes without oxygen, brain damage starts to occur, soon followed by death.[17] However, this does not occur instantaneously as people will commonly stop breathing slowly, minutes to hours after the drug or drugs were used.[18] An opioid overdose can be identified by a combination of three signs and symptoms referred to as the "opioid overdose triad":[19]

- Pinpoint pupils;
- Unconsciousness; and,
- Respiratory depression.

**Figure 1**

Source: Maya Doe-Simkins, MPH, Boston Medical Center.

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[11] *Information Sheet on Opioid Overdose*, World Health Organization, November 2014. http://www.who.int/substance_abuse/information-sheet/en/ (last visited 2/27/15).
[12] *How Do Opioids Affect the Brain and Body?,* National Institute on Drug Abuse. http://www.drugabuse.gov/publications/research-reports/prescription-drugs/opioids/how-do-opioids-affect-brain-body (last visited 2/27/15).
[13] *Imaging of Opioid Receptors in the Central Nervous System,* Gjermund Henriksen, Frode Willoch; Brain (2008) 131 (5): 1171-1196.
[14] *Information Sheet on Opioid Overdose*, World Health Organization, November 2014. http://www.who.int/substance_abuse/information-sheet/en/ (last visited 2/27/15).
[15] *Opioids and the Control of Respiration*, K.T.S. Pattinson, BJA, Volume 100, Issue 6, Pages 747-758. http://bja.oxfordjournals.org/content/100/6/747.full (last visited 2/27/15).
[16] *Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects*, Harm Reduction Coalition, Fall 2012. http://harmreduction.org/our-work/overdose-prevention/ (last visited 2/27/15).
[17] Id.
[18] Id.
[19] *Information Sheet on Opioid Overdose*, World Health Organization, November 2014. http://www.who.int/substance_abuse/information-sheet/en/ (last visited 2/27/15).

Opioid Antagonist

An opioid antagonist is a drug that blocks the effects of exogenously administered opioids. Opioid antagonists are used in opioid overdoses to counteract life-threatening depression of the central nervous system and respiratory system, allowing an overdose victim to breathe normally.[20] This occurs because opioid antagonists create a stronger bond with opioid receptors than opioids. This forces the opioids from the opioid receptors and allows the transmission of signals for respiration to resume.[21] This effect lasts only for a short period of time[22] with the narcotic effect of the opioids returning if still present in large quantities in the body. In this scenario additional doses of an opioid antagonist would be required and it is why it is generally recommended that anyone who has experienced an overdose seek medical attention.

Community-based opioid antagonist prevention programs can be successful in increasing the number of opioid overdose reversals. Opioid antagonists were originally prescribed and distributed only to emergency personnel (EMTs, firefighters and law enforcement). In 1996, community-based programs began offering opioid antagonists and other opioid overdose prevention services, in states authorizing such activities, to persons who use drugs, their families and friends and service providers (healthcare providers, homeless shelters and substance abuse treatment programs).[23] In October 2010, a national advocacy and capacity-building organization surveyed 50 programs known to distribute opioid antagonists in the United States, to collect data on various issues including overdose reversals.[24] Forty-eight programs responded to the survey and reported training and distributing opioid antagonists to 53,032 persons and receiving reports of 10,171[25] overdose reversals.[26] Based upon these findings, the report concluded that providing opioid overdose education and opioid antagonists to persons who use drugs and to persons who might be present at an opioid overdose can help reduce opioid overdose mortality.[27]

Multiple states have enacted statutes to allow for the prescription and lay-person use of opioid antagonists (figure 2). For example, as of November 2014:[28]

- Twenty-seven states have statutes which allow for “third-party” prescriptions of opioid antagonists.

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[20] *Understanding Naloxone,* Harm Reduction Coalition. http://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/understanding-naloxone/ (last visited 2/27/15).

[21] *Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects*, Harm Reduction Coalition, Fall 2012. http://harmreduction.org/our-work/overdose-prevention/ (last visited 2/27/15).

[22] The half-life for a common opioid antagonist in adults ranged from 30 to 81 minutes. Acute opiate withdrawal is a potential side-effect of naloxone; however, this would be time limited to the half-life of naloxone.

[23] *Community-Based Opioid Overdose Prevention Programs Providing Naloxone — United States, 2010*, Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report (MMWR), February 17, 2012 / 61(06);101-105. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6106a1.htm (last visited 2/27/15).

[24] Id.

[25] The findings in this report are subject to at least three limitations. First, other opioid antagonist distribution programs might exist that were unknown to the national advocacy group. Second, all data is based on unconfirmed self-reports from the 48 responding programs. Finally, the numbers of persons trained in opioid antagonist administration and the number of overdose reversals involving opioid antagonists likely were underreported because of incomplete data collection and unreported overdose reversals. However, because not all untreated opioid overdoses are fatal, some of the persons with reported overdose reversals likely would have survived without opioid antagonist administration. *Community-Based Opioid Overdose Prevention Programs Providing Naloxone — United States, 2010*, Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report (MMWR), February 17, 2012 / 61(06);101-105.

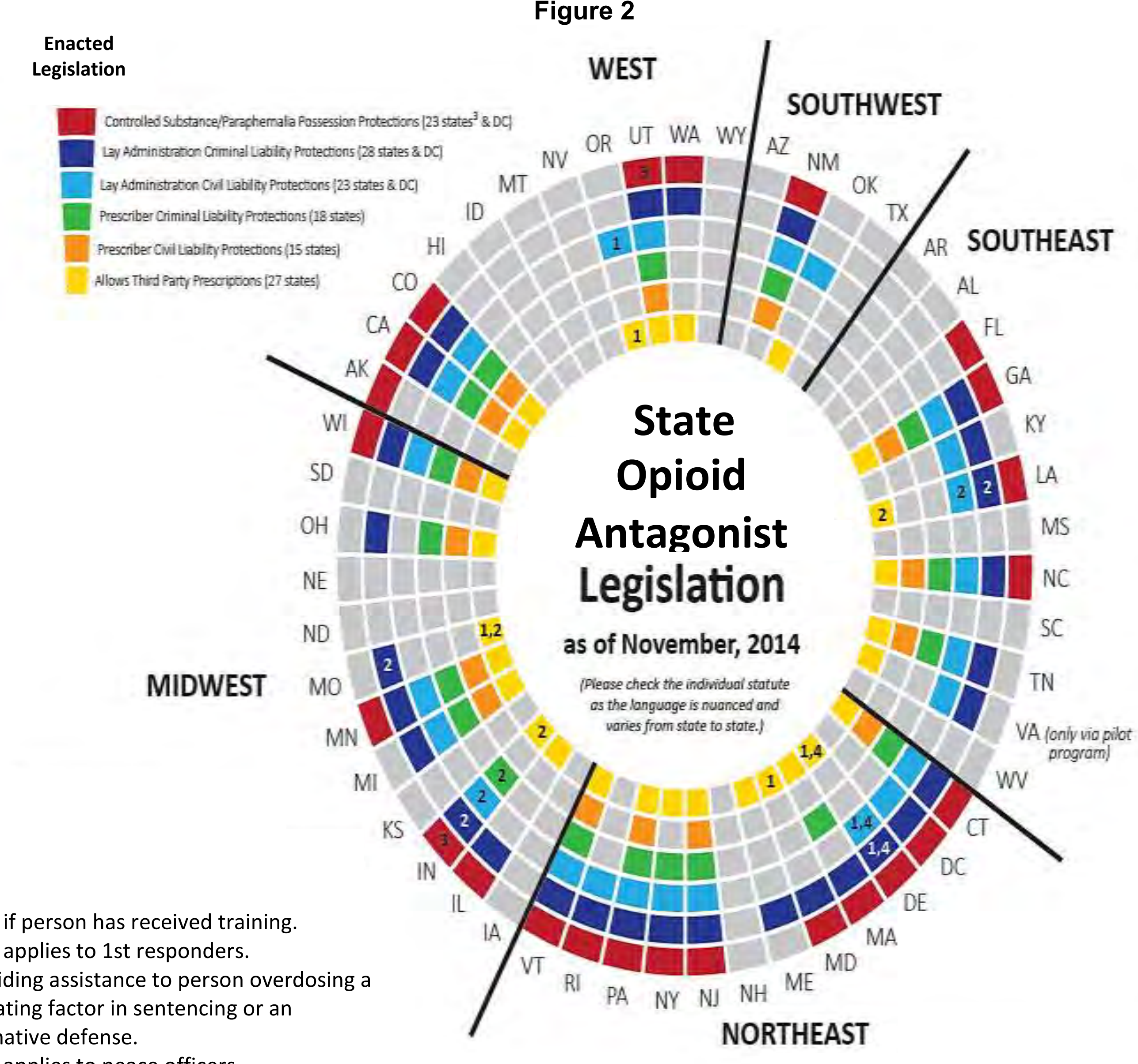
[26] *Community-Based Opioid Overdose Prevention Programs Providing Naloxone — United States, 2010*, Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report (MMWR), February 17, 2012 / 61(06);101-105. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6106a1.htm (last visited 2/27/15).

[27] Id.

[28] *Updated Infographic: Overdose Prevention, State by State*, Office of National Drug Control Policy. http://www.whitehouse.gov/blog/2014/12/17/updated-infographic-overdose-prevention-state-state (last visited 2/27/15).

- Fifteen states have statutes which protect prescribers from civil liability actions.
- Eighteen states have statutes which protect prescribers from criminal liability actions.
- Twenty-three states and the District of Columbia have statutes which protect lay persons from civil liability for administering opioid antagonists to someone believed to be experiencing an opioid induced overdose.
- Twenty-eight states and the District of Columbia have statutes which protect lay persons from criminal liability for administering opioid antagonists to someone believed to be experiencing an opioid induced overdose.
- Twenty-three states and the District of Columbia have statutes which prevent charge or prosecution for possession of a controlled substance and/or paraphernalia for persons who seek medical/emergency assistance for someone that is experiencing an opioid induced overdose.

**Figure 2**




[1]Only if person has received training.
[2]Only applies to 1st responders.
[3]Providing assistance to person overdosing a mitigating factor in sentencing or an affirmative defense.
[4]Only applies to peace officers.

**Source:** Office of National Drug Control Policy

Florida Opioid –Related Data

Opioids also play a prominent role in drug overdose deaths in Florida. In 2013, there were 8,286 drug-related deaths in the state.[29] Opioids were listed as the cause of death in 2,573 cases and were present in an additional 2,730 cases.[30] The four most harmful drugs, found in more than 50 percent of the deaths in which these drugs were present, were all opioids:[31]

- Heroin (97%)
- Methadone (67%)
- Fentanyl (63.4%),
- Morphine (59.9%).

Florida's Good Samaritan Act

The Good Samaritan Act, found in s. 768.13, F.S., provides immunity from civil liability for those who render emergency care and treatment to individuals in need of assistance. The statute provides immunity from liability for civil damages to any person who:

- Gratuitously and in good faith renders emergency care or treatment either in direct response to emergency situation or at the scene of an emergency, without objection of the injured victim, if that person acts as an ordinary reasonably prudent person would have acted under the same or similar circumstances;[32]
- Participates in emergency response activities of a community emergency response team if that person acts prudently and within scope of his or her training;[33] or
- Gratuitously and in good faith renders emergency care or treatment to an injured animal at the scene of an emergency if that person acts as an ordinary reasonably prudent person would have acted under the same or similar circumstances.[34]

**Effect of Proposed Changes**

CS/HB 751 creates the Emergency Treatment and Recovery Act. Patients and caregivers are authorized to store and possess emergency opioid antagonists. The bill authorizes patients and caregivers (family members, friends, or persons in a position to have recurring contact with a person at risk of experiencing an opioid overdose) to administer an emergency opioid antagonist to a person believed in good faith to be experiencing an opioid overdose, regardless of whether that person has a prescription for an emergency opioid antagonist. This authorization only applies in an emergency situation when a physician is not immediately available. The bill authorizes healthcare practitioners to prescribe, and pharmacists to dispense, emergency opioid antagonists to patients and caregivers for this purpose. The bill defines "emergency opioid antagonist" as naloxone hydrochloride or any similarly acting drug that blocks the effects of exogenously administered opioids and is approved by the United States Food and Drug Administration for the treatment of opioid overdose.

The bill authorizes emergency responders to possess, store, and administer approved emergency opioid antagonists.

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[29] *Drugs Identified in Deceased Persons by Florida Medical Examiners 2013 Report,* Florida Department of Law Enforcement, October 2014.
[30] Id. A decedent may have more than one drug listed as the cause of death.
[31] Id.
[32] Section 768.13(2)(a), F.S.
[33] Section 768.13(2)(d), F.S.
[34] Section 768.13(3), F.S.

The bill provides civil liability immunity under s. 768.13, F.S., (Good Samaritan Act) for any person who possesses, administers, prescribes, dispenses, or stores an approved emergency opioid antagonist in compliance with the bill's requirements.

The bill provides that any authorized healthcare practitioner, dispensing healthcare practitioner, or pharmacist will not be subject to professional sanction or other disciplinary licensing action for acts or omissions if he or she is otherwise in compliance with the bill's requirements. Additionally, a healthcare practitioner, dispensing healthcare practitioner or pharmacist is immune from civil or criminal liability related to the prescribing or dispensing of an opioid antagonist pursuant to the provisions of this bill.

The bill does not limit any existing immunities for emergency responders or others provided under this chapter or any other applicable provision of law.

The act will take effect upon becoming a law.

B. SECTION DIRECTORY:

**Section 1**: Provides citation for the Emergency Treatment and Recovery Act.
**Section 2**: Creates s. 381.887, F.S., relating to emergency treatment for suspected opioid overdose.
**Section 3**: Provides the act shall take effect upon becoming a law.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill does not appear to have any impact on state revenues.

2. Expenditures:

   The bill does not appear to have any impact on state expenditures.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   The bill does not appear to have any impact on local government revenues.

2. Expenditures:

   The bill does not appear to have any impact on local government expenditures.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill does not appear to have any direct economic impact on the private sector.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill does not appear to create a need for rulemaking or rulemaking authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 11, 2015, the Civil Justice Subcommittee adopted two amendments and reported the bill favorably as a committee substitute. The amendments:

- Limit the scope of the bill to only the antagonist naloxone hydrochloride or similarly acting drug, as opposed to any drug which would has the effect of blocking the effects of an opioid overdose;
- Add that a healthcare practitioner is not civilly or criminally liable for prescribing an opioid antagonist pursuant to this law;
- Add that a dispensing healthcare practitioner or pharmacist is not civilly or criminally liable for prescribing an opioid antagonist pursuant to this law; and
- Make technical, grammatical and style improvements.

This analysis is drafted to the committee substitute as passed by the Civil Justice Subcommittee.

1 A bill to be entitled
2 An act relating to emergency treatment for opioid
3 overdose; providing a short title; creating s.
4 381.887, F.S.; providing definitions; providing
5 purpose; authorizing certain health care practitioners
6 to prescribe an emergency opioid antagonist to a
7 patient or caregiver under certain conditions;
8 authorizing storage, possession, and administration of
9 an emergency opioid antagonist by such patient or
10 caregiver and certain emergency responders; providing
11 immunity from liability; providing immunity from
12 professional sanction or disciplinary action for
13 certain health care practitioners and pharmacists,
14 under certain circumstances; providing applicability;
15 providing an effective date.
16
17 Be It Enacted by the Legislature of the State of Florida:
18
19 Section 1. This act may be cited as the "Emergency
20 Treatment and Recovery Act."
21 Section 2. Section 381.887, Florida Statutes, is created
22 to read:
23 381.887 Emergency treatment for suspected opioid
24 overdose.—
25 (1) As used in this section, the term:
26 (a) "Administer" or "administration" means to introduce an

27 emergency opioid antagonist into the body of a person.
28 (b) "Authorized health care practitioner" means a licensed
29 practitioner authorized by the laws of the state to prescribe
30 drugs.
31 (c) "Caregiver" means a family member, friend, or person
32 in a position to have recurring contact with a person at risk of
33 experiencing an opioid overdose.
34 (d) "Emergency opioid antagonist" means naloxone
35 hydrochloride or any similarly acting drug that blocks the
36 effects of opioids administered from outside the body and that
37 is approved by the United States Food and Drug Administration
38 for the treatment of an opioid overdose.
39 (e) "Patient" means a person at risk of experiencing an
40 opioid overdose.
41 (2) The purpose of this section is to provide for the
42 prescription of an emergency opioid antagonist to patients and
43 caregivers and to encourage the prescription of emergency opioid
44 antagonists by health care practitioners.
45 (3) An authorized health care practitioner may prescribe
46 an emergency opioid antagonist to a patient or caregiver for use
47 in accordance with this section, and pharmacists may dispense an
48 emergency opioid antagonist pursuant to a prescription issued in
49 the name of the patient or caregiver, appropriately labeled with
50 instructions for use. Such patient or caregiver is authorized to
51 store and possess approved emergency opioid antagonists and, in
52 an emergency situation when a physician is not immediately

53 available, administer the emergency opioid antagonist to a
54 person believed in good faith to be experiencing an opioid
55 overdose, regardless of whether that person has a prescription
56 for an emergency opioid antagonist.
57 (4) Emergency responders, including, but not limited to,
58 law enforcement officers, paramedics, and emergency medical
59 technicians, are authorized to possess, store, and administer
60 approved emergency opioid antagonists as clinically indicated.
61 (5) A person, including, but not limited to, an authorized
62 health care practitioner, a dispensing health care practitioner,
63 or a pharmacist, who possesses, administers, prescribes,
64 dispenses, or stores an approved emergency opioid antagonist in
65 compliance with this section and s. 768.13 is afforded the civil
66 liability immunity protections provided under s. 768.13.
67 (6)(a) An authorized health care practitioner, acting in
68 good faith, is not subject to discipline or other adverse action
69 under any professional licensure statute or rule and is immune
70 from any civil or criminal liability as a result of prescribing
71 an opioid antagonist in accordance with this section.
72 (b) A dispensing health care practitioner or pharmacist,
73 acting in good faith, is not subject to discipline or other
74 adverse action under any professional licensure statute or rule
75 and is immune from any civil or criminal liability as a result
76 of dispensing an opioid antagonist in accordance with this
77 section.
78 (7) This section does not limit any existing immunities

79 for emergency responders or others provided under this chapter
80 or any other applicable provision of law.
81 Section 3. This act shall take effect upon becoming a law.

HB 4017

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 4017 Pain-Management Clinics
**SPONSOR(S):** Spano
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 450

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Health Quality Subcommittee | 11 Y, 0 N | Nilson | O'Callaghan |
| 2) Health & Human Services Committee | | Nilson | Calamas |

## SUMMARY ANALYSIS


Leading up to 2009, parts of Florida had become centers for prescription drug trafficking, particularly in opioids. This trafficking stemmed, in part, from unregulated pain-management clinics. The resulting increases in crime and mortality, and the resulting decrease in the quality of life experienced by Floridians, resulted in the Florida Legislature determining that pain-management clinics, as well as other entities in the drug supply chain, should be regulated to prevent these outcomes.

From 2009 to 2012, the Legislature enacted and refined a substantial set of regulations designed to combat prescription drug overprescribing and trafficking, including regulation of pain-management clinics. The law defines pain-management clinics as facilities that advertise in any medium for any type of pain-management services or where in any month a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol. The law currently requires pain-management clinic registration, inspection, reporting, and penalties for violations of several laws. The law also currently requires physicians practicing at a clinic to ensure that the clinic meets certain requirements.

The pain-management clinic statutes also include "sunset provisions," such that the two sections that regulate pain-management clinics will expire on January 1, 2016.

HB 4017 repeals the sunset provisions for pain-management clinic regulations, requiring such clinics to continue to be subject to those regulations beyond January 1, 2016.

This bill does not appear to have a fiscal impact on state or local government.

This bill becomes effective upon becoming a law.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

### A. EFFECT OF PROPOSED CHANGES:

**Current Situation**

Prescription Drug Trafficking

Florida had a severe prescription drug trafficking problem prior to 2011-2012 caused by many factors, including physicians prescribing without proper clinical justification in office and pain-management clinic settings, weak standards of care for physicians, and cash-based prescription drug disbursement. So-called "pain-management clinics" in Florida became harbors for illegally trafficked drugs, including oxycodone, carisoprodol, and alpazolam.[1] Physicians could plausibly deny any illegal activity, as long as the drug traffickers would follow the same basic procedures a general patient would follow if that patient were truly in pain and in need of medication.[2] The cash-only pain-management clinic structure was especially effective for traffickers if the owners of the pain-management clinics were not physicians, as this specific type of clinic was unregulated by any state agency.[3] From 2007 to 2009, the number of pain-management clinics in Broward County alone increased from 4 to 115.[4] From late 2008 to early 2009, doctors in South Florida dispensed over 53% of the total oxycodone dispensed by the top 100 doctors in the United States.[5]

This increase correlated to higher mortality, higher crime, higher addiction rates, and lower quality of life in Florida.[6] From 2006 to 2008, the number of deaths per day with lethal dose reports of prescription drugs increased from 7 to 10.[7] Drug crime and its related costs to Florida increased substantially.[8] From 2004 to 2008, treatment admissions related to prescription drugs rose 150%.[9]

Pain-Management Clinic Legislative History

The Legislature determined that unregulated pain-management clinics were the source of a substantial amount of drug trafficking in Florida, primarily in opioids like oxycodone, a Schedule II controlled substance.[10] In 2009, the Florida Legislature established a regulatory structure for pain-management clinics.[11]

In 2010, the Legislature created s. 458.3265 and s. 459.0137, F.S., to consolidate, clarify, and expand the standards for pain-management clinics.[12]

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[1] *The Proliferation of Pain Clinics in South Florida*, Interim Report of the Broward County Grand Jury 3 (17th Jud. Cir. Fla., Nov. 19, 2009).
[2] *Id.* at 4.
[3] *Id.* at 17.
[4] *Id.* at 6.
[5] *Id.* at 9.
[6] *Id.* at 9-11.
[7] *Id.* at 9.
[8] *Id.* at 10-11.
[9] *Id.* at 12.
[10] *See* ch. 893, F.S.
[11] Chapter 2009-198, ss. 3, 4, Laws of Fla. The Florida Legislature also established a Prescription Drug Monitoring Program at this time. *See* ch. 2009-197, Laws of Fla. As of March 2014, 49 states have a Prescription Drug Monitoring Program. "The Role of a Prescription Drug Monitoring Program in Reducing Prescription Drug Diversion, Misuse, and Abuse," U.S. DEP'T OF HEALTH & HUMAN SERVICES (June 2014).
[12] Ch. 2010-211, ss. 4, 8, Laws of Fla.

In 2011, the Legislature modified the standards substantially, in part by codifying rules promulgated by the Department of Health (DOH).[13] In addition to the substantive modifications, the Legislature enacted sunset provisions requiring the pain-management clinic regulations in s. 458.3265 and s. 459.0137, F.S., to automatically expire on January 1, 2016.[14]

In 2012, the Legislature further modified these standards by adding exemptions for certain types of medical practice;[15] however, the Legislature left the sunset provisions intact.[16]

Pain-Management Clinic Regulation

Florida law defines a "pain-management clinic" as a publicly or privately owned facility that advertises in any medium for any type of pain-management services or where in any month a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol.[17]

Section 458.3265, F.S., within the medical practice act and s. 459.0137, F.S., within the osteopathic practice act regulate the registration, management, and inspections of pain-management clinics, and the allopathic and osteopathic physicians employed by such clinics. These sections create a registration requirement for pain-management clinics.

*Registration*

A pain-management clinic must register with DOH unless:

- The clinic is licensed under ch. 395, F.S.;
- The majority of the physicians who provide services in the clinic primarily provide surgical services;
- The clinic is publicly owned, with total assets exceeding $50 million in the most recent fiscal quarter;
- The clinic is affiliated with an accredited medical school;
- The clinic does not prescribe controlled substances for pain treatment;
- The clinic is owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3);
- The clinic is wholly owned and operated by one or more board eligible[18] or board-certified anesthesiologists, physiatrists, rheumatologists, or neurologists; or
- The clinic is wholly owned and operated by a physician multispecialty practice where one or more board eligible[19] or board-certified medical specialists have both (1) completed certain fellowships in pain medicine or are board-certified in pain medicine by certain boards, and (2) perform interventional pain procedures of the type routinely billed using surgical codes.[20]

Each location must be registered separately, regardless of whether it is operated under the same name or management as another clinic.[21] Additionally, a change of ownership requires submission of a new registration application.[22]

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[13] Ch. 2011-141, ss. 4, 7, Laws of Fla. In addition, the Legislature touched every point of the prescription drug chain, including manufacturing, wholesale distribution, physician dispensing, standards of care, and pharmacy regulation. Ch. 2011-141, Laws of Fla.
[14] *Id.*
[15] Ch. 2012-160, ss. 32, 33, Laws of Fla.
[16] *Id.*
[17] S. 458.3265(1)(a)(1.)(c.), F.S.; s. 459.0137(1)(a)(1.)(c.), F.S.
[18] "Board eligible" means successful completion of an anesthesia, physical medicine and rehabilitation, rheumatology, or neurology residency program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association for a period of 6 years from successful completion of such residency program. S. 458.3265(1)(a)(1.)(a.), F.S.; s. 459.0137(1)(a)(1.)(a.), F.S.
[19] *See* note 21, *supra*.
[20] S. 458.3265(1)(a)(2.), F.S.; s. 459.0137(1)(a)(2.), F.S.
[21] S. 458.3265(1)(b), F.S.; s. 459.0137(1)(b), F.S.

DOH must deny a pain-management clinic's registration if:

- The clinic is neither fully owned by a physician or group of physicians licensed under ch. 458 or ch. 459, F.S.; nor health care clinic licensed under ch. 400, Part X.[23]
- The clinic is owned by, has a contractual relationship with, or employs a physician:
  - Whose Drug Enforcement Administration number has ever been revoked;
  - Whose application for a license to prescribe, dispense, or administer a controlled substance has been denied by any jurisdiction; or
  - Who has been convicted of or pleaded guilty or nolo contendere to a felony for receipt of illicit and diverted drugs, including any Schedule I-V substance, anywhere in the United States.[24]

DOH must revoke a pain-management clinic's registration if the same reasons for denial above apply to a registered clinic.[25] However, by rule, DOH may grant an exemption to such denial or revocation for felony convictions if more than 10 years have elapsed since adjudication.[26] DOH may also revoke a clinic's registration based on inspection.[27]

If a clinic's registration is revoked or suspended, the clinic must stop operating, and the clinic must remove all identification that the location is a pain-management clinic.[28] Additionally, the clinic must follow certain procedures to dispose of its medicinal drugs.[29] A required 5 year cooling-off period prohibits anyone whose registration has been revoked from applying for a permit to operate a pain-management clinic.[30] If a clinic's registration is suspended, that suspension may not exceed 1 year.[31]

*Pain-Management Clinic Physicians*

A physician may not practice medicine at a pain-management clinic unless the clinic is registered and the physician is qualified to practice in the clinic pursuant to the governing board's rules. If a physician practices medicine at the clinic in violation of these requirements, the physician is subject to board discipline under s. 456.072, F.S.[32]

Only physicians licensed under ch. 458 or ch. 459, F.S., may dispense medication at pain-management clinics;[33] however, s. 465.0276, F.S., prohibits physicians from dispensing Schedule II and Schedule III controlled substances. If a physician prescribes a controlled substance for a patient, the physician, or a physician assistant or advanced registered nurse practitioner, must perform a physical examination of the patient on the same day.[34] If that prescription[35] is for more than a 72-hour dose and for the

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[22] S. 458.3265(1)(m), F.S.; s. 459.0137(1)(m), F.S.
[23] S. 458.3265(1)(d), F.S.; s. 459.0137(1)(d), F.S.
[24] S. 458.3265(1)(e), F.S.; s. 459.0137(1)(e), F.S.
[25] S. 458.3265(1)(f), F.S.; s. 459.0137(1)(f), F.S.
[26] *Id.*
[27] S. 458.3265(1)(g), F.S.; s. 459.0137(1)(g), F.S.
[28] S. 458.3265(1)(h), (i), F.S.; s. 459.0137(1)(h), (i), F.S.
[29] S. 458.3265(1)(j), F.S.; s. 459.0137(1)(j), F.S.
[30] S. 458.3265(1)(k), F.S.; s. 459.0137(1)(k), F.S.
[31] S. 458.3265(1)(l), F.S.; s. 459.0137(1)(l), F.S.
[32] S. 458.3265(2)(a), F.S.; s. 459.0137(2)(a), F.S. Discipline may include suspension or revocation of a license, restriction of practice or license, reprimand, fines, or other actions available to the board. S. 465.072(2), F.S.
[33] S. 458.3265(2)(b), F.S.; s. 459.0137(2)(b), F.S.
[34] S. 458.3265(2)(c), F.S.; s. 459.0137(2)(c), F.S.
[35] Physicians are responsible for their prescription blanks (and any other method used for prescription), must comply with the security requirements of s. 893.065, F.S., and must notify DOH of any stolen or missing prescription blanks (or breach of any other method used for prescription). S. 458.3265(2)(d), F.S.; s. 459.0137(2)(d), F.S.

treatment of chronic nonmalignant pain, the physician must document the reason for the quantity in the patient's record.[36]

Every physician practicing in a pain-management clinic must ensure compliance with a list of requirements, which relate to clinic access, clinic infrastructure, patient privacy, clinic security,[37] infection control,[38] clinic safety, and clinic personnel.[39] However, these requirements do not supersede the standard of care, skill, and treatment required of physicians recognized in general law related to health care licensure.[40]

*Designated Physicians*

Each clinic must designate a physician who is responsible for complying with the registration and other requirements in the section.[41] This designated, fully licensed physician must practice at the clinic, and if the clinic does not have this designated physician, the clinic is at risk for summary suspension.[42]

A designated physician at a registered clinic must notify the governing board within 10 days after the designated physician's termination of employment at the clinic.[43] Any physician at a registered clinic must notify the governing board within 10 days after beginning or ending the physician's practice at the clinic.[44]

The designated physician must ensure compliance with a list of quality and reporting requirements. The designated physician must implement a quality assurance program ("QAP") for each clinic to monitor and evaluate patient care, evaluate methods to improve the care, identify and correct facility deficiencies, alert the designated physician to identify and resolve recurring problems, and provide for opportunities to improve the facility's performance and enhance and improve the quality of care provided to the public. In addition, the QAP must:

- Identify, investigate, and analyze the frequency and causes of adverse incidents to patients;
- Identify trends or patterns of incidents;
- Develop measures to correct, reduce, minimize, or eliminate the risk of adverse incidents to patients; and
- Document these functions which must be periodically reviewed at least every quarter by the designated physician.[45]

The designated physician must report all adverse incidents to DOH pursuant to s. 458.351 or s. 459.026, F.S., as applicable, and must quarterly report to the governing board:

- The number of new and repeat patients seen and treated at the clinic who are prescribed controlled substance medications for the treatment of chronic, nonmalignant pain;
- The number of patients discharged due to drug abuse;
- The number of patients discharged due to drug diversion; and
- The number of treated at the pain clinic who have their domicile outside of Florida.[46]

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36 S. 458.3265(2)(c), F.S.; s. 459.0137(2)(c), F.S.
37 S. 458.3265(2)(f)(1.), F.S.; s. 459.0137(2)(f)(1.), F.S.
38 S. 458.3265(2)(g), F.S.; s. 459.0137(2)(g), F.S.
39 S. 458.3265(2)(h), F.S.; s. 459.0137(2)(h), F.S.
40 S. 458.3265(2)(f)(2.), F.S.; s. 459.0137(2)(f)(2.), F.S.
41 S. 458.3265(1)(c), F.S.; s. 459.0137(1)(c), F.S.
42 *Id.*
43 S. 458.3265(2)(e), F.S.; s. 459.0137(2)(e), F.S.
44 *Id.*
45 S. 458.3265(2)(i), F.S.; s. 459.0137(2)(i), F.S.
46 S. 458.3265(2)(j), F.S.; s. 459.0137(2)(j), F.S.

*Inspections*

DOH is required to inspect each pain-management clinic annually, unless the clinic is accredited by a board-approved agency.[47] During this inspection, DOH must make a reasonable attempt to discuss each violation with the owner or designated physician before issuing a formal written notification.[48] The owner or designated physician must document any action taken to correct a violation, and DOH must verify this action with followup visits.[49]

*Penalties*

DOH may impose a fine on a clinic of up to $5,000 per violation[50] of:

- DOH rules;
- S. 458.3265 or s. 459.0137, F.S., relating to pain-management clinics;
- The Florida Drug and Cosmetic Act;
- The Federal Food, Drug, and Cosmetic Act;
- The Florida Comprehensive Drug Abuse Prevention and Control Act; or
- The federal Comprehensive Drug Abuse Prevention and Control Act.[51]

Additionally, if the clinic's designated physician knowingly and intentionally misrepresents actions taken to correct a violation, DOH may impose a fine and, if the clinic is owner-operated, may revoke or deny registration.[52]

DOH must consider the following factors when determining the amount of the fine:

- The gravity of the violation, including the probability of death or serious harm to a patient from the clinic's or physician's action, the severity of the action or harm, and the extent of the violation;
- Actions the owner or designated physician took to correct the violation;
- Prior violations at the clinic; and
- The financial benefits that the clinic derived from the violation.[53]

An owner or designated physician who operates an unregistered clinic is subject to a $5,000 fine per day,[54] and an owner of a clinic who fails to apply to register the clinic upon a change of ownership and then operates the clinic under the new ownership is subject to a fine of $5,000.[55]

In 2011, the Legislature added sunset provisions for s. 458.3265 and s. 459.0137, F.S.[56] Currently, s. 458.3265 and s. 459.0137, F.S., governing pain-management clinics, are set to expire on January 1, 2016.[57]

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[47] S. 458.3265(3)(a), F.S.; s. 459.0137(3)(a), F.S.
[48] S. 458.3265(3)(b), F.S.; s. 459.0137(3)(b), F.S.
[49] S. 458.3265(3)(c), F.S.; s. 459.0137(3)(c), F.S.
[50] Each day a violation continues constitutes an additional violation. S. 458.3265(5)(b), F.S.; s. 459.0137(5)(b), F.S.
[51] S. 458.3265(5)(a), F.S.; s. 459.0137(5)(a), F.S.
[52] S. 458.3265(5)(c), F.S.; s. 459.0137(5)(c), F.S.
[53] S. 458.3265(5)(a), F.S.; s. 459.0137(5)(a), F.S.
[54] S. 458.3265(5)(d), F.S.; s. 459.0137(5)(d), F.S.
[55] S. 458.3265(5)(e), F.S.; s. 459.0137(5)(e), F.S.
[56] Ch. 2011-141, ss. 4, 7, Laws of Fla.
[57] S. 458.3265(6), F.S.; s. 459.0137(6), F.S.

Florida Prescription Drug Deaths

Overall prescription drug overdose deaths dropped 7.3% during 2012-2013, while oxycodone overdose deaths dropped 27.3%.[58] Oxycodone deaths have decreased a total of 64.8% when comparing deaths in 2010 to 2013.[59] From September 2010 to Fiscal Year 2013-2014, the number of registered pain-management clinics dropped from 943 to 362.[60]

**Effect of the Bill**

This bill repeals the sunset provisions applicable to pain-management clinic regulations in s. 458.3265 and s. 459.0137, F.S., which would otherwise cause those sections to expire on January 1, 2016.

B. SECTION DIRECTORY:

**Section 1:** Amends s. 458.3265, F.S., related to pain-management clinics.
**Section 2:** Amends s. 459.0137, F.S., related to pain-management clinics.
**Section 3:** Provides that the act takes effect upon becoming a law.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

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[58] "Drugs Identified in Deceased Persons by Florida Medical Examiners," FLA. DEP'T OF LAW ENFORCEMENT 2013 ANNUAL REPORT i (Oct. 2014).
[59] *Id.*
[60] "2015 Agency Legislative Bill Analysis: HB 4017," FLA. DEP'T OF HEALTH (Jan. 30, 2015).

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to pain-management clinics; amending
3 ss. 458.3265 and 459.0137, F.S.; deleting the
4 expiration of provisions related to the registration
5 and regulation of pain-management clinics; providing
6 an effective date.
7
8 Be It Enacted by the Legislature of the State of Florida:
9
10 Section 1. Subsection (6) of section 458.3265, Florida
11 Statutes, is amended to read:
12 458.3265 Pain-management clinics.—
13 ~~(6) EXPIRATION.—This section expires January 1, 2016.~~
14 Section 2. Subsection (6) of section 459.0137, Florida
15 Statutes, is amended to read:
16 459.0137 Pain-management clinics.—
17 ~~(6) EXPIRATION.—This section expires January 1, 2016.~~
18 Section 3. This act shall take effect upon becoming a law.

PCB HHSC 15-02

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** PCB HHSC 15-02 State Group Insurance Program
**SPONSOR(S):** Health & Human Services Committee; Brodeur
**TIED BILLS:** **IDEN./SIM. BILLS:**

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

## SUMMARY ANALYSIS


The State Group Insurance Program (program), administered by the Department of Management Services (DMS), is an optional benefit for employees that includes health, life, dental, vision, disability, and other supplemental insurance benefits. The program offers employees a choice among a health maintenance organization (HMO) plan, prefer provider plan (PPO) plan, and a high-deductible health plan (HDHP) with a health saving account (HSA). However, only one benefit level is offered for each plan type. Additionally, the employee's premium for the HMO and PPO are the same, even though the HMO provides greater benefits.

The bill directs DMS to establish employee contribution rates for the 2016 plan year which reflect the full actuarial benefit difference between the HMO and the PPO. The PPO contribution rate must be less than the employee contribution level for the 2015 plan year. Consequently, next year, employees will be given a choice between paying more for the higher value HMO and paying less, compared to the prior year, for the lower value PPO. Employees will have a choice between richer benefits and greater take-home pay.

The bill adds new products and services to the program by giving DMS broad authority to contract for a wide variety of additional products and services. Employees will be able to purchase new products as optional benefits. DMS is directed to contract with at least one entity that provides comprehensive pricing and inclusive services for surgery and other types of medical procedures.

Beginning in 2016, DMS is directed to implement a 3-year price transparency pilot project in at least one, but no more than three areas of the state. The purpose of the pilot is to reward value-based pricing by publishing the prices of certain diagnostic and surgical procedures and sharing any savings generated by the enrollee's choice of providers. Participation in the project will be voluntary for state employees.

Beginning in the 2018 plan year, the bill provides that state employees will have health plan choices at four different benefit levels. If the state's contribution for premium is more than the cost of the plan selected by the employee, then the employee may use the remainder to:

- Fund a flexible spending arrangement.
- Fund a health savings account.
- Purchase additional benefits offered through the state group insurance program.
- Increase the employee's salary.

The bill directs DMS to hire an independent benefits consultant (IBC). The IBC will assist DMS in developing a plan for the implementation of the new benefit levels in the program. The plan shall be submitted to the Governor, the President of the Senate and the Speaker of the House of Representatives no later than January 1, 2017. The IBC will also provide ongoing assessments and analysis for the program.

The state may experience both costs and savings. See fiscal comments.

The bill has an effective date of July 1, 2015.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**State Group Insurance Program**

Overview

The State Group Insurance Program (state program) is created by s. 110.123, F.S., and is administered by the Division of State Group Insurance (DSGI) within the Department of Management Services (DMS or department).

The state program is an optional benefit for all state employees including all state agencies, state universities, the court system, and the Legislature. The program includes health, life, dental, vision, disability, and other supplemental insurance benefits.

The health insurance benefit for active employees has premium rates for single, spouse program[1], or family coverage regardless of plan selection. The state contributed approximately 90% toward the total annual premium for active employees for a total of $1.55 billion out of total premium of $2 billion for FY 2013-14[2]. The enrollees contributed $393 million and remaining $89 million was from other sources such as interest, refunds, and rebates.

Cafeteria Plans

A cafeteria plan is a plan that offers flexible benefits under Section 125 of the Internal Revenue Code. Employees choose from a "menu" of benefits. The plan can provide a number of selections, including medical, accident, disability, vision, dental and group term life insurance. It can reimburse actual medical expenses or pay children's day care expenses.

A cafeteria plan reduces both the employer's and employee's tax burden. Contributions by the employer are not subject to the employer social security contribution. Contributions made by the employee are not subject to federal income or social security taxes.

The employer chooses the range of benefits it wishes to offer in a cafeteria plan. The plan can be a simple premium-only plan where only health insurance is offered. Full flex plans, which offer a wide variety of benefits and choices, are more often offered by large employers and allow for more consumer-directed consumption of benefits. In some full flex plans, the employee is offered the choice between receiving additional compensation in lieu of benefits.

The state program qualifies as a cafeteria plan[3] even though it offers relatively narrow health plan options compared to other cafeteria plans.

Health Plan Options

The program provides limited options for employees to choose as their health plan. The preferred provider organization (PPO) plan is the statewide, self-insured health plan administered by Florida Blue, whose current contract is for the 2015 through 2018 plan years. The administrator is responsible

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[1] The Spouse Program provides discounted rates for family coverage when both spouses work for the state.

[2] Fiscal information provided by DSGI.

[3] 26 USC sec. 125 requires that a cafeteria plan allow its members to choose between two or more benefits "consisting of cash and qualified benefits." The proposed regulations define "cash" to include a "salary reduction arrangement" whereby salary is deducted pre-tax to pay the employee's share of the insurance premium. Since the state program allows a "salary reduction arrangement", the program qualifies as a cafeteria plan. 26 C.F.R. ss. 1.125-1, et seq.

for processing health claims, providing access to a Preferred Provider Care Network, and managing customer service, utilization review, and case management functions. The standard health maintenance organization (HMO) plan is an insurance arrangement in which the state has contracted with multiple statewide and regional HMOs[4].

Prior to the 2011 plan year, the participating HMOs were fully insured; in other words, the HMOs assumed all financial risk for the covered benefits. During the 2010 session, the Legislature enacted s. 110.12302, F.S., which directed DMS to require costing options for both fully insured and self-insured plan designs as part of the department's solicitation for HMO contracts for the 2012 plan year and beyond. The department included these costing options in its Invitation to Negotiate[5] to HMOs for contracts for plans years beginning January 1, 2012. The department entered into contracts for the 2012 and 2013 plan years with two HMOs with a fully insured plan design and four with a self-insured plan design. The contracts with the HMOs have been renewed for the 2015 plan year.

Additionally, the program offers two high-deductible health plans (HDHP[6]) with health savings accounts[7]. The Health Investor PPO Plan is the statewide HDHP with an integrated health saving account. It is also administered by Florida Blue. The Health Investor HMO Plan is an HDHP with an integrated health saving account in which the state has contracted with multiple state and regional HMOs. Both have an individual deductible of $1,350 for individual and $2,600 for family for network providers. The state makes a $500 per year contribution to the health savings account for single coverage and a $1,000 per year contribution for family coverage. The employee may make additional annual contributions[8] to a limit of $3,350 for single coverage and $6,650 for family coverage. Both the employer and employee contributions are not subject to federal income tax on the employee's income. Unused funds roll over automatically every year. A health savings account is owned by the employee and is portable.

The following charts illustrate the benefit design of each of the plan choices:

| | HMO Standard | PPO Standard | |
|---|---|---|---|
| | Network Only | Network | Out-of-Network |
| Deductible | None | $250 \| $500 Single \| Family | $750 \| $1,500 Single \| Family |
| Primary Care | $20 copayment | $15 copayment | 40% of out-of-network allowance plus the amount between the charge and the allowance |
| Specialist | $40 copayment | $25 copayment | |
| Urgent Care | $25 copayment | $25 copayment | |
| Emergency Room | $100 copayment | $100 copayment | |
| Hospital Stay | $250 copayment | 20% after $250 copayment | 40% after $500 copayment plus the amount between the charge and the allowance |

[4]The HMOs include Aetna, AvMed, Capital Health Plan, Coventry Health Care of Florida, Florida Health Care Plans and UnitedHealthcare.
[5] ITN NO.: DMS 10/11-011
[6] High-deductible health plans with linked health savings accounts are also call consumer-directed health plans (CDHP) because costs of health care are more visible to the enrollee.
[7] 26 USC sec. 223; To qualify as a high-deductible plan, the annual deductible must be at least $1,300 for single plans and $2,600 for family coverage, but annual out-of-pocket expenses cannot exceed $6,450 for individual and $12,900 for family coverage. These amounts are adjusted annually by the IRS.
[8] The IRS annually sets the contribution limit as adjusted by inflation.

| Generic \| Preferred \| Non-Preferred Prescriptions | $7 \| $30 \| $50 Retail<br>$14 \| $60 \| $100 Mail Order | $7 \| $30 \| $50 Retail<br>$14 \| $60 \| $100 Mail Order | Pay in full, file claim |
|---|---|---|---|
| Out-of-Pocket Maximum | $1,500 \| $3,000 Single \| Family | $2,500 \| $5,000 (coinsurance only) Single \| Family | |

| | PPO and HMO Health Investor | |
|---|---|---|
| | Network | Out-of-Network (PPO Only) |
| Deductible | $1,250 \| $2,500 Single \| Family | $2,500 \| $5,000 Single \| Family |
| Primary Care | After meeting deductible, 20% of network allowed amount | After meeting deductible, 40% of out-of-network allowance plus the amount between the charge and the allowance |
| Specialist | | |
| Urgent Care | | |
| Emergency Room | | |
| Hospital Stay | | After meeting deductible, 40% after $1,000 copayment plus the amount between the charge and the allowance |
| Generic \| Preferred \| Non-Preferred Prescriptions | After meeting deductible , 30% \| 30% \| 50% Retail and Mail Order | Pay in full, file claim |
| Out-of-Pocket Maximum | $3,000 \| $6,000 (coinsurance only) Single \| Family | $7,500 \| $15,000 (coinsurance only) Single \| Family |

Flexible Spending Accounts

Currently, the state program offers flexible spending accounts (FSAs)[9] as an optional benefit for employees. The FSA is funded though pre-tax payroll deductions from the employee's salary[10]. The funds can be used to pay for medical expenses that are not covered by the employees' health plan. Prior to 2013, there was no limit on the contribution to a FSA; however, it is now limited to $2,500 and subsequently adjusted for inflation. Unlike a HSA, a FSA is a "use it or lose it" arrangement.[11] If the employee does not annually use the contributions to the FSA, the contributions are forfeited.

[9] Sec. 125 I.R.C.; *see* IRS Publication 969 (2014) available at http://www.irs.gov/pub/irs-pdf/p969.pdf (last viewed March 14, 2015).
[10] Employers are also allowed to contribute to FSAs.
[11] Beginning in 2013, an employee may carryover up to $500 into the next calendar year.

Employer and Employee Contributions

The state program is considered employer-sponsored since the state contracts with providers and contributes a substantial amount on behalf of the employee toward the cost of the insurance premium. The state's employer contribution is part of a state employee's overall compensation. The state program is a defined-benefit program. In a defined-contribution program, the employer pays a set amount toward the monthly premium and the employee pays the remainder.

The following chart shows the monthly contributions[12] of the state and the employee to employee health insurance premiums.

| Subscriber Category | Coverage Type | PPO and HMO Standard | | | PPO and HMO Health Investor | | |
|---|---|---|---|---|---|---|---|
| | | Employer | Enrollee | Total | Employer* | Enrollee | Total |
| Career Service /OPS | Single | 591.52 | 50.00 | 641.52 | 591.52 | 15.00 | 606.52 |
| | Family | 1,264.06 | 180.00 | 1,444.06 | 1,264.06 | 64.30 | 1,328.36 |
| | Spouse | 1,429.08 | 30.00 | 1,459.08 | 1,298.36 | 30.00 | 1,328.36 |
| "Payalls" (SES/SMS) | Single | 637.34 | 8.34 | 645.68 | 598.18 | 8.34 | 606.52 |
| | Family | 1,429.06 | 30.00 | 1,459.06 | 1,298.36 | 30.00 | 1,328.36 |

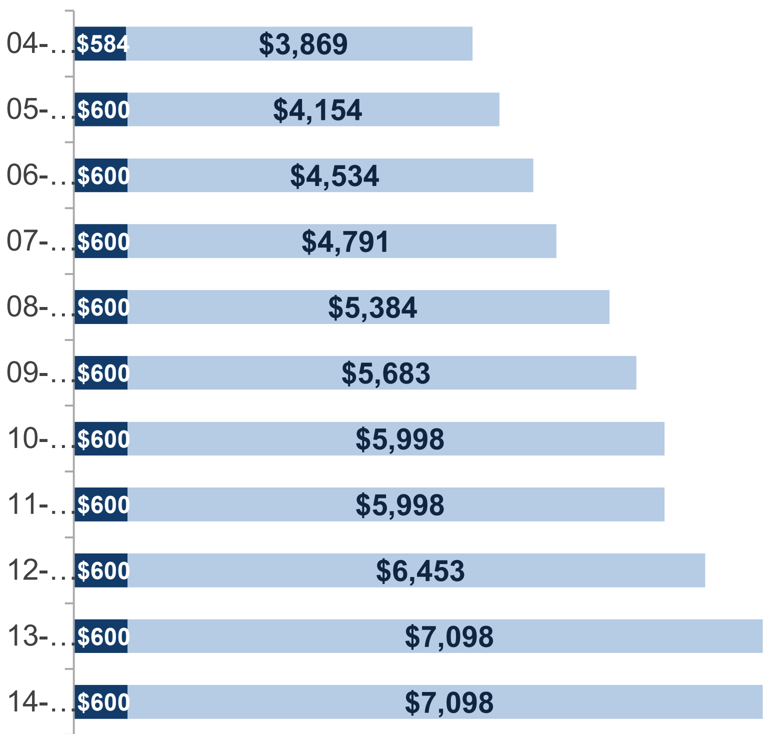
* Includes employer tax-free Health Savings Account (HSA) contribution - $41.66 and $83.33 per month for single and family coverage, respectively

The state program is projected to spend $2.2 billion in FY 2015-2016 in health benefit costs.[13] The aggregate annual spending growth rate of the program is 9.5%. The state has absorbed almost all of the cost of the increase and employee contributions have remained the same for the last nine years as illustrated by the following chart.[14]

[12] Department of Management Services, *Overview of the State Group Health Insurance Program*, presentation to the Health and Human Services Committee on March 12, 2015, slide 6 (on file with Committee staff).

[13] Id.

[14] Id at slide 15.


Single Coverage Annual Premium
Employee
State
04-…
05-…
06-…
07-…
08-…
09-…
10-…
11-…
12-…
13-…
14-…
$584
$3,869
$600
$4,154
$600
$4,534
$600
$4,791
$600
$5,384
$600
$5,683
$600
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$7,098
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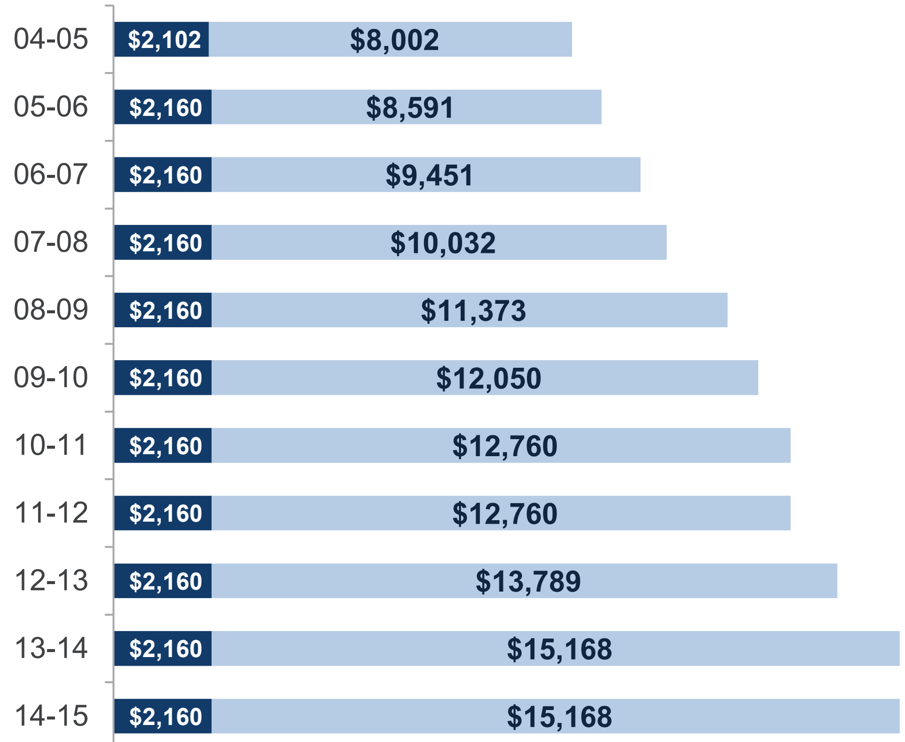

Family Coverage Annual Premium
Employee
State
04-05
05-06
06-07
07-08
08-09
09-10
10-11
11-12
12-13
13-14
14-15
$2,102
$8,002
$2,160
$8,591
$2,160
$9,451
$2,160
$10,032
$2,160
$11,373
$2,160
$12,050
$2,160
$12,760
$2,160
$12,760
$2,160
$13,789
$2,160
$15,168
$2,160
$15,168

Plan Enrollment

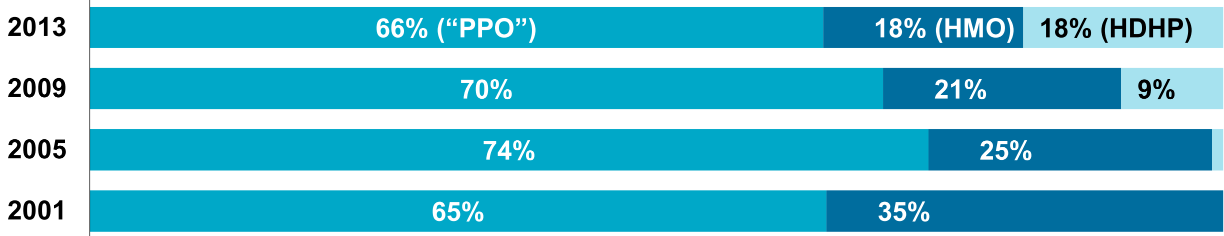
The state program has 361,342 covered lives and 173,097 policyholders.[15] Currently, 50.7% of enrollees chose the standard HMO and 47.9% chose the standard PPO.[16] Only 1.4% of enrollees chose either HDHP.[17] During the most recent open enrollment, PPO enrollment increased slightly, by 0.05%, and HMO enrollment decreased by 0.46%.[18] Five year Open Enrollment trends show that annual enrollment in the PPO plans decreased.[19]

**Employer Sponsored Insurance Trends**

In 2010, DSGI contracted with Mercer Consulting to prepare a Benchmarking Report[20] (report) for the state. The report compares Florida's program to the programs of other large employers[21], both in the public and in the private sectors. The report found that the State of Florida contributes a higher percentage of the premium to employee health benefits than other states and private employers. At the time, Florida paid 84% of the monthly premium for a family PPO plan, but the average for large national employers was 69%. This results in Florida state employees paying less in monthly premiums than other states' employees and private employees. For example, the monthly premium for a family PPO plan for a Florida state employee is $180 and in 2011, the average premium for large national employers was $361.

Today, the monthly premium for a family PPO plan for a Florida state employee is still $180; however, the state now pays 88% of the premium[22] and the benchmark premium for large national employers ranges from $270 to $391 with the company paying 71% to 79% of the premium.[23]

The national trend among large employer health plans is increasing enrollment in high-deductible health plans (HDHP) and declining enrollment in HMOs as illustrated in the following chart[24]:




The state program's trend is the reverse of the national trend in HMO, PPO, and HDHP because of the HMO's high actuarial value and no difference in premiums between the HMO and PPO. The actuarial value (AV) measures the percentage of expected medical costs that a health plan will cover and is generally considered a measure of the health plan's generosity. The state program's standard HMO as

[15] Supra at FN 12, slide 5.
[16] Id. at slide 7.
[17] Id. at slide 8.
[18] State Employees' Group Health Self-Insurance Trust Fund, *Report on the Financial Outlook*, March 9, 2015, available at http://edr.state.fl.us/Content/conferences/healthinsurance/HealthInsuranceOutlook.pdf (last viewed March 14, 2015).
[19] Supra at FN 12, slide 10.
[20] Mercer Consulting, *State of Florida Benchmarking Report* (March 24, 2011), available at: http://www.dms.myflorida.com/content/download/81475/468865/version/1/file/2010+Small+Employer+Benchmarking+Report+for+State+of+Florida.pdf
[21] For the purpose of the report, "large employers" had 500 or more employees.
[22] The state contributes 92% of the premium for the individual PPO plan.
[23] *Market-Based Framework for Health Plan Program Changes*, Mercer Health & Benefits, presentation to the Health and Human Services Committee on January 16, 2014, at slide 18.
[24] Mercer at slide 6.

an AV of 93%, the standard PPO has an AV of 86%, and the HDHP has an AV of 80%.[25] Accordingly, enrollees in the state program gravitate toward the high value, low cost HMO because they experience no price difference between the plans.

**Employee Choice**

The FY 2011-2012 General Appropriations Act directed DMS to develop a report of plan alternatives and options for the state program. DMS contracted with Buck Consultants which released its report[26] on September 29, 2011. The report concludes:

> The state's current approach to its health plan is best described as paternalistic, whereby the state serves as the architect/custodian of the plan, providing generous benefits and allowing employees to be passive and perhaps even entitled, with little concern about costs. Historically prevalent among large and governmental employers, this approach is rapidly being replaced by initiatives that focus on increasing and improving consumerism behaviors. In the consumerism approach the employer and employees maintain shared accountability, with the employer providing a supportive environment, partnering with employees and enabling them to make informed decisions, considering costs and outcomes of the health care services they seek and receive.

In a presentation before the Health and Human Services Committee on January 16, 2014, Mercer Health & Benefits (Mercer) reported that the state program is behind other large employers in key survey trends.[27] The state program has plans with lower premiums and higher benefits than industry benchmarks.[28] There is virtually no enrollment in HDHPs versus significant growth nationally.[29] Florida's plan costs and annual trend increase are higher than national survey data.[30] State employees have little real choice among health plan options since there is only a 7% difference in the "richness of the benefits" between the HMO and PPO, and the price is the same.[31] Consequently, 99% of enrollees chose the HMO or PPO with little to no incentive to choose the HDHP.[32]

**Effect of the Bill**

Premium Adjustments

Current law provides that "the state contribution toward the cost of any plan in the state group insurance program shall be uniform with respect to all state employees . . .participating in the same coverage tier[33] in the same plan."[34] Since there is a 7% difference is the actuarial value between the HMO and the PPO, the state currently pays more from the State Employees' Group Health Self-Insurance Trust Fund (Trust Fund) for the HMO benefits. However, each year the Legislature sets uniform premium amounts in the General Appropriations Act for state paid premiums. The premiums are deposited into the Trust Fund and used to pay the expenses of the state program.

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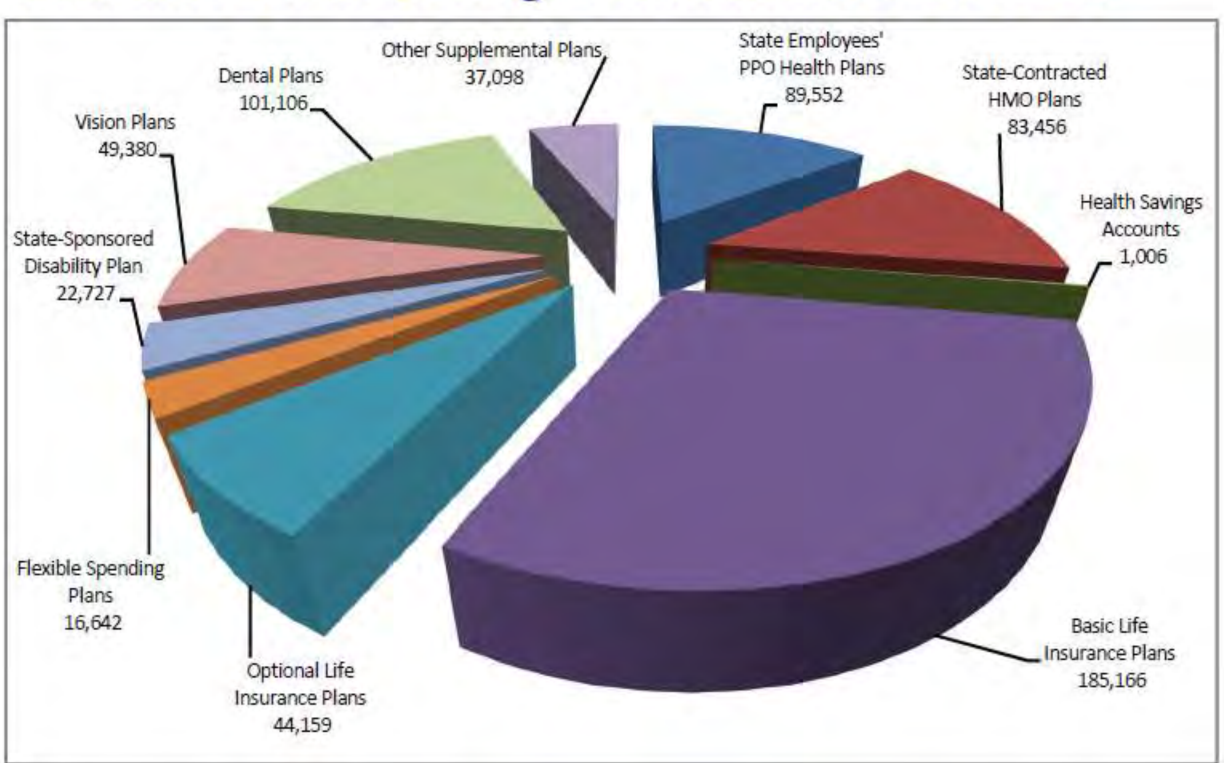
[25] Mercer at slide 20.
[26] Buck Consultants, *Strategic Health Plan Options for the State of Florida* (September 29, 2011), available at: http://www.dms.myflorida.com/content/download/81468/468856/version/1/file/Strategic+Health+Plan+Options+for+the+State+of+Florida+9-30-11+-+Final.pdf (last viewed on March 14, 2015).
[27] Mercer at slide 5.
[28] Mercer at slide 5.
[29] Mercer at slide 5.
[30] Mercer at slide 6.
[31] Mercer at slide 9.
[32] Mercer at slide 9.
[33] The coverage tier is either individual or family.
[34] S. 110.123(3)(f), F.S.

The bill directs DMS to establish employee contribution rates for 2016 plan year that reflect the full actuarial benefit difference between the HMO and the PPO. The rates must be revenue neutral to the Trust Fund and the PPO contribution rate must be less than the employee contribution level for the 2015 plan year. Consequently, next year employees will have a choice between paying more for the higher value HMO and paying less for the lower value PPO. Employees will have a choice between richer benefits and greater take-home pay and the state will still make a uniform contribution on behalf of each employee.

Additional Benefits

Many state employees enroll in products offered by the state program other than health insurance, as illustrated in the following chart:




The bill allows DMS to contract for additional products to be included in the state program. These include:

- Prepaid limited health service organizations as authorized under part I of chapter 636.
- Discount medical plan organizations as authorized under part II of chapter 636.
- Prepaid health clinic service providers licensed under part II of chapter 641.
- Health care providers, including hospitals and other licensed health facilities, health care clinics, licensed health professionals, and other licensed health care providers, who sell service contracts and arrangements for a specified amount and type of health services.
- Provider organizations, including service networks, group practices, professional associations, and other incorporated organizations of providers, who sell service contracts and arrangements for a specified amount and type of health services.
- Entities that provide specific health services in accordance with applicable state law and sell service contracts and arrangements for a specified amount and type of health services.
- Entities that provide health services or treatments through a bidding process.

- Entities that provide health services or treatments through bundling or aggregating the health services or treatments.
- Entities that provide other innovative and cost-effective health service delivery methods.

The bill also directs DMS to contract with at least one entity that provides comprehensive pricing and inclusive services for surgery and other medical procedures. These bundled services will be another option for state employees. The entity will be required to have procedures and evidence-based standards to assure only high quality health care providers are included. Assistance must be provided to the enrollee in accessing care and in the coordination of the care. The bundled services must provide cost savings to the state program and the enrollee, which will be shared by the state and the enrollee. The cost savings payable to an enrollee can be paid:

- To the enrollee's flexible spending account;
- To the enrollee's health savings account;
- To the enrollee's health reimbursement account; or
- To the enrollee as additional health plan reimbursements not exceeding the amount of the enrollee's out-of-pocket medical expenses.

The selected entity must provide an educational campaign for employees to learn about the offered services.

By January 15 of each year, DMS must report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the participation level and cost-savings to both the enrollee and the state resulting from contract.

Price Transparency Pilot Project

The costs of health care procedures are often unknown and unknowable to consumers and can vary dramatically among providers.[35] The following chart shows the extreme price differences across the country of the average cost to Medicare for a joint replacement.

| | Hospital Charges | Actual Payment |
|---|---|---|
| Maryland | $21,230 | $20,048 |
| Delaware | $32,629 | $14,765 |
| Hawaii | $39,463 | $18,512 |
| Georgia | $46,856 | $13,303 |
| Pennsylvania | $51,014 | $13,679 |
| South Carolina | $57,557 | $13,651 |
| Arkansas | $63,290 | $21,160 |
| New Jersey | $66,639 | $15,059 |
| Nevada | $71,782 | $13,621 |
| California | $88,238 | $17,187 |

Note: This includes all joints other than hips.
*Source: Centers for Medicare & Medicaid Services, May 8, 2013*

California Public Employees' Retirement System (CalPERS), the second largest benefits program in the country started a "reference pricing" initiative in 2011. CalPERS set a threshold of $30,000 for

[35] How to Bring the Price of Health Care Into the Open, The Wall Street Journal, Melinda Beck, February 23, 2014, available at: http://online.wsj.com/news/articles/SB10001424052702303650204579375242842086688?mod=trending_now_5 (last viewed March 14, 2015). Does Knowing Medical Prices Save Money? CalPERS Experiment Says Yes, Kaiser Health New, Ankita Rao, December 6, 2013, available at: http://capsules.kaiserhealthnews.org/index.php/2013/12/does-knowing-medical-prices-save-money-calpers-experiment-says-yes/ (last viewed March 14, 2015).

hospital payments for both for inpatient hip and knee replacements and designated certain hospitals where enrollees could get care at or below that price. If enrollees had surgery at designated hospitals, they paid only their plans' typical deductible and coinsurance up to the out-of-pocket maximum. Patients could go to other in-network hospitals for care but were responsible for both the typical cost sharing and all allowed amounts exceeding the $30,000 threshold, which were not subject to an out-of-pocket maximum. The initiative resulted in $2.8 million for CalPERS and $300,000 in savings for enrollees in 2011 without sacrificing quality.[36]

The bill directs DMS to implement beginning in 2016 a 3-year price transparency pilot project. The purpose of the pilot is to reward value-based pricing by publishing the prices of certain diagnostic and surgical procedures and sharing any savings generated by the enrollee's choice of providers. Participation in the project will be voluntary for state employees.

DMS must select between one and three areas of the state for the project. DMS will designate between 20 and 50 diagnostic procedures and elective surgical procedures that are commonly utilized by enrollees. The health plans will provide to DMS the contracted prices by provider for these procedures. DMS shall designate a benchmark price for each procedure.

If an employee participating in the project selects a provider who offers the procedure at a price below the benchmark, the state shall pay to the employee fifty percent of the difference between the benchmark and the price paid. The amount payable to the employee can be paid:

- To the employee's flexible spending account;
- To the employee's health savings account;
- To the employee's health reimbursement account; or
- To the employee as additional health plan reimbursements not exceeding the amount of the enrollee's out-of-pocket medical expenses.

By January 1 of 2017, 2018, and 2019, the department shall report to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the participation level, the amount paid to enrollees, and cost-savings to both the enrollees and the state resulting from the price transparency pilot project.

Additional Benefit Choices

Beginning in the 2018 plan year, the bill provides that state employees will have health plan choices at four different benefit levels. These levels are:

- Platinum Level (at least 90% AV)
- Gold Level (at least 80% AV)
- Silver Level (at least 70% AV)
- Bronze Level (at least 60% AV)

The state will make a defined contribution for each employee toward the cost of purchasing a health plan. Employees will have the following options:

- Use the entire employer contribution to pay for health insurance and pay any additional premium if the cost of the plan exceeds the employer contribution.
- Use part of the employer contribution to pay for health insurance and have the balance credited to a flexible spending arrangement.

[36] The Potential of Reference Pricing to Generate Health Care Savings: Lessons from a California Pioneer, Center for Studying Health System Change, Amanda E. Lechner, Rebecca Gourevitch, Paul B. Ginsburg, Research Brief No. 30, December 2013, available at: http://www.hschange.org/CONTENT/1397/#ib6 (last viewed March 14, 2015).

- Use part of the employer contribution to pay for health insurance and have the balance credited to a health savings account.
- Use part of the employer contribution to pay for health insurance and use the balance to purchase additional benefits offered through the state group insurance program.
- Use part of the employer contribution to pay for health insurance and have the balance used to increase the employees pay.[37]

The state currently pays 92 percent of the employee's premium for an individual plan and 88 percent for a family plan for a Platinum level plan (HMO) or a Gold level plan (PPO).

The following chart illustrates a hypothetical[38] example for a Career Service employee with a family plan and a defined contribution benchmarked using the current state contribution, current employee contribution, and the current plan cost:

| Family Coverage | Current Plan (86% - 93% AV) | 80% AV Coverage | 70% AV Coverage | 60% AV Coverage |
|---|---|---|---|---|
| State Contribution | $15,168 | $15,168 | $15,168 | $15,168 |
| Plan Cost | $17,328 | $14,344 | $12,852 | $11,361 |
| Employee Contribution | $2,160 | $0 | $0 | $0 |
| Employee Receives | $0 | $824 | $2,316 | $3,807 |

Under this hypothetical, the employee may choose the same value health plan as the employee has today and pay the same amount as today. Unlike today, the employee may also choose a different health plan and use the remainder toward other health benefits or receive additional salary.

Independent Benefits Consultant

The bill also directs DMS to competitively procure an independent benefits consultant (IBC). The IBC must not be or have a financial relationship in any HMO or insurer. Additionally, the IBC must have substantial experience in designing and administering benefit plans for large employers and public employers.

The IBC will assist DMS in developing a plan for the implementation of the new benefit levels in the state program. The plan shall be submitted to the Governor, the President of the Senate and the Speaker of the House of Representatives no later than January 1, 2017, and include recommendations for:

- Employer and employee contribution policies.
- Steps necessary for maintaining or improving total employee compensation levels when the transition is initiated.
- An education strategy to inform employees on the additional choices available in the state program.

The ongoing duties of the IBC include:

- Providing assessments of trends in benefits and employer sponsored insurance that affect the state program.

[37] The employee must use part of the employer contribution to purchase health insurance. The employee may not receive pay in lieu of benefits.

[38] All examples must be hypothetical since the 2018 benefit structure and plan actuarial values cannot be known at this time.

- Conducting comprehensive analysis of the state program including available benefits, coverage options, and claims experience.
- Identifying and establishing appropriate adjustment procedures necessary to respond to any risk segmentation that may occur when increased choices are offered to employees.
- Assist the department with:
  - The submission of any necessary plan revisions for federal review.
  - Ensuring compliance with applicable federal and state regulations.
  - Monitoring the adequacy of funding and reserves for the state self-insured plan.

The IBC will assist DMS in preparing recommendations for any modifications to the state program no later than January 1 of each year which shall be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

B. SECTION DIRECTORY:

**Section 1:** Amends s. 110.123, F.S., relating to the State Group Insurance Program.
**Section 2:** Creates s. 110.12303, F.S., relating to the State Group Insurance Program; additional benefits; price transparency pilot program; reporting.
**Section 3:** Creates s. 110.12304, F.S., relating to Independent Benefits Consultant.
**Section 4:** Creates an unnumbered section of law requiring the Department of Management Services to recommend premium alternatives normalized to reflect benefit design and value for state group health insurance plan and fully insured HMO plans; requiring the General Appropriations Act for the 2017 plan year to establish enrollee premiums that reflect the differences in benefit design and value among the HMO plan options and the PPO plan options.
**Section 5:** Appropriates $151,216 in recurring funds and $507,546 in nonrecurring funds and authorizes 2 full-time equivalent positions and associated salary rate for the 2015-2016 fiscal year to implement the act.
**Section 6:** Provides an effective date of July 1, 2015, except as otherwise expressly provided in the act and except for this section, which shall take effect upon becoming a law.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See fiscal comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will provide additional opportunities for private companies to contract to provide services to the state and its employees.

D. FISCAL COMMENTS:

The bill has an indeterminate fiscal impact as a result of the contract with the IBC. DMS will have costs associated with contracting with the IBC, but may experience overall savings by contracting with a single consultant for multiple tasks.

The state and its employees may experience savings as a result of the price transparency pilot project.

Beginning in FY 2017-2018, employees will be given a choice of benefit packages. Consequently, the state may experience an overall savings if employees choose lower-cost options. The state may experience savings due to the changes in plan design to the state group insurance program if the changes result in lower overall program costs or a lower rate of cost increase for the program.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Department of Management Services has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to the state group insurance program;
3 amending s. 110.123, F.S.; revising applicability of
4 certain definitions; defining the term "plan year";
5 authorizing the program to include additional
6 benefits; authorizing an employee to use a certain
7 portion of the state's contribution to purchase
8 additional program benefits and supplemental benefits
9 under specified circumstances; providing for the
10 program to offer health plans in specified benefit
11 levels; providing for the Department of Management
12 Services to develop a plan for implementation of the
13 benefit levels; providing reporting requirements;
14 providing for expiration of the implementation plan;
15 creating s. 110.12303, F.S.; authorizing additional
16 benefits to be included in the program; providing that
17 the department shall contract with at least one entity
18 that provides comprehensive pricing and inclusive
19 services for surgery and other medical procedures;
20 providing contract requirements; providing reporting
21 requirements; providing for the department to
22 establish a 3-year price transparency pilot project in
23 certain areas of the state; providing project
24 requirements; providing reporting requirements;
25 creating s. 110.12304, F.S.; directing the department
26 to contract with an independent benefits consultant;

27 providing qualifications and duties of the independent
28 benefits consultant; providing reporting requirements;
29 directing the department to provide premium
30 alternatives to the Governor and Legislature by a
31 specified date; providing criteria for calculating
32 premium alternatives; providing that the General
33 Appropriations Act shall establish premiums for
34 enrollees that reflect the differences in benefit
35 design and value among the health maintenance
36 organization plan options and the preferred provider
37 organization plan options; providing an appropriation
38 and authorizing positions; providing effective dates.
39
40 Be It Enacted by the Legislature of the State of Florida:
41
42 Section 1. Subsection (2) and paragraphs (b), (f), (h),
43 and (j) of subsection (3) of section 110.123, Florida Statutes,
44 are amended, and paragraph (k) is added to subsection (3) of
45 that section, to read:
46 110.123 State group insurance program.—
47 (2) DEFINITIONS.—As used in <u>sections 110.123-110.1239</u> ~~this~~
48 ~~section~~, the term:
49 (a) "Department" means the Department of Management
50 Services.
51 (b) "Enrollee" means all state officers and employees,
52 retired state officers and employees, surviving spouses of



CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

V

53 deceased state officers and employees, and terminated employees
54 or individuals with continuation coverage who are enrolled in an
55 insurance plan offered by the state group insurance program.
56 "Enrollee" includes all state university officers and employees,
57 retired state university officers and employees, surviving
58 spouses of deceased state university officers and employees, and
59 terminated state university employees or individuals with
60 continuation coverage who are enrolled in an insurance plan
61 offered by the state group insurance program.
62 (c) "Full-time state employees" means employees of all
63 branches or agencies of state government holding salaried
64 positions who are paid by state warrant or from agency funds and
65 who work or are expected to work an average of at least 30 or
66 more hours per week; employees paid from regular salary
67 appropriations for 8 months' employment, including university
68 personnel on academic contracts; and employees paid from other-
69 personal-services (OPS) funds as described in subparagraphs 1.
70 and 2. The term includes all full-time employees of the state
71 universities. The term does not include seasonal workers who are
72 paid from OPS funds.
73 1. For persons hired before April 1, 2013, the term
74 includes any person paid from OPS funds who:
75 a. Has worked an average of at least 30 hours or more per
76 week during the initial measurement period from April 1, 2013,
77 through September 30, 2013; or
78 b. Has worked an average of at least 30 hours or more per

79 week during a subsequent measurement period.
80 2. For persons hired after April 1, 2013, the term
81 includes any person paid from OPS funds who:
82 a. Is reasonably expected to work an average of at least
83 30 hours or more per week; or
84 b. Has worked an average of at least 30 hours or more per
85 week during the person's measurement period.
86 (d) "Health maintenance organization" or "HMO" means an
87 entity certified under part I of chapter 641.
88 (e) "Health plan member" means any person participating in
89 a state group health insurance plan, a TRICARE supplemental
90 insurance plan, or a health maintenance organization plan under
91 the state group insurance program, including enrollees and
92 covered dependents thereof.
93 (f) "Part-time state employee" means an employee of any
94 branch or agency of state government paid by state warrant from
95 salary appropriations or from agency funds, and who is employed
96 for less than an average of 30 hours per week or, if on academic
97 contract or seasonal or other type of employment which is less
98 than year-round, is employed for less than 8 months during any
99 12-month period, but does not include a person paid from other-
100 personal-services (OPS) funds. The term includes all part-time
101 employees of the state universities.
102 (g) "Plan year" means a calendar year.
103 (h) ~~(g)~~ "Retired state officer or employee" or "retiree"
104 means any state or state university officer or employee who



CODING: Words ~~stricken~~ are deletions; words underlined are additions.

V

105 retires under a state retirement system or a state optional
106 annuity or retirement program or is placed on disability
107 retirement, and who was insured under the state group insurance
108 program at the time of retirement, and who begins receiving
109 retirement benefits immediately after retirement from state or
110 state university office or employment. The term also includes
111 any state officer or state employee who retires under the
112 Florida Retirement System Investment Plan established under part
113 II of chapter 121 if he or she:
114 1. Meets the age and service requirements to qualify for
115 normal retirement as set forth in s. 121.021(29); or
116 2. Has attained the age specified by s. 72(t)(2)(A)(i) of
117 the Internal Revenue Code and has 6 years of creditable service.
118 (i) ~~(h)~~ "State agency" or "agency" means any branch,
119 department, or agency of state government. "State agency" or
120 "agency" includes any state university for purposes of this
121 section only.
122 (j) ~~(i)~~ "Seasonal workers" has the same meaning as provided
123 under 29 C.F.R. s. 500.20(s)(1).
124 (k) ~~(j)~~ "State group health insurance plan or plans" or
125 "state plan or plans" mean the state self-insured health
126 insurance plan or plans offered to state officers and employees,
127 retired state officers and employees, and surviving spouses of
128 deceased state officers and employees pursuant to this section.
129 (l) ~~(k)~~ "State-contracted HMO" means any health maintenance
130 organization under contract with the department to participate

131 in the state group insurance program.
132 (m) ~~(l)~~ "State group insurance program" or "programs" means
133 the package of insurance plans offered to state officers and
134 employees, retired state officers and employees, and surviving
135 spouses of deceased state officers and employees pursuant to
136 this section, including the state group health insurance plan or
137 plans, health maintenance organization plans, TRICARE
138 supplemental insurance plans, and other plans required or
139 authorized by law.
140 (n) ~~(m)~~ "State officer" means any constitutional state
141 officer, any elected state officer paid by state warrant, or any
142 appointed state officer who is commissioned by the Governor and
143 who is paid by state warrant.
144 (o) ~~(n)~~ "Surviving spouse" means the widow or widower of a
145 deceased state officer, full-time state employee, part-time
146 state employee, or retiree if such widow or widower was covered
147 as a dependent under the state group health insurance plan, ~~a~~
148 TRICARE supplemental insurance plan, or a health maintenance
149 organization plan established pursuant to this section at the
150 time of the death of the deceased officer, employee, or retiree.
151 "Surviving spouse" also means any widow or widower who is
152 receiving or eligible to receive a monthly state warrant from a
153 state retirement system as the beneficiary of a state officer,
154 full-time state employee, or retiree who died prior to July 1,
155 1979. For the purposes of this section, any such widow or
156 widower shall cease to be a surviving spouse upon his or her

157 remarriage.
158 (p) ~~(o)~~ "TRICARE supplemental insurance plan" means the
159 Department of Defense Health Insurance Program for eligible
160 members of the uniformed services authorized by 10 U.S.C. s.
161 1097.
162 (3) STATE GROUP INSURANCE PROGRAM.—
163 (b) It is the intent of the Legislature to offer a
164 comprehensive package of health insurance and retirement
165 benefits and a personnel system for state employees which are
166 provided in a cost-efficient and prudent manner, and to allow
167 state employees the option to choose benefit plans which best
168 suit their individual needs. ~~Therefore,~~ The state group
169 insurance program ~~is established which~~ may include the state
170 group health insurance plan or plans, health maintenance
171 organization plans, group life insurance plans, TRICARE
172 supplemental insurance plans, group accidental death and
173 dismemberment plans, ~~and~~ group disability insurance plans, ~~.~~
174 ~~Furthermore, the department is additionally authorized to~~
175 ~~establish and provide as part of the state group insurance~~
176 ~~program any~~ other group insurance plans or coverage choices, and
177 other benefits authorized by law ~~that are consistent with the~~
178 ~~provisions of this section~~.
179 (f) Except as provided for in subparagraph (h)2., the
180 state contribution toward the cost of any plan in the state
181 group insurance program shall be uniform with respect to all
182 state employees in a state collective bargaining unit

183 participating in the same coverage tier in the same plan. This
184 section does not prohibit the development of separate benefit
185 plans for officers and employees exempt from the career service
186 or the development of separate benefit plans for each collective
187 bargaining unit. For the 2018 plan year and thereafter, if the
188 state's contribution is more than the premium cost of the health
189 plan selected by the employee, subject to any federal
190 limitations, the employee may elect to have the balance:
191 1. Credited to the employee's flexible spending account.
192 2. Credited to the employee's health savings account.
193 3. Used to purchase additional benefits offered through
194 the state group insurance program.
195 4. Used to increase the employee's salary.
196 (h)1. A person eligible to participate in the state group
197 insurance program may be authorized by rules adopted by the
198 department, in lieu of participating in the state group health
199 insurance plan, to exercise an option to elect membership in a
200 health maintenance organization plan which is under contract
201 with the state in accordance with criteria established by this
202 section and by said rules. The offer of optional membership in a
203 health maintenance organization plan permitted by this paragraph
204 may be limited or conditioned by rule as may be necessary to
205 meet the requirements of state and federal laws.
206 2. The department shall contract with health maintenance
207 organizations seeking to participate in the state group
208 insurance program through a request for proposal or other

209 procurement process, as developed by the Department of
210 Management Services and determined to be appropriate.
211 a. The department shall establish a schedule of minimum
212 benefits for health maintenance organization coverage, and that
213 schedule shall include: physician services; inpatient and
214 outpatient hospital services; emergency medical services,
215 including out-of-area emergency coverage; diagnostic laboratory
216 and diagnostic and therapeutic radiologic services; mental
217 health, alcohol, and chemical dependency treatment services
218 meeting the minimum requirements of state and federal law;
219 skilled nursing facilities and services; prescription drugs;
220 age-based and gender-based wellness benefits; and other benefits
221 as may be required by the department. Additional services may be
222 provided subject to the contract between the department and the
223 HMO. As used in this paragraph, the term "age-based and gender-
224 based wellness benefits" includes aerobic exercise, education in
225 alcohol and substance abuse prevention, blood cholesterol
226 screening, health risk appraisals, blood pressure screening and
227 education, nutrition education, program planning, safety belt
228 education, smoking cessation, stress management, weight
229 management, and women's health education.
230 b. The department may establish uniform deductibles,
231 copayments, coverage tiers, or coinsurance schedules for all
232 participating HMO plans.
233 c. The department may require detailed information from
234 each health maintenance organization participating in the

235 procurement process, including information pertaining to
236 organizational status, experience in providing prepaid health
237 benefits, accessibility of services, financial stability of the
238 plan, quality of management services, accreditation status,
239 quality of medical services, network access and adequacy,
240 performance measurement, ability to meet the department's
241 reporting requirements, and the actuarial basis of the proposed
242 rates and other data determined by the director to be necessary
243 for the evaluation and selection of health maintenance
244 organization plans and negotiation of appropriate rates for
245 these plans. Upon receipt of proposals by health maintenance
246 organization plans and the evaluation of those proposals, the
247 department may enter into negotiations with all of the plans or
248 a subset of the plans, as the department determines appropriate.
249 Nothing shall preclude the department from negotiating regional
250 or statewide contracts with health maintenance organization
251 plans when this is cost-effective and when the department
252 determines that the plan offers high value to enrollees.
253 d. The department may limit the number of HMOs that it
254 contracts with in each service area based on the nature of the
255 bids the department receives, the number of state employees in
256 the service area, or any unique geographical characteristics of
257 the service area. The department shall establish by rule service
258 areas throughout the state.
259 e. All persons participating in the state group insurance
260 program may be required to contribute towards a total state

261 group health premium that may vary depending upon the plan<u>,</u>
262 <u>coverage level,</u> and coverage tier selected by the enrollee and
263 the level of state contribution authorized by the Legislature.
264 3. The department is authorized to negotiate and to
265 contract with specialty psychiatric hospitals for mental health
266 benefits, on a regional basis, for alcohol, drug abuse, and
267 mental and nervous disorders. The department may establish,
268 subject to the approval of the Legislature pursuant to
269 subsection (5), any such regional plan upon completion of an
270 actuarial study to determine any impact on plan benefits and
271 premiums.
272 4. In addition to contracting pursuant to subparagraph 2.,
273 the department may enter into contract with any HMO to
274 participate in the state group insurance program which:
275 a. Serves greater than 5,000 recipients on a prepaid basis
276 under the Medicaid program;
277 b. Does not currently meet the 25-percent non-
278 Medicare/non-Medicaid enrollment composition requirement
279 established by the Department of Health excluding participants
280 enrolled in the state group insurance program;
281 c. Meets the minimum benefit package and copayments and
282 deductibles contained in sub-subparagraphs 2.a. and b.;
283 d. Is willing to participate in the state group insurance
284 program at a cost of premiums that is not greater than 95
285 percent of the cost of HMO premiums accepted by the department
286 in each service area; and

287 e. Meets the minimum surplus requirements of s. 641.225.
288
289 The department is authorized to contract with HMOs that meet the
290 requirements of sub-subparagraphs a.-d. prior to the open
291 enrollment period for state employees. The department is not
292 required to renew the contract with the HMOs as set forth in
293 this paragraph more than twice. Thereafter, the HMOs shall be
294 eligible to participate in the state group insurance program
295 only through the request for proposal or invitation to negotiate
296 process described in subparagraph 2.
297 5. All enrollees in a state group health insurance plan, a
298 TRICARE supplemental insurance plan, or any health maintenance
299 organization plan have the option of changing to any other
300 health plan that is offered by the state within any open
301 enrollment period designated by the department. Open enrollment
302 shall be held at least once each calendar year.
303 6. When a contract between a treating provider and the
304 state-contracted health maintenance organization is terminated
305 for any reason other than for cause, each party shall allow any
306 enrollee for whom treatment was active to continue coverage and
307 care when medically necessary, through completion of treatment
308 of a condition for which the enrollee was receiving care at the
309 time of the termination, until the enrollee selects another
310 treating provider, or until the next open enrollment period
311 offered, whichever is longer, but no longer than 6 months after
312 termination of the contract. Each party to the terminated

313 contract shall allow an enrollee who has initiated a course of
314 prenatal care, regardless of the trimester in which care was
315 initiated, to continue care and coverage until completion of
316 postpartum care. This does not prevent a provider from refusing
317 to continue to provide care to an enrollee who is abusive,
318 noncompliant, or in arrears in payments for services provided.
319 For care continued under this subparagraph, the program and the
320 provider shall continue to be bound by the terms of the
321 terminated contract. Changes made within 30 days before
322 termination of a contract are effective only if agreed to by
323 both parties.
324 7. Any HMO participating in the state group insurance
325 program shall submit health care utilization and cost data to
326 the department, in such form and in such manner as the
327 department shall require, as a condition of participating in the
328 program. The department shall enter into negotiations with its
329 contracting HMOs to determine the nature and scope of the data
330 submission and the final requirements, format, penalties
331 associated with noncompliance, and timetables for submission.
332 These determinations shall be adopted by rule.
333 8. The department may establish and direct, with respect
334 to collective bargaining issues, a comprehensive package of
335 insurance benefits that may include supplemental health and life
336 coverage, dental care, long-term care, vision care, and other
337 benefits it determines necessary to enable state employees to
338 select from among benefit options that best suit their

339 individual and family needs. <u>Beginning with the 2016 plan year,</u>
340 <u>the package of benefits may also include products and services</u>
341 <u>described in s. 110.12303.</u>
342 a. Based upon a desired benefit package, the department
343 shall issue a request for proposal or invitation to negotiate
344 for ~~health insurance~~ providers interested in participating in
345 the state group insurance program, and the department shall
346 issue a request for proposal or invitation to negotiate for
347 ~~insurance~~ providers interested in participating in the non-
348 health-related components of the state group insurance program.
349 Upon receipt of all proposals, the department may enter into
350 contract negotiations with ~~insurance~~ providers submitting bids
351 or negotiate a specially designed benefit package. Insurance
352 providers offering or providing supplemental coverage as of May
353 30, 1991, which qualify for pretax benefit treatment pursuant to
354 s. 125 of the Internal Revenue Code of 1986, with 5,500 or more
355 state employees currently enrolled may be included by the
356 department in the supplemental insurance benefit plan
357 established by the department without participating in a request
358 for proposal, submitting bids, negotiating contracts, or
359 negotiating a specially designed benefit package. These
360 contracts shall provide state employees with the most cost-
361 effective and comprehensive coverage available; however, <u>except</u>
362 <u>as provided in subparagraph (f)3.,</u> no state or agency funds
363 shall be contributed toward the cost of any part of the premium
364 of such supplemental benefit plans. With respect to dental

365 coverage, the division shall include in any solicitation or
366 contract for any state group dental program made after July 1,
367 2001, a comprehensive indemnity dental plan option which offers
368 enrollees a completely unrestricted choice of dentists. If a
369 dental plan is endorsed, or in some manner recognized as the
370 preferred product, such plan shall include a comprehensive
371 indemnity dental plan option which provides enrollees with a
372 completely unrestricted choice of dentists.
373 b. Pursuant to the applicable provisions of s. 110.161,
374 and s. 125 of the Internal Revenue Code of 1986, the department
375 shall enroll in the pretax benefit program those state employees
376 who voluntarily elect coverage in any of the supplemental
377 ~~insurance~~ benefit plans as provided by sub-subparagraph a.
378 c. Nothing herein contained shall be construed to prohibit
379 insurance providers from continuing to provide or offer
380 supplemental benefit coverage to state employees as provided
381 under existing agency plans.
382 (j) For the 2018 plan year and thereafter, health plans
383 shall be offered in the following benefit levels:
384 1. Platinum level, which shall have an actuarial value of
385 at least 90 percent.
386 2. Gold level, which shall have an actuarial value of at
387 least 80 percent.
388 3. Silver level, which shall have an actuarial value of at
389 least 70 percent.
390 4. Bronze level, which shall have an actuarial value of at



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391 least 60 percent ~~Notwithstanding paragraph (f) requiring uniform~~
392 ~~contributions, and for the 2011-2012 fiscal year only, the state~~
393 ~~contribution toward the cost of any plan in the state group~~
394 ~~insurance plan is the difference between the overall premium and~~
395 ~~the employee contribution. This subsection expires June 30,~~
396 ~~2012~~.
397 (k) In consultation with the independent benefits
398 consultant described in s. 110.12304, the department shall
399 develop a plan for the implementation of the benefit levels
400 described in paragraph (j). The plan shall be submitted to the
401 Governor, the President of the Senate, and the Speaker of the
402 House of Representatives no later than January 1, 2017, and
403 include recommendations for:
404 1. Employer and employee contribution policies.
405 2. Steps necessary for maintaining or improving total
406 employee compensation levels when the transition is initiated.
407 3. An education strategy to inform employees of the
408 additional choices available in the state group insurance
409 program.
410
411 This paragraph expires July 1, 2017.
412 Section 2. Section 110.12303, Florida Statutes, is created
413 to read:
414 110.12303 State group insurance program; additional
415 benefits; price transparency pilot program; reporting.—Beginning
416 with the 2016 plan year:



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417 (1) In addition to the comprehensive package of health
418 insurance and other benefits required or authorized to be
419 included in the state group insurance program, the package of
420 benefits may also include products and services offered by:
421 (a) Prepaid limited health service organizations as
422 authorized by part I of chapter 636.
423 (b) Discount medical plan organizations as authorized by
424 part II of chapter 636.
425 (c) Prepaid health clinics licensed under part II of
426 chapter 641.
427 (d) Licensed health care providers, including hospitals
428 and other health facilities, health care clinics, and health
429 professionals, who sell service contracts and arrangements for a
430 specified amount and type of health services.
431 (e) Provider organizations, including service networks,
432 group practices, professional associations, and other
433 incorporated organizations of providers, who sell service
434 contracts and arrangements for a specified amount and type of
435 health services.
436 (f) Entities that provide specific health services in
437 accordance with applicable state law and sell service contracts
438 and arrangements for a specified amount and type of health
439 services.
440 (g) Entities that provide health services or treatments
441 through a bidding process.
442 (h) Entities that provide health services or treatments

443 through the bundling or aggregating of health services or
444 treatments.
445 (i) Entities that provide other innovative and cost-
446 effective health service delivery methods.
447 (2)(a) The department shall contract with at least one
448 entity that provides comprehensive pricing and inclusive
449 services for surgery and other medical procedures which may be
450 accessed at the option of the enrollee. The contract shall
451 require the entity to:
452 1. Have procedures and evidence-based standards to ensure
453 the inclusion of only high-quality health care providers.
454 2. Provide assistance to the enrollee in accessing and
455 coordinating care.
456 3. Provide cost savings to the state group insurance
457 program to be shared with both the state and the enrollee. Any
458 cost savings payable to an enrollee may be:
459 i. Credited to the employee's flexible spending account;
460 ii. Credited to the employee's health savings account;
461 iii. Credited to the employee's health reimbursement
462 account; or
463 iv. Paid as additional health plan reimbursements not
464 exceeding the amount of the employee's out-of-pocket medical
465 expenses.
466 4. Provide an educational campaign for employees to learn
467 about the services offered by the entity.
468 (b) On or before January 15 of each year, the department

469 shall report to the Governor, the President of the Senate, and
470 the Speaker of the House of Representatives on the participation
471 level and cost-savings to both the enrollee and the state
472 resulting from the contract or contracts described in subsection
473 (2).
474 (3) The department shall establish a 3-year price
475 transparency pilot project in at least one area, but not more
476 than three areas, of the state where a substantial percentage of
477 the state group insurance program enrollees live. The purpose of
478 the project is to reward value-based pricing by publishing the
479 prices of certain diagnostic and elective surgical procedures
480 and sharing with the enrollee and the state any savings
481 generated by the enrollee's choice of providers.
482 (a) Participation in the project shall be voluntary for
483 enrollees.
484 (b) The department shall designate between 20 and 50
485 diagnostic procedures and elective surgical procedures that are
486 commonly utilized by enrollees.
487 (c) Health plans shall provide the department with the
488 contracted price by provider for each designated procedure. The
489 department shall post the prices on its website and shall
490 designate one price per procedure as the benchmark price, using
491 a mean, average, or other method of comparing the prices.
492 (d) If an enrollee participating in the project selects a
493 provider that performs the designated procedure at a price below
494 the benchmark price for that procedure, the enrollee shall



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495 receive from the state 50 percent of the difference between the
496 price of the procedure by the selected provider and the
497 benchmark price. The amount payable to the enrollee may be:
498 i. Credited to the employee's flexible spending account;
499 ii. Credited to the employee's health savings account;
500 iii. Credited to the employee's health reimbursement
501 account; or
502 iv. Paid as additional health plan reimbursements not
503 exceeding the amount of the employee's out-of-pocket medical
504 expenses.
505 (e) On or before January 1 of 2017, 2018, and 2019, the
506 department shall report to the Governor, the President of the
507 Senate, and the Speaker of the House of Representatives on the
508 participation level, amount paid to enrollees, and cost-savings
509 to both the enrollees and the state resulting from the price
510 transparency pilot project.
511 Section 3. Section 110.12304, Florida Statutes, is created
512 to read:
513 110.12304 Independent benefits consultant.—
514 (1) The department shall competitively procure an
515 independent benefits consultant.
516 (2) The independent benefits consultant may not:
517 (a) Be owned or controlled by a health maintenance
518 organization or insurer.
519 (b) Have an ownership interest in a health maintenance
520 organization or insurer.

521 (c) Have a direct or indirect financial interest in a
522 health maintenance organization or insurer.
523 (3) The independent benefits consultant must have
524 substantial experience in consultation and design of employee
525 benefit programs for large employers and public employers,
526 including experience with plans that qualify as cafeteria plans
527 pursuant to s. 125 of the Internal Revenue Code of 1986.
528 (4) The independent benefits consultant shall:
529 (a) Provide an ongoing assessment of trends in benefits
530 and employer-sponsored insurance that affect the state group
531 insurance program.
532 (b) Conduct a comprehensive analysis of the state group
533 insurance program, including available benefits, coverage
534 options, and claims experience.
535 (c) Identify and establish appropriate adjustment
536 procedures necessary to respond to any risk segmentation that
537 may occur when increased choices are offered to employees.
538 (d) Assist the department with the submission of any
539 necessary plan revisions for federal review.
540 (e) Assist the department in ensuring compliance with
541 applicable federal and state regulations.
542 (f) Assist the department in monitoring the adequacy of
543 funding and reserves for the state self-insured plan.
544 (g) Assist the department in preparing recommendations for
545 any modifications to the state group insurance program which
546 shall be submitted to the Governor, the President of the Senate,

547 and the Speaker of the House of Representatives no later than
548 January 1 of each year.
549 Section 4. (1) For the 2017 plan year, the Department of
550 Management Services shall recommend premium alternatives with
551 amounts normalized to reflect benefit design and value for the
552 state group health insurance plans and the fully insured health
553 maintenance organization plans. The premium alternatives shall
554 be provided for both individual and family coverage. The
555 recommended premiums shall reflect the costs to the program for
556 the medical and prescription drug benefits with associated
557 administrative costs and fees. Each alternative shall be
558 presented:
559 (a) Separately for the self-insured preferred provider
560 organization and for each self-insured health maintenance
561 organization plan.
562 (b) Separately for each fully insured health maintenance
563 organization plan.
564 (c) As a pooling of all self-insured health maintenance
565 organization plans.
566
567 Prescription drug benefits shall be incorporated into the
568 recommended premiums based on the enrolled health plan
569 membership.
570 (2) The Department of Management Services shall provide
571 the premium alternatives to the Governor, the President of the
572 Senate, and the Speaker of the House of Representatives no later

573 than December 1, 2015.
574 (3) For the 2017 plan year, the General Appropriations Act
575 shall establish premiums for enrollees that reflect the
576 differences in benefit design and value among the health
577 maintenance organization plan options and the preferred provider
578 plan options offered in the state group insurance program.
579 Section 5. (1) For the 2015-2016 fiscal year, the sums of
580 $151,216 in recurring funds and $507,546 in nonrecurring funds
581 are appropriated from the State Employees Health Insurance Trust
582 Fund to the Department of Management Services, and 2 full-time
583 equivalent positions and associated salary rate of 120,000 are
584 authorized, for the purpose of implementing this act.
585 (2)(a) The recurring funds appropriated in this section
586 shall be allocated to the following specific appropriation
587 categories within the Insurance Benefits Administration Program:
588 $150,528 in Salaries and Benefits and $688 in Special Categories
589 Transfer to Department of Management Services - Human Resources
590 Purchased per Statewide Contract.
591 (b) The nonrecurring funds appropriated in this section
592 shall be allocated to the following specific appropriation
593 categories: $500,000 in Special Categories Contracted Services
594 and $7,546 in Expenses.
595 Section 6. Except as otherwise expressly provided in this
596 act and except for this section, which shall take effect upon
597 becoming a law, this act shall take effect July 1, 2015.

State Group Insurance/
Mercer Report

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State of Florida
Division of State Group Insurance

# MARKET-BASED FRAMEWORK FOR HEALTH PLAN PROGRAM CHANGES

January 2014

**Mercer Health & Benefits, Atlanta, GA**

# Agenda

- **Purpose** – To identify opportunities to improve the State of Florida’s health plan by comparing today’s program to critical success factors, approaches and trends in the employer market today
- Background – basic definitions
- Summary of key findings and observations
- Supporting information to help answer some key questions*
- Discussion & questions
- Appendix (supporting background and detail)

*** Key Questions:**

- How do the State of Florida plans and premiums compare to market surveys?
- How might “best practice” consumerism and “defined contribution” (DC) pricing of plans work for us?
- How do we differ from successful plans that use wellness, incentives, “consumer-driven health plans” (CDHP), and member health and engagement programs and techniques?
- What are three alternative approaches, or phases to consider, to embrace these findings?
- What are some of the key considerations to be evaluated?

# Background — basic definitions
## Consumerism, consumer-driven health plans (CDHP) and accounts

- **"Consumerism" –** an activity that encourages or empowers improved health, or informed, or responsible spending for, or use of, healthcare related goods or services
- **CDHP** – typically a Preferred Provider Organization (PPO) medical plan with a "high deductible" and an "account"
- **Accounts** – typically a Health Savings Account ("HSA"), or a Health Reimbursement Arrangement ("HRA")
- State of Florida – offers CDHP options (i.e., Health Investor Health Plans (HIHP)) with an HSA account (both PPO HSAs and HMO HSAs are offered)
- CDHP plans – provide employee incentives (via lower premiums, up-front account deposits that carry over from year to year, visible account balances, etc.) to encourage employees to be active participants in their healthcare consumption and health

**Employers create plan savings with some combination of …**

- Increased deductibles
- Increased coinsurance
- Increased or eliminated copays

**… to redeploy dollars saved using some combination of:**

Contribution Offsets

Account Deposits

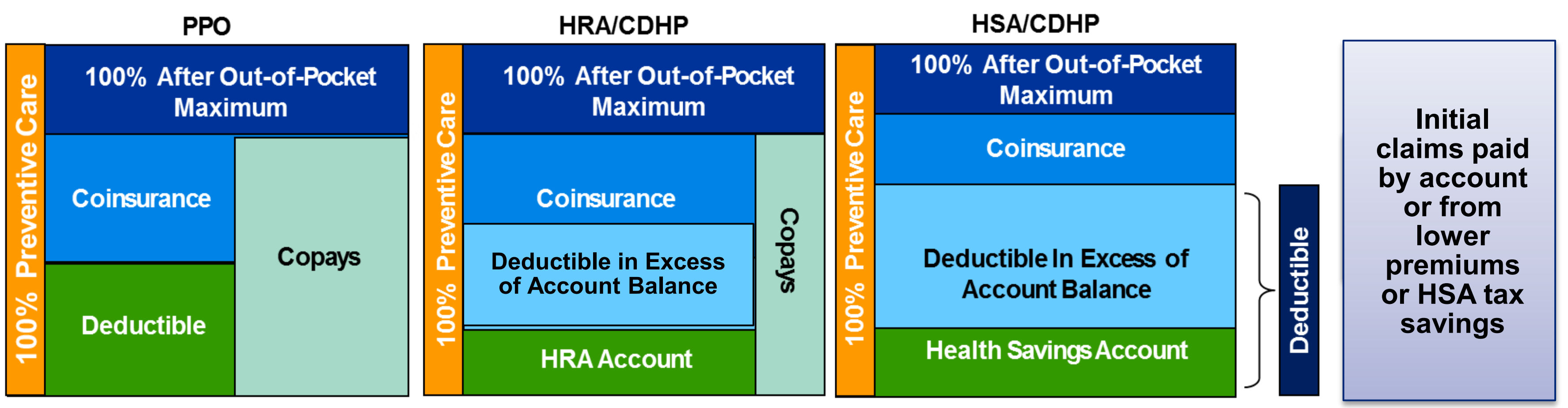
Incentives

OR

Combo of some or all three

# Background — basic definitions
## Comparison of PPO vs. HSA vs. HRA

**Consumer Driven Health Plans — a high-deductible PPO with a health savings account (HSA) or health reimbursement account (HRA)**




| Primary Differences | HRA | HSA |
|---|---|---|
| Account Description | Notional / non-cash; claims paid from general plan assets | Employee-owned cash; deposits in a financial institution |
| Account is in the employee's name and remains theirs after withdrawing from plan | No | Yes |
| Employee Contributions Allowed | No | Yes (and tax favored) |
| Employer Contribution Allowed | Yes | Yes (and tax favored) |
| Plan must meet qualified high deductible plan design requirements (e.g., eligibility limits, minimum deductibles, maximum out-of-pocket limits, no co-pays, etc.) | No | Yes |

# Background — basic definitions
## Consumerism and the role of defined contribution

**Key Concepts**

- Properly pricing each plan option to fairly reflect the true difference in the value of benefits from each option is a critical component to consumerism

- Employers are increasingly basing their contributions on the lowest cost plan (e.g., CDHP plan), and using defined contribution (i.e., requiring employees to pay more or "buy-up" for more expensive coverage)

**Defined contribution strategies**

1. **Core / "buy-up or buy-down" approach**
   - Employer sets the dollar contribution annually that will be contributed:
     – Based on a dollar budget or % of the cost for a "core" plan option
2. **Fixed employer increase approach**
   - This approach allows an employer to manage the longer term increases in their medical costs and incentivizes employees to actively engage in their health care decision making
   - Employer increases their contribution by a set amount each year for the "core" plan:
     – Approach requires employees to pay the projected difference in the cost increase
     – Increase is typically determined in advance based on budgets, not year-to-year medical inflation
3. **Flat dollar subsidy / voucher**
   - Allows employees to use HRAs to purchase individual coverage (vs. getting taxable cash back)
   - Approach is rare; employers who attempt to use this DC strategy will likely be subject to the $2,000 (per employee) employer minimum value penalty regulations under the Affordable Care Act

# Summary of key findings and observations

1. **The State of Florida's plans lag some key large employer survey* trends:**
   - State of Florida enrollment is in plans with lower premiums and higher benefits than industry benchmarks
   - Virtually no (~1%) enrollment in State HIHP / HSA plans, versus significant growth of CDHPs nationally
   - Employers increasingly use incentives to grow participation in new wellness / condition-specific programs
     - State of Florida has no incentives and few such programs

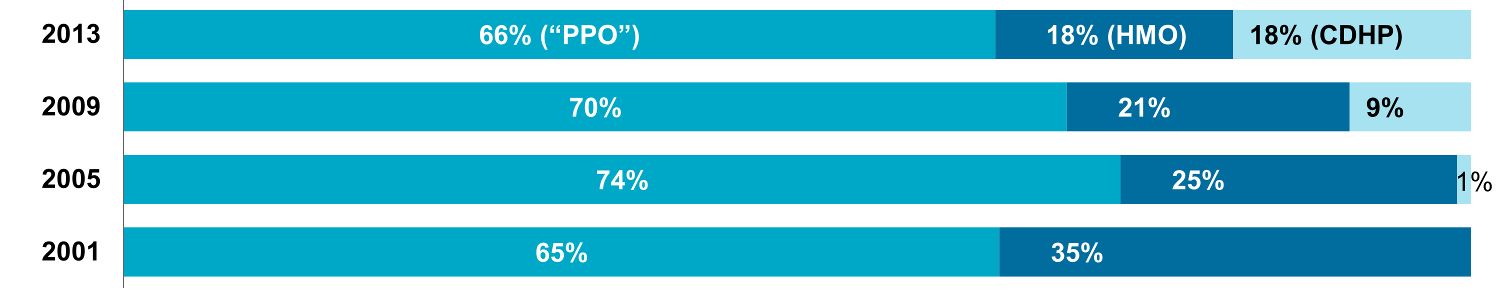
2. **Effective employer health plans use common success strategies to help control costs:**
   - They encourage good purchasing behavior by offering a broad range of benefit choices that use defined contribution and “buy-up / buy-down” consumerism pricing
   - They focus on employee engagement – wellness, incentives, employee education and “account-based” Health Savings “HSA” and Health Reimbursement “HRA” plans

3. **Significant financial opportunity exists for the State of Florida:**
   - Begin building the foundation to improve health and significantly lower health costs over time
   - Change requires “breaking inertia,” substantial communication and investment, and strategies to respond to health care reform’s 2018 excise tax (or “Cadillac tax”)
   - Timing will be impacted by unique State of Florida implementation needs and HR issues

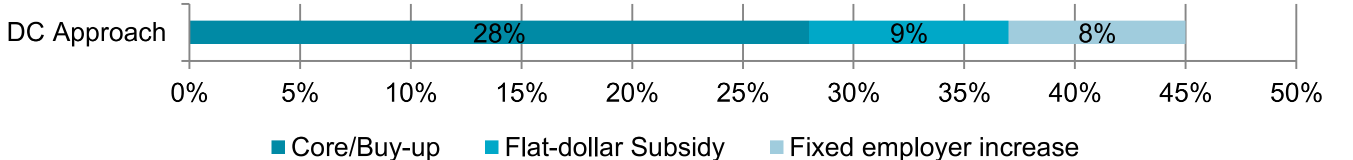
*Mercer Employer-Sponsored Health Plan Annual Survey – “Large Employer (LE)“ has 500 or more employees

# Survey findings and observations for large employers (LEs)
## Versus State of Florida plans and premiums

- State of Florida HMO enrollment (56%) and CDHP (HIHP <1%) is higher and lower than LEs, respectively




- 45% of LE’s use a DC approach; the State of Florida charges the same for both HMO and PPO plans



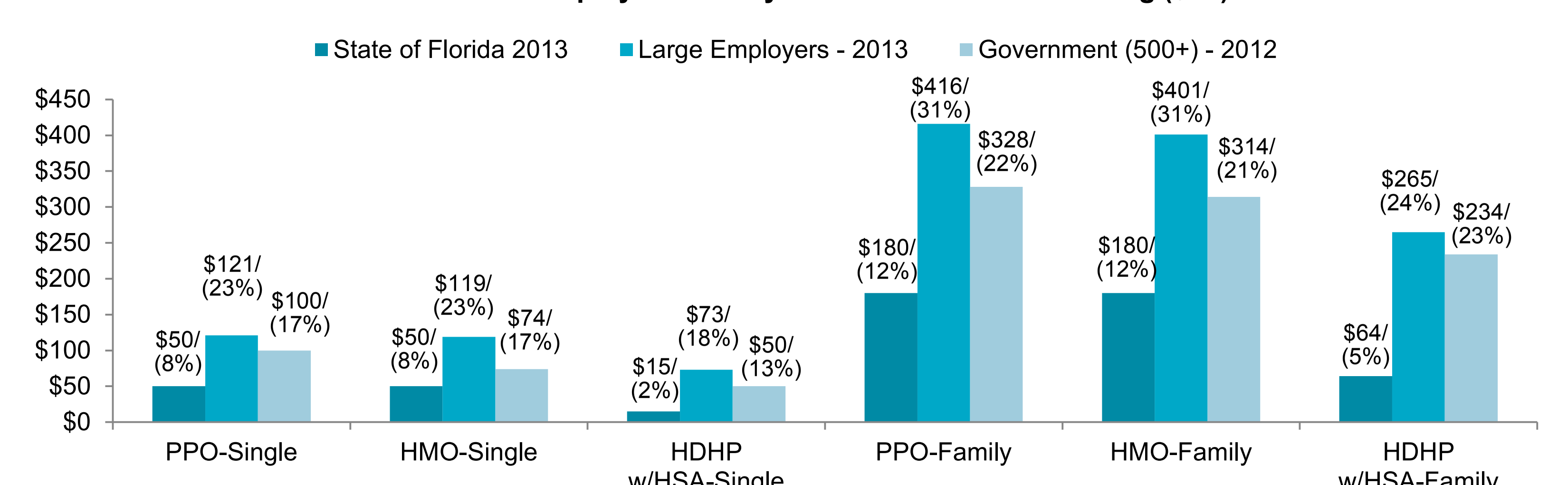

- State of Florida’s total plan costs and annual trend increases are higher than Mercer survey National data, partly given the very limited number of historical State of Florida design and premium changes

| | National | State of Florida |
|---|---|---|
| PPO 2013 Medical Plan Cost | $10,658 (South $9,894) | $13,400 average career service premium |
| HMO 2013 Medical Plan Cost | $11,134 (South $10,753) | |
| Annual Cost increases since 2007 **before** plan changes | 7.4% - 9.8% | Approximately 6% - 8% |
| Annual Cost increases since 2007 **after** plan changes | 4.1% - 6.9% | Approximately 6% - 8% |
| Increase in PPO / HMO Single and Family employee contributions since 2007 | Single: 36% - 38%, Family 20% - 26% | 0% for career service employees |
| Pre-Medicare Retiree’s % share of medical costs | 37%, for 49% who share costs* | 100% of established non-actuarial value |
| Medicare Retiree’s % share of medical costs | 38%, for 46% who share costs* | 100% of retiree rate |

*Of the 24% Medicare and 17% pre-Medicare eligible total surveyed employers that offer any coverage

# Survey findings and observations
## Versus State of Florida plans and premiums

- Plan value is determined by the richness of benefits or “actuarial value.” (AV) is defined as the percentage of total average claims dollars paid by an employer’s plan
- Average LE PPO plan has AV of 87% versus the State of Florida's PPO AV of 86% – roughly the same
- More than half of the State of Florida's enrollment is in HMOs with a 93% AV
- State of Florida employee contributions – dollar contributions and cost sharing percentages – are both much lower (refer to chart below) than market levels



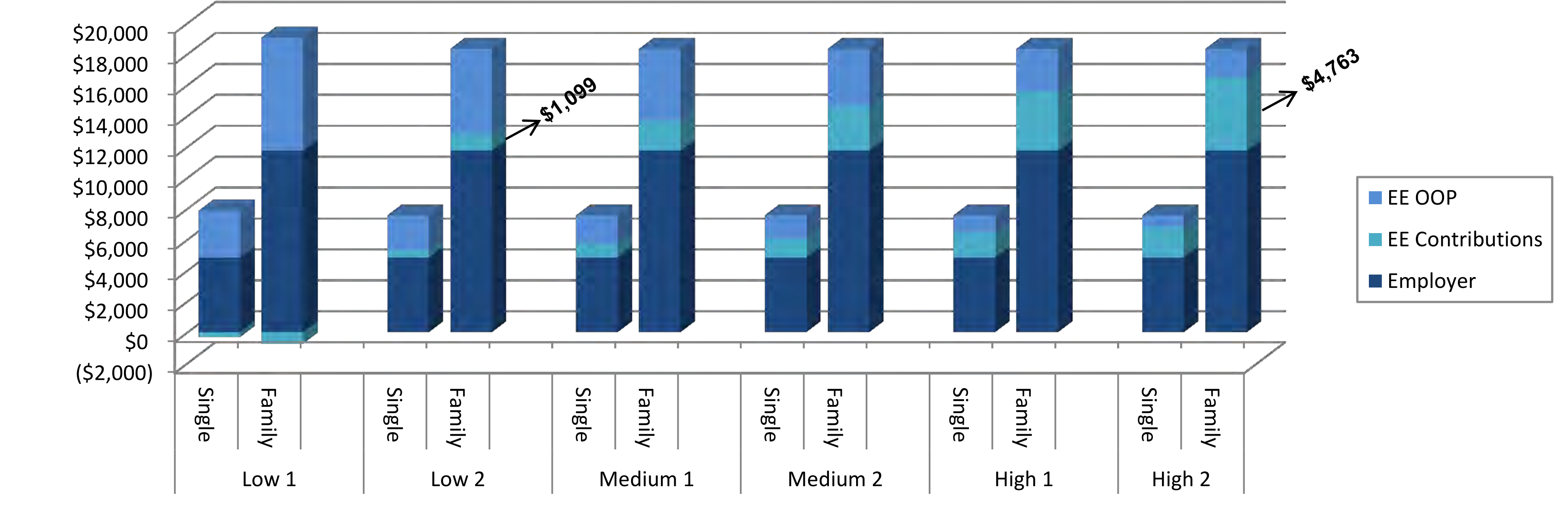

Note: 2013 Employee cost sharing % shown in ()
Source: Mercer’s 2012 and 2013 National Survey of Employer-Sponsored Health Plans

- Supporting data for other elements compared to 2012 benchmark ranges in Appendix (p. 18)

# "Best healthcare practice" — illustration 1: based on national survey data
## Consumerism and DC approach to pricing plan options

***Start with solid foundation success elements – offer broad choice of benefit plans with fairly priced or defined contribution premiums to encourage consumerism***

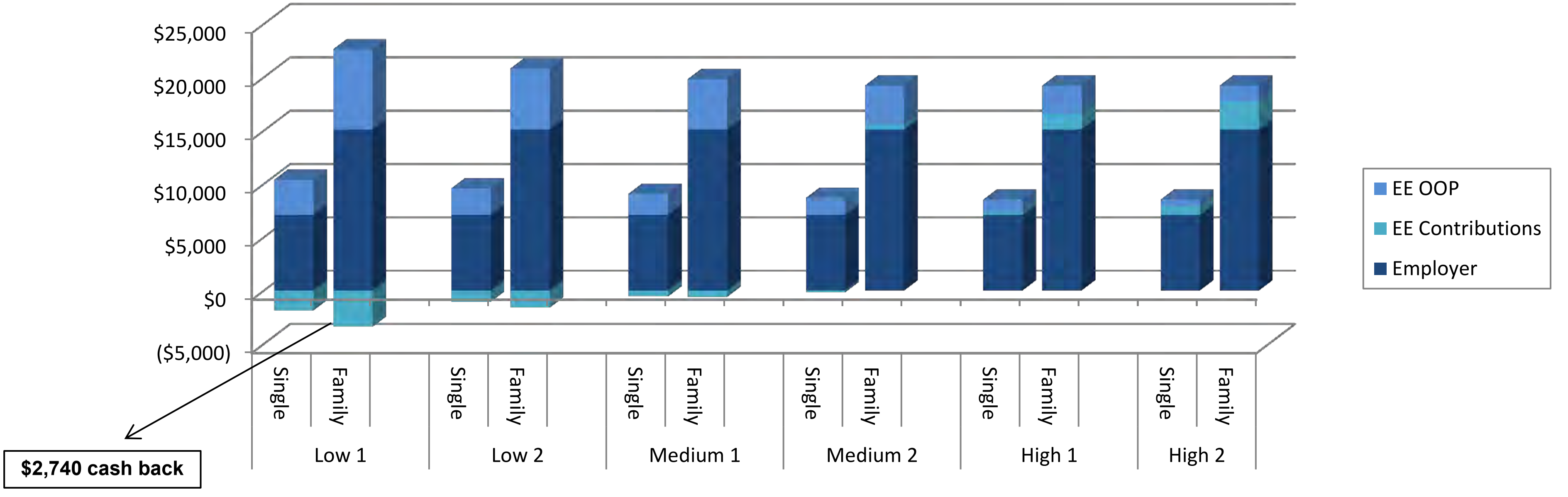
- Offer a complete range of plan options with significantly different actuarial values (see 30% spread below); For the Low 2 plan (70% AV), employee contributions are $1,511 less ($1,964 minus $453) than the High 2 (90% AV) for Single Coverage, and $3,664 less (**$4,763 minus $1,099**) for Family coverage
- Reflect true benefit value differences by providing an equal core "buy-up / buy-down" employer DC amount (i.e., $4,835 in the table), regardless of the plan selected
- Make the sum of employee contributions and out-of-pocket (OOP) equal for every plan option



# “Best healthcare practice” — illustration 2: based on State of Florida plans
## Consumerism and DC approach to pricing plan options (continued)

***Consumerism unlikely until a buy-up / buy-down approach is adopted that engages employees with accurately priced, broader options, and higher contributions***

- 99% of enrollees are in plans with the same employee contributions and only a 7% difference in richness of benefits (“actuarial value”), creating little consumerism, or real choice, between benefits and premiums
- It would be a challenge to offer new, less rich benefit options alongside current plans and contributions – large taxable “cash back” (with HR, communication and administrative issues) may be required
- “Adverse selection” can also be a big issue – including employees or dependents who today do not participate – may choose to “opt back in” to the plan to obtain both benefits and significant “cash back”



# Engagement via wellness, incentives, consumerism and health activities
## Current plans lag some key employer trends

- **The State has little HIHP / HSA enrollment (~1%)** – likely little chance of CDHP growth until actions are taken to “break the inertia” (e.g., investment in effective communication campaigns, varying prices by plan, active and mandatory open enrollment, visible leadership endorsement, account-based incentives, etc.)
- **Successful, large organizations partner CDHPs with accounts, wellness and incentives:**
  - 62% of employers with >5,000 employees used incentives in 2012 – up from 39% in 2010
  - Incentives drive program effectiveness – completion rates for health risk assessments and biometric screenings are twice as high when incentives are used
- **Employers are rapidly adopting CDHPs** to simultaneously achieve multiple objectives:
  - Avoiding or delaying the 40% health care reform “Cadillac tax,” effective 2018
  - Maximize employee engagement with consumer purchasing choices and health activities
  - Achieving financial savings by avoiding (versus cutting) costs – significant cumulative 5-year savings
- **We illustrate 3 alternative pathways (next slide)** to add over time new consumer choices, integrate health management and CDHP; and leading to a “best health care practice” state (alternative 3)
- **Pace of change is dependent** on the degree of activity with the following actions:
  - Revising the number and type of plans offered, with prices accurately reflecting benefit costs by plan
  - Embracing CDHP options relative to more traditional plan types
  - Introducing incentives and disincentives to encourage CDHP, wellness and healthier behavior

# Health management — illustrative pathways for the State of Florida
## "Relative" pros / cons of 3 alternatives

| Alternative 1 (Basic) | | Alternative 2 (Moderate) | | Alternative 3 ("Best Healthcare Practice") |
|---|---|---|---|---|
| Re-priced Low PPO | → | Low PPO with HRA | → | PPO/HRA |
| Re-priced HMO | → | High PPO with HRA | → | Low HSA |
| New HDHP | → | New HSA | → | High HSA |

| Dimension | Alternative 1 (Basic) | Alternative 2 (Moderate) | Alternative 3 ("Best Healthcare Practice") |
|---|---|---|---|
| Financial | Savings primarily available via plan design cuts or increased contributions | → | Significant trend reduction over time and "win-win" savings via avoided costs |
| Employee impact & health consumption | Limited or modest health improvement; minimal behavior change, and limited negative impact on employees | → | Greatest opportunity for reduction of health risks, with significant change to how employees engage in their health |
| Organizational | Minimal administrative impact | → | Significant administrative impact; requires cultural shift over time |
| | No direct or short-term impact on employee attraction and retention | → | High potential HR impact (+/-); consider competitiveness of wages, as benefits move toward CDHP / "best practice" |
| | Impact to employee relations limited to higher cost-shifting and cuts over time | → | Potentially large employee relations impact (+/-) during the transition, with financial "win-win" over time avoids cuts |
| | Basic communication and benefit delivery needs | → | Extensive internal / external communication; infrastructure investments needed (e.g., web tools, incentives, portals) |

# Key considerations

- This document highlights the more unique differences and critical success factors for the State of Florida
- Adopting major fundamental and comprehensive program change likely requires multiple years to decide and implement, perhaps transitioning to an ultimate state over multiple years and three or more phases
- **Some foundation / strategy decisions are particularly key given the current state of the program:**
  - Short- and long-term financial goals, and potential impact on broader HR / total rewards objectives
  - Desired competitive position and resulting savings from traditional plan design and contribution changes
  - Comfort with trade-offs from moving to CDHP plans – “how far, how fast?” – for your participants
  - Interest in offering a broad choice of plan options with proper pricing and defined contribution
  - Desire and flexibility to pursue incentives and disincentives to support health initiatives
- **Key practical items to consider even after core decisions are made:**
  - Impact of general changes on special groups (e.g., early retirees, Medicare-eligible retirees, “payalls”)
  - Activities to support change (data analyses, compliance, procurements, communication, administrative)
  - Timing will be impacted by unique State of Florida implementation needs and HR issues

# Appendix

# Background
## Project Objectives

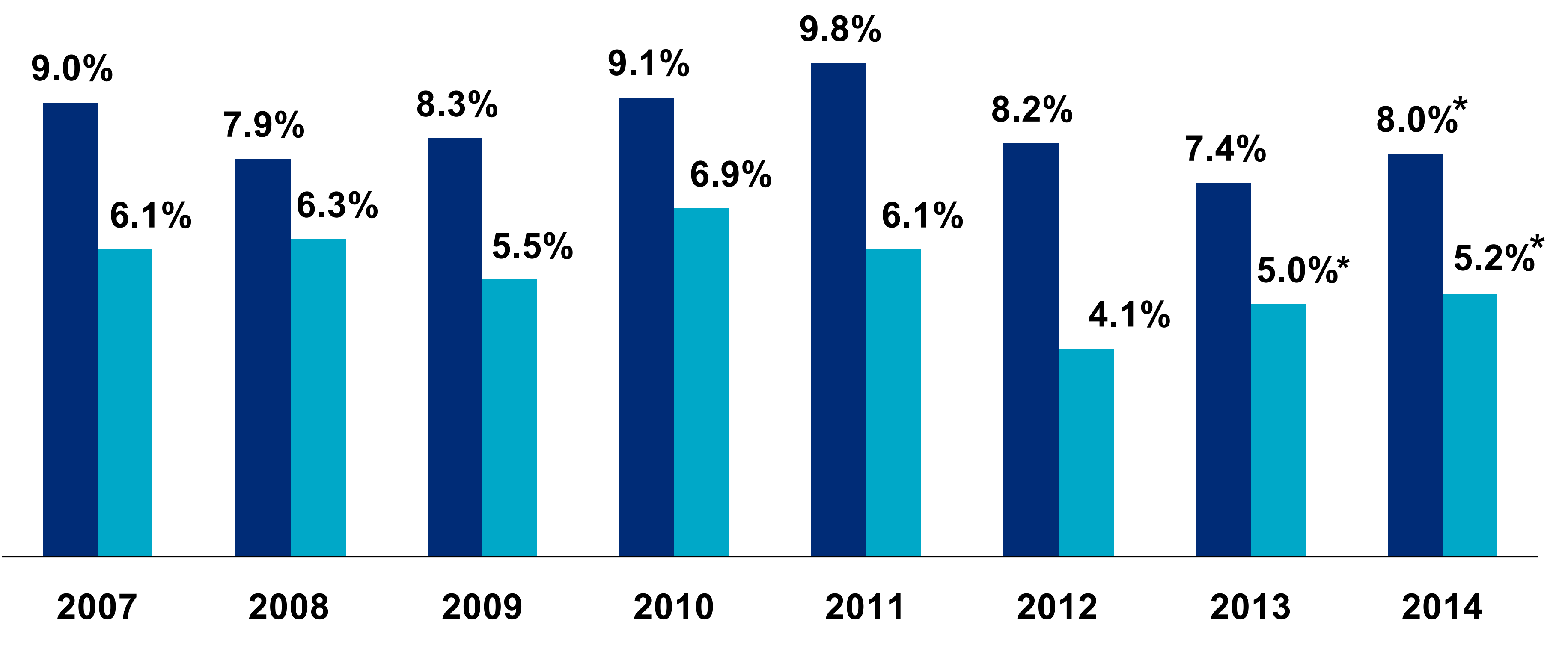
- The Department of Management Services, Division of State Group Insurance, (DSGI) requested that Mercer assist in developing a market-based, strategic framework for changes to the State of Florida's medical and prescription drug plans

**Objectives:**

- Mercer agreed to provide a PowerPoint presentation that meets the following objectives:
  - Provides an overview of trends in employer responses to health insurance market changes including an identification of critical program elements necessary to build the framework of a successful multi-year strategic plan
  - Reviews and analyzes the State's current program against market survey data and best practices
  - Discusses and illustrates three alternative approaches that could be used as part of a multi-year strategy. The alternative approaches will take into consideration the speed and intensity of change to the State's program over three to five years
  - Discusses the potential implications of the "Cadillac tax" regulation scheduled to take effect in 2018
  - Discusses any specific concerns that are unique to the State's program, or employee groups, such as early retirees, Medicare-eligible retirees, "payalls," etc.

## Market trends

**Employers see underlying cost trend falling below 8%. They plan to hold their actual cost increase to around 5.2% in 2014**




* Projected

State of Florida annual trend preliminary data indicates that increases after plan changes has ranged from 6% - 8% (except for FY 2011-2012 when self-funding / Rx changes were made)

# Foundation — plan offerings

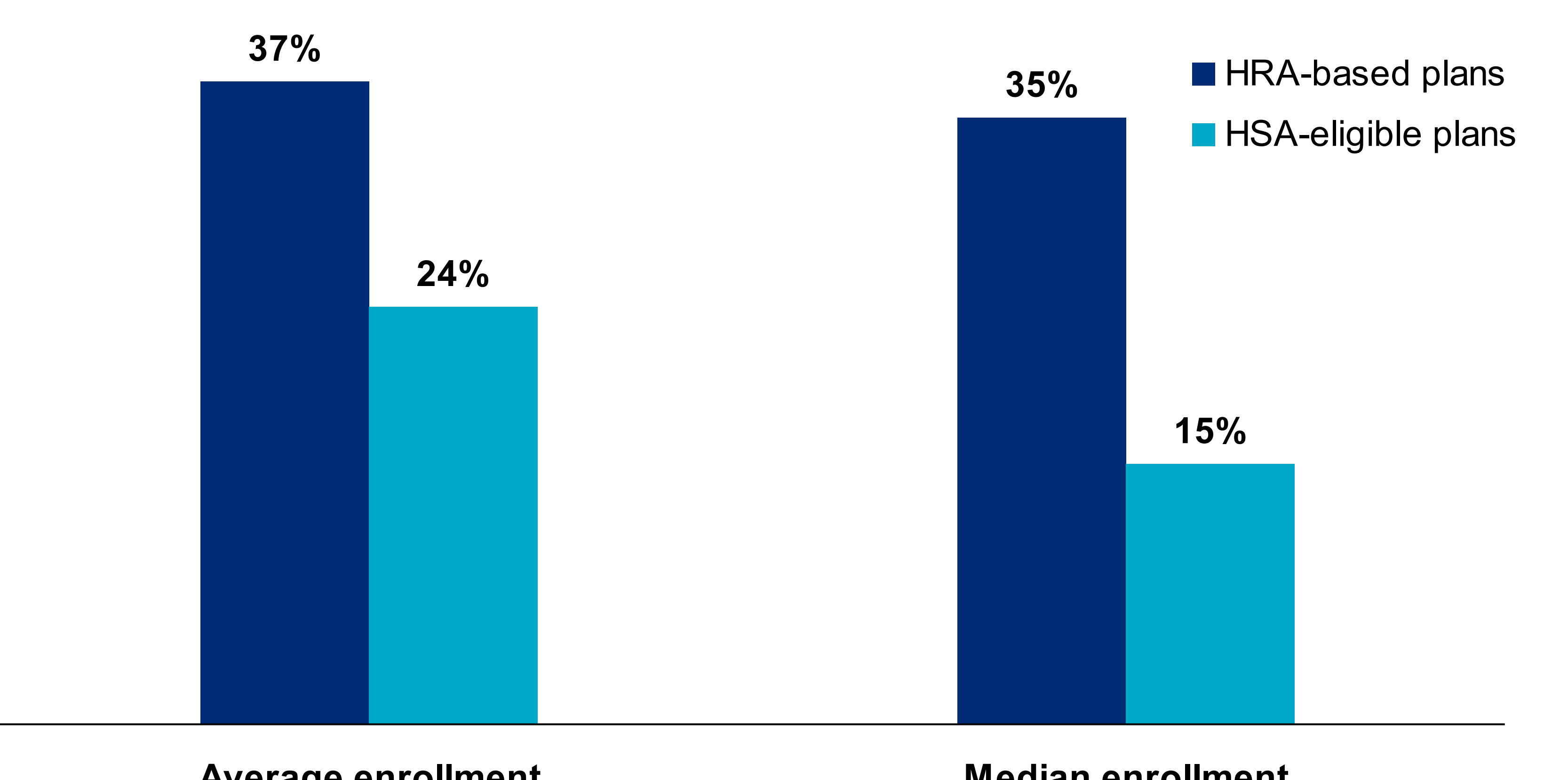
## Consumer-Driven Health Plans (CDHP)

- Over the past three years (Table below), both the percentage of large employers offering CDHPs, and the percentage of covered employees enrolled in CDHPs, has nearly doubled:
  - In 2012, over a third of all large employers offered a CDHP, and 15% of their employees were enrolled. The larger the employer, the more likely they are to offer a CDHP
  - Of employers with 20,000 or more employees, 65% offered a CDHP in 2012
  - The State of Florida, like other large employers, offers a CDHP option (i.e., Health Investor Health Plans (HIHP)) with a health savings account (both PPO and HMO are offered)

| Number of employees | 2008 | 2009 | 2010 | 2011 | 2012 | Very likely to offer CDHP in 2013 |
|---|---|---|---|---|---|---|
| 10 - 499 | 9% | 15% | 16% | 20% | 22% | 21% |
| 500 - 999 | 14% | 16% | 18% | 26% | 35% | 36% |
| 1,000 - 4,999 | 22% | 20% | 24% | 34% | 33% | 39% |
| 5,000 - 9,999 | 28% | 42% | 39% | 42% | 46% | 49% |
| 10,000 - 19,999 | 40% | 39% | 41% | 46% | 53% | 59% |
| 20,000 or more | 45% | 43% | 51% | 48% | 59% | 65% |

## Employees increasingly enrolled in HRA and HSA account-based plans

### Percent of covered employees enrolled*, among large CDHP sponsors




*When CDHP is offered as an option alongside other medical plan choice

# Foundation — competitive position
## Plan design comparison to benchmark ranges

- The table shows the **medians** for surveyed plan provisions. Note that while the HRAs have similar survey data for the cost-sharing provisions shown (similar to qualified high deductible plans like with HSAs), employers often retain the use of HRAs with physician and/or pharmacy co-pays (i.e., more likely to report such HRAs as PPOs)
- Benchmark ranges based on National Jumbo, Large, Government, and State employers

| 2012 Mercer Survey Data | Benchmark Ranges | | | | 2013 State of Florida | | | |
|---|---|---|---|---|---|---|---|---|
| | PPO | HMO | HSA | HRA | PPO - Standard | HMO - Standard | PPO - Health Investor | HMO - Health Investor |
| Employee Contribution $ - Single | $100-$117 | $74-$132 | $35-$66 | $73-$82 | **$50** | **$50** | **$15** | **$15** |
| Employee Contribution % - Single | 14%-25% | 15%-23% | 4%-19% | 3%-23% | **8%** | **8%** | **2%** | **2%** |
| Employee Contribution $ - Family | $270-$391 | $300-$373 | $164-$259 | $274-$308 | **$180** | **$180** | **$64** | **$64** |
| Employee Contribution % - Family | 21%-29% | 17%-28% | 14%-23% | 5%-27% | **12%** | **12%** | **5%** | **5%** |
| Deductible - Single* | $300-$500 | $0 | $1,500 | $1,500 | $250 | $0 | $1,250 | $1,250 |
| Deductible - Family* | $750-$1,000 | $0 | $3,000 | $3,150-$3,300 | $500 | $0 | $2,500 | $2,500 |
| Coinsurance | 20% | 0% | 20% | 15%-20% | 20% | 0% | 20% | 20% |
| Out-of-Pocket Maximum - Single | $1,500-$2,500 | None | $3,300-$3,800 | $3,000-$3,525 | $2,750 | $1,500 | $4,250 | $4,250 |
| Out-of-Pocket Maximum - Family | $3,250-$5,000 | None | $5,700-$6,000 | $5,025-$6,000 | $5,500 | $3,000 | $8,500 | $8,500 |
| % active employees enrolled | 57%-66% | 18%-33% | 4%-16% | 4%-16% | 42.5% | 56.2% | 0.9% | 0.4% |
| Employer Contribution to HSA - Single | N/A | N/A | $500-$750 | N/A | N/A | N/A | $500 | $500 |
| Employer Contribution to HSA - Family | N/A | N/A | $1,000-$1,520 | N/A | N/A | N/A | $1,000 | $1,000 |
| Employer Contribution to HRA - Single | N/A | N/A | N/A | $500-$782 | N/A | N/A | N/A | N/A |
| Employer Contribution to HRA - Family | N/A | N/A | N/A | $1,000-$2,296 | N/A | N/A | N/A | N/A |

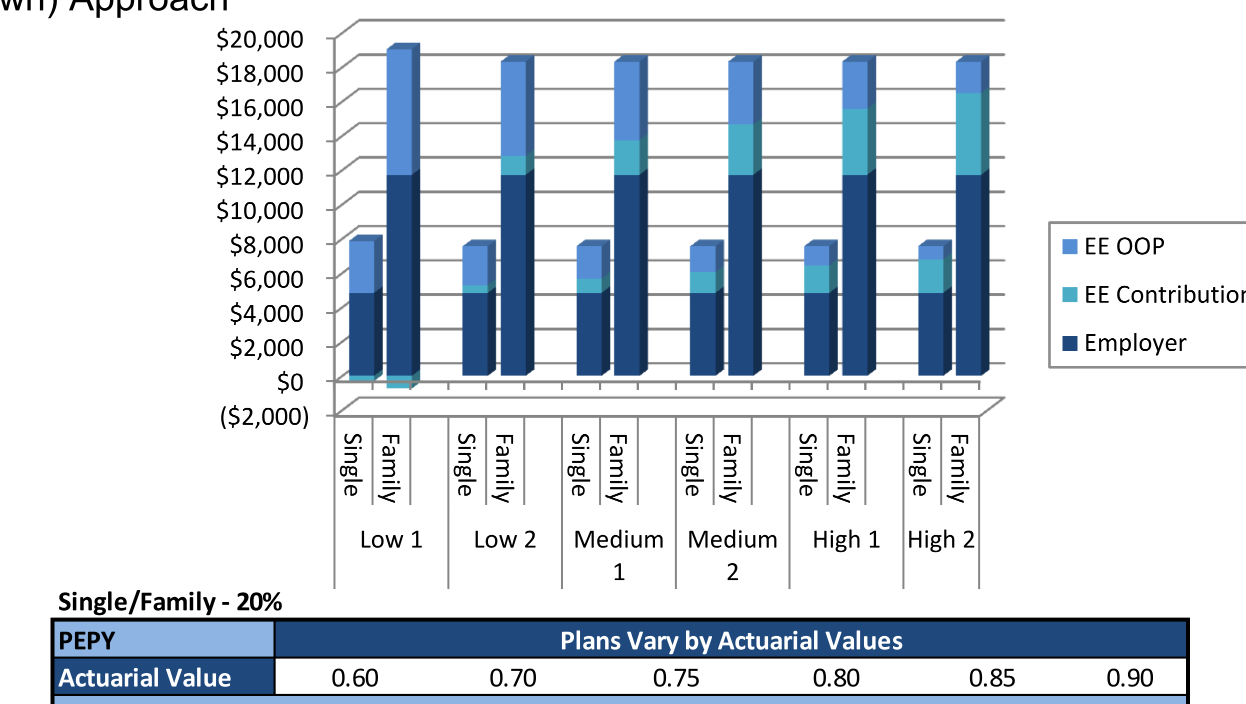
Note: Out-of-pocket maximums include deductible.

**Red = notable variations**

***Average** Deductible for National Large Employers for PPO is $666 Single and $1,545 Family, and HSA is $1,808 Single and $3,655 Family.
Source: Mercer's 2012 National Survey of Employer-Sponsored Health Plans

# "Best healthcare practice" / trends — national survey illustration
## A consumerism and defined contribution approach to pricing plan options

**Illustration 1:** Offer a Mix of Account-Based and Traditional Plans and Use a Defined Contribution (Core / Buy-Up / Buy-Down) Approach



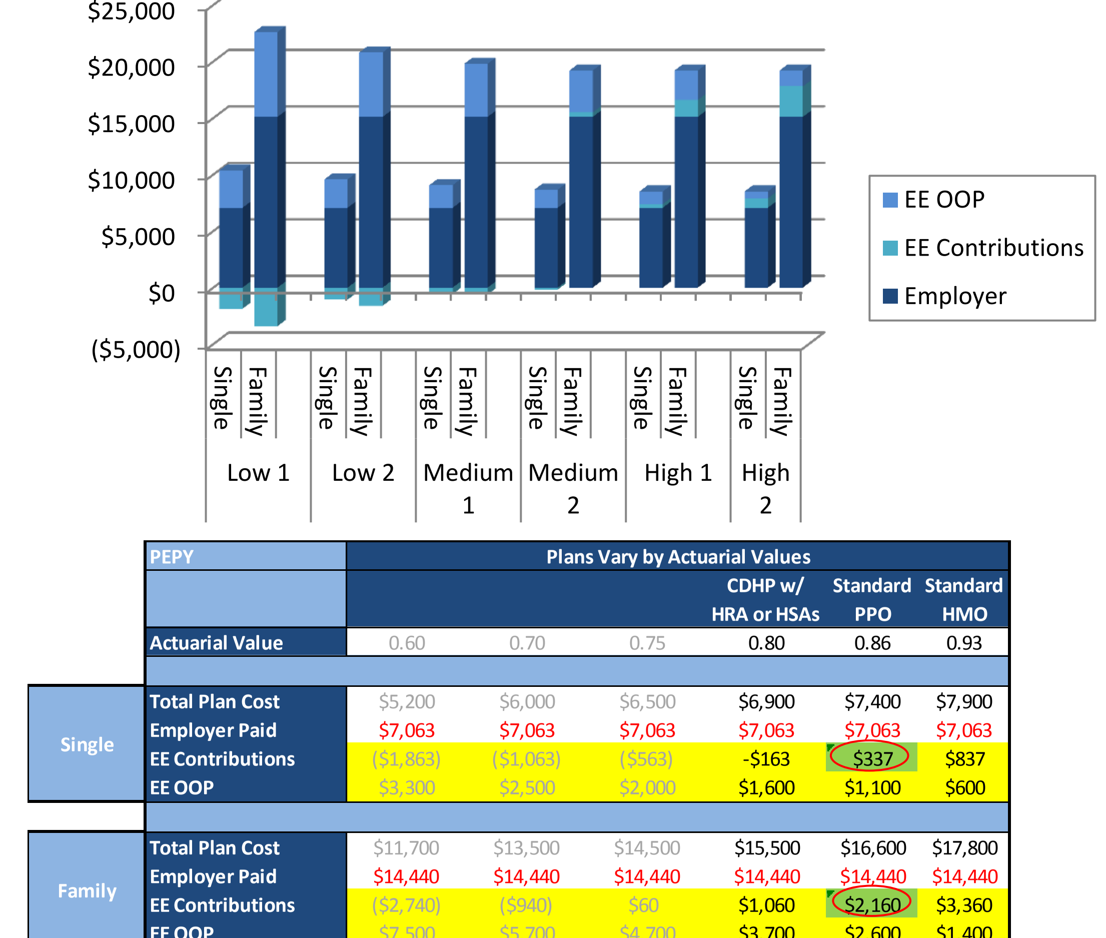

**Single/Family - 20%**

| | PEPY | Plans Vary by Actuarial Values | | | | | |
|---|---|---|---|---|---|---|---|
| | Actuarial Value | 0.60 | 0.70 | 0.75 | 0.80 | 0.85 | 0.90 |
| Single | Total Plan Cost | $4,533 | $5,288 | $5,666 | $6,044 | $6,422 | $6,799 |
| | Employer Paid | $4,835 | $4,835 | $4,835 | $4,835 | $4,835 | $4,835 |
| | EE Contributions | ($302) | $453 | $831 | $1,209 | $1,586 | $1,964 |
| | EE OOP | $3,022 | $2,266 | $1,889 | $1,511 | $1,133 | $755 |
| Family | Total Plan Cost | $10,992 | $12,824 | $13,740 | $14,656 | $15,572 | $16,488 |
| | Employer Paid | $11,725 | $11,725 | $11,725 | $11,725 | $11,725 | $11,725 |
| | EE Contributions | -$733 | $1,099 | $2,015 | $2,931 | $3,847 | $4,763 |
| | EE OOP | $7,328 | $5,496 | $4,580 | $3,664 | $2,748 | $1,832 |

# “Best healthcare practice” / trends — State of Florida illustration
## A consumerism and defined contribution approach to pricing plan options

**Illustration 2:** How the State of Florida’s Plans Might Look if Part of a Consumerism Portfolio Offering (using the current 12% employee approximate cost share of aggregate premium levels)

- The red circled numbers show pricing to buy-up / buy-down from the Standard PPO




| | PEPY | Plans Vary by Actuarial Values | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | CDHP w/ HRA or HSAs | Standard PPO | Standard HMO |
| | Actuarial Value | 0.60 | 0.70 | 0.75 | 0.80 | 0.86 | 0.93 |
| Single | Total Plan Cost | $5,200 | $6,000 | $6,500 | $6,900 | $7,400 | $7,900 |
| | Employer Paid | $7,063 | $7,063 | $7,063 | $7,063 | $7,063 | $7,063 |
| | EE Contributions | ($1,863) | ($1,063) | ($563) | -$163 | $337 | $837 |
| | EE OOP | $3,300 | $2,500 | $2,000 | $1,600 | $1,100 | $600 |
| Family | Total Plan Cost | $11,700 | $13,500 | $14,500 | $15,500 | $16,600 | $17,800 |
| | Employer Paid | $14,440 | $14,440 | $14,440 | $14,440 | $14,440 | $14,440 |
| | EE Contributions | ($2,740) | ($940) | $60 | $1,060 | $2,160 | $3,360 |
| | EE OOP | $7,500 | $5,700 | $4,700 | $3,700 | $2,600 | $1,400 |

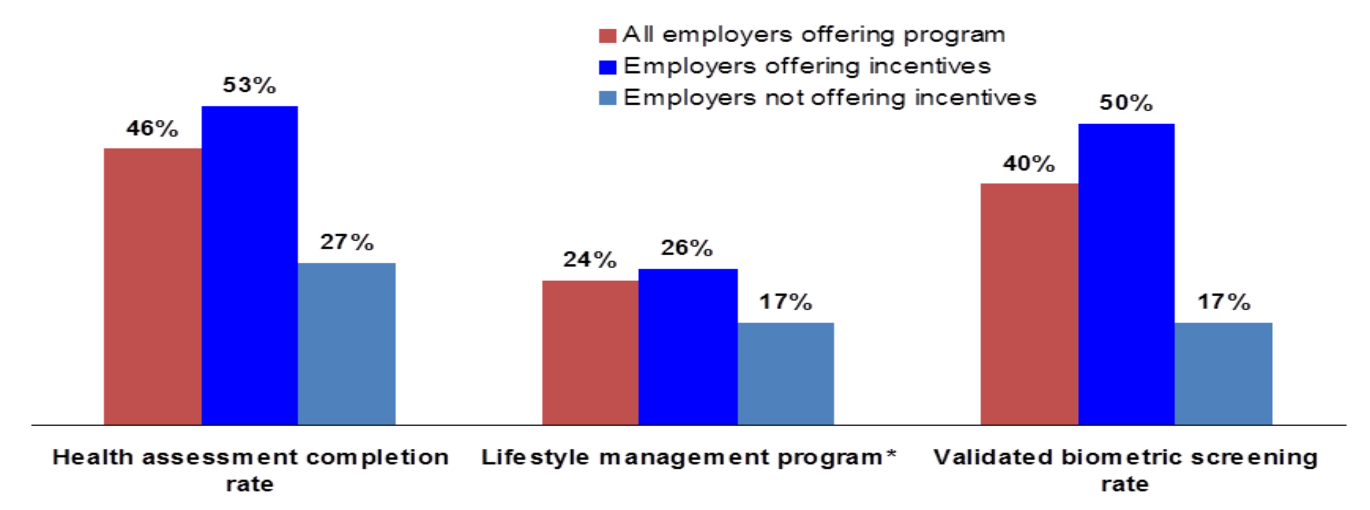
# Health management — incentives
## Prevalence among large employers

- The use of wellness and incentives is growing and large employers are tying incentives to wellness programs that include behavior modification, health assessment completion, and biometric screenings. Disincentives and outcome-based incentives are on the rise

- Almost half of all large employers (48%) in 2012 used incentives
- 62% of employers with 5,000 or more employees used incentives in 2012

# Health management — incentives
## Impact on participation in wellness programs

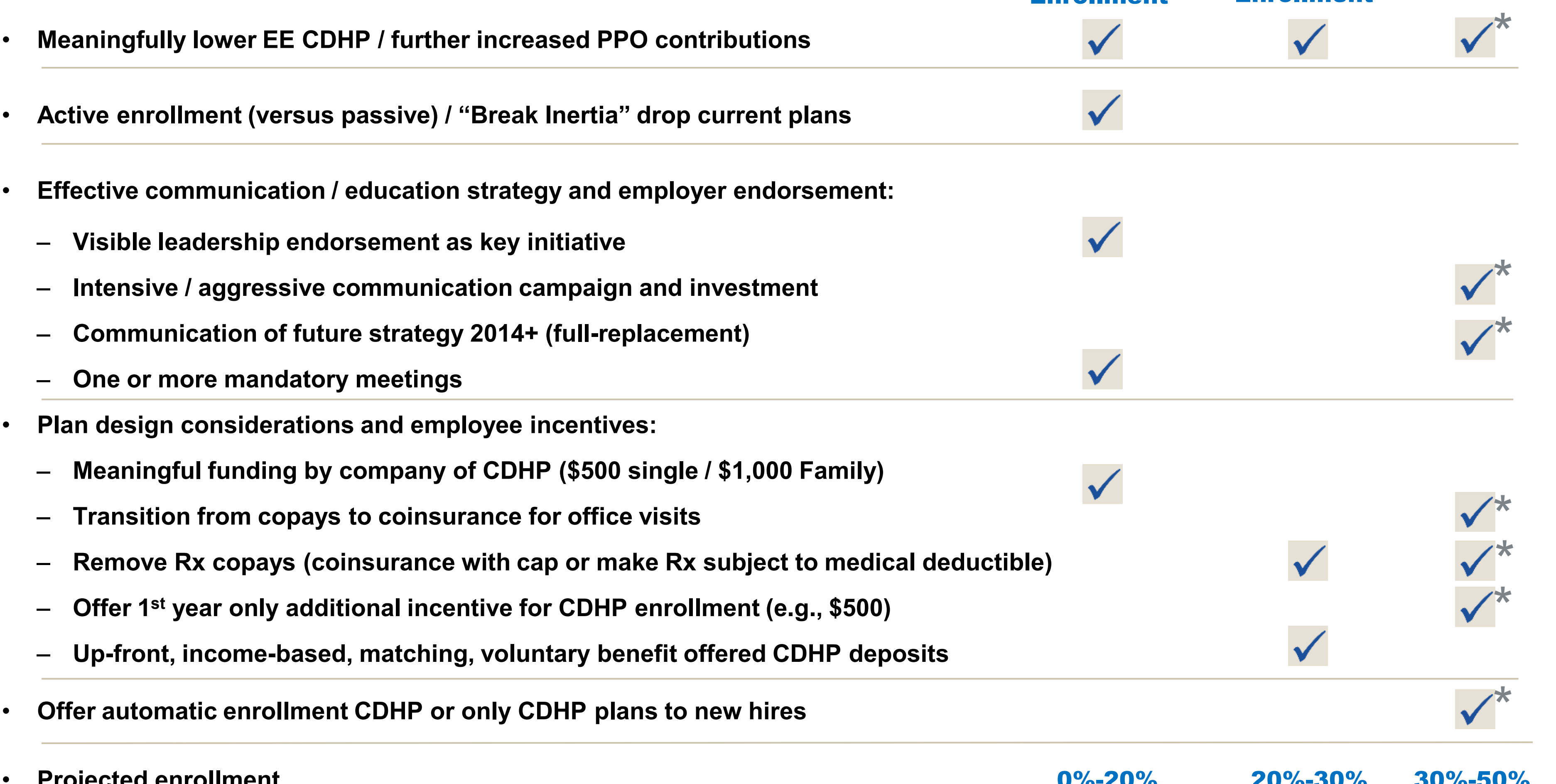
- When incentives are used:
  - Health assessment completion participation rates nearly doubled (from 27% to 53%)
  - Biometric screening participation rates more than doubled (from 17% to 50%)
  - Participation rates in lifestyle coaching increased from 17% to 26%




*Lifestyle management participation is defined as employees who had an assessment completed

# Health management — engagement

## Keys to CDHP enrollment (10%-50%) — key implementation decisions



| | Initial Projected Enrollment | Moderate Enrollment | Higher* Enrollment |
|---|---|---|---|
| • Meaningfully lower EE CDHP / further increased PPO contributions | ✓ | ✓ | ✓* |
| • Active enrollment (versus passive) / "Break Inertia" drop current plans | ✓ | | |
| • Effective communication / education strategy and employer endorsement: | | | |
| – Visible leadership endorsement as key initiative | ✓ | | |
| – Intensive / aggressive communication campaign and investment | | | ✓* |
| – Communication of future strategy 2014+ (full-replacement) | | | ✓* |
| – One or more mandatory meetings | ✓ | | |
| • Plan design considerations and employee incentives: | | | |
| – Meaningful funding by company of CDHP ($500 single / $1,000 Family) | ✓ | | |
| – Transition from copays to coinsurance for office visits | | | ✓* |
| – Remove Rx copays (coinsurance with cap or make Rx subject to medical deductible) | | ✓ | ✓* |
| – Offer 1st year only additional incentive for CDHP enrollment (e.g., $500) | | | ✓* |
| – Up-front, income-based, matching, voluntary benefit offered CDHP deposits | | ✓ | |
| • Offer automatic enrollment CDHP or only CDHP plans to new hires | | | ✓* |
| • Projected enrollment | 0%-20% | 20%-30% | 30%-50% |

***A combination of all the checked items likely needed to get 30-50% 1st year CDHP enrollment**

# Innovation — health care reform
## “Cadillac tax”

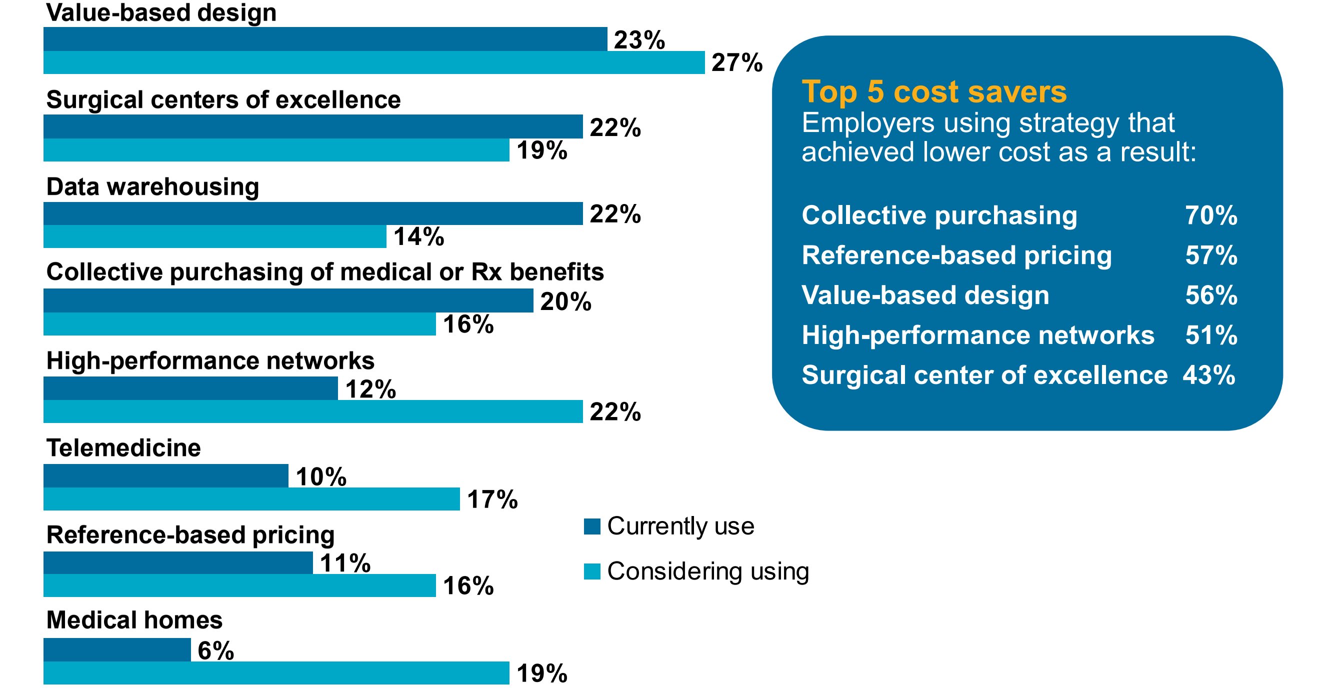
- A 40% “Cadillac tax” will be levied on the aggregate cost of employer-sponsored coverage in 2018
- The tax will apply on behalf of employees, former employees and surviving spouses who receive employer-sponsored coverage with a value equal or greater than $10,200 for “self-only,” and $27,500 for “coverage other than self-only”
- Higher thresholds ($11,850 / $30,950) will apply to retirees and workers in high-risk professions and for single multi-employer plan coverage ($27,500)
- Cost indexing will apply after 2018, and will be based on the consumer price index (CPI) +1% for 2018 and 2019. After 2020, cost indexing will be based on CPI with no additional margin
- As 2018 approaches, employers like the State of Florida will need to consider whether to adjust their plan designs and plan offerings to avoid the “Cadillac tax”
- Of all PPACA provisions employers are currently facing, 48% of employers surveyed in Mercer’s 2012 National Survey of Employer-Sponsored Health Plans said that their biggest worry is the “Cadillac tax”

# Innovation — population specific

- What considerations are there for particular groups at the State of Florida?
  - Early Retiree Approach – Lower cost options would be available to early retirees, likely benefiting those who want lower contributions by selecting from additional new options. While early retirees do not pay the full actuarial value, they can continue to pay the “established” active premiums as they do today. Public exchange options exist as well
  - Payall Approach – “Payall” employees currently pay very low contributions so implementing a DC approach that is calibrated to current contribution levels would likely result in large taxable “cash back” (with HR, communication and administrative issues) for this group. Potential higher contribution strategies or limiting plan options may need to be discussed if the goal is to introduce consumerism or avoid risk selection for this group
  - Medicare-eligible retirees Approach – Medicare-eligible retirees may have alternative options available such as Medicare Advantage and Supplement plans. The State could procure its own Medicare Advantage plan or use private exchanges to offer all market options. Since Medicare-eligible retirees pay the full premium, they are unaffected by a defined contribution approach

# Innovation — other trends

- Within the spectrum of innovations are those that can improve the quality of care employees receive and make care delivery more efficient
- While many of these and other new solutions are still emerging and may have limited cost savings potential unless used in conjunction with consumerism, early results are promising:
  - For example, more than half of the employers that have implemented reference-based pricing, value-based design, and high-performance networks have already been able to document a positive impact on cost



# Innovation — observations and considerations

- While innovation is rapidly expanding throughout the market, it is increasingly difficult to identify sustainable strategies with likely strong “ROI” for the organization, particularly relative to the risk of unknown health care reform, regulatory, provider, insurer, technology and consumer factors
- The suitability of these innovations for a particular large employer is largely dependent on the employer’s ability to identify and commit to longer term objectives, priorities and resources
- How many resources (staff, IT, budgets, communications, various group’s and constituent support) will be available for health management, innovative and provider initiatives?
- Responding to known and unknown Health Care Reform considerations is a significant compliance, financial and strategic consideration (e.g., the Cadillac tax needs to be closely monitored)

# Disclaimer

***All estimates are based upon the information available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use***

MERCER

PCB HHSC 15-03

## HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** PCB HHSC 15-03 Conscience Protection for Private Child-Placing Agencies
**SPONSOR(S):** Health & Human Services Committee; Brodeur
**TIED BILLS:** **IDEN./SIM. BILLS:**

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| Orig. Comm.: Health & Human Services Committee | | Tuszynski | Calamas |

### SUMMARY ANALYSIS


Conscience protection laws prevent individuals and entities from being required to perform services that violate their religious beliefs or moral convictions. These statutes have historically related to abortion, sterilization, and contraception, but conscience protection legislation was recently enacted in relation to adoption services. Two states have enacted legislation that permits private child-placing agencies to refuse to perform adoptions services if a proposed placement would violate the agency's written religious or moral convictions or policies.

PCB HHSC 15-03 creates adoption services conscience protection within s. 409.175, F.S., to allow private child-placing agencies to object to performing, assisting in, recommending, consenting to, or participating in the placement of a child if a placement violates the agency's written religious or moral convictions or policies.

The bill also protects the licensure, grants, contracts, and ability to participate in government programs for those agencies that object to performing adoption services required for the placement of a child if that placement violates the agency's written religious or moral convictions or policies.

The bill does not have a fiscal impact on state or local government.

The bill provides an effective date of July 1, 2015.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Present Situation**

Adoptions

Adoption is the legal procedure by which a child becomes, through court action, part of a family other than that of his or her birth parents.[1] Adoption services are performed by all community-based lead agencies throughout the state[2] as well as private child-placing agencies. All child-placing agencies must be licensed by the Department of Children and Families (DCF), and include any person, corporation, or agency, public or private, other than a parent or legal guardian, that places or arranges for placement of a child in an adoptive home.[3,4] As of December 2014, Florida has 82 licensed private child-placing agencies that perform both public and private adoptions.[5] Licensure of these agencies require compliance with personnel requirements, written policies, financial reports, purpose statements, intake procedures, and record keeping.[6]

*Child Welfare System Adoptions*

Adoption is a method of achieving permanency for children who have suffered abuse, neglect, or abandonment and who are unable to be reunified with their parents. Research indicates that children generally have better outcomes through adoption than through placement in long-term foster care.[7]

In Florida, DCF provides child welfare services.[8] Statute requires child welfare services, including adoption services, to be delivered through community-based care (CBC) lead agencies contracted by DCF.[9] For example, CBC's provide pre- and post-adoption services and administer maintenance adoption subsidies which provide ongoing financial support for children adopted from the foster care system.

During Fiscal Year 2013-14, 3,415 adoptions of children within the child welfare system were finalized in Florida. Over the last 6 federal fiscal years, the number of finalized adoptions has ranged from 2,945 to 3,870 annually.[10]

The vast majority of children adopted in FY 2013-14 were adopted by either relatives (50.29%) or foster parents (27.25%). Recruited parents comprised 22.47% of adoptions.

*Private Adoptions*

Private adoptions are adoptions that occur outside of the child welfare system. Licensed child-placing agencies act as intermediaries between natural and potential adoptive parents providing adoption

[1] The Florida Bar, *Adoption in Florida,* available at http://www.floridabar.org/tfb/tfbconsum.nsf/#ConsumerPamphlets (last visited March 16, 2015).
[2] S. 409.986(1), F.S.
[3] S. 409.175, F.S.
[4] Rule 65C-15, F.A.C.
[5] Email from Nicole Stookey, Deputy Director of Legislative Affairs, Department of Children and Families RE: Adoptions, licensure numbers (March 16, 2015).
[6] Supra. at FN 4.
[7] Evan B. Donaldson Adoption Institute, *Keeping the Promise: Critical Need for Post-Adoption Services to Enable Children and Families to Succeed*, Oct. 2010, p. 8.
[8] S. 20.19(4)(a)3., F.S.
[9] Supra. at FN 2.
[10] U.S. Department of Health and Human Services, Administration on Children, Youth, and Families, 2013. *Adoption of Children with Public Child Welfare Agency Involvement by State, FY 2003 through 2013, available at* http://www.acf.hhs.gov/sites/default/files/cb/children_adopted.pdf. (last visited Feb.16, 2015).

services. These services include home studies, counseling, education, legal services, and post-placement services.[11] These adoptions are arranged by licensed child-placing agencies and require judicial action, but are not otherwise tracked by the state.[12]

Conscience Protections

*Healthcare*

Historically, conscience protections grant health care providers the ability to refuse to perform services related to abortion, sterilization, and more recently contraception, if those services are contrary to the provider's religious beliefs. In 1973, the Church[13] Amendment became the first conscience clause enacted into law. It was passed in response to the United States Supreme Court's decision in *Roe v. Wade*[14] and stated that public officials may not require individuals or entities who receive public funds to perform medical procedures, or make facilities available for procedures, that are "contrary to [the individual or entity's] religious beliefs or moral convictions."[15]

By 1978 almost all states had conscience protection legislation related to abortion.[16] Today, every state but West Virginia has conscience protection statutes for individual providers in relation to abortion.[17] Section 390.0111(8), F.S., grants conscience protection for hospitals, physicians, or any person who refuses to participate in the termination of a pregnancy in Florida.[18] In addition to these state statutes there are federal statutes providing conscience protections for health care providers related to abortion.[19]

Similarly, 17 states have conscience protection statutes for individual providers related to sterilization, and 10 states have conscience protection statutes for individual providers related to contraception.[20] Florida does not have specific conscience protection for sterilization, but has conscience protection for physicians or other persons for refusing to furnish contraception.[21]

*Education*

Conscience protection has also emerged in education. In 2011, Missouri amended its Constitution to include, "no student shall be compelled to perform or participate in academic assignments or educational presentations that violate his or her religious beliefs."[22] Although most do not amend their constitutions, the vast majority of states have adopted legislation allowing parents to opt their children out of educational curriculum that they contend conflicts with their religious beliefs.[23] In 2013, the state of New Hampshire enacted a broad statutory provision allowing any parent to opt out of specific curricula based on any "objectionable" reason.[24]

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[11] The Florida Bar, *Adoption in Florida,* available at http://www.floridabar.org/tfb/tfbconsum.nsf/#ConsumerPamphlets (last visited March 16, 2015).
[12] Id.
[13] Sen. Frank Church (R-ID).
[14] 410 U.S. 113 (1973).
[15] 42 U.S.C. § 300a-7(b).
[16] Rachel Benson Gold, *Conscience Makes a Comeback In the Age of Managed Care, The Guttmacher Report on Public Policy* (Feb. 1998).
[17] Guttmacher Institute - State Policies in Brief, *Refusing to Provide Health Services* available at http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf (last visited on March 15, 2015).
[18] S. 390.0111(8), F.S.
[19] 42 U.S.C. 2996f(b) (Prohibits federal funds to be used in litigation to procure abortion or to compel any individual to perform an abortion.) ; 20 U.S.C. §1688 (Provides neutrality with respect to abortion in Title IX.); 42 U.S.C. §238n (Prohibits discrimination by the Federal Government against any health care entity that does not provide, train in, or refer for abortions.); 42 U.S.C. §1395w-22(j)(3)(B) (Conscience protection for providers who accept Medicare.); 42 U.S.C. §1396u-2(b)(3) (Conscience protection for providers who accept Medicaid.); and Pub. L. No. 111-148 (Allows qualified health plans under the Patient Protection and Affordable Care Act to choose whether to cover abortions.).
[20] Id.
[21] S. 381.0051(5), F.S.
[22] Mo. Const. Art. 1 §5.
[23] Claire Marshall, *The Spread of Conscience Clause Legislation*, American Bar Association available at http://www.americanbar.org/publications/human_rights_magazine_home/2013_vol_39/january_2013_no_2_religious_freedom/the_spread_of_conscience_clause_legislation.html (last viewed March 16, 2015).
[24] N.H. Rev. Stat. Ann. § 186.11

*Adoption Services*

Two states have enacted adoption services conscience protection legislation: North Dakota in 2003,[25,26] and Virginia in 2012.[27] Both the North Dakota and Virginia adoption services conscience protection laws protect private child-placing agencies from:

- Being required to perform any duties related to the placement of a child for adoption if the proposed placement would violate the agency's written religious or moral convictions or policies.
- Denial of initial licensure, revocation of licensure, or failure to renew licensure based on the agency's objection to performing the duties required to place a child for adoption in violation of the agency's written religious or moral convictions or policies.
- Denial of grants, contracts, or participation in government programs based on the agency's objection to performing the duties required to place a child for adoption in violation of the agency's written religious or moral convictions or policies.

North Dakota's statute states that the agency's refusal to perform the duties required to place a child for adoption does not constitute a determination that the proposed adoption is not in the best interest of the child.[28] The Virginia statute is silent as to a best interest determination and states that the refusal to perform the duties required to place a child for adoption is limited to the extent allowed by federal law and shall not form a basis of any claim for damages.[29]

In 2006, Catholic Charities of Boston stopped providing adoption services based on a conflict between church teaching and state law. Like Florida, to participate in adoption placements in Massachusetts, whether or not the agency receives state funding, the child-placing agencies must be licensed.[30] However, Massachusetts law prohibits discrimination based on sexual orientation.[31] Catholic Charities Chair of the Board of Trustees explained, "In spite of much effort and analysis, Catholic Charities of Boston finds that it cannot reconcile the teaching of the Church, which guides our work, and the statutes and regulation of the Commonwealth."[32] The previous year, Catholic Charities had been responsible for over a third of all Boston area private adoptions.[33] Catholic Charities of San Francisco stopped providing adoption services for the same reasons that same year,[34] similar events occurred in Illinois in 2011.[35]

**Effect of Proposed Changes**

PCB HHSC 15-03 creates conscience protection in s. 409.175, F.S. The conscience protection addresses licensure, contracts, and liability of private child placing agencies.

The bill relieves any private child-placing agency from the requirement to participate in any placement of a child that would violate the agency's written religious or moral convictions or policies.

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[25] N.D. Cent. Code § 50-12-03 (2003)
[26] N.D. Cent. Code § 50-12-07.1 (2003)
[27] Va. Code Ann. § 63.2-1709.3 (2012)
[28] Supra. at FN 12.
[29] Va. Code Ann. § 63.2-1709.3(D) (2012)
[30] Mass. Gen. Laws Ann. Ch. 15D, § 8.
[31] Mass. Gen. Laws Ann. Ch. 151b, § 4.
[32] J. Bryan Hehir & Mr. Jeffrey Kaneb, *Statement of Catholic Charities, Archdiocese of Boston, On Adoption Programs*, ARCHDIOCESE OF BOSTON NEWS/EVENTS, Mar. 10, 2006.
[33] Colleen Theresa Rutledge, *Caught in the Crossfire: How Catholic Charities of Boston was Victim to the Clash Between Gay Rights and Religious Freedom*, Duke J. Gender L. & Pol'y (2008).
[34] Cicero A. Estrella, *Catholic Charities Scaling Back Its Role in Adoption Services*, San Francisco Chronicle, August 3, 2006.
[35] Catholic Conference of Illinois, *Join Statement of the Bishops of Belleville, Joliet, and Springfield*, November 14, 2011 available at http://www.ilcatholic.org/bishops-of-belleville-joliet-springfield-dioceses-drop-lawsuit-against-state/ (last viewed March 17, 2015).

The bill creates licensure protection by barring the Department of Children and Families from denial or revocation of licensure because of a private child-placing agency's refusal to participate in a placement against the agency's written religious or moral convictions or policies.

The bill provides private contract protection by barring the state, local government, or community-based care lead agency from denial of any grant, contract, or participation in a government program because of a private child-placing agency's refusal to participate in a placement against the agency's written religious or moral convictions or policies.

The bill creates liability protection for private child-placing agencies for refusal to participate in a placement that would violate its written religious or moral convictions or policies.

B. SECTION DIRECTORY:

**Section 1**: Amends s. 409.175, F.S., relating to licensure of child-placing agencies.
**Section 2**: Provides an effective date of July 1, 2015.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not Applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to conscience protection for private
3 child-placing agencies; amending s. 409.175, F.S.;
4 prohibiting a private child-placing agency from being
5 required to place or be involved in a placement that
6 would violate the agency's religious or moral
7 convictions; prohibiting the department from taking
8 actions related to licensure based on the agency's
9 objections to involvement in certain placements;
10 prohibiting certain entities from denying grants,
11 contracts, or participation in government programs to
12 a private child-placing agency due to its objecting to
13 involvement in certain placements; providing that
14 refusal to be involved in such placements is not the
15 basis of any claim for injunctive relief or damages;
16 providing an effective date.
17
18 Be It Enacted by the Legislature of the State of Florida:
19 Section 1. Subsection (18) is added to section 409.175,
20 Florida Statutes, to read:
21 409.175 Licensure of family foster homes, residential
22 child-caring agencies, and child-placing agencies; public
23 records exemption.—
24 (18)(a) No private child-placing agency shall be required
25 to perform, assist in, recommend, consent to, or participate in
26 any placement of a child when the proposed placement would

27 violate the agency's written religious or moral convictions or
28 policies.
29 (b) The department may not deny an application for an
30 initial license or renewal of a license, or revoke the license,
31 of a private child-placing agency because of the agency's
32 objection to performing, assisting in, recommending, consenting
33 to, or participating in a placement of a child that violates the
34 agency's written religious or moral convictions or policies.
35 (c) The state or a local government or community-based care
36 lead agency may not deny a private child-placing agency any
37 grant, contract, or participation in a government program
38 because of the agency's objection to participating in a
39 placement of a child that violates the agency's written
40 religious or moral convictions or policies.
41 (d) Refusal of a private child-placing agency to perform,
42 assist in, recommend, consent to, or participate in a placement
43 of a child that violates the agency's written religious or moral
44 convictions or policies shall not form the basis of any claim
45 for injunctive relief or for damages.
46 Section 2. This act shall take effect July 1, 2015.