Health & Human Services Committee

Thursday, March 26, 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 26, 2015 09:00 am
End Date and Time:	Thursday, March 26, 2015 11:00 am
Location:	Morris Hall (17 HOB)
Duration:	2.00 hrs

Consideration of the following bill(s):

CS/HB 281 Prescription Medication by Health Innovation Subcommittee, Pigman
CS/HB 541 Athletic Trainers by Health Quality Subcommittee, Plasencia
CS/CS/HB 731 Employee Health Care Plans by Insurance & Banking Subcommittee, Health Innovation Subcommittee, Plakon
CS/HB 749 Continuing Care Communities by Insurance & Banking Subcommittee, Van Zant
CS/HB 951 Dietetics and Nutrition by Health Quality Subcommittee, Magar
CS/HB 1039 Nurse Registries by Health Innovation Subcommittee, Stone
CS/HB 1055 Child Protection by Children, Families & Seniors Subcommittee, Harrell

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 25, 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 25, 2015.

NOTICE FINALIZED on 03/24/2015 16:02 by Iseminger.Bobbye

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 281 Prescription Medication
SPONSOR(S): Health Innovation Subcommittee; Pigman
TIED BILLS: **IDEN./SIM. BILLS:** SB 532

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	11 Y, 0 N, As CS	Castagna	Poche
2) Health & Human Services Committee		Castagna	Calamas

SUMMARY ANALYSIS

Currently, physician assistants (PAs) are authorized to order medicinal drugs for a hospitalized patient of their supervising physician. Florida law does not authorize advanced registered nurse practitioners (ARNPs) to do the same.

HB 281 authorizes ARNPs, acting under the supervision of a physician, to order medications, including controlled substances, for a patient in a facility licensed under ch. 395, F.S., including hospitals, ambulatory surgical centers, and mobile surgical facilities. The bill amends the Pharmacy Act in chapter 465, F.S., and the Controlled Substances Act in chapter 893, F.S., to exempt from the definition of prescription an order for medication that is dispensed in a facility licensed under chapter 395, F.S., to a patient.

The bill appears to have no fiscal impact on state or local governments.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Physician Assistants

Regulation and Licensure

A physician assistant (PA) is a person licensed to perform health care services, in the specialty areas in which he or she has been trained, delegated by a supervising physician.[1] PAs are governed under the respective physician practice acts for medical doctors (MDs) and doctors of osteopathic medicine (DOs).[2] PAs are regulated by the Florida Council on Physician Assistants (Council) in conjunction with either the Board of Medicine for PAs licensed under ch. 458, F.S., or the Board of Osteopathic Medicine for PAs licensed under ch. 459, F.S. Currently, there are 6,511 in-state, and 724 out-of-state, active licensed PAs.[3]

An applicant for a PA license must apply to the Department of Health (Department). The Department must issue a license to a person certified by the Council as having met all of the following requirements:

- At least 18 years of age;
- Satisfactorily passed a proficiency examination with an acceptable score established by the National Commission on Certification of Physician Assistants;[4]
- Completed an application form and paid the registration fee;
- Holds a certificate of completion from a PA training program, including certain course descriptions relating to pharmacotherapy if the PA applicant seeks prescribing authority;
- Provides a sworn statement of any felony convictions;
- Provides a sworn statement of any revocation or denial of licensure or certification in any state; and
- Provides two letters of recommendation.

A PA license is renewed every two years by:

- Submitting an application;
- Paying a $275 renewal fee;[5] and
- Submitting proof of completion of at least 100 hours of continuing medical education (CME) during the two years prior to application for renewal.[6]

[1] SS. 458.347(1), F.S., and 459. 022(1)(e), F.S.
[2] SS. 458.347, F.S., and 459.022, F.S.
[3] Email correspondence with the Department of Health on March 14, 2015 (on file with subcommittee staff).
[4] National Commission on Certification of Physician Assistants, *Physician Assistant National Certifying Exam (PANCE)*, available at https://www.nccpa.net/pance (last visited March 14, 2015).
[5] Rule 64B8-30.019, F.A.C.
[6] In addition to the above requirements, prescribing PAs must complete 10 hours of CME in each specialty of their supervising physician. These hours are included in general CME requirements. Florida Board of Medicine, *Physician Assistants,* available at http://flboardofmedicine.gov/renewals/physician-assistants/ (last visited March 14, 2015).

Supervising Physician

A PA practices under the delegated authority of a supervising physician. A physician supervising a PA must be qualified in the medical area in which the PA is practicing and is responsible and liable for the performance, acts, and omissions of the PA.[7]

The Boards have established that responsible supervision of a PA is the ability of the supervising physician to exercise control and provide direction over the services or tasks performed by the PA. The following factors are used to determine if PA supervision is adequate:

- The complexity of the task;
- The risk to the patient;
- The background, training and skill of the PA;
- The adequacy of the direction in terms of its form;
- The setting in which the tasks are performed;
- The availability of the supervising physician;
- The necessity for immediate attention; and
- The number of other persons that the supervising physician must supervise.[8]

The supervising physician is required to periodically review the PA's performance.

A supervising physician may only delegate tasks and procedures to the physician assistant which are within the supervising physician's scope of practice.[9] The decision to permit the physician assistant to perform a task or procedure under direct or indirect supervision is made by the supervising physician based on reasonable medical judgment regarding the probability of morbidity and mortality to the patient.[10] Direct supervision refers to the physical presence of the supervising physician so that the physician is immediately available to the PA when needed. Indirect supervision refers to the reasonable physical proximity of the supervising physician to the PA or availability by telecommunication.[11]

Delegable Tasks

The following tasks are not permitted to be delegated to a PA, except when specifically authorized by statute:

- Prescribing, dispensing, or compounding medicinal drugs; and
- Final diagnosis.

A supervising physician may delegate authority to a PA the authority to:

- Prescribe or dispense any medicinal drug used in the supervising physician's practice;[12]
- Order medicinal drugs for a hospitalized patient of the supervising physician;[13] and

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[7] SS. 458.347(3), F.S., and 459.022(3), F.S.; Rules 64B8-30.012, F.A.C., and 64B15-6.010, F.A.C.
[8] Rules 64B8-30.001, F.A.C., and 64B15-6.001, F.A.C.
[9] Supra at FN 7.
[10] Id.
[11] Specific procedures are not permitted to be performed under indirect supervision, including routine insertion of chest tubes, removal of pacer wires or atrial monitoring lines from cardiac stress testing, routine insertion of central venous catheters, injection of intrathecal medication without prior approval of the supervising physician, interpretation of laboratory tests, X-ray studies and EKG's without the supervising physician's interpretation and final review, and administration of general, spinal, and epidural anesthetics (this may be performed under direct supervision only by physician assistants who graduated from Board-approved programs for the education of anesthesiology assistants). *See* Rules in Supra at FN 7.
[12] SS. 458.347(4)(f)1., F.S., and 459.022(4)(e), F.S., directs the Council to establish a formulary listing the medical drugs that a PA may not prescribe. The formulary in Rules 64B8-30.008, F.A.C., and 64B15-6.0038, F.A.C., prohibits PAs from prescribing controlled substances, as defined in Chapter 893, F.S., general, spinal or epidural anesthetics, and radiographic contrast materials.
[13] In 2013, ss.458.347 and 459.022, F.S., were amended to clarify that a PA is authorized to order controlled substances for hospitalized patients.

- Administer a medicinal drug under the direction and supervision of the physician.

Currently, PAs are prohibited from prescribing controlled substances, general, spinal, or epidural anesthetics, and radiographic contrast materials.[14] However, physicians may delegate to PAs the authority to order controlled substances in facilities licensed under ch. 395, F.S.[15]

Advanced Registered Nurse Practitioners

Regulation and Licensure

In Florida, an advanced practice nurse is an advanced registered nurse practitioner (ARNP),[16] and is categorized as a certified nurse practitioner, certified nurse midwife, or certified registered nurse anesthetist.[17] As of March 2015, there are 17,719 ARNPs practicing in Florida.

Section 464.003(2), F.S., defines "advanced or specialized nursing practice" to include, in addition to practice of professional nursing that registered nurses are authorized to perform, advanced-level nursing acts approved by the Board of Nursing (Board) as appropriate for ARNPs to perform based on their specialized education, training, and experience. Advanced or specialized nursing acts may only be performed if authorized under a supervising physician's protocol.[18]

ARNPs are regulated under part I of ch. 464, F.S., the Nurse Practice Act. The Board, established under s. 464.004, F.S., provides the eligibility criteria for applicants to be certified as ARNPs and the applicable regulatory standards for ARNP nursing practices. For an applicant to be eligible to be certified as an ARNP, the applicant must:

- Have a registered nurse license;
- Have earned, at least, a master's degree; and
- Submit to the Board proof of a current national advanced practice certification from a board-approved nursing specialty board.[19]

Pursuant to s. 456.048, F.S., all ARNPs must carry malpractice insurance or demonstrate proof of financial responsibility. An applicant for certification is required to submit proof of coverage or financial responsibility within sixty days of certification and before each biennial renewal. An ARNP must have professional liability coverage of at least $100,000 per claim with a minimum annual aggregate of at least $300,000, or an unexpired irrevocable letter of credit, which is payable to the ARNP as beneficiary, in the amount of at least $100,000 per claim with a minimum aggregate availability of at least $300,000.[20]

Supervising Physician

Under s. 464.012(3), F.S., ARNPs may only perform nursing practices delineated in a written physician protocol filed with the Board.[21] Florida law allows a primary care physician to supervise ARNPs in up to four offices, in addition to the physician's primary practice location. If the physician provides specialty

[14] Rules 64B8-30.008, F.A.C., and 64B15-6.0038, F.A.C.
[15] SS. 458.347(4)(g), F.S., and 459.022(4)(f), F.S.; the facilities licensed in ch. 395, F.S., include hospitals, ambulatory surgical centers, and mobile surgical facilities.
[16] S. 464.003(3), F.S.
[17] S. 464.012(4), F.S.
[18] S. 464.012, F.S.
[19] S. 464.012(1), F.S., and Rule 64B9-4.002, F.A.C. A nursing specialty board must attest to the competency of nurses in a clinical specialty area, require nurses to take a written examination prior to certification, require nurses to complete a formal program prior to eligibility of examination, maintain program accreditation, and identify standards or scope of practice statements appropriate for each nursing specialty.
[20] Rule 64B9-4.002(5), F.A.C.
[21] Allopathic and osteopathic physicians are also required to provide notice of the written protocol and the supervisory relationship to the Board of Medicine or Board of Osteopathic Medicine, respectively. SS. 458.348 and 459.025, F.S.

health care services, then only two medical offices, in addition to the physician's primary practice location, may be supervised.

The supervision limitations do not apply in the following facilities:

- Hospitals;
- Colleges of medicine or nursing;
- Nonprofit family-planning clinics;
- Rural and federally qualified health centers;
- Nursing homes;
- Assisted living facilities;
- Student health care centers or school health clinics; and
- Other government facilities. [22]

To ensure appropriate medical care, the number of ARNPs a supervising physician may supervise is limited based on consideration of the following factors:

- Risk to the patient;
- Educational preparation, specialty, and experience in relation to the supervising physician's protocol;
- Complexity and risk of the procedures;
- Practice setting; and
- Availability of the supervising physician or dentist.[23]

Delegable Tasks

Within the framework of a written physician protocol, an ARNP may:

- Monitor and alter drug therapies;
- Initiate appropriate therapies for certain conditions;
- Order diagnostic tests and physical and occupational therapy;
- Perform certain acts within his or her specialty;
- Perform medical acts authorized by a joint committee; and
- Perform additional functions determined by rule. [24]

Florida law does not authorize ARNPs to prescribe, independently administer, or dispense controlled substances.[25]

Controlled Substances

Controlled substances are drugs with the potential for abuse. Chapter 893, F.S., sets forth the Florida Comprehensive Drug Abuse Prevention and Control Act (Act) and classifies controlled substances into five categories, known as schedules. The distinguishing factors between the different drug schedules are the "potential for abuse" of the substance and whether there is a currently accepted medical use for the substance. Schedules are used to regulate the manufacture, distribution, preparation and dispensing of the substances.[26]

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[22] SS. 458.348(4)(e), and 459.025(3)(e), F.S.
[23] Rule 64B9-4.010, F.A.C.
[24] S. 464.012(3), F.S. Section 464.012(4), F.S., authorizes additional acts that certified registered nurse anesthetists, certified nurse midwives, and certified nurse practitioners are authorized to perform within their specialty and a supervisory physician protocol.
[25] SS. 893.02(21), F.S., and 893.05(1), F.S.
[26] Drug Enforcement Administration, Office of Diversion Control, *Controlled Substance Schedules*, available at www.deadiversion.usdoj.gov/21cfr/cfr/2108cfrt.htm (last visited March 14, 2015).

The Act defines "prescription" as an order for drugs or medicinal supplies written, signed, or transmitted by word of mouth, telephone, telegram, or other means of communication by a duly licensed practitioner licensed by the laws of the state to prescribe such drugs or medicinal supplies, issued in good faith and in the course of professional practice, intended to be filled, compounded, or dispensed by another person licensed by the laws of the state to do so.[27] The Act includes provisions on required protocols for prescribing and administration of controlled substances by health care practitioners and proper dispensing by pharmacists and health care practitioners.[28]

Any health care professional wishing to prescribe controlled substances must apply for a registration number from the federal Drug Enforcement Administration (DEA).[29] Registration numbers are linked to state licenses and may be suspended or revoked upon any disciplinary action taken against a licensee.[30] The DEA will grant registration numbers to a wide range of health care professionals, including physicians, nurse practitioners, physician assistants, optometrists, dentists, and veterinarians, but such professionals may only prescribe controlled substances as authorized under state law. Registration numbers must be renewed every three years.[31]

Drug Enforcement Administration

The Drug Enforcement Administration (DEA), housed within the U.S. Department of Justice, serves to enforce the controlled substances laws and regulations of the United States, including preventing and investigating the diversion of controlled pharmaceuticals. [32]

The DEA's Practitioner Manual includes requirements for valid prescriptions. The DEA defines "prescription" as an order for medication which is dispensed to or for an ultimate user, but is not an order for a medication dispensed for immediate administration to the user, such as an order to dispense a drug to a patient in a hospital setting.[33] The DEA provides that a controlled substance prescription may only be issued by a physician, dentist, podiatrist, veterinarian, mid-level practitioner, or other registered practitioner who is:

- Authorized to prescribe controlled substances by the jurisdiction in which the practitioner is licensed to practice;
- Registered with the DEA, or exempt from registration (e.g., Public Health Service, Federal Bureau of Prisons, military practitioners); or
- An agent or employee of a hospital or other institution acting in the normal course of business or employment under the DEA registration number of the hospital or other institution which is registered in lieu of the individual practitioner being registered.[34]

Effect of Proposed Changes

HB 281 permits an ARNP to order medications and controlled substances for hospitalized patients, if acting within the framework of an established protocol with a licensed physician. Such permission is limited to ordering medications and controlled substances in a licensed facility under chapter 395, F.S. The facilities licensed under ch. 395, F.S., include hospitals, ambulatory surgical centers, and mobile surgical facilities. The bill also clarifies the authority of a PA, delegated by a supervising physician, to

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[27] The definition also includes protocol for out-of-state, licensed practitioners who are prescribing in Florida, pharmacist prescription verification, and prescription blank requirements for controlled substances. S. 893.02(22), F.S.
[28] SS. 893.04, F.S., and 893.05, F.S.
[29] U.S. Department of Justice, Drug Enforcement Administration, Office of Diversion Control, *Questions & Answers-Registration*, available at http://www.deadiversion.usdoj.gov/drugreg/faq.htm# (last visited on March 14, 2015).
[30] Drug Enforcement Administration, *Practitioners Manual- Section II*, available at http://www.deadiversion.usdoj.gov/pubs/manuals/pract/section2.htm (last visited March 16, 2015).
[31] Id..
[32] Drug Enforcement Administration, *About Us*, available at http://www.deadiversion.usdoj.gov/Inside.html (last visited March 16, 2015).
[33] Drug Enforcement Administration, *Practitioner's Manual-Section V*, available at http://www.deadiversion.usdoj.gov/pubs/manuals/pract/section5.htm (last visited March 14, 2015).
[34] Id.

order medications for administration to the physician's patient in a facility licensed under chapter 395 F.S.

The bill amends s. 465.003, F.S., to clarify that the term "prescription" does not include an "order" that is dispensed for administration to a patient in a facility licensed under ch. 395, F.S. The bill clarifies that the sale of medicinal drugs dispensed as a prescription is eligible for the sales tax exemption under s. 212.08, F.S.

The bill amends several sections of the Controlled Substances Act to clarify the difference between a prescription and an order in a facility licensed under chapter 395, F.S. In s. 893.02, F.S., the definition of prescription is amended to clarify that a prescription does not include an order that is dispensed for administration to a patient in a facility licensed under ch. 395, F.S. The bill authorizes a PA or ARNP, acting under the supervision of a physician, to order a controlled substance for administration to a patient in a facility licensed under chapter 395, F.S.

The bill makes other technical changes to conform statutory language to changes made by the bill.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 458.347, F.S., relating to physician assistants.
Section 2: Amends s. 459.022, F.S., relating to physician assistants.
Section 3: Amends s. 464.012, F.S., relating to certification of advanced registered nurse practitioners, fees.
Section 4: Amends s. 465.003, F.S., relating to definitions.
Section 5: Amends s. 465.187, F.S., relating to the sale of medicinal drugs.
Section 6: Amends s. 893.02, F.S., relating to definitions.
Section 7: Amends s. 893.04, F.S., relating to pharmacists and practitioner.
Section 8: Amends s. 893.05, F.S., relating to practitioners and persons administering controlled substances in their absence.
Section 9: 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:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 18, 2015, the Health Innovation Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment clarifies that PAs and ARNPs, acting under the supervision of a physician rather than under the direction of a physician, may order a controlled substance for a patient in a facility licensed under ch. 395, F.S. The analysis is drafted to the committee substitute.

A bill to be entitled

An act relating to prescription medication; amending ss. 458.347 and 459.022, F.S.; authorizing a licensed physician assistant acting under the direction of a supervisory physician to order medication for administration to a specified patient; conforming provisions; amending s. 464.012, F.S.; authorizing an advanced registered nurse practitioner to order medication for administration to a specified patient; amending ss. 465.003 and 893.02, F.S.; revising the definition of the term "prescription" to exclude an order that is dispensed for administration to a specified patient; amending ss. 465.187 and 893.04, F.S.; conforming provisions; amending s. 893.05, F.S.; authorizing a licensed physician assistant or advanced registered nurse practitioner acting under the supervision of a physician to order a controlled substance for administration to a specified patient; providing an effective date.

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

Section 1. Paragraph (g) of subsection (4) of section 458.347, Florida Statutes, is amended to read:

458.347 Physician assistants.—

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(g) A supervisory physician may delegate to a licensed physician assistant the authority to, and the licensed physician assistant acting under the direction of the supervisory physician may, order medication ~~medications~~ for administration to the supervisory physician's patient ~~during his or her care~~ in a facility licensed under chapter 395~~, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation. For the purpose of this paragraph, an order is not considered a prescription. A licensed physician assistant working in a facility that is licensed under chapter 395 may order any medication under the direction of the supervisory physician~~.

Section 2. Paragraph (f) of subsection (4) of section 459.022, Florida Statutes, is amended to read:

459.022 Physician assistants.—

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(f) A supervisory physician may delegate to a licensed physician assistant the authority to, and the licensed physician assistant acting under the direction of the supervisory physician may, order medication ~~medications~~ for administration to the supervisory physician's patient ~~during his or her care~~ in a facility licensed under chapter 395~~, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation. For the purpose of this paragraph, an order is not considered a prescription. A licensed physician assistant working in a facility that is licensed under chapter 395 may~~

~~order any medication under the direction of the supervisory physician~~.

Section 3. Paragraph (e) is added to subsection (3) of section 464.012, Florida Statutes, to read:

464.012 Certification of advanced registered nurse practitioners; fees.—

(3) An advanced registered nurse practitioner shall perform those functions authorized in this section within the framework of an established protocol that is filed with the board upon biennial license renewal and within 30 days after entering into a supervisory relationship with a physician or changes to the protocol. The board shall review the protocol to ensure compliance with applicable regulatory standards for protocols. The board shall refer to the department licensees submitting protocols that are not compliant with the regulatory standards for protocols. A practitioner currently licensed under chapter 458, chapter 459, or chapter 466 shall maintain supervision for directing the specific course of medical treatment. Within the established framework, an advanced registered nurse practitioner may:

(e) Order medication for administration to a patient in a facility licensed under chapter 395.

Section 4. Subsection (14) of section 465.003, Florida Statutes, is amended to read:

465.003 Definitions.—As used in this chapter, the term:

(14) "Prescription" includes any order for drugs or

medicinal supplies written or transmitted by any means of communication by a duly licensed practitioner authorized by the laws of the state to prescribe such drugs or medicinal supplies and intended to be dispensed by a pharmacist. The term also includes an orally transmitted order by the lawfully designated agent of such practitioner. The term also includes an order written or transmitted by a practitioner licensed to practice in a jurisdiction other than this state, but only if the pharmacist called upon to dispense such order determines, in the exercise of her or his professional judgment, that the order is valid and necessary for the treatment of a chronic or recurrent illness. The term "prescription" also includes a pharmacist's order for a product selected from the formulary created pursuant to s. 465.186. The term "prescription" does not include an order that is dispensed for administration to a patient in a facility licensed under chapter 395. Prescriptions may be retained in written form or the pharmacist may cause them to be recorded in a data processing system, provided that such order can be produced in printed form upon lawful request.

Section 5. Section 465.187, Florida Statutes, is amended to read:

465.187 Sale of medicinal drugs.—The sale of medicinal drugs dispensed upon the prescription ~~order~~ of a practitioner pursuant to this chapter shall be entitled to the exemption from sales tax provided for in s. 212.08.

Section 6. Subsection (22) of section 893.02, Florida

Statutes, is amended to read:

893.02 Definitions.—The following words and phrases as used in this chapter shall have the following meanings, unless the context otherwise requires:

(22) "Prescription" means and includes an order for drugs or medicinal supplies written, signed, or transmitted by any ~~word of mouth, telephone, telegram, or other~~ means of communication by a duly licensed practitioner authorized ~~licensed~~ by the laws of the state to prescribe such drugs or medicinal supplies, issued in good faith and in the course of professional practice, intended to be ~~filled, compounded, or~~ dispensed by a ~~another~~ person authorized ~~licensed~~ by the laws of the state to do so, and meeting the requirements of s. 893.04. The term also includes an order for drugs or medicinal supplies so transmitted or written by a physician, dentist, veterinarian, or other practitioner licensed to practice in a state other than Florida, but only if the pharmacist called upon to fill such an order determines, in the exercise of his or her professional judgment, that the order was issued pursuant to a valid patient-physician relationship, that it is authentic, and that the drugs or medicinal supplies so ordered are considered necessary for the continuation of treatment of a chronic or recurrent illness. However, if the physician writing the prescription is not known to the pharmacist, the pharmacist shall obtain proof to a reasonable certainty of the validity of said prescription. A prescription order for a controlled substance shall not be

issued on the same prescription blank with another prescription order for a controlled substance which is named or described in a different schedule, nor shall any prescription order for a controlled substance be issued on the same prescription blank as a prescription order for a medicinal drug, as defined in s. 465.003(8), which does not fall within the definition of a controlled substance as defined in this act. The term "prescription" does not include an order that is dispensed for administration to a patient in a facility licensed under chapter 395.

Section 7. Subsection (2) of section 893.04, Florida Statutes, is amended to read:

893.04 Pharmacist and practitioner.—

(2)(a) A pharmacist may not dispense a controlled substance listed in Schedule II, Schedule III, or Schedule IV to any patient or patient's agent without first determining, in the exercise of her or his professional judgment, that the prescription ~~order~~ is valid. The pharmacist may dispense the controlled substance, in the exercise of her or his professional judgment, when the pharmacist or pharmacist's agent has obtained satisfactory patient information from the patient or the patient's agent.

(b) Any pharmacist who dispenses by mail a controlled substance listed in Schedule II, Schedule III, or Schedule IV is exempt from the requirement to obtain suitable identification for the prescription dispensed by mail if the pharmacist has

obtained the patient's identification through the patient's prescription benefit plan.

(c) Any controlled substance listed in Schedule III or Schedule IV may be dispensed by a pharmacist upon an oral prescription if, before filling the prescription, the pharmacist reduces it to writing or records the prescription electronically if permitted by federal law. Such prescriptions must contain the date of the oral authorization.

(d) Each ~~written~~ prescription written ~~prescribed~~ by a practitioner in this state for a controlled substance listed in Schedule II, Schedule III, or Schedule IV must include both a written and a numerical notation of the quantity of the controlled substance prescribed and a notation of the date in numerical, month/day/year format, or with the abbreviated month written out, or the month written out in whole. A pharmacist may, upon verification by the prescriber, document any information required by this paragraph. If the prescriber is not available to verify a prescription, the pharmacist may dispense the controlled substance but may insist that the person to whom the controlled substance is dispensed provide valid photographic identification. If a prescription includes a numerical notation of the quantity of the controlled substance or date, but does not include the quantity or date written out in textual format, the pharmacist may dispense the controlled substance without verification by the prescriber of the quantity or date if the pharmacy previously dispensed another prescription for the

person to whom the prescription was written.

(e) A pharmacist may not dispense more than a 30-day supply of a controlled substance listed in Schedule III upon an oral prescription issued in this state.

(f) A pharmacist may not knowingly dispense ~~fill~~ a prescription that has been forged for a controlled substance listed in Schedule II, Schedule III, or Schedule IV.

Section 8. Subsection (1) of section 893.05, Florida Statutes, is amended to read:

893.05 Practitioners and persons administering controlled substances in their absence.—

(1) A practitioner, in good faith and in the course of his or her professional practice only, may prescribe, administer, dispense, mix, or otherwise prepare a controlled substance, or the practitioner may cause the controlled substance ~~same~~ to be administered by a licensed nurse or an intern practitioner under his or her direction and supervision only. A veterinarian may so prescribe, administer, dispense, mix, or prepare a controlled substance for use on animals only, and may cause it to be administered by an assistant or orderly under the veterinarian's direction and supervision only. A certified optometrist licensed under chapter 463 may not administer or prescribe a controlled substance listed in Schedule I or Schedule II of s. 893.03. A licensed physician assistant or advanced registered nurse practitioner, acting under the supervision of a physician, may order a controlled substance for administration to a patient,

consistent with the requirements of s. 458.347, s. 459.022, or s. 464.012.

Section 9. 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	_____

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Pigman offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsection (7) of section 110.12315, Florida Statutes, is amended to read:

110.12315 Prescription drug program.—The state employees' prescription drug program is established. This program shall be administered by the Department of Management Services, according to the terms and conditions of the plan as established by the relevant provisions of the annual General Appropriations Act and implementing legislation, subject to the following conditions:

(7) The department shall establish the reimbursement schedule for prescription pharmaceuticals dispensed under the program. Reimbursement rates for a prescription pharmaceutical

must be based on the cost of the generic equivalent drug if a generic equivalent exists, unless the physician, advanced registered nurse practitioner, or physician assistant prescribing the pharmaceutical clearly states on the prescription that the brand name drug is medically necessary or that the drug product is included on the formulary of drug products that may not be interchanged as provided in chapter 465, in which case reimbursement must be based on the cost of the brand name drug as specified in the reimbursement schedule adopted by the department.

Section 2. Paragraph (c) of subsection (1) of section 310.071, Florida Statutes, is amended to read:

310.071 Deputy pilot certification.—

(1) In addition to meeting other requirements specified in this chapter, each applicant for certification as a deputy pilot must:

(c) Be in good physical and mental health, as evidenced by documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician within the preceding 6 months. The board shall adopt rules to establish requirements for passing the physical examination, which rules shall establish minimum standards for the physical or mental capabilities necessary to carry out the professional duties of a certificated deputy pilot. Such standards shall include zero tolerance for any controlled substance regulated under chapter 893 unless that individual is under the care of a physician,

advanced registered nurse practitioner, or physician assistant and that controlled substance was prescribed by that physician, advanced registered nurse practitioner, or physician assistant. To maintain eligibility as a certificated deputy pilot, each certificated deputy pilot must annually provide documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician. The physician must know the minimum standards and certify that the certificateholder satisfactorily meets the standards. The standards for certificateholders shall include a drug test.

Section 3. Subsection (3) of section 310.073, Florida Statutes, is amended to read:

310.073 State pilot licensing.—In addition to meeting other requirements specified in this chapter, each applicant for license as a state pilot must:

(3) Be in good physical and mental health, as evidenced by documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician within the preceding 6 months. The board shall adopt rules to establish requirements for passing the physical examination, which rules shall establish minimum standards for the physical or mental capabilities necessary to carry out the professional duties of a licensed state pilot. Such standards shall include zero tolerance for any controlled substance regulated under chapter 893 unless that individual is under the care of a physician, advanced registered nurse practitioner, or physician assistant

and that controlled substance was prescribed by that physician, advanced registered nurse practitioner, or physician assistant. To maintain eligibility as a licensed state pilot, each licensed state pilot must annually provide documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician. The physician must know the minimum standards and certify that the licensee satisfactorily meets the standards. The standards for licensees shall include a drug test.

Section 4. Paragraph (b) of subsection (3) of section 310.081, Florida Statutes, is amended to read:

310.081 Department to examine and license state pilots and certificate deputy pilots; vacancies.—

(3) Pilots shall hold their licenses or certificates pursuant to the requirements of this chapter so long as they:

(b) Are in good physical and mental health as evidenced by documentary proof of having satisfactorily passed a physical examination administered by a licensed physician or physician assistant within each calendar year. The board shall adopt rules to establish requirements for passing the physical examination, which rules shall establish minimum standards for the physical or mental capabilities necessary to carry out the professional duties of a licensed state pilot or a certificated deputy pilot. Such standards shall include zero tolerance for any controlled substance regulated under chapter 893 unless that individual is under the care of a physician, advanced registered nurse

practitioner, or physician assistant and that controlled substance was prescribed by that physician, advanced registered nurse practitioner, or physician assistant. To maintain eligibility as a certificated deputy pilot or licensed state pilot, each certificated deputy pilot or licensed state pilot must annually provide documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician. The physician must know the minimum standards and certify that the certificateholder or licensee satisfactorily meets the standards. The standards for certificateholders and for licensees shall include a drug test.

Upon resignation or in the case of disability permanently affecting a pilot's ability to serve, the state license or certificate issued under this chapter shall be revoked by the department.

Section 5. Subsection (7) of section 456.072, Florida Statutes, is amended to read:

456.072 Grounds for discipline; penalties; enforcement.—

(7) Notwithstanding subsection (2), upon a finding that a physician has prescribed or dispensed a controlled substance, or caused a controlled substance to be prescribed or dispensed, in a manner that violates the standard of practice set forth in s. 458.331(1)(q) or (t), s. 459.015(1)(t) or (x), s. 461.013(1)(o) or (s), or s. 466.028(1)(p) or (x), or that an advanced registered nurse practitioner has prescribed or dispensed a

controlled substance, or caused a controlled substance to be prescribed or dispensed, in a manner that violates the standard of practice set forth in s. 464.018(1)(n) or (p)6., the physician or advanced registered nurse practitioner shall be suspended for a period of not less than 6 months and pay a fine of not less than $10,000 per count. Repeated violations shall result in increased penalties.

Section 6. Subsections (2) and (3) of section 456.44, Florida Statutes, are amended to read:

456.44 Controlled substance prescribing.—

(2) REGISTRATION.—~~Effective January 1, 2012,~~ A physician licensed under chapter 458, chapter 459, chapter 461, or chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner certified under part I of chapter 464 who prescribes any controlled substance, listed in Schedule II, Schedule III, or Schedule IV as defined in s. 893.03, for the treatment of chronic nonmalignant pain, must:

(a) Designate himself or herself as a controlled substance prescribing practitioner on his or her ~~the physician's~~ practitioner profile.

(b) Comply with the requirements of this section and applicable board rules.

(3) STANDARDS OF PRACTICE.—The standards of practice in this section do not supersede the level of care, skill, and

treatment recognized in general law related to health care licensure.

(a) A complete medical history and a physical examination must be conducted before beginning any treatment and must be documented in the medical record. The exact components of the physical examination shall be left to the judgment of the registrant ~~clinician~~ who is expected to perform a physical examination proportionate to the diagnosis that justifies a treatment. The medical record must, at a minimum, document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, a review of previous medical records, previous diagnostic studies, and history of alcohol and substance abuse. The medical record shall also document the presence of one or more recognized medical indications for the use of a controlled substance. Each registrant must develop a written plan for assessing each patient's risk of aberrant drug-related behavior, which may include patient drug testing. Registrants must assess each patient's risk for aberrant drug-related behavior and monitor that risk on an ongoing basis in accordance with the plan.

(b) Each registrant must develop a written individualized treatment plan for each patient. The treatment plan shall state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and shall indicate if any further diagnostic

evaluations or other treatments are planned. After treatment begins, the registrant ~~physician~~ shall adjust drug therapy to the individual medical needs of each patient. Other treatment modalities, including a rehabilitation program, shall be considered depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment. The interdisciplinary nature of the treatment plan shall be documented.

(c) The registrant ~~physician~~ shall discuss the risks and benefits of the use of controlled substances, including the risks of abuse and addiction, as well as physical dependence and its consequences, with the patient, persons designated by the patient, or the patient's surrogate or guardian if the patient is incompetent. The registrant ~~physician~~ shall use a written controlled substance agreement between the registrant ~~physician~~ and the patient outlining the patient's responsibilities, including, but not limited to:

1. Number and frequency of controlled substance prescriptions and refills.

2. Patient compliance and reasons for which drug therapy may be discontinued, such as a violation of the agreement.

3. An agreement that controlled substances for the treatment of chronic nonmalignant pain shall be prescribed by a single treating registrant ~~physician~~ unless otherwise authorized by the treating registrant ~~physician~~ and documented in the medical record.

(d) The patient shall be seen by the registrant ~~physician~~ at regular intervals, not to exceed 3 months, to assess the efficacy of treatment, ensure that controlled substance therapy remains indicated, evaluate the patient's progress toward treatment objectives, consider adverse drug effects, and review the etiology of the pain. Continuation or modification of therapy shall depend on the registrant's ~~physician's~~ evaluation of the patient's progress. If treatment goals are not being achieved, despite medication adjustments, the registrant ~~physician~~ shall reevaluate the appropriateness of continued treatment. The registrant ~~physician~~ shall monitor patient compliance in medication usage, related treatment plans, controlled substance agreements, and indications of substance abuse or diversion at a minimum of 3-month intervals.

(e) The registrant ~~physician~~ shall refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention shall be given to those patients who are at risk for misusing their medications and those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder requires extra care, monitoring, and documentation and requires consultation with or referral to an addiction medicine specialist or psychiatrist.

(f) A registrant ~~physician~~ registered under this section must maintain accurate, current, and complete records that are

accessible and readily available for review and comply with the requirements of this section, the applicable practice act, and applicable board rules. The medical records must include, but are not limited to:

1. The complete medical history and a physical examination, including history of drug abuse or dependence.

2. Diagnostic, therapeutic, and laboratory results.

3. Evaluations and consultations.

4. Treatment objectives.

5. Discussion of risks and benefits.

6. Treatments.

7. Medications, including date, type, dosage, and quantity prescribed.

8. Instructions and agreements.

9. Periodic reviews.

10. Results of any drug testing.

11. A photocopy of the patient's government-issued photo identification.

12. If a written prescription for a controlled substance is given to the patient, a duplicate of the prescription.

13. The registrant's ~~physician's~~ full name presented in a legible manner.

(g) Patients with signs or symptoms of substance abuse shall be immediately referred to a board-certified pain management physician, an addiction medicine specialist, or a mental health addiction facility as it pertains to drug abuse or

addiction unless the registrant is a physician who is board-certified or board-eligible in pain management. Throughout the period of time before receiving the consultant's report, a prescribing registrant ~~physician~~ shall clearly and completely document medical justification for continued treatment with controlled substances and those steps taken to ensure medically appropriate use of controlled substances by the patient. Upon receipt of the consultant's written report, the prescribing registrant ~~physician~~ shall incorporate the consultant's recommendations for continuing, modifying, or discontinuing controlled substance therapy. The resulting changes in treatment shall be specifically documented in the patient's medical record. Evidence or behavioral indications of diversion shall be followed by discontinuation of controlled substance therapy, and the patient shall be discharged, and all results of testing and actions taken by the registrant ~~physician~~ shall be documented in the patient's medical record.

This subsection does not apply to a board-eligible or board-certified anesthesiologist, physiatrist, rheumatologist, or neurologist, or to a board-certified physician who has surgical privileges at a hospital or ambulatory surgery center and primarily provides surgical services. This subsection does not apply to a board-eligible or board-certified medical specialist who has also completed a fellowship in pain medicine approved by the Accreditation Council for Graduate Medical Education or the

American Osteopathic Association, or who is board eligible or board certified in pain medicine by the American Board of Pain Medicine, the American Board of Interventional Pain Physicians, the American Association of Physician Specialists, or a board approved by the American Board of Medical Specialties or the American Osteopathic Association and performs interventional pain procedures of the type routinely billed using surgical codes. This subsection does not apply to a registrant, advanced registered nurse practitioner, or physician assistant who prescribes medically necessary controlled substances for a patient during an inpatient stay in a hospital licensed under chapter 395.

Section 7. Paragraph (b) of subsection (2) of section 458.3265, Florida Statutes, is amended to read:

458.3265 Pain-management clinics.—

(2) PHYSICIAN RESPONSIBILITIES.—These responsibilities apply to any physician who provides professional services in a pain-management clinic that is required to be registered in subsection (1).

(b) A person may not dispense any medication on the premises of a registered pain-management clinic unless he or she is a physician licensed under this chapter or chapter 459. A person may not prescribe any controlled substance regulated under chapter 893 on the premises of a registered pain-management clinic unless he or she is a physician licensed under this chapter or chapter 459.

Section 8. Paragraph (f) of subsection (4) of section 458.347, Florida Statutes, is amended to read:

458.347 Physician assistants.—

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(f)1. The council shall establish a formulary of medicinal drugs that a fully licensed physician assistant having prescribing authority under this section or s. 459.022 may not prescribe. The formulary must include ~~controlled substances as defined in chapter 893,~~ general anesthetics~~,~~ and radiographic contrast materials.

2. In establishing the formulary, the council shall consult with a pharmacist licensed under chapter 465, but not licensed under this chapter or chapter 459, who shall be selected by the State Surgeon General.

3. Only the council shall add to, delete from, or modify the formulary. Any person who requests an addition, deletion, or modification of a medicinal drug listed on such formulary has the burden of proof to show cause why such addition, deletion, or modification should be made.

4. The boards shall adopt the formulary required by this paragraph, and each addition, deletion, or modification to the formulary, by rule. Notwithstanding any provision of chapter 120 to the contrary, the formulary rule shall be effective 60 days after the date it is filed with the Secretary of State. Upon adoption of the formulary, the department shall mail a copy of such formulary to each fully licensed physician assistant having

prescribing authority under this section or s. 459.022, and to each pharmacy licensed by the state. The boards shall establish, by rule, a fee not to exceed $200 to fund the provisions of this paragraph and paragraph (e).

Section 9. Paragraph (b) of subsection (2) of section 459.0137, Florida Statutes, is amended to read:

459.0137 Pain-management clinics.—

(2) PHYSICIAN RESPONSIBILITIES.—These responsibilities apply to any osteopathic physician who provides professional services in a pain-management clinic that is required to be registered in subsection (1).

(b) A person may not dispense any medication on the premises of a registered pain-management clinic unless he or she is a physician licensed under this chapter or chapter 458. A person may not prescribe any controlled substance regulated under chapter 893 on the premises of a registered pain-management clinic unless he or she is a physician licensed under this chapter or chapter 458.

Section 10. Section 464.012, Florida Statutes, is amended to read:

464.012 Certification of advanced registered nurse practitioners; fees; controlled substance prescribing.—

(1) Any nurse desiring to be certified as an advanced registered nurse practitioner shall apply to the department and submit proof that he or she holds a current license to practice

professional nursing and that he or she meets one or more of the following requirements as determined by the board:

(a) Satisfactory completion of a formal postbasic educational program of at least one academic year, the primary purpose of which is to prepare nurses for advanced or specialized practice.

(b) Certification by an appropriate specialty board. Such certification shall be required for initial state certification and any recertification as a registered nurse anesthetist or nurse midwife. The board may by rule provide for provisional state certification of graduate nurse anesthetists and nurse midwives for a period of time determined to be appropriate for preparing for and passing the national certification examination.

(c) Graduation from a program leading to a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills. For applicants graduating on or after October 1, 1998, graduation from a master's degree program shall be required for initial certification as a nurse practitioner under paragraph (4)(c). For applicants graduating on or after October 1, 2001, graduation from a master's degree program shall be required for initial certification as a registered nurse anesthetist under paragraph (4)(a).

(2) The board shall provide by rule the appropriate requirements for advanced registered nurse practitioners in the

categories of certified registered nurse anesthetist, certified nurse midwife, and nurse practitioner.

(3) An advanced registered nurse practitioner shall perform those functions authorized in this section within the framework of an established protocol that is filed with the board upon biennial license renewal and within 30 days after entering into a supervisory relationship with a physician or changes to the protocol. The board shall review the protocol to ensure compliance with applicable regulatory standards for protocols. The board shall refer to the department licensees submitting protocols that are not compliant with the regulatory standards for protocols. A practitioner currently licensed under chapter 458, chapter 459, or chapter 466 shall maintain supervision for directing the specific course of medical treatment. Within the established framework, an advanced registered nurse practitioner may:

(a) Prescribe, dispense, administer, or order any ~~Monitor and alter~~ drug ~~therapies~~.

(b) Initiate appropriate therapies for certain conditions.

(c) Perform additional functions as may be determined by rule in accordance with s. 464.003(2).

(d) Order diagnostic tests and physical and occupational therapy.

(4) In addition to the general functions specified in subsection (3), an advanced registered nurse practitioner may perform the following acts within his or her specialty:

(a) The certified registered nurse anesthetist may, to the extent authorized by established protocol approved by the medical staff of the facility in which the anesthetic service is performed, perform any or all of the following:

1. Determine the health status of the patient as it relates to the risk factors and to the anesthetic management of the patient through the performance of the general functions.

2. Based on history, physical assessment, and supplemental laboratory results, determine, with the consent of the responsible physician, the appropriate type of anesthesia within the framework of the protocol.

3. Order under the protocol preanesthetic medication.

4. Perform under the protocol procedures commonly used to render the patient insensible to pain during the performance of surgical, obstetrical, therapeutic, or diagnostic clinical procedures. These procedures include ordering and administering regional, spinal, and general anesthesia; inhalation agents and techniques; intravenous agents and techniques; and techniques of hypnosis.

5. Order or perform monitoring procedures indicated as pertinent to the anesthetic health care management of the patient.

6. Support life functions during anesthesia health care, including induction and intubation procedures, the use of appropriate mechanical supportive devices, and the management of fluid, electrolyte, and blood component balances.

7. Recognize and take appropriate corrective action for abnormal patient responses to anesthesia, adjunctive medication, or other forms of therapy.

8. Recognize and treat a cardiac arrhythmia while the patient is under anesthetic care.

9. Participate in management of the patient while in the postanesthesia recovery area, including ordering the administration of fluids and drugs.

10. Place special peripheral and central venous and arterial lines for blood sampling and monitoring as appropriate.

(b) The certified nurse midwife may, to the extent authorized by an established protocol which has been approved by the medical staff of the health care facility in which the midwifery services are performed, or approved by the nurse midwife's physician backup when the delivery is performed in a patient's home, perform any or all of the following:

1. Perform superficial minor surgical procedures.

2. Manage the patient during labor and delivery to include amniotomy, episiotomy, and repair.

3. Order, initiate, and perform appropriate anesthetic procedures.

4. Perform postpartum examination.

5. Order appropriate medications.

6. Provide family-planning services and well-woman care.

7. Manage the medical care of the normal obstetrical patient and the initial care of a newborn patient.

(c) The nurse practitioner may perform any or all of the following acts within the framework of established protocol:

1. Manage selected medical problems.

2. Order physical and occupational therapy.

3. Initiate, monitor, or alter therapies for certain uncomplicated acute illnesses.

4. Monitor and manage patients with stable chronic diseases.

5. Establish behavioral problems and diagnosis and make treatment recommendations.

(5) The board shall certify, and the department shall issue a certificate to, any nurse meeting the qualifications in this section. The board shall establish an application fee not to exceed $100 and a biennial renewal fee not to exceed $50. The board is authorized to adopt such other rules as are necessary to implement the provisions of this section.

Section 11. Paragraph (p) is added to subsection (1) of section 464.018, Florida Statutes, to read:

464.018 Disciplinary actions.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(p) For an advanced registered nurse practitioner:

1. Presigning blank prescription forms.

2. Prescribing for office use any medicinal drug appearing on Schedule II in chapter 893.

3. Prescribing, ordering, dispensing, administering, supplying, selling, or giving a drug that is an amphetamine or a sympathomimetic amine drug, or a compound designated pursuant to chapter 893 as a Schedule II controlled substance, to or for any person except for:

a. The treatment of narcolepsy; hyperkinesis; behavioral syndrome in children characterized by the developmentally inappropriate symptoms of moderate to severe distractibility, short attention span, hyperactivity, emotional lability, and impulsivity; or drug-induced brain dysfunction.

b. The differential diagnostic psychiatric evaluation of depression or the treatment of depression shown to be refractory to other therapeutic modalities.

c. The clinical investigation of the effects of such drugs or compounds when an investigative protocol is submitted to, reviewed by, and approved by the department before such investigation is begun.

4. Prescribing, ordering, dispensing, administering, supplying, selling, or giving growth hormones, testosterone or its analogs, human chorionic gonadotropin (HCG), or other hormones for the purpose of muscle building or to enhance athletic performance. As used in this subparagraph, the term "muscle building" does not include the treatment of injured muscle. A prescription written for the drug products listed in this paragraph may be dispensed by a pharmacist with the presumption that the prescription is for legitimate medical use.

5. Promoting or advertising on any prescription form a community pharmacy unless the form also states: "This prescription may be filled at any pharmacy of your choice."

6. Prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including a controlled substance, other than in the course of his or her professional practice. For the purposes of this subparagraph, it is legally presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the advanced registered nurse practitioner's professional practice, without regard to his or her intent.

7. Prescribing, dispensing, or administering a medicinal drug appearing on any schedule set forth in chapter 893 to himself or herself, except a drug prescribed, dispensed, or administered to the advanced registered nurse practitioner by another practitioner authorized to prescribe, dispense, or administer medicinal drugs.

8. Prescribing, ordering, dispensing, administering, supplying, selling, or giving amygdalin (laetrile) to any person.

9. Dispensing a controlled substance listed on Schedule II or Schedule III in chapter 893 in violation of s. 465.0276.

10. Promoting or advertising through any communication medium the use, sale, or dispensing of a controlled substance appearing on any schedule in chapter 893.

Section 12. Subsection (21) of section 893.02, Florida Statutes, is amended to read:

893.02 Definitions.—The following words and phrases as used in this chapter shall have the following meanings, unless the context otherwise requires:

(21) "Practitioner" means a physician licensed under ~~pursuant to~~ chapter 458, a dentist licensed under ~~pursuant to~~ chapter 466, a veterinarian licensed under ~~pursuant to~~ chapter 474, an osteopathic physician licensed under ~~pursuant to~~ chapter 459, an advanced registered nurse practitioner certified under chapter 464, a naturopath licensed under ~~pursuant to~~ chapter 462, a certified optometrist licensed under ~~pursuant to~~ chapter 463, ~~or~~ a podiatric physician licensed under ~~pursuant to~~ chapter 461, or a physician assistant licensed under chapter 458 or chapter 459, provided such practitioner holds a valid federal controlled substance registry number.

Section 13. Paragraph (n) of subsection (1) of section 948.03, Florida Statutes, is amended to read:

948.03 Terms and conditions of probation.—

(1) The court shall determine the terms and conditions of probation. Conditions specified in this section do not require oral pronouncement at the time of sentencing and may be considered standard conditions of probation. These conditions

may include among them the following, that the probationer or offender in community control shall:

(n) Be prohibited from using intoxicants to excess or possessing any drugs or narcotics unless prescribed by a physician, advanced registered nurse practitioner, or physician assistant. The probationer or community controllee may ~~shall~~ not knowingly visit places where intoxicants, drugs, or other dangerous substances are unlawfully sold, dispensed, or used.

Section 14. Subsection (3) of s. 310.071, Florida Statutes, is reenacted for the purpose of incorporating the amendment made by this act to s. 310.071, Florida Statutes, in a reference thereto.

Section 15. Subsection (10) of s. 458.331, paragraph (g) of subsection (7) of s. 458.347, subsection (10) of s. 459.015, paragraph (f) of subsection (7) of s. 459.022, and paragraph (b) of subsection (5) of s. 465.0158, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to s. 456.072, Florida Statutes, in references thereto.

Section 16. Paragraph (mm) of subsection (1) of s. 456.072 and s. 466.02751, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to s. 456.44, Florida Statutes, in references thereto.

Section 17. Section 458.303, paragraph (e) of subsection (4) and paragraph (c) of subsection (9) of s. 458.347, paragraph (b) of subsection (7) of s. 458.3475, paragraph (e) of subsection (4) and paragraph (c) of subsection (9) of s.

459.022, and paragraph (b) of subsection (7) of s. 459.023, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to s. 458.347, Florida Statutes, in references thereto.

Section 18. Paragraph (a) of subsection (1) of s. 456.041, subsections (1) and (2) of s. 458.348, and subsection (1) of s. 459.025, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to s. 464.012, Florida Statutes, in references thereto.

Section 19. Subsection (11) of s. 320.0848, subsection (2) of s. 464.008, subsection (5) of s. 464.009, subsection (2) of s. 464.018, and paragraph (b) of subsection (1), subsection (3), and paragraph (b) of subsection (4) of s. 464.0205, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to s. 464.018, Florida Statutes, in references thereto.

Section 20. Section 775.051, Florida Statutes, is reenacted for the purpose of incorporating the amendment made by this act to s. 893.02, Florida Statutes, in a reference thereto.

Section 21. Paragraph (a) of subsection (3) of s. 944.17, subsection (8) of s. 948.001, and paragraph (e) of subsection (1) of s. 948.101, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to s. 948.03, Florida Statutes, in references thereto.

Section 22. This act shall take effect July 1, 2015.

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

Remove everything before the enacting clause and insert:
An act relating to drug prescription by advanced registered nurse practitioners and physician assistants; amending s. 110.12315, F.S.; expanding the categories of persons who may prescribe brand drugs under the prescription drug program when medically necessary; amending ss. 310.071, 310.073, and 310.081, F.S.; exempting controlled substances prescribed by an advanced registered nurse practitioner or a physician assistant from the disqualifications for certification or licensure, and for continued certification or licensure, as a deputy or state pilot; amending s. 456.072, F.S.; applying existing penalties for violations relating to the prescribing or dispensing of controlled substances to an advanced registered nurse practitioner; amending s. 456.44, F.S.; deleting an obsolete date; requiring advanced registered nurse practitioners and physician assistants who prescribe controlled substances for certain pain to make a certain designation, comply with registration requirements, and follow specified standards of practice; providing applicability; amending ss. 458.3265 and 459.0137, F.S.; limiting the authority to prescribe a controlled substance in a pain-management clinic to a physician licensed under ch. 458 or ch. 459, F.S.; amending s. 458.347, F.S.; expanding the prescribing authority of a licensed physician assistant; amending s. 464.012, F.S.; authorizing an advanced

registered nurse practitioner to prescribe, dispense, administer, or order drugs, rather than to monitor and alter drug therapies; amending s. 464.018, F.S.; specifying acts that constitute grounds for denial of a license for or disciplinary action against an advanced registered nurse practitioner; amending s. 893.02, F.S.; redefining the term "practitioner" to include advanced registered nurse practitioners and physician assistants under the Florida Comprehensive Drug Abuse Prevention and Control Act; amending s. 948.03, F.S.; providing that possession of drugs or narcotics prescribed by an advanced registered nurse practitioner or physician assistant is an exception from a prohibition relating to the possession of drugs or narcotics during probation; reenacting s. 310.071(3), F.S., to incorporate the amendment made to s. 310.071, F.S., in a reference thereto; reenacting ss. 458.331(10), 458.347(7)(g), 459.015(10), 459.022(7)(f), and 465.0158(5)(b), F.S., to incorporate the amendment made to s. 456.072, F.S., in references thereto; reenacting ss. 456.072(1)(mm) and 466.02751, F.S., to incorporate the amendment made to s. 456.44, F.S., in references thereto; reenacting ss. 458.303, 458.347(4)(e) and (9)(c), 458.3475(7)(b), 459.022(4)(e) and (9)(c), and 459.023(7)(b), F.S., to incorporate the amendment made to s. 458.347, F.S., in references thereto; reenacting ss. 456.041(1)(a), 458.348(1) and (2), and 459.025(1), F.S., to incorporate the amendment made to s. 464.012, F.S., in references thereto; reenacting ss. 320.0848(11), 464.008(2),

464.009(5), 464.018(2), and 464.0205(1)(b), (3), and (4)(b), F.S., to incorporate the amendment made to s. 464.018, F.S., in references thereto; reenacting s. 775.051, F.S., to incorporate the amendment made to s. 893.02, F.S., in a reference thereto; reenacting ss. 944.17(3)(a), 948.001(8), and 948.101(1)(e), F.S., to incorporate the amendment made to s. 948.03, F.S., in references thereto; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 541 Athletic Trainers
SPONSOR(S): Health Quality Subcommittee; Plasencia
TIED BILLS: **IDEN./SIM. BILLS:**

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

SUMMARY ANALYSIS

Athletic trainers are regulated by the Department of Health (DOH), and the Board of Athletic Training (Board), within DOH. Athletic training is the recognition, prevention, and treatment of an injury sustained during an athletic activity which affects the athlete's ability to participate or perform.

Athletic trainers are required to practice within a written protocol established with a supervising physician. The written protocol must require the athletic trainer to notify the supervising physician of a new injury as soon as possible. Practicing athletic training without a license constitutes a misdemeanor of the first degree.

The bill revises the requirements to become licensed as an athletic trainer by removing the requirement that the applicant must be at least 21 years of age. An applicant who graduated college prior to 2004 must hold a current certification from the Board of Certification. The bill requires the college or university from which the applicant holds a degree to be accredited by the Commission on Accreditation of Athletic Training Education. The degree must be from a professional athletic training degree program. The bill requires an applicant, who applies on or after July 1, 2016, to undergo a criminal background check. Applicants must also be certified in both cardiopulmonary resuscitation and the use of an automated external defibrillator.

The bill removes the requirement for athletic trainers to practice within the written protocol of a physician, as determined by the Board. Instead, the bill requires athletic trainers to practice under the direction of a physician. The physician must communicate his or her direction through oral or written prescription or protocols as deemed appropriate by the physician, and the athletic trainer must provide service or care in the manner dictated by the physician. The bill authorizes the Board to adopt rules for mandatory requirements and guidelines for communication between the athletic trainer and a physician.

The bill adds certain acts committed by an athletic trainer to a list of punishable acts, which constitute misdemeanors of the first degree, and prohibits sexual misconduct in the practice of athletic training in accordance with current law under s. 456.063, F.S. The bill removes the DOH's disciplinary authority for certain advertising acts.

The bill clarifies that when an athletic training student is acting under the direct supervision of a licensed athletic trainer, the athletic trainer must be physically present.

The bill also states that nothing in the athletic training practice act prevents or restricts third party payors from reimbursing employers of athletic trainers for covered services rendered by a licensed athletic trainer.

There is an insignificant negative fiscal impact on the DOH, to the extent rulemaking is required to conform to the provisions of the bill. There is no fiscal impact on local governments.

The bill provides an effective date of January 1, 2016.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Athletic Trainers

Athletic Trainers are regulated by the Florida Department of Health (DOH), and the Board of Athletic Training (Board), within DOH.[1] Athletic training is the recognition, prevention, and treatment of an injury sustained during an athletic activity which affects the athlete's ability to participate or perform.[2] An athletic activity includes the participation in an event that is conducted by an educational institution, a professional athletic organization, or an amateur athletic organization, involving exercises, sports, games, or recreation requiring any of the physical attributes of strength, agility, flexibility, range of motion, speed, and stamina.[3]

In 1994, the Legislature began fully regulating and licensing the practice of athletic training to protect the public and ensure that athletes are assisted by individuals adequately trained to recognize, prevent, and treat physical injuries sustained during athletic activities.[4]

As of June 30, 2014, there were 1,935 active licensed athletic trainers. During FY 2013-14, DOH received 356 applications from individuals seeking initial licensure as an athletic trainer.[5]

Applicants seeking licensure as an athletic trainer must: complete the application form and remit the required fees;[6] be at least 21 years of age; possess a baccalaureate degree from a college or university accredited by the United States Department of Education or the Commission on Recognition of Postsecondary Accreditation, or a program approved by the Board; complete an approved athletic training curriculum from a college or university accredited by an accrediting agency recognized and approved by the United States Department of Education or the Commission on Recognition of Postsecondary Accreditation, or approved by the Board; be certified in cardiovascular pulmonary resuscitation from the American Red Cross, the American Heart Association, or an equivalent certification entity as determined by the Board; submit proof of taking a two-hour course on the prevention of medical errors; and submit a certified copy of the National Athletic Trainers Association Board of Certification certificate or a notarized copy of examination results.[7]

Licensed athletic trainers are required to complete 24 hours of continuing education courses biennially. The courses must focus on the prevention of athletic injuries; the recognition, evaluation, and immediate care of athletic injuries; rehabilitation and reconditioning of athletic injuries; health care administration; or professional development and responsibility of athletic trainers.[8]

An athletic trainer is required to practice within a written protocol[9] established with a supervising physician.[10] The athletic trainer and the supervising physician must review the protocol prior to the

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[1] Part XIII, ch. 468, F.S. and Rule 64B33, F.A.C.
[2] S. 468.701(3) and (5), F.S.
[3] S. 468.701(2), F.S.
[4] Ch. 94-119, L.O.F. and s. 468.70, F.S.
[5] Florida Department of Health, Division of Medical Quality Assurance: *Annual Report July 1, 2009 to June 30, 2010,* at 13 and 17, available at: http://mqawebteam.com/annualreports/1314/#14 (last viewed March 13, 2015).
[6] The application fee is $100 and the initial licensure fee for even years is $125 and in odd years is $75. Rule 64B33-3.001, F.A.C. The license for the profession of athletic training is renewed September 30 of each even year. Rule 64B-9.001, F.A.C.
[7] S. 468.707, F.S., and Rule 64B33-2.001, F.A.C.
[8] Rule 64B33-2.005, F.A.C.
[9] The written protocol must include: the athletic trainer's name, license number, and curriculum vitae; the supervising physician's name, license number, and curriculum vitae; method of contacting the supervising physician, specifically delineating the method to report new injuries as soon as practicable; the patient population to be treated (e.g., specific scholastic athletic programs, patients of a specific

athletic trainer renewing his or her license.[11] Licensure renewal for athletic trainers is required biennially.[12]

The Board considers the following principles, methods, and procedures within the scope of a licensed athletic trainer's practice: injury prevention; injury recognition and evaluation; first aid; emergency care; injury management/treatment and disposition; rehabilitation through the use of safe and appropriate physical rehabilitation practices, including those techniques and procedures following injury and recovery that restore and maintain normal function status; conditioning; performance of tests and measurements to prevent, evaluate, and monitor acute and chronic injuries; selection of preventive and supportive devices, temporary splinting and bracing, protective equipment, strapping, and other immobilization devices and techniques to protect an injured structure, facilitate ambulation and restore normal functioning; organization and administration of facilities within the scope of the profession; and education and counseling to the public regarding the care and prevention of athletic injuries.[13]

In the course of treatment and rehabilitation of muscle skeletal injuries, a licensed athletic trainer may administer: therapeutic exercise; massage; mechanical devices; cryotherapy (e.g., ice, cold packs, cold water immersion, spray coolants); thermotherapy (e.g., topical analgesics, moist/dry hot packs, heating pads, paraffin bath); and other therapeutic agents with the properties of water (e.g., whirlpool), electricity (e.g., electrical stimulation, diathermy[14]), light (e.g., infrared, ultraviolet), or sound (e.g., ultrasound); and topical prescription medications (e.g., steroid preparation for phonopheresis[15]) only at the direction of a physician.[16]

Effect of Proposed Changes

The bill clarifies and strengthens the practice requirements for athletic trainers by expressly prohibiting athletic trainers from providing, offering to provide, or representing that he or she is qualified to provide any care or services that he or she lacks the education, training, or experience to provide, or that he or she is otherwise prohibited by law from providing. The bill also provides that the service and care provided by an athletic trainer must relate to the prevention, recognition, evaluation, management, disposition, treatment, or rehabilitation of a physically active person who sustained an injury involving exercise, sports, recreation, or a related physical activity. In providing such care and services, the bill authorizes athletic trainers to use physical modalities, such as heat, light, sound, cold, electricity, and mechanical devices.

The bill revises the requirements to become licensed as an athletic trainer by removing the requirement that the applicant must be at least 21 years of age. An applicant who graduated college prior to 2004 must hold a current certification from the Board of Certification. The bill requires the college or university from which the applicant holds a degree to be accredited by the Commission on Accreditation of Athletic Training Education. The degree must be from a professional athletic degree program. The bill requires an applicant, who applies on or after July 1, 2016, to undergo a criminal background check. Applicants must also be certified in both cardiopulmonary resuscitation and the use of an AED.

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clinic, patients with specific physician referral); the method of assessment of a patient's status and treatment; delineation of the items considered within the scope of practice for the athletic trainer to include the use of modalities/equipment that may be initiated by the athletic trainer or require a physician's order; and identification of resources for emergency patient care (e.g., nearest hospital with emergency services, ambulance service). Rule 64B33-4.001(1), F.A.C.

[10] S. 468.713, F.S., "....the physician must be licensed under chapter 458 (allopathic physician), 459 (osteopathic physician), or 460 (chiropractic physician)."

[11] Rule 64B33-4.001(2), F.A.C.

[12] Rule 64B33-3.001(3), F.A.C.

[13] Rule 64B33-3.001(3), F.A.C.

[14] Diathermy is a method of physical therapy that involves using high-frequency electric current, ultrasound, or microwaves to deliver heat to muscles and ligaments.

[15] Phonophoresis has been used in an effort to enhance the absorption of topically applied analgesics and anti-inflammatory agents through the therapeutic application of ultrasound.

[16] Rule 64B33-3.001(4), F.A.C.

The bill removes the requirement for athletic trainers to practice within the written protocol of a physician, as determined by the Board. Instead, the bill requires athletic trainers to practice under the direction of a physician. The physician must communicate his or her direction through oral or written prescription or protocols as deemed appropriate by the physician, and the athletic trainer must provide service or care in the manner dictated by the physician. The bill authorizes the Board to adopt rules for mandatory requirements and guidelines for communication between the athletic trainer and a physician, including reporting new or recurring injuries or conditions to the physician.

The bill prohibits acts of sexual misconduct under s. 456.063, F.S., instead of including such prohibition within the athletic training practice act.

The bill adds certain acts committed by an athletic trainer to the list of punishable acts, which constitute misdemeanors of the first degree. Specifically, the bill prohibits unlicensed persons from practicing athletic training; representing themselves as an athletic trainer; using the title "athletic trainer" or "licensed athletic trainer;" or using the abbreviation "AT" or "LAT," or any other abbreviation that suggests licensure as an athletic trainer.

The bill clarifies that when an athletic training student is acting under the direct supervision of a licensed athletic trainer, the athletic trainer must be physically present.

The bill removes the DOH's authority to discipline an athletic trainer for failing to include the athletic trainer's name and license number in advertising.

The bill also states that the athletic training practice act does not prevent or restrict third party payors from reimbursing employers of athletic trainers for covered services rendered by a licensed athletic trainer.

The bill removes an outdated provision which requires initial appointees to the Board to be appointed in a manner to provide for staggered terms.

The bill provides an effective date of January 1, 2016.

B. SECTION DIRECTORY:

Section 1: Amends s. 468.70, F.S., relating to legislative intent.
Section 2: Amends s. 468.701, F.S., relating to definitions.
Section 3: Amends s. 468.703, F.S., relating to the Board of Athletic Training.
Section 4: Amends s. 468.705, F.S., relating to rulemaking authority.
Section 5: Amends s. 468.707, F.S., relating to licensure requirements.
Section 6: Amends s. 468.709, F.S., relating to fees.
Section 7: Amends s. 468.711, F.S., relating to renewal of license; continuing education.
Section 8: Amends s. 468.713, F.S., relating to responsibilities of athletic trainers.
Section 9: Amends s. 468.715, F.S., relating to sexual misconduct.
Section 10: Amends s. 468.717, F.S., relating to violations and penalties.
Section 11: Amends s. 468.719, F.S., relating to disciplinary actions.
Section 12: Amends s. 468.723, F.S., relating to exemptions.
Section 13: Amends s. 456.0135, F.S., relating to general background screening provisions.
Section 14: Provides an effective date of January 1, 2016.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   To the extent the DOH will have to adopt rules to conform to the new requirements of this bill, the DOH may incur insignificant costs associated with rulemaking, which may be absorbed within existing resources.

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 rule-making authority is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 16, 2015, the Health Quality Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The amendment:

- Authorized an athletic trainer to provide certain care or services only related to certain specified activities.
- Removed an outdated provision which requires initial appointees to the Board of Athletic Training (Board) to be appointed in a manner to provide for staggered terms.
- Authorized the Board to adopt rules for mandatory requirements and guidelines for communication between the athletic trainer and a physician, including reporting new or recurring injuries or conditions to the physician.
- Revised the background screening requirements of the bill by requiring the current background screening requirements for health care practitioners under s. 456.0135, F.S., to apply to athletic trainer applicants and makes those requirements effective on or after July 1, 2016, instead of July 1, 2015.
- Required a baccalaureate degree or higher obtained from a college or university to be from a professional athletic degree program as a condition of licensure.
- Clarified that applicants who graduated before 2004, must hold a current certification rather than credential from the Board of Certification.
- Removed language authorizing a physician to communicate his or her direction to an athletic trainer through advice and referral.
- Replaced the term client with the term patient where applicable.
- Changed the effective date of the bill to January 1, 2016.

The analysis is drafted to the committee substitute as passed by the Health Quality Subcommittee.

A bill to be entitled

An act relating to athletic trainers; amending s. 468.70, F.S.; revising legislative intent; amending s. 468.701, F.S.; revising definitions; amending s. 468.703, F.S.; deleting the requirement for the Governor to appoint the initial members of the Board of Athletic Training; amending s. 468.705, F.S.; revising the board's authorization to adopt certain rules relating to communication between an athletic trainer and a supervising physician; amending s. 468.707, F.S.; revising requirements for licensure; authorizing the board to require a background screening for an applicant in certain circumstances; amending s. 468.709, F.S.; deleting the requirement for the board to establish an examination fee; amending s. 468.711, F.S.; revising continuing education requirements for license renewal; amending s. 468.713, F.S.; revising responsibilities of athletic trainers to include requirements that a trainer must practice under the direction of a physician; amending s. 468.715, F.S.; prohibiting sexual misconduct by an athletic trainer; amending s. 468.717, F.S.; prohibiting unlicensed persons from practicing athletic training or representing themselves as athletic trainers; prohibiting an unlicensed person from using specified titles;

amending s. 468.719, F.S.; revising grounds for disciplinary action; amending s. 468.723, F.S.; providing exemptions; amending s. 456.0135, F.S.; revising general background screening provisions to include athletic trainers; providing an effective date.

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

Section 1. Section 468.70, Florida Statutes, is amended to read:

468.70 Legislative intent.—It is the intent of the Legislature that athletic trainers practicing in this state meet minimum requirements for safe practice and that an athletic trainer who falls below minimum competency or who otherwise presents a danger to the public be prohibited from practicing in this state ~~athletes be assisted by persons adequately trained to recognize, prevent, and treat physical injuries sustained during athletic activities~~. ~~Therefore,~~ It is the further intent of the Legislature to protect the public by licensing and fully regulating athletic trainers.

Section 2. Section 468.701, Florida Statutes, is amended to read:

468.701 Definitions.—As used in this part, the term:

~~(1) "Athlete" means a person who participates in an athletic activity.~~

~~(2) "Athletic activity" means the participation in an activity, conducted by an educational institution, a professional athletic organization, or an amateur athletic organization, involving exercises, sports, games, or recreation requiring any of the physical attributes of strength, agility, flexibility, range of motion, speed, and stamina.~~

~~(3) "Athletic injury" means an injury sustained which affects the athlete's ability to participate or perform in athletic activity.~~

(1)~~(4)~~ "Athletic trainer" means a person licensed under this part who has met the requirements under this part, including education requirements as set forth by the Commission on Accreditation of Athletic Training Education or its successor and necessary credentials from the Board of Certification. An individual who is licensed as an athletic trainer may not provide, offer to provide, or represent that he or she is qualified to provide any care or services that he or she lacks the education, training, or experience to provide, or that he or she is otherwise prohibited by law from providing.

(2)~~(5)~~ "Athletic training" means service and care provided by an athletic trainer under the direction of a physician as specified in s. 468.713. Such service and care must relate to the prevention, recognition, evaluation, management, disposition, treatment, or rehabilitation of a physically active person who sustained an injury, illness, or other condition involving exercise, sport, recreation, or related physical

activity. For the provision of such care and services, an athletic trainer may use physical modalities, including, but not limited to, heat, light, sound, cold, electricity, and mechanical devices ~~the recognition, prevention, and treatment of athletic injuries~~.

(3)~~(6)~~ "Board" means the Board of Athletic Training.

(4)~~(7)~~ "Board of Certification" means the nationally accredited certifying body for athletic trainers or its successor agency.

(5)~~(8)~~ "Department" means the Department of Health.

~~(9) "Direct supervision" means the physical presence of the supervisor on the premises so that the supervisor is immediately available to the trainee when needed.~~

~~(10) "Supervision" means the easy availability of the supervisor to the athletic trainer, which includes the ability to communicate by telecommunications.~~

Section 3. Section 468.703, Florida Statutes, is amended to read:

468.703 Board of Athletic Training.—

(1) The Board of Athletic Training is created within the department and shall consist of nine members appointed by the Governor and confirmed by the Senate.

(2) Five members of the board must be licensed athletic trainers, certified by the Board of Certification. One member of the board must be a physician licensed under chapter 458 or chapter 459. One member of the board must be a physician

licensed under chapter 460. Two members of the board shall be consumer members, each of whom must be a resident of this state who has never worked as an athletic trainer, who has no financial interest in the practice of athletic training, and who has never been a licensed health care practitioner as defined in s. 456.001(4).

~~(3) For the purpose of staggering terms, the Governor shall appoint the initial members of the board as follows:~~

~~(a) Three members for terms of 2 years each.~~

~~(b) Three members for terms of 3 years each.~~

~~(c) Three members for terms of 4 years each.~~

(3)~~(4)~~ As the terms of the members expire, the Governor shall appoint successors for terms of 4 years and such members shall serve until their successors are appointed.

(4)~~(5)~~ All provisions of chapter 456 relating to activities of the board shall apply.

(5)~~(6)~~ The board shall maintain its official headquarters in Tallahassee.

Section 4. Section 468.705, Florida Statutes, is amended to read:

468.705 Rulemaking authority.—The board is authorized to adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of this part conferring duties upon it. The provisions of s. 456.011(5) shall apply to the board's activity. Such rules shall include, but not be limited to, the allowable scope of practice regarding the use of equipment, procedures,

and medication; mandatory requirements and guidelines for communication between the athletic trainer and a physician, including the reporting to the physician of new or recurring injuries or conditions; ~~, requirements for a written protocol between the athletic trainer and a supervising physician,~~ licensure requirements; ~~,~~ licensure examination; ~~,~~ continuing education requirements; ~~,~~ fees; ~~,~~ records ~~,~~ and reports to be filed by licensees; ~~,~~ protocols; ~~,~~ and any other requirements necessary to regulate the practice of athletic training.

Section 5. Section 468.707, Florida Statutes, is amended to read:

468.707 Licensure ~~by examination;~~ requirements.—Any person desiring to be licensed as an athletic trainer shall apply to the department on a form approved by the department. An applicant shall also provide records or other evidence, as determined by the board, to prove he or she has met the requirements of this section. The department shall license each applicant who:

(1) Has completed the application form and remitted the required fees.

(2) For a person who applies on or after July 1, 2016, has submitted to background screening pursuant to s. 456.0135. The board may require a background screening for an applicant whose license has expired or who is undergoing disciplinary action ~~is at least 21 years of age~~.

(3) Has obtained a baccalaureate or higher degree from a

college or university professional athletic training degree program accredited by the Commission on Accreditation of Athletic Training Education or its successor ~~an accrediting agency~~ recognized and approved by the United States Department of Education or the Commission on Recognition of Postsecondary Accreditation, approved by the board, or recognized by the Board of Certification, and has passed the national examination to be certified by the Board of Certification.

(4) If graduated before ~~after~~ 2004, has a current certification from ~~has completed an approved athletic training curriculum from a college or university accredited by a program recognized by~~ the Board of Certification.

(5) Has current certification in both cardiopulmonary ~~cardiovascular pulmonary~~ resuscitation and the use of an automated external defibrillator set forth in the continuing education requirements ~~with an automated external defibrillator from the American Red Cross or the American Heart Association, or an equivalent certification~~ as determined by the board pursuant to s. 468.711.

(6) Has completed any other requirements as determined by the department and approved by the board ~~passed the examination and is certified by the Board of Certification~~.

Section 6. Paragraph (b) of subsection (1) of section 468.709, Florida Statutes, is amended to read:

468.709 Fees.—

(1) The board shall, by rule, establish fees for the

following purposes:

~~(b) An examination fee, not to exceed $200.~~

Section 7. Subsection (2) of section 468.711, Florida Statutes, is amended to read:

468.711 Renewal of license; continuing education.—

(2) The board may, by rule, prescribe continuing education requirements, not to exceed 24 hours biennially. The criteria for continuing education shall be approved by the board and must include a current certification ~~certificate~~ in both cardiopulmonary ~~cardiovascular pulmonary~~ resuscitation and the use of ~~with~~ an automated external defibrillator as set forth in the continuing education requirements ~~from the American Red Cross or the American Heart Association or an equivalent training~~ as determined by the board.

Section 8. Section 468.713, Florida Statutes, is amended to read:

468.713 Responsibilities of athletic trainers.—An athletic trainer shall practice under the direction of ~~within a written protocol established between the athletic trainer and~~ a ~~supervising~~ physician licensed under chapter 458, chapter 459, chapter 460, or otherwise authorized by Florida law to practice medicine. The physician shall communicate his or her direction through oral or written prescriptions or protocols as deemed appropriate by the physician for the provision of services and care by the athletic trainer. An athletic trainer shall provide service or care in the manner dictated by the physician ~~or, at~~

~~an athletic event, pursuant to direction from a physician licensed under chapter 458, chapter 459, chapter 460, or otherwise authorized by Florida law to practice medicine. A written protocol shall require that the athletic trainer notify the supervising physician of new injuries as soon as practicable~~.

Section 9. Section 468.715, Florida Statutes, is amended to read:

468.715 Sexual misconduct.—The athletic trainer-patient ~~trainer-athlete~~ relationship is founded on mutual trust. ~~Sexual misconduct in the practice of athletic training means violation of the athletic trainer-athlete relationship through which the athletic trainer uses such relationship to induce or attempt to induce the athlete to engage, or to engage or attempt to engage the athlete, in sexual activity outside the scope of the practice or the scope of generally accepted examination or treatment of the athlete.~~ Sexual misconduct in the practice of athletic training is prohibited under s. 456.063.

Section 10. Subsections (1) and (5) of section 468.717, Florida Statutes, are amended to read:

468.717 Violations and penalties.—Each of the following acts constitutes a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083:

(1) Practicing athletic training, representing oneself as an athletic trainer, or providing athletic trainer services to a patient without being licensed under this part ~~Practicing~~

~~athletic training for compensation without holding an active license under this part~~.

(5) Using the title "athletic trainer" or "licensed athletic trainer," the abbreviation "AT" or "LAT," or a similar title or abbreviation that suggests licensure as an athletic trainer without being licensed under this part.

Section 11. Subsection (1) of section 468.719, Florida Statutes, is amended to read:

468.719 Disciplinary actions.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

~~(a) Failing to include the athletic trainer's name and license number in any advertising, including, but not limited to, business cards and letterhead, related to the practice of athletic training. Advertising shall not include clothing or other novelty items.~~

(a) ~~(b)~~ Committing incompetency or misconduct in the practice of athletic training.

(b) ~~(c)~~ Committing fraud or deceit in the practice of athletic training.

(c) ~~(d)~~ Committing negligence, gross negligence, or repeated negligence in the practice of athletic training.

(d) ~~(e)~~ ~~While practicing athletic training,~~ Being unable to practice athletic training with reasonable skill and safety because of a mental or physical condition or ~~to athletes by reason of~~ illness, or the use of alcohol, controlled substances,

or any other substance that impairs one's ability to practice ~~or drugs or as a result of any mental or physical condition~~.

(e)~~(f)~~ Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

Section 12. Section 468.723, Florida Statutes, is amended to read:

468.723 Exemptions.—This part does not prevent or restrict:

(1) A person licensed in this state under another chapter from engaging in the practice for which he or she is licensed and ~~The professional practice of a licensee of the department who is~~ acting within the scope of such practice.

(2) An athletic training student acting under the direct supervision of a licensed athletic trainer. For purposes of this subsection, "direct supervision" means the physical presence of an athletic trainer so that the athletic trainer is immediately available to the athletic training student and able to intervene on behalf of the athletic training student in accordance with the standards set forth by the Commission on Accreditation of Athletic Training Education or its successor.

(3) A person from administering standard first aid treatment to another person ~~an athlete~~.

(4) A person authorized to practice athletic training in another state when such person is employed by or a volunteer for an out-of-state secondary or postsecondary educational institution, or a recreational, competitive, or professional

organization that is temporarily present in this state ~~A person licensed under chapter 548, provided such person is acting within the scope of such license~~.

(5) A person providing personal training instruction for exercise, aerobics, or weightlifting, if the person does not represent himself or herself as an athletic trainer or as able to provide "athletic trainer" services and if any recognition or treatment of injuries is limited to the provision of first aid.

(6) Third-party payors from reimbursing employers of athletic trainers for covered services rendered by a licensed athletic trainer.

Section 13. Subsection (1) of section 456.0135, Florida Statutes, is amended to read:

456.0135 General background screening provisions.—

(1) An application for initial licensure received on or after January 1, 2013, under chapter 458, chapter 459, chapter 460, chapter 461, chapter 464, s. 465.022, part XIII of chapter 468, or chapter 480 shall include fingerprints pursuant to procedures established by the department through a vendor approved by the Department of Law Enforcement and fees imposed for the initial screening and retention of fingerprints. Fingerprints must be submitted electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for national processing. Each board, or the department if there is no board, shall screen the results to

determine if an applicant meets licensure requirements. For any subsequent renewal of the applicant's license that requires a national criminal history check, the department shall request the Department of Law Enforcement to forward the retained fingerprints of the applicant to the Federal Bureau of Investigation unless the fingerprints are enrolled in the national retained print arrest notification program.

Section 14. This act shall take effect January 1, 2016.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 731 Employee Health Care Plans
SPONSOR(S): Insurance & Banking Subcommittee; Health Innovation Subcommittee; Plakon
TIED BILLS: **IDEN./SIM. BILLS:** SB 968

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	11 Y, 0 N, As CS	Tuszynski	Poche
2) Insurance & Banking Subcommittee	12 Y, 0 N, As CS	Haston	Cooper
3) Health & Human Services Committee		Tuszynski	Calamas

SUMMARY ANALYSIS

The Employee Health Care Access Act (EHCAA) was enacted in Florida in 1992 to promote the availability of health insurance coverage to small employers with fifty or less employees, regardless of claims experience or employee health status. The EHCAA requires health insurers and health maintenance organizations (carriers) in the small group market to offer coverage to all small employers, including sole proprietors, on a guaranteed-issue basis. Carriers are required to offer a standard benefit plan, a basic health benefit plan, and a high deductible plan, which meets the requirements of health savings account plans, to any small employer who applies for coverage, regardless of the health status of the employees. The EHCAA establishes limitations on exclusions and mandates various other enrollment and reporting requirements to foster fairness and efficiency in the small group health insurance market.

The Patient Protection and Affordable Care Act (PPACA) made many fundamental changes to the health insurance industry by imposing extensive requirements on health insurers and health insurance policies relating to required benefits, rating and underwriting standards, required review of rate increases, and other requirements. Many of the changes outlined in the PPACA apply to individual and small group markets. For example, the PPACA requires coverage offered in the individual and small group markets to provide defined essential health benefits packages and limits rate adjustment based on certain factors, while prohibiting adjustments based on other factors.

The bill amends the EHCAA, removing the following provisions which are out of date or conflict with the PPACA:

- The requirement that a carrier offer standard, basic, and high deductible plans to a small employer. Federal law requires all small group health plans to include essential health benefits, which are not included in these plans.
- The requirement for an annual August open enrollment period for sole proprietors. Federal law now requires small employer carriers to have continuous open enrollment.
- The requirement for small employer carriers to submit a semiannual report to the Office of Insurance Regulation concerning the use of rating factors to adjust premiums in the small group market.
- A provision that indexes reinsurance premium rates to approximate gross premium rates of standard and basic health plans.
- A provision requiring development of agent compensation standards for the sale of basic and standard health plans.
- The requirement for the Chief Financial Officer to appoint the health benefit plan committee, as well as the duties of that committee to make recommendations concerning basic and standard health plans.

The bill defines "stop-loss insurance policy," and requires a small employer stop-loss insurance policy to cover 100 percent of all claims equal to or above the attachment point. Under the bill, a small employer stop-loss insurance policy is considered health insurance and is subject to the EHCAA if the policy has an aggregate attachment point that is lower than the greatest of:

- $2,000 multiplied by the number of employees;
- 120 percent of expected claims, to be determined in accordance with actuarial standards of practice; or
- $20,000.

The bill requires that a self-insured health benefit plan established or maintained by an employer with 51 or more covered employees be considered health insurance if the plan's stop-loss coverage has an aggregate attachment point that is lower than the greater of:

- 110 percent of expected claims, to be determined in accordance with actuarial standards of practice; or
- $20,000.

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

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Employee Heath Care Access Act

The Employee Health Care Access Act (EHCAA)[1] was enacted in Florida in 1992 to promote the availability of health insurance coverage to small employers with fifty or less employees, regardless of claims experience or employee health status.[2] The EHCAA requires health insurers and health maintenance organizations (carriers) in the small group market to offer coverage to all small employers, including sole proprietors, on a guaranteed-issue basis. For sole proprietors, the offer of coverage may be limited to a one-month open enrollment period in August.[3]

Carriers are required to offer a standard benefit plan, a basic health benefit plan, and a high deductible plan, which meets the requirements of health savings account plans, to any small employer who applies for coverage, regardless of the health status of the employees.[4] A small employer carrier that offers coverage to a small employer must offer to all of the employer's eligible employees and their dependents.[5] The EHCAA establishes limitations on exclusions and mandates various other enrollment and reporting requirements to foster fairness and efficiency in the small group health insurance market.[6]

The EHCAA also created the Florida Small Employer Carrier Reinsurance Program (Program). The Program, now operating as the Florida Health Insurance Advisory Board (Board),[7] recommends to the Office of Insurance Regulation (OIR), among other things, market conduct and other requirements for agents and carriers selling and writing policies in the small group market, including:

- The registration by each carrier of its intention to be a small employer carrier;
- The publication of a list of all small employer carriers, including a requirement applicable to agents and carriers that a health benefit plan may not be sold by a carrier that is not identified as a small employer carrier;
- The availability of a toll-free telephone number for access by small employers to information concerning the Program;
- Periodic reports by carriers and agents concerning health benefit plans issued; and
- Methods for small employer carriers and agents to demonstrate that they are marketing or issuing health benefit plans to small employers.[8]

The EHCAA mandates that the Chief Financial Officer (CFO) appoint a health benefit plan committee (Committee) to submit recommendations to the board in relation to standard, basic, high deductible, and limited plans.[9] In 2002, following double digit rate increases for small employers, a lag in the offering of small group coverage, and a failure to update plan benefits since the early 1990s, the Committee recommended comprehensive revisions to the standard and basic plans to include more

[1] s. 627.6699, F.S.
[2] Ch. 92-33, Laws of Fla.
[3] s. 627.6699(5)(c)2., F.S.
[4] s. 627.6699(12)(b)1., F.S.
[5] s. 627.6699(5)(h)5., F.S.
[6] s. 627.6699, F.S.
[7] The Board's responsibilities were expanded in 2005 to include an advisory role on health insurance issues to OIR, the Agency for Health Care Administration, the Department of Financial Services, executive departments and the Legislature. *See* s. 627.6699(11)(o), F.S.
[8] ss. 627.6699(11)(e)1. – 5., F.S.
[9] s. 627.6699(12)(a)1., F.S.

robust benefits that mirrored those benefits offered in plans on the market at the time.[10] The recommendations were adopted by the CFO for all small group plan coverage effective April 1, 2003.[11] It appears that the 2002 report may have been the last work of this Committee.

Under the EHCAA, each carrier is required to submit a semiannual report that shows the effects of certain rating factors in setting premiums.[12] The report allows OIR to compare the actual adjusted aggregate premiums charged to policyholders by each carrier to the premiums that would have been charged if the carrier's approved modified community rates were applied.[13] A modified community rate allows a carrier to spread financial risk across a large population using separate rating factors such as age, gender, family composition, and tobacco usage.[14] It also permits adjustments to the rate for claims experience, health status, and certain expenses incurred by the carrier.[15] If the aggregate premium actually charged exceeds the premium that would have been charged by applying the modified community rate by 4 percent or more, the carrier is limited in the application of rate adjustments.[16]

Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act (PPACA)[17] made many fundamental changes to the health insurance industry by imposing extensive requirements on health insurers and health insurance policies relating to required benefits, rating and underwriting standards, required review of rate increases, and other requirements.[18] Among its sweeping changes to the U.S. health care system are requirements for health insurers to make coverage available to all individuals and employers, without exclusions for preexisting conditions and without basing premiums on any health-related factors.

Many of the changes outlined in the PPACA apply to individual and small group markets, except those plans that have grandfathered status under the law.[19] For example, the PPACA requires coverage offered in the individual and small group markets to provide the following categories of services (essential health benefits package):[20]

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

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[10] Florida Small Employer Benefits Plan Committee, Nov. 2002, *available at* www.floir.com/siteDocuments/Sm_Emp_Grp_Benefit_Comm_Rpt_%20Nov02.pdf
[11] Florida Department of Financial Services, *Informational Memorandum DFS-03-001M*, Mar. 6, 2003, *available at* www.floir.com/siteDocuments/dfs-03-001m.pdf.
[12] s. 627.6699(6)(b)(5), F.S.
[13] *Id.*
[14] s. 627.6699(3)(o), F.S.
[15] *Id.*
[16] s. 627.6699(6)(b)(5), F.S.
[17] Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148.
[18] Most of the insurance regulatory provisions in PPACA amend Title XXVII of the Public Health Service Act (PHSA), 42 U.S.C. § 300gg et seq.
[19] For an insured plan, grandfathered health plan coverage is group or individual coverage in which an individual was enrolled on March 23, 2010, subject to conditions for maintaining grandfathered status as specified by law and rule. *See* PPACA s. 1251; 42 U.S.C. § 18011.
[20] PPACA s. 1302; 42 U.S.C. § 300gg-6.

Also, the PPACA requires that premiums for individual and small group policies may vary only by:[21]

- Age, up to a maximum ratio of 3 to 1. This means that the rates for older adults cannot be more than three times greater than the rates for younger adults.
- Tobacco, up to a maximum ratio of 1.5 to 1.
- Geographic rating area.
- Whether coverage is for an individual or a family.

The PPACA prohibits an insurer from establishing rules for eligibility based on any of the following health status-related factors: health status, medical condition, claims experience, receipt of health care, medical history, genetic information, disability, evidence of insurability (including conditions arising out of domestic violence), or any other health-status related factor deemed appropriate by the U.S. Department of Health and Human Services.[22]

Small employer carriers are required, under the PPACA, to have continuous open enrollment.[23]

Stop-Loss Insurance Coverage

Florida law defines stop-loss insurance as an arrangement in which an insurer insures a policyholder against the risk that any one claim will exceed a specified dollar amount or that an entire self-insurance plan's loss will exceed a specified amount.[24] Stop-loss insurance is more fully defined in Rule 69O-149.0025(23), F.A.C., as coverage purchased by an entity, generally an employer, for the purpose of covering the entity's obligation for the excess cost of medical care provided under a self-insured health benefit plan. Such insurance coverage takes effect once a claim cost or total plan loss reaches a certain amount, known as the attachment point. Small employers who are self-insured for health care coverage of their employees purchase stop-loss insurance to limit their financial risk in the case of catastrophic medical costs incurred by their employees.

Rule 69O-149.0025(23), F.A.C., establishes standards to distinguish a small group health insurance policy, which is subject to the provisions of the EHCAA, from a stop-loss insurance policy, which is exempt from the provisions of the EHCAA. Such coverage is considered a health insurance policy, rather than a stop-loss insurance policy, if it:

- Has an attachment point for claims incurred per individual which is lower than $20,000; or
- For insured employer groups with fifty or fewer covered employees, has an aggregate attachment point which is lower than the greater of:
    - $4,000 times the number of employees;
    - 120 percent of expected claims; or
    - $20,000; or
- For insured employer groups with fifty-one or more covered employees, has an aggregate attachment point which is lower than 110 percent of expected claims.[25]

Insurers are required to determine the number of covered employees of an employer, for purposes of applying the appropriate attachment point, on a consistent basis. An insurer can base its determination of the number of employees employed on an annual basis or at a specific time.[26]

[21] PPACA s. 1201; 42 U.S.C. § 300gg.
[22] PPACA s. 1201; 42 U.S.C. § 300gg-4.
[23] 45 C.F.R. § 147.104.
[24] s. 627.6482(14), F.S.
[25] Rule 69O-149.0025(23), F.A.C.
[26] Rule 69O-149.0025(23)(b)3., F.A.C.

Effect of Proposed Changes

The bill deletes s. 627.6699(12), F.S., which removes the requirement that a carrier offer standard, basic, and high deductible plans to a small employer. Federal law requires all small group health plans, except those plans with grandfather status, to include essential health benefits. The plans required to be offered to small group employers in s. 627.6699(12), F.S., do not include essential health benefits and cannot be sold in Florida. However, because the requirement remains in statute, insurers are required to submit plan forms to OIR, which are then rejected. By removing the requirement, insurers will not be required to submit the plan forms to OIR for review, and OIR will not be required to review the forms. The bill also removes the requirement that a small group carrier submit information regarding standard and basic plans on a quarterly basis to the OIR.

The bill removes the requirement for an annual August open enrollment period for sole proprietors. Federal law now requires small employer carriers to have continuous open enrollment, which supersedes the annual open enrollment period in statute.

The bill also removes the requirement for small employer carriers to submit a semiannual report to OIR with information related to actual aggregate premiums charged to policyholders and the aggregate premiums that would have been charged using the carrier's approved modified community rating, which is based on certain factors in statute. Federal law allows premiums for individual and small group policies to be adjusted using a much narrower group of factors. Because carriers adjust rates using the same limited factors set out in federal law, the semiannual report no longer includes useful information.

The bill deletes language that bases reinsurance premium rates on the approximate gross premium rates of standard and basic health plans. Standard and basic health plans can no longer be offered or sold under federal law because such plans do not include essential health benefits. As a result, keying reinsurance premium rates to rates of plans that are not offered or sold is moot. While no other basis for these rates is provided, any rate set by the board is subject to the approval of OIR.

The bill deletes language that requires the board to develop standards for compensation of agents for the sale of basic and standard health plans. As those plans do not include essential health benefits and cannot be sold in Florida, these compensation standards are unnecessary.

The bill also removes the requirement for the CFO to appoint the health benefit plan committee, as well as the duties of that committee to make recommendations concerning basic and standard health plans. Federal law removes the ability to sell standard, basic, high deductible and limited plans, so recommendations by the committee as to those plans are unnecessary. Furthermore, it does not seem that the Committee has made any recommendations to the board since 2002.

The bill defines "stop-loss insurance policy" and exempts such policies from the EHCAA.

The bill requires that a small employer stop-loss insurance policy be considered a health insurance policy and subject to the EHCAA if the policy has an aggregate attachment point that is lower than the greatest of:

- $2,000 multiplied by the number of employees;
- 120 percent of expected claims, to be determined in accordance with actuarial standards of practice; or
- $20,000.

The bill requires any small employer stop-loss insurance policy authorized under the bill to cover 100 percent of all claims equal to or above the attachment point.

The bill requires that a self-insured health benefit plan established or maintained by an employer with 51 or more covered employees be considered health insurance if the plan's stop-loss coverage has an aggregate attachment point that is lower than the greater of:

- 110 percent of expected claims, to be determined in accordance with actuarial standards of practice; or
- $20,000.

The bill also requires a carrier to use a uniform methodology for determining the number of employees to calculate the attachment point. The bill permits the methodology to be based on the number of employees employed on an annual basis or at a specific point in time during the year.

The bill also corrects cross-references and makes other conforming changes.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 627.6699, F.S., relating to the Employee Health Care Access Act.
Section 2: Creates s. 627.66997, F.S., relating to stop-loss insurance.
Section 3: Amends s. 627.642, F.S., relating to outline of coverage.
Section 4: Amends s. 627.6475, F.S., relating to individual reinsurance pool.
Section 5: Amends s. 627.657, F.S., relating to provisions of group health insurance policies.
Section 6: Amends s. 627.6571, F.S., relating to guaranteed renewability of coverage.
Section 7: Amends s. 627.6675, F.S., relating to conversion on termination.
Section 8: Amends s. 641.31074, F.S., relating to guaranteed renewability.
Section 9: Amends s. 641.3922, F.S., relating to conversion contracts.
Section 10: 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:

The bill deletes the requirement that a small group carrier offer standard and basic health benefit plan and high deductible plan to each small employer, upon request. The carrier may realize a decreased administrative burden in creating these plans and forms and submitting them to OIR. OIR may realize a decrease in workload as a result of no longer requiring the submission of the plan forms.

The bill removes multiple reporting requirements, which may lower the administrative burden on carriers and decrease the workload of OIR in creating and reviewing of these reports.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 3, 2015, the Health Innovation Subcommittee adopted one amendment and reported the bill favorable as a committee substitute. The amendment made the following changes:

- Adds a definition of "stop-loss insurance policy".
- Requires the calculation of expected claims, as a basis for determining the stop-loss policy attachment point, to be in accordance with actuarial standards of practice.
- Increases the dollar amount, as a basis for determining the stop-loss policy attachment point, to twenty thousand dollars.
- Requires a stop-loss insurance policy to cover 100 percent of all claims equal to or greater than the attachment point.
- Makes a technical change in language from "providers" to "carriers".

On March 18, 2015, the Insurance & Banking Subcommittee adopted one amendment and reported the bill favorable as a committee substitute. The amendment made the following changes:

- Adds language distinguishing attachment points for small employer stop-loss insurance policies and stop-loss coverage for self-insured health benefit plans established or maintained by an employer with 51 or more covered employees.
- Adds a subsection providing criteria for determining when a self-insured health benefit plan established or maintained by an employer with 51 or more covered employees is considered health insurance.

The staff analysis is drafted to reflect the committee substitute as passed by the Insurance & Banking Subcommittee.

A bill to be entitled

An act relating to employee health care plans; amending s. 627.6699, F.S.; revising definitions; removing provisions requiring certain insurance carriers to provide semiannual reports to the Office of Insurance Regulation; repealing requirements that certain insurance carriers offer standard, basic, high deductible, and limited health benefit plans; making conforming changes; creating s. 627.66997, F.S.; authorizing certain health benefit plans to use a stop-loss insurance policy; defining the term "stop-loss insurance policy"; providing requirements for such policies; amending ss. 627.642, 627.6475, and 627.657, F.S.; conforming cross-references; amending ss. 627.6571, 627.6675, 641.31074, and 641.3922, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Subsection (2) of section 627.6699, Florida Statutes, is amended, paragraphs (c) through (x) of subsection (3) are redesignated as paragraphs (b) through (w), respectively, and present paragraphs (b) and (o) of that subsection, subsection (5), paragraph (b) of subsection (6), paragraphs (g), (h), (j), and (l) through (o) of subsection

(11), subsections (12) through (14), paragraph (k) of subsection (15), and subsections (16) through (18) of that section are amended, to read:

627.6699 Employee Health Care Access Act.—

(2) PURPOSE AND INTENT.—The purpose and intent of this section is to promote the availability of health insurance coverage to small employers regardless of their claims experience or their employees' health status, to establish rules regarding renewability of that coverage, to establish limitations on the use of exclusions for preexisting conditions~~, to provide for development of a standard health benefit plan and a basic health benefit plan to be offered to all small employers~~, to provide for establishment of a reinsurance program for coverage of small employers, and to improve the overall fairness and efficiency of the small group health insurance market.

(3) DEFINITIONS.—As used in this section, the term:

~~(b) "Basic health benefit plan" and "standard health benefit plan" mean low-cost health care plans developed pursuant to subsection (12).~~

(n)~~(o)~~ "Modified community rating" means a method used to develop carrier premiums which spreads financial risk across a large population; allows the use of separate rating factors for age, gender, family composition, tobacco usage, and geographic area as determined under paragraph (5)(f) ~~(5)(j)~~; and allows adjustments for: claims experience, health status, or duration

of coverage as permitted under subparagraph (6)(b)5.; and administrative and acquisition expenses as permitted under subparagraph (6)(b)5.

(5) AVAILABILITY OF COVERAGE.—

~~(a) Beginning January 1, 1993, every small employer carrier issuing new health benefit plans to small employers in this state must, as a condition of transacting business in this state, offer to eligible small employers a standard health benefit plan and a basic health benefit plan. Such a small employer carrier shall issue a standard health benefit plan or a basic health benefit plan to every eligible small employer that elects to be covered under such plan, agrees to make the required premium payments under such plan, and to satisfy the other provisions of the plan.~~

(a)~~(b) In the case of~~ A small employer carrier that ~~which~~ does not~~, on or after January 1, 1993,~~ offer coverage but renews or continues ~~which does, on or after January 1, 1993, renew or continue~~ coverage in force must~~, such carrier shall be required to~~ provide coverage to newly eligible employees and dependents on the same basis as small employer carriers that offer ~~which are offering~~ coverage ~~on or after January 1, 1993~~.

(b)~~(c)~~ Every small employer carrier must, as a condition of transacting business in this state,~~:~~

~~1.~~ offer and issue all small employer health benefit plans on a guaranteed-issue basis to every eligible small employer, with 2 to 50 eligible employees, that elects to be covered under

such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section.

~~2. In the absence of enrollment availability in the Florida Health Insurance Plan, offer and issue basic and standard small employer health benefit plans and a high-deductible plan that meets the requirements of a health savings account plan or health reimbursement account as defined by federal law, on a guaranteed-issue basis, during a 31-day open enrollment period of August 1 through August 31 of each year, to every eligible small employer, with fewer than two eligible employees, which small employer is not formed primarily for the purpose of buying health insurance and which elects to be covered under such plan, agrees to make the required premium payments, and satisfies the other provisions of the plan. Coverage provided under this subparagraph shall begin on October 1 of the same year as the date of enrollment, unless the small employer carrier and the small employer agree to a different date. A rider for additional or increased benefits may be medically underwritten and may only be added to the standard health benefit plan. The increased rate charged for the additional or increased benefit must be rated in accordance with this section. For purposes of this subparagraph, a person, his~~

~~or her spouse, and his or her dependent children constitute a single eligible employee if that person and spouse are employed by the same small employer and either that person or his or her spouse has a normal work week of less than 25 hours. Any right to an open enrollment of health benefit coverage for groups of fewer than two employees, pursuant to this section, shall remain in full force and effect in the absence of the availability of new enrollment into the Florida Health Insurance Plan.~~

~~3. This paragraph does not limit a carrier's ability to offer other health benefit plans to small employers if the standard and basic health benefit plans are offered and rejected.~~

~~(d) A small employer carrier must file with the office, in a format and manner prescribed by the committee, a standard health care plan, a high deductible plan that meets the federal requirements of a health savings account plan or a health reimbursement arrangement, and a basic health care plan to be used by the carrier. The provisions of this section requiring the filing of a high deductible plan are effective September 1, 2004.~~

~~(e) The office at any time may, after providing notice and an opportunity for a hearing, disapprove the continued use by the small employer carrier of the standard or basic health benefit plan on the grounds that such plan does not meet the requirements of this section.~~

(c) ~~(f)~~ Except as provided in paragraph (d) ~~(g)~~, a health

benefit plan covering small employers must comply with preexisting condition provisions specified in s. 627.6561 or, for health maintenance contracts, in s. 641.31071.

(d) ~~(g)~~ A health benefit plan covering small employers, issued or renewed on or after January 1, 1994, must comply with the following conditions:

1. All health benefit plans must be offered and issued on a guaranteed-issue basis~~, except that benefits purchased through riders as provided in paragraph (c) may be medically underwritten for the group, but may not be individually underwritten as to the employees or the dependents of such employees~~. Additional or increased benefits may only be offered by riders.

2. ~~The provisions of~~ Paragraph (c) applies ~~(f) apply~~ to health benefit plans issued to a small employer who has two or more eligible employees~~,~~ and to health benefit plans that are issued to a small employer who has fewer than two eligible employees and that cover an employee who has had creditable coverage continually to a date not more than 63 days before the effective date of the new coverage.

3. For health benefit plans that are issued to a small employer who has fewer than two employees and that cover an employee who has not been continually covered by creditable coverage within 63 days before the effective date of the new coverage, preexisting condition provisions must not exclude coverage for a period beyond 24 months following the employee's

effective date of coverage and may relate only to:

a. Conditions that, during the 24-month period immediately preceding the effective date of coverage, had manifested themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received; or

b. A pregnancy existing on the effective date of coverage.

(e) ~~(h)~~ All health benefit plans issued under this section must comply with the following conditions:

1. For employers who have fewer than two employees, a late enrollee may be excluded from coverage for no longer than 24 months if he or she was not covered by creditable coverage continually to a date not more than 63 days before the effective date of his or her new coverage.

2. Any requirement used by a small employer carrier in determining whether to provide coverage to a small employer group, including requirements for minimum participation of eligible employees and minimum employer contributions, must be applied uniformly among all small employer groups having the same number of eligible employees applying for coverage or receiving coverage from the small employer carrier, except that a small employer carrier that participates in, administers, or issues health benefits pursuant to s. 381.0406 which do not include a preexisting condition exclusion may require as a condition of offering such benefits that the employer has had no

health insurance coverage for its employees for a period of at least 6 months. A small employer carrier may vary application of minimum participation requirements and minimum employer contribution requirements only by the size of the small employer group.

3. In applying minimum participation requirements with respect to a small employer, a small employer carrier shall not consider as an eligible employee employees or dependents who have qualifying existing coverage in an employer-based group insurance plan or an ERISA qualified self-insurance plan in determining whether the applicable percentage of participation is met. However, a small employer carrier may count eligible employees and dependents who have coverage under another health plan that is sponsored by that employer.

4. A small employer carrier shall not increase any requirement for minimum employee participation or any requirement for minimum employer contribution applicable to a small employer at any time after the small employer has been accepted for coverage, unless the employer size has changed, in which case the small employer carrier may apply the requirements that are applicable to the new group size.

5. If a small employer carrier offers coverage to a small employer, it must offer coverage to all the small employer's eligible employees and their dependents. A small employer carrier may not offer coverage limited to certain persons in a group or to part of a group, except with respect to late

enrollees.

6. A small employer carrier may not modify any health benefit plan issued to a small employer with respect to a small employer or any eligible employee or dependent through riders, endorsements, or otherwise to restrict or exclude coverage for certain diseases or medical conditions otherwise covered by the health benefit plan.

7. An initial enrollment period of at least 30 days must be provided. An annual 30-day open enrollment period must be offered to each small employer's eligible employees and their dependents. A small employer carrier must provide special enrollment periods as required by s. 627.65615.

~~(i)1. A small employer carrier need not offer coverage or accept applications pursuant to paragraph (a):~~

~~a. To a small employer if the small employer is not physically located in an established geographic service area of the small employer carrier, provided such geographic service area shall not be less than a county;~~

~~b. To an employee if the employee does not work or reside within an established geographic service area of the small employer carrier; or~~

~~c. To a small employer group within an area in which the small employer carrier reasonably anticipates, and demonstrates to the satisfaction of the office, that it cannot, within its network of providers, deliver service adequately to the members of such groups because of obligations to existing group contract~~

~~holders and enrollees.~~

~~2. A small employer carrier that cannot offer coverage pursuant to sub-subparagraph 1.c. may not offer coverage in the applicable area to new cases of employer groups having more than 50 eligible employees or small employer groups until the later of 180 days following each such refusal or the date on which the carrier notifies the office that it has regained its ability to deliver services to small employer groups.~~

~~3.a. A small employer carrier may deny health insurance coverage in the small-group market if the carrier has demonstrated to the office that:~~

~~(I) It does not have the financial reserves necessary to underwrite additional coverage; and~~

~~(II) It is applying this sub-subparagraph uniformly to all employers in the small-group market in this state consistent with this section and without regard to the claims experience of those employers and their employees and their dependents or any health-status-related factor that relates to such employees and dependents.~~

~~b. A small employer carrier, upon denying health insurance coverage in connection with health benefit plans in accordance with sub-subparagraph a., may not offer coverage in connection with group health benefit plans in the small-group market in this state for a period of 180 days after the date such coverage is denied or until the insurer has demonstrated to the office that the insurer has sufficient financial reserves to underwrite~~

~~additional coverage, whichever is later. The office may provide for the application of this sub-subparagraph on a service-area-specific basis.~~

~~4. The commission shall, by rule, require each small employer carrier to report, on or before March 1 of each year, its gross annual premiums for all health benefit plans issued to small employers during the previous calendar year, and also to report its gross annual premiums for new, but not renewal, standard and basic health benefit plans subject to this section issued during the previous calendar year. No later than May 1 of each year, the office shall calculate each carrier's percentage of all small employer group health premiums for the previous calendar year and shall calculate the aggregate gross annual premiums for new, but not renewal, standard and basic health benefit plans for the previous calendar year.~~

(f) ~~(j)~~ The boundaries of geographic areas used by a small employer carrier must coincide with county lines. A carrier may not apply different geographic rating factors to the rates of small employers located within the same county.

(6) RESTRICTIONS RELATING TO PREMIUM RATES.—

(b) For all small employer health benefit plans that are subject to this section and issued by small employer carriers on or after January 1, 1994, premium rates for health benefit plans are subject to the following:

1. Small employer carriers must use a modified community rating methodology in which the premium for each small employer

is determined solely on the basis of the eligible employee's and eligible dependent's gender, age, family composition, tobacco use, or geographic area as determined under paragraph (5)(f) ~~(5)(j)~~ and in which the premium may be adjusted as permitted by this paragraph. A small employer carrier is not required to use gender as a rating factor for a nongrandfathered health plan.

2. Rating factors related to age, gender, family composition, tobacco use, or geographic location may be developed by each carrier to reflect the carrier's experience. The factors used by carriers are subject to office review and approval.

3. Small employer carriers may not modify the rate for a small employer for 12 months from the initial issue date or renewal date, unless the composition of the group changes or benefits are changed. However, a small employer carrier may modify the rate one time within the 12 months after the initial issue date for a small employer who enrolls under a previously issued group policy that has a common anniversary date for all employers covered under the policy if:

a. The carrier discloses to the employer in a clear and conspicuous manner the date of the first renewal and the fact that the premium may increase on or after that date.

b. The insurer demonstrates to the office that efficiencies in administration are achieved and reflected in the rates charged to small employers covered under the policy.

4. A carrier may issue a group health insurance policy to

a small employer health alliance or other group association with rates that reflect a premium credit for expense savings attributable to administrative activities being performed by the alliance or group association if such expense savings are specifically documented in the insurer's rate filing and are approved by the office. Any such credit may not be based on different morbidity assumptions or on any other factor related to the health status or claims experience of any person covered under the policy. This subparagraph does not exempt an alliance or group association from licensure for activities that require licensure under the insurance code. A carrier issuing a group health insurance policy to a small employer health alliance or other group association shall allow any properly licensed and appointed agent of that carrier to market and sell the small employer health alliance or other group association policy. Such agent shall be paid the usual and customary commission paid to any agent selling the policy.

5. Any adjustments in rates for claims experience, health status, or duration of coverage may not be charged to individual employees or dependents. For a small employer's policy, such adjustments may not result in a rate for the small employer which deviates more than 15 percent from the carrier's approved rate. Any such adjustment must be applied uniformly to the rates charged for all employees and dependents of the small employer. A small employer carrier may make an adjustment to a small employer's renewal premium, up to 10 percent annually, due to

the claims experience, health status, or duration of coverage of the employees or dependents of the small employer. ~~Semiannually, small group carriers shall report information on forms adopted by rule by the commission, to enable the office to monitor the relationship of aggregate adjusted premiums actually charged policyholders by each carrier to the premiums that would have been charged by application of the carrier's approved modified community rates.~~ If the aggregate resulting from the application of such adjustment exceeds the premium that would have been charged by application of the approved modified community rate by 4 percent for the current policy term ~~reporting period~~, the carrier shall limit the application of such adjustments only to minus adjustments ~~beginning within 60 days after the report is sent to the office~~. For any subsequent policy term ~~reporting period~~, if the total aggregate adjusted premium actually charged does not exceed the premium that would have been charged by application of the approved modified community rate by 4 percent, the carrier may apply both plus and minus adjustments. A small employer carrier may provide a credit to a small employer's premium based on administrative and acquisition expense differences resulting from the size of the group. Group size administrative and acquisition expense factors may be developed by each carrier to reflect the carrier's experience and are subject to office review and approval.

6. A small employer carrier rating methodology may include separate rating categories for one dependent child, for two

dependent children, and for three or more dependent children for family coverage of employees having a spouse and dependent children or employees having dependent children only. A small employer carrier may have fewer, but not greater, numbers of categories for dependent children than those specified in this subparagraph.

7. Small employer carriers may not use a composite rating methodology to rate a small employer with fewer than 10 employees. For the purposes of this subparagraph, the term "composite rating methodology" means a rating methodology that averages the impact of the rating factors for age and gender in the premiums charged to all of the employees of a small employer.

8. A carrier may separate the experience of small employer groups with fewer than 2 eligible employees from the experience of small employer groups with 2-50 eligible employees for purposes of determining an alternative modified community rating.

a. If a carrier separates the experience of small employer groups, the rate to be charged to small employer groups of fewer than 2 eligible employees may not exceed 150 percent of the rate determined for small employer groups of 2-50 eligible employees. However, the carrier may charge excess losses of the experience pool consisting of small employer groups with less than 2 eligible employees to the experience pool consisting of small employer groups with 2-50 eligible employees so that all losses

are allocated and the 150-percent rate limit on the experience pool consisting of small employer groups with less than 2 eligible employees is maintained.

b. Notwithstanding s. 627.411(1), the rate to be charged to a small employer group of fewer than 2 eligible employees, insured as of July 1, 2002, may be up to 125 percent of the rate determined for small employer groups of 2-50 eligible employees for the first annual renewal and 150 percent for subsequent annual renewals.

9. A carrier shall separate the experience of grandfathered health plans from nongrandfathered health plans for determining rates.

(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.—

(g) A reinsuring carrier may reinsure with the program coverage of an eligible employee of a small employer, or any dependent of such an employee, subject to each of the following provisions:

~~1. With respect to a standard and basic health care plan, the program must reinsure the level of coverage provided; and, with respect to any other plan, the program must reinsure the coverage up to, but not exceeding, the level of coverage provided under the standard and basic health care plan.~~

1.~~2.~~ Except in the case of a late enrollee, a reinsuring carrier may reinsure an eligible employee or dependent within 60 days after the commencement of the coverage of the small employer. A newly employed eligible employee or dependent of a

small employer may be reinsured within 60 days after the commencement of his or her coverage.

2.~~3.~~ A small employer carrier may reinsure an entire employer group within 60 days after the commencement of the group's coverage under the plan. ~~The carrier may choose to reinsure newly eligible employees and dependents of the reinsured group pursuant to subparagraph 1.~~

3.~~4.~~ The program may not reimburse a participating carrier with respect to the claims of a reinsured employee or dependent until the carrier has paid incurred claims of at least $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier shall be responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 of incurred claims during a calendar year and the program shall reinsure the remainder.

4.~~5.~~ The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the Department of Labor, unless the board proposes and the office approves a lower adjustment factor.

5.~~6.~~ A small employer carrier may terminate reinsurance for all reinsured employees or dependents on any plan

anniversary.

6.~~7.~~ The premium rate charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to requirements that limit the amount of risk that may be ceded to the program, which requirements are more restrictive than subparagraph 3. ~~4.~~, shall be reduced by an amount equal to that portion of the risk, if any, which exceeds the amount set forth in subparagraph 3. ~~4.~~ which may not be ceded to the program.

7.~~8.~~ The board may consider adjustments to the premium rates charged for reinsurance by the program for carriers that use effective cost containment measures, including high-cost case management, as defined by the board.

8.~~9.~~ A reinsuring carrier shall apply its case-management and claims-handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions, other managed care provisions or methods of operation, consistently with both reinsured business and nonreinsured business.

(h)1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that

reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of basic reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the office~~, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard and basic health benefit plan~~. The premium rates set by the board may vary by geographical area, as determined under this section, to reflect differences in cost. The multiplying factors must be established as follows:

a. The entire group may be reinsured for a rate that is 1.5 times the rate established by the board.

b. An eligible employee or dependent may be reinsured for a rate that is 5 times the rate established by the board.

2. The board periodically shall review the methodology established, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose changes to the rates which shall be subject to the approval of the office.

(j)1. Before July 1 of each calendar year, the board shall determine and report to the office the program net loss for the previous year, including administrative expenses for that year,

and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.

2. Any net loss for the year shall be recouped by assessment of the carriers, as follows:

a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount which shall not exceed 5 percent of each reinsuring carrier's premiums from health benefit plans covering small employers. If such assessments have been collected and additional moneys are needed, the board shall make a second tier of assessments in an amount which shall not exceed 0.5 percent of each carrier's health benefit plan premiums. Except as provided in paragraph (m) ~~(n)~~, risk-assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.

b. The board shall equitably assess carriers for operating losses of the plan based on market share. The board shall annually assess each carrier a portion of the operating losses of the plan. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of small employer health benefit plans in the state during the calendar year for which the

assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk-assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.

c. Subject to the approval of the office, the board shall make an adjustment to the assessment formula for reinsuring carriers that are approved as federally qualified health maintenance organizations by the Secretary of Health and Human Services pursuant to 42 U.S.C. s. 300e(c)(2)(A) to the extent, if any, that restrictions are placed on them that are not imposed on other small employer carriers.

3. Before July 1 of each year, the board shall determine and file with the office an estimate of the assessments needed

to fund the losses incurred by the program in the previous calendar year.

4. If the board determines that the assessments needed to fund the losses incurred by the program in the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings, including any recommendations for changes to the plan of operation, to the office within 180 days following the end of the calendar year in which the losses were incurred. The evaluation shall include an estimate of future assessments, the administrative costs of the program, the appropriateness of the premiums charged and the level of carrier retention under the program, and the costs of coverage for small employers. If the board fails to file a report with the office within 180 days following the end of the applicable calendar year, the office may evaluate the operations of the program and implement such amendments to the plan of operation the office deems necessary to reduce future losses and assessments.

5. If assessments exceed the amount of the actual losses and administrative expenses of the program, the excess shall be held as interest and used by the board to offset future losses or to reduce program premiums. As used in this paragraph, the term "future losses" includes reserves for incurred but not reported claims.

6. Each carrier's proportion of the assessment shall be determined annually by the board, based on annual statements and

other reports considered necessary by the board and filed by the carriers with the board.

7. Provision shall be made in the plan of operation for the imposition of an interest penalty for late payment of an assessment.

8. A carrier may seek, from the office, a deferment, in whole or in part, from any assessment made by the board. The office may defer, in whole or in part, the assessment of a carrier if, in the opinion of the office, the payment of the assessment would place the carrier in a financially impaired condition. If an assessment against a carrier is deferred, in whole or in part, the amount by which the assessment is deferred may be assessed against the other carriers in a manner consistent with the basis for assessment set forth in this section. The carrier receiving such deferment remains liable to the program for the amount deferred and is prohibited from reinsuring any individuals or groups in the program if it fails to pay assessments.

~~(l) The board, as part of the plan of operation, shall develop standards setting forth the manner and levels of compensation to be paid to agents for the sale of basic and standard health benefit plans. In establishing such standards, the board shall take into consideration the need to assure the broad availability of coverages, the objectives of the program, the time and effort expended in placing the coverage, the need to provide ongoing service to the small employer, the levels of~~

~~compensation currently used in the industry, and the overall costs of coverage to small employers selecting these plans.~~

(l) ~~(m)~~ The board shall monitor compliance with this section, including the market conduct of small employer carriers, and shall report to the office any unfair trade practices and misleading or unfair conduct by a small employer carrier that has been reported to the board by agents, consumers, or any other person. The office shall investigate all reports and, upon a finding of noncompliance with this section or of unfair or misleading practices, shall take action against the small employer carrier as permitted under the insurance code or chapter 641. The board is not given investigatory or regulatory powers, but must forward all reports of cases or abuse or misrepresentation to the office.

(m) ~~(n)~~ Notwithstanding paragraph (j), the administrative expenses of the program shall be recouped by assessment of risk-assuming carriers and reinsuring carriers and such amounts shall not be considered part of the operating losses of the plan for the purposes of this paragraph. Each carrier's portion of such administrative expenses shall be determined by multiplying the total of such administrative expenses by a fraction, the numerator of which equals the carrier's earned premium pertaining to direct writing of small employer health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of such premiums earned by all carriers in the state

during such calendar year.

(n) ~~(o)~~ The board shall advise the office, the Agency for Health Care Administration, the department, other executive departments, and the Legislature on health insurance issues. Specifically, the board shall:

1. Provide a forum for stakeholders, consisting of insurers, employers, agents, consumers, and regulators, in the private health insurance market in this state.

2. Review and recommend strategies to improve the functioning of the health insurance markets in this state with a specific focus on market stability, access, and pricing.

3. Make recommendations to the office for legislation addressing health insurance market issues and provide comments on health insurance legislation proposed by the office.

4. Meet at least three times each year. One meeting shall be held to hear reports and to secure public comment on the health insurance market, to develop any legislation needed to address health insurance market issues, and to provide comments on health insurance legislation proposed by the office.

5. Issue a report to the office on the state of the health insurance market by September 1 each year. The report shall include recommendations for changes in the health insurance market, results from implementation of previous recommendations, and information on health insurance markets.

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

~~(a)1. The Chief Financial Officer shall appoint a health benefit plan committee composed of four representatives of carriers which shall include at least two representatives of HMOs, at least one of which is a staff model HMO, two representatives of agents, four representatives of small employers, and one employee of a small employer. The carrier members shall be selected from a list of individuals recommended by the board. The Chief Financial Officer may require the board to submit additional recommendations of individuals for appointment.~~

~~2. The plans shall comply with all of the requirements of this subsection.~~

~~3. The plans must be filed with and approved by the office prior to issuance or delivery by any small employer carrier.~~

~~4. After approval of the revised health benefit plans, if the office determines that modifications to a plan might be appropriate, the Chief Financial Officer shall appoint a new health benefit plan committee in the manner provided in subparagraph 1. to submit recommended modifications to the office for approval.~~

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

~~Service, that meet the criteria set forth in this section.~~

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

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

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

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

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

~~group products that are not issued to small employers.~~

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

~~This subparagraph does not prohibit a small employer carrier from including in its policy or contract additional managed care and cost containment provisions, subject to the approval of the office, which have potential for controlling costs in a manner that does not result in inequitable treatment of insureds or subscribers. The carrier may use such provisions to the same extent as authorized for group products that are not issued to small employers.~~

~~4. The standard health benefit plan shall include:~~

~~a. Coverage for inpatient hospitalization;~~

~~b. Coverage for outpatient services;~~

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

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

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

~~f. Coverage for mammograms pursuant to s. 627.6613;~~

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

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

~~i. Coverage for services provided by a hospice licensed~~

~~under s. 400.602 in cases where such coverage would be the most appropriate and the most cost-effective method for treating a covered illness.~~

~~5. The standard health benefit plan and the basic health benefit plan may include a schedule of benefit limitations for specified services and procedures. If the committee develops such a schedule of benefits limitation for the standard health benefit plan or the basic health benefit plan, a small employer carrier offering the plan must offer the employer an option for increasing the benefit schedule amounts by 4 percent annually.~~

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

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

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

~~9. Each small employer carrier that provides for inpatient~~

~~and outpatient services by allopathic hospitals may provide as an option of the insured similar inpatient and outpatient services by hospitals accredited by the American Osteopathic Association when such services are available and the osteopathic hospital agrees to provide the service.~~

~~(c) If a small employer rejects, in writing, the standard health benefit plan, the basic health benefit plan, and the high deductible health savings account plan or a health reimbursement arrangement, the small employer carrier may offer the small employer a limited benefit policy or contract.~~

~~(d)1. Upon offering coverage under a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract for a small employer group, the small employer carrier shall provide such employer group with a written statement that contains, at a minimum:~~

~~a. An explanation of those mandated benefits and providers that are not covered by the policy or contract;~~

~~b. An explanation of the managed care and cost control features of the policy or contract, along with all appropriate mailing addresses and telephone numbers to be used by insureds in seeking information or authorization; and~~

~~c. An explanation of the primary and preventive care features of the policy or contract.~~

~~Such disclosure statement must be presented in a clear and understandable form and format and must be separate from the~~

~~policy or certificate or evidence of coverage provided to the employer group.~~

~~2. Before a small employer carrier issues a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract, the carrier must obtain from the prospective policyholder a signed written statement in which the prospective policyholder:~~

~~a. Certifies as to eligibility for coverage under the standard health benefit plan, basic health benefit plan, or limited benefit policy or contract;~~

~~b. Acknowledges the limited nature of the coverage and an understanding of the managed care and cost control features of the policy or contract;~~

~~c. Acknowledges that if misrepresentations are made regarding eligibility for coverage under a standard health benefit plan, a basic health benefit plan, or a limited benefit policy or contract, the person making such misrepresentations forfeits coverage provided by the policy or contract; and~~

~~d. If a limited plan is requested, acknowledges that the prospective policyholder had been offered, at the time of application for the insurance policy or contract, the opportunity to purchase any health benefit plan offered by the carrier and that the prospective policyholder rejected that coverage.~~

~~A copy of such written statement must be provided to the~~

~~prospective policyholder by the time of delivery of the policy or contract, and the original of such written statement must be retained in the files of the small employer carrier for the period of time that the policy or contract remains in effect or for 5 years, whichever is longer.~~

~~3. Any material statement made by an applicant for coverage under a health benefit plan which falsely certifies the applicant's eligibility for coverage serves as the basis for terminating coverage under the policy or contract.~~

~~(c) A small employer carrier may not use any policy, contract, form, or rate under this section, including applications, enrollment forms, policies, contracts, certificates, evidences of coverage, riders, amendments, endorsements, and disclosure forms, until the insurer has filed it with the office and the office has approved it under ss. 627.410 and 627.411 and this section.~~

(12)~~(13)~~ STANDARDS TO ASSURE FAIR MARKETING.—

(a) Each small employer carrier shall actively market health benefit plan coverage~~, including the basic and standard health benefit plans~~, including any subsequent modifications or additions to those plans, to eligible small employers in the state. ~~Before January 1, 1994, if a small employer carrier denies coverage to a small employer on the basis of the health status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health~~

~~benefit plan and a standard health benefit plan. Beginning January 1, 1994,~~ Small employer carriers must offer and issue all plans on a guaranteed-issue basis.

(b) A ~~No~~ small employer carrier or agent shall not, directly or indirectly, engage in the following activities:

1. Encouraging or directing small employers to refrain from filing an application for coverage with the small employer carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

2. Encouraging or directing small employers to seek coverage from another carrier because of the health status, claims experience, industry, occupation, or geographic location of the small employer.

(c) ~~The provisions of~~ Paragraph (a) does ~~shall~~ not apply with respect to information provided by a small employer carrier or agent to a small employer regarding the established geographic service area or a restricted network provision of a small employer carrier.

(d) A ~~No~~ small employer carrier shall not, directly or indirectly, enter into any contract, agreement, or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small employer except if the compensation arrangement provides

compensation to an agent on the basis of percentage of premium, provided that the percentage shall not vary because of the health status, claims experience, industry, occupation, or geographic area of the small employer.

~~(e) A small employer carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an agent, if any, for the sale of a basic or standard health benefit plan.~~

(e) ~~(f)~~ A ~~No~~ small employer carrier shall not terminate, fail to renew, or limit its contract or agreement of representation with an agent for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the agent with the small employer carrier unless the agent consistently engages in practices that violate this section or s. 626.9541.

(f) ~~(g)~~ A ~~No~~ small employer carrier or agent shall not induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

(g) ~~(h)~~ Denial by a small employer carrier of an application for coverage from a small employer shall be in writing and shall state the reason or reasons for the denial.

(h) ~~(i)~~ The commission may establish regulations setting forth additional standards to provide for the fair marketing and broad availability of health benefit plans to small employers in this state.

(i)~~(j)~~ A violation of this section by a small employer carrier or an agent is ~~shall be~~ an unfair trade practice under s. 626.9541 or ss. 641.3903 and 641.3907.

(j)~~(k)~~ If a small employer carrier enters into a contract, agreement, or other arrangement with a third-party administrator to provide administrative, marketing, or other services relating to the offering of health benefit plans to small employers in this state, the third-party administrator shall be subject to this section.

(13)~~(14)~~ DISCLOSURE OF INFORMATION.—

(a) In connection with the offering of a health benefit plan to a small employer, a small employer carrier:

1. Shall make a reasonable disclosure to such employer, as part of its solicitation and sales materials, of the availability of information described in paragraph (b); and

2. Upon request of the small employer, provide such information.

(b)1. Subject to subparagraph 3., with respect to a small employer carrier that offers a health benefit plan to a small employer, information described in this paragraph is information that concerns:

a. The provisions of such coverage concerning an insurer's right to change premium rates and the factors that may affect changes in premium rates;

b. The provisions of such coverage that relate to renewability of coverage;

c. The provisions of such coverage that relate to any preexisting condition exclusions; and

d. The benefits and premiums available under all health insurance coverage for which the employer is qualified.

2. Information required under this subsection shall be provided to small employers in a manner determined to be understandable by the average small employer, and shall be sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage.

3. An insurer is not required under this subsection to disclose any information that is proprietary or a trade secret under state law.

(14) ~~(15)~~ SMALL EMPLOYERS ACCESS PROGRAM.—

(k) Benefits. ~~The benefits provided by the plan shall be the same as the coverage required for small employers under subsection (12).~~ Upon the approval of the office, the insurer may ~~also~~ establish an optional mutually supported benefit plan that ~~which~~ is an alternative plan developed within a defined geographic region of this state or any other such alternative plan that ~~which~~ will carry out the intent of this subsection. Any small employer carrier issuing new health benefit plans may offer a benefit plan with coverages similar to, but not less than, any alternative coverage plan developed pursuant to this subsection.

(15) ~~(16)~~ APPLICABILITY OF OTHER STATE LAWS.—

(a) Except as expressly provided in this section, a law

requiring coverage for a specific health care service or benefit, or a law requiring reimbursement, utilization, or consideration of a specific category of licensed health care practitioner, does not apply to ~~a standard or basic health benefit plan policy or contract or~~ a limited benefit policy or contract offered or delivered to a small employer unless that law is made expressly applicable to such policies or contracts. A law restricting or limiting deductibles, coinsurance, copayments, or annual or lifetime maximum payments does not apply to any health plan policy~~, including a standard or basic health benefit plan policy or contract,~~ offered or delivered to a small employer unless such law is made expressly applicable to such policy or contract. ~~However, every small employer carrier must offer to eligible small employers the standard benefit plan and the basic benefit plan, as required by subsection (5), as such plans have been approved by the office pursuant to subsection (12).~~

~~(b) Except as provided in this section, a standard or basic health benefit plan policy or contract or limited benefit policy or contract offered to a small employer is not subject to any provision of this code which:~~

~~1. Inhibits a small employer carrier from contracting with providers or groups of providers with respect to health care services or benefits;~~

~~2. Imposes any restriction on a small employer carrier's ability to negotiate with providers regarding the level or~~

~~method of reimbursing care or services provided under a health benefit plan; or~~

~~3. Requires a small employer carrier to either include a specific provider or class of providers when contracting for health care services or benefits or to exclude any class of providers that is generally authorized by statute to provide such care.~~

(b) ~~(c)~~ Any second tier assessment paid by a carrier pursuant to paragraph (11)(j) may be credited against assessments levied against the carrier pursuant to s. 627.6494.

(c) ~~(d)~~ Notwithstanding chapter 641, a health maintenance organization may ~~is authorized to~~ issue contracts providing benefits equal to the ~~standard health benefit plan, the basic health benefit plan, and the~~ limited benefit policy authorized by this section.

(16) ~~(17)~~ RESTRICTIONS ON COVERAGE.—

(a) A plan under which coverage is purchased in whole or in part with any state or federal funds through an exchange created pursuant to the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148, may not provide coverage for an abortion, as defined in s. 390.011(1), except if the pregnancy is the result of an act of rape or incest, or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician,

place the woman in danger of death unless an abortion is performed. Coverage is deemed to be purchased with state or federal funds if any tax credit or cost-sharing credit is applied toward the plan.

(b) This subsection does not prohibit a plan from providing any person or entity with separate coverage for an abortion if such coverage is not purchased in whole or in part with state or federal funds.

(c) As used in this section, the term "state" means this state or any political subdivision of the state.

(17)~~(18)~~ RULEMAKING AUTHORITY.—The commission may adopt rules to administer this section, including rules governing compliance by small employer carriers and small employers.

Section 2. Section 627.66997, Florida Statutes, is created to read:

627.66997 Stop-loss insurance.—

(1) A self-insured health benefit plan established or maintained by a small employer, as defined in s. 627.6699(3)(v), is exempt from s. 627.6699 and may use a stop-loss insurance policy issued to the employer. For purposes of this subsection, the term "stop-loss insurance policy" means an insurance policy issued to a small employer which covers the small employer's obligation for the excess cost of medical care on an equivalent basis per employee provided under a self-insured health benefit plan.

(a) A small employer stop-loss insurance policy is

considered a health insurance policy and is subject to s. 627.6699 if the policy has an aggregate attachment point that is lower than the greatest of:

1. Two thousand dollars multiplied by the number of employees;

2. One hundred twenty percent of expected claims, as determined by the stop-loss insurer in accordance with actuarial standards of practice; or

3. Twenty thousand dollars.

(b) Once claims under the small employer health benefit plan reach the aggregate attachment point set forth in paragraph (a), the stop-loss insurance policy authorized under this section must cover 100 percent of all claims that exceed the aggregate attachment point.

(2) A self-insured health benefit plan established or maintained by an employer with 51 or more covered employees is considered health insurance if the plan's stop-loss coverage, as defined in s. 627.6482(14), has an aggregate attachment point that is lower than the greater of:

(a) One hundred ten percent of expected claims, as determined by the stop-loss insurer in accordance with actuarial standards of practice; or

(b) Twenty thousand dollars.

(3) Stop-loss insurance carriers shall use a consistent basis for determining the number of an employer's covered employees. Such basis may include, but is not limited to, the

1041 average number of employees employed annually or at a uniform
1042 time.
1043 Section 3. Subsection (3) of section 627.642, Florida
1044 Statutes, is amended to read:
1045 627.642 Outline of coverage.—
1046 (3) In addition to the outline of coverage, a policy as
1047 specified in s. 627.6699(3)(k) ~~627.6699(3)(l)~~ must be
1048 accompanied by an identification card that contains, at a
1049 minimum:
1050 (a) The name of the organization issuing the policy or the
1051 name of the organization administering the policy, whichever
1052 applies.
1053 (b) The name of the contract holder.
1054 (c) The type of plan only if the plan is filed in the
1055 state, an indication that the plan is self-funded, or the name
1056 of the network.
1057 (d) The member identification number, contract number, and
1058 policy or group number, if applicable.
1059 (e) A contact phone number or electronic address for
1060 authorizations and admission certifications.
1061 (f) A phone number or electronic address whereby the
1062 covered person or hospital, physician, or other person rendering
1063 services covered by the policy may obtain benefits verification
1064 and information in order to estimate patient financial
1065 responsibility, in compliance with privacy rules under the
1066 Health Insurance Portability and Accountability Act.

(g) The national plan identifier, in accordance with the compliance date set forth by the federal Department of Health and Human Services.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.

Section 4. Paragraph (g) of subsection (7) and paragraph (a) of subsection (8) of section 627.6475, Florida Statutes, are amended to read:

627.6475 Individual reinsurance pool.—

(7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.—

(g) Except as otherwise provided in this section, the board and the office shall have all powers, duties, and responsibilities with respect to carriers that issue and reinsure individual health insurance, as specified for the board and the office in s. 627.6699(11) with respect to small employer carriers, including, but not limited to, the provisions of s. 627.6699(11) relating to:

1. Use of assessments that exceed the amount of actual losses and expenses.

2. The annual determination of each carrier's proportion of the assessment.

3. Interest for late payment of assessments.

4. Authority for the office to approve deferment of an assessment against a carrier.

5. Limited immunity from legal actions or carriers.

6. Development of standards for compensation to be paid to agents. Such standards shall be limited to those specifically enumerated in s. 627.6699(12)(d) ~~627.6699(13)(d)~~.

7. Monitoring compliance by carriers with this section.

(8) STANDARDS TO ASSURE FAIR MARKETING.—

(a) Each health insurance issuer that offers individual health insurance shall actively market coverage to eligible individuals in the state. The provisions of s. 627.6699(12) ~~627.6699(13)~~ that apply to small employer carriers that market policies to small employers shall also apply to health insurance issuers that offer individual health insurance with respect to marketing policies to individuals.

Section 5. Subsection (2) of section 627.657, Florida Statutes, is amended to read:

627.657 Provisions of group health insurance policies.—

(2) The medical policy as specified in s. 627.6699(3)(k) ~~627.6699(3)(l)~~ must be accompanied by an identification card that contains, at a minimum:

(a) The name of the organization issuing the policy or name of the organization administering the policy, whichever applies.

(b) The name of the certificateholder.

(c) The type of plan only if the plan is filed in the

state, an indication that the plan is self-funded, or the name of the network.

(d) The member identification number, contract number, and policy or group number, if applicable.

(e) A contact phone number or electronic address for authorizations and admission certifications.

(f) A phone number or electronic address whereby the covered person or hospital, physician, or other person rendering services covered by the policy may obtain benefits verification and information in order to estimate patient financial responsibility, in compliance with privacy rules under the Health Insurance Portability and Accountability Act.

(g) The national plan identifier, in accordance with the compliance date set forth by the federal Department of Health and Human Services.

The identification card must present the information in a readily identifiable manner or, alternatively, the information may be embedded on the card and available through magnetic stripe or smart card. The information may also be provided through other electronic technology.

Section 6. Paragraph (e) of subsection (2) of section 627.6571, Florida Statutes, is amended to read:

627.6571 Guaranteed renewability of coverage.—

(2) An insurer may nonrenew or discontinue a group health insurance policy based only on one or more of the following

conditions:

(e) In the case of an insurer that offers health insurance coverage through a network plan, there is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the insurer or in the area in which the insurer is authorized to do business ~~and, in the case of the small-group market, the insurer would deny enrollment with respect to such plan under s. 627.6699(5)(i)~~.

Section 7. Subsection (11) of section 627.6675, Florida Statutes, is amended to read:

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

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

(11) ALTERNATIVE PLANS.~~—The insurer shall, in addition to the option required by subsection (10), offer the standard health benefit plan, as established pursuant to s. 627.6699(12).~~ The insurer may, at its option, ~~also~~ offer alternative plans for group health conversion in addition to the plans required by this section.

Section 8. Paragraph (e) of subsection (2) of section 641.31074, Florida Statutes, is amended to read:

641.31074 Guaranteed renewability of coverage.—

(2) A health maintenance organization may nonrenew or discontinue a contract based only on one or more of the following conditions:

(e) There is no longer any enrollee in connection with such plan who lives, resides, or works in the service area of the health maintenance organization or in the area in which the health maintenance organization is authorized to do business ~~and, in the case of the small group market, the organization~~

~~would deny enrollment with respect to such plan under s. 627.6699(5)(i)~~.

Section 9. Subsection (10) of section 641.3922, Florida Statutes, is amended to read:

641.3922 Conversion contracts; conditions.—Issuance of a converted contract shall be subject to the following conditions:

(10) ALTERNATE PLANS.—~~The health maintenance organization shall offer a standard health benefit plan as established pursuant to s. 627.6699(12).~~ The health maintenance organization may, at its option, ~~also~~ offer alternative plans for group health conversion in addition to those required by this section, provided any alternative plan is approved by the office or is a converted policy, approved under s. 627.6675 and issued by an insurance company authorized to transact insurance in this state. Approval by the office of an alternative plan shall be based on compliance by the alternative plan with the provisions of this part and the rules promulgated thereunder, applicable provisions of the Florida Insurance Code and rules promulgated thereunder, and any other applicable law.

Section 10. This act shall take effect July 1, 2015.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 749 Continuing Care Communities
SPONSOR(S): Van Zant and others
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1126

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	10 Y, 0 N	Guzzo	Poche
2) Insurance & Banking Subcommittee	12 Y, 0 N, As CS	Bauer	Cooper
3) Health & Human Services Committee		Guzzo	Calamas

SUMMARY ANALYSIS

Continuing care communities (CCCs) are retirement facilities that furnish residents with shelter and health care for an entrance fee and monthly payments. CCCs are regulated by the Department of Financial Services, the Agency for Health Care Administration and the Office of Insurance Regulation (OIR). Pursuant to chapter 651, F.S., CCCs are governed by a contract between the facility and the resident. In Florida, continuing care contracts are considered a kind of specialty insurance product and are reviewed and approved by OIR. The OIR authorizes and monitors a facility's operation as well as determines the facility's financial status and the management capabilities of its managers and owners. Currently, there are 71 CCCs in Florida.

A resident of a CCC must pay an entrance fee upon entering into a contract with a facility. The contract must include the terms under which a resident is due a refund of any portion of the entrance fee. If the contract provides that the resident does not receive a transferable membership or ownership right in the facility, and the resident has occupied his or her unit, the refund must be calculated on a pro-rata basis with the facility retaining up to two-percent per month of occupancy by the resident and up to a five-percent processing fee, the balance of which must be paid within 120 days after the resident gives notice of intent to cancel. Similarly, a contract may provide a one-percent declining-scale refund, but the refund must be paid from the proceeds of the next entrance fees received by the provider for units for which there are no prior claims.

The bill makes several changes to ch. 651, F.S. Specifically, the bill:

- Requires a CCC contract, paying a two-percent refund, to provide for payment to a resident within 90 days after the contract is terminated and the unit is vacated, instead of 120 days after notice of intent to cancel;
- Requires a CCC contract, paying a one-percent refund, to provide for payment to a resident for the unit that is vacated, or a like or similar unit, whichever is applicable, by specified time frames;
- Clarifies that CCCs must be accredited for OIR to waive equivalent requirements in rule or law;
- Makes a CCC contract a preferred claim against a provider in receivership or liquidation proceedings;
- Requires OIR to notify the executive office of the governing body of the CCC provider about all deficiencies found as part of an examination;
- Requires a CCC to provide a copy of any final examination report and corrective action plan to the executive officer of the governing body of the provider within 60 days after issuance of the report;
- Requires each CCC to establish a residents' council to provide input on subjects that impact the general residential quality of life;
- Authorizes the board of directors or governing board of a provider to allow a facility resident to be a voting member of the board or governing body of the facility; and
- Requires all CCCs to provide a copy of the most recent third-party financial audit to the president or chair of the residents' council within 30 days of filing the annual report with OIR.

The bill does not appear to have a fiscal impact on state or local government. The bill may have a positive impact on the private sector.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Continuing Care Communities (CCCs)

A CCC is a residential alternative for older adults (usually age 65 and older) that provides flexible housing options, a coordinated system of services and amenities, and a lifetime continuum of care that addresses the varying health and wellness needs of residents as they grow older.[1] The foundation of the CCC model is based on enabling residents to move within the community if their health care needs change and they require supervision.[2] The services provided by the CCC and purchased by the resident are governed by contract, or resident service agreement. Entry fees can range from $20,000 to more than $1 million, depending on the geographic location of the CCC, features of the living space, size of the living unit, additional services and amenities selected, whether one or two individuals receive services, and the type of service contract.[3]

There are 1,926 CCCs in the United States.[4] The average number of units in a CCC is 280.[5] Over eighty-percent of CCCs are not-for-profit sponsored, and roughly half of CCCs are faith-based.[6] CCCs feature a combination of living arrangements and nursing beds. There are 71 CCCs in Florida, and a total of 24,775 CCC residents.[7]

The typical accommodations and services include:

- Independent living units – a cottage, townhouse, cluster home, or apartment; the resident is generally healthy and requires little, or no, assistance with activities of daily living.
- Assisted living – a studio or one-bedroom apartment designed for frail individuals who can still maintain a level of independence but need some assistance with activities of daily living.
- Nursing – nursing services are offered on-site or nearby the CCC to provide constant care for recovery from a short-term injury or illness, treatment of a chronic condition, or higher levels of services.
- Memory-care support – offers dedicated cognitive support care with the goal of maximizing function, maintaining dignity, preserving sense of self, and optimizing independence.[8]

In Florida, oversight of CCCs is primarily shared between the Agency for Health Care Administration (AHCA) and the Office of Insurance Regulation (OIR), pursuant to ch. 651, F.S. ("the Act"). AHCA regulates aspects of CCCs related to the provision of health care such as assisted living, skilled nursing care, quality of care, and concerns with medical facilities.

The Act gives OIR primary responsibility of licensing CCCs, examining them for compliance with applicable laws and rules, and monitoring their financial condition for the protection of the public from

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[1] Continuing Care Retirement Community Task Force, Leading Age, American Seniors Housing Association, *Today's Continuing Care Retirement Community*, at page 2 (Jane E. Zarem ed. 2010).
[2] Id.
[3] Id., at page 9.
[4] Ziegler, *Senior Living Overview* (October 8, 2014) , at page 26, available at www.flicra.com/pdfs/FLiCRA%20Presentation%2010-8-14.pdf (last visited March 7, 2015).
[5] Id.
[6] Id.
[7] Presentation to the Governor's Continuing Care Advisory Council, September 29, 2014, available at http://www.floir.com/siteDocuments/CouncilPresentation.pdf. (last visited March 7, 2015).
[8] See supra, FN 1, at 4.

insolvency risks and unethical practices.[9] In addition, the Department of Financial Services (DFS) shares some solvency regulatory authority with OIR pursuant to s. 651.114(6), F.S., which provides that OIR and DFS may intervene in CCCs with "all the necessary powers and duties" they possess under the Insurers Rehabilitation and Liquidation Act[10] in regard to delinquency proceedings of insurance companies. As with insurers and other risk-bearing entities, OIR and DFS have coordinated authority to determine the basis for and to initiate delinquency proceedings against CCCs and place them under administrative supervision, rehabilitation, or liquidation.[11]

CCC Certificate of Authority

In order to offer continuing care[12] services in Florida, a provider must be licensed by obtaining a certificate of authority (COA) from OIR.[13] To obtain a COA, each applicant must first apply for and obtain a provisional COA.[14] The OIR is responsible for receiving, reviewing and approving or denying applications for provisional COAs within a specified time period.[15] Upon receipt of a provisional COA, a provider may collect entrance fees and reservation deposits from prospective residents of a proposed continuing care facility.[16]

To obtain a COA, each provider holding a provisional COA must submit additional documentation regarding financing of the proposed facility, receipt of aggregate entrance fees from prospective residents, completed financial audit statements, and other specific information.[17] The OIR is required to issue a COA once it determines that a provider meets all requirements of law, has submitted all necessary information required by statute, has met all escrow requirements, and has paid appropriate fees set out in s. 651.015(2), F.S.[18] Further, a COA will only be issued once a provider submits proof to OIR that a minimum of fifty-percent of the units available, for which entrance fees are being charged, are reserved.[19] Upon receiving a COA, a provider may request the release of entrance fees held in escrow.[20]

Pursuant to s. 651.028, F.S., if a provider is accredited by a process found by the OIR to be acceptable and substantially equivalent to the provisions of ch. 651, F.S., the OIR may, pursuant to rule of the Financial Services Commission, waive any requirements of ch. 651, F.S., with respect to the provider if the OIR finds that such waivers are not inconsistent with the security protections of ch. 651, F.S.

CCC Contracts

Continuing care services are governed by a contract between the facility and the resident of a CCC. In Florida, continuing care contracts are considered a kind of specialty insurance product, and are reviewed and approved for the market by the OIR.[21] Each contract for continuing care services must:

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[9] OFFICE OF INSURANCE REGULATION, *Specialty Product Administration*, http://www.floir.com/Sections/Specialty/is_sp_index.aspx (last visited February 6, 2015).
[10] Part I, ch. 631, F.S. is the Insurers Rehabilitation and Liquidation Act.
[11] ss. 631.031 and 651.114(6), F.S. *Administrative supervision* allows DFS to supervise the management of a consenting troubled insurance company in an attempt to cure the company's troubles rather than close it down. In *rehabilitation*, DFS is authorized as receiver to conduct all business of the insurer in an attempt to place the insurance company back in sound financial condition. In *liquidation*, DFS is authorized as receiver to gather the insurance company's assets, convert them to cash, distribute them to various claimants, and shut down the company.
[12] s. 651.011(2), F.S., defines continuing care as "furnishing shelter or nursing care or personal services to a resident who resides in a facility, whether such nursing care or personal services are provided in the facility or in another setting designated in the contract for continuing care, by an individual not related by consanguinity or affinity to the resident, upon payment of an entrance fee."
[13] s. 651.011(9), F.S.
[14] s. 651.022, F.S.; *see also* s. 651.022(2) and (3), F.S., for detailed description of information, reports and studies required to be submitted with an application for a provisional COA.
[15] s. 651.022(5) and (6), F.S.
[16] s. 651.022(7), F.S., which requires the fee to be deposited into escrow or placed in deposit with DFS, until a COA is issued by OIR.
[17] s. 651.023(1), F.S.
[18] s. 651.023(4), F.S.
[19] s. 651.023(4)(a), F.S.
[20] s. 651.023(6), F.S.
[21] s. 651.055(1), F.S.

- Provide for continuing care of one resident, or two residents living in a double occupancy room, under regulations established by the provider;
- List all properties transferred to the facility and their market value at the time of transfer;
- Specify all services to be provided to each resident;
- Describe terms and conditions for cancellation of the contract;
- Describe the health and financial conditions required for a person to be accepted as a resident and to continue as a resident;
- Describe the circumstances under which the resident will be permitted to remain in the facility in the event of financial difficulties of the resident; and
- Provide the fees that will be charged if the resident marries while at the designated facility, the terms concerning the entry of a spouse to the facility, and the consequences if the spouse does not meet the requirements for entry.[22]

The contract is also required to provide that it may be canceled by giving at least 30 days' written notice by the provider, the resident, or the person who provided the transfer of property or funds for the care of such resident.[23]

In the event of receivership or liquidation proceedings against a provider, all continuing care contracts executed by a provider must be deemed preferred claims against all assets owned by the provider.[24]

Entrance Fee Refunds

A resident of a CCC must pay an entrance fee upon entering into a contract with a facility, which does not secure the resident an ownership interest in the CCC unit, but allows the resident to occupy the unit and to access the CCC's services. According to CCC providers, entrance fees can range from $100,000 to $1 million,[25] and vary according to local housing markets, geographic location, and the level of service and amenities of the CCC.[26] In addition to the entrance fee, CCCs charge *monthly fees* which typically cover housing costs, amenities, meals, and health care. The pricing of a CCC's entrance fees and monthly fees is typically accomplished through actuarial analysis.[27]

Traditionally, entrance fees were non-refundable, amortizing over 4 years. However, due to growing demand from residents and their estates, several CCCs allow for partial or full refunds with declining-scale features.[28] Current law requires that the contract include the terms for which a resident is due a refund of any portion of the entrance fee.[29] If the contract provides that the resident does not receive a transferable membership or ownership right in the facility, and the resident has occupied his or her unit, the refund must be calculated on a pro-rata basis with the facility retaining up to two-percent per month of occupancy by the resident and up to a five-percent processing fee, the balance of which must be paid within 120 days after the resident gives notice of intent to cancel. This is known as a two-percent declining-scale refund and provides a resident with up to 47.5 months of residency before the refund is reduced to zero. Similarly, a contract may provide a one-percent declining-scale refund and is allowed to have the timing of any resident refund dependent on the resale of any unit but is not allowed to make the timing dependent on the resale of a particular unit or type of units.[30]

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[22] Id.
[23] s. 651.055(1)(g), F.S.
[24] s. 651.071, F.S.
[25] AMERICAN ASSOCIATION FOR RETIRED PERSONS, *About Continuing Care Communities*, http://www.aarp.org/relationships/caregiving-resource-center/info-09-2010/ho_continuing_care_retirement_communities.html (last viewed Mar. 12, 2015).
[26] U.S. GOV'T ACCOUNTABILITY OFFICE, *Older Americans: Continuing Care Retirement Communities Can Provide Benefits, but Not Without Some Risk* (GAO-10-611) (June 2010), *available at* http://www.gao.gov/new.items/d10611.pdf.
[27] Kelly Greene, *Continuing-Care Retirement Communities: Weighing the Risks*, THE WALL STREET JOURNAL (Aug. 7, 2010), http://www.wsj.com/articles/SB10001424052748704499604575407290112356422 (citing the National Investment Center for the Seniors Housing and Care Industry).
[28] See footnote 1, at p. 8.
[29] s. 651.055(1)(g), F.S.
[30] Id.

Resident Rights and Residents' Council

Section 651.081, F.S., provides for the creation of a single statewide residents' council. Section 651.085, F.S., requires the governing body of a provider, or the designated representative of the provider, to hold quarterly meetings with the residents of the CCC for the purpose of free discussion of issues and concerns of residents, as well as the facility's financial condition and potential fee increases. The residents' council is tasked with different duties associated with the quarterly meetings between residents and the governing body of the provider, as provided in s. 651.085, F.S.

References to the residents' council in s. 651.085, F.S., may be confused or misinterpreted to allow for multiple councils instead of the singular council as created by s. 651.081, F.S. Currently, it is optional to both establish a residents' council and to do so through the election process outlined in statute.

Examinations and Inspections

The OIR is authorized to examine at any time, and at least once every three years, the business of any applicant for a certificate of authority and any provider engaged in the execution of care contracts in the same manner as provided for the examination of insurance companies[31] pursuant to s. 624.316, F.S.[32] The OIR is required to notify the provider in writing of all deficiencies in its compliance with the provisions of ch. 651, F.S., and must set a reasonable length of time for compliance by the provider.[33] At the time of routine examination, OIR must determine if all disclosures required under ch. 651, F.S., have been made to the president or chair of the residents' council. According to the OIR, the OIR gives a copy of its examination findings to a member of the CCC's management (typically, the executive director). However, these findings are not always shared with the CCC's board of directors, so that the board is unaware of regulatory issues.[34]

Effect of Proposed Changes

Refunds of Entrance Fees for Cancelled CCC Contracts

The bill amends s. 651.055, F.S., to modify the timing of refunds paid by CCCs to their residents for certain contracts. A CCC contract, paying a two-percent declining-scale refund, must provide for payment to a resident within 90 days after the contract is terminated and the unit is vacated, instead of 120 days after notice of intent to cancel as required by current law. Similarly, the bill requires a CCC contract, paying a one-percent declining-scale refund, to provide for payment to a resident from:

- The proceeds of the next entrance fees received by the provider for units for which there are no prior claims by any resident;
- The proceeds of the next entrance fee received by the provider for a like or similar unit as specified in the residency or reservation contract signed by the resident for which there are no prior claims by any resident until paid in full; or
- The proceeds of the next entrance fee received by the provider for the unit that is vacated if the contract is approved by the OIR before October 1, 2015. Providers may not use this refund option after October 1, 2016, and must submit a new or amended contract with an alternative refund provision to the office for approval by August 2, 2016.

[31] s. 624.316, F.S., "...The office shall examine the affairs, transactions, accounts, records, and assets of each authorized insurer and of the attorney in fact of a reciprocal insurer as to its transactions affecting the insurer as often as it deems advisable, except as provided in this section. The examination may include examination of the affairs, transactions, accounts, and records relating directly or indirectly to the insurer and of the assets of the insurer's managing general agents and controlling or controlled person, as defined in s. 625.012. The examination shall be pursuant to a written order of the office. Such order shall expire upon receipt by the office of the written report of the examination."
[32] s. 651.105(1), F.S.
[33] s. 651.105(4), F.S.
[34] Office of Insurance Regulation, Agency Analysis of House Bill 749, p. 2 (Mar. 2, 2015).

For contracts entered into on or after January 1, 2016, that provide for a refund from the proceeds of the next entrance fee received by the provider for a like or similar unit, the bill requires any refund that is due upon the resident's death or relocation of the resident to another level of care that results in the termination of the contract to be paid the earlier of:

- Thirty days after receipt by the provider of the next entrance fee received for a like or similar unit for which there is no prior claim by any resident until paid in full; or
- No later than a specified maximum number of months or years, determined by the provider and specified in the contract, after the contract is terminated and the unit is vacated.

Further, the bill requires any refund that is due to be paid to a resident who vacates the unit and voluntarily terminates a contract after the seven-day rescission period, to be paid within thirty days of receipt by the provider of the next entrance fee for a like or similar unit for which there are no prior claims. A contract is voluntarily terminated when a resident provides written notice of intent to leave and moves out of the CCC after the seven-day rescission period. The bill defines the term "like or similar units" to mean a residential dwelling categorized into a group of units which have similar characteristics such as comparable square footage, number of bedrooms, location, age of construction, or a combination of one or more of these features. A CCC that offers such contracts must have a minimum of the lesser of five-percent of the total number of independent living units or ten units in each category unless the category consists of single family home, in which case there is no limit.

Notice of Examination Report and Corrective Action Report; Disclosure of Audit

The bill amends s. 651.105, F.S., to require the OIR to notify the executive office of the governing body of the CCC provider about all deficiencies found as part of an examination, and requires a CCC to provide a copy of any final examination report and corrective action plan to the executive officer of the governing body of the provider within 60 days after issuance of the report.

Residents' Councils and Quarterly Meetings

The bill amends s. 651.081, F.S., to require each CCC to establish a residents' council to provide a forum for residents' input on subjects that impact the general residential quality of life, and requires that the council must be established through an election by the residents. The bill provides mandatory attributes of a residents' council. Residents' council activities must be independent of the CCRC provider. Additionally, the CCRC provider is not responsible for the costs of the residents' council or ensuring the council's compliance with statute. The residents' council must adopt its own bylaws and governance documents, subject to the residents' vote and approval. The governing documents may include term limits for council members.

The council must also provide for open meetings when appropriate. The council's governing documents must define the process by which residents may submit such inquiries and issues and the timeframe for the council to respond. The council must also serve as a liaison to provide input on such matters to the appropriate representative of the CCRC.

If a licensed CCRC files for federal chapter 11 bankruptcy, the CCC must include in its required filing with the United States Trustee the 20 largest unsecured creditors, the name and contact information of a designated resident of the residents' council, and, if appropriate, a statement explaining why the designated resident was chosen by the residents' council to serve as a representative of the residents' interest on the creditors' committee.

The bill amends s. 651.085, F.S., to authorize the board of directors or governing board of a licensed provider to allow a facility resident to be a voting member of the board or governing body of the facility. The bill also amends s. 651.091, F.S., to require all CCCs to provide a copy of the most recent third-

party financial audit to the president or chair of the residents' council within 30 days of filing the annual report to OIR.

Priority of Claims in Receivership or Liquidation Proceedings

The bill amends s. 651.071, F.S., to make CCC contracts and continuing care at-home contracts preferred claims against a provider in receivership and liquidation proceedings, subordinate to any secured claims.[35]

Waiver of CCC Requirements

The bill amends s. 651.028, F.S., to require that a CCC must be accredited without stipulations or conditions for the OIR to waive any statutory requirements under ch. 651, F.S.[36]

B. SECTION DIRECTORY:

Section 1: Amends s. 651.055, F.S., relating to continuing care contracts; right to rescind.
Section 2: Amends s. 651.028, F.S., relating to accredited facilities.
Section 3: Amends s. 651.071, F.S., relating to contracts as preferred claims on liquidation or receivership.
Section 4: Amends s. 651.105, F.S., relating to examination and inspections.
Section 5: Amends s. 651.081, F.S., relating to resident's council.
Section 6: Amends s. 651.085, F.S., relating to quarterly meetings between residents and the governing body of the provider; resident representation before the governing body of the provider.
Section 7: Amends s. 651.091, F.S., relating to availability, distribution, and posting of reports and records; requirement of full disclosure.
Section 8: Provides an effective date of October 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.

[35] "Preferred claims" are not interests in any particular property; they are similar to priority claims in bankruptcy, which are satisfied from all assets after secured claims (including valid statutory liens) have been paid in full. *See* Nathalie D. Martin, *The Insolvent Life Care Provider: Who Leads the Dance Between the Federal Bankruptcy Code and State Continuing-Care Statutes?* 61 Ohio St. L.J. 267, 310-311 (2000).
[36] Typically, the only requirement that OIR waives is the requirement to submit quarterly reports. OIR Analysis, p. 2.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill may have a positive fiscal impact on the private sector by providing clearer processes to refund entrance fees to residents and improving disclosures between CCCs and their residents.

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 18, 2015, the Insurance & Banking Subcommittee considered and adopted two amendments and reported the bill favorably as a committee substitute. The first amendment removed reference to bankruptcy, so that the treatment of continuing care contracts as preferred claims applies only in receivership and liquidation proceedings. The second amendment clarified that a residents' council shall adopt its own bylaws and governance documents, subject to the residents' vote and approval.

The analysis is drafted to the committee substitute as passed by the Insurance & Banking Subcommittee.

A bill to be entitled

An act relating to continuing care communities; amending s. 651.055, F.S.; revising requirements for continuing care contracts; amending s. 651.028, F.S.; revising authority of the Office of Insurance Regulation to waive requirements for accredited facilities; amending s. 651.071, F.S.; providing that continuing care and continuing care at-home contracts are preferred claims subject to a secured claim in the event of liquidation or receivership proceedings against a provider; revising subordination of claims; amending s. 651.105, F.S.; revising notice requirements; revising duties of the office; requiring an agent of a provider to provide a copy of an examination report and corrective action plan under certain conditions; amending s. 651.081, F.S.; requiring a residents' council to provide a forum for certain purposes; requiring a residents' council to adopt its own bylaws and governance documents under certain conditions; amending s. 651.085, F.S.; revising provisions relating to quarterly meetings between residents and the governing body of the provider; revising powers of the residents' council; amending s. 651.091, F.S.; revising continuing care facility reporting requirements; providing an effective date.

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

Section 1. Paragraphs (g) through (k) of subsection (1) of section 651.055, Florida Statutes, are amended to read:

651.055 Continuing care contracts; right to rescind.—

(1) Each continuing care contract and each addendum to such contract shall be submitted to and approved by the office before its use in this state. Thereafter, no other form of contract shall be used by the provider until it has been submitted to and approved by the office. Each contract must:

(g) Provide that the contract may be canceled by giving at least 30 days' written notice of cancellation by the provider, the resident, or the person who provided the transfer of property or funds for the care of such resident. However, if a contract is canceled because there has been a good faith determination that a resident is a danger to himself or herself or others, only such notice as is reasonable under the circumstances is required.

(h) ~~1.~~ Describe ~~The contract must also provide~~ in clear and understandable language, in print no smaller than the largest type used in the body of the contract, the terms governing the refund of any portion of the entrance fee.

1. ~~2.~~ For a resident whose contract with the facility provides that the resident does not receive a transferable membership or ownership right in the facility, and who has

occupied his or her unit, the refund shall be calculated on a pro rata basis with the facility retaining up to 2 percent per month of occupancy by the resident and up to a 5 percent processing fee. Such refund must be paid within 120 days after giving the notice of intention to cancel. For contracts entered into on or after January 1, 2016, refunds must be made within 90 days after the contract is terminated and the unit is vacated. A resident who enters into a contract before January 1, 2016, may voluntarily sign a contract addendum approved by the office that provides for such revised refund requirement.

2.~~3.~~ In addition to a processing fee not to exceed 5 percent, if the contract provides for the facility to retain no more than ~~up to~~ 1 percent per month of occupancy by the resident and the resident does not receive a transferable membership or ownership right in the facility, the contract shall~~, it may~~ provide that such refund will be paid from one of the following:

a. The proceeds of the next entrance fees received by the provider for units for which there are no prior claims by any resident until paid in full;

b. The proceeds of the next entrance fee received by the provider for a like or similar unit as specified in the residency or reservation contract signed by the resident for which there are no prior claims by any resident until paid in full; or

c. The proceeds of the next entrance fee received by the provider for the unit that is vacated if the contract is

approved by the office before October 1, 2015. Providers may not use this refund option after October 1, 2016, and must submit a new or amended contract with an alternative refund provision to the office for approval by August 2, 2016~~, if the provider has discontinued marketing continuing care contracts, within 200 days after the date of notice~~.

3. For contracts entered into on or after January 1, 2016, that provide for a refund in accordance with sub-subparagraph 2.b., the following provisions apply:

a. Any refund that is due upon the resident's death or relocation of the resident to another level of care that results in the termination of the contract must be paid the earlier of:

(I) Thirty days after receipt by the provider of the next entrance fee received for a like or similar unit for which there is no prior claim by any resident until paid in full; or

(II) No later than a specified maximum number of months or years, determined by the provider and specified in the contract, after the contract is terminated and the unit is vacated.

b. Any refund that is due to a resident who vacates the unit and voluntarily terminates a contract after the 7-day rescission period required in subsection (2) must be paid within 30 days after receipt by the provider of the next entrance fee for a like or similar unit for which there are no prior claims by any resident until paid in full and is not subject to the provisions in sub-subparagraph a. A contract is voluntarily terminated when a resident provides written notice of intent to

leave and moves out of the continuing care facility after the 7-day rescission period.

4. For purposes of this paragraph, the term "like or similar unit" means a residential dwelling categorized into a group of units which have similar characteristics such as comparable square footage, number of bedrooms, location, age of construction, or a combination of one or more of these features as specified in the residency or reservation contract. Each category must consist of at least 5 percent of the total number of residential units designated for independent living or 10 residential units designated for independent living, whichever is less. However, a group of units consisting of single family homes may contain fewer than 10 units.

5. If the provider has discontinued marketing continuing care contracts, any refund due a resident must be paid within 200 days after the contract is terminated and the unit is vacated.

6.~~4.~~ Unless subsection (5) applies, for any prospective resident, regardless of whether or not such a resident receives a transferable membership or ownership right in the facility, who cancels the contract before occupancy of the unit, the entire amount paid toward the entrance fee shall be refunded, less a processing fee of up to 5 percent of the entire entrance fee; however, the processing fee may not exceed the amount paid by the prospective resident. Such refund must be paid within 60 days after the resident gives ~~giving~~ notice of intention to

cancel. For a resident who has occupied his or her unit and who has received a transferable membership or ownership right in the facility, the foregoing refund provisions do not apply but are deemed satisfied by the acquisition or receipt of a transferable membership or an ownership right in the facility. The provider may not charge any fee for the transfer of membership or sale of an ownership right.

(i) ~~(h)~~ State the terms under which a contract is canceled by the death of the resident. These terms may contain a provision that, upon the death of a resident, the entrance fee of such resident is considered earned and becomes the property of the provider. If the unit is shared, the conditions with respect to the effect of the death or removal of one of the residents must be included in the contract.

(j) ~~(i)~~ Describe the policies that may lead to changes in monthly recurring and nonrecurring charges or fees for goods and services received. The contract must provide for advance notice to the resident, of at least 60 days, before any change in fees or charges or the scope of care or services is effective, except for changes required by state or federal assistance programs.

(k) ~~(j)~~ Provide that charges for care paid in one lump sum may not be increased or changed during the duration of the agreed upon care, except for changes required by state or federal assistance programs.

(l) ~~(k)~~ Specify whether the facility is, or is affiliated with, a religious, nonprofit, or proprietary organization or

management entity; the extent to which the affiliate organization will be responsible for the financial and contractual obligations of the provider; and the provisions of the federal Internal Revenue Code, if any, under which the provider or affiliate is exempt from the payment of federal income tax.

Section 2. Section 651.028, Florida Statutes, is amended to read:

651.028 Accredited facilities.—If a provider is accredited <u>without stipulations or conditions</u> by a process found by the office to be acceptable and substantially equivalent to the provisions of this chapter, the office may, pursuant to rule of the commission, waive any requirements of this chapter with respect to the provider if the office finds that such waivers are not inconsistent with the security protections intended by this chapter.

Section 3. Subsection (1) of section 651.071, Florida Statutes, is amended to read:

651.071 Contracts as preferred claims on liquidation or receivership.—

(1) In the event of receivership or liquidation proceedings against a provider, all continuing care and continuing care at-home contracts executed by a provider shall be deemed preferred claims against all assets owned by the provider; however, such claims are subordinate to ~~those priority claims set forth in s. 631.271 and~~ any secured claim.

Section 4. Subsections (4) and (5) of section 651.105, Florida Statutes, are amended, and subsection (6) is added to that section, to read:

651.105 Examination and inspections.—

(4) The office shall notify the provider and the executive officer of the governing body of the provider in writing of all deficiencies in its compliance with the provisions of this chapter and the rules adopted pursuant to this chapter and shall set a reasonable length of time for compliance by the provider. In addition, the office shall require corrective action or request a corrective action plan from the provider which plan demonstrates a good faith attempt to remedy the deficiencies by a specified date. If the provider fails to comply within the established length of time, the office may initiate action against the provider in accordance with the provisions of this chapter.

(5) At the time of the routine examination, the office shall determine if all disclosures required under this chapter have been made to the president or chair of the residents' council and the executive officer of the governing body of the provider.

(6) A representative of the provider must give a copy of the final examination report and corrective action plan, if one is required by the office, to the executive officer of the governing body of the provider within 60 days after issuance of the report.

Section 5. Section 651.081, Florida Statutes, is amended to read:

651.081 Residents' council.—

(1) Residents living in a facility holding a valid certificate of authority under this chapter have the right of self-organization, the right to be represented by an individual of their own choosing, and the right to engage in concerted activities for the purpose of keeping informed on the operation of the facility that is caring for them or for the purpose of other mutual aid or protection.

(2)(a) Each facility shall establish a residents' council created for the purpose of representing residents on matters set forth in s. 651.085. The residents' council shall ~~may~~ be established through an election in which the residents, as defined in s. 651.011, vote by ballot, physically or by proxy. If the election is to be held during a meeting, a notice of the organizational meeting must be provided to all residents of the community at least 10 business days before the meeting. Notice may be given through internal mailboxes, communitywide newsletters, bulletin boards, in-house television stations, and other similar means of communication. An election creating a residents' council is valid if at least 40 percent of the total resident population participates in the election and a majority of the participants vote affirmatively for the council. The initial residents' council created under this section is valid for at least 12 months. A residents' organization formalized by

bylaws and elected officials must be recognized as the residents' council under this section and s. 651.085. Within 30 days after the election of a newly elected president or chair of the residents' council, the provider shall give the president or chair a copy of this chapter and rules adopted thereunder, or direct him or her to the appropriate public website to obtain this information. Only one residents' council may represent residents before the governing body of the provider as described in s. 651.085(2).

(b) In addition to those matters provided in s. 651.085, a residents' council shall provide a forum in which a resident may submit issues or make inquiries related to, but not limited to, subjects that impact the general residential quality of life and cultural environment. The residents' council shall serve as a formal liaison to provide input related to such matters to the appropriate representative of the provider.

(c) The activities of a residents' council are independent of the provider. The provider is not responsible for ensuring, or for the associated costs of, compliance of the residents' council with the provisions of this section with respect to the operation of a resident's council.

(d) A residents' council shall adopt its own bylaws and governance documents subject to the vote and approval of the residents. The residents' council shall provide for open meetings when appropriate. The governing documents shall define the manner in which residents may submit an issue to the council

and define a reasonable timeframe in which the residents' council shall respond to a resident submission or inquiry. A residents' council may include term limits in its governing documents to ensure consistent integration of new leaders. If a licensed facility files for bankruptcy under chapter 11 of the United States Bankruptcy Code, 11 U.S.C. chapter 11, the facility, in its required filing of the 20 largest unsecured creditors with the United States Trustee, shall include the name and contact information of a designated resident selected by the residents' council, and a statement explaining that the designated resident was chosen by the residents' council to serve as a representative of the residents' interest on the creditors' committee, if appropriate.

Section 6. Section 651.085, Florida Statutes, is amended to read:

651.085 Quarterly meetings between residents and the governing body of the provider; resident representation before the governing body of the provider.—

(1) The governing body of a provider, or the designated representative of the provider, shall hold quarterly meetings with the residents of the continuing care facility for the purpose of free discussion of subjects including, but not limited to, income, expenditures, and financial trends and problems as they apply to the facility, as well as a discussion on proposed changes in policies, programs, and services. At quarterly meetings where monthly maintenance fee increases are

discussed, a summary of the reasons for raising the fee as specified in subsection (4) must be provided in writing to the president or chair of the residents' council. Upon request of the residents' council, a member of the governing body of the provider, such as a board member, general partner, principal owner, or designated representative shall attend such meetings. Residents are entitled to at least 7 days' advance notice of each quarterly meeting. An agenda and any materials that will be distributed by the governing body or representative of the provider shall be posted in a conspicuous place at the facility and shall be available upon request to residents of the facility. The office shall request verification from a facility that quarterly meetings are held and open to all residents ~~if it receives a complaint from the residents' council that a facility is not in compliance with this subsection~~. In addition, a facility shall report to the office in the annual report required under s. 651.026 the dates on which quarterly meetings were held during the reporting period.

(2) A residents' council formed pursuant to s. 651.081, members of which are elected by the residents, shall ~~may~~ designate a resident to represent them before the governing body of the provider o~~r organize a meeting or ballot election of the residents to determine whether to elect a resident to represent them before the governing body of the provider. If a residents' council does not exist, any resident may organize a meeting or ballot election of the residents of the facility to determine~~

~~whether to elect a resident to represent them before the governing body and, if applicable, elect the representative. The residents' council, or the resident that organizes a meeting or ballot election to elect a representative, shall give all residents notice at least 10 business days before the meeting or election. Notice may be given through internal mailboxes, communitywide newsletters, bulletin boards, in-house television stations, and other similar means of communication. An election of the representative is valid if at least 40 percent of the total resident population participates in the election and a majority of the participants vote affirmatively for the representative.~~ The initial designated representative elected under this section shall be elected to serve at least 12 months.

(3) The designated representative shall be notified at least 14 days in advance of any meeting of the full governing body at which proposed changes in resident fees or services will be discussed. The representative shall be invited to attend and participate in that portion of the meeting designated for the discussion of such changes.

(4) At a quarterly meeting prior to the implementation of any increase in the monthly maintenance fee, the designated representative of the provider must provide the reasons, by department cost centers, for any increase in the fee that exceeds the most recently published Consumer Price Index for All Urban Consumers, all items, Class A Areas of the Southern Region. Nothing in this subsection shall be construed as placing

a cap or limitation on the amount of any increase in the monthly maintenance fee, establishing a presumption of the appropriateness of the Consumer Price Index as the basis for any increase in the monthly maintenance fee, or limiting or restricting the right of a provider to establish or set monthly maintenance fee increases.

(5) The board of directors or governing board of a licensed provider may at its sole discretion allow a resident of the facility to be a voting member of the board or governing body of the facility. The board of directors or governing board of a licensed provider may establish specific criteria for the nomination, selection, and term of a resident as a member of the board or governing body. If the board or governing body of a licensed provider operates more than one licensed facility, regardless of whether the facility is in-state or out-of-state, the board or governing body may select at its sole discretion one resident from among its facilities to serve on the board of directors or governing body on a rotating basis.

Section 7. Paragraph (d) of subsection (2) of section 651.091, Florida Statutes, is amended to read:

651.091 Availability, distribution, and posting of reports and records; requirement of full disclosure.—

(2) Every continuing care facility shall:

(d) Distribute a copy of the full annual statement and a copy of the most recent third party financial audit filed with the annual report to the president or chair of the residents'

council within 30 days after filing the annual report with the office, and designate a staff person to provide explanation thereof.

Section 8. This act shall take effect October 1, 2015.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 951 Dietetics and Nutrition
SPONSOR(S): Health Quality Subcommittee; Magar
TIED BILLS: **IDEN./SIM. BILLS:** SB 1208

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	11 Y, 0 N, As CS	Castagna	O'Callaghan
2) Health & Human Services Committee		Castagna TC	Calamas CC

SUMMARY ANALYSIS

Dietician/nutritionists (DNs) are regulated under Part X of Ch. 468, F.S., the Dietetics and Nutrition Practice Act (Act), and by the Board of Medicine under the Department of Health's (Department) Division of Medical Quality Assurance.

The bill expands the scope of practice for licensed DNs by authorizing DNs to order therapeutic diets. The bill also states that the Act does not preclude a licensed dietician or nutritionist from independently ordering a therapeutic diet if otherwise authorized to order such a diet in Florida.

Additionally, the bill allows DNs to become licensed without an examination when applicants for such licensure are:

- Registered with the Commission on Dietetic Registration (Commission) and are in compliance with all of the qualifications in ch. 468.509, F.S., related to the practice of dietetics and nutrition; or
- Certified as nutrition specialists by the Certification Board for Nutrition Specialists, or are Diplomates of the American Clinical Board of Nutrition, and are in compliance with the qualifications under s. 468.509, F.S.

The bill provides title protection for certain qualified individuals. Specifically, the bill authorizes only individuals who are:

- Registered with the Commission as a DN to use the title "Registered Dietician/Nutritionist" and the designation "R.D.N.";
- Certified by the Certification Board for Nutrition Specialists to use the title "Certified Nutrition Specialist" and the designation "CNS"; and
- Certified by the American Clinical Board of Nutrition to use the title "Diplomate of the American Clinical Board of Nutrition" and the designation of "DACBN."

The bill has an insignificant negative fiscal impact on the Department and no fiscal impact on local government.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Dietetics and Nutrition Practice in Florida

Section 468.503(3), F.S., defines dietetics as the integration and application of the principles derived from the sciences of nutrition, biochemistry, food, physiology, and management and from the behavioral and social sciences to achieve and maintain a person's health throughout the person's life. It is an integral part of preventive, diagnostic, curative, and restorative health care of individuals, groups, or both.[1] Dietetics and nutrition practice includes:

- Assessing nutrition needs and status using appropriate data;
- Recommending appropriate dietary regimens, nutrition support, and nutrient intake;
- Improving health status through nutrition research, counseling, and education; and
- Developing, implementing, and managing nutrition care systems, which includes, but is not limited to, evaluating, modifying, and maintaining appropriate standards of high quality in food and nutrition care services.[2]

Dietetics and nutrition practitioners work in health care systems, home health care, foodservice, research and educational organizations, as well as in private practice. They provide medical nutrition therapy in settings such as hospitals and nursing facilities and use specific nutrition services to treat chronic conditions, illnesses, or injuries. Community-based dietetics practitioners provide health promotion, disease prevention, and wellness services.[3]

The Dietetics and Nutrition Practice Council

The Dietetics and Nutrition Practice Council (Council) is an advisory council under the supervision of the Board of Medicine (Board) within the Department of Health's Division of Medical Quality Assurance and was established to ensure that every dietitian, nutritionist, or nutrition counselor practicing in this state meets minimum requirements for safe practice. The Council is responsible for licensing, monitoring, disciplining and educating dietitians/nutritionists and nutrition counselors to assure competency and safety to practice in Florida.[4]

The Council is comprised of five members appointed by the Board, three are licensed dietitians, one is a nutrition counselor, and one is a consumer member who is 60 years of age or older. Members are appointed to 4-year staggered terms. To be eligible for appointment, each licensed member must have been a licensee under this part for at least 3 years prior to his or her appointment. No council member shall serve more than two successive terms.[5]

Licensure

There are variations of licensure and credentialing for this profession. Two licensed professionals exist under Florida law, a "licensed dietitian/nutritionist" (DN) and a "licensed nutrition counselor."

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[1] Section 468.503(3), F.S.
[2] Section 468.503(4), F.S.
[3] Academy of Nutrition and Dietetics, *About Us*, available at http://www.eatrightpro.org/resources/about-us (last visited March 12, 2015).
[4] Florida Dep't of Health, *Dietetics and Nutrition Council*, available at http://www.floridahealth.gov/licensing-and-regulation/dietetic-nutrition/council/index.html (last visited March 12, 2015).
[5] Section 468.506, F.S.

To be licensed as a DN one must pass the licensure examination, show the successful completion of 900 hours of pre-professional planned and continuous supervised practice in dietetics or nutrition,[6] completion of a 2-hour course relating to prevention of medical errors, pay the licensure fee, and have possession of the following:[7]

- At least a bachelor's degree with a major course of study in human nutrition, food and nutrition, dietetics, or food management or an equivalent major,[8] as determined by the Council, from an accredited Council approved program; or
- An academic degree with a major course of study in human nutrition, food and nutrition, dietetics, or food management from a foreign country, provided that degree has been validated by an accrediting agency approved by the U.S. Department of Education as equivalent to the baccalaureate or post baccalaureate degree conferred by a regionally accredited college or university in the United States.

The licensure examination requirement is waived for individuals who present the Board proof of a registered dietician credential from the Commission.[9]

A DN license must be renewed every 2 years upon receipt of a renewal application, fee, and proof of the successful completion of continuing education requirements as determined by the Board.[10]

Therapeutic Diets

Dietetic and nutrition specialists, such as Registered Dieticians (RDs) and Registered Dietician Nutritionists (RDNs), provide a wide range of services related to food and nutrition including ordering or developing plans for therapeutic diets. Therapeutic diets are a diet intervention ordered by a health care practitioner as part of the treatment for a disease or clinical condition creating an altered nutritional status, to eliminate, decrease, or increase certain substances in a person's diet such as, sodium or calcium.[11] Therapeutic diets may also involve changing the texture of foods or replacing food with tube feedings.[12]

Section 468.516(1)(a), F.S., prohibits DNs from implementing a dietary plan (also referred to as a therapeutic diet) for a patient who is under the active care of a physician licensed under ch. 458 or ch. 459 F.S., or a chiropractor licensed under ch. 460, F.S., without the oral or written dietary order of the referring physician or chiropractor. However, if the DN is unable to obtain authorization or a consultation from the active treating physician or chiropractor, the DN may provide nutrition services and implement the dietary plan.

A Federal Centers for Medicare and Medicaid Services Rule[13] change that was finalized in May of 2014 permits RDNs and RDs to order patient therapeutic diets independently in a hospital setting instead of under the direction and supervision of a health care practitioner. This change allows physicians and other practitioners more time to care for patients and allows RDNs and RDs to better provide timely,

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[6] At least 200 hours must be performed in a clinical nutrition setting, such as hospital and 200 hours must be performed in a community nutrition setting, such as a public health program. Rule 64B8-42.002, F.A.C.
[7] Section 468.509, F.S., and Rule 64B8-42.002, F.A.C.
[8] An equivalent major must be a course of study specially designed to prepare an individual to integrate and apply principles of nutrition. Any major must include at least 30 semester hours covering human nutrition, nutrition in health and disease, nutrition education and counseling, food science, nutrition in the community, and administration of food service or nutrition programs. Rule 64B8-42.002, F.A.C.
[9] Section 468.509(3), F.S.
[10] Section 468.514, F.S.
[11] Academy of Nutrition and Dietetics, Definition of Terms List, available at http://www.eatright.org/uploadedFiles/Members/1(1).pdf. (last visited March 12, 2015).
[12] California Department of Social Services, *Types of Therapeutic Diets,* available at http://webcache.googleusercontent.com/search?q=cache:sVskiJU_rjsJ:www.cdss.ca.gov/agedblinddisabled/res/VPTC2/9%2520Food%2520Nutrition%2520and%2520Preparation/Types_of_Therapeutic_Diets.pdf+&cd=3&hl=en&ct=clnk&gl=us (last visited March 17, 2015).
[13] 42 C.F.R. §482.28(b)(1) addresses criteria that hospitals must meet to be eligible to participate in Medicaid and Medicare, specifically hospitals' food and dietetic services.

cost-effective, and evidence-based nutrition services as the recognized nutrition experts on a hospital interdisciplinary team.[14]

Dietetics and Nutrition Credentialing Organizations

The Academy of Nutrition and Dietetics

The Academy of Nutrition and Dietetics (Academy) was founded in 1917 to help the government conserve food and improve the public's health and nutrition. The Academy has over 75,000 members from various food and nutrition professions.[15] The Academy's goal is to improve the nation's health and advance dietetics through research, education, and advocacy.

The Commission on Dietetic Registration (Commission) is an arm of the Academy that administers credentialing programs. The Commission has 11 members, including 9 with three-year terms elected by credentialed practitioners, one public representative appointed for a five-year term, and one newly credentialed Registered Dietician Nutritionist or Registered Dietician appointed for a one-year term.[16]

The Commission grants seven separate and distinct credentials including a Registered Dietitian Nutritionist (RDN) and Registered Dietitian (RD) credential.[17] This credential is granted for individuals who have:

- Completed the minimum of a Baccalaureate degree granted by a U.S. regionally accredited college or university, or foreign equivalent;
- Met current minimum academic requirements (Didactic Program in Dietetics) as approved by the Accreditation Council for Education in Nutrition and Dietetics (ACEND) of the Academy of Nutrition and Dietetics;
- Completed a supervised practice program accredited by the ACEND of the Academy of Nutrition and Dietetics;
- Successfully completed the Registration Examination for Dietitians;
- Remitted the annual registration fee; and
- Complied with the Professional Development Portfolio recertification requirements.[18]

Some states, including Florida, require licensure applicants to pass the Commission's licensure exam as part of state licensure requirements.

Certification Board for Nutrition Specialists

The Certification Board for Nutrition Specialists (CBNS) is a credentialing body for nutrition care professionals with advanced degrees and training in nutrition science. The CBNS supports scientific training and the participation of professional nutritionists in independent evaluations of scientific data.[19]

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[14] Academy of Nutrition and Dietetics, *FAQs - CMS Final Rule Related to Therapeutic Diet Orders*, available at http://www.eatrightpro.org/resource/advocacy/quality-health-care/consumer-protection-and-licensure/faqs-cms-final-rule-related-to-therapeutic-diet-orders (last visited March 12, 2015).

[15] *Supra* fn. 3.

[16] Commission on Dietetic Registration, *About DCR*, available at http://www.cdrnet.org/about(last visited March 17, 2015).

[17] As of 2013, the Commission has granted credentials to a total of 89,385 RDs. The other credentials issued by the Commission are: Nutrition and Dietetics Technician, Registered / Dietetic Technician, Registered, Board Certified Specialist in Renal Nutrition, Board Certified Specialist in Pediatric Nutrition, Board Certified Specialist in Sports Dietetics, Board Certified Specialist in Gerontological Nutrition, and Board Certified Specialist in Oncology Nutrition. Commission on Dietetic Registration, *About CDR*, available at http://www.cdrnet.org/about (last visited March 12, 2015).

[18] Commission on Dietetic Regsitration, Who Is a Registered Dietician or Registered Dietician Nutritionist, available at http://www.cdrnet.org/about/who-is-a-registered-dietitian-rd The credentialing program for an RDN and RD is accredited by the National Commission for Certifying Agencies.

[19] Certification Board for Nutrition Specialists, *About the BCNS*, available at http://cbns.org/about/ (last visited March 23, 2015).

The Certified Nutrition Specialist (CNS) credential, offered by the CBNS, is granted to individuals who have:

- Completed a master's or doctoral degree in the field of nutrition or a doctoral degree in a field of clinical health care from a U.S. accredited education program or its foreign equivalent. The academic requirement also includes specific coursework requirements in the fields of:
  - Nutrition,
  - Biochemistry,
  - Physiology, and
  - Clinical or life sciences;
- Completed 1,000 hours of documented supervised practice experience in nutrition; and
- Successfully completed the CBNS certifying examination.[20]

To maintain the CNS credential, the individual must be re-certified every five years with payment of the required fee and completion of 75 continuing nutrition education credits.[21]

American Clinical Board of Nutrition

The American Clinical Board of Nutrition (ACBN) is a credentialing body for nutrition specialists. The ACBN was founded in 1986 and is the first and only nutrition certifying agency to offer Diplomate status to health care providers beyond the doctoral level in the U.S. and internationally. The ACBN provides an examination that evaluates the competency of all types of qualified doctoral-level health care providers and ensures a standard level of knowledge in the field of clinical nutrition.[22]

The ACBN's Diplomate credential is offered to individuals who have submitted the required application and fee and who have:

- Earned a doctoral degree from an accredited education program holding status with the U.S. Department of Education;
- Completed a minimum of 300 hours of nutrition education from an accredited education program;
- Completed a minimum of two years practice experience;
- Submitted a published article or paper on some aspect of nutrition; and
- Successfully completed the two-part examination which includes a section on case histories[23] and 150 examination questions.[24]

The ACBN requires Diplomates to be re-certified annually with submission of a fee and proof of 12 hours at ACBN approved nutritional educational seminars or submission of the following:

- Proof of engagement in nutrition education at a college, university, foundation, or agency having status with the U.S. Department of Education, or an agency having a reciprocal agreement with the recognized agency;
- A paper on nutrition for publication with a minimum of ten references; or
- At least two case histories suitable for publication.[25]

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[20] Certification Board for Nutrition Specialists, *Eligibility Requirements for the CNS Credential,* available at http://cbns.org/?page_id=238&preview=true (last visited March 23, 2015).
[21] *Id.*
[22] American Clinical Board of Nutrition, *Welcome to the ACBN*, available at http://www.acbn.org/index.html (last visited March 23, 2015).
[23] A case history is a written narrative showing all aspects of a health care provider's care of an actual patient, from medical history documenting to follow-up and release from care. American Clinical Board of Nutrition, *Candidates Handbook*, available at http://www.acbn.org/handbook.html (last visited March 23, 2015).
[24] *Id.*
[25] *Id.*

Effect of Proposed Changes

CS/HB 951 amends part X of ch. 468, F.S., the Dietetics and Nutrition Practice Act (Act).

Currently DNs are only authorized to implement a therapeutic diet that is ordered by a patient's treating physician or chiropractor.[26] The bill expands the scope of practice for licensed DNs by authorizing DNs to order therapeutic diets. The bill also states that the Act does not preclude a licensed DN from independently ordering a therapeutic diet if otherwise authorized to order such a diet in Florida.

Additionally, the bill allows individuals to become licensed as a DN without an examination when applicants for such licensure are:

- Registered with the Commission on Dietetic Registration (Commission) and are in compliance with all of the qualifications in ch. 468, F.S., related to the practice of dietetics and nutrition; or
- Certified as nutrition specialists by the Certification Board for Nutrition Specialists, or are Diplomates of the American Clinical Board of Nutrition, and are in compliance with the qualifications under s. 468.509, F.S.[27]

The bill provides title protection for certain qualified individuals. Specifically, the bill authorizes only individuals who are:

- Registered with the Commission as a DN to use the title "Registered Dietician/Nutritionist" and the designation "R.D.N.";
- Certified by the Certification Board for Nutrition Specialists to use the title "Certified Nutrition Specialist" and the designation "CNS"; and
- Certified by the American Clinical Board of Nutrition to use the title "Diplomate of the American Clinical Board of Nutrition" and the designation of "DACBN."

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

B. SECTION DIRECTORY:

Section 1. Amends s. 468.503, F.S., relating to definitions.
Section 2. Amends s. 468.505, F.S., relating to exemptions; exceptions.
Section 3. Amends s. 468.509, F.S., relating to dietician/nutritionist; requirements for licensure.
Section 4. Amends s. 468.516, F.S., relating to practice requirements.
Section 5. 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:

   The bill may have an insignificant negative fiscal impact on the Department associated with enforcing the additional title protections provided in the bill and associated with amending any rules to conform to changes made by the bill.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

[26] Section 468.516(1)(a), F.S.
[27] The Commission, the CBNS, and the ACBN are all accredited by the National Commission for Certifying Agencies.

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:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 16, 2015, the Health Quality Subcommittee adopted a strike all amendment to the bill and reported the bill favorably as a committee substitute. The amendment:

- Defines the Commission on Dietetic Registration, which is the current credentialing body used by the DOH.
- Inserts the title "registered dietician/nutritionist" into the Dietetics and Nutrition Practice Act and authorizes other titles and title abbreviations that may be used by certified practitioners of dietetics and nutrition.
- Authorizes registered dieticians and registered dietician/nutritionists to order therapeutic diets.
- Authorizes licensure without examination for registered dieticians or registered dietician/ nutritionists.
- States that the Dietetics and Nutrition Practice Act does not preclude a licensed dietician/nutritionist from independently ordering a therapeutic diet if they are otherwise authorized to do so.

The analysis is drafted to the committee substitute.

A bill to be entitled

An act relating to dietetics and nutrition; amending s. 468.503, F.S.; defining the term "commission"; revising definitions; amending s. 468.505, F.S.; authorizing certain certified individuals to use specified titles and designations; amending s. 468.509, F.S.; requiring the Board of Medicine to waive the examination requirement for specified applicants; amending s. 468.516, F.S.; providing that a licensed dietitian or nutritionist treating a patient who is under the active care of a licensed physician or licensed chiropractor is not precluded from ordering a therapeutic diet; providing an effective date.

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

Section 1. Subsections (3) through (11) of section 468.503, Florida Statutes, are renumbered as subsections (4) through (12), respectively, present subsections (4) and (11) are amended, and a new subsection (3) is added to that section, to read:

468.503 Definitions.—As used in this part:

(3) "Commission" means the Commission on Dietetic Registration, the credentialing agency of the Academy of Nutrition and Dietetics.

(5) ~~(4)~~ "Dietetics and nutrition practice" shall include assessing nutrition needs and status using appropriate data; recommending appropriate dietary regimens, nutrition support, and nutrient intake; ordering therapeutic diets; improving health status through nutrition research, counseling, and education; and developing, implementing, and managing nutrition care systems, which includes, but is not limited to, evaluating, modifying, and maintaining appropriate standards of high quality in food and nutrition care services.

(12) ~~(11)~~ "Registered dietitian" or "registered dietitian/nutritionist" means an individual registered with the commission ~~on Dietetic Registration, the accrediting body of the American Dietetic Association~~.

Section 2. Subsection (4) of section 468.505, Florida Statutes, is amended to read:

468.505 Exemptions; exceptions.—

(4) Notwithstanding any other provision of this part, an individual registered by the commission ~~on Dietetic Registration of the American Dietetic Association~~ has the right to use the title "Registered Dietitian" or "Registered Dietitian/Nutritionist," and the designation "R.D." or "R.D.N." An individual certified by the Certification Board for Nutrition Specialists has the right to use the title "Certified Nutrition Specialist" and the designation "CNS" and an individual certified by the American Clinical Board of Nutrition has the right to use the title "Diplomate of the American Clinical Board

of Nutrition" and use the designation "DACBN."

Section 3. Subsection (3) of section 468.509, Florida Statutes, is amended to read:

468.509 Dietitian/nutritionist; requirements for licensure.—

(3) The board shall waive the examination requirement for an applicant who presents evidence satisfactory to the board that the applicant is:

(a) A registered dietitian or registered dietitian/nutritionist who is registered with the commission and complies with the qualifications under this section; or

(b) A certified nutrition specialist who is certified by the Certification Board for Nutrition Specialists or who is a Diplomate of the American Clinical Board of Nutrition and complies with the qualifications under this section.

Section 4. Subsection (3) is added to section 468.516, Florida Statutes, to read:

468.516 Practice requirements.—

(3) This section does not preclude a licensed dietitian/nutritionist from independently ordering a therapeutic diet if otherwise authorized to order such a diet in this state.

Section 5. This act shall take effect July 1, 2015.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1039 Nurse Registries
SPONSOR(S): Health Innovation Subcommittee; Stone
TIED BILLS: **IDEN./SIM. BILLS:** SB 904

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Innovation Subcommittee	12 Y, 0 N, As CS	Langston	Poche
2) Health & Human Services Committee		Langston	Calamas

SUMMARY ANALYSIS

In Florida, a nurse registry is a business, akin to an employment agency, that is licensed to secure temporary employment for nurses, home health aides, certified nursing assistants, homemakers, and companions in a patient's home or with health care facilities or other entities. Nurse registries are licensed under Part III of ch. 400, F.S., and are regulated by the Agency for Health Care Administration (AHCA).

A health care professional referred for contract by a nurse registry is compensated as an independent contractor and may provide services directly to patients or private duty or staffing services to licensed health care facilities or other entities. The independent contractor, and not any employee of the nurse registry, is the only person who may enter the home of the patient and provide care. Nurse registries' only employees are administrative staff.

Currently, each operational site of a nurse registry must be licensed unless all locations are within a single county; in that case, all those locations are listed on a license. If offices are located in multiple counties within a service area, then a separate license is required for each county in which an office is located.

CS/HB 1039 amends s. 400.462, F.S., to define the term "satellite office" as a secondary office of a nurse registry within the same heath service planning district is the operational site. Eleven health service planning districts are defined in s. 408.032(5), F.S., consisting of between one and sixteen counties. The bill permits a nurse registry to operate an unlimited number of satellite offices within a health service planning district if there is a nurse registry operational site also located in the health service planning district.

The bill also amends s. 400.506, F.S., to limit the activities that can take place at a satellite office. The satellite office may store supplies and records, register and process contractors, and conduct business by telephone. The operational site must administer the satellite office and maintain all original records.

Additionally, the bill expands the requirements for relocating an existing office or opening a new satellite office. A nurse registry must advise the AHCA in writing of its intent and submit evidence of its legal right to occupy the proposed site and evidence that the property is zoned for use as a nurse registry.

There is an insignificant negative fiscal impact to state government. There is no fiscal impact to local governments.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Nurse Registries

A nurse registry is a business that procures, offers, promises, or attempts to procure health care related contracts for registered nurses, licensed practical nurses, certified nursing assistants, home health aides, homemakers and companions to provide services to patients in their homes and temporary staff to health care facilities or other business entities.[1] Nurse registries are governed by part II of chapter 408, F.S.,[2] associated rules in Chapter 59A-35, F.A.C., and the nurse registry rules in Chapter 59A-18, F.A.C. A nurse registry must be licensed by the Agency for Health Care Administration (AHCA) to offer contracts in Florida.[3]

A nurse registry has several responsibilities established by statute and rule, including:

- Confirming and annually reconfirming the licensure or certification of independent contractors;[4]
- Establishing a system for recording and following-up on complaints involving independent contractors referred for contract;[5]
- Preparing and maintaining a written comprehensive emergency management plan;[6] and
- Complying with the background screening requirements in s. 400.512, F.S., which require a level II background check for all employees and contractors.[7]

The workers referred by the nurse registry are hired as independent contractors by the patient, health care facility, or other business entities.[8] Examples of the differences between a nurse registry and other types of health care service pools are:

- A nurse registry and a home health agency may provide services that are privately paid for by insurance or other means to patients in their home or place of residence and provide staff to health care facilities, schools, or other business entities; a health care service pool cannot.
- A nurse registry and a health care services pool do not qualify for Medicare reimbursements; a home health agency does.
- A nurse registry cannot have any employees except for the administrator, alternate administrator and office staff – all individuals who enter the home of patients to provide direct care must be independent contractors.[9]

In July 2014, there were 517 nurse registries, 114 of which were in Broward County, and 112 of which were in Palm Beach County.[10] By January 2015, that number had grown to 541 licensed nurse registries with 367 different ownerships consisting of corporations, limited liability companies, and one

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[1] S. 400.642(21), F.S.
[2] S. 400.506(2), F.S. A nurse registry is also governed by the provisions in s. 400.506, F.S.
[3] S. 400.506(1), F.S.
[4] Rule 59A-18.005(3) and (4), F.A.C.
[5] Rule 59A-18.017(4), F.A.C.
[6] Rule 59A-18.018(1), F.A.C.
[7] S. 400.506(9), F.S.
[8] Id.
[9] Agency for Health Care Administration, *Frequently Asked Questions Nurse Registries: What is a nurse registry?* http://ahca.myflorida.com/mchq/Health_Facility_Regulation/Home_Care/NR_FAQS/section1.shtml (last visited March 13, 2015).
[10] Anne Menard, Power Point Presentation: *AHCA Nurse Registry Regulatory Update*, July 22, 2014, *available at* http://ahca.myflorida.com/mchq/Health_Facility_Regulation/Home_Care/docs/2014_NR_Regulatory_Update.pptx (last visited on March 13, 2015).

sole proprietor (companies).[11] A total of 62 companies, or 17 percent, owned two or more licensed nurse registries.[12] Of those 62 companies, eight companies have multiple nurse registries within one of the eleven health service planning districts.[13] There are currently 548 licensed nurse registries in the state.[14]

Licensing

Nurse registries are licensed by AHCA. The initial license application requires a fee of $2,000.[15] The license can be renewed every two years with a fee of $2,000.[16] The renewal application must be submitted to AHCA no less than 60 days prior to expiration of the current license.[17]

All nurse registries must apply for the licensure in the geographic service area in which the main office is located.[18] The license permits the nurse registry to refer its independent contractors to provide services to patients or clients in their homes or to provide staffing in facilities located throughout the specified geographic service area.[19] Geographic service areas are defined in the rule as "AHCA area boundaries," which are the same as the "heath service planning districts" in s. 408.032(5), F.S., and most contain multiple counties.

Nurse registries may apply for a license in one or more of the counties within a specific geographic service area.[20] While only one license is needed to provide services within a geographic area, a separate license is required for each office in a different county, even within the same geographic service area. If all office locations are in the same county, only one license is required; in that case the additional locations are listed on the license for the main office.[21] However, additional offices located in counties other than the county in which the main office is located require a separate license.[22]

AHCA Area Boundaries ("Health Service Planning Districts")

Area/ District	Counties
1	Escambia, Walton, Santa Rosa and Okaloosa
2	Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla and Washington
3	Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee and Union
4	Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia
5	Pasco and Pinellas
6	Hardee, Highlands, Hillsborough, Manatee and Polk
7	Brevard, Orange, Osceola and Seminole
8	Charlotte, Collier, Desoto, Glades, Hendry, Lee and Sarasota
9	Indian River, Martin, Okeechobee, Palm Beach and St. Lucie
10	Broward
11	Dade and Monroe

[11] Agency for Health Care Administration, *2015 Agency Legislative Bill Analysis*, February 17, 2015 (on file with Health Innovation Subcommittee Staff).
[12] Id.
[13] Id.
[14] Agency for Health Care Administration, *Facility/Provider Search Results-Nurse Registries*, report generated March 15, 2015, available at http://www.floridahealthfinder.gov/FacilityLocator/ListFacilities.aspx.
[15] Rule 59A-18.004(3), F.A.C.
[16] S. 400.506(3), F.S.; Rule 59A-18.004(6), F.A.C.
[17] S. 408.806(2), F.S; Rule 59A-18.004(6), F.A.C.
[18] Rule 59A-18.004(4), F.A.C.
[19] S. 408.032(5), F.S.; Rule 59A-18.002(7), F.A.C.
[20] Rule 59A-18.004(4), F.A.C.
[21] S. 400.506(1), F.S.
[22] Id.

Nurse registries are surveyed by AHCA's field offices biennially.[23] In addition to the biennial inspection, nurse registries may also be inspected to determine compliance with the relevant statutes and rules.[24]

A nurse registry must provide 21 to 120 days advance notification of any change in the address of the main or principal office.[25]

Effect of Proposed Changes

Satellite Office

CS/HB 1039 amends s. 400.462, F.S., to add and define the term "satellite office" as a secondary office of a nurse registry within the same health service planning district, as defined in s. 408.032, F.S, as a licensed nurse registry operational site.

The bill creates s. 400.506(1)(b), F.S., which describes what activities can occur at a satellite office. A satellite office may:

- Store supplies and records;
- Register and process contractors; and
- Conduct business by telephone.

The bill prohibits a satellite office from keeping any original records. The operational site must administer all satellite offices and keep the original records.

Licensing

The bill amends s. 400.506(1), F.S., to allow a single license for more than one office within a health planning service district. This provision reduces the number of licenses a nurse registry needs. It would expand the coverage of the operational site license from all offices within a county to all operational sites and satellite offices located in a health service planning district, which usually consists of more than one county.[26]

Notification of Change of Address

The bill requires nurse registries to notify AHCA in writing of a proposed change of address for the operational site or the opening of a satellite office. This is consistent with what is presently required by rule. In addition, the bill requires that, prior to relocating an operational site or opening a satellite office, the nurse registry must submit:

- Evidence of its legal right to use the property; and
- A certificate of occupancy, certificate of use, or other evidence that the property is zoned for use by the nurse registry.

The bill provides an effective date of July 1, 2015

B. SECTION DIRECTORY:

Section 1: Amends s. 400.462, F.S., relating to definitions.
Section 2: Amends s. 400.506, F.S., relating to licensure of nurse registries; requirements; penalties.

[23] S. 408.811(1)(b), F.S.
[24] S. 400.484(1), F.S.
[25] Rule 59A-35.040(2)(b)5., F.A.C.
[26] Health Service Planning District 10, consisting of Broward County, is the only single county district.

Section 3: Reenacts s. 400.497, F.S., relating to rules establishing minimum standards; reenacts s. 400.506(3), F.S., relating to licensing of nurse registries; and s. 817.505(3)(h), F.S., relating to patient brokering prohibited; exceptions; penalties.

Section 4: Provides for an effective date of July 1, 2015.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   AHCA may realize an indeterminate loss of revenue from licensing fees since nurse registries can set up multiple satellite offices throughout the health service planning district without paying license fees for offices located outside of the county where its main office is located.

2. Expenditures:

   There is an insignificant negative fiscal impact on AHCA associated with rulemaking activities necessary to implement the provisions of the bill. These costs are nonrecurring and can be absorbed within current resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Nurse registries will see reduced license fees as only one license is required for each, typically multi-county, health service planning district. Nurse registries will be able to set up unlimited satellite offices per health service planning district at no additional licensing cost.

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:

AHCA has sufficient rulemaking authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 18, 2015, the Health Innovation Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The amendment made the following changes to the bill:

- Replaced the term "geographic service area" with "health service planning district;" health service planning district is currently defined in statute.
- Removed the deletion of the exemption from penalties for improper remunerations of certain persons for nurse registries that bill the Florida Medicaid Program.

The analysis is drafted to the committee substitute as passed by the Health Innovation Subcommittee.

A bill to be entitled

An act relating to nurse registries; amending s. 400.462, F.S.; defining a term; amending s. 400.506, F.S.; providing for the licensure of more than one nurse registry operational site within the same health service planning district; authorizing a licensed nurse registry to operate a satellite office; requiring a nurse registry operational site to keep all original records; requiring a nurse registry to provide notice and certain evidence before it relocates an operational site or opens a satellite office; reenacting s. 400.497, F.S., relating to rules establishing minimum standards with respect to home health agencies, s. 817.505(3)(h), F.S., relating to an exception from a prohibition on patient brokering, and s. 400.506(3), F.S., relating to a nurse registry application fee, to incorporate the amendment made by the act to s. 400.506, F.S., in references thereto; providing an effective date.

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

Section 1. Subsections (28) and (29) of section 400.462, Florida Statues, are renumbered as subsections (29) and (30), respectively, and a new subsection (28) is added to that section to read:

400.462 Definitions.—As used in this part, the term:

(28) "Satellite office" means a secondary office of a nurse registry established pursuant to s. 400.506(1) in the same health service planning district as a licensed nurse registry operational site.

Section 2. Subsection (1) of section 400.506, Florida Statutes, is amended to read:

400.506 Licensure of nurse registries; requirements; penalties.—

(1)(a) A nurse registry is exempt from the licensing requirements of a home health agency but must be licensed as a nurse registry. The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to ss. 400.506-400.518 and part II of chapter 408 and to entities licensed by or applying for such license from the Agency for Health Care Administration pursuant to ss. 400.506-400.518. A license issued by the agency is required for the operation of a nurse registry. Each operational site of the nurse registry must be licensed, unless there is more than one site within the health service planning district for which a license is issued. In such case, ~~a county. If there is more than one site within a county, only one license per county is required.~~ each operational site within the health service planning district must be listed on the license.

(b) A licensed nurse registry may operate a satellite office as defined in s. 400.462. The nurse registry operational

site must administer all satellite offices. A satellite office may store supplies and records, register and process contractors, and conduct business by telephone as is done at other operational sites. Nurse registries may use signs and advertisements to notify the public of the location of a satellite office. All original records must be kept at the operational site.

(c) A nurse registry must provide notice, in writing, to the agency at the state and area office levels, as required by agency rule, of a proposed change of address for an operational site or the opening of a satellite office. Before relocating an operational site or opening a satellite office, the nurse registry must submit evidence of its legal right to use the proposed property, as well as a certificate of occupancy, a certificate of use, or other evidence that the property is zoned for nurse registry use.

Section 3. Section 400.497, paragraph (h) of subsection (3) of section 817.505, and subsection (3) of section 400.506, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to section 400.506, Florida Statutes, in references thereto.

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	_____

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Stone offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Subsections (28) and (29) of section 400.462, Florida Statues, are renumbered as subsections (29) and (30), respectively, and a new subsection (28) is added to that section to read:

400.462 Definitions.—As used in this part, the term:

(28) "Satellite office" means a secondary office of a nurse registry established pursuant to s. 400.506(1) in the same health service planning district as a licensed nurse registry operational site.

Section 2. Subsection (2) of section 400.464, Florida Statutes, is amended to read:

400.464 Home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.—

(2) If the licensed home health agency operates related offices, each related office outside the health service planning district ~~county~~ where the main office is located must be separately licensed. The counties where the related offices are operating within the health service planning district must be specified on the license in the main office.

Section 3. Subsection (1) of section 400.506, Florida Statutes, is amended to read:

400.506 Licensure of nurse registries; requirements; penalties.—

(1)(a) A nurse registry is exempt from the licensing requirements of a home health agency but must be licensed as a nurse registry. The requirements of part II of chapter 408 apply to the provision of services that require licensure pursuant to ss. 400.506-400.518 and part II of chapter 408 and to entities licensed by or applying for such license from the Agency for Health Care Administration pursuant to ss. 400.506-400.518. A license issued by the agency is required for the operation of a nurse registry. Each operational site of the nurse registry must be licensed, unless there is more than one site within the health service planning district for which a license is issued. In such case, ~~a county. If there is more than one site within a county, only one license per county is required.~~ each

operational site within the health service planning district must be listed on the license.

(b) A licensed nurse registry may operate a satellite office as defined in s. 400.462. The nurse registry operational site must administer all satellite offices. A satellite office may store supplies and records, register and process contractors, and conduct business by telephone as is done at other operational sites. Nurse registries may use signs and advertisements to notify the public of the location of a satellite office. All original records must be kept at the operational site.

(c) A nurse registry must provide notice, in writing, to the agency at the state and area office levels, as required by agency rule, of a proposed change of address for an operational site or the opening of a satellite office. Before relocating an operational site or opening a satellite office, the nurse registry must submit evidence of its legal right to use the proposed property and evidence that the property is zoned for nurse registry use.

Section 4. Section 400.497, paragraph (h) of subsection (3) of section 817.505, and subsection (3) of section 400.506, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to section 400.506, Florida Statutes, in references thereto.

Section 5. This act shall take effect July 1, 2015.

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

Remove everything before the enacting clause and insert:
An act relating to home health services; amending. s. 400.462, F.S.; defining a term; amending s. 400.464, F.S.; allowing home health agencies to operate related offices inside of the main office's health service planning district without an additional license; amending s. 400.506, F.S.; providing for the licensure of more than one nurse registry operational site within the same health service planning district; authorizing a licensed nurse registry to operate a satellite office; requiring a nurse registry operational site to keep all original records; requiring a nurse registry to provide notice and certain evidence before it relocates an operational site or opens a satellite office; reenacting s. 400.497, F.S., relating to rules establishing minimum standards with respect to home health agencies, s. 817.505(3)(h), F.S., relating to an exception from a prohibition on patient brokering, and s. 400.506(3), F.S., relating to a nurse registry application fee, to incorporate the amendment made by the act to s. 400.506, F.S., in references thereto; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1055 Child Protection
SPONSOR(S): Children, Families & Seniors Subcommittee; Harrell
TIED BILLS: **IDEN./SIM. BILLS:**

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

SUMMARY ANALYSIS

A child protection team (CPT) is a medically directed, multidisciplinary team that works with local sheriff's offices and the Department of Children and Families (DCF) in cases of child abuse and neglect to supplement investigation activities. Child protection teams provide expertise in evaluating alleged child abuse and neglect, assessing risk and protective factors, and providing recommendations for interventions to protect children.

The bill:

- Amends s. 39.303, F.S., to require the Statewide Medical Director for Child Protection and district CPT medical directors to hold certain licenses and certifications.
- Adds "a member of a child protection team, as defined in s. 39.01, when carrying out his or her duties as a team member" to the definition of "Officer, employee, or agent" for the purposes of sovereign immunity.
- Requires the inclusion of the local child protection team medical director on any Critical Incident Rapid Response Team initiated by DCF to conduct investigations of certain child deaths or other serious incidents.

The bill also adds child abuse and neglect cases as an authorized use of the "expert witness certificate."

The bill does not appear to have any fiscal impact on state or local governments.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Child Protection Teams

A child protection team (CPT) is a medically directed, multidisciplinary team that supplements the child protective investigation efforts of local sheriffs' offices and the Department of Children and Families (DCF) in cases of child abuse and neglect.[1] They are independent, community-based programs that provide expertise in evaluating alleged child abuse and neglect, assessing risk and protective factors, and providing recommendations for interventions to protect children and to enhance a caregiver's capacity to provide a safer environment when possible.[2] The Children's Medical Services (CMS) program in the Department of Health (DOH) is authorized via statute to contract for these CPT services with local community-based programs.[3] There are 23 CPTs across the state providing services to all 67 Florida counties.[4]

Child abuse, abandonment and neglect reports to the DCF central abuse hotline that must be referred to child protection teams include cases involving:

- Injuries to the head, bruises to the neck or head, burns, or fractures in a child of any age.
- Bruises anywhere on a child five years of age or younger.
- Any report alleging sexual abuse of a child.
- Any sexually transmitted disease in a prepubescent child.
- Reported malnutrition or failure of a child to thrive.
- Reported medical neglect of a child.
- A sibling or other child remaining in a home where one or more children have been pronounced dead on arrival or have been injured and later died as a result of suspected abuse, abandonment or neglect.
- Symptoms of serious emotional problems in a child when emotional or other abuse, abandonment, or neglect is suspected.[5]

The State Surgeon General and the DOH Deputy Secretary for Children's Medical Services, in consultation with the DCF Secretary, have responsibility for the screening, employment, and any necessary termination of child protection team medical directors, both at the state and district level.[6] There is currently no statutory requirement related to the qualifications of either the Statewide Medical Director for Child Protection or the district team medical directors. The Florida Administrative Code requires a district team medical director to be a licensed to practice in Florida, board certified in pediatrics, and interested in the field of child abuse and neglect with satisfactory completion of training deemed necessary by the Department of Health.[7]

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[1] Florida Department of Health, Children's Medical Services. *Child Protection Teams* http://www.floridahealth.gov/AlternateSites/CMS-Kids/families/child_protection_safety/child_protection_teams.html (last visited March 10, 2015).
[2] Id.
[3] Section 39.303, F.S.
[4] Children's Medical Services, *Child Protection Teams: CPT Statewide Directory*, available at http://www.floridahealth.gov/alternatesites/cms-kids/home/contact/cpt.pdf (last accessed March 12, 2015)
[5] Id.
[6] Supra. at FN 4.
[7] Rule 64C-8.002, F.A.C.

Specialty Certification for Child Abuse Pediatrics

Child abuse pediatricians are responsible for the diagnosis and treatment of children and adolescents who are suspected victims of child maltreatment. This includes physical abuse, sexual abuse, factitious illness (medical child abuse), neglect, and psychological/emotional abuse. These specialty pediatricians participate in multidisciplinary collaborative work within the medical, child welfare, and law enforcement systems. They are also often called to provide expert testimony in court proceedings.[8]

The American Board of Medical Specialties approved the child abuse pediatrics specialty in 2006 and the American Board of Pediatrics issued the first certification exams in late 2009. Three years of full-time, broad-based fellowship training in child abuse pediatrics are required for fellows entering training on or after January 1, 2010.[9] Three-year child abuse fellowships are in various stages of development at academic medical centers because of the new specialty designation. Most of them are housed within children's hospitals across the country, similar to other pediatric specialty fellowships, and will be comprised of both clinical and research training and a requirement for a scholarly project, which will help advance the field.[10] As of December 31, 2013, there were 324 child abuse pediatrics diplomates nationwide, including 12 in Florida.[11]

Sovereign Immunity

Sovereign immunity bars lawsuits against the state or its political subdivisions for the torts of officers, employees, or agents of such governments unless the immunity is expressly waived.

Article X, Section 13, of the Florida Constitution recognizes the concept of sovereign immunity and gives the Legislature the power to waive such immunity in part or in full by general law. Section 768.28, F.S., contains the limited waiver of sovereign immunity applicable to the state. Under this statute, officers, employees, and agents of the state will not be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function.

Instead, the state steps in as the party litigant and defends against the claim. The recovery by any one person is limited to $200,000 for one incident and the total for all recoveries related to one incident is limited to $300,000.[12] The sovereign immunity recovery caps do not prevent a plaintiff from obtaining a judgment in excess of the caps, but the plaintiff cannot recover the excess damages without action by the Legislature.[13]

However, personal liability may result from actions in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.[14]

Whether sovereign immunity applies turns on the degree of control of the agent of the state retained by the state.[15] In *Stoll v. Noel*, the Florida Supreme Court held that independent contractor physicians may be agents of the state for purposes of sovereign immunity. The court examined the employment

[8] Council of Pediatric Subspecialties. *Pediatric Child Abuse*, available at: http://pedsubs.org/SubDes/ChildAbuse.cfm. (last visited March 10, 2015).
[9] Child Abuse Pediatrics Certification, Eligibility Criteria for Certification in Child Abuse Pediatrics, available at https://www.abp.org/content/child-abuse-pediatrics-certification (last visited March 11, 2015)
[10] Giardino, A., Hanson, N., Hill, K.S, and Leventhal, J.M. Child Abuse Pediatrics: New Specialty, Renewed Mission. *Pediatrics* 2011; 128(1):156-159.
[11] American Board of Pediatrics, *Workforce Databook*, available at https://www.abp.org/sites/abp/files/pdf/workforcebook.pdf (last visited March 11, 2015).
[12] S. 768.28(5), F.S.
[13] Id.
[14] S. 768.28(9)(a), F.S.
[15] *Stoll v. Noel*, 694 So. 2d 701, 703 (Fla. 1997).

contract between the physicians and the state to determine whether the state's right to control was sufficient to create an agency relationship and held that it did.[16]

The *Stoll* court explained that whether the Children's Medical Services (CMS) physician consultants are agents of the state turns on the degree of control retained or exercised by CMS. The manuals and guides given to physician consultants demonstrated that CMS had final authority over all care and treatment provided to CMS patients, and that CMS could refuse to allow a physician consultant's recommended course of treatment of any CMS patient for either medical or budgetary reasons.[17] Furthermore, the court's conclusion was supported by the state's acknowledgement that the manual creates an agency relationship between CMS and its physician consultants, and despite its potential liability in this case, the state acknowledged full financial responsibility for the physicians' actions. The court stated that the state's interpretation of its manual is entitled to judicial deference and great weight.[18]

Expert Testimony in Child Abuse Cases and Expert Witness Certificate

Section 458.3175, F.S., requires an expert witness who is licensed in another jurisdiction to obtain an "expert witness certificate" from DOH before that expert witness may testify in medical negligence cases or provide an affidavit in the pre-suit portion of a medical negligence case. The certificate is good for 2 years, and only authorizes the physician to do the following:

- Provide a verified written medical expert opinion; and
- Provide expert testimony about the prevailing professional standard of care in connection with medical negligence litigation pending in this state against a physician licensed in Florida.[19]

In criminal child abuse and neglect cases, s. 827.03(3), F.S., allows expert testimony in child abuse and neglect cases by physicians licensed under chapter 458, F.S., or 459, F.S., or by physicians who have obtained an expert witness certification under s. 458.3175, F.S. To provide expert testimony of mental injury in child abuse and neglect cases, physicians must be licensed under chapter 458, F.S., or 459, F.S., and have completed an accredited residency in psychiatry, or obtained an expert witness certification under s. 458.3175, F.S.[20]

While s. 827.03, F.S., allows experts to testify in criminal child abuse and neglect cases if they have an expert witness certificate, s. 458.3175, F.S., only authorizes a very narrow enumerated use of this certificate and does not currently allow physicians to give expert testimony in child abuse and neglect cases.

Critical Incident Rapid Response Team

The Critical Incident Rapid Response Team (CIRRT) was created by the Legislature in 2014. The CIRRTs are established within DCF to conduct investigations of child death or other serious incidents reported to the central abuse hotline if the child or another child in his or her home was the subject of a verified report of abuse or neglect within the previous 12 months.[21] The purpose of the CIRRT is to perform an immediate root-cause analysis of critical incidents and rapidly determine the need to change policies and practices related to child protection and welfare.[22]

Statute requires that the CIRRT be comprised of a multiagency team of at least five professionals with expertise in child protection, child welfare, and organizational management; a majority of the team must

[16] Id.
[17] Id.
[18] Id.
[19] S. 758.3175(2), F.S.
[20] S. 827.03(3)(b), F.S.
[21] S. 39.2015(2), F.S.
[22] S. 39.2015(1), F.S.

reside in judicial circuits outside the location of the incident.[23] It does not require a CPT member to be appointed to the CIRRT, although CPT members may be appointed to the CIRRT due to their expertise in child protection.

Effect of Proposed Changes

Child Protection Teams

CS/HB 1055 amends s. 39.303, F.S., to require the Statewide Medical Director for Child Protection to be:

- A licensed physician under chapters 458 or 459;
- A board-certified pediatrician; and
- A diplomate in the subspecialty of child abuse pediatrics from the American Board of Pediatrics.

The bill requires each district CPT medical director to be:

- A licensed physician under chapters 458 or 459;
- A board-certified pediatrician; and
- A diplomate in the subspecialty of child abuse pediatrics from the American Board of Pediatrics within 2 years after the date of his or her employment as district medical director; or
- Meet the requirements established by a third-party credentialing entity recognizing a demonstrated specialized competence in child abuse pediatrics.

Third-Party Credentialing Entity

The bill requires DOH to approve one or more third-party credentialing entities to develop and administer a professional credentialing program for district medical directors. DOH must approve an entity within 90 days after receiving documentation that demonstrates the third-party credentialing entity's compliance with certain minimum standards, including:

- Establishment of child abuse pediatrics core competencies,[24] certification standards, testing instruments, and recertification standards;
- A demonstrated ability to administer a professional code of ethics, disciplinary process, biennial continuing education and certification renewal requirements, and an education provider program;
- Establishment of a process to administer the certification application, award, and maintenance processes according to national psychometric standards;
- Establishment of, and ability to maintain a publicly accessible Internet-based database that contains information on each person who applies for and is awarded certification, such as the person's first and last name, certification status, and ethical or disciplinary history; and

Sovereign Immunity

The bill amends s. 768.28(9)(b), F.S., adding "a member of a child protection team, as defined in s. 39.01[25], when carrying out his or her duties as a team member" to the definition of "Officer, employee or agent." This explicitly enumerates CPT members as falling under the sovereign immunity protections of the state.

[23] S. 39.2015(3), F.S.

[24] These core competency standards must be established according to nationally recognized psychometric standards.

[25] S. 39.01 defines a CPT as, "[A] team of professionals established by the Department of Health to receive referrals from the protective investigators and protective supervision staff of the department and to provide specialized and supportive services to the program in processing child abuse, abandonment, or neglect cases. A child protection team shall provide consultation to other programs of the department and other persons regarding child abuse, abandonment, or neglect cases."

Expert Witness Certificate

The bill amends s. 458.3175(2), F.S., adding child abuse and neglect cases as an authorized use of the "expert witness certificate."

Critical Incident Rapid Response Team

The bill amends s. 39.2015, F.S., to require the inclusion of the local child protection team medical director on any CIRRT.

Lastly, the bill reenacts ss. 39.3031 and 391.026(2), F.S., to incorporate the amendments made by the bill.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 39.2015(3), F.S., relating to critical incident rapid response team.
Section 2: Amends s. 39.303, F.S., relating to child protection teams.
Section 3: Amends s. 768.28, F.S., relating to sovereign immunity.
Section 4: Amends s. 458.3175, F.S., relating to expert witness certificates.
Section 5 Amends s. 39.301, F.S., relating to conforming references.
Section 6: Reenacts s. 39.3031, F.S., relating to rules for implementation.
Section 7: Reenacts s. 391.026(2), F.S., relating to powers and duties of the department.
Section 8: Provides for an effective date.

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:

The cost of obtaining the required child abuse pediatric subspecialty certification from the American Board of Pediatrics or the third-party credential is unknown. The subspecialty certification through the American Board of Pediatrics requires a three-year fellowship.

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 reenacts the relevant section of statute giving the Department of Health sufficient rule-making authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 17, 2015, the Children, Families & Seniors Subcommittee adopted a strike-all amendment. The amendment:

- Requires district medical directors to obtain a subspecialty certification in child abuse pediatrics from the American Board of Pediatrics or meet minimum requirements established by a third-party credentialing entity.
- Requires the Department of Health to approve one or more third-party credentialing entities for the purpose of developing a professional credentialing program for district medical directors.
- Removes the amendment to s. 827.03, F.S., in relation to mental injury expert testimony, and adds child abuse and neglect cases as an authorized use of the "expert witness certificate" under s. 458.3175, F.S.
- Removes the parallel definition of "Officer, employee, or agent" in s. 768.28(9)(b)3. for sovereign immunity and adds CPT members to the existing definition of "Officer, employee, or agent" in s. 768.28(9)(b)2.

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

A bill to be entitled

An act relating to child protection; amending s. 39.2015, F.S.; providing requirements for the representation of Children's Medical Services on multiagency teams investigating certain child deaths or other serious incidents; amending s. 39.303, F.S.; requiring the Statewide Medical Director for Child Protection and the district medical directors to hold certain qualifications; requiring the Department of Health to approve a third-party credentialing entity to administer a credentialing program for district medical directors; amending s. 768.28, F.S.; specifying that child protection team members are covered by state sovereign immunity provisions when carrying out their duties; amending s. 458.3175, F.S.; providing that a physician who holds an expert witness certificate may provide expert testimony in criminal child abuse and neglect cases; amending s. 39.301, F.S.; correcting a cross-reference; reenacting ss. 39.3031 and 391.026(2), F.S., relating to child protection teams, to incorporate the amendments made by the act to s. 39.303, F.S., in references thereto; providing an effective date.

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

Section 1. Subsection (3) of section 39.2015, Florida Statutes, is amended to read:

39.2015 Critical incident rapid response team.—

(3) Each investigation shall be conducted by a multiagency team of at least five professionals with expertise in child protection, child welfare, and organizational management. The team may consist of employees of the department, community-based care lead agencies, Children's Medical Services, and community-based care provider organizations; faculty from the institute consisting of public and private universities offering degrees in social work established pursuant to s. 1004.615; or any other person with the required expertise. The team shall include, at a minimum, the local child protection team medical director. The majority of the team must reside in judicial circuits outside the location of the incident. The secretary shall appoint a team leader for each group assigned to an investigation.

Section 2. Section 39.303, Florida Statutes, is amended to read:

39.303 Child protection teams; services; eligible cases.—

(1) The Children's Medical Services Program in the Department of Health shall develop, maintain, and coordinate the services of one or more multidisciplinary child protection teams in each of the service districts of the Department of Children and Families. Such teams may be composed of appropriate representatives of school districts and appropriate health, mental health, social service, legal service, and law

enforcement agencies. The Department of Health and the Department of Children and Families shall maintain an interagency agreement that establishes protocols for oversight and operations of child protection teams and sexual abuse treatment programs. The State Surgeon General and the Deputy Secretary for Children's Medical Services, in consultation with the Secretary of Children and Families, shall maintain the responsibility for the screening, employment, and, if necessary, the termination of child protection team medical directors, at headquarters and in the 15 districts.

(2)(a) The Statewide Medical Director for Child Protection must be a physician licensed under chapter 458 or chapter 459 who is a board-certified pediatrician with a subspecialty certification in child abuse from the American Board of Pediatrics.

(b) Each district medical director must be a physician licensed under chapter 458 or chapter 459 who is a board-certified pediatrician and, within 2 years after the date of his or her employment as a district medical director, either obtains a subspecialty certification in child abuse from the American Board of Pediatrics or meets the minimum requirements established by a third-party credentialing entity recognizing a demonstrated specialized competence in child abuse pediatrics pursuant to paragraph (d). Child protection team medical directors shall be responsible for oversight of the teams in the districts.

(c) All medical personnel participating on a child protection team must successfully complete the required child protection team training curriculum as set forth in protocols determined by the Deputy Secretary for Children's Medical Services and the Statewide Medical Director for Child Protection.

(d) The Department of Health shall approve one or more third-party credentialing entities for the purpose of developing and administering a professional credentialing program for district medical directors. Within 90 days after receiving documentation from a third-party credentialing entity, the department shall approve a third-party credentialing entity that demonstrates compliance with the following minimum standards:

1. Establishment of child abuse pediatrics core competencies, certification standards, testing instruments, and recertification standards according to national psychometric standards.

2. Establishment of a process to administer the certification application, award, and maintenance processes according to national psychometric standards.

3. Demonstrated ability to administer a professional code of ethics and disciplinary process that applies to all certified persons.

4. Establishment of, and ability to maintain, a publicly accessible Internet-based database that contains information on each person who applies for and is awarded certification, such

as the person's first and last name, certification status, and ethical or disciplinary history.

5. Demonstrated ability to administer biennial continuing education and certification renewal requirements.

6. Demonstrated ability to administer an education provider program to approve qualified training entities and to provide precertification training to applicants and continuing education opportunities to certified professionals.

(3) ~~(1)~~ The Department of Health shall use and convene the teams to supplement the assessment and protective supervision activities of the family safety and preservation program of the Department of Children and Families. This section does not remove or reduce the duty and responsibility of any person to report pursuant to this chapter all suspected or actual cases of child abuse, abandonment, or neglect or sexual abuse of a child. The role of the teams shall be to support activities of the program and to provide services deemed by the teams to be necessary and appropriate to abused, abandoned, and neglected children upon referral. The specialized diagnostic assessment, evaluation, coordination, consultation, and other supportive services that a child protection team shall be capable of providing include, but are not limited to, the following:

(a) Medical diagnosis and evaluation services, including provision or interpretation of X rays and laboratory tests, and related services, as needed, and documentation of related findings.

(b) Telephone consultation services in emergencies and in other situations.

(c) Medical evaluation related to abuse, abandonment, or neglect, as defined by policy or rule of the Department of Health.

(d) Such psychological and psychiatric diagnosis and evaluation services for the child or the child's parent or parents, legal custodian or custodians, or other caregivers, or any other individual involved in a child abuse, abandonment, or neglect case, as the team may determine to be needed.

(e) Expert medical, psychological, and related professional testimony in court cases.

(f) Case staffings to develop treatment plans for children whose cases have been referred to the team. A child protection team may provide consultation with respect to a child who is alleged or is shown to be abused, abandoned, or neglected, which consultation shall be provided at the request of a representative of the family safety and preservation program or at the request of any other professional involved with a child or the child's parent or parents, legal custodian or custodians, or other caregivers. In every such child protection team case staffing, consultation, or staff activity involving a child, a family safety and preservation program representative shall attend and participate.

(g) Case service coordination and assistance, including the location of services available from other public and private

agencies in the community.

(h) Such training services for program and other employees of the Department of Children and Families, employees of the Department of Health, and other medical professionals as is deemed appropriate to enable them to develop and maintain their professional skills and abilities in handling child abuse, abandonment, and neglect cases.

(i) Educational and community awareness campaigns on child abuse, abandonment, and neglect in an effort to enable citizens more successfully to prevent, identify, and treat child abuse, abandonment, and neglect in the community.

(j) Child protection team assessments that include, as appropriate, medical evaluations, medical consultations, family psychosocial interviews, specialized clinical interviews, or forensic interviews.

~~All medical personnel participating on a child protection team must successfully complete the required child protection team training curriculum as set forth in protocols determined by the Deputy Secretary for Children's Medical Services and the Statewide Medical Director for Child Protection.~~ A child protection team that is evaluating a report of medical neglect and assessing the health care needs of a medically complex child shall consult with a physician who has experience in treating children with the same condition.

(4) ~~(2)~~ The child abuse, abandonment, and neglect reports

that must be referred by the department to child protection teams of the Department of Health for an assessment and other appropriate available support services as set forth in subsection (3) ~~(1)~~ must include cases involving:

(a) Injuries to the head, bruises to the neck or head, burns, or fractures in a child of any age.

(b) Bruises anywhere on a child 5 years of age or under.

(c) Any report alleging sexual abuse of a child.

(d) Any sexually transmitted disease in a prepubescent child.

(e) Reported malnutrition of a child and failure of a child to thrive.

(f) Reported medical neglect of a child.

(g) Any family in which one or more children have been pronounced dead on arrival at a hospital or other health care facility, or have been injured and later died, as a result of suspected abuse, abandonment, or neglect, when any sibling or other child remains in the home.

(h) Symptoms of serious emotional problems in a child when emotional or other abuse, abandonment, or neglect is suspected.

(5) ~~(3)~~ All abuse and neglect cases transmitted for investigation to a district by the hotline must be simultaneously transmitted to the Department of Health child protection team for review. For the purpose of determining whether face-to-face medical evaluation by a child protection team is necessary, all cases transmitted to the child protection

team which meet the criteria in subsection (4) ~~(2)~~ must be timely reviewed by:

(a) A physician licensed under chapter 458 or chapter 459 who holds board certification in pediatrics and is a member of a child protection team;

(b) A physician licensed under chapter 458 or chapter 459 who holds board certification in a specialty other than pediatrics, who may complete the review only when working under the direction of a physician licensed under chapter 458 or chapter 459 who holds board certification in pediatrics and is a member of a child protection team;

(c) An advanced registered nurse practitioner licensed under chapter 464 who has a specialty in pediatrics or family medicine and is a member of a child protection team;

(d) A physician assistant licensed under chapter 458 or chapter 459, who may complete the review only when working under the supervision of a physician licensed under chapter 458 or chapter 459 who holds board certification in pediatrics and is a member of a child protection team; or

(e) A registered nurse licensed under chapter 464, who may complete the review only when working under the direct supervision of a physician licensed under chapter 458 or chapter 459 who holds certification in pediatrics and is a member of a child protection team.

(6) ~~(4)~~ A face-to-face medical evaluation by a child protection team is not necessary when:

(a) The child was examined for the alleged abuse or neglect by a physician who is not a member of the child protection team, and a consultation between the child protection team board-certified pediatrician, advanced registered nurse practitioner, physician assistant working under the supervision of a child protection team board-certified pediatrician, or registered nurse working under the direct supervision of a child protection team board-certified pediatrician, and the examining physician concludes that a further medical evaluation is unnecessary;

(b) The child protective investigator, with supervisory approval, has determined, after conducting a child safety assessment, that there are no indications of injuries as described in paragraphs (4)(a)-(h) ~~(2)(a)-(h)~~ as reported; or

(c) The child protection team board-certified pediatrician, as authorized in subsection (5) ~~(3)~~, determines that a medical evaluation is not required.

Notwithstanding paragraphs (a), (b), and (c), a child protection team pediatrician, as authorized in subsection (5) ~~(3)~~, may determine that a face-to-face medical evaluation is necessary.

(7) ~~(5)~~ In all instances in which a child protection team is providing certain services to abused, abandoned, or neglected children, other offices and units of the Department of Health, and offices and units of the Department of Children and Families, shall avoid duplicating the provision of those

services.

(8) ~~(6)~~ The Department of Health child protection team quality assurance program and the Family Safety Program Office of the Department of Children and Families shall collaborate to ensure referrals and responses to child abuse, abandonment, and neglect reports are appropriate. Each quality assurance program shall include a review of records in which there are no findings of abuse, abandonment, or neglect, and the findings of these reviews shall be included in each department's quality assurance reports.

Section 3. Paragraph (b) of subsection (9) of section 768.28, Florida Statutes, is amended, and paragraph (a) of that subsection is republished, to read:

768.28 Waiver of sovereign immunity in tort actions; recovery limits; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.—

(9)(a) No officer, employee, or agent of the state or of any of its subdivisions shall be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function, unless such officer, employee, or agent acted in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. However, such officer, employee, or agent shall be considered an adverse

witness in a tort action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function. The exclusive remedy for injury or damage suffered as a result of an act, event, or omission of an officer, employee, or agent of the state or any of its subdivisions or constitutional officers shall be by action against the governmental entity, or the head of such entity in her or his official capacity, or the constitutional officer of which the officer, employee, or agent is an employee, unless such act or omission was committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. The state or its subdivisions shall not be liable in tort for the acts or omissions of an officer, employee, or agent committed while acting outside the course and scope of her or his employment or committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

(b) As used in this subsection, the term:

1. "Employee" includes any volunteer firefighter.

2. "Officer, employee, or agent" includes, but is not limited to, any health care provider when providing services pursuant to s. 766.1115; any nonprofit independent college or university located and chartered in this state which owns or operates an accredited medical school, and its employees or agents, when providing patient services pursuant to paragraph

(10)(f); ~~and~~ any public defender or her or his employee or agent, including, among others, an assistant public defender and an investigator; and any member of a child protection team, as defined in s. 39.01, when carrying out his or her duties as a team member.

Section 4. Paragraph (c) is added to subsection (2) of section 458.3175, Florida Statutes, to read:

458.3175 Expert witness certificate.—

(2) An expert witness certificate authorizes the physician to whom the certificate is issued to do only the following:

(c) Provide expert testimony in criminal child abuse and neglect cases in this state.

Section 5. Paragraph (c) of subsection (14) of section 39.301, Florida Statutes, is amended to read:

39.301 Initiation of protective investigations.—

(14)

(c) The department, in consultation with the judiciary, shall adopt by rule:

1. Criteria that are factors requiring that the department take the child into custody, petition the court as provided in this chapter, or, if the child is not taken into custody or a petition is not filed with the court, conduct an administrative review. Such factors must include, but are not limited to, noncompliance with a safety plan or the case plan developed by the department, and the family under this chapter, and prior abuse reports with findings that involve the child, the child's

sibling, or the child's caregiver.

2. Requirements that if after an administrative review the department determines not to take the child into custody or petition the court, the department shall document the reason for its decision in writing and include it in the investigative file. For all cases that were accepted by the local law enforcement agency for criminal investigation pursuant to subsection (2), the department must include in the file written documentation that the administrative review included input from law enforcement. In addition, for all cases that must be referred to child protection teams pursuant to s. 39.303(4) and (5) ~~39.303(2) and (3)~~, the file must include written documentation that the administrative review included the results of the team's evaluation.

Section 6. For the purpose of incorporating the amendments made by this act to section 39.303, Florida Statutes, in a reference thereto, section 39.3031, Florida Statutes, is reenacted to read:

39.3031 Rules for implementation of s. 39.303.—The Department of Health, in consultation with the Department of Children and Families, shall adopt rules governing the child protection teams pursuant to s. 39.303, including definitions, organization, roles and responsibilities, eligibility, services and their availability, qualifications of staff, and a waiver-request process.

Section 7. For the purpose of incorporating the amendments

made by this act to section 39.303, Florida Statutes, in a reference thereto, subsection (2) of section 391.026, Florida Statutes, is reenacted to read:

391.026 Powers and duties of the department.—The department shall have the following powers, duties, and responsibilities:

(2) To provide services to abused and neglected children through child protection teams pursuant to s. 39.303.

Section 8. This act shall take effect July 1, 2015.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. CS/HB 1055 (2015)

Amendment No. 1

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	_____

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Harrell offered the following:

Amendment

Remove line 39 and insert:

minimum, a child protection team medical director. The

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. CS/HB 1055 (2015)

Amendment No. 2

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	_____

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Harrell offered the following:

Amendment (with title amendment)

Between lines 324 and 325, insert:

Section 5. Subsection (2) of section 459.0066, Florida Statutes, is amended to read:

459.0066 Expert witness certificate.—

(2) An expert witness certificate authorizes the physician to whom the certificate is issued to do only the following:

(a) Provide a verified written medical expert opinion as provided in s. 766.203.

(b) Provide expert testimony about the prevailing professional standard of care in connection with medical negligence litigation pending in this state against a physician licensed under chapter 458 or this chapter.

(c) Provide expert testimony in criminal child abuse and neglect cases in this state.

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

Remove line 18 and insert:

child abuse and neglect cases; amending s. 459.0066, F.S.; providing that an osteopathic physician who holds an expert witness certificate may provide expert testimony in criminal child abuse and neglect cases;