The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH REGULATION
Senator Garcia, Chair
Senator Sobel, Vice Chair

MEETING DATE: Tuesday, April 12, 2011
TIME: 1:00 —6:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Garcia, Chair; Senator Sobel, Vice Chair; Senators Altman, Bennett, Diaz de la Portilla, Fasano, Gaetz, Gardiner, Jones, Latvala, Norman, and Ring

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 1770** Hays (Identical H 1247)	Parental Notice of Abortion; Revises notice requirements relating to the termination of pregnancy of a minor. Provides exceptions to the notice requirements. Revises procedure for judicial waiver of notice. Provides for the minor to petition for a hearing within a specified time. Provides that in a hearing relating to waiving the requirement for parental notice, the court consider certain additional factors, including whether the minor's decision to terminate her pregnancy was due to undue influence. Provides a procedure for appeal if judicial waiver of notice is not granted, etc. HR 04/04/2011 Not Considered HR 04/12/2011 JU BC	
2	**SB 688** Richter (Identical H 4045, Compare H 1295, CS/S 1458)	Assisted Living Facilities; Repeals a provision authorizing the Department of Elderly Affairs to collect information regarding the cost of providing certain services in facilities and to conduct field visits and audits. Repeals a provision authorizing a local subsidy. CF 04/04/2011 Favorable HR 04/12/2011 CA	
3	**SB 690** Richter (Identical H 4047, Compare CS/H 119, H 1295, CS/S 1736)	Assisted Living Facilities; Removes an obsolete provision requiring the Department of Elderly Affairs to submit to the Legislature for review and comment a copy of proposed department rules establishing standards for resident care. CF 04/04/2011 Favorable HR 04/12/2011 RC	
4	**SB 692** Richter (Identical H 4049, Compare H 1295)	Assisted Living Facilities; Removes an obsolete reporting requirement. CF 04/04/2011 Favorable HR 04/12/2011 RC	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
5	**SB 1000** Wise (Identical H 797)	Interscholastic and Intrascholastic Sports; Removes certain provisions relating to a pilot program in which a middle school student or a high school student in a private school may participate in athletics at a public school. Provides for statewide implementation of the program. Requires that the athletic director of each public school maintain the records of students participating in the program. Limits participation in the program to students who are enrolled in non-FHSAA member private schools consisting of a maximum number of students, etc. ED 03/17/2011 Favorable HR 04/12/2011 BC	
6	**CS/SB 1754** Banking and Insurance / Garcia (Identical CS/H 1193)	Health Insurance; Prohibits a person from being compelled to purchase health insurance except under specified conditions. Specifies that the act does not prohibit the collection of certain debts. BI 03/22/2011 Temporarily Postponed BI 04/05/2011 Fav/CS HR 04/12/2011 RC	
7	**SB 1146** Sachs (Similar CS/H 91)	Drug-related Overdoses; Provides that a person acting in good faith who seeks medical assistance for an individual experiencing a drug-related overdose may not be charged, prosecuted, or penalized for specified offenses in certain circumstances. Provides that a person who experiences a drug-related overdose and needs medical assistance may not be charged, prosecuted, or penalized for specified offenses in certain circumstances, etc. CJ 03/28/2011 Fav/1 Amendment HR 04/12/2011 JU BC	
8	**SB 1192** Rich (Compare CS/H 579)	Public Records/Regional Autism Centers; Provides an exemption from public records requirements for all records that relate to a client of a regional autism center, the client's family, or a teacher or other professional who receives the services of a center or participates in center activities. Provides for release of specified confidential and exempt information by a center under certain circumstances. Provides for review and repeal of the exemption. Provides a statement of public necessity. CF 03/14/2011 Favorable HR 04/12/2011 GO	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
9	**CS/SB 1426** Banking and Insurance / Hays (Identical CS/H 4101)	Repeal of Health Insurance Provisions; Repeals provisions relating to a requirement that the board of directors of the Florida Health Insurance Plan annually report to the Governor and the Legislature. Deletes a requirement that the Office of Insurance Regulation of the Department of Financial Services annually report to the Governor and the Legislature concerning the Small Employers Access Program. BI 03/16/2011 Fav/CS HR 04/04/2011 Not Considered HR 04/12/2011 BC	
10	**CS/SB 1554** Transportation / Hays (Similar H 1135)	Emergency Vehicles; Increases the fine for the failure to comply with a provision relating to yielding to emergency vehicles. Conforms provisions to changes made by the act. TR 03/16/2011 Fav/CS HR 04/04/2011 Not Considered HR 04/12/2011 MS	
11	**SB 1788** Bogdanoff (Identical H 4113)	Bicycle Regulations; Removes a requirement to keep one hand on the handlebars while operating a bicycle. Conforms a cross-reference to changes made by the act. TR 03/22/2011 Favorable CA 04/04/2011 Favorable HR 04/12/2011	

TAB	OFFICE and APPOINTMENT (HOME CITY)	FOR TERM ENDING	COMMITTEE ACTION
12	**Senate Confirmation Hearing:** A public hearing will be held for consideration of the below-named executive appointment to the office indicated.		
	Secretary of Health Care Administration		
	Dudek, Elizabeth (Tallahassee)	Pleasure of Governor	
	State Surgeon General		
	Farmer, Harry Frank, Jr. (Ormond Beach)	Pleasure of Governor	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
13	**CS/SB 1158** Children, Families, and Elder Affairs / Garcia (Similar CS/H 843)	Teaching Agency for Home and Community-based Care; Authorizes the Department of Elderly Affairs to designate a home health agency as a teaching agency for home and community-based care. Establishes criteria for qualification. Authorizes a teaching agency to be affiliated with an academic research university in the state that meets certain criteria. Authorizes a teaching agency to be affiliated with an academic health center, etc. CF 03/28/2011 Fav/CS HR 04/12/2011 BC	
14	**SB 1358** Oelrich (Similar H 909)	Emergency Medical Services; Deletes the requirement for emergency medical technicians and paramedics to complete an educational course on the modes of transmission, infection control procedures, clinical management, and prevention of human immunodeficiency virus and acquired immune deficiency syndrome. Redefines the term "basic life support" for purposes of the Raymond H. Alexander, M.D., Emergency Medical Transportation Services Act. Revises the requirements for certification for an out-of-state trained emergency medical technician or paramedic, etc. HR 04/04/2011 Not Considered HR 04/12/2011 BC	
15	**SB 472** Evers (Similar CS/H 467)	Prepaid Limited Health Service Organizations/Taxes; Provides that an organization providing services solely to Medicaid recipients under a contract with Medicaid is exempt from paying certain insurance premium taxes. Provides for retroactive operation. Specifies that the act is remedial in nature and not a basis for certain refunds of tax. HR 04/12/2011 BC	
16	**SB 1544** Jones (Compare CS/H 1067)	Death and Fetal Death Registration; Provides for advanced registered nurse practitioners to provide certification of death or fetal death. HR 04/12/2011 Temporarily Postponed RI BC	Temporarily Postponed

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
17	**SB 1918** Margolis (Similar CS/H 1237)	Legal and Medical Referral Service Advertising; Requires advertising from a medical or lawyer referral service related to motor vehicle accidents to comply with certain requirements regarding content. Requires advertisements or unsolicited written communications from certain legal referral services related to motor vehicle accidents to comply with the Supreme Court of Florida's Rules Regulating The Florida Bar. Provides civil and criminal penalties for violations relating to legal and medical referral advertising and relief to persons affected, etc. HR 04/12/2011 JU BC	
18	**SB 1892** Bennett (Compare CS/CS/H 479, S 1590, CS/CS/S 1972)	Health Care; Requires the Board of Medicine and the Board of Osteopathic Medicine to issue expert witness certificates to certain physicians licensed outside the state. Expands the scope of practice to authorize an advanced registered nurse practitioner to order, administer, monitor, and alter any drug or drug therapies that are necessary for the proper medical care and treatment of a patient under specified circumstances. Revises the burden of proof that a claimant must demonstrate in order to prove medical negligence by a health care provider, etc. HR 04/12/2011 BC	
19	**SB 1608** Ring (Compare H 1271)	Dentistry; Provides that an applicant who has maintained his or her dental license in good standing in another state for a specified number of years immediately before applying to take the licensing examinations to practice dentistry in this state is entitled to take such examinations. HR 04/04/2011 Not Considered HR 04/12/2011 BC	
20	**SB 162** Sobel (Identical H 1265)	Tanning Facilities; Requires that the operator or proprietor of a tanning facility witness the signing of a written statement by the parent or legal guardian of a minor before the minor is allowed to use a tanning device. Prohibits a minor younger than a certain age from using a tanning device at a tanning facility. Deletes provisions authorizing the use of a tanning device by certain minors if accompanied by a parent or legal guardian, etc. HR 04/12/2011 JU BC	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
21	**SB 1838** Wise (Identical H 1137)	Assisted Living Facilities; Creates the Florida Assisted Living Quality Improvement Initiative Pilot Project. Requires the Agency for Health Care Administration to create pilot projects in area offices. Authorizes licensed assisted living facilities to enroll in the pilot project. Establishes quality improvement teams. Provides conditions for termination of a quality improvement agreement with a facility. Provides procedures for investigating and monitoring complaints. Requires the agency to develop an assessment tool to evaluate the project, etc. HR 04/12/2011 CF BC	
22	**SB 1396** Bogdanoff (Compare CS/H 661, CS/CS/S 1972)	Nursing Home Litigation Reform; Specifies conditions under which a nursing home resident has a cause of action against a licensee or management company. Requires the trial judge to conduct an evidentiary hearing before a claimant can assert a claim against certain interested parties. Provides a timeframe for a claimant to elect survival damages or wrongful death damages. Requires evidence of the basis for punitive damages. Provides limitations for admissibility of survey and licensure reports and the presentation of testimony or other evidence of staffing deficiencies, etc. HR 03/28/2011 Temporarily Postponed HR 04/12/2011 JU BC	
23	**SB 1480** Evers (Identical H 1409)	Public Swimming Pools and Spas; Requires public swimming pools and spas to be equipped with certain safety features. HR 04/12/2011 RI CM BC	
24	**SM 1762** Smith (Identical HM 731)	Methylenedioxypyrovalerone (MDVP); Urges the Congress of the United States to ban the sale, distribution, and possession of methylenedioxypyrovalerone (MDVP). HR 04/12/2011	
25	**SB 1778** Bogdanoff (Similar H 4121)	Clove Cigarettes; Repeals provisions relating to prohibitions against sale, use, possession, transfer, or other disposing of clove cigarettes or similar products. HR 04/12/2011	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
26	**SB 2168** Health Regulation	Ratification of Rules; Ratifies specified rules for the sole and exclusive purpose of satisfying any condition on effectiveness established by s. 120.541(3), F.S., which requires ratification of any rule that meets any of the specified thresholds that may likely have an adverse impact or excessive regulatory cost. HR 04/12/2011	
27	**SB 1748** Flores (Similar CS/H 1397)	Abortions; Restricts the circumstances in which an abortion may be performed in the third trimester or after viability. Requires an abortion clinic to provide conspicuous notice on any form or medium of advertisement that the abortion clinic is prohibited from performing abortions in the third trimester or after viability. Prohibits a termination of pregnancy from being performed in a location other than a validly licensed hospital, abortion clinic, or physician's office, etc. HR 03/28/2011 Not Considered HR 04/04/2011 Not Considered HR 04/12/2011 CJ BC	

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1770
INTRODUCER:	Senator Hays
SUBJECT:	Parental Notice of Abortion
DATE:	April 1, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	O'Callaghan	Stovall	HR	**Pre-meeting**
2.			JU	
3.			BC	
4.				
5.				
6.				

I. Summary:

This bill amends s. 390.01114, F.S., relating to parental notification of an abortion to be performed on a minor. This bill amends the law as it relates to parental notification of an abortion by:

- Defining "constructive notice" to include notice by writing that must be mailed to a minor's parent or legal guardian prior to the abortion by certified mail *and* by first-class mail.
- Requiring notice that is given by telephone to a parent or legal guardian to be confirmed in writing, signed by the physician, and mailed to the parent or legal guardian of the minor by first-class and certified mail.
- Requiring a physician to make reasonable attempts to contact the parent or legal guardian, whenever possible, during a medical emergency that renders the abortion medically necessary, without endangering the minor.
- Requiring the physician to provide notice directly to a parent or legal guardian of the medical emergency requiring an abortion and any additional risks to the minor and if no notice is directly provided, then notice is required in writing to the parent or legal guardian, which must be mailed by first-class and certified mail.
- Providing that a parent or guardian's legal right to be noticed can only be waived if the written waiver is notarized, dated not more than 30 days before the abortion, and contains a specific waiver of the parent or legal guardian's right to notice of the minor's abortion.
- Reducing the number of courts in which a minor is able to file a petition for waiver of parental notice.
- Changing the time within which a court must rule on a minor's petition for a waiver of parental notice from 48 hours to 3 business days.
- Removing the automatic grant of a petition when a court fails to rule within a certain time.

- Providing that a minor may have her petition heard by a chief judge of the circuit within 48 hours of filing the petition when a circuit court has not ruled within 3 business days.
- Providing the minor with the right to appeal a court decision that does not grant judicial waiver of parental notice, providing the timeline within which the appellate court must rule, and providing the standard of review the appellate court must use.
- Requiring the court to consider specific factors when determining whether the minor is sufficiently mature to decide whether to terminate her pregnancy.
- Changing the standard upon which a court must find that the notification of a parent or guardian of the abortion is not in the best interest of the minor, from preponderance of the evidence to clear and convincing evidence.
- Providing that when the court considers what is in the best-interest of the minor, the court is not to consider financial implications for the minor or the minor's family.
- Requiring the final written order by the court to include its factual findings determining the maturity of the minor.
- Requiring the Office of State Courts Administrator to include in its annual report to the Governor and Legislature, regarding the number of petitions filed for a waiver of parental notice, the reason for each waiver of notice granted.

The bill also includes a severability clause, which severs any provision of the bill that is held invalid and saves the remaining provisions.

This bill substantially amends s. 390.01114, F.S.

This bill creates and undesignated section of the Florida Statutes.

II. Present Situation:

Background

Under Florida law the term "abortion" means the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.[1] "Viability" means that stage of fetal development when the life of the unborn child may, with a reasonable degree of medical probability, be continued indefinitely outside the womb.[2] Induced abortion can be elective (performed for nonmedical indications) or therapeutic (performed for medical indications). An abortion can be performed by surgical or medical means (medicines that induce a miscarriage).[3] An abortion in Florida must be performed by a physician licensed to practice medicine or osteopathic medicine who is licensed under ch. 458, F.S., or ch. 459, F.S., or a physician practicing medicine or osteopathic medicine in the employment of the United States.[4] No person who is a member of, or associated with, the staff of a hospital, or any employee of a hospital or physician in which, or by whom, the termination of a pregnancy has been authorized or performed, who states an objection to the procedure on moral or religious grounds is required

[1] Section 390.011, F.S.
[2] Section 390.0111(4), F.S.
[3] Suzanne R. Trupin, M.D., *Elective Abortion*, December 21, 2010, *available at*: http://www.emedicine.com/med/TOPIC3312.HTM (Last visited March 31, 2011).
[4] Section 390.0111(2) and s. 390.011(7), F.S.

to participate in the procedure. The refusal to participate may not form the basis for any disciplinary or other recriminatory action.[5]

In 2007, a total of 91,954 abortions were performed in Florida: for 83,890 of those, the gestational age of the fetus was 12 weeks and under; for 8,063, the gestational age of the fetus was 13 to 24 weeks; and for 1, the gestational age was over 25 weeks.[6]

Parental Notice of Abortion Act[7]

In 1999, the Legislature enacted a law requiring parents of minors to be notified prior to the minor's termination of a pregnancy. This law was constitutionally challenged on grounds that the act violated a person's right to privacy under the Florida Constitution. The Florida Supreme Court concluded that the act violated Florida's constitutional right to privacy because the minor was not afforded a mechanism by which to bypass parental notification if certain exigent circumstances existed.[8] In response to the court's decision, the Legislature proposed a constitutional amendment authorizing the Florida Legislature, notwithstanding a minor's right to privacy under the Florida Constitution, to require a physician to notify a minor's parent or guardian prior to termination of the minor's pregnancy, which was subsequently ratified by Florida voters.[9] The amendment provides:

> The Legislature shall not limit or deny the privacy right guaranteed to a minor under the United States Constitution as interpreted by the United States Supreme Court. Notwithstanding a minor's right of privacy provided in Section 23 of Article I, the Legislature is authorized to require by general law for notification to a parent or guardian of a minor before the termination of the minor's pregnancy. The Legislature shall provide exceptions to such requirement for notification and shall create a process for judicial waiver of the notification.[10]

The Legislature responded to this authorization by enacting the Parental Notice of Abortion Act (Act).[11]

A physician performing an abortion must provide "actual notice"[12] to the parent or legal guardian of a minor[13] before performing an abortion on a minor. The notice may be given by a referring physician. The physician who performs the abortion must receive the written statement of the referring physician certifying that the referring physician has given actual notice. If actual notice

[5] Section 390.0111(8), F.S.
[6] Florida Vital Statistics Annual Report 2007, *available at:* http://www.flpublichealth.com/VSBOOK/VSBOOK.aspx# (Last visited on March 31, 2011).
[7] Section 390.01114, F.S.
[8] *North Florida Women's Health and Counseling Services v. State*, 866 So. 2d 612 (Fla. 2003).
[9] See FLA. CONST. art. X, s. 22.
[10] *Id.*
[11] Laws of Fla. 2005-52, s 2
[12] "Actual notice" means notice that is given directly, in person or by telephone, to a parent or legal guardian of a minor, by a physician, at least 48 hours before the inducement or performance of a termination of pregnancy, and documented in the minor's files. Section 390.01114(2)(a), F.S.
[13] A minor is a person under the age of 18 years. Section 390.01114(2)(f), F.S.

is not possible after a reasonable effort has been made, the physician performing the abortion or the referring physician must give "constructive notice."[14]

Notice given by the physician performing the abortion must include the name and address of the facility providing the abortion and the name of the physician providing the notice. Notice given by a referring physician must include the name and address of the facility where he or she is referring the minor and the name of the physician providing the notice.

If actual notice is provided by telephone, the physician must actually speak with the parent or guardian, and must record in the minor's medical file the name of the parent or guardian to whom the notice was provided, the phone number dialed, and the date and time of the call. If constructive notice is given, the physician must document that notice by placing copies of any document related to the constructive notice, including, but not limited to, a copy of the letter and the return receipt, in the minor's medical file.

There are several exceptions to the notice requirement. Notice is not required if:[15]

- In the physician's good faith clinical judgment, a medical emergency exists and there is insufficient time for the attending physician to comply with the notification requirements. If a medical emergency exists, the physician may proceed but must document reasons for the medical necessity in the patient's medical records.
- Notice is waived in writing by the person who is entitled to notice.
- Notice is waived by the minor who is or has been married or has had the disability of nonage removed under s. 743.015, F.S., or a similar statute of another state.
- Notice is waived by the patient because the patient has a minor child dependent on her.
- Notice is waived by judicial waiver.

A physician who violates any of the parental notice requirements may be subject to disciplinary action under s. 458.331 or s. 459.015, F.S.[16]

A minor may petition any circuit court within the jurisdiction of the District Court of Appeal in which she resides for a waiver of the parental notice requirement and may participate in proceedings on her own behalf. The petition may be filed under a pseudonym or through the use of initials, as provided by court rule. The petition must include a statement that the petitioner is pregnant and notice has not been waived. The court is required to advise the minor that she has a right to court-appointed counsel and must provide her with counsel upon her request at no cost to the minor.[17]

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[14] "Constructive notice" means notice that is given in writing, signed by the physician, and mailed at least 72 hours before the inducement or performance of the termination of pregnancy, to the last known address of the parent or legal guardian of the minor, by certified mail, return receipt requested, and delivery restricted to the parent or legal guardian. After the 72 hours have passed, delivery is deemed to have occurred. Section 390.01114(2)(c), F.S.

[15] Section 390.01114(3)(b), F.S.

[16] The Department of Health, or the appropriate board, may suspend or permanently revoke a license; restrict a practice or license, impose an administrative fine not to exceed $10,000 for each count or separate offense; issue a reprimand or letter of concern; place the licensee on probation for a period of time and subject it to conditions; take corrective action; impose an administrative fine for violations regarding patient rights; refund fees billed and collected from the patient or a third party on behalf of the patient; or require that the practitioner undergo remedial education.

[17] Section 390.01114(4)(a), F.S.

These court proceedings must be given precedence over other pending matters to the extent necessary to ensure that the court reaches a decision promptly. The court is required to rule, and issue written findings of fact and conclusions of law, within 48 hours[18] after the petition is filed, except that the 48-hour limitation may be extended at the request of the minor. If the court fails to rule within the 48-hour period and an extension has not been requested, the petition is granted, and the notice requirement is waived.[19]

If the court finds, by clear and convincing evidence, that the minor is sufficiently mature to decide whether to terminate her pregnancy, the court must issue an order authorizing the minor to consent to the abortion without the notification of a parent or guardian, otherwise the court must dismiss the petition.

If the court finds, by a preponderance of the evidence, that there is evidence of child abuse or sexual abuse of the petitioner by one or both of her parents or her guardian, or that the notification of a parent or guardian is not in the best interest of the petitioner, the court is required to issue an order authorizing the minor to consent to the abortion without the notification of a parent or guardian, otherwise the court must dismiss the petition. If the court finds evidence of child abuse or sexual abuse of the minor petitioner by any person, the court must report the evidence of child abuse or sexual abuse of the petitioner, as provided in s. 39.201, F.S.[20]

Section 390.01114, F.S., also provides for the court procedures, including an appeals process, for hearings on a petition for waiver of parental notice.[21]

The Supreme Court of Florida, through the Office of the State Courts Administrator, is required to report by February 1 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives on the number of petitions filed for a waiver of parental notice for the preceding year, and the timing and manner of disposal of such petitions by each circuit court.[22] The Office of the State Courts Administrator reports that from January through December 2010 there were 381 petitions filed for a waiver of parental notice; 371 of those petitions were granted, 10 of those petitions were dismissed, and none of the petitions were granted by default because the court did not enter an order within 48 hours.[23]

[18] The Florida Supreme Court defines "48 hours" as meaning exactly 48 hours from the filing of the petition and specifically includes weekends, holidays, and times after regular business hours of the court. Rule 8.820(d), Florida Rules of Juvenile Procedure.
[19] Section 390.01114(4)(b), F.S.
[20] Section 39.201, F.S., requires that that finding of such evidence must be reported to the Department of Children and Family Services.
[21] *See* s. 390.01114(4), F.S.
[22] Section 390.01114(6), F.S.
[23] Information received on March 23, 2011, from the Office of the State Courts Administrator via e-mail to Senate Health Regulation Committee professional staff. A copy of the email is on file with the committee.

Relevant Case Law

In 1973, the landmark case of *Roe v. Wade* established that restrictions on a woman's access to secure an abortion are subject to a strict scrutiny standard of review.[24] In *Roe*, the U.S. Supreme Court determined that a woman's right to have an abortion is part of the fundamental right to privacy guaranteed under the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution, justifying the highest level of review.[25] Specifically, the Court concluded that: (1) during the first trimester, the state may not regulate the right to an abortion; (2) after the first trimester, the state may impose regulations to protect the health of the mother; and (3) after viability, the state may regulate and proscribe abortions, except when it is necessary to preserve the life or health of the mother.[26] Therefore, a state regulation limiting these rights may be justified only by a compelling state interest, and the legislative enactments must be narrowly drawn to express only legitimate state interests at stake.[27]

In 1992, in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the U.S. Supreme Court relaxed the standard of review in abortion cases involving adult women from strict scrutiny to unduly burdensome, while still recognizing that the right to an abortion emanates from the constitutional penumbra of privacy rights.[28] In *Planned Parenthood*, the Court determined that, prior to fetal viability, a woman has the right to an abortion without being unduly burdened by government interference.[29] The Court concluded that the state may regulate the abortion as long as the regulation does not impose an undue burden on a woman's decision to choose an abortion.[30] If the purpose of a provision of law is to place substantial obstacles in the path of a woman seeking an abortion before viability, it is invalid; however, after viability the state may restrict abortions if the law contains exceptions for pregnancies endangering a woman's life or health.[31]

The unduly burdensome standard as applied in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, which is generally considered to be a hybrid between strict scrutiny and intermediate level scrutiny, shifted the Court's focus to whether a restriction creates a substantial obstacle to access. This is the prevailing standard today applied in cases in which abortion access is statutorily restricted.

However, the undue burden standard was held not to apply in Florida. The 1999 Legislature passed a parental notification law, the Parental Notice of Abortion Act, requiring a physician to give at least 48 hours of actual notice to one parent or to the legal guardian of a pregnant minor before terminating the pregnancy of the minor. Although a judicial waiver procedure was included, the act was never enforced.[32] In 2003, the Florida Supreme Court[33] ruled this

[24] 410 U.S. 113 (1973).
[25] 410 U.S. 113, 154 (1973).
[26] 410 U.S. 113, 162-65 (1973).
[27] 410 U.S. 113, 152-56 (1973).
[28] 505 U.S. 833, 876-79 (1992).
[29] *Id.*
[30] *Id*.
[31] *Id.*
[32] *See* s. 390.01115, F.S. (repealed by s. 1, ch. 2005-52, Laws of Florida). Ch. 2005-52, Laws of Florida created s. 390.01114, F.S., the revised Parental Notice of Abortion Act.

legislation unconstitutional on the grounds that it violated a minor's right to privacy, as expressly protected under Article I, s. 23 of the Florida Constitution.[34] Citing the principle holding of *In re T.W.*,[35] the Court reiterated that, as the privacy right is a fundamental right in Florida, any restrictions on privacy warrant a strict scrutiny review, rather than that of an undue burden. Here, the Court held that the state failed to show a compelling state interest and therefore, the Court permanently enjoined the enforcement of the Parental Notice of Abortion Act.[36]

In the case of *In re Petition of Jane Doe,*[37] the Second District Court of Appeal of Florida provided an in-depth review of considerations by courts throughout the country in assessing maturity, for purposes of determining whether to permit a judicial waiver of the parental notification requirement for an abortion.

The *Jane Doe* case noted that the trial courts have drawn inferences from the minor's composure, analytic ability, appearance, thoughtfulness, tone of voice, expressions, and her ability to articulate her reasoning and conclusions.[38] The *Jane Doe* case also noted that another court,[39] in its attempt to define maturity, observed:

> Manifestly, as related to a minor's abortion decision, maturity is not solely a matter of social skills, level of intelligence or verbal skills. More importantly, it calls for experience, perspective and judgment. As to experience, the minor's prior work experience, experience in living away from home, and handling personal finances are some of the pertinent inquiries. Perspective calls for appreciation and understanding of the relative gravity and possible detrimental impact of each available option, as well as realistic perception and assessment of possible short term and long-term consequences of each of those options, particularly the abortion option. Judgment is of very great importance in determining maturity. The exercise of good judgment requires being fully informed so as to be able to weigh alternatives independently and realistically. Among other things, the minor's conduct is a measure of good judgment. Factors such as stress and ignorance of alternatives have been recognized as impediments to the exercise of proper judgment by minors, who because of those factors "may not be able intelligently to decide whether to have an abortion."

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[33] *North Florida Women's Health and Counseling Services, Inc., et al., v. State of Florida*, 866 So. 2d 612, 619-20 (Fla. 2003)

[34] The constitutional right of privacy provision reads: "Every natural person has the right to be let alone and free from governmental intrusion into the person's private life except as otherwise provided herein. This section shall not be construed to limit the public's right of access to public records and meetings as provided by law." FLA. CONST. art. I, s. 23.

[35] 551 So. 2d 1186, 1192 (Fla. 1989).

[36] *North Florida Women's Health and Counseling Services, supra* note 16, at 622 and 639-40.

[37] *In re Petition of Jane Doe*, 973 So. 2d 548 (Fla. 2d DCA 2008). The motion for rehearing en banc was denied. In this case, the court held that the juvenile failed to prove by clear and convincing evidence that she was sufficiently mature to warrant waiving the requirement for parental notification of abortion and also failed to establish that parental notification concerning abortion was not in her best interest.

[38] *Id.* at 552, citing *Ex parte Anonymous*, 806 So.2d 1269, 1274 (Ala. 2001).

[39] *Id.* at 551, citing *H.B. v. Wilkinson*, 639 F.Supp. 952, 954 (D.Utah 1986), which cited *Am. Coll. of Obstetricians & Gynecologists v. Thornburgh,* 737 F.2d 283, 296 (Pa. 3d Cir.1984), *affirmed* 476 U.S. 747 (1986).

The *Jane Doe* case further opined that another court similarly has stated that when evaluating maturity, pertinent factors include, but are not limited to, the minor's physical age, her understanding of the medical risks associated with the procedure as well as emotional consequences, her consideration of options other than abortion, her future educational and life plans, her involvement in civic activities, any employment, her demeanor and her seeking advice or emotional support from an adult.[40]

Finally, the *Jane Doe* case discussed that the Supreme Court of Texas, after surveying the decisions of other courts, wrote that those courts had inquired into how a minor might respond to certain contingencies, particularly assessing whether the minor will seek counseling in the event of physical or emotional complications. Many courts have assessed the minor's school performance and activities, as well as the minor's future and present life plans. A few courts have explicitly assessed the minor's character and judgment directly. Most of the decisions have also considered the minor's job experience and experience handling finances, particularly assessing whether the minor is aware of the financial obligations inherent in raising a child. Almost all courts conduct the maturity inquiry, either explicitly or implicitly, against the background circumstances of the minor's experience. These include the minor's relationship with her parents, whether she has social and emotional support, particularly from the male who would be a father, and other relevant life experiences.[41]

The *Jane Doe* case also addressed the contention that notification of the parent or guardian was not in the appellant's best interest. The court stated, some factors to be considered are: the minor's emotional or physical needs; the possibility of intimidation, other emotional injury, or physical danger to the minor; the stability of the minor's home and the possibility that notification would cause serious and lasting harm to the family structure; the relationship between the parents and the minor and the effect of notification on that relationship; and the possibility that notification may lead the parents to withdraw emotional and financial support from the minor.[42]

III. Effect of Proposed Changes:

This bill amends s. 390.01114, F.S., relating to parental notification of an abortion to be performed on a minor. This bill defines "constructive notice" to include notice by writing that must be mailed to a minor's parent or legal guardian 72 hours prior to the abortion by certified mail, return receipt requested with restricted delivery to the parent or legal guardian *and* by first-class mail.

The bill requires actual notice that is given by telephone to be confirmed in writing, signed by the physician, and mailed to the parent or legal guardian of the minor by first-class and by certified mail, return receipt requested, with delivery restricted to the parent or legal guardian. Furthermore, the bill requires a physician to make reasonable attempts to contact the parent or legal guardian, whenever possible, during a medical emergency that renders the abortion medically necessary, without endangering the minor. The physician providing such notice of the

[40] *Id.* at 551-552, citing *In re Doe*, 924 So.2d 935, 939 (Fla. 1st DCA 2006).
[41] *Id.* at 552, citing *In re Doe 2*, 19 S.W.3d 249, 256 (Tex. 2000).
[42] *Id.* at 553, citing *In re Doe*, 932 So.2d 278, at 285-86 (Fla. 2d DCA 2005); see also *In re Doe 2*, 166 P.3d 293, 296 (Colo. App. 2007); *In re Doe*, 19 Kan.App.2d 204, 866 P.2d 1069, 1075 (1994); *In re Doe 2*, 19 S.W.3d 278, 282 (Tex. 2000).

medical emergency must do so directly by telephone or in person and must provide the parent or legal guardian with the details of the medical emergency and any additional risks to the minor. If the parent or legal guardian has not been notified within 24 hours after the abortion, the physician must provide the notice in writing and the notice must be signed by the physician. The written notice must be mailed to the last known address of the parent or legal guardian of the minor, by first-class mail and by certified mail, return receipt requested, with delivery restricted to the parent or legal guardian.

A physician does not have to provide parental notice if a parent or guardian waives his or her right to be noticed and the written waiver is notarized, dated not more than 30 days before the abortion, and contains a specific waiver of the parent or legal guardian's right to notice of the minor's abortion.

The number of courts in which a minor is able to file a petition for waiver of the parental notice requirement is reduced because the bill authorizes a minor to petition any circuit court in which she resides rather than any circuit court within the jurisdiction of the District Court of Appeal in which she resides.

The bill also changes the time within which a court must rule on a minor's petition for a waiver of parental notice from 48 hours to 3 business days and removes the automatic grant of a petition when a court fails to rule within a certain time. If the court fails to rule within 3 business days after the filing of the petition, the minor may immediately petition the chief judge of the circuit for a hearing, which must be held within 48 hours of receiving the minor's petition. The chief judge must enter an order within 24 hours after the hearing.

The bill provides the minor with the right to appeal a court decision that does not grant judicial waiver of parental notice, and provides that the appellate court must rule within 7 days after receipt of the appeal. However, if the court rules to remand the case, a ruling must take place within 3 business days after the remand. The standard that must be used by the appellate court when overturning a ruling on appeal is an abuse of discretion standard and the decision may not be based on the weight of the evidence presented to the circuit court because the proceeding is not adversarial.

The bill provides specific factors that the court must consider when determining whether the minor is sufficiently mature to decide whether to terminate her pregnancy. The factors the court is required to consider include:

- The minor's age, overall intelligence, emotional development and stability, credibility and demeanor as a witness, ability to accept responsibility, ability to assess both the immediate and long-range consequences of the minor's choices, and ability to understand and explain the medical risks of terminating her pregnancy and to apply that understanding to her decision; and
- Whether there may be an undue influence by another on the minor's decision to have an abortion.

The bill also changes the standard upon which a court must find that the notification of a parent or guardian of the abortion is not in the best interest of the minor, from preponderance of the evidence to clear and convincing evidence. The bill provides that the best-interest standard used

by the court does not include financial best interest, financial considerations, or the potential financial impact on the minor or the minor's family if the minor does not terminate the pregnancy.

The bill requires the final written order by the court to include its factual findings determining the maturity of the minor.

The bill requires the Supreme Court, through the Office of State Courts Administrator, to include in its annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives, regarding the number of petitions filed for a waiver of parental notice, the reason for each waiver of notice granted.

The bill also includes a severability clause, which severs any provision of the bill that is held invalid and saves the remaining provisions.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

Under s. 390.01116, F.S., any information in a court record, which could be used to identify a minor petitioning a circuit court for a judicial waiver of parental notice, is confidential and exempt from public disclosure.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

D. Other Constitutional Issues:

If the bill, should it become law, is challenged because of its additional parental notification requirements, it will be subject to a strict scrutiny review, rather than that of an undue burden test pursuant to *North Florida Women's Health and Counseling Services, Inc., et al., v. State of Florida*,[43] as discussed above under the subheading, "Relevant Case Law."

The bill may be challenged as encroaching on the Florida Supreme Court's specific constitutional authority to adopt rules for the practice and procedure in all courts. Section 3, Article II of the Florida Constitution provides that the powers of the state

[43] 866 So. 2d 612 (Fla. 2003).

government shall be divided into legislative, executive, and judicial branches. No person belonging to one branch shall exercise any powers appertaining to either of the other branches unless expressly provided herein.

Section 2, Article V, of the Florida Constitution provides, among other things, that the supreme court shall adopt rules for the practice and procedure in all courts including the time for seeking appellate review, the administrative supervision of all courts, the transfer to the court having jurisdiction of any proceeding when the jurisdiction of another court has been improvidently involved, and a requirement that no cause shall be dismissed because an improper remedy has been sought.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Physicians may incur additional administrative costs because the bill requires physicians to mail additional notifications.

C. Government Sector Impact:

The Office of the State Courts Administrator may incur administrative costs associated with changing its reporting requirements as required under the bill. It is indeterminate the impact, if any, the bill's requirements for additional court procedures will have on the state court system.

VI. Technical Deficiencies:

Lines 119 through 21 need clarification because a minor does not reside in a circuit court. An amendment might delete lines 119 through 120 and insert: (a) A minor may petition any circuit court in <u>the</u> ~~a~~ judicial circuit ~~within the jurisdiction of the District Court of Appeal~~.

VII. Related Issues:

Lines 144 through 152 of the bill provide for a minor's appellate rights and certain appellate procedures. Existing law, which can be found in lines 209 through 213 of the bill, already provide for a minor's right to appeal and provide that the Supreme Court is to provide the procedures for appellate review by rule. Therefore, these two provisions may conflict with each other.

The bill does not include an automatic waiver of the parental notice requirement if the court fails to rule after the Appellate Court remands for a ruling.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 688
INTRODUCER:	Senator Richter
SUBJECT:	Assisted Living Facilities
DATE:	April 11, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Daniell	Walsh	CF	**Favorable**
2.	O'Callaghan	Stovall	HR	**Pre-meeting**
3.			CA	
4.				
5.				
6.				

I. Summary:

This bill repeals the provision of law authorizing the Department of Elder Affairs (DOEA) to conduct field visits and audits of assisted living facilities (ALFs) in order to collect information requested by the Legislature regarding the actual cost of providing room, board, and personal care to residents. The law providing that local governments or organizations may contribute to the cost of care of residents in local ALFs is also repealed.

This bill repeals section 429.54, Florida Statutes.

II. Present Situation:[1]

An assisted living facility (ALF) is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[2] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[3] Activities of daily living include: ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks. An ALF may be operated

[1] Information contained the Present Situation of this bill analysis is from an interim report by the Committee on Health Regulation of the Florida Senate. *See* Comm. on Health Reg., The Florida Senate, *Assisted Living Facility Licensure Review* (Interim Report 2010-118) (Oct. 2009), *available at* http://archive.flsenate.gov/data/Publications/2010/Senate/reports/interim_reports/pdf/2010-118hr.pdf (last visited April 8, 2011).

[2] Section 429.02(5), F.S.

[3] Section 429.02(16), F.S.

for profit or not-for-profit, and can range from small houses resembling private homes to larger developments with hundreds of residential beds.

Assisted living facilities are currently licensed by the Agency for Health Care Administration (AHCA) pursuant to part I of ch. 429, F.S., relating to assisted living facilities and part II of ch. 408, F.S., relating to the general licensing provisions for health care facilities. ALFs are also subject to regulation under Rule 58A-5 of the Florida Administrative Code. These rules are adopted by the DOEA in consultation with AHCA, the Department of Children and Family Services (DCF), and the Department of Health (DOH).[4] An ALF must also comply with Uniform Fire Safety Standards for ALFs and standards enforced by DOH concerning food hygiene; physical plant sanitation; biomedical waste; and well, pool, or septic systems.[5]

An ALF is required to provide care and services appropriate to the needs of the residents accepted for admission to the facility. Generally, the care and services include at a minimum:

- Supervising the resident in order to monitor the resident's diet; being aware of the general health, safety, and physical and emotional well-being of the resident; and recording significant changes, illnesses, incidents, and other changes which resulted in the provision of additional services;
- Contacting appropriate persons upon a significant change in the resident or if the resident is discharged or moves out;
- Providing and coordinating social and leisure activities in keeping with each resident's needs, abilities, and interests;
- Arranging for health care by assisting in making appointments, reminding residents about scheduled appointments, and providing or arranging for transportation as needed; and
- Providing to the resident a copy of, and adhering to, the Resident Bill of Rights.

Local governments or organizations may help subsidize the cost of providing care to residents in ALFs. Implementation of a local subsidy requires authorization of the DOEA and may not result in a reduction of the state supplement.[6] In order to help ascertain the actual cost of providing room, board, and personal care to residents in ALFs, s. 429.54(1), F.S., authorizes the DOEA to conduct field visits and audits of facilities as necessary. If randomly selected, the owner of the facility must submit a report, audit, and other accountings of cost as requested by the DOEA.

There are currently 2,932 licensed ALFs in Florida.[7] In addition to a standard license, an ALF may have specialty licenses that authorize an ALF to provide limited nursing services (LNS), limited mental health (LMH) services,[8] and extended congregate care (ECC) services.

The biennial licensure fees for the ALF standard license and specialty licenses are found in s. 429.07(4), F.S. This section refers to the general health care licensure provisions in part II of

[4] Section 429.41(1), F.S.
[5] *See* rules 64E-12, 64E-11, and 64E-16, F.A.C.
[6] Section 429.54(2), F.S.
[7] Senate professional staff of the Health Regulation Committee received this information via email on March 25, 2011. A copy of the email is on file with the committee.
[8] An ALF that serves three or more mental health residents must obtain a limited mental health specialty license. A mental health resident is an individual who receives social security disability income (SSDI) due to a mental disorder or supplemental security income (SSI) due to a mental disorder, and receives OSS.

ch. 408, F.S. Section 408.805, F.S., provides for licensure fees to be adjusted annually by not more than the change in the Consumer Price Index (CPI) based on the 12 months immediately preceding the increase. The following chart reflects the licensure fees contained in s. 429.07(4), F.S., and the adjusted licensure fees based on the CPI that are currently in effect.[9]

Fee Description	Per s. 429.07(4), F.S.	CPI adjusted (current fee)
Standard ALF Application Fee	$300	$366
Standard ALF Per-Bed Fee (non-OSS)	$50	$61
Total Licensure fee for Standard ALF	$10,000	$13,443
ECC Application Fee	$400	$515
ECC Per-Bed Fee (licensed capacity)	$10	$10
LNS Application Fee	$250	$304
LNS Per-Bed Fee (licensed capacity)	$10	$10

III. Effect of Proposed Changes:

This bill repeals the DOEA's authority to the collect information as requested by the Legislature about the ALFs actual costs associated with providing room, board, and personal care to residents by conducting field visits and audits of the ALFs. Further, this bill repeals the requirement that owners of randomly sampled ALFs must cooperate with the DOEA and submit the reports, audits, and accountings of cost that the DOEA requires by rule.

Additionally, the bill repeals the authority of local governments or organizations to contribute to the cost of care of residents in local ALFs by subsidizing the rate of state-authorized payment to such facilities.

The bill provides an effective date of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

[9] Found on the AHCA website at: http://ahca.myflorida.com/MCHQ/LONG_TERM_CARE/Assisted_living/alf/ALF_fee_increase.pdf, (Last visited on March 25, 2011).

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill repeals s. 429.54, F.S., which authorizes local governments or organizations to contribute to the cost of care of ALF residents upon approval of the DOEA. By repealing this section of law, ALFs may no longer receive subsidies from local governments or organizations. However, according to the DOEA, they are unaware of any local governments or organizations currently subsidizing the cost of care for residents.[10]

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

[10] E-mail from Kevin Reilly, Director of Legislative Affairs, Dep't of Elder Affairs, to professional staff of the Senate Committee on Health Regulation (April 8, 2011) (on file with the Senate Committee on Health Regulation).

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 690
INTRODUCER:	Senator Richter
SUBJECT:	Assisted Living Facilities
DATE:	April 11, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Daniell	Walsh	CF	**Favorable**
2.	O'Callaghan	Stovall	HR	**Pre-meeting**
3.			RC	
4.				
5.				
6.				

I. Summary:

This bill removes the requirement that the Department of Elderly Affairs (DOEA) must submit a copy of proposed rules to the Speaker of the House of Representatives, the President of the Senate, and appropriate committees of substance for review and comment prior to promulgation.

This bill substantially amends s. 429.41, F.S.

II. Present Situation:[1]

An assisted living facility (ALF) is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[2] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[3] Activities of daily living include: ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks. An ALF may be operated for profit or not-for-profit, and can range from small houses resembling private homes to larger developments with hundreds of residential beds.

[1] A majority of the information contained the Present Situation of this bill analysis is from an interim report by the Committee on Health Regulation of the Florida Senate. *See* Comm. on Health Reg., The Florida Senate, *Assisted Living Facility Licensure Review* (Interim Report 2010-118) (Oct. 2009), *available at* http://archive.flsenate.gov/data/Publications/2010/Senate/reports/interim_reports/pdf/2010-118hr.pdf (last visited April 11, 2011).

[2] Section 429.02(5), F.S.

[3] Section 429.02(16), F.S.

Assisted living facilities are currently licensed by the Agency for Health Care Administration (AHCA) pursuant to part I of ch. 429, F.S., relating to assisted living facilities and part II of ch. 408, F.S., relating to the general licensing provisions for health care facilities. Assisted living facilities are also subject to regulation under chapter 58A-5 of the Florida Administrative Code. These rules are adopted by the DOEA in consultation with the AHCA, the Department of Children and Family Services, and the Department of Health, and must include minimum standards in relation to:

- The requirements for maintenance of facilities which will ensure the health, safety, and comfort of residents and protection from fire hazard;
- The preparation and annual update of a comprehensive emergency management plan;
- The number, training, and qualifications of all personnel having responsibility for the care of residents;
- All sanitary conditions within the facility and the surroundings which will ensure the health and comfort of residents;
- License application and license renewal, transfer of ownership, proper management of resident funds and personal property, surety bonds, resident contracts, refund policies, financial ability to operate, and facility and staff records;
- Inspections, complaint investigations, moratoriums, classification of deficiencies, levying and enforcement of penalties, and use of income from fees and fines;
- The enforcement of the resident bill of rights;
- Facilities holding a limited nursing, extended congregate care, or limited mental health license;
- The use of physical or chemical restraints; and
- The establishment of specific policies and procedures on resident elopement.[4]

The DOEA is urged to draft rules that encourage the development of homelike facilities that promote dignity, individuality, strengths, and decision-making of the residents.
Section 429.41(3), F.S., requires that the DOEA submit all proposed rules to the Speaker of the House of Representatives, the President of the Senate, and the appropriate committee for review and comment prior to promulgation.

During the 2010 Regular Session, HB 1565 passed the Legislature, but was vetoed by Governor Crist. During the 2011 Special Session "A," the veto was overridden and the bill became law.[5] This law requires state agencies to determine the impact of proposed agency rules and if the rules have an adverse impact on small businesses or is likely to increase regulatory costs in excess of $200,000 in the aggregate within 1 year after implementation of the rule, the agency must prepare a statement of estimated regulatory costs (SERC).[6] The SERC must provide whether the rules will financially impact small businesses by $1 million or more over the first 5 years of enactment. If the economic analysis concludes that the rules meet or exceed this threshold, the rules must be presented to the Speaker of the House of Representatives and the President of the Senate and cannot take effect until ratified by the Legislature.

[4] Section 429.41(1), F.S.
[5] Chapter 2010-279, Laws of Fla.
[6] Section 120.54(3)(b)1., F.S. *See also* s. 120.541, F.S.

The DOEA will be required to follow the rulemaking procedure outlined in HB 1565 irrespective of the fact that s. 429.41, F.S., requires the DOEA to submit proposed rules to the Speaker of the House of Representatives, the President of the Senate, and appropriate committees. However, s. 429.41, F.S., is not redundant or duplicative because HB 1565 requires rules to be submitted to the Legislature if certain conditions exist, while s. 429.41, F.S., requires the DOEA to submit a copy of *all* proposed rules.

III. Effect of Proposed Changes:

This bill amends s. 429.41, F.S., to remove the requirement that the DOEA submit a copy of proposed rules to the Speaker of the House of Representatives, the President of the Senate, and appropriate committees of substance for review and comment prior to promulgation.

The bill also removes the requirement that rules promulgated by the DOEA must encourage the development of homelike facilities which promote the dignity, individuality, personal strengths, and decision-making ability of residents.

The bill provides an effective date of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The DOEA would no longer have to submit all rules to the Legislature for review and comment prior to promulgation and therefore, rules should be implemented more quickly, unless they must still be ratified by the Legislature under s. 120.54(3)(b)1., F.S., and s. 120.541, F.S.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 692
INTRODUCER:	Senator Richter
SUBJECT:	Assisted Living Facilities
DATE:	April 11, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Daniell	Walsh	CF	**Favorable**
2.	O'Callaghan	Stovall	HR	**Pre-meeting**
3.			RC	
4.				
5.				
6.				

I. Summary:

This bill removes the statutory requirement that the Agency for Health Care Administration (AHCA) distribute all biennial and interim visit reports of assisted living facilities (ALFs) to the local ombudsman council, at least one public library, and to the district Adult Services and Mental Health Program Offices.

This bill substantially amends s. 429.35, F.S.

II. Present Situation:

An assisted living facility (ALF) is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[1] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[2] Activities of daily living include: ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks. An ALF may be operated for profit or not-for-profit, and can range from small houses resembling private homes to larger developments with hundreds of residential beds.

Assisted living facilities are currently licensed by the AHCA pursuant to part I of ch. 429, F.S., relating to assisted living facilities and part II of ch.408, F.S., relating to the general licensing provisions for health care facilities. Assisted living facilities are also subject to regulation under

[1] Section 429.02(5), F.S.
[2] Section 429.02(16), F.S.

chapter 58A-5 of the Florida Administrative Code. These rules are adopted by the Department of Elder Affairs (DOEA) in consultation with the AHCA, the Department of Children and Family Services, and the Department of Health.[3]

As of February 2011, there were 2,926 ALFs licensed in Florida.[4] All licensed ALFs must have a biennial inspection[5] and between January 2010 and February 2011, 2,366 biennial inspection visits were conducted.[6]

Section 429.35(2), F.S., requires the AHCA, within 60 days after a biennial inspection and 30 days after any interim visit, to forward the results to:

- The local ombudsman council in the appropriate planning and service area;
- At least one public library, or if none, then to the county seat; and
- The district Adult Services and Mental Health Program Offices.

Section 408.806(8), F.S., allows the AHCA to provide electronic access to information or documents, such as inspection results. The AHCA provides written reports of all inspections to the provider. Compliance and noncompliance with regulations are cited in the report. Upon review by the AHCA, the reports are posted on the inspections report website[7] and a monthly email is sent to the Office of State Long-Term Care Ombudsman (office) of all inspections completed. The office distributes this information to the local ombudsman councils.[8]

III. Effect of Proposed Changes:

This bill amends s. 429.35, F.S., to remove the requirement that the AHCA distribute, within 60 days after the date of the biennial inspection visit or within 30 days after the date of any interim visit, all biennial and interim visit reports of ALFs to the local ombudsman council, at least one public library or to the county seat in which the inspected ALF is located if there is no library, and to the district Adult Services and Mental Health Program Offices.[9]

The bill provides an effective date of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

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[3] Section 429.41(1), F.S.
[4] Agency for Health Care Admin., *2011Bill Analysis and Economic Impact Statement SB 692* (Feb. 28, 2011) (on file with the Senate Health Regulation Committee).
[5] Section 408.811(1)(b), F.S.
[6] Agency for Health Care Admin., *supra* note 4.
[7] *See* http://apps.ahca.myflorida.com/dm_web/(S(n3dnev45xakyh155qllelimg))/Default.aspx (last visited April 7, 2011).
[8] Agency for Health Care Admin., *supra* note 4.
[9] According AHCA, the reports will continue to be available on the agency's website for retrieval and review. *Id*.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

By eliminating the requirement that the AHCA forward the results of all biennial and interim visit reports to the local ombudsman council, the public library, and the district Adult Services and Mental Health Program Offices, the bill may have a positive fiscal impact on the AHCA.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Education Pre-K - 12 Committee

BILL:	SB 1000
INTRODUCER:	Senator Wise
SUBJECT:	Interscholastic and Intrascholastic Sports
DATE:	April 7, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Matthews	ED	**Favorable**
2.	Brown	Stovall	HR	**Pre-meeting**
3.			BC	
4.				
5.				
6.				

I. Summary:

This bill removes from statute the two-year pilot program which provided for sports participation of private middle and high school students of three counties at public high schools within the residential zoning area and makes permanent its applicability statewide.

Student records relating to eligibility, compliance and participation in the program are required to be maintained by the athletic director at the participating Florida High School Athletic Association (FHSAA) member public school. A non-FHSAA private school is required to provide student records to the FHSAA upon request.

The bill limits participation of a non-FHSAA private school student at a public school to those students enrolled at private schools with a student population of no greater than 125 students.

This bill substantially amends the following section of the Florida Statutes: 1006.15.

II. Present Situation:

FHSAA

The Florida High School Athletic Association, established in law in s. 1006.20, F.S., is the governing body of Florida public school athletics. The FHSAA is organized by an executive director, a Board of Directors, a Representative Assembly, and Sectional Committees. Currently, the FHSAA governs 748 public and private member schools.[1] Section 1006.15, F.S., imposes

[1] http://www.fhsaa.org/about

general eligibility requirements for participating students, based on academic thresholds and satisfactory conduct and also addresses participation by private, charter, and home education students.

The Legislature grants the FHSAA authority to adopt bylaws. The FHSAA publishes its bylaws in a handbook, available online.[2]

Participation in Sports by Students at Schools They Are Not Attending

Home education students are authorized to participate in sports at the public school to which the student would be assigned, or a private school under certain conditions.[3] Charter school students are also authorized to participate in sports at the public school to which they would have been assigned.[4]

Pilot Program for Private School Students to Participate in Sports at Public Schools

The 2007 Legislature passed a law which implemented a two-year pilot program to enable middle and high private school students to participate in interscholastic or intrascholastic sports at public schools within the zoning area of the student. Participation was limited to students residing in Bradford, Duval, and Nassau counties.[5] The two years included in the program were the 2008-09 and 2009-10 academic years.[6]

The legislation required certain conditions for participation, including:

- The private school must be a non-FHSAA member that does not offer an interscholastic or intrascholastic program;
- The student meets conduct guidelines established by the FHSAA and participating district school boards;
- Transportation arrangements are to be borne by the parents. The public school, district school board, and the FHSAA are exempt from any related civil liability;
- The private school student is limited to participation at one public school for each academic year.

In addition to requiring provision of a copy of the guidelines to the Governor, Senate President, and House Speaker, this legislation required the FHSAA and the district school boards to produce a report on specific information about the student participants and to make recommendations on program improvements.

[2] The handbook is available at the FHSA website, at: http://www.fhsaa.org/rules/fhsaa-handbook
[3] s. 1006.15(3)(c), F.S.
[4] s. 1006.15(3)(d), F.S.
[5] ch. 2008-228, L.O.F.
[6] s. 1006.15, F.S.

Program Report

The FHSAA provided a report, dated December 15, 2009, which detailed the following regarding interest and participation:

- As of the date of the letter, 23 students submitted the appropriate application form;
- Of those, 11 were middle school students and 12 were high school students;
- Of the 23, 11 were from Bradford county, 10 were from Duval county, and two were from Nassau county;
- Of the applicants, 15 were approved, two were denied, and six failed to provide additional information required for eligibility determinations; and
- Two students later transferred to the public school in which they participated.

The report also indicated that no problems existed other than coordination between start and end times of the schools and transportation. No recommendations were made regarding expansion or continuation of the program.[7]

III. Effect of Proposed Changes:

Section 1 amends s. 1006.15, F.S., to remove language which established the pilot program and tested private school student sports participation at public schools in certain circumstances. The bill expands the program's current limited application of Bradford, Duval, and Nassau counties to all counties. In addition to maintaining qualifying conditions, the bill addresses the keeping and production of participant student records.

Public schools at which the eligible private school student participates in sports are required to maintain student records of the private school students. A non-FHSAA private school is required to provide student records to the FHSAA upon request. It is up to the individual school to determine how these records are to be kept.

The bill limits participation of a non-FHSAA private school student at a public school to those students enrolled at private schools with a student population of no greater than 125 students.

The bill makes non-FHSAA member private school students eligible to participate in sports at public schools, just as home education students and charter school students are now. These students would be subject to the same standards as other participants.

Section 2 provides that the bill takes effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

[7] Letter to the Governor, Dr. Roger Dearing, Executive Director, FHSAA (December 15, 2009).

B. Public Records/Open Meetings Issues:

The provisions of the bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

There may be local school costs associated with maintaining and providing records of students; however, these are expected to be insignificant.

According to the Florida Department of Education, there are 1,600 private schools with a student population of under 125 students. It is unknown how many students would pursue the option provided in this bill and how many would qualify as eligible.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	CS/SB 1754
INTRODUCER:	Banking and Insurance Committee and Senator Garcia
SUBJECT:	Health Insurance
DATE:	April 6, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Burgess	BI	**Fav/CS**
2.	Brown	Stovall	HR	**Pre-meeting**
3.			RC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

The bill provides that a person may not be compelled to purchase health insurance, except as a condition of:

- Public employment;
- Voluntary participation in a state or local benefit;
- Operating a dangerous instrumentality;
- Undertaking an occupation having a risk of occupational injury or illness;
- An order of child support; or
- An activity between private persons.

The bill also provides that the prohibition against compelling a person to purchase health insurance would not prohibit the collection of debts lawfully incurred for health insurance.

This bill creates section 624.24, Florida Statutes.

II. Present Situation:

The Federal Patient Protection and Affordable Care Act

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act, (PPACA), P.L. 111-148, as amended by the Reconciliation Act, P.L. 111-152. The PPACA is a broad-based, national approach designed to reform various aspects of the health insurance system including access and affordability of coverage.

The PPACA establishes new requirements on individuals, employers, and health plans; restructures the private health insurance market; and creates exchanges for individuals and employers to obtain coverage. An exchange is not an insurer; however, it would provide eligible individuals and businesses with access to insurers' plans.

The PPACA expands the Medicaid program in 2014 to include nonelderly, nonpregnant individuals with income below 133 percent of the federal poverty level who were previously ineligible for Medicaid. Also in 2014, some individuals who do not qualify for Medicaid, but who meet other requirements, will be provided with premium tax credits and cost-sharing subsidies to help pay for the premiums and out-of-pocket costs of health plans offered through an exchange.

The PPACA requires most U.S. citizens and legal residents to obtain health insurance by January 1, 2014,[1] or potentially pay taxes or penalties for non-compliance. A taxpayer is exempt from the penalty if the individual has a household income below a certain threshold, is a member of an Indian tribe, or has a religious objection to purchasing health insurance. An individual who fails to maintain coverage is required to pay an annual tax penalty of the greater of $95 for each household member (up to $285), or 1 percent of household income in 2014, $325 or 2 percent of household income in 2015, and $695 or 2.5 percent of income in subsequent years. The tax penalty for an entire family is capped at $2,250. The applicable tax penalty for dependents under the age of 18 is one-half the amount for adults.

If an individual that is subject to the tax penalty fails to pay the tax penalty, the Internal Revenue Service can attempt to collect funds by reducing the amount of an individual's tax refund in the future. However, individuals that fail to pay the tax penalty will not be subject to any criminal prosecution for such failure.

Congressional Authority and Constitutionality

Commerce Clause (U.S. Const. Art. I, Sec. 8, Clause 3)
Congress has the power to regulate interstate commerce, including local matters and issues that "substantially affect" interstate commerce. Proponents of insurance reforms assert that although health care delivery is local, the sale and purchase of medical supplies and health insurance occurs across state lines; thus regulation of health care is within Commerce Clause authority. Arguing in support of an individual mandate, proponents point to insurance market destabilization caused by the large uninsured population as reason enough to authorize

[1] Section 1501(b) as amended by section 101006 (b) of P.L. 111-148 and by s. 1002 of P.L. 111-152.

Congressional action under the Commerce Clause.[2] Opponents suggest that the decision not to purchase health care coverage is not a commercial activity and cite to *United States v. Lopez*[3] which held that Congress is prohibited from "…unfettered use of the Commerce Clause authority to police individual behavior that does not constitute interstate commerce."[4]

The Tenth Amendment and the Anti-Commandeering Doctrine (U.S. Const. Amend. 10)
The Tenth Amendment reserves to the states all power that is not reserved expressly for the federal government in the U.S. Constitution. Opponents of federal insurance reform assert that the individual mandate violates federalism principles because the U.S. Constitution does not authorize the federal government to regulate health care. They argue, "…state governments – unlike the federal government – have greater, plenary authority and police powers under their state constitutions to mandate the purchase of health insurance."[5] Further, opponents argue that the state health insurance exchange mandate may violate the anti-commandeering doctrine, which prohibits the federal government from requiring state officials to carry out onerous federal regulations.[6] Proponents for reform suggest that Tenth Amendment jurisprudence only places wide and weak boundaries around Congressional regulatory authority to act under the Commerce Clause.[7]

State Legislative Actions

State Legislation Implementing PPACA
As of September 27, 2010, at least 25 states have enacted or adopted legislation or taken official action to form a committee, task force, or board concerning health insurance reform implementation.[8] Additionally, at least 14 governors have issued executive orders to begin the process of health insurance reform implementation.[9]

State Legislation Opposing PPACA
In response to the federal health insurance reform, state legislators in at least 40 states have filed legislation to limit, alter, or oppose certain state or federal action, including single-payer provisions and mandates that would compel the purchase of health insurance.[10] In 30 of the states, the legislation includes a proposed constitutional amendment by ballot.[11]

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[2] Jack Balkin, *The Constitutionality of the Individual Mandate for Health Insurance*, N. Eng. J. Med. 362:6, at 482 (February 11, 2010).
[3] 514 U.S. 549 (1995).
[4] Peter Urbanowicz and Dennis G. Smith, *Constitutional Implications of an 'Individual Mandate' in Health Care Reform*, The Federalist Society for Law and Public Policy, at 4 (July 10, 2009).
[5] *Id*.
[6] Matthew D. Adler, *State Sovereignty and the Anti-Commandeering Cases*, The Annals of the American Academy of Policy and Social Science, 574, at 158 (March 2001).
[7] Hall, *supra* note 25, at 8-9.
[8] National Conference of State Legislators, *State Actions to Implement Federal Health Reform*, Nov. 22, 2010, available at http://www.ncsl.org/default.asx?tabid=20231#Legislative (last visited Jan. 3, 2011).
[9] *Id*.
[10] National Conference of State Legislatures, *State Legislation and Actions Challenging Certain Health Reforms, 2010*, Dec. 18, 2010, *available at* http://www.ncsl.org/?tabid=18906 (last visited Jan. 3, 2011).
[11] *Id.*

Florida Insurance Coverage Requirements

Florida law does not require state residents to maintain health insurance coverage. However, Florida law does require drivers to carry Personal Injury Protection (PIP) insurance,[12] which includes specified medical benefits, as a condition of registering a motor vehicle.[13] Florida law also requires employers to secure the payment of workers' compensation coverage. Employers secure workers' compensation coverage by purchasing insurance or meeting the requirements to self-insure.[14] Workers' compensation insurance provides certain medical and indemnity benefits.[15]

III. Effect of Proposed Changes:

Section 1 creates s. 624.24, F.S., and provides that a person may not be compelled to purchase health insurance, except as a condition of:

- Public employment;
- Voluntary participation in a state or local benefit;
- Operating a dangerous instrumentality;
- Undertaking an occupation having a risk of occupational injury or illness;
- An order of child support; or
- An activity between private persons.

The bill also provides that the act does not prohibit the collection of debts lawfully incurred for health insurance.

Section 2 provides that the bill takes effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of the bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

[12] Section 627.736, F.S.
[13] Section 320.02(5)(a), F.S.
[14] Section 440.38, F.S.
[15] Sections 440.13, 440.15, and 440.16, F.S.

D. Other Constitutional Issues:

Florida and 25 other states brought an action in the United States District Court for the Northern District of Florida challenging the constitutionality of the PPACA. On January 31, 2011, Judge Roger Vinson found the Act unconstitutional.[16] The court rejected the argument by the United States that the individual mandate is a tax and made it clear that he agreed with the plaintiffs' argument that the power the individual mandate seeks to harness "is simply without precedent."

On March 3, 2011, Judge Vinson granted a stay of his order on the condition that the federal government seek an immediate appeal and an expedited review. The federal government filed the appeal and motion for expedited review to the United State Court of Appeal for the Eleventh Circuit on March 8, 2011.[17] Florida and the other plaintiffs have filed a motion requesting a more condensed briefing and oral argument schedule than requested by the federal government. The Eleventh Circuit responded on March 11, 2011 setting the briefing schedule beginning on April 4, 2011 and ending May 25, 2011.[18]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

[16] State of Florida, et al. v. United States Department of Health and Human Services, et al., --- F.Supp.2d ----, 2011 WL 285683 (N.D.Fla.).
[17] Case No. 11-11021-HH.
[18] State of Fla., et al. v. U.S. Dept. of Health & Human Serv., Nos. 11-11021-HH & 11-11067-HH, Order on Appellants' Mtn. to Expedite Appeal (11th Cir. March 11, 2011).

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Banking and Insurance Committee on April 5, 2011:
Designates section of Florida Statutes that is being created.

B. Amendments:

None.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Criminal Justice Committee

BILL:	SB 1146
INTRODUCER:	Senator Sachs
SUBJECT:	Drug-related Overdoses
DATE:	April 7, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Cellon	Cannon	CJ	**Fav/1 amendment**
2.	Brown	Stovall	HR	
3.			JU	
4.			BC	
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	☐	Statement of Substantial Changes
B. AMENDMENTS.....	☒	Technical amendments were recommended
	☐	Amendments were recommended
	☐	Significant amendments were recommended

I. Summary:

The bill creates s. 893.21, F.S., entitled the "911 Good Samaritan Act" and provides that:

- A person making a good faith effort to obtain or provide medical assistance for an individual experiencing a drug-related overdose may not be charged, prosecuted, or penalized for possession of a controlled substance if the evidence for possession was obtained as a result of the person's seeking medical assistance.
- A person who experiences a drug-related overdose and is in need of medical assistance may not be charged, prosecuted, or penalized for possession of a controlled substance if the evidence for possession was obtained as a result of the overdose and the need for medical assistance.

The bill states that the above-described protection from prosecution for possession offenses may not be grounds for suppression of evidence in other criminal prosecutions. The bill also adds the following to the list of mitigating circumstances a judge may consider when departing from the lowest permissible sentence:

- The defendant was making a good faith effort to obtain or provide medical assistance for an individual experiencing a drug-related overdose.

This bill substantially amends section 921.0026, Florida Statutes.

The bill creates section 893.21, Florida Statutes.

II. Present Situation:

Florida law currently contains a number of provisions that provide immunity from civil liability to persons in specified instances. Florida law also contains various provisions that allow criminal defendants to have their sentences reduced or suspended in certain instances. A description of these provisions follows.

Florida "Good Samaritan" Laws

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

- Gratuitously and in good faith renders emergency care or treatment either in direct response to emergency situations or at the scene of an emergency, without objection of the injured victim, if that person acts as an ordinary reasonable and prudent person would have acted under the same or similar circumstances.[1]
- Participates in emergency response activities of a community emergency response team if that person acts prudently and within the scope of his or her training.[2]
- Gratuitously and in good faith renders emergency care or treatment to an injured animal at the scene of an emergency if that person acts as an ordinary reasonable and prudent person would have acted under the same or similar circumstances.[3]

Section 768.1325, F.S., provides that a person is immune from civil liability for any harm resulting from the use or attempted use of an automated external defibrillator device on a victim of a perceived medical emergency, without objection of the victim.

Section 768.1355, F.S., entitled the Florida Volunteer Protection Act, provides that any person who volunteers to perform any service for any nonprofit organization without compensation will incur no civil liability for any act or omission that results in personal injury or property damage if:

- The person was acting in good faith within the scope of any official duties performed under the volunteer service and the person was acting as an ordinary reasonable and prudent person would have acted under the same or similar circumstances; and
- The injury or damage was not caused by any wanton or willful misconduct on the part of the person in the performance of the duties.

[1] Section 768.13(2)(a), F.S.
[2] Section 768.13(2)(d), F.S.
[3] Section 768.13(3), F.S.

Reduction or Suspension of Criminal Sentence

Section 921.186, F.S., allows the state attorney to move the sentencing court to reduce or suspend the sentence of persons convicted of a felony who provide substantial assistance in the identification, arrest, or conviction of any accomplice, accessory, coconspirator, or principal of the defendant; or any other person engaged in felonious criminal activity.

Mitigating Circumstances

The Criminal Punishment Code applies to sentencing for felony offenses committed on or after October 1, 1998. Criminal offenses are ranked in the "offense severity ranking chart"[4] from level one (least severe) to level ten (most severe) and are assigned points based on the severity of the offense as determined by the Legislature. If an offense is not listed in the ranking chart, it defaults to a ranking based on the degree of the felony.[5]

The points are added in order to determine the "lowest permissible sentence" for the offense. A judge cannot impose a sentence below the lowest permissible sentence unless the judge makes written findings that there are "circumstances or factors that reasonably justify the downward departure."[6] Mitigating circumstances under which a departure from the lowest permissible sentence is reasonably justified include:

- The defendant was an accomplice to the offense and was a relatively minor participant in the criminal conduct.
- The defendant acted under extreme duress or under the domination of another person.
- The defendant cooperated with the state to resolve the current offense or any other offense.[7]

Currently, there are no mitigating circumstances related to defendants who make a good faith effort to obtain or provide medical assistance for an individual experiencing a drug-related overdose.

Possession of a Controlled Substance

Section 893.02, F.S., states possession of a controlled substance[8] includes "temporary possession for the purpose of verification or testing, irrespective of dominion or control."

Actual or constructive possession of certain controlled substances, unless such controlled substance was lawfully obtained from a practitioner or pursuant to a valid prescription or order of a practitioner while acting in the course of his or her professional practice, is a third degree felony punishable[9] by up to 5 years in prison and a fine up to $5,000.[10]

[4] Section 921.0022, F.S.
[5] Section 921.0024, F.S., provides that a defendant's sentence is calculated based on points assigned for factors including: the offense for which the defendant is being sentenced; injury to the victim; additional offenses that the defendant committed at the time of the primary offense; and the defendant's prior record and other aggravating factors.
[6] Section 921.0026, F.S.
[7] *Id*.
[8] Section 893.02(4), F.S., defines controlled substance as "any substance named or described in Schedules I-V of s. 893.03, F.S."
[9] As provided in ss. 775.082, 775.083, or 775.084, F.S.
[10] Section 893.13(6)(a), F.S.

Possession of less than 20 grams of cannabis[11] is a first degree misdemeanor punishable[12] by up to 1 year in prison and a fine up to $1,000.[13]

Possession of more than 10 grams of any substance named or described in s. 893.03(1)(a) or (1)(b), F.S., or any combination thereof, or any mixture containing any such substance is a first degree felony punishable[14] by up to 30 years in prison and a fine up to $10,000.[15]

Paragraphs (1)(a)-(l) of s. 893.135, F.S., prohibit the actual or constructive possession of various quantities of controlled substances that appear in s. 893.03, F.S., and are commonly referred to as "scheduled" drugs. The scheduled drugs are listed in Schedules I-V according to the potential for abuse or addiction, currently accepted medical use in treatment in the United States, and relative degree of danger to the user. Possession violations of s. 893.135(1)(a)-(l), F.S., are drug trafficking offenses that carry minimum mandatory prison sentences that increase in severity as the amount or weight of the drug possessed increases, including capital crimes if deaths result from the manufacture or importation of the drug.[16]

911 Good Samaritan Laws in Other States

In New Mexico, the 911 Good Samaritan Act prevents the prosecution for drug possession based on evidence "gained as a result of the seeking of medical assistance" to treat a drug overdose.[17] This law, which took effect in June 2007, was the first of its kind in the country.[18]

While many states have considered similar Good Samaritan immunity legislation, Washington is the only other state to have passed such a law.[19]

III. Effect of Proposed Changes:

Section 1 provides that this act may be cited as the "911 Good Samaritan Act."

Section 2 creates s. 893.21, F.S., to provide that a person who in good faith seeks medical assistance for an individual experiencing a drug-related overdose may not be charged, prosecuted, or penalized for possession of a controlled substance if the evidence for possession was obtained as a result of the person's seeking medical assistance.

The bill provides that a person who experiences a drug-related overdose and is in need of medical assistance may not be charged, prosecuted, or penalized for possession of a controlled

[11] For the purposes of s. 893.13(6)(b), F.S., cannabis is defined as all parts of any plant of the genus Cannabis, whether growing or not, and the seeds thereof.
[12] As provided in ss. 775.082 or 775.083 F.S.
[13] Section 893.13(6)(b), F.S.
[14] As provided in ss. 775.082, 775.083, or 775.084, F.S.
[15] Section 893.13(6)(c), F.S.
[16] Sections 893.03 and 893.135(1), F.S.
[17] "Preventing Overdose, Saving Lives." Drug Policy Alliance. March 2009. http://www.drugpolicy.org/library/overdose2009.cfm (Last accessed March 12, 2011.)
[18] *Id.*
[19] SB 5516 entitled "Drug Overdose Prevention." Effective June 2010.

substance if the evidence for possession was obtained as a result of the overdose and the need for medical assistance.

The bill states that the above-described protection from prosecution for possession offenses may not be grounds for suppression of evidence in other criminal prosecutions.

Section 3 amends s. 921.0026, F.S., to add the following to the list of mitigating circumstances a judge may consider when departing from the lowest permissible sentence: "The defendant was making a good faith effort to obtain or provide medical assistance for an individual experiencing a drug-related overdose."

Section 4 provides an effective date for the bill of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of the bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

On March 2, 2011, the Criminal Justice Impact Conference (CJIC) met and determined that this bill would have no impact on the Department of Corrections.

VI. Technical Deficiencies:

None.

VII. Related Issues:

It is generally preferable that bills relating to criminal laws have an October 1 effective date, which provides more time for judges, officials, and practitioners in the field to prepare for the effect of the new law. For example, upon enactment, the Criminal Code score sheets must be revised and redistributed, oftentimes jury instructions must be written, proposed and adopted by the Supreme Court, and the law enforcement community must become familiar with the change in the law.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

Barcode 789392 by Criminal Justice on March 28, 2011:
Changes the effective date to October 1, 2011.

789392

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
03/28/2011	.	
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The Committee on Criminal Justice (Smith) recommended the following:

Senate Amendment

Delete line 70
and insert:
Section 4. This act shall take effect October 1, 2011.

112706

LEGISLATIVE ACTION

Senate . House

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The Committee on Health Regulation (Sobel) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsection (6) is added to section 1004.55, Florida Statutes, to read:

1004.55 Regional autism centers; public-record exemptions.—

(6)(a) *Client records.*—

1. All records that relate to a client of a regional autism center who receives the services of a center or participates in center activities, and all records that relate to the client's

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family, are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

2. A client who receives the services of a center, if competent, or the client's parent or legal guardian if the client is incompetent, shall be provided with a copy of the client's individual record upon request.

3. A regional autism center may release the confidential and exempt records as follows:

a. To physicians, attorneys, or governmental entities having need of the confidential and exempt information to aid a client, as authorized by the client, if competent, or the client's parent or legal guardian if the client is incompetent.

b. In response to a subpoena or to persons authorized by order of court.

c. To the State Board of Education or the Board of Governors of the State University System when the director of the center deems it necessary for the treatment of the client, maintenance of adequate records, compilation of treatment data, or evaluation of programs.

4. If personal identifying information of a client or the client's family has been removed, a regional autism center may release information contained in the confidential and exempt records as follows:

a. To a person engaged in bona fide research if that person agrees to sign a confidentiality agreement with the regional autism center, agrees to maintain the confidentiality of the information received, and, to the extent permitted by law and after the research has concluded, destroy any confidential information obtained.

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b. For statistical and research purposes by the director of the center or designee, if any confidential and exempt information is removed in the reporting of such statistical or research data.

(b) *Financial donor information.*—Personal identifying information of a donor or prospective donor to a regional autism center who desires to remain anonymous is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(c) *Review and repeal.*—This subsection is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2016, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. (1) The Legislature finds that it is a public necessity that all records that relate to a client of a regional autism center who receives the services of a center or participates in center activities, and all records that relate to the client's family, be made confidential and exempt from public-records requirements. Matters of personal health are traditionally private and confidential concerns between the patient and the health care provider. The private and confidential nature of personal health matters pervades both the public and private health care sectors. For these reasons, the individual's expectation of and right to privacy in all matters regarding his or her personal health necessitates this exemption. The Legislature further finds that it is a public necessity to protect records regarding clients of a regional autism center or the client's family, because the release of such records could be defamatory to the client or could cause

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unwarranted damage to the name or reputation of that client or the client's family. Information contained in records and communications of a regional autism center relating to the condition of autism or related disorders contain sensitive personal information that, if released, could cause harm to a client of the center or his or her family. Protecting such records ensures an environment in which the discussion of the condition of autism or related disorders can be conducted in a free and open manner, thus enabling individuals with autism and their families to receive appropriate diagnostic and treatment information and cope more effectively with the enormous challenges posed by neurodevelopmental disorders and sensory impairments.

(2) The Legislature also finds that it is a public necessity that personal identifying information of a donor or prospective donor to a regional autism center be made confidential and exempt from public-records requirements if such donor or prospective donor desires to remain anonymous. If the identity of a prospective or actual donor who desires to remain anonymous is subject to disclosure, there is a chilling effect on donations because donors are concerned about disclosure of personal information leading to theft and, in particular, identity theft, including personal safety and security. Therefore, the Legislature finds that it is a public necessity to make confidential and exempt from public-records requirements information that would identify a donor or prospective donor to a regional autism center if such donor or prospective donor wishes to remain anonymous.

Section 3. This act shall take effect July 1, 2011.

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100
101 ================ T I T L E A M E N D M E N T ================
102 And the title is amended as follows:
103
104 Delete everything before the enacting clause
105 and insert:
106 A bill to be entitled
107 An act relating to public records; amending s.
108 1004.55, F.S.; providing an exemption from public-
109 records requirements for all records that relate to a
110 client of a regional autism center who receives the
111 services of a center or participates in center
112 activities and the client's family; providing for the
113 release of specified confidential and exempt
114 information by a center under certain circumstances;
115 providing an exemption from public-records
116 requirements for personal identifying information of a
117 donor or prospective donor to a regional autism center
118 if the donor or prospective donor wishes to remain
119 anonymous; providing for review and repeal of the
120 exemptions; providing a statement of public necessity;
121 providing an effective date.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL: SB 1192

INTRODUCER: Children, Families, and Elder Affairs Committee and Senators Rich and Flores

SUBJECT: Public Records/Regional Autism Centers

DATE: April 11, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Daniell	Walsh	CF	**Favorable**
2.	O'Callaghan	Stovall	HR	**Pre-meeting**
3.			GO	
4.				
5.				
6.				

I. Summary:

This bill creates a public-records exemption for all records that relate to a client of a regional autism center, the client's family, or a teacher or other professional who receives the services of a center or participates in center activities. The bill provides certain circumstances under which the records may be released by the regional autism center and the bill states a public necessity for the exemption. It also provides for repeal of the public-records exemption on October 2, 2016, unless it is saved from repeal by the Open Government Sunset Review process and reenacted by the Legislature.

This bill substantially amends section 1004.55, Florida Statutes.

II. Present Situation:

Florida Public-Records Law

Florida has a long history of providing public access to government records. The Legislature enacted the first public-records law in 1892.[1] In 1992, Floridians adopted an amendment to the State Constitution that raised the statutory right of access to public records to a constitutional level.[2] Article I, section 24 of the Florida Constitution guarantees every person a right to inspect or copy any public record of the legislative, executive, and judicial branches of government.

[1] Sections 1390, 1391, F.S. (Rev. 1892).
[2] FLA. CONST. art. I, s. 24.

The Public-Records Act[3] specifies conditions under which public access must be provided to records of the executive branch and other agencies. Unless specifically exempted, all agency[4] records are available for public inspection. Section 119.011(12), F.S., defines the term "public records" very broadly to include "all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material …made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency." The Florida Supreme Court has interpreted the definition of public records to encompass all materials made or received by an agency in connection with official business which are "intended to perpetuate, communicate, or formulize knowledge."[5] Unless made exempt, all such materials are open for public inspection at the moment they become records.[6]

Only the Legislature is authorized to create exemptions to open-government requirements. Exemptions must be created by general law, and such law must specifically state the public necessity justifying the exemption. Further, the exemption must be no broader than necessary to accomplish the stated purpose of the law. A bill enacting an exemption or substantially amending an existing exemption may not contain other substantive provisions, although it may contain multiple exemptions that relate to one subject.[7]

Records may be identified as either exempt from public inspection or exempt and confidential. If the Legislature makes a record exempt and confidential, the information may not be released by an agency to anyone other than to the persons or entities designated in the statute.[8] If a record is simply made exempt from public inspection, the exemption does not prohibit the showing of such information at the discretion of the agency holding it.[9]

Open Government Sunset Review Act

The Open Government Sunset Review Act[10] provides for the systematic review of exemptions from the Public-Records Act in the fifth year after the exemption's enactment. By June 1 of each year, the Division of Statutory Revision of the Office of Legislative Services is required to certify to the President of the Senate and the Speaker of the House of Representatives the language and statutory citation of each exemption scheduled for repeal the following year. The act states that an exemption may be created, revised, or maintained only if it serves an identifiable public purpose and if the exemption is no broader than necessary to meet the public purpose it serves.[11] An identifiable public purpose is served if the Legislature finds that the purpose is sufficiently compelling to override the strong public policy of open government and cannot be accomplished without the exemption. An identifiable public purpose is served if the exemption:

[3] Chapter 119, F.S.
[4] An agency includes any state, county, or municipal officer, department, or other separate unit of government that is created or established by law, as well as any other public or private agency or person acting on behalf of any public agency. Section 119.011(2), F.S.
[5] *Shevin v. Byron, Harless, Shafer, Reid, and Assocs., Inc.*, 379 So. 2d 633, 640 (Fla. 1980).
[6] *Tribune Co. v. Cannella*, 458 So. 2d 1075, 1077 (Fla. 1984).
[7] FLA. CONST. art. I, s. 24(c).
[8] *WFTV, Inc. v. School Bd. of Seminole*, 874 So. 2d 48, 53 (Fla. 5th DCA 2004), *review denied*, 892 So. 2d 1015 (Fla. 2004).
[9] *Id*. at 54.
[10] Section 119.15, F.S.
[11] Section 119.15(6)(b), F.S.

- Allows the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be greatly impaired without the exemption;
- Protects information of a sensitive personal nature concerning individuals, the release of which information would be defamatory to such individuals or cause unwarranted damage to the good name or reputation of such individuals or would jeopardize the safety of such individuals; or
- Protects information of a confidential nature concerning entities, including, but not limited to, a formula, pattern, device, combination of devices, or combination of information which is used to protect or further a business advantage over those who do not know or use it, the disclosure of which information would injure the affected entity in the marketplace.[12]

The act also requires the Legislature, as part of the review process, to consider the following six questions that go to the scope, public purpose, and necessity of the exemption:

- What specific records or meetings are affected by the exemption?
- Whom does the exemption uniquely affect?
- What is the identifiable public purpose or goal of the exemption?
- Can the information contained in the records or discussed in the meeting be readily obtained by alternative means?
- Is the record or meeting protected by another exemption?
- Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?[13]

Regional Autism Centers

Section 1004.55, F.S., designates seven regional autism centers throughout the state to provide nonresidential resource and training services for persons of all ages and all levels of intellectual functioning who have:

- Autism;
- A pervasive developmental disorder that is not otherwise specified;
- An autistic-like disability;
- A dual sensory impairment; or
- A sensory impairment with other handicapping conditions.

Each center must be operationally and fiscally independent, provide services within its geographical region of the state, and coordinate services within and between state and local agencies provided by those agencies or school districts. The seven centers are located at:

- The College of Medicine at Florida State University;
- The College of Medicine at the University of Florida;

[12] *Id*.
[13] Section 119.15(6)(a), F.S.

- The University of Florida Health Science Center;
- The Louis de la Parte Florida Mental Health Institute at the University of South Florida;
- The Mailman Center for Child Development and the Department of Psychology at the University of Miami;
- The College of Health and Public Affairs at the University of Central Florida; and
- The Department of Exceptional Student Education at Florida Atlantic University.[14]

Each of these centers must provide:

- Expertise in autism, autistic-like behaviors, and sensory impairments;
- Individual and direct family assistance;
- Technical assistance and consultation services;
- Professional training programs;
- Public education programs;
- Coordination and dissemination of local and regional information regarding available resources; and
- Support to state agencies in the development of training for early child care providers and educators with respect to developmental disabilities.[15]

Health Insurance Portability and Accountability Act

The federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule establishes national standards, and requires appropriate safeguards, to protect individuals' medical records and other personal health information.[16] The Privacy Rule applies only to "covered entities," which are health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically.[17] Many organizations, institutions, and researchers that use, collect, access, and disclose individually identifiable health information are not covered entities.[18]

The Privacy Rule also gives patients rights over their health information, including rights to examine and obtain a copy of their health records and to request corrections; it also sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization.[19]

In 2009, the Institute of Medicine's Committee on Health Research and the Privacy of Health Information issued a report concluding that the HIPAA Privacy Rule does not adequately protect

[14] Section 1004.55(1), F.S.
[15] Section 1004.55(4), F.S.
[16] U.S. Department of Health and Human Services, *Health Information Privacy: The Privacy Rule*, available at http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/index.html (Last visited on April 7, 2011).
[17] *Id. See also* U.S. Department of Health and Human Services, *HIPAA Privacy Rule: To Whom Does the Privacy Rule Apply and Whom Will It Affect?*, available at http://privacyruleandresearch.nih.gov/pr_06.asp (Last visited April 7, 2011).
[18] U.S. Department of Health and Human Services, *HIPAA Privacy Rule: To Whom Does the Privacy Rule Apply and Whom Will It Affect?*, available at http://privacyruleandresearch.nih.gov/pr_06.asp (Last visited April 7, 2011).
[19] *Supra* fn. 43.

the privacy of people's personal health information and hinders important health research discoveries.[20]

The HIPPA Privacy Rule does not protect against all forced disclosure since it permits disclosures required by law, for example. Various federal agencies may grant a Certificate of Confidentiality for studies that collect information that, if disclosed, could damage subjects' financial standing, employability, insurability, or reputation, or have other adverse consequences. By protecting research and institutions from forced disclosure of such information, Certificates of Confidentiality help achieve research objectives and promote participation in research studies.[21]

Family Educational Rights and Privacy Act

The Family Educational Rights and Privacy Act (FERPA)[22] is a federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education.[23]

FERPA gives parents certain rights with respect to their children's education records. These rights transfer to the student when he or she reaches the age of 18 or attends a school beyond the high school level. Students to whom the rights have transferred are "eligible students."[24]

Parents or eligible students have the right to inspect and review the student's education records maintained by the school. Schools are not required to provide copies of records unless, for reasons such as great distance, it is impossible for parents or eligible students to review the records. Schools may charge a fee for copies.[25]

Parents or eligible students have the right to request that a school correct records which they believe to be inaccurate or misleading. If the school decides not to amend the record, the parent or eligible student then has the right to a formal hearing. After the hearing, if the school still decides not to amend the record, the parent or eligible student has the right to place a statement with the record setting forth his or her view about the contested information.[26]

Generally, schools must have written permission from the parent or eligible student in order to release any information from a student's education record. However, FERPA allows schools to disclose those records, without consent, to the following parties or under the following conditions:

- School officials with legitimate educational interest;

[20] The Institute of Medicine, *Beyond the HIPAA Privacy Rule: Enhancing Privacy, Improving Health Through Research*. The National Academies' press release announcing the report is available at: http://www.iom.edu/Reports/2009/Beyond-the-HIPAA-Privacy-Rule-Enhancing-Privacy-Improving-Health-Through-Research.aspx (Last visited on April 7, 2011).
[21] *Id.*
[22] 20 U.S.C. § 1232g; 34 C.F.R. Part 99.
[23] U.S. Department of Education, *Family Educational Rights and Privacy Act (FERPA)*, available at: http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html (Last visited on April 7, 2011).
[24] *Id.*
[25] *Id.*
[26] *Id.*

- Other schools to which a student is transferring;
- Specified officials for audit or evaluation purposes;
- Appropriate parties in connection with financial aid to a student;
- Organizations conducting certain studies for or on behalf of the school;
- Accrediting organizations;
- To comply with a judicial order or lawfully issued subpoena;
- Appropriate officials in cases of health and safety emergencies; and
- State and local authorities, within a juvenile justice system, pursuant to specific State law.[27]

Schools may disclose, without consent, "directory" information such as a student's name, address, telephone number, date and place of birth, honors and awards, and dates of attendance. However, schools must tell parents and eligible students about directory information and allow parents and eligible students a reasonable amount of time to request that the school not disclose directory information about them. Schools must notify parents and eligible students annually of their rights under FERPA. The actual means of notification (special letter, inclusion in a PTA bulletin, student handbook, or newspaper article) is left to the discretion of each school.[28]

III. Effect of Proposed Changes:

This bill creates a public-records exemption making all records that relate to a client of a regional autism center, the client's family, or a teacher or other professional who receives the services of a center or participates in center activities confidential and exempt. The bill provides that the regional autism center may release the confidential and exempt information or records as follows:

- To physicians, attorneys, and governmental entities having a need for the record to aid a client;
- In response to a subpoena or otherwise authorized by court order;
- To a qualified researcher, the State Board of Education, or the Florida Board of Governors when the director of the center deems it necessary for the treatment of the client, maintenance of adequate records, compilation of treatment data, or evaluation of programs, as long as all personally identifiable information is first removed; or
- For statistical and research purposes by the director of the center, provided that any personally identifiable information is removed.

The exemption is subject to the provisions of the Open Government Sunset Review Act and will expire on October 2, 2016, unless reviewed and saved from repeal through reenactment by the Legislature.

The bill also provides a public necessity statement to justify the exemption. Specifically, the bill states that matters of personal health are traditionally private and confidential concerns and that an individual has an expectation of and right to privacy in all matters regarding his or her personal health. Furthermore, the bill provides that it is a public necessity to protect the records of clients of a regional autism center, the client's family, or a teacher or other professional who

[27] 34 CFR § 99.31.
[28] *Supra* fn. 23.

receives the services of a center because release of such records could be defamatory to the client or could cause unwarranted damage to the name or reputation of that client or the client's family. By protecting these records it ensures an environment in which the discussion of the condition of autism or related disorders can be conducted in a free and open manner, which in turn will enable individuals with autism and their families to receive appropriate diagnostic and treatment information.

The bill provides an effective date of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of article VII, section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

This bill creates a public records exemption for all records that relate to a client of a regional autism center, the client's family, or a teacher or other professional who receives the services of a center or participates in center activities. This bill appears to comply with the requirements of article I, section 24 of the Florida Constitution that public-records exemptions state the public necessity justifying the exemption, be no broader than necessary to accomplish the stated purpose, and be addressed in legislation separate from substantive law changes.

Additionally, because this bill is creating a new public-records exemption, it is subject to a two-thirds vote of each house of the Legislature for enactment as required by article I, section 24 of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of article III, subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The seven regional autism centers in the state are located in conjunction with state universities, which, because universities are public entities, makes the records of clients accessible and subject to Florida's public-record law. According to the Board of Governors, the research centers do not fall under the protection of the Health Insurance Portability and Accountability Act (HIPAA) or the Family Educational Rights and

Privacy Act (FERPA), so the passage of this bill will protect the identity and personal information of clients, clients' families, and teachers or other professionals receiving the services of the center.[29]

C. Government Sector Impact:

According to the Board of Governors, "[t]here will be additional Autism Center staff effort involved in removing personal identification information from requests for data by outside customers in the absence of permission to release such information. However, the amount of time required should be minimal and should not create a material employee workload issue."[30]

VI. Technical Deficiencies:

On line 40 of the bill, it provides that a "qualified researcher" may have access to portions of the confidential and exempt information covered by the bill. The bill does not define this term and it is unclear who will be considered a "qualified researcher."

Additionally, the bill provides that the public-records exemption is necessary because the release of the records could be defamatory to the client or could cause unwarranted damage to the name or reputation of that client or the client's family (lines 71-73). Although the public-records exemption is for all records that relate to a client of a regional autism center, the client's family, *or a teacher or other professional* who receives the services of a center or participates in center activities, the public necessity portion of the bill does not mention that the release of the records could cause damage to the name or reputation of the teacher or other professional.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

[29] Bd. of Governors, *2011 Legislative Bill Analysis, HB 579* (Feb. 10, 2011) (on file with the Senate Health Regulation Committee) (HB 579 is identical to this bill).
[30] *Id*.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	CS/SB 1426
INTRODUCER:	Committee on Banking and Insurance; and Senator Hays
SUBJECT:	Repeal of Health Insurance Provisions
DATE:	March 30, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Burgess	Burgess	BI	**Fav/CS**
2.	Brown	Stovall	HR	**Pre-meeting**
3.			BC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

The bill deletes s. 627.64872(6), F.S., which currently requires the Board of Directors of the Florida Health Insurance Plan (FHIP) to submit to the Governor, the President of the Senate and the Speaker of the House of Representatives, an annual report which is to include an independent actuarial study.

The bill deletes s. 627.6699(15)(l), F.S., which currently requires the Office of Insurance Regulation (OIR) to submit to the Governor, the President of the Senate and the Speaker of the House of Representatives, an annual report which summarizes the activities of the Small Employer Access Program (SEAP), including written and earned premiums, program enrollment, administrative expenses, and paid and incurred losses.

The bill provides an effective date of July 1, 2011.

This bill substantially amends the following sections of the Florida Statutes: 627.64872, 627.6699.

II. Present Situation:

Florida Health Insurance Plan

In 1983, the Florida Legislature created the Florida Comprehensive Health Association (FCHA) as a high-risk insurance pool to cover individuals who were unable to purchase health insurance from the open market due to pre-existing conditions. The program is financed through premiums from the participants and assessments on insurance companies, but has been closed to new enrollment since 1991.[1]

In 2004, the Florida Legislature created the FHIP,[2] which was intended to replace the FCHA as the state's high-risk insurance pool.[3] The benefits provided by the FHIP are the same as the standard and basic plans for small employers.[4] The FHIP must also provide an option for the purchase of alternative coverage, such as catastrophic coverage which includes a minimum level of primary care coverage, and a high deductible plan that meets all the requirements for a health savings account. Eligibility for the plan is limited to individuals who have received two notices of rejection for coverage from health insurers and individuals covered under the FCHA at the time the FHIP was created.[5]

The FHIP was created to be run by a nine person Board of Directors, chaired by the Director of the OIR. Five Board members would be appointed by the Governor and one member each would be appointed by the President of the Senate, the Speaker of the House of Representatives, and the Chief Financial Officer.[6] The Board is required to submit to the Governor, the President of the Senate, and the Speaker of the House of Representatives an annual report which is to include an independent actuarial study that must contain five elements specifically enumerated in s. 627.64872(6)(a)-(e), F.S.

According to the OIR, funds for the start-up of the FHIP have not been appropriated, and as a result, the FHIP is not in operation.[7] Therefore, the requirement that a report be provided that details, among other data, the number of people covered and projected to be covered, is moot.

Small Employers Access Program

In 1992, the Florida Legislature enacted the Employee Health Care Access Act (EHCAA).[8] The purpose of the act was to promote the availability of health insurance coverage to small

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[1] *See* Department of Financial Services website: myfloridacfo.com/consumers/InsuranceLibrary/Insurance/Residual_Markets/Residual_Markets – Florida_Comprehensive_Health_Association. htm; last visited March 12, 2011.
[2] Section 627.64872, F.S.
[3] *See* Department of Financial Services website:http://www.myfloridacfo.com/consumers/InsuranceLibrary/Insurance/Residual_Markets/Residual_Markets_-_The_Florida_Health_Insurance_Plan.htm; last visited March 12, 2011.
[4] *See* s. 627.6699(12), F.S.
[5] Section 627.64872(9), F.S.
[6] Section 627.64872(3), F.S.
[7] Florida Office of Insurance Regulation Bill Analysis for SB 1426 (March 9, 2011).
[8] Ch. 92-33, s. 117, L.O.F.

employers, regardless of claims experience or their employees' health status.[9] In 2004, the SEAP was created within the EHCAA.[10] The purpose of the SEAP was to provide additional health insurance options for small businesses consisting of up to 25 employees, including any municipality, county, school district, hospital located in a rural community, and any nursing home employer.[11] The OIR is required to submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives summarizing the activities of the program over the past year, including written and earned premiums, program enrollment, administrative expenses, and paid and incurred losses.[12]

According to OIR, the SEAP is not operational. The enacting legislation required a competitive bid for an insurer to administer the program. The OIR issued the required request for proposals in 2004, and no insurer submitted a bid. Therefore, the annual reporting requirement contained in the section is moot.[13]

III. Effect of Proposed Changes:

Section 1 repeals s. 627.64872(6), F.S., thereby eliminating the annual reporting requirement for the FHIP. The Board of Directors of the FHIP would no longer be required to submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 2 repeals s. 627.6699(15)(l), F.S., thereby eliminating the annual reporting requirement for the SEAP. The SEAP would no longer be required to submit an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 3 provides an effective date for the bill of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of the bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

[9] Section 627.6699(2), F.S.
[10] Ch. 2004-297, s. 24, L.O.F.
[11] Section 627.6699(15)(b), F.S.
[12] Section 627.6699(15)(l), F.S.
[13] Florida Office of Insurance Regulation Bill Analysis for SB 1426 (March 9, 2011).

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None

C. Government Sector Impact:

None

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Senate Banking and Insurance Committee on 3/16/2011:
The original bill would have removed only one of the five specified elements that are required to be contained in the annual report submitted by the Board of Directors of the FHIP. The original bill would have continued to obligate the Board to submit the remaining four elements in an annual report. The CS removes altogether the requirement that the Board submit an annual report.

B. Amendments:

None.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	CS/SB 1554
INTRODUCER:	Transportation Committee and Senator Hays
SUBJECT:	Emergency Vehicles
DATE:	April 1, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Sookhoo	Spalla	TR	**Fav/CS**
2.	Fernandez	Stovall	HR	**Pre-meeting**
3.			MS	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

This bill increases the fine for a violation of section 316.126(1)(b)[1] of the Florida Statutes, from $30 to $100 in addition to any additional court costs. This increased fine has the potential to decrease the number of violations of s. 316.126(1)(b), F.S., and may increase the safety of parked emergency vehicle and wrecker operators.

This bill amends s. 318.18 of the Florida Statutes.

II. Present Situation:

Section 316.126(1)(b), F.S., relates to the operation of vehicles when approaching a parked emergency vehicle or a wrecker that is performing a recovery or a loading on the roadside. Currently, when a driver approaches an emergency vehicle or wrecker with engaged visual signals, drivers must yield the right-of-way and proceed to vacate the lane nearest the emergency vehicle or wrecker and move over if driving on a highway of two or more lanes moving in the same direction. Should this condition not be feasible, drivers are instructed to slow to a speed

[1] Section 316.126(1)(b), Florida Statutes, is more commonly known as the "Move Over Act" which passed during the 2002 Legislation.

that is 20 MPH less than the posted speed limit. If the posted speed is 20 MPH or less, drivers must slow to 5 MPH.

The current fine for a violation of s. 316.126(1)(b), F.S., is $30.

III. Effect of Proposed Changes:

This CS will increase the total fine for a violation of s. 316.126, F.S., from $30 to $100 plus additional court costs. In 2010, there were 2,438 citations written for s. 316.126(1)(b), F.S[2]. At the proposed fine of $100, revenues would increase by $170,660 based on the current level of citations being issued. However, due to an increased fine, there is a potential for a reduction in violations.

This bill will take effect July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this CS have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this CS have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this CS have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Individuals violating s. 316.126(1)(b), F.S., will pay an increased fine of $100 for this offense.

[2] Department of Highway Safety and Motor Vehicles, *Senate Bill 1554 Agency Bill Analysis* (March 30, 2011) (on file with the Senate Committee on Health Regulation).

C. Government Sector Impact:

The proposed $70 fine increase is estimated to increase revenues for state and local government by $170,660 based on the current level of citations being issued. This bill has no fiscal impact on the Department of Highway Safety and Motor Vehicles.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Transportation on March 16, 2011:
This committee substitute decreased the proposed fine from $200 to $100 plus applicable court costs and fees.

B. Amendments:

None.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1788
INTRODUCER:	Senator Bogdanoff
SUBJECT:	Bicycle Regulations
DATE:	April 8, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Sookhoo	Spalla	TR	**Favorable**
2.	Wood	Yeatman	CA	**Favorable**
3.	Fernandez	Stovall	HR	**Pre-meeting**
4.				
5.				
6.				

I. Summary:

This bill removes the requirement to keep at least one hand on a handlebar while operating a bicycle. In addition, this bill renumbers cross-references to conform to the amendment incorporated into ss. 316.2065 and 322.27, F.S.

This bill substantially amends ss. 316.2065 and 322.27 of the Florida Statutes.:

II. Present Situation:

Bicyclists are considered vehicle operators; they are required to obey the same rules of the road as other vehicle operators, including obeying traffic signs, signals, and lane markings.[1] Each year, more than 500,000 people in the US are treated in emergency departments, and more than 700 people die as a result of bicycle-related injuries.[2] In 2009, 630 pedalcyclists[3] were killed and an additional 51,000 were injured in motor vehicle traffic crashes. Pedalcyclist deaths accounted for 2 percent of all motor vehicle traffic fatalities, and made up 2 percent of all the people injured in traffic crashes during the year.[4]

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[1] U.S. Department of Transportation, National Highway Traffic Safety Administration, Traffic Safety Facts: 2009 Data, *available at* http://www-nrd.nhtsa.dot.gov/Pubs/811386.pdf, (Last visited on April 8, 2011).
[2] Bicycle Related Injuries, Centers for Disease Control and Prevention, *available at* http://www.cdc.gov/HomeandRecreationalSafety/bikeinjuries.html, (Last visited on April 8, 2011).
[3] The term pedalcyclists includes operators of two-wheel nonmotorized vehicles, tricycles, and unicycles powered solely by pedals.
[4] *Supra* note 1.

Section 316.2065(7), F.S., specifies that operators of a bicycle must keep at least one hand upon the handlebars. Violators of this section are subject to a general civil traffic violation for pedestrian/bicycle infractions. The base fine is $15 plus $8.50 in required fees. Other fees depend upon the county in which the violation occurs, either because only certain counties are eligible to assess the fee by statute or because the option and amount is determined by ordinance.[5] The total cost of the violation generally varies between $56.50 and $82.50.[6]

Pedestrian and bicycle infractions overall accounted for 16,792 of the 4.9 million tickets issued statewide in 2009. It is unknown how many, if any, were issued for not having at least one hand on the handlebar while operating a bicycle. No specific statistics are kept as to the distribution of these infractions, but this infraction is believed to be a very small percentage.[7]

III. Effect of Proposed Changes:

Section 1 removes the requirement for having at least one hand on the handlebars when operating a bicycle as specified in s. 316.2065(7), F.S. The section also renumbers subsections (8) through (20), F.S., and cross-references contained therein. According to the Florida Department of Transportation (FDOT) it is unsafe not to keep at least one hand on the handlebars when riding a bicycle. Because this regulatory change may disincentivise the safe operation of bicycles by some users, the FDOT believes it could result in an increased number of injuries due to bicycle accidents and an increase in related personal injury costs and possibly litigation costs.[8] The Florida Department of Highway Safety and Motor Vehicles (HSMV) likewise believes that the change "will result in bicycles being operated in a less safe manner, which could increase bicycle accidents."[9]

Section 2 amends cross-references in s. 322.27, F.S., to reflect the renumbering of s. 316.2065(7) done in Section 1.

Section 3 provides an effective date of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this CS have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

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[5] These fees are authorized by ss. 318.1215, 318.18, 938.15, and 938.19, F.S.

[6] Florida Association of Court Clerks and Comptrollers, *Distribution Schedule of Court-Related Filing Fees, Service Charges, Costs, and Fines Effective July 2010*, 15 (July 24, 2010), http://www.flclerks.com/Pub_info/2010_Pub_Info/2010_Distribution_Schedule_of_Court_Related_Funds_FACC_0610FINAL.pdf, (Last visited Mar. 11, 2011).

[7] Conversation with Richard Mechlin, Florida Highway Patrol (Mar. 29, 2011).

[8] E-mail from Cindy Price, Florida Department of Transportation, to Shirlyne Everette, Senate Transportation Committee (Mar. 15, 2011) (on file with the Senate Committee on Community Affairs).

[9] Department of Highway Safety and Motor Vehicles, *Senate Bill 1788 Bill Analysis* (Feb. 3, 2011) (on file with the Senate Committee on Community Affairs).

B. Public Records/Open Meetings Issues:

The provisions of this CS have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this CS have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

According to both FDOT[10] and HSMV,[11] costs due to personal injury may increase by an unquantified amount. The FDOT also expressed concerns about resulting litigation.

C. Government Sector Impact:

The HSMV states that local governments may see additional costs for increased emergency medical services if bicycle-related accidents increase.[12]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

[10] *Supra* note 8.
[11] *Supra* note 9.
[12] *Id.*

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STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

I, Kurt S. Browning, Secretary of State,
do hereby certify that

Elizabeth Dudek

is duly appointed

Secretary,
Agency for Health Care Administration

for a term beginning on the
Twenty-First day of March, A.D., 2011,
to serve at the pleasure of the Governor
and is subject to be confirmed by the Senate
during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the First day of April, A.D., 2011.

Secretary of State

DSDE 99 (3/03)

RICK SCOTT
GOVERNOR

March 28, 2011

Mr. Kurt S. Browning, Secretary
Department of State
R. A. Gray Building, Room 316
500 South Bronough Street
Tallahassee, Florida 32399-0250

Dear Secretary Browning:

Please be advised I have made the following appointment under the provisions of Section 20.42, Florida Statutes:

Ms. Elizabeth Dudek
4617 Killimore Lane
Tallahassee, Florida 32309

as Secretary of Health Care Administration, subject to confirmation by the Senate. This appointment is effective March 21, 2011, for a term ending at the pleasure of the Governor.

Sincerely,

Rick Scott
Governor

RS/jlw

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 488-2272 • FAX (850) 922-4292

1030

STATE OF FLORIDA
DEPARTMENT OF STATE

Division of Elections

I, Kurt S. Browning, Secretary of State,
do hereby certify that

H. Frank Farmer

is duly appointed

State Surgeon General,
Department of Health

for a term beginning on the
Fourth day of April, A.D., 2011,
to serve at the pleasure of the Governor
and is subject to be confirmed by the Senate
during the next regular session of the Legislature.

Given under my hand and the Great Seal of the State of Florida, at Tallahassee, the Capital, this the First day of April, A.D., 2011.

Secretary of State

DSDE 99 (3/03)

RICK SCOTT
GOVERNOR

RECEIVED
DEPARTMENT OF STATE

2011 APR -1 PM 3:11

DIVISION OF ELECTIONS
TALLAHASSEE, FL

March 25, 2011

Mr. Kurt S. Browning, Secretary
Department of State
R. A. Gray Building, Room 316
500 South Bronough Street
Tallahassee, Florida 32399-0250

Dear Secretary Browning:

Please be advised I have made the following appointment under the provisions of Section 20.43(2), Florida Statutes:

Dr. H. Frank Farmer, Jr.
Four Allenwood Look
Ormond Beach, Florida 32174

as State Surgeon General of the Department of Health, succeeding Ana M. Viamonte Ros, subject to confirmation by the Senate. This appointment is effective April 4, 2011, for a term ending at the pleasure of the Governor.

Sincerely,

Rick Scott
Governor

RS/jlw

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 488-2272 • FAX (850) 922-4292

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	CS/SB 1158
INTRODUCER:	Children, Families, and Elder Affairs Committee and Senator Garcia
SUBJECT:	Teaching Agency for Home and Community-based Care
DATE:	April 12, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Daniell	Walsh	CF	**Fav/CS**
2.	Fernandez/O'Callaghan	Stovall	HR	**Pre-meeting**
3.			BC	
4.				
5.				
6.				

Please see Section VIII. for Additional Information:

A. COMMITTEE SUBSTITUTE.....	X	Statement of Substantial Changes
B. AMENDMENTS.....		Technical amendments were recommended
		Amendments were recommended
		Significant amendments were recommended

I. Summary:

This bill creates a new section of law authorizing the Department of Elderly Affairs to designate a home health agency as a teaching agency for home and community-based care if the home health agency meets certain requirements. The bill also defines the term "teaching agency for home and community-based care."

The bill authorizes a teaching agency for home and community-based care to be affiliated with an academic health center in the state in order to foster the development of methods for improving and expanding the capabilities of home health agencies to respond to the medical, health care, psychological, and social needs of frail and elderly persons.

This bill creates section 430.81, Florida Statutes.

II. Present Situation:

Home Health Agencies

A "home health agency" is an organization that provides home health services and staffing

services.[1] Home health services are health and medical services and medical supplies furnished to an individual in the individual's home or place of residence.[2] These services include:

- Nursing care;
- Physical, occupational, respiratory, or speech therapy;
- Home health aide services;
- Dietetics and nutrition practice and nutrition counseling; and
- Medical supplies, restricted to drugs and biologicals prescribed by a physician.

A home health agency, as well as all of its related offices, must be licensed by the Agency for Health Care Administration (AHCA) in order to operate in the state.[3] The licensure requirements for home health agencies are found in the general provisions of part II of ch. 408, F.S., the specific home health agency provisions of part III of ch. 400, F.S., and ch. 59A-8 of the Florida Administrative Code. A home health agency license is valid for 2 years, unless sooner suspended or revoked.

To obtain a home health agency license, an applicant must submit, among other things, the following:

- An application under oath which includes the name, address, social security number and federal employer identification number or taxpayer identification number of the applicant and each controlling interest, and the name of the person who will manage the provider;
- The total number of beds requested;
- Proof of a certificate of authority in certain cases;
- An affidavit of compliance with the law;
- A description and explanation of any exclusions, suspensions, or terminations of the applicant from the Medicare, Medicaid, or federal Clinical Laboratory Improvement Amendment programs;
- Proof of the applicant's legal right to occupy the property;
- Information identifying the service areas and counties to be served and services to be provided;
- The number and discipline of professional staff to be employed;
- A business plan;
- Evidence of contingency funding;
- Proof of professional and commercial liability insurance of not less than $250,000 per claim;
- Proof of financial ability to operate; and
- A licensure fee.[4]

Additionally, an applicant must comply with background screening requirements and pass a survey by the AHCA's inspectors.[5]

[1] Section 400.462(12), F.S.
[2] Section 400.462(14), F.S.
[3] Section 400.464(1) and (2), F.S.
[4] *See* ss. 400.471, 408.806, 408.810, F.S.
[5] *See* s. 408.810(1), F.S., and ch. 59A-8.003, F.A.C.

Prior to 2008, the AHCA saw significant growth in the number of applications and new licenses of home health care agencies.[6] The AHCA received 431 new licensure applications for home health agencies during 2007.[7] In 2008, the Legislature significantly strengthened the home health agency license requirements to address fraud and abuse in the Medicaid and Medicare programs. According to the AHCA, the new accreditation requirements have slowed the growth in new licenses, but the AHCA continues to receive a high volume of applications.[8] As of February 23, 2011, there were 2,317 licensed home health agencies in the state of Florida.[9]

Florida law prohibits unlicensed activity and authorizes the AHCA to fine unlicensed providers $500 for each day of noncompliance, and authorizes state attorneys and the AHCA to bring an action to enjoin unlicensed providers.[10] Unlicensed activity is a second-degree misdemeanor and each day of continued operation is a separate offense.[11]

The requirements for training of health care professionals are under the Department of Education (DOE) and the requirements for licensing and continuing education are determined by the Board of Nursing and other Boards under the Department of Health. Home health agencies are currently permitted under at s. 400.497(1), F.S., to train their own home health aides. However, home health agencies must become licensed by the DOE as a career education school in order to train any home health aides that will be employed by other home health agencies, to train certified nursing assistants, or others.[12]

Lead Agencies

The Department of Elder Affairs (DOEA or department) is created in s. 20.41, F.S. This section directs the department to plan and administer its programs and services through planning and service areas designated by the department. The department is designated as the state unit on aging as defined in the federal Older Americans Act (the act).[13]

The department serves as the primary state agency responsible for administering human services programs for the elderly and for developing policy recommendations for long-term care;[14] recommends state and local level organizational models for the planning, coordination, implementation, and evaluation of programs serving the elderly population;[15] and oversees

[6] Comm. on Health Regulation, The Florida Senate, *Review Regulatory Requirements for Home Health Agencies* (Interim Project Report 2008-135) (Nov. 2007), *available at* http://archive.flsenate.gov/data/Publications/2008/Senate/reports/interim_reports/pdf/2008-135hr.pdf (last visited April 8, 2011).
[7] Comm. on Health and Human Servs. Appropriations, The Florida Senate, *Bill Analysis and Fiscal Impact Statement CS/CS/SB 1986* (April 16, 2009), *available at* http://archive.flsenate.gov/data/session/2009/Senate/bills/analysis/pdf/2009s1986.ha.pdf (last visited April 8, 2011).
[8] *Id*.
[9] Agency for Health Care Admin., *2011 Bill Analysis & Economic Impact Statement SB 1158* (rcv'd Mar. 22, 2011) (on file with the Senate Committee on Children, Families, and Elder Affairs).
[10] Section 408.464(4)(b) and (f), F.S.
[11] Section 408.464(4)(e), F.S.
[12] *Supra* note 9.
[13] Section 20.41(5), F.S.
[14] Section 430.03(1), F.S.
[15] Section 430.03(6), F.S.

implementation of federally funded and state funded programs and services for the state's elderly population.[16]

Federal law directs the department to administer the act using Florida's 11 Area Agencies on Aging (AAA).[17] Contractual agreements to implement the department's programs are executed at three levels:

- Contracts between DOEA and the AAAs for each major program;
- Contracts between the AAAs and lead agencies or service providers; and
- Contracts between lead agencies and local service providers.

The department works closely with the 11 AAAs in Florida. The AAAs administer funds locally and contract with a variety of provider agencies to offer a wide array of services designed to address the needs of their senior constituencies. Some of the services offered through AAAs are congregate and home delivered meals; Senior Center activities and adult day care; case management; and information and referral.

A lead agency is an agency designated at least once every six years by an AAA as a result of a request for proposal process.[18] Lead agencies provide and coordinate services for elders in designated areas. There are 58 lead agencies serving all of Florida's 67 counties.[19] Lead agency providers are either non-profit corporations or county government agencies, and are the only entities that can provide fee-for-service case management on an ongoing basis.[20]

Teaching Nursing Home Pilot Project

Section 430.80, F.S., authorizes the implementation of a teaching nursing home pilot project. The statute defines a "teaching nursing home" as a nursing home facility licensed under ch. 400, F.S., which contains a minimum of 400 licensed nursing home beds; has access to a resident senior population of sufficient size to support education, training, and research relating to geriatric care; and has a contractual relationship with a federally-funded, accredited geriatric research center in Florida. Currently, there is no statute that provides a similar program for home and community-based care.

To be designated as a teaching nursing home, a nursing home licensee must:

- Provide a comprehensive program of integrated senior services that include institutional services and community-based services;
- Participate in a nationally recognized accreditation program and hold a valid accreditation;
- Have been in business in Florida for a minimum of 10 consecutive years;

[16] Section 430.03(7), F.S.
[17] 42 U.S.C. s. 3025, codified in s. 20.41, F.S.
[18] Section 430.203(9), F.S.
[19] Some lead agencies provide services in more than one county due to the scarcity of providers in some rural counties
[20] Dep't of Elder Affairs, *Elder Services Network Components and Their Roles, available a*t http://elderaffairs.state.fl.us/english/pubs/pubs/sops2007/Files/Elder%20Services%20Network%20Components%20and%20their%20roles.pdf (last visited April 8, 2011).

- Demonstrate an active program in multidisciplinary education and research that relates to gerontology;[21]
- Have a formalized contractual relationship with at least one accredited health profession education program located in Florida;
- Have senior staff members who hold formal faculty appointments at universities that have at least one accredited health profession education program; and
- Maintain insurance coverage or proof of financial responsibility in a minimum amount of $750,000.[22]

A teaching nursing home may be affiliated with a medical school in Florida and a federally funded center of excellence in geriatric research and education, in order to foster the development of methods for improving and expanding the capability of health care facilities to respond to the medical, psychological, and social needs of frail and elderly persons by providing the most effective and appropriate services.

Section 430.80, F.S., provides that the Legislature may appropriate funds to the nursing home facility designated as a teaching nursing home, and a teaching nursing home may not expend any funds received for any purpose other than operating and maintaining a teaching nursing home and conducting geriatric research.[23]

Academic Health and Science Centers

Academic Health and Science Centers in the State University System serve three primary purposes:

- Teaching students going into healthcare professions;
- Conducting research to advance healthcare knowledge; and
- Serving patients with healthcare problems.

These centers provide facilities, faculty and staff, curriculum, and health science students with the opportunity to train in the various health science areas and get practical experience in their disciplines during their training. Currently, there are two state Academic Health and Science Centers: University of Florida and the University of South Florida. [24] The health and science academic programs at the two universities include undergraduate, graduate, professional degree, and post-professional degree instruction. Besides instruction, they provide patient care and conduct research in the healthcare field.[25]

[21] Gerontology is defined as "the comprehensive study of aging and the problems of the aged." Merriam-Webster, *gerontology*, http://www.merriam-webster.com/dictionary/gerontology (last visited April 8, 2011).
[22] Section 430.80(3), F.S.
[23] Sections 430.80(5) and (7), F.S.
[24] There are four other medical education programs at state universities in Florida; however, they are not classified as academic health and science centers. These include Florida State University, Florida Atlantic University, University of Central Florida, and Florida International University.
[25] "Board of Governors, State University System of Florida Academic Health and Science Centers," Office of Program Policy Analysis and Government Accountability, Government Program Summaries. February 25, 2011.

III. Effect of Proposed Changes:

This bill creates s. 430.81, F.S., which authorizes the Department of Elderly Affairs (DOEA or department) to designate a home health agency as a teaching agency for home and community-based care if the home health agency:

- Has been a not-for-profit, designated community care for the elderly lead agency for home and community-based services for more than 10 consecutive years;
- Participates in a nationally recognized accreditation program and holds valid accreditation;
- Has been in business in Florida for a minimum of 20 consecutive years;
- Demonstrates an active program in multidisciplinary education and research that relates to gerontology;
- Has a formalized affiliation agreement with at least one established academic research university with a nationally accredited health professions program in Florida;
- Has salaried academic faculty from a nationally accredited health professions program;
- Is a Medicare and Medicaid certified home health agency[26] that has participated in the nursing home diversion program for a minimum of 5 consecutive years; and
- Maintains insurance coverage pursuant to s. 400.141(1)(s), F.S.,[27] or proof of financial responsibility in a minimum amount of $750,000.

Proof of financial responsibility may include maintaining an escrow account[28] or obtaining and maintaining an unexpired, irrevocable, nontransferable, and nonassignable letter of credit issued by any bank or savings association authorized to do business in the state.[29] The bill provides that the letter of credit is to be used to satisfy the obligation of the home health agency to a claimant upon presentation of a final judgment against the facility or upon presentation of a settlement agreement signed by all parties to the agreement when the final judgment or settlement is a result of a liability claim against the home health agency.

The bill defines the term "teaching agency for home and community-based care" as "a home health agency that is licensed under part III of chapter 400 and has access to a resident population of sufficient size to support education, training, and research related to geriatric care."[30]

The bill also authorizes a teaching agency for home and community-based care to be affiliated with an academic health center in the state in order to foster the development of methods for improving and expanding the capabilities of home health agencies to respond to the medical, health care, psychological, and social needs of frail and elderly persons. A teaching agency for home and community-based care is to serve as a resource for research and for training health

[26] Home health agencies can become certified for Medicare and/or Medicaid, but they must meet the Medicare Conditions of Participation in 42 Code of Federal Regulations, Part 484 prior to certification. These federal regulations require applicants to comply with a complex comprehensive assessment prior to an initial certification survey.
[27] Section 400.141, F.S., relates to the administration and management of nursing home facilities.
[28] *See* s. 625.52, F.S.
[29] *See* Chapter 675, F.S.
[30] The AHCA has estimated that, based on the criteria required in the bill, there will be approximately 10 home health agencies that will qualify as a teaching agency for home and community-based care.

care professionals in providing health care services in homes and community-based settings to frail and elderly persons.

The bill provides an effective date of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this CS have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this CS have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this CS have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

According to the Board of Governors (board), the bill "appears to have little fiscal impact to the state universities." However, one of the bill's requirements (that the teaching agency must have salaried academic faculty from a nationally accredited health professions program) is not specific as to the source of the salary. According to the board, "it is not clear if that portion of the faculty member's time devoted to the teaching agency would be funded by the state university, from teaching agency funds, or a combination of the two sources. Clarification of this point will be necessary to assess any potential costs to the universities."[31]

VI. Technical Deficiencies:

None.

[31] Board of Governors, *2011 Legislative Bill Analysis SB 1158* (Mar. 7, 2011) (on file with the Senate Committee on Children, Families, and Elder Affairs).

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Children, Families, and Elder Affairs on March 28, 2011:
The committee substitute:

- Changes the governmental entity that is authorized to designate a home health agency as a teaching agency for home and community-based care (teaching agency) from the Agency for Health Care Administration (AHCA) to the Department of Elderly Affairs;
- Expands the eligibility criteria for becoming a teaching agency by removing the limitations that the home health agency serve a geographic area with a minimum of 200,000 adults age 60 or older and that the home health agency be in business in the state for a minimum of 30 consecutive years (the committee substitute changes it to 20 consecutive years); and
- Removes language authorizing AHCA to collect a fee of up to $250 from home health agencies seeking to become a teaching agency.

B. Amendments:

None.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1358
INTRODUCER:	Senator Oelrich
SUBJECT:	Emergency Medical Services
DATE:	April 1, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Fernandez/O'Callaghan	Stovall	HR	**Pre-meeting**
2.			BC	
3.				
4.				
5.				
6.				

I. Summary:

This bill deletes the requirement for emergency medical technicians (EMTs), paramedics, and 911 public safety telecommunicators, certified under ch. 401, F.S., to complete a course approved by the Department of Health (DOH), regarding the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) as a condition of certification and recertification. The bill updates Florida EMTs and paramedics training requirements to reflect the new 2009 national training standards.

The bill redefines "basic life support" to include the name of the new National EMS Education Standards and changes the timetable for revision of the comprehensive state plan for emergency medical services and programs from biennially to every 5 years.

This bill substantially amends the following sections of the Florida Statutes: 381.0034, 401.23, 401.24, 401.27, and 401.2701

II. Present Situation:

HIV/AIDS

Acquired Immune Deficiency Syndrome is a physical disorder that results in the loss of immunity in affected persons. It is caused by a retrovirus known as the Human Immunodeficiency Virus. The HIV infection and AIDS remain leading causes of illness and death in the United States. Since the beginning of the HIV/AIDS epidemic in the early 1980s, it

is estimated that over 1 million persons in the United States have been diagnosed with AIDS.[1] According to the Centers for Disease Control and Prevention (CDC), the annual number of AIDS cases and deaths declined substantially after 1994, but stabilized during the period 1999-2004.[2] The number of HIV/AIDS cases among racial/ethnic minority populations and persons exposed to HIV through heterosexual contact has increased since 1994.[3] Florida ranks third among the states in the cumulative number of reported AIDS cases, with 121,161 cases reported through January 2011.[4]

Florida has comprehensive HIV testing and partner notification laws. Additionally Florida law requires certain health care practitioners who provide prenatal services to offer HIV testing along with the testing for other sexually transmissible diseases to pregnant women.

Emergency Medical Technicians/Paramedics, Standards and Certification

The Department of Health, Division of Emergency Operations regulates EMTs and paramedics. "Emergency Medical Technician" is defined under s. 401.23, F.S., to mean a person who is certified by the DOH to perform basic life support, which is the treatment of medical emergencies through the use of techniques described in the Emergency Medical Technician Basic Training Course Curriculum of the U.S. Department of Transportation. "Paramedic" means a person who is certified by the DOH to perform basic *and* advanced life support.

The DOH must establish, by rule, educational and training criteria and examinations for the certification and recertification of EMTs and paramedics.[5] An applicant for certification or recertification as an EMT or paramedic must have completed an appropriate training course as follows:

- For an EMT, an emergency medical technician training course equivalent to the most recent emergency medical technician basic training course of the U.S. Department of Transportation as approved by the DOH.
- For a paramedic, a paramedic training program equivalent to the most recent paramedic course of the U.S. Department of Transportation as approved by the DOH.

The DOH must also establish by rule, a procedure for biennial renewal certification of EMTs and paramedics. Such rules for EMTs must require a U.S. Department of Transportation refresher training program of at least 30 hours as approved by the DOH every 2 years. Rules for paramedics must require candidates for renewal to have taken at least 30 hours of continuing education units during the 2-year period.

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[1] HIV/AIDS in the United States. Revised August 2009. CDC. Available at: <http://www.cdc.gov/hiv/resources/factsheets/PDF/us.pdf> (Last visited April 1, 2011).
[2] CDC Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings. *MMWR (Morbidity and Mortality Weekly Report)* September 22, 2006; 55(RR 14):1-17. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm> (Last visited on April 1, 2011).
[3] *Ibid.*
[4] The Florida Division of Disease Control Surveillance Report (Hepatitis, HIV/AIDS, STD and TB). January 2011, No. 314. Available at: <http://www.doh.state.fl.us/disease_ctrl/aids/trends/msr/2011/MSR0111.pdf > (Last visited on April 1, 2011).
[5] s. 401.27, F.S.

911 Public Safety Telecommunicator[6]

"911 public safety telecommunicator" means a public safety dispatch or 911 operator whose duties include, among other things, answering, receiving, transferring, and dispatching functions related to 911 calls and dispatching law enforcement officers, fire rescue services, emergency medical services, and other public safety services to the scene of an emergency. Certain 911 public safety telecommunicators are required to be certified pursuant to s. 401.465, F.S. The DOH is to establish, by rule, educational and training criteria for the certification and recertification of 911 public safety telecommunicators.

Requirement for Instruction on HIV/AIDS

In 2006, the Legislature revised the requirements for the HIV/AIDS continuing education instruction in the general licensing provisions for health practitioners regulated by s. 456, 033, F.S.[7] Under s. 381.0034(3), F.S., the DOH must require applicants for initial licensure or certification as EMTs, paramedics, 911 public safety telecommunicator, midwives, radiologic technologists, or clinical laboratory personnel to complete an educational course on HIV and AIDS. These professions must complete a department-approved course on HIV/AIDS at the time of initial licensure or certification, or do so within 6 months of licensure or certification upon an affidavit showing good cause.

The course must cover modes of transmission, infection control procedures, clinical management, and prevention of HIV/AIDS. The course must also include information on current Florida law on AIDS and its impact on testing, confidentiality of test results, treatment of patients, and any protocols and procedures applicable to HIV counseling and testing, reporting, the offering of HIV testing to pregnant women, and partner notification. Failure to comply with the educational requirement is grounds for disciplinary action.[8]

Section 381.0034(1), F.S., also provides that the DOH must require, as a condition of biennial relicensure, persons certified or licensed as EMTs, paramedics, 911 public safety telecommunicator, midwives, radiologic technologists, and clinical laboratory personnel to complete an educational course approved by the DOH on HIV/AIDS. Each licensee or certificate holder is to submit confirmation of having completed the course when submitting fees or an application for each biennial renewal.

Emergency Medical Services Training Programs[9]

Any private or public institution in Florida desiring to conduct an approved program for the education of EMTs and paramedics must submit a completed application, which must include documentation verifying that the curriculum:

- Meets the course guides and instructor's lesson plans in the most recent Emergency Medical Technician-Basic National Standard Curricula for emergency medical technician programs

[6] S. 401.465, F.S.
[7] *See* 2006-251, L.O.F.
[8] S. 381.0034(2), F.S.
[9] S. 401.2701, F.S.

and Emergency Medical Technician-Paramedic National Standard Curricula for paramedic programs;
- Includes 2 hours of instruction on the trauma scorecard methodologies for assessment of adult trauma patients and pediatric trauma patients as specified by the DOH by rule; and
- Includes 4 hours of instruction on HIV/AIDS training consistent with the requirements of ch. 381, F.S.

Emergency Medical Services State Plan[10]

Under s. 401.24, F.S., the DOH is responsible for the improvement and regulation of basic and advanced life support programs and is required to biennially develop and revise a comprehensive state plan for basic and advanced life support services.

Emergency Medical Technician National Standard Curriculum[11]

The National Highway Traffic Safety Administration (NHTSA) has assumed responsibility for the development of training courses that are responsive to the standards established by the Highway Safety Act of 1966 (amended). Since these courses are designed to provide national guidelines for training, it is NHTSA's intention that they be of the highest quality and be maintained in a current and up-to-date status from the point of view of both technical content and instructional strategy.

In 1994, the NHTSA completed an extensive revision of the national standard Emergency Medical Technician-Basic Curriculum.[12] The EMT-Basic National Standard Curriculum is a core curriculum of minimum required information, to be presented within a 110-hour training program, intended to prepare a medically competent EMT-Basic to operate in the field. The 110-hour time constraint of the program, as recommended by the national emergency medical services community during the 1990 NHTSA *Consensus Workshop on Emergency Medical Services Training Programs*, necessitates the need for enrichment and continuing education in order to bring a student to full competency.[13]

The 1994 EMT-Basic: National Standard Curriculum Instructor's Course Guide[14] specifically mentions that: "It is important to understand that this curriculum does not provide students with extensive knowledge in hazardous materials, blood-borne pathogens, emergency vehicle operations or rescue practices in unusual environments. These areas are not core elements of education and practice as identified in the *National EMS Education and Practice Blueprint*. Identified areas of competency not specifically designed within the EMT-Basic: National Standard Curriculum should be taught in conjunction with this program as a local or state option."

[10] S. 401.24, F.S.
[11] National Standard Curricula available at: <www.nhtsa.gov/people/injury/ems/pub/emtbnsc.pdf > (Last visited on April 1, 2011).
[12] See NHTSA Emergency Medical Technician: Basic Refresher Curriculum, Instructor Course Guide. Available at: <http://www.nhtsa.dot.gov/people/injury/ems/pub/basicref.pdf> (Last visited on April 1, 2011).
[13] See NHTSA EMT-Basic: National Standard Curriculum, Instructor's Course Guide. Available at: <http://www.nhtsa.dot.gov/people/injury/ems/pub/emtbnsc.pdf> (Last visited on April 1, 2011).
[14] See NHTSA EMT-Standard: National Standard Curriculum, Instructor's Course Guide. Available at: <http://www.nhtsa.dot.gov/people/injury/ems/pub/emtbnsc.pdf> (Last visited on April 1, 2011).

The EMT-Paramedic: National Standard Curriculum represents the minimum required information to be presented within a course leading to certification as a paramedic. It is recognized that there is additional specific education that will be required of paramedics who operate in the field, i.e. ambulance driving, heavy and light rescue, basic extrication, special needs, and so on. It is also recognized that this information might differ from locality to locality, and that each training program or system should identify and provide special instruction for these training requirements.[15]

The 1998 EMT-Paramedic: National Standard Curriculum Introduction[16] also specifically mentions that: "It is important to recognize that this curriculum does not provide students with extensive knowledge in hazardous materials, blood-borne pathogens, emergency vehicle operations or rescue practices in unusual environments. These areas are not core elements of education and practice as identified in the *National EMS Education and Practice Blueprint*. Identified areas of competency not specifically designed within the EMT-Paramedic: National Standard Curriculum should be taught in conjunction with this program as a local or state option."

The National EMS Education Standards[17]

The National EMS Education Standards (Standards), led by the National Association of EMS Educators, replace the NHTSA National Standard Curricula at all licensure levels. The Standards define the competencies, clinical behaviors, and judgments that must be met by entry-level EMS personnel to meet practice guidelines defined in the National EMS Scope of Practice Model. Content and concepts defined in the National EMS Core Content are also integrated within the Standards.

The Standards comprise of four components:

1. Competency - This statement represents the minimum competency required for entry-level personnel at each licensure level.
2. Knowledge Required to Achieve Competency - This represents an elaboration of the knowledge within each competency (when appropriate) that entry-level personnel would need to master in order to achieve competency.
3. Clinical Behaviors/Judgments - This section describes the clinical behaviors and judgments essential for entry-level EMS personnel at each licensure level.
4. Educational Infrastructure - This section describes the support standards necessary for conducting EMS training programs at each licensure level.

Each statement in the Standards presumes that the expected knowledge and behaviors are within the scope of practice for that EMS licensure level, as defined by the National EMS Scope of Practice Model. Each competency applies to patients of all ages, unless a specific age group is identified.

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[15] EMT: Paramedic National Standard Curriculum. Available at: <http://www.nhtsa.gov/people/injury/ems/EMT-P/disk_1%5B1%5D/Intro.pdf> (Last visited on April 1, 2011).
[16] *Id.*
[17] *See* The national EMS Education Standards at:< http://www.ems.gov/pdf/811077a.pdf> (Last visited on April 1, 2011).

The Standards also assume there is a progression in practice from the Emergency Medical Responder level to the Paramedic level. That is, licensed personnel at each level are responsible for all knowledge, judgments, and behaviors at their level and at all levels preceding their level. For example, a Paramedic is responsible for knowing and doing everything identified in that specific area, as well as knowing and doing all tasks in the three preceding levels.

III. Effect of Proposed Changes:

Section 1 amends s. 381.0034, F.S., to remove the requirement for each person licensed or certified under ch. 401, F.S., Medical Telecommunications and Transportation, to complete an educational course about HIV and AIDS as a condition of certification.

Section 2 amends s. 401.23, F.S., to define "basic life support" as treatment of medical emergencies by a qualified person through the use of techniques described in the Emergency Medical Technician Basic Training Course Curriculum or the National EMS Education Standards of the United States Department of Transportation, s approved by the DOH.

Section 3 amends s. 401.24, F.S., relating to emergency medical services state plan, to require the DOH to develop and revise the comprehensive state plan every 5 years rather than every 2 years.

Section 4 amends s. 401.27, F.S., relating to personnel standards and certification, to require the completion of a training course equivalent to the most recent National EMS Education Standards, as approved by the DOH, in order for a person to apply for certification or recertification as an EMT or paramedic. The bill extends the timeframe to pass the examination to become certified as an EMT or paramedic from 1 to 2 years following successful course completion.

Section 5 amends s. 401.2701, F.S., to include the National EMS Education Standards as an option to teach EMT and paramedic training programs as approved by the department.

Section 6 provides an effective date of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of the bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24 (a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

D. Other Constitutional Issues:

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The DOH indicated that the bill would require the department to promulgate rules to remove the HIV/AIDS requirement in 64J-1.008 and 64J-1.009, F.A.C. In addition, DOH will need to revise a form. The DOH indicated that it will incur indeterminate costs.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

386990

LEGISLATIVE ACTION

Senate . House

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The Committee on Health Regulation (Bennett) recommended the following:

Senate Amendment (with title amendment)

Delete lines 27 - 32

and insert:

Section 2. The provisions of this act shall operate prospectively. The prospective operation of this act does not provide a basis for an assessment of taxes not paid, nor a basis for determining any right to a refund of taxes paid, prior to the effective date of the act.

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

And the title is amended as follows:

386990

Delete lines 7 - 9

and insert:

insurance premium taxes; providing for prospective operation; specifying that the act does not provide a basis for assessment of taxes not paid or a right to a refund of taxes paid prior to the effective date of the act;

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 472
INTRODUCER:	Senators Evers, Detert, and others
SUBJECT:	Prepaid Limited Health Service Organizations/Taxes
DATE:	April 11, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Stovall	HR	**Pre-meeting**
2.			BC	
3.				
4.				
5.				
6.				

I. Summary:

The bill amends Florida Statutes to exempt the premiums, contributions, and assessments received by a prepaid limited health service organization, under contract with Medicaid[1] solely to provide services to Medicaid recipients, from a specific insurance premium tax.

The bill provides for remedial retroactive application of the exemption to December 31, 1998. The bill expressly states that the retroactive application does not create a right to a refund for any tax, penalty, or interest on certain premium taxes paid to the Department of Revenue (DOR) prior to the effective date.

This bill substantially amends the following section of the Florida Statutes: 636.0145.

II. Present Situation:

Part I of ch. 636, F.S., regulates the operation and administration of prepaid limited health service organizations[2] (PLHSOs) and discount medical plan organizations in the state of Florida. PLHSOs solely providing services to Medicaid recipients under a contract with Medicaid are

[1] Section 409.902, F.S., provides that the Agency for Health Care Administration is designated as the single state agency authorized to make payments for medical assistance and related services under Title XIX of the Social Security Act and that this program of medical assistance is designated the "Medicaid program."

[2] Section 636.003(7), F.S., defines a "prepaid limited health service organization" as "any person, corporation, partnership, or any other entity which, in return for a prepayment, undertakes to provide or arrange for, or provide access to, the provision of a limited health service to enrollees through an exclusive panel of providers, and s. 636.003(5), F.S., defines a "limited health service" as ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, and pharmaceutical services.

exempt from several provisions of ch. 636, F.S., including those related to rates and charges;[3] changes in rates and benefits, material modifications, and the addition of limited health services;[4] restrictions upon expulsion or refusal to issue or renew a contract;[5] notice of cancellation of contract;[6] and extension of benefits.[7]

Since 1994, Florida law has imposed a tax on the insurance premiums, contributions, and assessments received by a PLHSO.[8] The premium tax is to be paid annually and is calculated at a rate of 1.75 percent of the gross amount of premiums, contributions, and assessments collected on health insurance policies issued by PLHSOs.[9]

There are currently four PLHSOs which provide mental health services to Medicaid recipients through a contract with the Agency for Health Care Administration (AHCA) that are subject to this tax.[10] One organization, Lakeview Center, Inc. (Lakeview), filed a legal challenge in 2007 to the imposition of the tax by the Department of Revenue (DOR).[11] According to the court's order, Lakeview had been paying the premium tax under s. 624.509, F.S., since 2003. Lakeview subsequently came to believe that the tax was paid in error and sought a refund from the DOR. The request for refund was denied and Lakeview timely filed a Complaint with the Circuit Court for the Second Circuit in Tallahassee.

The court found that Lakeview contracted with the AHCA to provide mental health and other services to Medicaid recipients. Lakeview was paid a fixed sum by the AHCA to provide the stated services. Lakeview argued that the fixed sum paid by the AHCA under the contract did not constitute a "premium" to trigger the imposition of the premium tax under s. 624.509, F.S. The court disagreed, finding that a rule established by the Office of Insurance Regulation (OIR), which regulated Lakeview as an insurer in the state of Florida, defined "premium"[12] and concluded that the fixed rate paid to Lakeview by the AHCA met the definition and was taxable. Lakeview appealed the circuit court ruling to Florida's First District Court of Appeal, but the lower court's ruling was per curiam affirmed by the appellate court.[13,14]

Currently, one or more PLHSOs have been paying the premium tax and others have not. Additional information regarding the identity of those PLHSOs, the amount of taxes that have

[3] Section 636.017, F.S.
[4] Section 636.018, F.S.
[5] Section 636.022, F.S.
[6] Section 636.028, F.S.
[7] Section 636.034, F.S.
[8] Section 636.066(1), F.S.
[9] Section 624.509(1)(a), F.S.
[10] Email from the Agency for Health Care Administration to the Senate Committee on Health Regulation, Feb. 11, 2011, 4:40 p.m., on file with the Committee. The four PLHSOs are: Lakeview Center, Inc. (d/b/a Access Behavioral Health), Magellan Behavioral Health of Florida, Inc., North Florida Behavioral Health Partners, Inc., and Florida Health Partners, Inc.
[11] *See* Lakeview Center, Inc. v. State of Florida, Dept. of Revenue, No. 2007-CA-1255 (Fla. 2nd Cir. Co. Jan 23, 2008).
[12] Rule 69O-203.013(6), F.A.C. (2007), defined "premium" as "[t]he contracted sum paid by or on behalf of a subscriber or group of subscribers on a prepaid per capita or a prepaid aggregate basis for limited health services rendered by or through the PLHSO."
[13] Lakeview Center, Inc. v. State of Florida, Dept. of Revenue, 8 So.3d 1136 (Fla. 1st DCA 2009)(unpublished disposition).
[14] "Per curiam affirmed," or PCA, refers to a decision of a court, without identifying any judges by name, finding that the decision of a lower court was correct. Such a decision is often made without rendering an opinion and the lack of record for its basis can preclude further review.

been paid, and the amount of taxes still owed is not available from the DOR due to state confidentiality provisions.[15] However, according to the AHCA, the state has paid over $844 million to PLHSOs for the provision of Medicaid behavioral health services over a 13-year period beginning in state fiscal year 1997-98 through state fiscal year 2009-10. The application of a 1.75 percent premium tax on capitations paid to such PLHSOs in state fiscal year 2009-10 would amount to $3.2 million.

PLHSO Capitation Rates

The PLHSOs under contract with the AHCA solely for the provision of Medicaid behavioral health services are managed care plans known as "prepaid mental health plans" or PMHPs. The AHCA contracts with PMHPs by competitive procurement under s. 409.912(4)(b), F.S., and pays them a fixed, lump-sum payment per beneficiary on a monthly basis, typically at the beginning of the month. These prepayments are designed to cover services needed in the aggregate for any given month in a 12-month period. Such a fixed, prepayment is known as a "capitation."[16]

Managed care plans that provide for services on a prepaid, capitated basis agree to accept the capitation payment and assume financial risk for delivering the covered services, regardless of whether the capitation fully covers the cost for all services that need to be provided. Capitated entities sometimes assume full risk, i.e. the coverage is comprehensive with no mitigation factors for the risk assumed, and others assume partial risk, i.e. the coverage is limited as opposed to comprehensive and/or the risk may be mitigated by loss prevention or shared-savings arrangements. PMHPs assume partial risk since they cover only behavioral health services. Payment systems based on capitation are designed to provide the state with less risk and more predictability for Medicaid spending and to incent the capitated entities to manage the provision of services in a cost-effective manner.[17]

Actuarial Soundness

Florida law and federal regulations require that capitation rates for Medicaid managed care plans must be actuarially sound. The federal Centers for Medicare and Medicaid Services (CMS) requires Medicaid capitation rates developed at the state level to be actuarially certified prior to CMS approval. The AHCA has contracted with Milliman, Inc., for actuarial services related to capitation rates for PMHPs, both to develop the rates and to certify them as actuarially sound.[18]

Following the First District Court of Appeal's 2009 per curiam affirmation of the Second Circuit Court's ruling against Lakeview, the AHCA instructed Milliman that because PMHPs that are PLHSOs[19] would presumably be required to pay the 1.75 percent premium tax under s. 624.509(1)(a), F.S., Milliman should take the tax under consideration when calculating and

[15] Section 213.053(2)(a), F.S.
[16] Senate Committee on Health Regulation, *Issue Brief 2011-221: Overview of the Medicaid Managed Care Programs in Florida*, November 2010, available at http://flsenate.gov/Committees/InterimReports/2011/2011-221hr.pdf, (Last visited on April 9, 2011).
[17] *Id.*
[18] Senate Committee on Health Regulation, *Issue Brief 2011-226: Medicaid Managed Care Rate-setting*, November 2010, available at http://flsenate.gov/Committees/InterimReports/2011/2011-226hr.pdf, (Last visited on April 9, 2011).
[19] One PMHP currently under AHCA contract is not a PLHSO and is therefore not subject to the premium tax.

certifying the 2010-11 capitation rates for PMHPs, in the interest of maintaining actuarial soundness.

The following passage is from Milliman's actuarial certification of the 2010-11 PMHP rates:[20]

> **PMHP Administrative Costs and Premium Taxes**:
> We added a 14.75 percent allowance (as a percentage of the capitation rate) for PMHP administrative services and state premium taxes. The encounter data rate must include an allowance for administrative service because it is based on the actual utilization of services by PMHP enrollees. We selected a 13 percent administration load based on typical administrative costs of behavioral health organizations across the country, a 2 percent of revenue margin allowance, and our judgment. The state premium tax allowance is 1.75 percent of revenue.

In this way, capitation rates for PMHPs that are PLHSOs were increased by 1.75 percent for the current contract year in order to offset an expected tax payout by the PMHPs to the DOR reflecting the same percent of revenue paid by the AHCA to the PMHPs. The AHCA has indicated that the 1.75 percent offset (i.e. increased payments by the AHCA to the PMHPs) is to be maintained in perpetuity for PMHPs subject to the 1.75 percent premium tax.

The effect of this offset is that capitation rates for PLHSOs have been increased with Medicaid dollars so that the PLHSOs can pay the premium taxes to the DOR, without harming the actuarial soundness of the capitation rates.

III. Effect of Proposed Changes:

Section 1 amends s. 636.0145, F.S., to exempt any entity providing services solely to Medicaid recipients through a contract with Medicaid from payment of the premium tax required by s. 624.509, F.S.

Section 2 creates a non-statutory provision of law for retroactive application of the exemption to December 31, 1998. The bill provides that the retroactive application is remedial in nature and does not create the right to a refund of any tax, penalty, or interest to any company that has paid the tax, penalty, or interest prior to July 1, 2011.

Section 3 provides an effective date for the bill of July 1, 2011.

Other Potential Implications:
Exempting PLHSOs from the tax on premiums, contributions, and assessments would impact the way in which the AHCA's actuarial contractor currently calculates capitation rates for those organizations. The 1.75 percent increase in the capitation rates for 2010-11 to offset the tax would be eliminated prospectively since it would no longer be necessary.

[20] Milliman, Inc., *State of Florida Agency for Health Care Administration, September 1, 2010 – August 31, 2011 Prepaid Mental Health Plan Capitation Rate Development,* August 19, 2010, p. 7. On file with staff of the Senate Committee on Health Regulation.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of the bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The bill would exempt the specified PLHSOs from taxes on premiums, contributions, and assessments that are currently in place under s. 624.509, F.S.

B. Private Sector Impact:

Prospectively, the bill should have a neutral effect on private-sector PLHSOs currently subject to the tax because the amount of the bill's tax relief should be offset by an equivalent reduction in their capitation rates.

However, to the degree that one or more PLHSOs might owe unpaid taxes that were due in prior years, those PLHSOs would be positively impacted by the bill's retroactive application of the tax exemption because any unpaid taxes owed from prior years would become nullified by the bill.

C. Government Sector Impact:

On February 25, 2011, the Revenue Estimating Conference (Conference) reviewed the bill for fiscal impact. The Conference was unable to publicly disclose the names of the potential taxpayers or the amounts of taxes paid or owed, due to confidentiality concerns.

However, the Conference determined the bill has a non-recurring negative fiscal impact to GR of $11.2 million for state fiscal year 2011-12 and a recurring negative impact to GR of $1.6 million beginning that same year.[21] The combination of recurring and non-recurring dollars for state fiscal year 2011-12 brings the total negative GR impact to $12.8 million for that year.

[21] See http://edr.state.fl.us/Content/conferences/revenueimpact/pdf/page76.pdf, (Last visited on April 9, 2011).

Non-Recurring Negative Fiscal Impact: $11.2 million
The non-recurring negative GR impact for 2011-12 would presumably result from the bill's retroactive application of the tax exemption, which would render the DOR unable to collect unpaid taxes from prior years during the 2011-12 state fiscal year.

Recurring Negative Fiscal Impact: $1.6 million
There would be a recurring fiscal impact to GR; even though the bill's recurring impact to the private sector might be neutral. Medicaid dollars that are being used to boost the PLHSOs' capitation rates are a mixture of state funds and federal matching funds, with federal match accounting for 64.82 percent in the current state fiscal year.[22] However, when the law calls for PLHSOs to pay the premium tax after the end of each calendar year,[23] the tax dollars are to be deposited into GR.[24] In this way, the bill would cause a negative recurring impact to GR despite the neutral recurring impact to the private sector.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Penalties, Interest, and the Rate of Taxation
In its presentation to the Conference on February 25, 2011, the DOR indicated that interest pertaining to any unpaid taxes would likely be applied but penalties would likely be waived. Further, due to certain tax credits that would apply to PLHSOs in these cases,[25] the net tax rate actually paid by the PLHSOs would be less than 1.75 percent. Because of those tax credits, the Conference assumed a net tax rate of 0.7 percent instead of 1.75 percent when determining the fiscal impact described above.[26]

Tax Payments for 2011
It is unclear what would happen under the bill to dollars currently being used to boost capitation rates for PLHSOs in the 2010-11 contract year (for the purpose of offsetting the tax) if the PLHSOs are no longer required to pay the tax for the 2011 calendar year. It is also unclear how the difference between the assumed tax rate of 1.75 percent, which was used to boost the current capitation rates,[27] and the estimated net tax rate of 0.7 percent would be resolved.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

[22] Social Services Estimating Conference, *Medicaid Federal Share of Matching Funds,* March 1, 2011, available at http://edr.state.fl.us/Content/conferences/medicaid/fmap.pdf (last visited April 11, 2011).
[23] Section 624.509(1), F.S.
[24] Section 624.509(3), F.S.
[25] Section 624.509(5), F.S.
[26] *Supra* note 21.
[27] *Supra* note 20.

B. Amendments:

None.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1544
INTRODUCER:	Senator Jones
SUBJECT:	Death & Fetal Death Registration
DATE:	April 11, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	O'Callaghan	Stovall	HR	**Pre-meeting**
2.			RI	
3.			BC	
4.				
5.				
6.				

I. Summary:

Currently, only physicians and medical examiners are authorized or required to perform certain acts relating to death registration and, for fetal death registration, physicians, midwives, or hospital administrators are authorized or required to perform such acts. This bill authorizes and requires advanced registered nurse practitioners (ARNPs) to perform those acts.

Specifically, this bill authorizes ARNPs to file certificates of death or fetal death. Additionally, ARNPs are required to furnish the funeral director with medical certification of the cause of death and, for fetal deaths, are required to provide any medical or health information to the funeral director within 72 hours after expulsion or extraction of the fetus.

This bill also requires ARNPs to complete the medical certification of cause of death and make the medical certification available to the funeral director within 72 hours after receipt of a death or fetal death certificate from the funeral director if the ARNP was in charge of the decedent's care for the illness or condition that resulted in death or in attendance at the time of death or fetal death. The bill provides that an ARNP may be granted an extension by the local registrar to sign and complete the medical certification of cause of death under certain circumstances, but the ARNP must provide an estimated date for completion of the permanent certificate on the temporary certificate of death or fetal death.

This bill requires the ARNP to certify over his or her signature the cause of death to the best of his or her knowledge and belief. The bill also requires a permanent certificate that includes corrected information to be dated and signed by the ARNP.

This bill substantially amends s. 382.008, F.S.

II. Present Situation:

Advanced Registered Nurse Practitioners

Chapter 464, F.S., the Nurse Practice Act, governs the licensure and regulation of nurses in Florida. Nurses are licensed by the Department of Health (Department) and are regulated by the Board of Nursing (BON).

"Advanced registered nurse practitioner" means any person licensed in Florida to practice professional nursing and certified in advanced or specialized nursing practice, including certified registered nurse anesthetists, certified nurse midwives, and nurse practitioners.[1]

Any nurse desiring to be certified as an ARNP must 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 BON:

- 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.
- Certification by an appropriate specialty board.
- Graduation from a program leading to a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills.[2]

The BON is required to provide by rule the appropriate requirements for ARNPs in the categories of certified registered nurse anesthetist, certified nurse midwife, and nurse practitioner.[3]

An ARNP must perform authorized functions within the framework of an established protocol that is filed with the BON upon biennial license renewal and within 30 days after entering into a supervisory relationship with a physician or changes to the protocol. Within the established framework, an ARNP may:

- Monitor and alter drug therapies.
- Initiate appropriate therapies for certain conditions.
- Perform additional functions as may be determined by rule.
- Order diagnostic tests and physical and occupational therapy.[4]

In addition to the above functions, an ARNP may perform the following acts within his or her specialty:

- 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:
    - 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.

[1] Section 464.003(3), F.S.
[2] Section 464.012(1), F.S.
[3] Section 464.012(2), F.S.
[4] Section 464.012(3), F.S.

- 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.
- Order under the protocol preanesthetic medication.
- 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.
- Order or perform monitoring procedures indicated as pertinent to the anesthetic health care management of the patient.
- 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.
- Recognize and take appropriate corrective action for abnormal patient responses to anesthesia, adjunctive medication, or other forms of therapy.
- Recognize and treat a cardiac arrhythmia while the patient is under anesthetic care.
- Participate in management of the patient while in the postanesthesia recovery area, including ordering the administration of fluids and drugs.
- Place special peripheral and central venous and arterial lines for blood sampling and monitoring as appropriate.

- 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:
  - Perform superficial minor surgical procedures.
  - Manage the patient during labor and delivery to include amniotomy, episiotomy, and repair.
  - Order, initiate, and perform appropriate anesthetic procedures.
  - Perform postpartum examination.
  - Order appropriate medications.
  - Provide family-planning services and well-woman care.
  - Manage the medical care of the normal obstetrical patient and the initial care of a newborn patient.
- The nurse practitioner may perform any or all of the following acts within the framework of established protocol:
  - Manage selected medical problems.
  - Order physical and occupational therapy.
  - Initiate, monitor, or alter therapies for certain uncomplicated acute illnesses.
  - Monitor and manage patients with stable chronic diseases.
  - Establish behavioral problems and diagnosis and make treatment recommendations.[5]

[5] Section 464.012(4), F.S.

Death and Fetal Death Registration

Under ch. 382, F.S., the Florida Vital Statistics Act, there are certain requirements pertaining to death and fetal death registration.

A certificate for each death and fetal death which occurs in Florida is required to be filed on a form prescribed by the Department with the local registrar of the district in which the death occurred within 5 days after the death and prior to final disposition, and must be registered by the registrar if it has been completed and filed in accordance with ch. 382, F.S., or adopted rules.[6]

The certificate must:

- Include the decedent's social security number, if available;
- Include any aliases or "also known as" (AKA) names of a decedent in addition to the decedent's name of record, if requested by the informant;
- Be registered in the registration district in which the dead body or fetus is found within 5 days after such occurrence, if the place of death is unknown; and
- Be registered in the registration district in which the dead body was first removed from a moving conveyance, if the death occurs in a moving conveyance.[7]

The funeral director who first assumes custody of a dead body or fetus must file the certificate of death or fetal death. In the absence of the funeral director, the physician or other person in attendance at or after the death must file the certificate of death or fetal death. The person who files the certificate must obtain personal data from the next of kin or the best qualified person or source available. The medical certification of cause of death is required to be furnished to the funeral director, either in person or via certified mail, by the physician or medical examiner responsible for furnishing such information. For fetal deaths, the physician, midwife, or hospital administrator must provide any medical or health information to the funeral director within 72 hours after expulsion or extraction.[8]

The State Registrar may receive electronically a certificate of death or fetal death which is required to be filed with the registrar under ch. 382, F.S., through facsimile or other electronic transfer for the purpose of filing the certificate. The receipt of a certificate of death or fetal death by electronic transfer constitutes delivery to the State Registrar as required by law.[9]

Within 72 hours after receipt of a death or fetal death certificate from the funeral director, the medical certification of cause of death must be completed and made available to the funeral director by the physician in charge of the decedent's care for the illness or condition which resulted in death, the physician in attendance at the time of death or fetal death or immediately before or after such death or fetal death, or the medical examiner under certain circumstances. The physician or medical examiner must certify over his or her signature the cause of death to the best of his or her knowledge and belief.[10]

[6] Section 382.008(1), F.S.
[7] *Id.*
[8] Section 382.008(2)(a), F.S.
[9] Section 382.008(2)(b), F.S.
[10] Section 382.008(3), F.S.

The local registrar may grant the funeral director an extension of time upon a good and sufficient showing that an autopsy is pending; toxicology, laboratory, or other diagnostic reports have not been completed; or the identity of the decedent is unknown and further investigation or identification is required.[11]

If the physician or medical examiner has indicated that he or she will sign and complete the medical certification of cause of death, but will not be available until after the 5-day registration deadline, the local registrar may grant an extension of 5 days. If a further extension is required, the funeral director must provide written justification to the registrar.[12]

If the local registrar has granted an extension of time to provide the medical certification of cause of death, the funeral director must file a temporary certificate of death or fetal death which must contain all available information, including the fact that the cause of death is pending. The physician or medical examiner is required to provide an estimated date for completion of the permanent certificate.[13]

A permanent certificate of death or fetal death, containing the cause of death and any other information which was previously unavailable, must be registered as a replacement for the temporary certificate. The permanent certificate may also include corrected information if the items being corrected are noted on the back of the certificate and dated and signed by the funeral director, physician, or medical examiner, as appropriate.[14]

The original certificate of death or fetal death must contain all the information required by the Department for legal, social, and health research purposes. All information relating to cause of death in all death and fetal death records and the parentage, marital status, and medical information included in all fetal death records of Florida are confidential and exempt from Florida's public records laws, except for health research purposes as approved by the Department.[15]

III. Effect of Proposed Changes:

Currently, only physicians and medical examiners are authorized or required to perform certain acts relating to death registration and, for fetal death registration, physicians, midwives, or hospital administrators are authorized or required to perform such acts. This bill authorizes and requires ARNPs to perform those acts.

Specifically, this bill authorizes ARNPs to file certificates of death or fetal death. Additionally, ARNPs are required to furnish the funeral director with medical certification of the cause of death and, for fetal deaths, are required to provide any medical or health information to the funeral director within 72 hours after expulsion or extraction of the fetus.

[11] *Id.*
[12] *Id.*
[13] Section 382.008(4), F.S.
[14] Section 382.008(5), F.S.
[15] Section 382.008(6), F.S.

This bill also requires ARNPs to complete the medical certification of cause of death and make the medical certification available to the funeral director within 72 hours after receipt of a death or fetal death certificate from the funeral director if the ARNP was in charge of the decedent's care for the illness or condition that resulted in death or in attendance at the time of death or fetal death. The bill provides that an ARNP may be granted an extension by the local registrar to sign and complete the medical certification of cause of death if the ARNP indicates that he or she will not be available until after the 5-day registration deadline, but the ARNP must provide an estimated date for completion of the permanent certificate on the temporary certificate of death or fetal death.

This bill requires the ARNP to certify over his or her signature the cause of death to the best of his or her knowledge and belief. The bill also requires a permanent certificate that includes corrected information to be dated and signed by the ARNP.

The bill provides an effective date of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Health care providers may have a positive fiscal impact associated with the efficiency of having ARNPs perform the required acts for death and fetal death registration, instead of having to secure a physician to perform such acts.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1918
INTRODUCER:	Senator Margolis
SUBJECT:	Legal and Medical Referral Service Ads
DATE:	April 11, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	O'Callaghan	Stovall	HR	**Pre-meeting**
2.			JU	
3.			BC	
4.				
5.				
6.				

I. Summary:

This bill regulates certain lawyer referral services and medical referral services and their advertisements to prevent misleading or deceptive advertisements aimed at motor vehicle accident victims.

The bill requires advertisements by certain lawyer referral services and medical referral services to contain specific information in a certain manner and prohibits these advertisements from containing other information or representations. The bill requires advertisements for certain lawyer referral services disseminated in Florida to comply with the Supreme Court of Florida's Rules Regulating the Florida Bar pertaining to lawyer referral and advertising services as if the referral services were provided by members of the Florida Bar.

The bill provides for certain recordkeeping requirements by the lawyer referral and medical referral services. The bill prohibits a lawyer referral service or medical referral service from making recommendations based on financial or ownership interests and requires the disclosure of the referral service's financial interest in the health care provider, lawyer, or law firm to which the referral is being made.

This bill provides for certain civil, administrative, and criminal penalties.

This bill creates 11 undesignated sections of the Florida Statutes.

II. Present Situation:

Deceptive and Unfair Trade Practices

Federal Law
15 U.S.C. s. 45 makes any "unfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce" unlawful. The Federal Trade Commission (FTC) is the responsible entity for enforcing this provision. Under the Federal Trade Commission Act,[1] the FTC is empowered, among other things, to

- Prevent unfair methods of competition, and unfair or deceptive acts or practices in or affecting commerce;
- Seek monetary redress and other relief for conduct injurious to consumers;
- Prescribe trade regulation rules defining with specificity acts or practices that are unfair or deceptive, and establishing requirements designed to prevent such acts or practices;
- Conduct investigations relating to the organization, business, practices, and management of entities engaged in commerce; and
- Make reports and legislative recommendations to Congress.

Any person, partnership, or corporation who violates an order of the FTC after it has become final, and while such order is in effect, must forfeit and pay to the United States a civil penalty of not more than $10,000 for each violation, which may be recovered in a civil action brought by the Attorney General of the United States. Each separate violation of such an order is a separate offense, except that in a case of a violation through continuing failure to obey or neglect to obey a final order of the FTC, each day of continuance of such failure or neglect is deemed a separate offense. In such actions, the United States district courts are empowered to grant mandatory injunctions and other further equitable relief as deemed appropriate in the enforcement of the final orders of the FTC.[2]

Florida Law- Florida Deceptive and Unfair Trade Practices Act
Part II of ch. 501, F.S., contains the Florida Deceptive and Unfair Trade Practices Act (FDUTPA). Under the FDUTPA, s. 501.204, F.S., makes any "unfair methods of competition, unconscionable acts or practices, and unfair or deceptive acts or practices in the conduct of any trade or commerce" unlawful. The FDUTPA is enforced by specific "enforcing authorities." The enforcing authority is the office of the state attorney if a violation of the FDUTPA occurs in or affects the judicial circuit under the office's jurisdiction or the Department of Legal Affairs if the violation occurs in or affects more than one judicial circuit or if the office of the state attorney defers to the department in writing, or fails to act upon a violation within 90 days after a written complaint has been filed with the state attorney.

The enforcing authority may administer oaths and affirmations, subpoena witnesses or matter, and collect evidence if, by his or her own inquiry or as a result of complaints, the enforcing

[1] 15 U.S.C. ss. 41-58.
[2] *Id.*

authority has reason to believe that a person has engaged in, or is engaging in, an act or practice that violates the FDUTPA.[3]

The enforcing authority may bring:

- An action to obtain a declaratory judgment that an act or practice violates the FDUTPA.
- An action to enjoin any person who has violated, is violating, or is otherwise likely to violate, the FDUTPA.
- An action on behalf of one or more consumers or governmental entities for the actual damages caused by an act or practice in violation of the FDUTPA.

However, an action may not be brought by the enforcing authority more than 4 years after the occurrence of a violation of the FDUTPA or more than 2 years after the last payment in a transaction involved in a violation of the FDUTPA, whichever is later.

Any person, firm, corporation, association, or entity, or any agent or employee of the foregoing, who is willfully using, or has willfully used, a method, act, or practice that is unlawful under the FDUTPA, or who is willfully violating any administrative rules adopted under the FDUTPA, is liable for a civil penalty of not more than $10,000 for each such violation. Willful violations occur when the person knew or should have known that his or her conduct was unfair or deceptive or prohibited by rule. The civil penalty may be recovered in any action brought by the enforcing authority; or the enforcing authority may terminate any investigation or action upon agreement by the person, firm, corporation, association, or entity, or the agent or employee of the foregoing, to pay a stipulated civil penalty; or the civil penalty may be waived if the person, firm, corporation, association, or entity, or the agent or employee of the foregoing, has previously made full restitution or reimbursement or has paid actual damages to the consumers or governmental entities who have been injured by the unlawful act or practice or rule violation. If civil penalties are assessed in any litigation, the enforcing authority is entitled to reasonable attorney's fees and costs.

The Department of Legal Affairs may issue a cease and desist order if it is in the interest of the public. Any person who violates a cease and desist order of the department must pay a civil penalty of not more than $5,000 for each violation.

Without regard to any other remedy or relief to which a person is entitled, anyone aggrieved by a violation of the FDUTPA may bring an action to obtain a declaratory judgment that an act or practice violates the FDUTPA and to enjoin a person who has violated, is violating, or is otherwise likely to violate the FDUTPA. In any action brought by a person who has suffered a loss as a result of such a violation, the person may recover actual damages, plus attorney's fees and court costs.

Other Florida Laws
Section 817.41, F.S.,[4] prohibits misleading advertising including the following acts:

[3] Section 501.206(1), F.S.

- Making or disseminating or causing to be made or disseminated before the general public of Florida, or any portion thereof, any misleading advertisement;
- Advertising, in any way or by any medium whatsoever, any sale as a "wholesale sale," "below cost sale," or terms of similar purport, unless the goods, wares or merchandise offered for sale are offered by the seller at or below his or her delivered net cost price, or below the average wholesale price of such goods, wares, or merchandise;
- Knowingly and willfully advertising merchandise for sale at a special or wholesale price, in any way or by any medium whatsoever, if he or she does not have sufficient quantities of the advertised merchandise to meet the reasonably foreseeable demand, unless the fact of limited quantity and the approximate number of items is stated in the advertisement, or unless the retailer provides a means by which the consumer may obtain the advertised item at the advertised price within a reasonable time or a value equivalent thereto.

Civil suits may be filed under s. 817.41, F.S., and any prevailing party must be awarded costs, including reasonable attorney's fees, and may be awarded punitive damages in addition to actual damages proven.

Under s. 119.105, F.S., a person who comes into possession of exempt or confidential information contained in police reports may not use that information for any commercial solicitation of the victims or relatives of the victims of the reported crimes or accidents and may not knowingly disclose such information to any third party for the purpose of such solicitation during the period of time that information remains exempt or confidential.

Additionally, under s. 877.02, F.S., it is a misdemeanor for employees of hospitals, sanitariums, police departments, wrecker services, garages, prisons or courts, or for bail bondsmen, investigators, photographers, insurance or public adjustors to assist an attorney in soliciting legal business and under s. 316.066(3)(c), F.S., it is unlawful to use information from accident reports prepared by law enforcement officers for commercial solicitation.

The Supreme Court of Florida's Rules Regulating the Florida Bar

The Florida Bar's Standing Committee on Advertising ("SCA") has been charged by the Supreme Court of Florida with the responsibility of evaluating all non-exempt lawyer advertisements, as well as all direct mail communications to prospective clients, for compliance with the Rules Regulating The Florida Bar. Accordingly, such advertisements and communications must be filed with The Florida Bar for review. Due to the high volume of advertisements filed by Florida lawyers, the SCA has delegated the initial review function to the staff of the Ethics and Advertising Department of The Florida Bar.[5]

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[4] *See also* s. 817.06, F.S., which generally prohibits misleading advertising and provides that the penalty for misleading advertising is a misdemeanor of the second degree.

[5] The Florida Bar, Standing Committee on Advertising, *Handbook on Lawyer Advertising and Solicitation*, Eighth Edition 2010, available at: http://www.floridabar.org/TFB/TFBResources.nsf/Attachments/3AC2BAA33CF257D885256B29004BDEE8/$FILE/Handbook%202010%20(indexed).pdf?OpenElement (last visited on April 7, 2011).

Florida's lawyer advertising rules apply to advertisements or direct mail solicitations of Florida Bar members for legal employment in Florida or targeted to Florida residents or to advertisements or direct mail solicitations of out-of-state lawyers who have a regular or permanent presence in Florida to practice as authorized by law for legal employment in Florida or targeted to Florida residents.[6]

Florida's lawyer advertising rules do not apply to communications between lawyers, between a lawyer and that lawyer's own family members, or between a lawyer and that lawyer's own current and former clients.[7] Also, Florida's lawyer advertising rules do not apply to communications made by a lawyer at a prospective client's request.[8]

Although the lawyer advertising rules do not apply to some communications, the rule prohibiting conduct involving dishonesty, fraud, deceit, or misrepresentation applies to all communications of a lawyer.[9]

A lawyer may not contact a prospective client in-person, by telephone, telegraph, or facsimile, or through other means of direct contact, unless the prospective client is a family member, current client, or former client.[10]

A lawyer may not give anything of value to a person for recommending the lawyer's services. However, this prohibition does not prevent a lawyer from paying the reasonable cost of advertising or the payment of usual charges to a lawyer referral service or other legal service organization.[11]

Each television and radio advertisement that is required to be filed must be filed at least 20 days before its planned broadcast. The bar must provide an opinion within 15 days from the date of receipt of a complete filing. The lawyer cannot broadcast the advertisement until the lawyer either receives an opinion on the advertisement or 20 days have elapsed from the complete filing of the advertisement. A complete filing consists of the video or audio recording of the advertisement, a printed copy of a complete transcript of the advertisement which includes any on-screen text, and a $150 filing fee for timely filing ($250 filing fee if late).[12]

For all other types of media, a lawyer or law firm disseminating information about themselves or their services to prospective clients must file a copy of such advertisement or communication for review by staff of the SCA, unless the information is specifically exempted. The advertisement

[6] *See* Rules 4-7.1(b) and 4-7.1(c), Florida's Rules Regulating the Florida Bar.
[7] *See* Rules 4-7.1(e), 4-7.1(f), and 4-7.1(g), Florida's Rules Regulating the Florida Bar.
[8] Rule 4-7.1(h), Florida's Rules Regulating the Florida Bar.
[9] *Supra* fn. 5. *See also* Rules 4-7.1(i) and 4-8.4(c), Florida's Rules Regulating the Florida Bar.
[10] This prohibition does not extend to unsolicited direct mail communications made in compliance with Rule 4-7.4(b) or unsolicited e-mail communications made in compliance with Rule 4-7.6(c), Florida's Rules Regulating the Florida Bar.
[11] Rule 4-1.17, Florida's Rules Regulating the Florida Bar.
[12] *Supra* fn. 5. *See also* Rule 4-7.7(a)(1), Florida's Rules Regulating the Florida Bar.

or unsolicited direct mail must be filed either prior to or at the first time the advertisement is used.[13]

An advertisement in any public medium that contains no illustrations or information other than the following is exempt from the required filing:

- The name of the lawyer or law firm, a listing of lawyers associated with the firm, office locations and parking arrangements, disability accommodations, telephone numbers, Web site addresses, e-mail addresses, office and telephone service hours, and a designation such as "attorney" or "law firm";
- Date of admission to The Florida Bar and any other bars; current membership or positions held in The Florida Bar, its sections or committees; former membership or positions held in The Florida Bar, its sections or committees, together with dates of membership; former positions or employment held in the legal profession together with the dates the positions were held; years of experience practicing law, number of lawyers in the advertising firm, and a listing of federal courts and jurisdictions other than Florida where the lawyer is licensed to practice;
- Technical and professional licenses granted by the state or other recognized licensing authorities and educational degrees received, including dates and institutions; military service, including branch and dates of service;
- Foreign language ability;
- Fields of law in which the lawyer practices, including official certification logos, subject to Rule 4-7.2(c)(6) (governing communication of specialized areas of practice);
- Prepaid or group legal service plans in which the lawyer participates;
- Acceptance of credit cards;
- Fee for initial consultation and fee schedule, subject to Rule 4-7.2(c)(7) regarding cost disclosures and (c)(8) regarding honoring advertised fees;
- Common salutary language such as "best wishes," "good luck," "happy holidays," or "pleased to announce;"
- Punctuation marks and common typographical marks;
- An illustration of the scales of justice not deceptively similar to official certification logos or The Florida Bar logo, a gavel, traditional renditions of Lady Justice, the Statute of Liberty, the American flag, the American eagle, the State of Florida flag, an unadorned set of law books, the inside or outside of a courthouse, column(s), diploma(s), or a photograph of the lawyer or lawyers who are members of or employed by the firm against a plain background consisting of a single solid color or a plain unadorned set of law books.

A lawyer referral service advertisement is exempt from filing if it contains no information or illustrations other than its name, location, telephone number, the referral fee charged, its hours of operation, the process by which referrals are made, the areas of law in which referrals are offered, the geographic area in which the referral lawyers practice, and, if applicable, the service's nonprofit status, its status as a lawyer referral service approved by The Florida Bar, and the logo of its sponsoring bar association.[14]

[13] Rule 4-7.7(a)(2), Florida's Rules Regulating the Florida Bar.
[14] Rules 4-7.8(a) and 4-7.2(b)(2), Florida's Rules Regulating the Florida Bar.

All forms of lawyer advertising, including advertisements that are exempt from the filing requirement, must include the name of at least one lawyer, or the lawyer referral service, responsible for the advertising content and must disclose the town or city of one or more bona fide office locations of the lawyer or lawyers who will perform the services advertised. If the office is outside a city or town, the advertisement must disclose the county in which the office is located.

Lawyer advertisements may not include information that:

- Contains a material misrepresentation of fact or law - Rule 4-7.2(c)(1)(A).
- Is false or misleading - Rule 4-7.2(c)(1)(B).
- Fails to disclose material information necessary to prevent the information supplied from being false or misleading - Rule 4-7.2(c)(1)(C).
- Is unsubstantiated in fact - Rule 4-7.2(c)(1)(D).
- Is deceptive - Rule 4-7.2(c)(1)(E).
- Refers to past successes or results obtained - Rule 4-7.2 (c)(1)(F).
- Promises results - Rule 4-7.2(c)(1)(G).
- Compares the lawyer's services with the services of other lawyers, unless the comparison can be factually substantiated - Rule 4-7.2(c)(1)(I).
- Includes a testimonial - Rule 4-7.2(b)(1)(J).[15]

The majority of cases prosecuted against lawyers for advertising violations come from complaints to the bar's Lawyer Regulation Department filed by members of the public, including other attorneys. Additionally, a lawyer may be referred to Lawyer Regulation by the Standing Committee on Advertising or The Florida Bar Board of Governors for repeated violations. Although rare, a lawyer may be referred to Lawyer Regulation by Florida Bar staff for failing to respond to inquiries by bar staff. Complaints are prosecuted from Lawyer Regulation Headquarters in Tallahassee, Florida. If grievance committee review is necessary, the case is forwarded to the statewide advertising grievance committee. A statewide grievance committee was appointed in 2004 to hear only advertising cases for consistency.[16]

III. Effect of Proposed Changes:

This bill provides certain findings by the Legislature, including that there have been numerous complaints concerning misleading and deceptive advertisements directed to motor vehicle accident victims by entities who advertise they are available to refer motor vehicle accident victims to lawyers and health care providers; the public should not be deceived and misled by false or deceptive advertising that is for the purpose of directing motor vehicle accident victims to a specific health care provider, lawyer, or law firm; and although lawyer advertisements for motor vehicle accidents are regulated by the Supreme Court of Florida's Rules Regulating The Florida Bar, those rules are not directly applicable to non-lawyer entities that advertise to motor

[15] There are additional regulations for targeted direct mail advertisements or computer-accessed communications (e.g. websites or e-mail).
[16] *Supra* fn. 5.

vehicle accident victims and therefore, it is necessary to enact a law to protect the public from false and deceptive advertising to motor vehicle accident victims.

Section 1 defines "lawyer referral service" to mean any group or pooled advertising program operated by any person, group of persons, association, organization, or entity whose legal services advertisements use a common telephone number, a uniform resource locator (URL), or other form of contact and whose clients or prospective clients are referred only to lawyers or law firms participating in the group or pooled advertising program. A not-for-profit referral program in which participating lawyers do not pay a fee or charge of any kind to receive referrals or to belong to the referral panel and undertake the referred matters without expectation of remuneration is not considered a lawyer referral service.

"Medical referral services" is defined by the bill to mean any group or pooled advertising program operated by any person, group of persons, association, organization, or entity whose legal and medical services advertisements use a common telephone number, a uniform resource locator (URL), or other form of contact and whose patients or prospective patients are referred only to medical clinics or health care providers participating in the group or pooled advertising program.

The provisions of the bill do not apply to a lawyer referral service for, or operated by, a voluntary bar association or legal aid program recognized by The Florida Bar.

Section 2 requires all advertising by, or on behalf of, a medical or lawyer referral service to the general public for services related to injuries from a motor vehicle accident to comply with the following:

- If an advertisement includes any reference to referring a person to a health care provider, lawyer, or law firm, the advertisement must clearly disclose the county or counties in which the health care provider, lawyer, or law firm to whom the referral will be made has a bona fide office from which the services will be provided.
- Each advertisement is prohibited from including any false, misleading, or deceptive communication including a communication that:
  - Contains a material misrepresentation of fact.
  - Fails to disclose material information necessary to prevent the information supplied from being false or misleading.
  - Claims facts that cannot be substantiated.
  - Contains any reference to past successes or results obtained that would deceive the public into having unjustified expectations. The bill requires an advertisement to contain a disclaimer that "results will vary depending on the specific facts" whenever any reference to past successes or results is made, and the disclaimer must be communicated in the exact same manner as any reference to past successes or results.
  - Contains a reference to monetary amounts that create unjustified expectations, such as using deceptive statements like "Don't make a million dollar mistake." or "You may be entitled to $100,000." when there is no factual basis to suggest such monetary amounts to the general public.
  - Promises or suggests a specific result that cannot be guaranteed, including promising or suggesting a monetary result that cannot be guaranteed.

- Contains any testimonial by an actor, unless such testimonial includes a disclaimer, communicated in the exact same manner as the testimonial, that the testimonial is not a true story and the person providing the testimonial is an actor and not a real person.
- Contains any testimonial by a real person, unless the real person actually obtained the services of the entity advertising the services, and the testimonial is completely truthful and verifiable, and includes the disclaimer that "results may vary depending on the specific facts." The disclaimer must be communicated in the exact same manner as the real person testimonial.
- Contains any verbal or visual reference to any connection between any person in public safety, or purporting to be in public safety, or any public safety entity and the person or entity advertising the services to motor vehicle accident victims. This prohibition includes the use of any visual or verbal reference to any actor purporting to be connected in any way to a public safety officer or public safety entity and includes the use of any public safety badge, emblem, uniform, hat, vehicle, or any replica of any such item. An exception to this prohibition is when the person in charge of a public safety entity gives express written consent to reference the agency in the advertisement or communication.

Section 3 requires an advertisement or unsolicited written communication for legal services related to motor vehicle accidents disseminated in Florida by, or on behalf of, any lawyer referral service to comply with the Supreme Court of Florida's Rules Regulating The Florida Bar pertaining to lawyer referral and advertising services as if those services were provided by members of The Florida Bar, including filing requirements.

Section 4 requires each advertisement by, or on behalf of, a lawyer referral service related to motor vehicle accidents, which is submitted for publication in the print or electronic media or on a billboard in Florida, to be accompanied by an affidavit signed under oath by the owner, shareholder, principal, or officer of the referral service affirming under penalty of perjury[17] that the person:

- Has read and understands the Supreme Court of Florida's Rules Regulating The Florida Bar, which pertain to lawyer referral and advertising services;
- Acknowledges that he or she is the person responsible for the advertisement and for the adverse consequences of any prohibited advertising;
- Affirms that the advertisement complies with the Supreme Court of Florida's Rules Regulating The Florida Bar, which govern lawyer advertising;
- Acknowledges that a knowing violation of the Supreme Court of Florida's Rules Regulating The Florida Bar, which govern lawyer advertising, subjects the person to a civil penalty of $1,000 for the first offense and a civil penalty of $5,000 for each subsequent offense; and
- Has filed, or is responsible for filing and will file, the advertisement for review with The Florida Bar in compliance with the Supreme Court of Florida's Rules Regulating The Florida Bar, which govern lawyer advertising; or

[17] The penalty of perjury under s. 837.012, F.S., is a misdemeanor of the 1st degree punishable as provided in s. 775.082 or s. 775.083, F.S. (maximum imprisonment of 1 year or maximum fine of $1,000).

- Has determined that the advertisement is exempt from the filing requirement as set forth in the Supreme Court of Florida's Rules Regulating The Florida Bar, which govern lawyer advertising.

A copy of the affidavit must be submitted to The Florida Bar and maintained by the referral services for 2 years.

Section 5 requires an advertisement or unsolicited written communication disseminated in Florida by, or on behalf of, a lawyer referral service relating to motor vehicle accidents to contain prominently within the body of the advertisement or unsolicited written communication the statement:

> This advertisement is by a lawyer referral service. Lawyers may pay this service for referrals of prospective clients who respond to this advertisement. This lawyer referral service is not licensed to provide legal services in Florida.

Section 6 requires a referring person or entity to provide the person being referred with a written disclosure that clearly and unambiguously states any financial interest or financial relationship that the referring person or entity has with the health care provider, lawyer, or law firm to whom a referral is made. A copy of the written disclosure must be submitted to The Florida Bar and maintained by the referral service for 2 years.

Sections 7 and 8 prohibit a lawyer referral service from requiring a participating lawyer or law firm to recommend the services of a particular health care provider or other professional as a condition of participation in the referral service. Additionally, a medical referral service may not make referrals only to a medical clinic or health care provider with which the medical referral service has any financial or ownership interest.

Section 9 provides for civil, administrative, and criminal penalties and provides that a person or entity that violates the provisions of the bill must forfeit any monetary amount received as a result of an advertisement that violates this act.

Under the bill if any provision of the bill is violated, the person committing such violation is subject to a civil penalty of $1,000 for the first offense and $5,000 for each subsequent offense. Any sums collected from the civil penalty are to be deposited in the State Courts Revenue Trust Fund. Each prohibited advertisement that appears on a billboard, is published in print media, airs on radio or television, or appears on a computer website controlled by the party advertising the services constitutes a separate offense.

A person who claims a violation of any provision in this bill may file a complaint with the Department of Agriculture and Consumer Services. If the department fails to initiate legal proceedings within 90 days after receiving the complaint, the person who filed the complaint may, in a court of competent jurisdiction, seek to enforce such penalties and may seek an injunction against the person committing the violation. Only the person who first filed the complaint with the department on each individual violation is authorized to initiate an action.

A person who files a court action for a violation of any provision in this bill may recover attorney's fees and costs if he or she is successful in obtaining an injunction, penalties, or both and may recover 25 percent of all moneys paid as a civil penalty as a result of the person's action to enforce the provisions of the bill.

Section 10 provides that after an adjudication of guilt is entered for a first offense for a violation, any subsequent knowing violation is a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083, F.S. (maximum imprisonment of 60 days or maximum fine of $500). A person who violates any provision of the bill that relates to specific advertising requirements commits an unfair or deceptive trade practice as defined in part II of chapter 501, F.S., and is subject to the penalties and remedies provided therein. Further, any person injured by a violation may bring an action for recovery of damages. A judgment in favor of the person must be for actual damages, and the losing party is liable for the person's reasonable attorney's fees and costs.

Section 11 preserves existing law and provides that the provisions in this bill are cumulative and do not amend or repeal any other law, code, ordinance, rule, or penalty now in effect.

The bill provides an effective date of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

D. Other Constitutional Issues:

Access to Courts
Lines 247 through 250 of the bill provide that the right of a person to initiate court proceedings under the provisions of this bill is limited to the person who first filed the complaint with the Department of Agriculture and Consumer Services on each individual violation. This provision may be challenged as a violation of the constitutional right to have access to courts. However, the bill expressly preserves any other causes of action

available under any other state or local law, ordinance, or rule and section 10 authorizes a person to bring an action for recovery of actual damages.

Article I, Section 21 of the Florida Constitution provides, "The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay."

Freedom of Speech
Because this bill regulates advertising, and therefore a person's "speech," it may be challenged as violating the First Amendment of the U.S. Constitution[18] and Article I, Section 4 of the Florida Constitution.

The First Amendment of the U.S. Constitution provides:

> Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.

Article I, Section 4 of the Florida Constitution provides:

> Every person may speak, write and publish sentiments on all subjects but shall be responsible for the abuse of that right. No law shall be passed to restrain or abridge the liberty of speech or of the press. In all criminal prosecutions and civil actions for defamation the truth may be given in evidence. If the matter charged as defamatory is true and was published with good motives, the party shall be acquitted or exonerated.

The Florida Courts have generally interpreted state constitutional provisions related to freedom of speech and freedom of the press in accordance with the federal First Amendment jurisprudence.

The First Amendment protections extend to all forms of communication including written, verbal, and nonverbal. The government can impose content-based limits on speech if it can demonstrate a compelling interest. However, regulations which burden substantially more speech than is necessary to further a compelling interest are invalid.[19] Pertaining to commercial speech, the government may ban speech which proposes an unlawful transaction and may also ban false advertising, misleading advertising, and other forms of fraudulent speech because such forms of expression are not protected by the First Amendment.[20]

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[18] Applicable to the states by the Fourteenth Amendment of the U.S. Constitution.
[19] *Broadrick v. Oklahoma*, 413 U.S. 601 (1973).
[20] *Pittsburgh Press Co. v. Human Relations Commission*, 413 U.S. 376 (1973) and *Friedman v. Rogers*, 440 U.S. 1 (1979).

For a court to determine whether the government may regulate commercial speech, the following must be considered:

- Whether the speech at issue is not misleading and concerns lawful activity;
- Whether the government has a substantial interest in restricting that speech;
- Whether the regulation directly advances the asserted governmental interest; and
- Whether the regulation is narrowly tailored, but not necessarily the least restrictive means available, to serve the asserted governmental interest.[21]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The bill requires lawyer referral services to file advertisements with the Florida Bar in the same manner and under the same requirements as any lawyer submitting advertisements for approval. This would subject the referral services to a fee of $150 for each timely filed advertisement and $250 for a late filed advertisement.[22]

B. Private Sector Impact:

Lawyer referral services and medical referral services would incur a negative fiscal impact in order to comply with the provisions of the bill.

C. Government Sector Impact:

The Department of Agriculture and Consumer Services would incur a negative fiscal impact associated with investigating and initiating legal proceedings in response to complaints.

The Florida Bar might also incur administrative costs associated with reviewing additional filings.

VI. Technical Deficiencies:

The phrases “and not a real person,” “by a real person,” and “real person” in lines 137, 138, 144 should be deleted as they appear to be unnecessary.

VII. Related Issues:

The term “health care provider” is not defined in the bill. “Health care provider” is defined in other chapters of the Florida Statutes, with the definitions varying in scope. For example, under s. 766.202(4), F.S., in the medical negligence context, “health care provider” has a broad definition to encompass, among others, hospitals, certain birth centers, blood banks, plasma centers, anyone licensed to practice medicine, chiropractors, optometrists, and nurses.

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[21] *Board of Trustees of State Univ. of New York v. Fox*, 492 U.S. 469, 476-481 (1989). *See also State v. Cronin*, 774 So. 2d 871 (Fla. 1st DCA 2000).
[22] *Supra* fn. 5.

Lines 114 and 115 of the bill prohibits advertisements from containing "material" misrepresentations of fact and prohibits a failure to disclose "material" information necessary to prevent the information supplied in the advertisement from being false or misleading. The term "material" is open for interpretation and litigation may ensue in order for a court to interpret the term.

Lines 232 through 234 of the bill require a person or entity that violates the provisions of the bill to forfeit any monetary amount received as a result of an advertisement that violates the provisions of the bill. It is unclear whether this, in effect, means that the referral services will be required to ask each person they are referring whether they obtained the referral services because of an advertisement versus being told about the service from a friend or family member or by other means.

Lines 235 through 237 of the bill provide that a person or entity that violates the provisions of the bill is subject to a civil penalty. It is not clear who is responsible for collecting the civil penalty. Civil penalties under ch. 501, F.S., are recovered by the Department of Legal Affairs (Attorney General's Office) or the Office of the State Attorney. Although, lines 241 through 250 of the bill authorize the Department of Agriculture and Consumer Services to initiate legal proceedings after a complaint has been filed, there is no requirement that the Department of Agriculture and Consumer Services recover the civil penalty.

Lines 261 through 265 of the bill provide that "After an adjudication of guilt is entered for a first offense of violating this act," any subsequent knowing violation of this act is a misdemeanor of the second degree." It is unclear what the penalty is supposed to be for the first offense of which there is an adjudication of guilt.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate . House

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The Committee on Health Regulation (Sobel) recommended the following:

Senate Amendment (with title amendment)

Delete lines 242 - 358.

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

And the title is amended as follows:

Delete lines 27 - 37

and insert:

executed; amending s.

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LEGISLATIVE ACTION

Senate . House

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The Committee on Health Regulation (Bennett) recommended the following:

Senate Amendment (with title amendment)

Between lines 241 and 242
insert:

Section 7. Subsections (3), (4), and (5) of section 463.002, Florida Statutes, are amended to read:

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

(3)(a) "Licensed practitioner" means a person who is a primary health care provider licensed to engage in the practice of optometry under the authority of this chapter.

(b) A licensed practitioner who is not a certified optometrist shall be required to display at her or his place of

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practice a sign which states, "I am a Licensed Practitioner, not a Certified Optometrist, and I am not able to prescribe ~~topical~~ ocular pharmaceutical agents."

(c) All practitioners initially licensed after July 1, 1993, must be certified optometrists.

(4) "Certified optometrist" means a licensed practitioner authorized by the board to administer and prescribe ~~topical~~ ocular pharmaceutical agents.

(5) "Optometry" means the diagnosis of conditions of the human eye and its appendages; the employment of any objective or subjective means or methods, including the administration of ~~topical ocular~~ pharmaceutical agents, for the purpose of determining the refractive powers of the human eyes, or any visual, muscular, neurological, or anatomic anomalies of the human eyes and their appendages; and the prescribing and employment of lenses, prisms, frames, mountings, contact lenses, orthoptic exercises, light frequencies, and any other means or methods, including ~~topical ocular~~ pharmaceutical agents, for the correction, remedy, or relief of any insufficiencies or abnormal conditions of the human eyes and their appendages.

Section 8. Paragraph (g) of subsection (1) of section 463.005, Florida Statutes, is amended to read:

463.005 Authority of the board.—

(1) The Board of Optometry has authority to adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter conferring duties upon it. Such rules shall include, but not be limited to, rules relating to:

(g) Administration and prescription of ~~topical~~ ocular pharmaceutical agents.

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Section 9. Section 463.0055, Florida Statutes, is amended to read:

463.0055 Administration and prescription of ~~topical~~ ocular pharmaceutical agents; committee.—

(1) Certified optometrists may administer and prescribe ~~topical ocular~~ pharmaceutical agents as provided in this section for the diagnosis and treatment of ocular conditions of the human eye and its appendages without the use of surgery or other invasive techniques. However, a licensed practitioner who is not certified may use topically applied anesthetics solely for the purpose of glaucoma examinations, but is otherwise prohibited from administering or prescribing ~~topical~~ ocular pharmaceutical agents.

(2)(a) There is ~~hereby~~ created a committee composed of two certified optometrists licensed pursuant to this chapter, appointed by the Board of Optometry, two board-certified ophthalmologists licensed pursuant to chapter 458 or chapter 459, appointed by the Board of Medicine, and one additional person with a doctorate degree in pharmacology who is not licensed pursuant to chapter 458, chapter 459, or this chapter, appointed by the State Surgeon General. The committee shall review requests for additions to, deletions from, or modifications of a formulary of ~~topical~~ ocular pharmaceutical agents for administration and prescription by certified optometrists and shall provide to the board advisory opinions and recommendations on such requests. With regard to the administration and prescription of oral pharmaceutical agents by a certified optometrist for the diagnosis and treatment of diseases or conditions of the human eye and its appendages, the

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board shall be bound by the committee's recommendation on the duration of a certified optometrist's use of specific oral analgesic agents. The formulary shall consist of those topical ocular pharmaceutical agents which the certified optometrist is qualified to use in the practice of optometry. The board shall establish, add to, delete from, or modify the formulary by rule. Notwithstanding any provision of chapter 120 to the contrary, the formulary rule shall become effective 60 days from the date it is filed with the Secretary of State.

(b) The formulary may be added to, deleted from, or modified according to the procedure described in paragraph (a). Any person who requests an addition, deletion, or modification of an authorized ~~topical~~ ocular pharmaceutical agent shall have the burden of proof to show cause why such addition, deletion, or modification should be made.

(c) The State Surgeon General shall have standing to challenge any rule or proposed rule of the board pursuant to s. 120.56. In addition to challenges for any invalid exercise of delegated legislative authority, the administrative law judge, upon such a challenge by the State Surgeon General, may declare all or part of a rule or proposed rule invalid if it:

1. Does not protect the public from any significant and discernible harm or damages;

2. Unreasonably restricts competition or the availability of professional services in the state or in a significant part of the state; or

3. Unnecessarily increases the cost of professional services without a corresponding or equivalent public benefit.

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However, there shall not be created a presumption of the existence of any of the conditions cited in this subsection in the event that the rule or proposed rule is challenged.

(d) Upon adoption of the formulary required by this section, and upon each addition, deletion, or modification to the formulary, the board shall mail a copy of the amended formulary to each certified optometrist and to each pharmacy licensed by the state.

(3) A certified optometrist shall be issued a prescriber number by the board. Any prescription written by a certified optometrist for an ~~a topical~~ ocular pharmaceutical agent pursuant to this section shall have the prescriber number printed thereon.

Section 10. Subsection (3) of section 463.0057, Florida Statutes, is amended to read:

463.0057 Optometric faculty certificate.—

(3) The holder of a faculty certificate may engage in the practice of optometry as permitted by this section, but may not administer or prescribe ~~topical~~ ocular pharmaceutical agents unless the certificateholder has satisfied the requirements of s. 463.006(1)(b)4. and 5.

Section 11. Subsections (2) and (3) of section 463.006, Florida Statutes, are amended to read:

463.006 Licensure and certification by examination.—

(2) The examination shall consist of the appropriate subjects, including applicable state laws and rules and general and ocular pharmacology with emphasis on the ~~topical~~ application and side effects of ocular pharmaceutical agents. The board may by rule substitute a national examination as part or all of the

examination and may by rule offer a practical examination in addition to the written examination.

(3) Each applicant who successfully passes the examination and otherwise meets the requirements of this chapter is entitled to be licensed as a practitioner and to be certified to administer and prescribe ~~topical ocular~~ pharmaceutical agents in the diagnosis and treatment of ocular conditions.

Section 12. Subsection (20) 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:

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

Section 13. 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 same to be administered by a licensed nurse or an intern practitioner under his or her

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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 pharmaceutical agents in Schedule I or Schedule II of the Florida Comprehensive Drug Abuse Prevention and Control Act.

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

And the title is amended as follows:

Delete line 27

and insert:

executed; amending s. 463.002, F.S.; redefining the terms "licensed practitioner," "certified optometrist," and "optometry" within the practice of optometry; amending s. 463.005, F.S.; authorizing the Board of Optometry to adopt rules pertaining to the administration and prescription of ocular pharmaceutical agents; amending s. 463.0055, F.S.; expanding the type of pharmaceuticals that are prescribed and administered; requiring the optometrists who are members of a committee appointed by the Board of Optometry to be certified; requiring the committee to review requests for modifications of a formulary of ocular pharmaceutical agents; requiring the board to be bound by the committee's recommendation on the duration of a certified optometrist's use of specific oral analgesic agents;

conforming terminology to changes made by the act; amending ss. 463.0057 and 463.006, F.S.; specifying certain persons who may or may not prescribe or administer any ocular pharmaceutical agents; amending s. 893.02, F.S.; redefining the term "practitioner" as it relates to the Florida Comprehensive Drug Abuse Prevention and Control Act; amending s. 893.05, F.S.; prohibiting a certified optometrist from administering or prescribing certain pharmaceutical agents; amending s. 464.012, F.S.; expanding the

LEGISLATIVE ACTION

Senate . House

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The Committee on Health Regulation (Bennett) recommended the following:

Senate Amendment (with title amendment)

Delete lines 415 - 427

and insert:

(1) In any action for recovery of damages based on the death or personal injury of any person in which it is alleged that such death or injury resulted from the negligence of the following persons:

(a) A health care provider as defined in s. 766.202(4); or

(b) An emergency health care provider, which includes a person or an entity that provides services according to obligations imposed by s. 395.1041 or s. 401.45, but does not

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include a person or entity that is otherwise covered under this section,

the claimant shall have the burden of proving by clear and convincing ~~the greater weight of~~ evidence that the alleged actions of the health care provider or the emergency health care provider represented a breach of the prevailing professional standard of care for that health care provider or emergency health care provider. The prevailing professional standard of care for a given health care provider or emergency health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers or emergency health care providers.

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

And the title is amended as follows:

Delete line 44

and insert:

prove medical negligence by a health care provider or an emergency health care provider;

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1892
INTRODUCER:	Senator Bennett
SUBJECT:	Health Care
DATE:	April 9, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Stovall	Stovall	HR	**Pre-meeting**
2.			BC	
3.				
4.				
5.				
6.				

I. Summary:

The bill requires a physician or osteopathic physician who provides expert testimony concerning the prevailing professional standard of care of a physician or osteopathic physician to be licensed in this state under ch. 458, The Medical Practice Act, or ch. 459, F.S., The Osteopathic Medical Practice Act, or possess an expert witness certificate issued by the Board of Medicine (BOM) or the Board of Osteopathic Medicine (BOOM).

The bill extends the period of time immediately preceding the date of the occurrence that is the basis for the action within which an expert witness must have performed certain activities in order to qualify as an expert witness. The time frames are extended to 5 years if the health care provider against whom or on whose behalf the testimony is offered is a specialist or a health care provider other than a specialist or general practitioner.

A patient's informed consent for cataract surgery must include a properly executed standard informed consent form that sets forth the recognized specific risks related to cataract surgery. This form must be developed by the BOM and the BOOM. If this consent form is properly executed, it creates a rebuttable presumption that the physician properly disclosed the risks associated with cataract surgery.

An advance registered nurse practitioner (ARNP) is authorized to order and administer controlled substances under certain conditions and a certificated registered nurse anesthetist is authorized to order the administration of drugs that are commonly used to alleviate pain.

The bill requires a clause in an insurance policy or self-insurance policy for medical malpractice coverage to clearly state whether or not the insured has the exclusive right of veto of any

admission of liability or offer of judgment. The bill repeals the authority for a self-insurance policy or insurance policy for medical malpractice to grant authority for the insurer to bring the case to closure without the permission of the insured if the action is within the policy limits.

The bill changes the burden of proof to clear and convincing evidence for an action for recovery of damages based on death or personal injury resulting from medical negligence.

The bill requires a claimant to submit, along with the other required information, an executed authorization form, that is set forth in the bill, for the release of protected health information that is potentially relevant to the claim of personal injury or wrongful death when he or she notifies each prospective defendant of his or her intent to initiate litigation for medical negligence. The bill provides consequences for failing to submit the authorization form, revoking the authorization, or not completing the form in good faith.

A defendant or his or her legal representative may interview a claimant's treating physician without notice to the claimant.

The bill establishes in law that hospitals, ambulatory surgical centers, and mobile surgical facilities are not liable for the medical negligence of contracted health care providers, other than an employee, unless the entity expressly directs or exercises actual control over the specific conduct that caused injury.

This bill substantially amends the following sections of the Florida Statutes: 458.3175, 458.331, 458.351, 459.0066, 459.015, 459.026, 464.012, 627.4147, 766.102, 766.106, 766.206, and 768.0981.

This bill creates s. 766.1065, F.S.

II. Present Situation:

In any action for recovery of damages based on the death or personal injury of any person in which it is alleged that the death or injury resulted from the negligence of a health care provider, the claimant has the burden of proving by the greater weight of evidence that the alleged action of the health care provider represented a breach of the prevailing professional standard of care for that health care provider. The prevailing professional standard of care is that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.[1]

Presuit Investigation[2]

Prior to the filing of a lawsuit, the person allegedly injured by medical negligence or a party bringing a wrongful death action arising from an alleged incidence of medical malpractice (the claimant) and the defendant (the health care professional or health care facility) are required to conduct presuit investigations to determine whether medical negligence occurred and what damages, if any, are appropriate.

[1] S. 766.102, F.S.
[2] S. 766.203, F.S.

The claimant is required to conduct an investigation to ascertain that there are reasonable grounds to believe that:

- A named defendant in the litigation was negligent in the care or treatment of the claimant; and
- That negligence resulted in injury to the claimant.

Corroboration of reasonable grounds to initiate medical negligence litigation must be provided by the claimant's submission of a verified written medical expert opinion from a medical expert.

Before the defendant issues his or her response, the defendant or his or her insurer or self-insurer is required to ascertain whether there are reasonable grounds to believe that:

- The defendant was negligent in the care or treatment of the claimant; and
- That negligence resulted in injury to the claimant.

Corroboration of the lack of reasonable grounds for medical negligence litigation must be provided by submission of a verified written medical expert opinion which corroborates reasonable grounds for lack of negligent injury sufficient to support the response denying negligent injury.

These expert opinions are subject to discovery. Furthermore, the opinion must specify whether any previous opinion by that medical expert has been disqualified and if so, the name of the court and the case number in which the ruling was issued.

Medical Experts[3]

A person may not give expert testimony concerning the prevailing professional standard of care unless that person is a licensed health care provider and meets the following criteria:

- If the health care provider against whom or on whose behalf the testimony is offered is a specialist, the expert witness must:
  - Specialize in the same specialty as the health care provider against whom or on whose behalf the testimony is offered; or specialize in a similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients; and
  - Have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:
    - The active clinical practice of, or consulting with respect to, the same or similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients;
    - Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same or similar specialty; or
    - A clinical research program that is affiliated with an accredited health professional school or accredited residency or clinical research program in the same or similar specialty.

[3] S. 766.102(5), (9), and (12), F.S.

- If the health care provider against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness must have devoted professional time during the 5 years immediately preceding the date of the occurrence that is the basis for the action to:
  - The active clinical practice or consultation as a general practitioner;
  - The instruction of students in an accredited health professional school or accredited residency program in the general practice of medicine; or
  - A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the general practice of medicine.
- If the health care provider against whom or on whose behalf the testimony is offered is a health care provider other than a specialist or a general practitioner, the expert witness must have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:
  - The active clinical practice of, or consulting with respect to, the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered;
  - The instruction of students in an accredited health professional school or accredited residency program in the same or similar health profession in which the health care provider against whom or on whose behalf the testimony is offered; or
  - A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered.
- If the claim of negligence is against a physician licensed under chapter 458, osteopathic physician licensed under chapter 459, podiatric physician licensed under chapter 461, or chiropractic physician licensed under chapter 460 providing emergency medical services in a hospital emergency department, the court shall admit expert medical testimony only from physicians, osteopathic physicians, podiatric physicians, and chiropractic physicians who have had substantial professional experience within the preceding 5 years while assigned to provide emergency medical services in a hospital emergency department.

These provisions do not limit the power of the trial court to disqualify or qualify an expert witness on grounds other than the qualifications in this section (s. 766.102, F.S.). Relevant portions of the Florida Evidence Code provide requirements for expert opinion testimony.[4] The Florida Rules of Civil Procedure define "expert witness" as a person duly and regularly engaged in the practice of a profession who holds a professional degree from a university or college and has had special professional training and experience, or one possessed of special knowledge or skill about the subject upon which called to testify.[5]

The court shall refuse to consider the testimony or opinion attached to any notice of intent or to any response rejecting a claim of an expert who has been disqualified three times.[6]

Disciplinary action may be taken against a medical physician or osteopathic physician who has been found by any court in this state to have provided corroborating written medical expert

[4] Sections 90.702 and 90.704, F.S.
[5] Fla. R. Civ. P. 1.390(a).
[6] S. 766.206, F.S.

opinion attached to any statutorily required notice of claim or intent or to any statutorily required response rejecting a claim, without reasonable investigation.[7]

After Claimant's Presuit Investigation[8]

After completion of presuit investigation and prior to filing a complaint for medical negligence, a claimant shall notify each prospective defendant of intent to initiate litigation for medical negligence. Notice to each prospective defendant must include, if available, a list of all known health care providers seen by the claimant for the injuries complained of subsequent to the alleged act of negligence, all known health care providers during the 2-year period prior to the alleged act of negligence who treated or evaluated the claimant, and copies of all of the medical records relied upon by the expert in signing the affidavit. The requirement of providing the list of known health care providers may not serve as grounds for imposing sanctions for failure to provide presuit discovery.

A suit may not be filed for a period of 90 days after notice is mailed to any prospective defendant. The statue of limitations is tolled during the 90-day period. During the 90-day period, the prospective defendant or the defendant's insurer or self-insurer must conduct a presuit investigation to determine the liability of the defendant. Each insurer or self-insurer must have a procedure for the prompt investigation, review, and evaluation of claims during the 90-day period.

Each insurer or self-insurer shall investigate the claim in good faith, and both the claimant and prospective defendant shall cooperate with the insurer in good faith. If the insurer requires, a claimant shall appear before a pretrial screening panel or before a medical review committee and submit to a physical examination. Unreasonable failure of any party to comply with this section justifies dismissal of claims or defenses. There is no civil liability for participation in a pretrial screening procedure if done without intentional fraud.

At or before the end of the 90 days, the prospective defendant or the prospective defendant's insurer or self-insurer must provide the claimant with a response:

- Rejecting the claim;
- Making a settlement offer; or
- Making an offer to arbitrate in which liability is deemed admitted and arbitration will be held only on the issue of damages. This offer may be made contingent upon a limit of general damages.

The response is to be delivered to the claimant if not represented by counsel or to the claimant's attorney. Failure of the prospective defendant or insurer or self-insurer to reply to the notice within 90 days after receipt is deemed a final rejection of the claim.

[7] *See* s. 458.331(jj), F.S., and s. 459.015(mm), F.S.
[8] S. 766.106, F.S.

Discovery and Admissibility of Evidence

Statements, discussions, written documents, reports, or other work product generated by the presuit screening process are not discoverable or admissible in any civil action for any purpose by the opposing party. All participants, including, but not limited to, physicians, investigators, witnesses, and employees or associates of the defendant, are immune from civil liability arising from participation in the presuit screening process.[9]

Upon receipt by a prospective defendant of a notice of claim, the parties are required to make discoverable information available without undertaking formal discovery. Informational discovery may be used to obtain unsworn statements, the production of documents or things, and physical and mental examinations as follows:[10]

- Unsworn statements – Any party may require other parties to appear for the taking of an unsworn statement. Unsworn statements may be used only for the purpose of presuit screening and are not discoverable or admissible in any civil action for any purpose by any party.
- Documents or things – Any party may request discovery of documents or things. This includes medical records.
- Physical and mental examination – A prospective defendant may require an injured claimant to be examined by an appropriate health care provider. Unless otherwise impractical, a claimant is required to submit to only one examination of behalf of all potential defendants. The examination report is available to the parties and their attorney and may be used only for the purpose of presuit screening. Otherwise the examination is confidential.
- Written questions – Any party may request answers to written questions.
- Medical information release – The claimant must execute a medical information release that allows a prospective defendant or his or her legal representative to take unsworn statements of the claimant's treating physicians that address areas that are potentially relevant to the claim of personal injury or wrongful death. The claimant or claimant's legal representative has the right to attend the taking of these unsworn statements.

The failure to cooperate on the part of any party during the presuit investigation may be grounds to strike any claim made, or defense raised in the suit.

Advanced Registered Nurse Practitioners

Chapter 464, F.S., the Nurse Practice Act, governs the licensure and regulation of nurses in Florida. Nurses are licensed by the Department of Health (Department) and are regulated by the Board of Nursing (BON).

"Advanced registered nurse practitioner" means any person licensed in Florida to practice professional nursing and certified in advanced or specialized nursing practice, including certified registered nurse anesthetists, certified nurse midwives, and nurse practitioners.[11]

[9] S. 766.106(5), F.S.
[10] S. 766.106(6), F.S.
[11] S. 464.003(3), F.S.

Any nurse desiring to be certified as an ARNP must 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 BON:

- 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.
- Certification by an appropriate specialty board.
- Graduation from a program leading to a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills.[12]

The BON is required to provide by rule the appropriate requirements for ARNPs in the categories of certified registered nurse anesthetist, certified nurse midwife, and nurse practitioner.[13]

An ARNP must perform authorized functions within the framework of an established protocol that is filed with the BON upon biennial license renewal and within 30 days after entering into a supervisory relationship with a physician or changes to the protocol. Within the protocol, an ARNP may:

- Monitor and alter drug therapies.
- Initiate appropriate therapies for certain conditions.
- Perform additional functions as may be determined by rule.
- Order diagnostic tests and physical and occupational therapy.[14]

In addition to the above functions, an ARNP may perform the following acts within his or her specialty:

- 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:
  - 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.
  - 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.
  - Order under the protocol preanesthetic medication.
  - 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.
  - Order or perform monitoring procedures indicated as pertinent to the anesthetic health care management of the patient.
  - 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.

[12] S. 464.012(1), F.S.
[13] S. 464.012(2), F.S.
[14] S. 464.012(3), F.S.

  - Recognize and take appropriate corrective action for abnormal patient responses to anesthesia, adjunctive medication, or other forms of therapy.
  - Recognize and treat a cardiac arrhythmia while the patient is under anesthetic care.
  - Participate in management of the patient while in the postanesthesia recovery area, including ordering the administration of fluids and drugs.
  - Place special peripheral and central venous and arterial lines for blood sampling and monitoring as appropriate.
- 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:
  - Perform superficial minor surgical procedures.
  - Manage the patient during labor and delivery to include amniotomy, episiotomy, and repair.
  - Order, initiate, and perform appropriate anesthetic procedures.
  - Perform postpartum examination.
  - Order appropriate medications.
  - Provide family-planning services and well-woman care.
  - Manage the medical care of the normal obstetrical patient and the initial care of a newborn patient.
- The nurse practitioner may perform any or all of the following acts within the framework of established protocol:
  - Manage selected medical problems.
  - Order physical and occupational therapy.
  - Initiate, monitor, or alter therapies for certain uncomplicated acute illnesses.
  - Monitor and manage patients with stable chronic diseases.
  - Establish behavioral problems and diagnosis and make treatment recommendations.[15]

During the 2008-2009 legislative interim, staff of the Senate Health Regulation Committee researched the issues surrounding expanding the scope of practice for ARNPs to prescribe controlled substances. Among other things, staff reported that 47 states authorize ARNPs to prescribe controlled substances, 39 states authorize the prescribing of controlled substances in Schedule II through Schedule V, and 8 states authorize the prescribing of controlled substances in Schedule III through Schedule V. Many states place further limitations on the drugs that ARPNs may prescribe. These limitations may be set in one of more of the following ways: establishing the limitations within the terms of agreements between ARPNs and their supervising/collaborating physicians or dentists; requiring the ARNP to prescribe within established formularies; requiring the drugs prescribed to be within the ARPN's and collaborating physician's scope of practice; or prohibiting the prescribing of specific drugs by law. The reported findings and recommendations are available in Interim Report 2009-117, AUTHORIZATION FOR ADVANCED REGISTERED NURSE PRACTITIONERS TO PRESCRIBE CONTROLLED SUBSTANCES.[16]

[15] Section 464.012(4), F.S.
[16] *See* AUTHORIZATION FOR ADVANCED REGISTERED NURSE PRACTITIONERS TO PRESCRIBE CONTROLLED SUBSTANCES, Interim Report 2009-117, by the Florida Senate Health Regulation Committee, published October 2008, available at:

Cataract Surgery[17]

A cataract is a clouding of the lens in the eye that affects vision. Most cataracts are related to aging. By age 80, more than half of all Americans either have a cataract or have had cataract surgery.

The lens is a clear part of the eye that helps to focus light, or an image, on the retina. In a normal eye, light passes through the transparent lens to the retina. Once it reaches the retina, light is changed into nerve signals that are sent to the brain. The lens must be clear for the retina to receive a sharp image. If the lens is cloudy from a cataract, the image will be blurred.

Although most cataracts are related to aging, there are other types of cataract:

- Secondary cataract. Cataracts can form after surgery for other eye problems, such as glaucoma. Cataracts also can develop in people who have other health problems, such as diabetes. Cataracts are sometimes linked to steroid use.
- Traumatic cataract. Cataracts can develop after an eye injury, sometimes years later.
- Congenital cataract. Some babies are born with cataracts or develop them in childhood, often in both eyes. These cataracts may be so small that they do not affect vision. If they do, the lenses may need to be removed.
- Radiation cataract. Cataracts can develop after exposure to some types of radiation.

There are two types of cataract surgery.

- Phacoemulsification, or phaco. A small incision is made on the side of the cornea. A tiny probe is inserted into the eye. This device emits ultrasound waves that soften and break up the lens so that it can be removed by suction. Most cataract surgery today is done by phacoemulsification, also called "small incision cataract surgery."
- Extracapsular surgery. A longer incision is made on the side of the cornea and the cloudy core of the lens is removed in one piece. The rest of the lens is removed by suction. After the natural lens has been removed, it often is replaced by an artificial lens, called an intraocular lens (IOL).

Although this may not be an all inclusive list, some of the risks of cataract surgery include: infection, bleeding, and increased risk of retinal detachment. Serious infection can result in loss of vision. A retinal detachment is a medical emergency; even if treated promptly, some vision may be lost.

Florida Medical Consent Law

The Florida Medical Consent Law provides that no recovery shall be allowed in any court in this state against, among other medical practitioners, a medical physician or osteopathic physician in

http://archive.flsenate.gov/data/Publications/2009/Senate/reports/interim_reports/pdf/2009-117hr.pdf, (Last visited on April 9, 2011).

[17] *See* National Eye Institute, National Institutes of Health, Facts about Cataract, found at: http://www.nei.nih.gov/health/cataract/cataract_facts.asp, (Last visited on April 9, 2011).

an action brought for treating, examining, or operating on a patient without his or her informed consent when:

- The action of the physician in obtaining the consent of the patient or another person authorized to give consent for the patient was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community as that of the person treating, examining, or operating on the patient for whom the consent is obtained; and
- A reasonable individual, from the information provided by the physician, under the circumstances, would have a general understanding of the procedure, the medically acceptable alternative procedures or treatments, and the substantial risks and hazards inherent in the proposed treatment or procedures, which are recognized among other physicians in the same or similar community who perform similar treatments or procedures;
  Or
- The patient would reasonably under all the surrounding circumstances, have undergone such treatment or procedure had he or she been advised by the physician in accordance with the provisions described above.

A written consent which meets these requirements and is signed by the patient or another authorized person raises a rebuttable presumption of a valid consent. A valid signature on the consent is one which is given by a person who under all the surrounding circumstances is mentally and physically competent to give consent.

Medical physicians and osteopathic physicians may be subject to disciplinary action for performing professional services which have not been authorized by the patient or his or her legal representative.[18]

Administrative Rulemaking and Legislative Ratification

Chapter 2010-279, Laws of Florida (L.O.F.), became effective on November 17, 2010,[19] when the Legislature over-rode the Governor's veto of CS/CS/HB 1565, which was passed during the 2010 Regular Session. This law requires a proposed administrative rule that has an adverse impact or regulatory costs that exceed certain thresholds to be submitted to the Legislature for ratification before the rule can take effect. The Legislature provided for a statement of estimated regulatory costs (SERC) as the tool to assess a proposed rule's impact.

An agency proposing a rule is required to prepare a SERC of the proposed rule if the proposed rule:[20]

- Will have an adverse impact on small business; or
- Is likely to directly or indirectly increase regulatory costs in excess of $200,000 in the aggregate in this state within 1 year after the implementation of the rule.

[18] *See* s. 458.331(1)(p) and (u), F.S., and s. 459.015(s) and (y), F.S.
[19] House Joint Resolution 9-A passed during the 2010A Special Session on November 16, 2010.
[20] *See* s. 120.54(3)(b)1., F.S.

A SERC is required to include:[21]

- An economic analysis showing whether the rule directly or indirectly:
  - Is likely to have an adverse impact on economic growth, private sector job creation or employment, or private sector investment in excess of $1 million in the aggregate within 5 years after the implementation of the rule;
  - Is likely to have an adverse impact on business competitiveness, including the ability of persons doing business in the state to compete with persons doing business in other states or domestic markets, productivity, or innovation in excess of $1 million in the aggregate within 5 years after the implementation of the rule; or
  - Is likely to increase regulatory costs, including any transactional costs, in excess of $1 million in the aggregate within 5 years after the implementation of the rule.

  If the adverse impact or regulatory costs of the rule exceed any of these criteria, then the rule may not take effect until it is ratified by the Legislature;

- A good faith estimate of the number of individuals and entities likely to be required to comply with the rule, together with a general description of the types of individuals likely to be affected by the rule;
- A good faith estimate of the cost to the agency, and to any other state and local government entities, of implementing and enforcing the proposed rule, and any anticipated effect on state or local revenues;
- A good faith estimate of the transactional costs likely to be incurred by individuals and entities, including local government entities, required to comply with the requirements of the rule. "Transactional costs" are direct costs that are readily ascertainable based upon standard business practices, and include filing fees, the cost of obtaining a license, the cost of equipment required to be installed or used or procedures required to be employed in complying with the rule, additional operating costs incurred, the cost of monitoring and reporting, and any other costs necessary to comply with the rule;
- An analysis of the impact on small businesses,[22] and an analysis of the impact on small counties and small cities.[23] The impact analysis for small businesses must include the basis for the agency's decision not to implement alternatives that would reduce adverse impacts on small businesses;
- Any additional information that the agency determines may be useful; and
- A description of any regulatory alternative submitted by a substantially affected person and a statement adopting the alternative or a statement of the reasons for rejecting the alternative in favor of the proposed rule.

[21] *See* s. 120.541(2), F.S.

[22] "Small business" is defined to mean an independently owned and operated business concern that employs 200 or fewer permanent full-time employees and that, together with its affiliates, has a net worth of not more than $5 million or any firm based in this state which has a Small Business Administration 8(a) certification. As applicable to sole proprietorships, the $5 million net worth requirement shall include both personal and business investments.

[23] "Small county" and "small city" are defined to mean any county that has an unincarcerated population of 75,000 or less and any municipality that has an unincarcerated population of 10,000 or less, respectively, according to the most recent decennial census.

III. Effect of Proposed Changes:

Section 1 and section 4 create s. 458.3175, F.S., and s. 459.0066, F.S., respectively, to authorize the BOM or the BOOM to issue a certificate to a physician or osteopathic physician who is licensed to practice medicine or osteopathic medicine in another state or a province of Canada to provide expert testimony in this state pertaining to medical negligence litigation against a physician. The expert witness certificate authorizes the physician or osteopathic physician to provide a verified written medical opinion for purposes of presuit investigation of medical negligence claims 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 under ch. 458, F.S., or ch. 459, F.S.

A physician who is not licensed in this state but intends to provide expert testimony in this state must submit a completed application and pay an application fee in an amount not to exceed $50. The BOM or the BOOM may not issue a certificate to a physician who has had a previous expert witness certificate revoked by the BOM or the BOOM. The BOM or the BOOM is required to approve or deny the application within 5 business days after receipt of the completed application and fee, otherwise the application is approved by default. If a physician intends to rely on a certificate that is approved by default, he or she must notify the BOM or the BOOM in writing. An expert witness certificate is valid for 2 years.

An expert witness certificate does not authorize the physician to practice medicine or osteopathic medicine in this state, and a physician who does not otherwise practice medicine in this state is not required to obtain a license to practice medicine in this state, or pay other fees, including the neurological injury compensation assessment.

The BOM and the BOOM are required to adopt rules to administer their respective section of law.

Section 2 and section 5 amend s. 458.331, F.S., and s. 459.015, F.S., respectively, to add that providing misleading, deceptive, or fraudulent expert witness testimony related to the practice of medicine is grounds for denial of a license or other disciplinary action against a physician or osteopathic physician.

The bill adds a provision that the purpose of the respective section relating to grounds for disciplinary action and action by the board and department, is to facilitate uniform discipline for those acts made punishable under this section. And, to that end, a reference to the section constitutes a general reference under the doctrine of incorporation by reference. The effect of this provision is to avoid having to republish and reenact laws referencing this section to incorporate by reference all subsequent changes to it.

Section 3 and section 6 amend s. 458.351, F.S., and s. 459.026, F.S., respectively, relating to reports of adverse incidents in office practice settings. The BOM and the BOOM are required to adopt rules establishing a standard informed consent form that sets forth the recognized specific risks related to cataract surgery. As a part of this process, the boards are required to consider information from Florida-licensed physicians regarding recognized specific risks related to cataract surgery and the standard informed consent forms adopted for use in the medical field by

other states. These rules must be proposed by October 1, 2011, and are exempted from the provisions of s. 120.541, F.S., relating to adverse impacts, estimated regulatory costs, and legislative ratification of rules.

A patient's informed consent must include the patient's signature, or the signature of a person authorized by the patient to give consent, and the signature of a competent witness on the form adopted by the respective board. A properly executed consent form adopted by the applicable board is admissible as evidence and creates a rebuttable presumption that the physician properly disclosed the risks associated with cataract surgery. The rebuttable presumption must be included in the charge to the jury in a civil action against a physician based on his or her alleged failure to properly disclose the risks of cataract surgery.

This section provides that an incident resulting from recognized specific risks described in the signed consent form is not considered an adverse incident. Therefore such an incident is not required to be reported to the applicable board or by a hospital, ambulatory surgical center, or mobile surgical facility to the Agency for Health Care Administration.

Section 7 amends s. 464.012, F.S., to authorize an ARNP to order and administer any drug or drug therapies that are necessary for the proper medical care and treatment of a patient. This includes controlled substances in Schedule II through Schedule V if:

- The drugs are ordered or administered in accordance with the protocol between the supervising practitioner and the ARNP,
- The drugs ordered are consistent with the ARNP's educational preparation or for which clinical competency has been established and maintained,
- The protocol specifies:
  - The name of the ARNP, the drugs that may be ordered and the circumstances under which they may be ordered,
  - The extent of the practitioner's supervision of the ARNP and the method of periodic review of the ARNP's competence, including peer review, and
  - The illness, injury, or condition for which a Schedule II controlled substance is administered, if Schedule II controlled substances are authorized in the protocol,
- The administering or ordering of the drugs by the ARNP occurs under practitioner supervision, as defined to mean a collaboration between the ARNP and the supervising practitioner on the development of the protocol and the availability of the supervising practitioner via telephonic contact at the time the patient is examined by the ARNP. Physical presence is not required,
- The controlled substances are administered or ordered in accordance with a patient-specific protocol approved by the treating or supervising practitioner if Schedule II or Schedule III controlled substances are administered or ordered by the ARNP, and
- The board has certified that the ARNP has satisfactorily completed at least 6 months of direct supervision in the administering and ordering of drugs and a course in pharmacology covering the order, use, administration, and dispensing of controlled substances.

A practitioner may not supervise more than four ARNPs at any one time.

In addition, as a part of managing a patient in the postanesthesia recovery area, a certified registered nurse anesthetist may order the administration of drugs that are commonly used to alleviate pain.

Section 8 amends s. 627.4147, F.S., to repeal the authority for a self-insurance policy or insurance policy that provides coverage for medical malpractice to allow the insurer or self-insurer to determine, make, and conclude any offer of admission of liability and for arbitration, settlement offer, or offer of judgment if the offer is within the policy limits without the permission of the insured. The bill also repeals the statement that it is against public policy for an insurance or self-insurance policy to contain a clause giving the insured the exclusive right to veto an offer for admission of liability and for arbitration, settlement offer, or offer of judgment, when the offer is within the policy limits. Instead, the bill requires a clause in the policy to clearly state whether or not the insured has the exclusive right of veto if the offer is within policy limits, which is currently the law that applies for dentists.

Section 9 amends s. 766.102, F.S., to change the burden of proof for an action for recovery of damages based on death or personal injury allegedly resulting from the negligence of a health care provider.[24] The claimant must prove by clear and convincing evidence, rather than the greater weight of evidence, that the alleged actions of the health care provider represented a breach of the prevailing professional standard of care for that health care provider. Similarly, the bill adds, if an action for damages is based on death or personal injury allegedly resulting from the failure of a health care provider to order, perform, or administer supplemental diagnostic tests, the claimant has the burden of proving by clear and convincing evidence that the alleged actions of the health care provider represented a breach of the prevailing professional standard of care.

The bill provides that any records, policies, or testimony of an insurer's reimbursement policies or reimbursement determination regarding the care provided to the plaintiff are not admissible as evidence in any civil action. Definitions are provided for the terms "insurer", "reimbursement determination", and "reimbursement policies."

The bill extends the period of time immediately preceding the date of the occurrence that is the basis for the action within which the expert witness must have performed certain activities. If the health care provider against whom or on whose behalf the testimony is offered is:

- A specialist, in addition, to other things, the expert witness must have devoted professional time during the 5 years, rather than 3 years, immediately preceding the date of the occurrence that is the basis for the action to:
    - The active clinical practice of, or consulting with respect to, the same or similar specialty,

[24] The health care providers to which this provision apply are defined in s. 766.202(4) to include: any hospital, ambulatory surgical center, or mobile surgical facility as defined and licensed under chapter 395; a birth center licensed under chapter 383; any person licensed under chapter 458 (medical practice), chapter 459 (osteopathic medicine), chapter 460 (chiropractic medicine), chapter 461 (podiatric medicine), chapter 462 (naturopathy), chapter 463 (optometry), part I of chapter 464 (nursing), chapter 466 (dentistry), chapter 467 (midwifery), or chapter 486 (physical therapy); a clinical lab licensed under chapter 483; a health maintenance organization certificated under part I of chapter 641; a blood bank; a plasma center; an industrial clinic; a renal dialysis facility; or a professional association partnership, corporation, joint venture, or other association for professional activity by health care providers.

  - Instructing students in an accredited health professional school or accrediting residency or clinical research program in the same or similar specialty, or
  - A clinical research program that is affiliated with an accredited health professional school or accredited residency or clinical research program in the same or similar specialty.
- A health care provider other than a specialist or a general practitioner, the expert witness must have devoted professional time during the 5 years, rather than 3 years, immediately preceding the date of the occurrence that is the basis for the action to:
  - The active clinical practice of, or consulting with respect to, the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered,
  - Instructing students in an accredited health professional school or accrediting residency program in the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered, or
  - A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered.

In addition, this section requires a physician or osteopathic physician who provides expert testimony concerning the prevailing professional standard of care of a physician or osteopathic physician to be licensed in this state under The Medical Practice Act or The Osteopathic Medical Practice Act, or possess an expert witness certificate issued by the BOM or the BOOM.

A health care provider's failure to comply with or a breach of any federal requirement is not admissible as evidence in any medical negligence case in this state.

Section 10 amends s. 766.106, F.S., to require a claimant to submit, along with the other required information, an executed authorization form for the release of protected health information that is potentially relevant to the claim of personal injury or wrongful death when he or she notifies each prospective defendant of his or her intent to initiate litigation for medical negligence.

This section provides that notwithstanding the immunity from civil liability arising from participation in the presuit screening process that is currently afforded under the law, a physician who is licensed under the Medical Practice Act or the Osteopathic Medical Practice Act who submits a verified written expert medical opinion is subject to denial of a license or disciplinary action for providing misleading, deceptive, or fraudulent expert witness testimony related to the practice of medicine or osteopathic medicine.

The bill authorizes a prospective defendant or his or her legal representative access to interview the claimant's treating health care providers without notice to or the presence of the claimant or the claimant's legal representative (referred to as ex parte interview in the bill). However, a prospective defendant or his or her legal representative who takes an unsworn statement from a claimant's treating physicians must provide reasonable notice and opportunity to be heard to the claimant or the claimant's legal representative before taking unsworn statements. Unsworn statements are used for presuit screening and are not discoverable or admissible in a civil action for any purpose by any party.

Section 11 creates s. 766.1065, F.S., to establish an authorization form for the release of protected health information that is potentially relevant to the claim of personal injury or wrongful death. The bill sets forth the specific content of the form, including: identification of the parties; authorizing the disclosure of protected health information for specified purposes; description of the information and the health care providers from whom the information is available; identification of health care providers to whom the authorization for disclosure does not apply because the health care information is not potentially relevant to the claim of personal injury or wrongful death; the persons to whom the patient authorizes the information to be disclosed; a statement regarding the expiration of the authorization; acknowledgement that the patient understands that he or she has the right to revoke the authorization in writing, the consequences for the revocation, signing the authorization is not a condition for health plan benefits, and that the information authorized for disclosure may be subject to additional disclosure by the recipient and may not be protected by federal HIPAA privacy regulations;[25] and applicable signature by the patient or his or her representative.

The bill provides that the presuit notice is void if this authorization does not accompany the presuit notice and other materials required by s. 766.106(2), F.S. If the authorization is revoked, the presuit notice is deemed retroactively void from the date of issuance, and any tolling effect that the presuit notice may have had on the applicable statute-of-limitations period is retroactively rendered void.

Section 12 amends s. 766.206, F.S., to authorize the court to dismiss the claim if the court finds that the authorization form accompanying the notice of intent to initiate litigation for medical negligence was not completed in good faith by the claimant. If the court dismisses the claim, the claimant or the claimant's attorney is personally liable for all attorney's fees and costs incurred during the investigation and evaluation of the claim, including the reasonable attorney's fees and costs of the defendant or the defendant's insurer.

Section 13 amends s. 768.0981, F.S., to add hospitals, ambulatory surgical centers, and mobile surgical facilities to the group of insurers, prepaid limited health service organizations, health maintenance organizations, and prepaid health clinics that are not liable for the medical negligence of a health care provider within whom the entity has entered into a contract, other than an employee, unless the entity expressly directs or exercises actual control over the specific conduct that caused injury.

Section 14 provides an effective date of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

[25] HIPAA is the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-194) and generally include the privacy rules adopted thereunder. With certain exceptions, the HIPAA privacy rules preempt contrary provisions in state law, unless the state law is more stringent than the federal rules. *See* 45 C.F.R. Part 164.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Claimants who choose to use an expert witness who is not a physician or osteopathic physician licensed in this state may only use an expert witness who has a certificate from the Florida BOM or the Florida BOOM. This requirement, might limit or delay a claimant's ability to engage an expert witness to conduct a presuit investigation and proceed with a claim for medical negligence. The specific HIPAA-compliant form will facilitate the release and disclosure of protected health information and more clearly protect persons who release that information. The defense will have an additional discovery tool with the authorization to conduct ex parte interviews of treating health care providers. The changes to insurance and self-insurance policies provide physicians with greater control over the disposition of medical malpractice claims.

C. Government Sector Impact:

The BOM and the BOOM will be required to develop application forms and rules to administer the certification program for expert witnesses. Additional regulatory and enforcement activities may emerge as a result of the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Sections 3 and 6 create a new subsection relating to informed consent for cataract surgery. These provisions are unrelated to reports of adverse incidents in office practice settings and the placement within these sections of law may create confusion. If placed in another section of law, paragraph (d) that refers to an adverse incident could easily include a cross-reference to s. 4458.351, F.S., or s. 459.026, F.S.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

750302

LEGISLATIVE ACTION

Senate . House

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The Committee on Health Regulation (Ring) recommended the following:

Senate Amendment (with title amendment)

Delete lines 30 - 34
and insert:
(b) An applicant who:
1. Has maintained his or her dental license in good standing in another state for 3 years immediately before applying to take the examinations required in this section to practice dentistry in this state;
2. Is a graduate of a dental college or school that is not accredited in accordance with paragraph (2)(b) or of a dental college or school that is not approved by the board; and

750302

3. Has successfully passed the National Board of Dental Examiners dental examination or a regional dental examination,

is entitled to take the examinations required in this section to practice dentistry in this state.

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

And the title is amended as follows:

Delete lines 7 - 8

and insert:

practice dentistry in this state and who have met other requirements is entitled to take such examinations; providing an effective date.

496812

LEGISLATIVE ACTION

Senate . House

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The Committee on Health Regulation (Ring) recommended the following:

Senate Amendment (with directory and title amendments)

Between lines 34 and 35
insert:

(5) An applicant is ineligible to complete any of the examinations provided in subsection (4) and may not be licensed in this state to practice dentistry if the applicant has been:

(a) Disciplined by any regulatory board for misconduct related to the practice of dentistry in any jurisdiction; or

(b) Convicted of or has pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of dentistry in any jurisdiction.

496812

====== D I R E C T O R Y C L A U S E A M E N D M E N T ======
And the directory clause is amended as follows:

Delete lines 12 - 13

and insert:

Section 1. Subsection (3) of section 466.006, Florida Statutes, is amended, and subsection (5) is added to that section, to read:

================ T I T L E A M E N D M E N T ================
And the title is amended as follows:

Delete line 8

and insert:

such examinations; providing that an applicant is not eligible to complete state licensing examinations and may not practice dentistry in this state following certain acts of misconduct or convictions; providing an effective date.

268282

LEGISLATIVE ACTION

Senate . House

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The Committee on Health Regulation (Ring) recommended the following:

Senate Amendment to Amendment (496812) (with title amendment)

Delete lines 8 - 12
and insert:
(a) Disciplined by any regulatory board for misconduct related to the practice of dentistry in any jurisdiction;
(b) Convicted of or has pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of dentistry in any jurisdiction; or
(c) Had any judgments entered against her or him in a case related to the practice of dentistry.

268282

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14 ================ T I T L E A M E N D M E N T ================
15 And the title is amended as follows:
16 Delete line 29
17 and insert:
18 certain judgments or acts of misconduct or
19 convictions; providing

198334

LEGISLATIVE ACTION

Senate . House

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The Committee on Health Regulation (Ring) recommended the following:

Senate Amendment (with directory and title amendments)

Between lines 34 and 35
insert:
(5) An applicant who is a licensed dentist in another state and has successfully completed and passed that state's examination requirements to be licensed to practice dentistry is exempt from the examination requirements provided in paragraph (2)(c) and subsections (3) and (4).

====== D I R E C T O R Y C L A U S E A M E N D M E N T ======

198334

And the directory clause is amended as follows:

Delete lines 12 - 13

and insert:

Section 1. Subsection (3) of section 466.006, Florida Statutes, is amended, and subsection (5) is added to that section, to read:

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

And the title is amended as follows:

Delete line 8

and insert:

such examinations; exempting certain applicants from completing state licensing examinations to practice dentistry in this state; providing an effective date.

386156

LEGISLATIVE ACTION

Senate . House

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The Committee on Health Regulation (Diaz de la Portilla) recommended the following:

Senate Amendment (with title amendment)

Between lines 34 and 35
insert:

(c) After the applicant has passed the examinations required in this section to practice dentistry in this state, the applicant must complete a six month internship prior to licensure. The intern must be supervised by a dentist licensed under this chapter. The intern may be compensated for services that are rendered during the internship.

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

386156

And the title is amended as follows:

Delete line 8

and insert:

such examinations; requiring an applicant to complete an internship for licensure; providing for supervision of the intern; providing that an intern may be compensated for services; providing an effective date.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1608
INTRODUCER:	Senator Ring
SUBJECT:	Dentistry
DATE:	April 1, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	O'Callaghan	Stovall	HR	**Pre-meeting**
2.			BC	
3.				
4.				
5.				
6.				

I. Summary:

This bill provides that an applicant, who has maintained his or her dental license in good standing in another state for 3 years immediately before applying to take the licensing examinations to practice dentistry in Florida, is entitled to take those examinations. This provision exempts such applicants, who have not graduated from an accredited dental college or from a school approved by the Board of Dentistry, from having to complete a program of study at an accredited American dental school and receive a D.D.S. or D.M.D. from such school or complete a 2-year supplemental dental education program at an accredited dental school and receive a dental diploma, degree, or certificate in order to take the examinations.

This bill substantially amends s. 466.006, F.S.

II. Present Situation:

Accredited Dental Schools

The American Dental Association, Commission on Dental Accreditation (CODA), established in 1975, is nationally recognized by the United States Department of Education to accredit dental and dental-related education programs conducted at the post-secondary level. The CODA functions independently and autonomously in matters of developing and approving accreditation standards, making accreditation decisions on educational programs and developing and approving procedures that are used in the accreditation process.[1]

[1] America Dental Association, *Dental Education: Schools & Programs*, available at: http://www.ada.org/103.aspx (last viewed March 31, 2011).

Dental education, dental assisting, dental hygiene, dental laboratory technology, and advanced dental education programs, including dental specialties, general practice residencies, and advanced education in general dentistry are evaluated in accordance with published accreditation standards by the CODA.[2]

Dental Schools in Florida

There are currently 56 accredited dental schools, approximately 240 dental hygiene programs, and 250 dental assisting programs in the U.S. Florida currently has 2 accredited dental schools—1 public and 1 private—that produced 182 graduates in 2003, 18 accredited dental hygiene programs, and 25 accredited dental assisting programs.[3] The schools are the University of Florida College of Dentistry (UFCD) and Nova Southeastern University College of Dental Medicine (Nova).[4] The Lake Erie College of Osteopathic Medicine plans on opening a School of Dental Medicine at the Bradenton campus in April of 2012. The program has received initial CODA accreditation.[5]

Additionally, there are 3 accredited pediatric dental residency programs in Florida that produce 14 graduates each year—Nova (6 graduates), UFCD (5 graduates), and Miami Children's Hospital (3 graduates).[6] Approximately 92 percent of Florida dental school graduates remain in the state after graduation.[7]

Foreign Trained Dentists

Section 466.08, F.S., provides guidelines for certifying foreign dental schools. The foreign schools must prove that their educational program is reasonably comparable to that of similar accredited institutions in the United States and that the program adequately prepares its students for the practice of dentistry.[8]

In Florida, any dentist who did not attend a CODA accredited dental program (e.g., foreign trained dentists) are required to complete a 2-year supplemental education program at a CODA accredited dental school before they can sit for the Florida dental licensure examinations.[9]

Four states and the U.S. Virgin Islands do not grant an unrestricted dental license by credentials (grant reciprocity): Delaware, Florida, Hawaii, and Nevada.[10]

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[2] *Id.*
[3] Florida Department of Health, *Health Practitioner Oral Healthcare Workforce Ad Hoc Committee Report* (February 2009), available at: http://www.doh.state.fl.us/Family/dental/OralHealthcareWorkforce/index.html (last viewed March 31, 2011).
[4] America Dental Association, Dental Education Program Search, available at: http://www.ada.org/267.aspx (last viewed March 31, 2011).
[5] Lake Erie College of Osteopathic Medicine, School of Dental Medicine, available at: http://lecom.edu/school-dental-medicine.php (last viewed March 31, 2011)
[6] *Supra* fn. 3.
[7] *Id.*
[8] Section 466.008(4), F.S.
[9] Section 466.006(3), F.S. and ch. 64B5-2.0146, F.A.C.
[10] American Dental Association, Department of State Government Affairs, April 6, 2009, available at: http://www.ada.org/sections/advocacy/pdfs/licensure_recognition.pdf (last viewed on March 31, 2011).

Other States Licensing Requirements

State boards of dentistry, licensure statutes, and rules can affect the population of eligible dental providers available in a state and some states have amended licensure regulations to attract dentists. Examples of some of these common practices are: allowing foreign dental school graduates who complete U.S. dental residencies to meet eligibility requirements for licensure; conveying reciprocity or licensure by credentials; granting special licenses; or providing incentives (e.g., limiting liability) for dentists who work in public health/safety net clinics.[11]

Other states such as Minnesota, Connecticut, Arkansas, Mississippi, and California have developed programs to utilize foreign-trained dentists as dentists and dental hygienists in facilities that care for special needs patients and public health settings.[12]

California enacted a law (Assembly Bill 1116) in 1997 that provided the California dental board with the authority to determine whether unaccredited international dental programs are equivalent to similar accredited institutions in the U.S. Enacted in 1998, the law enabled the dental board to approve dental education programs outside the U.S.[13]

With a law on the books giving the California dental board the authority to approve educational programs outside the U.S., the Universidad De La Salle Bajio in the city of Leon, Mexico, applied for approval for its new 2-year international program in 2006. The California board of dentistry granted provisional approval to Universidad De La Salle in August 2002 after the first site visit. Following its second site visit, De La Salle's 5-year pre-doctoral dental education program received full certification in November 2004. The College of Dental Surgery in Manipal, India, was also evaluated for board approval. Students who are admitted to the De La Salle's California-approved track program are required to sign a disclaimer stating that they know this program is not CODA-approved. They are also informed that they will only qualify to get a license to practice in California once all licensure requirements for the state of California are met.[14] The cost of Universidad De La Salle's International Dental Studies Program that satisfies the educational requirement for California-approved dental licensure track is $21,000 per semester, which totals $84,000 in tuition for the two-year program.[15]

Florida Dental Exam

The Florida Board of Dentistry (Board) administers the Florida dental licensure exams. The Board sets the number, dates, and locations of exams. Licensure examinations are given at least twice a year depending on the projected candidate population.[16] Applicants for examination or re-examination must have taken and successfully completed the National Board of Dental

[11] *Supra* fn. 3.
[12] *Id.*
[13] American Dental Association, *ADA News: International dental program in Mexico raises questions*, available at: http://www.ada.org/1901.aspx (last viewed March 31, 2011).
[14] *Id.*
[15] American Dental Association, *ADA News: Costs of De La Salle vs. other IDPs in California*, available at: http://www.ada.org/1899.aspx (last viewed March 31, 2011).
[16] Florida Department of Health, Division of Medical Quality Assurance, Board of Dentistry, *Applications and Forms*, available at: http://www.doh.state.fl.us/mqa/dentistry/dn_applications.html (last viewed March 31, 2011).

Examiner's dental examination and received a National Board Certificate within the past 10 years.[17]

Each applicant is required to complete the examinations as provided for in s. 466.006, F.S. The examinations for dentistry consist of:

- A written examination; [18]
- A practical or clinical examination;[19] and
- A diagnostic skills examination.

The applicant for licensure must successfully complete all three exams within a thirteen month period in order to qualify for licensure.[20] If the candidate fails to successfully complete all three examinations within the allotted timeframe, then the candidate must retake all three of the examinations.[21] Additionally, all examinations are required to be conducted in English.[22]

The practical or clinical examination requires the applicant to provide a qualified patient,[23] who will participate in the examination as the patient.[24] The practical or clinical examination consists of four parts and the applicant must receive a grade of at least 75 percent on each part:

- Part 1-requires a preparation procedure and a restoration procedure.
- Part 2-requires demonstration of periodontal skills on a patient to include definitive debridement (root planing, deep scaling/removal of subgingival calculus, and removal of plaque, stain and supragingival calculus).
- Part 3-requires demonstration of endodontic skills on specified teeth.
- Part 4-requires demonstration of prosthetics skills to include the preparation for a 3-unit fixed partial denture on a specified model and the preparation of an anterior crown.

If an applicant fails to achieve a final grade of 75 percent or better on each of the 4 parts of the Practical or Clinical Examination, the applicant shall be required to retake only that part(s) that the applicant has failed.[25]

There are two fees associated with the licensure examination—$1,700 to the Board of Dental Examiners for administration of the licensure examination and $760 to the Department of Health for the application fee, exam development, and licensure.[26] Additionally, the applicant must supply any live patients and assume all associated costs to ensure the patients are present at the exam. For applicants who have not taken the National Boards within the last 10 years (e.g. a

[17] Rule 64B5-2.013, F.A.C.
[18] A final grade of 75 or better is required to pass the Written Examination. *See* rule 64B5-2.013, F.A.C.
[19] The practical or clinical exam requires the applicant to provide a patient who is at least 18 years of age and whose medical history is consistent with that prescribed by the board in order for patients to qualify as a patient for the examination. *See* rule 64B5-2.013, F.A.C.
[20] Rule 64B5-2.013, F.A.C..
[21] *Id*.
[22] *Id*.
[23] The patient must be at least 18 years of age and have a medical history consistent with the parameters prescribed by the Board.
[24] *Supra* fn. 20.
[25] *Id*.
[26] *Supra* fn. 16.

licensed dentist from another state who may have been in practice for 10 years or more), he or she must also retake Part II of the National Boards.

Shortage of Dentists

The pool of dentists to serve a growing population of Americans is shrinking. The American Dental Association found that 6,000 dentists retire each year in the U.S., while there are only 4,000 dental school graduates each year to replace them. The projected shortage of dentists is even greater in rural America. Of the approximately 150,000 general dentists in practice in the U.S., only 14 percent practice in rural areas, 7.7 percent in large rural areas, 3.7 percent in small rural areas, and 2.2 percent in isolated rural areas. In 2003, there were 2,235 federally designated dental supply shortage areas, 74 percent of which were located in non-metropolitan areas. In contrast, dental hygiene is predicted to be one of the top ten fastest growing health care professions over the next decade, growing by a projected 43 percent between 2006 and 2020.[27]

In 2010, there were 9,373 practicing dentists in Florida, meaning the ratio of dentists to the population in Florida is approximately 1 dentist for every 2,016 residents.[28] The estimated underserved population in 2008, in Florida, was 2.9 million people or 15.8 percent of the population.[29]

III. Effect of Proposed Changes:

This bill provides that an applicant, who has maintained his or her dental license in good standing in another state for 3 years immediately before applying to take the licensing examinations to practice dentistry in Florida, is entitled to take those examinations. This provision exempts such applicants, who have not graduated from an accredited dental college or from a school approved by the Board, from having to complete a program of study at an accredited American dental school and receive a D.D.S. or D.M.D., from such school or complete a 2-year supplemental dental education program at an accredited dental school and receive a dental diploma, degree, or certificate in order to take the examinations.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

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[27] National Rural Health Association, *Issue Paper: Recruitment and Retention of a Quality Health Workforce in Rural Areas*, November 2006. A copy of this report is on file with the Senate Health Regulation Committee.

[28] Professional staff of the Senate Health Regulation Committee received this information via email from the Department of Health on March 11, 2011. A copy of the email is on file with the committee.

[29] The Henry J. Kaiser Family Foundation, *Florida: Estimated Underserved Population Living in Dental Health Professional Shortage Areas (HPSAs) as of September, 2008*, available at: http://www.statehealthfacts.org/profileind.jsp?ind=681&cat=8&rgn=11 (Last visited on March 31, 2011).

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

See below in "Private Sector Impact."

B. Private Sector Impact:

Applicants who apply for the licensure examination to practice dentistry in Florida will be subject to the examination fees ($1,700 to the Board of Dental Examiners for administration of the licensure examination and $760 to the Department of Health for the application fee, exam development, and licensure). However, the applicant will save any costs that he or she would have incurred if the applicant had to complete the additional education requirements to sit for the examinations.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 162
INTRODUCER:	Senator Sobel
SUBJECT:	Tanning Facilities
DATE:	April 11, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	O'Callaghan	Stovall	HR	**Pre-meeting**
2.			JU	
3.			BC	
4.				
5.				
6.				

I. Summary:

This bill prohibits minors under the age of 14 from using tanning devices, such as tanning beds, at a tanning facility. Minors 14 years of age or older may use tanning devices with detailed parental or guardian consent. The consent requirement includes a statement signed by the minor's parent or guardian and must be witnessed by the tanning facility operator or proprietor. This statement includes an acknowledgement of the risks, an agreement that the minor will wear protective eyewear, and a specified number of tanning sessions authorized for the minor during a 12-month period.

The bill creates an exception allowing minors under the age of 14 to use tanning devices if a health care provider has prescribed use of the device for the purpose of medical treatment. However, even if the minor has a prescription for tanning bed use, the parent or guardian of the minor must satisfy the consent requirements included in the bill prior to the minor's use of the tanning device.

This bill substantially amends section 381.89, Florida Statutes.

II. Present Situation:

Ultraviolet Radiation Exposure Risks

Epidemiological data suggest that most skin cancers can be prevented if children, adolescents, and adults are protected from ultraviolet (UV) radiation.[1] In the United States, skin cancer is the most common form of cancer. Basal cell and squamous cell carcinomas, two types of skin cancer, are successfully cured at high rates. However, melanoma, the third most common skin cancer, poses a greater threat, especially among minors. Approximately 65 percent to 90 percent of melanomas are caused by exposure to UV light.[2] The American Cancer Society has estimated that there were 4,920 new cases of melanoma of the skin for the state of Florida in 2009.[3]

In June 2009, the World Health Organization (WHO) International Agency for Research on Cancer (IARC) reclassified UV radiation as "carcinogenic to humans," and raised the use of UV-emitting tanning devices to the highest risk category for causing cancer.[4]

According to the Centers for Disease Control and Prevention (CDC), the best way to prevent skin cancer is to protect oneself from the sun by seeking shade, covering up skin exposed to the sun, wearing a wide brim hat, wearing sunglasses, and wearing sunscreen. The CDC recommends avoiding tanning beds and sunlamps because they emit UV rays that are as dangerous as those from the sun.[5] The Florida Department of Health (DOH), Bureau of Chronic Disease Prevention, also recommends that individuals avoid sunlamps and tanning salons to prevent skin cancer.[6]

More than one half of a person's lifetime UV light exposure occurs during childhood and adolescence.[7] The CDC recommends that school health education programs to prevent skin cancer advise students to avoid using sunlamps and tanning beds. The National Health Interview Survey reported that, in 2005, 8.7 percent of teens aged 14-17 years used indoor tanning devices. Girls between the ages of 14 and 17 years were seven times more likely to use these devices than boys in the same age group.[8]

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[1] Centers for Disease Control and Prevention, *Skin Cancer Prevention and Education Initiatives* (2008/2009), *available at* http://www.myhealthcare.org/Ashburn-Sterling-Internal-Medicine-and-Pediatrics/site/0809_skin_fs_CDCfactsheet.pdf (last visited on April 7, 2011).
[2] Centers for Disease Control and Prevention, *Guidelines for School Programs to Prevent Skin Cancer* (Apr. 26, 2002), *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5104a1.htm (last visited on April 6, 2011).
[3] American Cancer Society, Surveillance and Health Policy Research, *Cancer Facts & Figures 2009*, 5, *available at* http://www.oralcancerfoundation.org/facts/pdf/Us_Cancer_Facts.pdf (last visited on April 7, 2011).
[4] International Agency for Research on Cancer, World Health Organization, *Biennial Report 2008-2009*, 9, *available at* http://governance.iarc.fr/SC/SC46/SC46_2Text.pdf (last visited April 7, 2011).
[5] Centers for Disease Control and Prevention, *supra* note 1.
[6] Florida Department of Health, *Skin Cancer Fact Sheet, available at* http://www.doh.state.fl.us/Family/cancer/facts/Skin.pdf (last visited April 6, 2011).
[7] Centers for Disease Control and Prevention, *supra* note 2.
[8] Centers for Disease Control and Prevention, *QuickStats: Percentage of Teens Aged 14-17 Years Who Used Indoor Tanning Devices During the Preceding 12 Months, by Sex and Age, available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5540a9.htm (last visited April 6, 2011).

As of September 2010, 32 states regulated minors' use of tanning devices.[9] The policies that govern minors' use of tanning devices vary, but generally include one or more of these limitations: age restrictions, parental accompaniment requirements, and parental written permission.

Federal Regulation of Sunlamp Products

Since 1979, the U.S. Food and Drug Administration (FDA) has regulated the manufacture of sunlamp products and ultraviolet lamps. The regulation, codified in 21 C.F.R. s. 1040.20, specifies several sunlamp product requirements including: protective eyewear, a UV radiation warning label, detailed user instructions, a timer system, a recommended exposure schedule, and the maximum recommended exposure time. The FDA also regulates the use of dihydroxyacetone (DHA), a color additive that darkens the skin by reacting with amino acids in the skin's surface, which is commonly the active ingredient in most sunless tanning sprays or bronzers.[10]

Regulation of Tanning Facilities in Florida

According to the DOH, there are currently more than 1,600 tanning facilities with over 7,100 tanning devices licensed by Florida.[11] The DOH, Bureau of Community Environmental Health, is responsible for regulating and licensing facilities that operate tanning devices that emit electromagnetic radiation of wavelengths between 200 and 400 nanometers.[12] The Florida Statutes and the Florida Administrative Code list the requirements for a tanning facility operating license and the regulations tanning facilities must follow, including: training requirements, sanitation standards, safety provisions, and record requirements.[13] County health departments are responsible for inspecting and approving tanning facilities as a prerequisite to granting an operating license and inspecting operating tanning facilities biannually.[14] The DOH does not regulate products or devices that create the appearance of a tan, such as airbrush tanning or spray-on tanning.

Tanning facilities are required to provide each customer a written warning that states:

- Not wearing the provided eye protection can cause damage to the eyes;
- Overexposure causes burns;
- Repeated exposure can cause premature aging of the skin or skin cancer;
- Abnormal skin sensitivity or burning may be caused by certain foods, cosmetics, or medications, including, without limitation, tranquilizers, diuretics, antibiotics, high blood pressure medicines, or birth control pills;
- Any person who takes prescription or over-the-counter medication should consult a physician before using a tanning device; and

[9] National Conference of State Legislatures, *Tanning Restrictions for Minors, A State-by-State Comparison*, *available at* http://www.ncsl.org/programs/health/tanningrestrictions.htm (last visited April 6, 2011).
[10] 21C.F.R. s. 73.1150.
[11] Florida Bureau of Community Environmental Health, *Tanning Facilities*, *available at* http://www.myfloridaeh.com/community/tanning/index.html (last visited April 6, 2011).
[12] Florida law defines a "tanning device" as "equipment that emits electromagnetic radiation of wavelengths between 200 and 400 nanometers and that is used for tanning the skin, including a sunlamp, tanning booth, or tanning bed or any accompanying equipment." Section 381.89(1)(c), F.S.
[13] Section 381.89, F.S., and ch. 64E-17, F.A.C.
[14] Florida Bureau of Community Environmental Health, *supra* note 11.

- The tanning facility's liability insurance information or a statement that the facility does not carry liability insurance for injuries cause by tanning devices.[15]

Tanning facilities are also required to post a sign near each tanning device which states, in all caps, "Danger, Ultraviolet Radiation," with a list of detailed instructions.[16] Each time a customer uses a tanning device or executes or renews a contract, facilities must require the customer to sign a written statement acknowledging that she or he has read and understands the warnings and agrees to use protective eyewear.[17]

By statute, tanning facilities must limit each customer to the maximum exposure time recommended by the manufacturer of the tanning device.[18] By rule, the DOH requires tanning facilities to limit customers to one tanning session within a 24-hour period.[19]

Minors 14 years of age or older may use a tanning device if the tanning facility has a statement on file signed by the minor's parent or legal guardian stating that the parent or legal guardian has read and understands the warnings provided by the tanning facility, consents to the minor's use of a tanning device, and agrees that the minor will use the provided protective eyewear. Minors under the age of 14 must be accompanied by a parent or legal guardian during each visit to a tanning facility.[20]

III. Effect of Proposed Changes:

The bill amends s. 381.89, F.S., relating to tanning facility regulation, to prohibit minors who are under 14 years of age from using tanning devices at a tanning facility.

The bill authorizes tanning facilities to provide services to minors 14 years of age or older, only after the tanning facility has a statement on file from the minor's parent or legal guardian, which was signed and witnessed by the operator or proprietor of the tanning facility, and includes:

- An acknowledgement that the parent or legal guardian has read and understands the tanning warnings;
- Consent for the minor's use of the tanning device;
- An agreement that the minor will use the protective eyewear; and
- A specific number of tanning sessions authorized in a 12-month period. The number of tanning sessions authorized by the parent or legal guardian may not exceed the number authorized by the rules of the DOH and the manufacturer's exposure schedule.

The bill creates an exception to allow minors under the age of 14 to use a tanning device if use of the device has been prescribed by a health care provider. However, the parent of the minor must

[15] Section 381.89(4)(a), F.S.
[16] Section 381.89(4)(b), F.S.
[17] Section 381.89(6)(g), F.S.
[18] Section 381.89(6)(e), F.S.
[19] Rule 64E-17.002, F.A.C.
[20] Section 381.89(7) and (8), F.S. The Florida Department of Health reports that, under current practice, in addition to accompanying the minor to the tanning session, the parent or legal guardian must also sign the acknowledgement statement, and the owner or proprietor of the tanning facility must keep this statement on file.

comply with the consent requirement, which includes signing the consent form in the presence of the operator or proprietor of the tanning facility.

The effective date of the bill is July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

In order to comply with the new parental and guardian consent procedures in the bill, tanning facilities may incur a cost to revise, copy, and print new parental or guardian tanning device consent forms.[21]

Tanning facilities are likely to lose a portion of their business because the bill prohibits minors under the age of 14 from using tanning devices unless use is prescribed by a health care provider. The DOH has reported that one operator of 5 tanning facilities estimated that about 3-5 percent of its clients are 15 years of age or under, and therefore, the result would be approximately a $43,344 negative impact over a 12 month period. Nationally, the Centers for Disease Control and Prevention estimates that 8.7 percent of teens between the ages of 14 and 17 use tanning devices.[22]

Tanning facilities that offer customers sunless tanning options may see an increase in clientele under the age of 14. The bill does not address alternative forms of tanning, such as sunless tanning sprays.

[21] Department of Health, *Bill Analysis, Economic Statement, and Fiscal Note for SB 162*, December 13, 2010, on file with the Senate Health Regulation Committee.
[22] Centers for Disease Control and Prevention, s*upra* note 8.

There is a potential reduction in health care costs associated with the reduction in injuries and illnesses for which tanning may be a risk factor.[23]

C. Government Sector Impact:

The DOH may receive more tanning facility complaints as a result of the bill. If substantially more complaints are received, then the DOH would incur a fiscal impact for the additional tanning facility inspections.[24]

VI. Technical Deficiencies:

None.

VII. Related Issues:

In some jurisdictions, laws regulating minors' use of tanning beds allow for the use of a tanning device if the minor has a prescription from a physician indicating the nature of the medical condition requiring treatment, the number of visits allowed, and the time of exposure for each visit.[25] The Legislature may wish to consider adopting similar language if it wishes to ensure that a minor's use of the tanning device does not exceed the amount of exposure contemplated by the health care provider.

The term "health care provider" is not defined in the bill. The Legislature may wish to define or narrow the scope of the term if it is the intent of the Legislature to capture only dermatologists or those providers who are most likely to prescribe, via a written medical prescription, UV light treatment for certain medical conditions.[26]

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

[23] Department of Health, s*upra* note 21.
[24] *Id.*
[25] For example, North Carolina prohibits a person 13 years and younger from using tanning equipment without a written prescription from the person's medical physician specifying the nature of the medical condition requiring the treatment, the number of visits, and the time of exposure for each visit. N.C. GEN. STAT. s. 104E-9.1(a)(2).
[26] "Health care provider" is defined in other chapters of the Florida Statutes, with the definitions varying in scope. For example, in the medical negligence context, "health care provider" has a broad definition to encompass, among others, hospitals, certain birth centers, blood banks, plasma centers, anyone licensed to practice medicine, chiropractors, optometrists, and nurses. Section 766.202(4), F.S.

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Proposed Committee Substitute by the Committee on Health Regulation

A bill to be entitled

An act relating to assisted living facilities; creating the Florida Assisted Living Quality Improvement Initiative Pilot Project; providing a purpose; providing definitions; creating the pilot project in area offices of the Agency for Health Care Administration; providing an expiration date for the pilot project; providing requirements for facilities to be eligible to participate in the pilot project; authorizing the Department of Elderly Affairs to adopt rules; providing duties of the department with regard to the pilot project; requiring the administrator of a facility that is eligible to participate in the pilot project to notify the Agency for Health Care Administration when the facility agrees to enroll; providing that enrollment in the pilot project is voluntary; requiring each facility to execute an agreement that includes a provision authorizing the agency to terminate the facility's participation in the pilot project; providing for open enrollment each year; providing that a facility's enrollment in the pilot project does not prohibit the facility from seeking alternative accreditation; requiring the owner or administrator of a facility that is enrolled in the pilot project to enter into a contract with a quality improvement team; providing for the composition and duties of a quality improvement team; providing for


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termination of the contract with a quality improvement team; providing for the resumption of inspections by the agency if a facility terminates enrollment in the pilot project; authorizing a facility to terminate its contract with a quality improvement team and execute a contract with a another team; requiring the agency to refer certain complaints regarding a facility to the quality improvement team; authorizing the agency to investigate repeated complaints and refer them to the appropriate law enforcement agency; authorizing the agency to investigate and conduct periodic appraisal visits of a facility; authorizing the agency to terminate a facility from the pilot project and require that the facility be subject to survey, inspection, and monitoring visits by the agency; requiring each quality improvement team to make available to the agency certain reports; authorizing a quality improvement team to use electronic means of capturing data and generating reports; providing that reports and documents of the quality improvement team may not be used in certain tort actions; prohibiting conflicts of interests between a facility owner, administrator, or employee and the members of a quality improvement team; providing an effective date.

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

Section 1. Florida Assisted Living Quality Improvement Initiative Pilot Project.—

(1) The purpose of the pilot project is to identify best practices for providing care to residents of licensed assisted living facilities, provide caregivers with the competencies and skills necessary to implement best practices, and develop, in collaboration with the facility, a quality improvement plan to reduce the need for institutional care.

(2) As used in this section, the term:

(a) "Agency" means the Agency for Health Care Administration.

(b) "Department" means the Department of Elderly Affairs.

(3)(a) The pilot project shall be limited to no more than four approved quality improvement teams throughout the pilot areas and 20 facilities in each of the area office locations of the agency which are identified as areas 4, 5, 6, 8, and 11. This pilot project shall expire in 2016 unless reenacted by the Legislature.

(b) Eligibility for participation is limited to facilities that have a good survey track record, have not been cited for any class I or class II violations, and have no more than five uncorrected class III violations on the prior two annual surveys and on any survey that resulted from a complaint.

(4) The department may adopt rules as needed to administer the pilot project, with input from providers, advocates, the agency, or others. The department shall:

(a) Establish a method to measure facility improvement and collect data.

(b) Create criteria for quality improvement plans.

(c) Establish standards and requirements for quality improvement teams.

(d) Establish the procedures for the agency to use in approving or revoking approval of quality improvement teams.

(e) Create an enrollment process and implementation timeline for the pilot project.

(f) Establish a process to notify residents and the local long-term care ombudsman council of each assisted living facility that is enrolled in the pilot project.

(g) Establish the components and provisions that must be contained in a contract between the facility and the approved quality improvement team.

(h) Establish the procedures for resolving complaints that are filed against a facility that is enrolled in the pilot project.

(5) The administrator of a licensed facility that is eligible to participate in the pilot project shall notify the agency when the facility agrees to enroll. Enrollment in the pilot project is voluntary. The agency shall enroll the first 20 eligible facilities in each area that seek enrollment. Before enrollment, each facility must execute a memorandum of agreement with the agency which includes a provision authorizing the agency to terminate the facility's participation in the pilot project at will. The agency's termination of a facility from the pilot project may not be challenged or appealed under chapter 120, Florida Statutes.

(6) Open enrollment in the pilot project shall begin on January 1 of each year. A facility's enrollment in the pilot project does not prohibit the facility from seeking alternative accreditation from a recognized health care accreditation organization, such as the Commission on Accreditation of

Rehabilitative Facilities or The Joint Commission.

(7) The owner or administrator of each facility enrolled in the pilot project shall enter into a contract with an approved quality improvement team to develop, in accordance with the department's rules, and implement a quality improvement plan for that facility. The facility must pay the quality improvement team reasonable compensation for the services provided under the contract. The quality improvement plan must be approved by the agency prior to any implementation of the plan. The owner or administrator shall consult with the quality improvement team for the purpose of meeting the goals outlined in the quality improvement plan.

(8) Each quality improvement team must evaluate the progress of the facility in meeting the goals of the quality improvement plan. A quality improvement team shall include a quality improvement specialist who has professional expertise or a background in working with behavioral health needs or aging-related needs, a licensed registered nurse, a licensed dietician, and a staff development representative.

(9) Each quality improvement team must be approved by the agency prior to entering into any contract with a facility. The agency may revoke the approval of the quality improvement team if the quality improvement team does not meet the requirements or standards established by department rule. If such approval is revoked, the quality improvement team may no longer provide contract services to the facility and the facility must, within 30 days, enter into a contract with another approved quality improvement team in order to remain enrolled in the pilot project.

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(10) Each quality improvement team shall:

(a) Conduct an annual assessment and followup visits as needed to monitor the progress of the facility in meeting the goals of the quality improvement plan.

(b) Consult with the owner and administrator of the facility in meeting plan requirements, create systems to monitor compliance with agency rules, ensure that training standards established under s. 429.52, Florida Statutes, are met, and provide access to community-based services that would improve the care of the residents and the conditions in the facility.

(c) Maintain records of the assessments and ongoing efforts to help the facility meet quality improvement goals.

(d) Issue a certification to each facility that meets agency standards and is in compliance with the goals of its quality improvement plan.

(11) A quality improvement team may terminate, without penalty, the contract executed under subsection (7) with a facility that has failed to meet the goals of the plan after reasonable efforts are made to seek cooperation and assistance from the owner and the administrator of the facility. If a contract is terminated under these conditions, the facility is automatically terminated from the pilot project.

(12) If a facility's enrollment in the pilot project is terminated, the quality improvement team shall notify the agency and that facility shall be subject to the survey, inspection, and monitoring visits conducted under s. 408.811, Florida Statutes. The facility is not eligible to reenroll in the pilot project until the agency has certified that the facility is in substantial compliance with agency rules.

(13) A facility that has entered into a contract with an approved quality improvement team may terminate that contract without penalty and enter into a contract with another approved team. If such termination is sought, the facility administrator shall notify the agency area office in writing and specify the reasons the facility seeks to terminate the contract. The area office supervisor shall approve or reject the request under the terms and conditions of the memorandum of agreement completed by the facility before enrolling in the pilot project.

(14) The agency shall refer any complaint concerning the facility to the quality improvement team if the complaint does not allege immediate jeopardy to a resident of the facility, serious substandard care, or actual harm to a resident of the facility. The team shall investigate the complaint and work with the owner or administrator to address the complaint. If there is a pattern of repeated complaints, the agency may investigate those complaints and refer the complaints to the appropriate law enforcement agency in the local jurisdiction for investigation to ensure the health, safety, and well-being of the facility's residents.

(15) The agency may investigate and conduct periodic appraisal visits at any time in order to ensure compliance with Florida law and the approved quality improvement plan and assess the quality improvement team and the facility. If the agency finds that the facility is in substantial noncompliance with the quality improvement plan or state law, the agency may terminate the facility from the pilot project and shall require the facility to be subject to the survey, inspection, and monitoring visits conducted under s. 408.811, Florida Statutes.

(16)(a) Each quality improvement team shall make available to the agency reports generated following a visit to an enrolled facility.

(b) Each quality improvement team may use electronic means of capturing data and generating reports relating to compliance with the quality improvement plan.

(17) Reports and documents generated by the quality improvement teams may not be used in any tort action sought against the licenseholder of an enrolled facility.

(18) A facility owner, administrator, or employee may not have an ownership interest in, or provide services to, any business owned by a member of a quality improvement team, and an owner, administrator, or employee may not participate as a member of a quality improvement team. The agency shall ensure that there are no conflicts of interest between the members of a quality improvement team and a facility that seeks to enroll or that is enrolled in the pilot project.

Section 2. This act shall take effect July 1, 2011.

LEGISLATIVE ACTION

Senate . House

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The Committee on Health Regulation (Bennett) recommended the following:

Senate Amendment (with title amendment)

Delete lines 88 - 218

and insert:

(e) Specify provisions to prohibit a quality improvement team from contracting with an assisted living facility in a manner that creates a conflict of interest.

(f) Create an enrollment process and implementation timeline for the pilot project.

(g) Establish a process to notify residents and the local long-term care ombudsman council of each assisted living facility that is enrolled in the pilot project.

(h) Establish the components and provisions that must be contained in a contract between the facility and the approved quality improvement team.

(i) Establish the procedures for resolving complaints that are filed against a facility that is enrolled in the pilot project.

(5) The administrator of a licensed facility that is eligible to participate in the pilot project shall notify the agency when the facility agrees to enroll. Enrollment in the pilot project is voluntary. The agency shall enroll the first 20 eligible facilities in each area that seek enrollment. Before enrollment, each facility must execute a memorandum of agreement with the agency which includes a provision authorizing the agency to terminate the facility's participation in the pilot project at will. The agency's termination of a facility from the pilot project may not be challenged or appealed under chapter 120, Florida Statutes.

(6) Open enrollment in the pilot project shall span from January 1 until March 1 of each year. A facility's enrollment in the pilot project does not prohibit the facility from seeking alternative accreditation from a recognized health care accreditation organization, such as the Commission on Accreditation of Rehabilitative Facilities or The Joint Commission.

(7) The owner or administrator of each facility enrolled in the pilot project shall enter into a contract with an approved quality improvement team to develop, in accordance with the department's rules, and implement a quality improvement plan for that facility. The facility must pay the quality improvement

team reasonable compensation for the services provided under the contract. The quality improvement plan must be approved by the agency prior to any implementation of the plan. The owner or administrator shall consult with the quality improvement team for the purpose of meeting the goals outlined in the quality improvement plan.

(8) Each quality improvement team must evaluate the progress of the facility in meeting the goals of the quality improvement plan. A quality improvement team shall include a quality improvement specialist who has professional expertise or a background in working with behavioral health needs or aging-related needs, a licensed registered nurse, a licensed dietician, and a staff development representative.

(9) Each quality improvement team must be approved by the agency prior to entering into any contract with a facility. The agency may revoke the approval of the quality improvement team if the quality improvement team does not meet the requirements or standards established by department rule. If such approval is revoked, the quality improvement team may no longer provide contract services to the facility and the facility must, within 30 days, enter into a contract with another approved quality improvement team in order to remain enrolled in the pilot project.

(10) Each quality improvement team shall:

(a) Conduct an annual assessment and followup visits as needed to monitor the progress of the facility in meeting the goals of the quality improvement plan.

(b) Consult with the owner and administrator of the facility in meeting plan requirements, create systems to monitor

compliance with agency rules, ensure that training standards established under s. 429.52, Florida Statutes, are met, and provide access to community-based services that would improve the care of the residents and the conditions in the facility.

(c) Maintain records of the assessments and ongoing efforts to help the facility meet quality improvement goals.

(d) Issue a certification to each facility that meets agency standards and is in compliance with the goals of its quality improvement plan.

(11) A quality improvement team may terminate, without penalty, the contract executed under subsection (7) with a facility that has failed to meet the goals of the plan after reasonable efforts are made to seek cooperation and assistance from the owner and the administrator of the facility. If a contract is terminated under these conditions, the facility is automatically terminated from the pilot project.

(12) If a facility's enrollment in the pilot project is terminated, the quality improvement team shall notify the agency and that facility shall be subject to the survey, inspection, and monitoring visits conducted under s. 408.811, Florida Statutes. The facility is not eligible to reenroll in the pilot project until the agency has certified that the facility is in substantial compliance with agency rules.

(13) A facility that has entered into a contract with an approved quality improvement team may terminate that contract without penalty and enter into a contract with another approved team. If such termination is sought, the facility administrator shall notify the agency area office in writing and specify the reasons the facility seeks to terminate the contract. The agency

shall approve or reject the request under the terms and conditions of the memorandum of agreement completed by the facility before enrolling in the pilot project.

(14) The agency shall refer any complaint concerning the facility to the quality improvement team if the complaint does not allege immediate jeopardy to a resident of the facility, serious substandard care, or actual harm to a resident of the facility. The team shall investigate the complaint and work with the owner or administrator to address the complaint. If there is a pattern of repeated complaints, the agency may investigate those complaints and refer the complaints to the appropriate law enforcement agency in the local jurisdiction for investigation to ensure the health, safety, and well-being of the facility's residents.

(15) The agency may investigate and conduct periodic appraisal visits at any time in order to ensure compliance with Florida law and the approved quality improvement plan and assess the quality improvement team and the facility. If the agency finds that the facility is in substantial noncompliance with the quality improvement plan or state law, the agency may terminate the facility from the pilot project and shall require the facility to be subject to the survey, inspection, and monitoring visits conducted under s. 408.811, Florida Statutes.

(16)(a) Each quality improvement team shall make available to the agency reports generated following a visit to an enrolled facility.

(b) Each quality improvement team may use electronic means of capturing data and generating reports relating to compliance with the quality improvement plan.

(17) Reports and documents generated by the quality improvement teams may not be used in any tort action sought against the licenseholder of an enrolled facility.

(18) A facility owner, administrator, or employee may not have an ownership interest in, or provide services to, any business owned by a member of a quality improvement team, and an owner, administrator, or employee may not participate as a member of a quality improvement team.

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

And the title is amended as follows:

Delete lines 31 - 51

and insert:

pilot project; authorizing a facility to terminate its contract with a quality improvement team and execute a contract with another team; requiring the agency to approve or reject the request for another team; requiring the agency to refer certain complaints regarding a facility to the quality improvement team; authorizing the agency to investigate repeated complaints and refer them to the appropriate law enforcement agency; authorizing the agency to investigate and conduct periodic appraisal visits of a facility; authorizing the agency to terminate a facility from the pilot project and require that the facility be subject to survey, inspection, and monitoring visits by the agency; requiring each quality improvement team to make available to the agency certain reports; authorizing a quality

improvement team to use electronic means of capturing data and generating reports; providing that reports and documents of the quality improvement team may not be used in certain tort actions; providing an effective date.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	PCS/SB 1838 (548162)
INTRODUCER:	Health Regulation Committee
SUBJECT:	Assisted Living Facilities
DATE:	April 11, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	O'Callaghan	Stovall	HR	**Pre-meeting**
2.			CF	
3.			BC	
4.				
5.				
6.				

I. Summary:

This proposed committee substitute (PCS) for SB 1838 creates the Florida Assisted Living Quality Improvement Initiative Pilot Project (pilot project), which is to be overseen by the Agency for Health Care Administration (AHCA) and which is to be administered by rule by the Department of Elderly Affairs (DOEA).

The purpose of the pilot project is to identify best practices for providing care to residents of licensed assisted living facilities (ALFs), provide caregivers with the competencies and skills necessary to implement best practices, and develop in collaboration with the ALF, a quality improvement plan to reduce the need for institutional care. Participation in the pilot project by eligible ALFs is voluntary.

The PCS provides that the pilot project:

- Is limited to specific area office locations under the AHCA;
- Is limited to a specific number of facilities per designated area;
- Is limited to four certified quality improvement teams, who evaluate the progress of the ALFs in meeting quality improvement plan goals and investigate complaints against the ALF; and
- Expires in 2016, unless reenacted by the Legislature.

The PCS also requires those ALFs enrolling in the pilot project to enter into a contract with an AHCA-approved quality improvement team to implement an AHCA-approved quality improvement plan. The PCS provides for the termination of the contract between the ALF and

the quality improvement team under certain circumstances, and such termination subjects the ALF to the survey, inspection, and monitoring requirements under current law.

The PCS requires the AHCA to refer complaints about an ALF to the appropriate quality improvement team, investigate a pattern of repeated complaints, and refer the repeated complaints to the appropriate law enforcement agency. The PCS authorizes the AHCA to investigate and conduct periodic appraisal visits at any time in order to ensure compliance with Florida law and the approved quality improvement plan and assess the quality improvement team and the ALF.

The PCS also provides for recordkeeping by the quality improvement team and certain reporting requirements.

The PCS includes a provision to prevent conflicts of interest between an ALF participating in the pilot project and a member of a quality improvement team.

This PCS creates an undesignated section of the Florida Statutes.

II. Present Situation:

Assisted Living Facilities

An ALF is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[1, 2] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[3] Activities of daily living include: ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.

The ALFs are licensed by the AHCA pursuant to part I of ch. 429, F.S., relating to assisted living facilities, and part II of ch. 408, F.S., relating to the general licensing provisions for health care facilities. The ALFs are also subject to regulation under Chapter 58A-5, Florida Administrative Code (F.A.C.). These rules are adopted by the DOEA in consultation with the AHCA, the Department of Children and Family Services (DCF), and the Department of Health (DOH).[4] An ALF must also comply with the Uniform Fire Safety Standards for ALFs contained in Chapter 69A-40, F.A.C., and standards enforced by the DOH concerning food hygiene; physical plant sanitation; biomedical waste; and well, pool, or septic systems.[5]

[1] Section 429.02(5), F.S.
[2] An ALF does not include an adult family-care home or a nontransient public lodging establishment. An adult family-care home is regulated under ss. 429.60 – 429.87, F.S., and is defined as a full-time, family-type living arrangement in a private home where the person who owns or rents the home, lives in the home. An adult family-care home provides room, board, and personal care, on a 24-hour basis, for no more than five disabled adults or frail elders, who are not relatives. A nontransient establishment (a.k.a. boarding house) is regulated under part I of ch. 509, F.S., and is defined as any public lodging establishment that is rented or leased to guests by an operator whose intention is that the dwelling unit occupied will be the sole residence of the guest.
[3] Section 429.02(16), F.S.
[4] Section 429.41(1), F.S.
[5] *See* ch. 64E-12, ch. 64E-11, and 64E-16, F.A.C.

There are currently 2,944 licensed ALFs in Florida.[6] In addition to a standard license, an ALF may have specialty licenses that authorize an ALF to provide limited nursing services (LNS), limited mental health (LMH) services,[7] and extended congregate care (ECC) services.

An ALF is required to provide care and services appropriate to the needs of the residents accepted for admission to the facility. Generally, the care and services include at a minimum:

- Supervising the resident in order to monitor the resident's diet; being aware of the general health, safety, and physical and emotional well-being of the resident; and recording significant changes, illnesses, incidents, and other changes which resulted in the provision of additional services;
- Contacting appropriate persons upon a significant change in the resident or if the resident is discharged or moves out;
- Providing and coordinating social and leisure activities in keeping with each resident's needs, abilities, and interests;
- Arranging for health care by assisting in making appointments, reminding residents about scheduled appointments, and providing or arranging for transportation as needed; and
- Providing to the resident a copy of, and adhering to, the Resident Bill of Rights.

An unlicensed person who has received the appropriate training may assist a resident in an ALF with the self-administration of medication. Persons under contract to the ALF, employees, or volunteers,[8] who are licensed under the nurse practice act[9] and uncompensated family members or friends may:[10]

- Administer medications to residents;
- Take a resident's vital signs;
- Manage individual weekly pill organizers for residents who self-administer medication;
- Give prepackaged enemas ordered by a physician; and
- Observe residents, document observations on the appropriate resident's record, and report observations to the resident's physician.

Additionally, in an emergency situation, persons licensed under the nurse practice act may carry out their professional duties until emergency medical personnel assume responsibility for care. A resident may independently arrange, contract, and pay for additional services provided by a third party of the resident's choice.

The owner or facility administrator determines whether an individual is appropriate for admission to the facility based on an assessment of the strengths, needs, and preferences of the individual; the health assessment; the preliminary service plan; the facility's residency criteria;

[6] Agency for Health Care Administration, *2011 Bill Analysis & Economic Impact Statement for SB 1838, HB 1137*, on file with the Senate Health Regulation Committee.
[7] An ALF that serves three or more mental health residents must obtain a limited mental health specialty license. A mental health resident is an individual who receives social security disability income (SSDI) due to a mental disorder or supplemental security income (SSI) due to a mental disorder, and receives OSS.
[8] An association spokesperson stated in an e-mail to Senate Health Regulation Committee professional staff that ALFs do not currently use volunteers for these purposes due to liability issues.
[9] Part I of ch. 464, F.S.
[10] Section 429.255, F.S.

services offered or arranged for by the facility to meet resident needs; and the ability of the facility to meet the uniform fire safety standards.[11]

A resident who requires 24-hour nursing supervision[12] may not reside in an ALF, unless the resident is enrolled as a hospice patient. Continued residency of a hospice patient is conditioned upon a mutual agreement between the resident and the facility, additional care being rendered through a licensed hospice, and the resident being under the care of a physician who agrees that the physical needs of the resident are being met.

If a resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, as determined by the facility administrator or health care provider, the resident must be discharged in accordance with the Resident Bill of Rights.[13]

Currently, the AHCA conducts biennial and follow-up compliance inspections as a component of the licensure process for ALFs.[14] The AHCA also investigates complaints made against an ALF and monitors and enforces the correction of deficient practices associated with surveys and complaints.[15]

Inspections and investigations are conducted by the AHCA's Bureau of Field Operations, which is divided into eight field offices. The biennial surveys and complaint investigations are conducted by the survey teams in each field office composed of AHCA-trained survey staff. The licensure and survey process is a highly coordinated effort between the AHCA's Bureau of Field Operations and Bureau of Long Term Care Services and, when appropriate, the AHCA's Office of General Counsel. During FY 09-10, the AHCA's Bureau of Field Operations completed 5,507 on-site surveys and complaint investigation visits in ALFs.[16]

III. Effect of Proposed Changes:

This PCS creates the Florida Assisted Living Quality Improvement Initiative Pilot Project, which is scheduled to expire in 2016, unless reenacted by the Legislature. The purpose of the pilot project is to identify best practices for providing care to residents of licensed ALFs, provide caregivers with the competencies and skills necessary to implement best practices, and develop, in collaboration with the ALF, a quality improvement plan to reduce the need for institutional care.

[11] Section 429.255, F.S., s. 429.26, F.S., and Rule 58A-5.030, F.A.C.
[12] Twenty-four-hour nursing supervision means services that are ordered by a physician for a resident whose condition requires the supervision of a physician and continued monitoring of vital signs and physical status. Such services must be: medically complex enough to require constant supervision, assessment, planning, or intervention by a nurse; required to be performed by or under the direct supervision of licensed nursing personnel or other professional personnel for safe and effective performance; required on a daily basis; and consistent with the nature and severity of the resident's condition or disease state or stage. Definition found at s. 429.02(26), F.S.
[13] Section 429.28, F.S.
[14] Section 408.811, F.S.
[15] *Supra* fn. 6.
[16] *Id.*

The pilot project is limited to the area office locations of the AHCA which are identified as areas 4,17 5, 6, 18 8,19 and 11.20 Only 20 facilities in each area may participate in the pilot project.

Quality Improvement Teams
The pilot project may include up to four AHCA-approved quality improvement teams. A quality improvement team evaluates the progress of the ALF in meeting quality improvement plan goals and must consist of a quality improvement specialist who has professional expertise or a background in working with behavioral health needs or aging-related needs, a licensed registered nurse, a licensed dietician, and a staff development representative.

The AHCA may revoke the approval of the quality improvement team if the quality improvement team does not meet the requirements or standards established by department rule. If such approval is revoked, the team may no longer provide contract services to the ALF it is contracted with and the ALF must enter into a contract with a different team within 30 days.

Each quality improvement team must:
- Conduct an annual assessment and follow-up visits as needed to monitor the progress of the ALF in meeting the goals of the quality improvement plan.
- Consult with the owner and administrator of the ALF in meeting plan requirements, create systems to monitor compliance with the AHCA's rules, ensure that training standards established under s. 429.52, F.S., are met, and provide access to community-based services that would improve the care of the residents and the conditions in the ALF.
- Maintain records of the assessments and ongoing efforts to help the ALF meet quality improvement goals.
- Issue a certification to each ALF that meets agency standards and is in compliance with the goals of its quality improvement plan.

Rulemaking
The DOEA may adopt rules as needed to administer the pilot project, with input from providers, advocates, the agency, or others. The DOEA is required to:
- Establish a method to measure facility improvement and collect data.
- Create criteria for certification of quality improvement plans.
- Establish standards and requirements for quality improvement teams.
- Establish the procedures for the AHCA to use in approving or revoking approval of quality improvement teams.
- Create an enrollment process and implementation timeline for the pilot project.

[17] Region 4 (Jacksonville Field Office) includes Baker, Clay, Duval, Flagler, Nassau, St. Johns and Volusia Counties. Agency for Health Care Administration, Health Quality Assurance, available at: http://ahca.myflorida.com/MCHQ/area4.shtml (Last visited on April 6, 2011).
[18] Regions 5 and 6 (St. Petersburg Field Office) include Hardee, Highlands, Hillsborough, Manatee, Pasco, Pinellas, and Polk Counties. Agency for Health Care Administration, Health Quality Assurance, available at: http://ahca.myflorida.com/MCHQ/area4.shtml (Last visited on April 6, 2011).
[19] Region 8 (Fort Myers Field Office) includes Charlotte, Collier, DeSoto, Glades, Hendry, Lee, Monroe, and Sarasota Counties. Agency for Health Care Administration, Health Quality Assurance, available at: http://ahca.myflorida.com/MCHQ/area4.shtml (Last visited on April 6, 2011).
[20] Region 11 (Miami Field Office) includes Miami-Dade County. Agency for Health Care Administration, Health Quality Assurance, available at: http://ahca.myflorida.com/MCHQ/area4.shtml (Last visited on April 6, 2011).

- Establish a process to notify residents and the local long-term care ombudsman council of each ALF that is enrolled in the pilot project.
- Establish the components and provisions that must be contained in a contract between the ALF and the approved quality improvement team.
- Establish the procedures for resolving complaints that are filed against an ALF that is enrolled in the pilot project.

Eligibility and Enrollment
Eligibility for participation in the pilot project is limited to ALFs that have a good survey track record, have not been cited for any Class I or Class II violations,[21] and have no more than five uncorrected Class III violations[22] on the prior two annual surveys and on any survey that resulted from a complaint.

The PCS provides that enrollment in the pilot project is voluntary and open enrollment in the pilot project is to begin on January 1 of each year.

The PCS requires the administrator of a licensed ALF that is eligible to participate in the pilot project to notify the AHCA when the ALF agrees to enroll in the pilot project and before enrollment, each ALF must execute a memorandum of agreement with the AHCA that includes a provision authorizing the AHCA to terminate the ALF's participation in the pilot project at will. The PCS provides that the AHCA's termination of an ALF from the pilot project may not be challenged or appealed under ch. 120, F.S.

An ALF's enrollment in the pilot project does not prohibit the ALF from seeking alternative accreditation from a recognized health care accreditation organization, such as the Commission on Accreditation of Rehabilitative Facilities or The Joint Commission.

The owner or administrator of each ALF enrolled in the pilot project must enter into a contract with an AHCA-approved quality improvement team to implement an AHCA-approved quality improvement plan for that facility. The ALF must pay the quality improvement team reasonable compensation for the services provided under the contract. The owner or administrator must consult with the quality improvement team for the purpose of meeting the goals outlined in the quality improvement plan.

Termination of Contracts under the Pilot Project
An ALF that has entered into a contract with an approved quality improvement team may, without penalty, terminate that contract and enter into a contract with another approved team. If such termination is sought, the ALF administrator must notify the agency area office in writing

[21] "Class I" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the AHCA determines present an imminent danger to the clients of the provider or a substantial probability that death or serious physical or emotional harm would result therefrom. "Class II" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the AHCA determines directly threaten the physical or emotional health, safety, or security of the clients, other than class I violations. *See* s. 408.813(2), F.S.
[22] "Class III" violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the AHCA determines indirectly or potentially threaten the physical or emotional health, safety, or security of clients, other than class I or class II violations. *See* s. 408.813(2)(c), F.S.

and specify the reasons the ALF seeks to terminate the contract. The area office supervisor must approve or reject the request under the terms and conditions of the memorandum of agreement completed by the ALF before enrolling the ALF in the pilot project.

A quality improvement team may elect to terminate, without penalty, the contract with an ALF that has failed to meet the goals of the plan after reasonable efforts are made to seek cooperation and assistance from the owner and the administrator of the ALF. An ALF is automatically terminated from the pilot project if its contract with the quality improvement team is terminated under these conditions. If an ALF's enrollment in the pilot project is terminated, the quality improvement team is required to notify the AHCA. Thereafter, the ALF is subject to the survey, inspection, and monitoring visits conducted under s. 408.811, F.S., and the ALF is not eligible to reenroll in the pilot project until the AHCA has certified that the ALF is in substantial compliance with the AHCA's rules.

Complaints and Investigations
The AHCA must refer any complaint concerning the ALF to the quality improvement team if the complaint does not allege immediate jeopardy to a resident of the ALF, serious substandard care, or actual harm to a resident of the ALF. The team must investigate the complaint and work with the owner or administrator to address the complaint. If there is a pattern of repeated complaints, the AHCA may investigate those complaints and refer the complaints to the appropriate law enforcement agency in the local jurisdiction for investigation to ensure the health, safety, and well-being of the ALF's residents.

The AHCA may investigate and conduct periodic appraisal visits at any time in order to ensure compliance with the approved quality improvement plan and state law and assess the quality improvement team and the ALF. If the AHCA finds that the ALF is in substantial noncompliance with the quality improvement plan or state law, the AHCA may terminate its pilot project agreement with the ALF and must require the ALF to be subject to the survey, inspection, and monitoring visits conducted under s. 408.811, F.S.

Reporting Requirements
Each quality improvement team must make available to the AHCA reports generated following a visit to an enrolled ALF and may use electronic means of capturing data and generating reports relating to compliance with the quality improvement plan.

Reports and documents generated by the quality improvement teams may not be used in any tort action sought against the licenseholder of an enrolled ALF.

Conflicts of Interest
A facility owner, administrator, or employee may not have an ownership interest in, or provide services to, any business owned by a member of a quality improvement team, and an owner, administrator, or employee may not participate as a member of a quality improvement team. The agency is required to ensure that there are no conflicts of interest between the members of a quality improvement team and a facility that seeks to enroll or that is enrolled in the pilot project.

The PCS provides that this act shall take effect on July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this PCS have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this PCS have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this PCS have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

To the extent that an ALF elects to participate in the pilot project, it may be subject to any costs associated with meeting the requirements of the quality improvement plan and will be required to pay a quality improvement team reasonable compensation for its services.

C. Government Sector Impact:

The AHCA may incur a positive fiscal impact associated with less surveying and inspection responsibilities, which will be taken over by the quality improvement teams, but may incur a negative fiscal impact associated with the administrative costs of approving quality improvement teams and quality improvement plans. The DOEA may incur a negative fiscal impact associated with the rulemaking responsibilities required in the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

541928

LEGISLATIVE ACTION

Senate . House

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The Committee on Health Regulation (Diaz de la Portilla) recommended the following:

Senate Amendment (with title amendment)

Delete lines 210 - 337.

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

And the title is amended as follows:

Delete lines 18 - 24

and insert:

vicarious liability of certain entities; providing an effective date.

799184

LEGISLATIVE ACTION

Senate . House

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The Committee on Health Regulation (Diaz de la Portilla) recommended the following:

Senate Amendment to Amendment (541928) (with title amendment)

Delete line 3
and insert:

Delete lines 28 - 338
and insert:

Section 1. Section 400.023, Florida Statutes, is reordered and amended to read:

400.023 Civil enforcement.—

799184

(1) A ~~Any~~ resident who ~~whose~~ alleges negligence or a violation of rights as specified in this part has ~~are violated shall have~~ a cause of action against the licensee or its management company, as identified in the state application for nursing home licensure. However, the cause of action may not be asserted individually against an officer, director, owner, including an owner designated as having a controlling interest on the state application for nursing home licensure, or agent of a licensee or management company unless, following an evidentiary hearing, the court determines there is sufficient evidence in the record or proffered by the claimant which establishes a reasonable basis for finding that the person or entity breached, failed to perform, or acted outside the scope of duties as an officer, director, owner, or agent, and that the breach, failure to perform, or action outside the scope of duties is a legal cause of actual loss, injury, death, or damage to the resident.

(2) The action may be brought by the resident or his or her guardian, by a person or organization acting on behalf of a resident with the consent of the resident or his or her guardian, or by the personal representative of the estate of a deceased resident regardless of the cause of death.

(5) If the action alleges a claim for the resident's rights or for negligence that:

(a) Caused the death of the resident, the claimant must ~~shall be required to~~ elect ~~either~~ survival damages pursuant to s. 46.021 or wrongful death damages pursuant to s. 768.21. If the claimant elects wrongful death damages, total noneconomic damages may not exceed $300,000, regardless of the number of

claimants.

(b) ~~If the action alleges a claim for the resident's rights or for negligence that~~ Did not cause the death of the resident, the personal representative of the estate may recover damages for the negligence that caused injury to the resident.

(3) The action may be brought in any court of competent jurisdiction to enforce such rights and to recover actual and punitive damages for any violation of the rights of a resident or for negligence.

(10) Any resident who prevails in seeking injunctive relief or a claim for an administrative remedy may ~~is entitled to~~ recover the costs of the action, and a reasonable attorney's fee assessed against the defendant not to exceed $25,000. Fees shall be awarded solely for the injunctive or administrative relief and not for any claim or action for damages whether such claim or action is brought together with a request for an injunction or administrative relief or as a separate action, except as provided under s. 768.79 or the Florida Rules of Civil Procedure. Sections 400.023-400.0238 provide the exclusive remedy for a cause of action for recovery of damages for the personal injury or death of a nursing home resident arising out of negligence or a violation of rights specified in s. 400.022. This section does not preclude theories of recovery not arising out of negligence or s. 400.022 which are available to a resident or to the agency. The provisions of chapter 766 do not apply to any cause of action brought under ss. 400.023-400.0238.

(6)~~(2)~~ If the ~~In any~~ claim brought pursuant to this part alleges ~~alleging~~ a violation of resident's rights or negligence causing injury to or the death of a resident, the claimant shall

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have the burden of proving, by a preponderance of the evidence, that:

(a) The defendant owed a duty to the resident;

(b) The defendant breached the duty to the resident;

(c) The breach of the duty is a legal cause of loss, injury, death, or damage to the resident; and

(d) The resident sustained loss, injury, death, or damage as a result of the breach.

(12) ~~Nothing in~~ This part does not ~~shall be interpreted to~~ create strict liability. A violation of the rights set forth in s. 400.022 or in any other standard or guidelines specified in this part or in any applicable administrative standard or guidelines of this state or a federal regulatory agency is ~~shall be~~ evidence of negligence but may ~~shall~~ not be considered negligence per se.

(7)~~(3)~~ In any claim brought pursuant to this section, a licensee, person, or entity has ~~shall have~~ a duty to exercise reasonable care. Reasonable care is that degree of care which a reasonably careful licensee, person, or entity would use under like circumstances.

(9)~~(4)~~ In any claim for resident's rights violation or negligence by a nurse licensed under part I of chapter 464, such nurse has a ~~shall have the~~ duty to exercise care consistent with the prevailing professional standard of care for a nurse. The prevailing professional standard of care for a nurse is ~~shall be~~ that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar nurses.

(8)~~(5)~~ A licensee is ~~shall~~ not ~~be~~ liable for the medical

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negligence of any physician rendering care or treatment to the resident except for the administrative services of a medical director as required in this part. ~~Nothing in~~ This subsection does not ~~shall be construed to~~ protect a licensee, person, or entity from liability for failure to provide a resident with appropriate observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care by nursing staff.

(4)~~(6)~~ The resident or the resident's legal representative shall serve a copy of any complaint alleging in whole or in part a violation of any rights specified in this part to the agency ~~for Health Care Administration~~ at the time of filing the initial complaint with the clerk of the court for the county in which the action is pursued. ~~The requirement of~~ Providing a copy of the complaint to the agency does not impair the resident's legal rights or ability to seek relief for his or her claim.

(11)~~(7)~~ An action under this part for a violation of rights or negligence ~~recognized herein~~ is not a claim for medical malpractice, and the provisions of s. 768.21(8) do not apply to a claim alleging death of the resident.

Section 2. Subsections (1), (2), and (3) of section 400.0237, Florida Statutes, are amended to read:

400.0237 Punitive damages; pleading; burden of proof.—

(1) In any action ~~for damages~~ brought under this part, a ~~no~~ claim for punitive damages is not ~~shall be~~ permitted unless, based on admissible ~~there is a reasonable showing by~~ evidence ~~in the record or~~ proffered by the claimant, ~~which would provide~~ a reasonable basis for recovery of such damages is demonstrated upon applying the criteria set forth in this section. The defendant may proffer admissible evidence to refute the


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claimant's proffer of evidence to recover punitive damages. The trial judge shall conduct an evidentiary hearing and weigh the admissible evidence proffered by the claimant and the defendant to ensure that there is a reasonable basis to believe that the claimant, at trial, will be able to demonstrate by clear and convincing evidence that the recovery of such damages is warranted. The claimant may move to amend her or his complaint to assert a claim for punitive damages as allowed by the rules of civil procedure. ~~The rules of civil procedure shall be liberally construed so as to allow the claimant discovery of evidence which appears reasonably calculated to lead to admissible evidence on the issue of punitive damages.~~ ~~No~~ Discovery of financial worth may not ~~shall~~ proceed until after the trial judge approves the pleading on ~~concerning~~ punitive damages ~~is permitted~~.

(2) A defendant, including the licensee or management company, against whom punitive damages is sought, may be held liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds that a specific individual or corporate defendant actively and knowingly participated in intentional misconduct, or engaged in conduct that constituted gross negligence, and that conduct contributed to the loss, damages, or injury suffered by the claimant ~~the defendant was personally guilty of intentional misconduct or gross negligence~~. As used in this section, the term:

(a) "Intentional misconduct" means that the defendant against whom a claim for punitive damages is sought had actual knowledge of the wrongfulness of the conduct and the high probability that injury or damage to the claimant would result

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and, despite that knowledge, intentionally pursued that course of conduct, resulting in injury or damage.

(b) "Gross negligence" means that the defendant's conduct was so reckless or wanting in care that it constituted a conscious disregard or indifference to the life, safety, or rights of persons exposed to such conduct.

(3) In the case of vicarious liability of an employer, principal, corporation, or other legal entity, punitive damages may not be imposed for the conduct of an identified employee or agent unless ~~only if~~ the conduct of the employee or agent meets the criteria specified in subsection (2) and officers, directors, or managers of the actual employer corporation or legal entity condoned, ratified, or consented to the specific conduct as alleged by the claimant in subsection (2).~~÷~~

~~(a) The employer, principal, corporation, or other legal entity actively and knowingly participated in such conduct;~~

~~(b) The officers, directors, or managers of the employer, principal, corporation, or other legal entity condoned, ratified, or consented to such conduct; or~~

~~(c) The employer, principal, corporation, or other legal entity engaged in conduct that constituted gross negligence and that contributed to the loss, damages, or injury suffered by the claimant.~~

Section 3. This act shall take effect July 1, 2011.

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

And the title is amended as follows:

Delete lines 7 - 10

799184

and insert:

Delete lines 2 - 24,

and insert:

An act relating to nursing homes; amending s. 400.023, F.S.; requiring the trial judge to conduct an evidentiary hearing to determine the sufficiency of evidence for claims against certain persons relating to a nursing home; limiting noneconomic damages in a wrongful death action against the nursing home; amending s. 400.0237, F.S.; revising provisions relating to punitive damages against a nursing home; authorizing a defendant to proffer admissible evidence to refute a claimant’s proffer of evidence for punitive damages; requiring the trial judge to conduct an evidentiary hearing and the plaintiff to demonstrate that a reasonable basis exists for the recovery of punitive damages; prohibiting discovery of the defendant’s financial worth until the judge approves the pleading on punitive damages; revising definitions; providing an effective date.

888128

LEGISLATIVE ACTION

Senate . House

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The Committee on Health Regulation (Diaz de la Portilla) recommended the following:

Senate Amendment

Delete line 70

and insert:

section, noneconomic damages may not exceed a total of $300,000,

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1396
INTRODUCER:	Senator Bogdanoff
SUBJECT:	Nursing Home Litigation Reform
DATE:	March 25, 2011 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Stovall	HR	**Pre-meeting**
2.			JU	
3.			BC	
4.				
5.				
6.				

I. Summary:

The bill amends statutory provisions relating to civil causes of action against nursing homes, punitive damages, and a nursing home's compliance or noncompliance with minimum staffing requirements as it relates to civil actions against the nursing home. The bill:

- Requires the court to hold an evidentiary hearing to determine if there is a reasonable basis to find that an officer, director, or owner of a nursing home acted outside the scope of duties in order for a lawsuit to proceed against an officer, director, or owner of a nursing home;
- Provides a cap of $250,000 on noneconomic damages in any claim for wrongful death in nursing home lawsuits, regardless of the number of claimants or defendants;
- Requires a claimant to bring a lawsuit pursuant to either the statute relating to nursing home civil enforcement or the statute relating to abuse of vulnerable adults;
- Requires a claimant to elect survival damages or wrongful death damages not later than 60 days before trial;
- Requires the court to hold an evidentiary hearing before allowing a claim for punitive damages to proceed;
- Changes the method for calculating attorney fees in punitive damage cases and provides more situations where the punitive damages claim will be split between the claimant and the state; and
- Limits the use of federal and state survey reports in nursing home litigation.

This bill substantially amends the following sections of the Florida Statutes: 400.023, 400.0237, 400.0238, and 400.23.

II. Present Situation:

"Nursing Homes and Related Health Care Facilities" is the subject of ch. 400, F.S. Part I of ch. 400, F.S., establishes the Office of State Long-Term Care Ombudsman, the State Long-Term Care Ombudsman Council, and the local long-term care ombudsman councils. Part II of ch. 400, F.S., provides for the regulation of nursing homes, and part III of ch. 400, F.S., provides for the regulation of home health agencies.

The Agency for Health Care Administration (AHCA) is charged with the responsibility of developing rules related to the operation of nursing homes. Section 400.023, F.S., creates a statutory cause of action against nursing homes that violate the rights of residents specified in s. 400.022, F.S. The action may be brought in any court to enforce the resident's rights and to recover actual and punitive damages for any violation of the rights of a resident or for negligence.[1] Prevailing plaintiffs may be entitled to recover reasonable attorney fees plus costs of the action, along with actual and punitive damages.[2]

Sections 400.023-400.0238, F.S., provide the exclusive remedy for a cause of action for recovery of damages for the personal injury or death of a nursing home resident arising out of negligence or a violation of rights specified in s. 400.022, F.S. No claim for punitive damages may be permitted unless there is a reasonable showing by evidence in the record or proffered by the claimant which would provide a reasonable basis for recovery of such damages.[3] A defendant may be held liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds that the defendant was personally guilty of intentional misconduct or gross negligence as specified in s. 400.0237(2), F.S.[4]

In the case of an employer, principal, corporation, or other entity, punitive damages may be imposed for conduct of an employee or agent only if the conduct meets the criteria specified in s. 400.0237(2), F.S., and the employer actively and knowingly participated in the conduct, ratified or consented to the conduct, or engaged in conduct that constituted gross negligence and that contributed to the loss, damages, or injury suffered by the claimant.[5]

Named Defendants and Causes of Action in Nursing Home Cases

Section 400.023, F.S., provides that "any resident whose rights as specified in this part are violated shall have a cause of action." It does not indicate who may be named as a defendant. Current law in ss. 400.023 - 400.0238, F.S., provides the exclusive remedy for a cause of action for personal injury or death of a nursing home resident or a violation of the resident's rights statute. Current law further provides that s. 400.023, F.S., "does not preclude theories of recovery not arising out of negligence or s. 400.022, F.S., which are available to the resident or to the agency."

[1] Sections 400.023 and 400.0237, F.S.
[2] *Id.*
[3] Section 400.0237(1), F.S.
[4] Section 400.0237(2), F.S.
[5] Section 400.0237(3), F.S.

Liability of Employees, Officers, Directors, or Owners

In *Estate of Canavan v. National Healthcare Corp.*, 889 So.2d 825 (Fla. 2d DCA 2004), the court considered whether the managing member of a limited liability company could be held personally liable for damages suffered by a resident in a nursing home. The claimant argued the managing member, Friedbauer, could be held liable:

> [Claimant] argues that the concept of piercing the corporate veil does not apply in the case of a tort and that it presented sufficient evidence of Friedbauer negligence, by act or omission, for the jury to reasonably conclude that Friedbauer caused harm to Canavan. [Claimant] argues that Friedbauer had the responsibility of approving the budget for the nursing home. He also functioned as the sole member of the "governing body" of the nursing home, and pursuant to federal regulation, the governing body is legally responsible for establishing and implementing policies regarding the management and operation of the facility and for appointing the administrator who is responsible for the management of the facility. Friedbauer was thus required by federal mandate to create, approve, and implement the facility's policies and procedures. Because he ignored complaints of inadequate staffing while cutting the operating expenses, and because the problems Canavan suffered, pressure sores, infections, poor hygiene, malnutrition and dehydration, were the direct result of understaffing, [claimant] argues that a reasonable jury could have found that Friedbauer's elevation of profit over patient care was negligent.[6]

The trial court granted a directed verdict in favor of Freidbauer, finding that there was no basis upon which a corporate officer could be held liable. On appeal, the court reversed:

> We conclude that the trial court erred in granting the directed verdict because there was evidence by which the jury could have found that Friedbauer's negligence in ignoring the documented problems at the facility contributed to the harm suffered by Canavan. This was not a case in which the plaintiffs were required to pierce the corporate veil in order to establish individual liability because Friedbauer's alleged negligence constituted tortious conduct, which is not shielded from individual liability. We, therefore, reverse the order granting the directed verdict and remand for a new trial against Friedbauer.[7]

Limitations on Causes of Action for Violations of Criminal Statutes

Section 415.111, F.S., provides criminal penalties for failing to report abuse of a vulnerable adult, for making certain confidential information public, for refusing to grant access to certain records, and for filing false reports relating to abuse of a vulnerable adult. Section 415.111, F.S., does not specifically provide for a civil cause of action while s. 415.1111, F.S., provides for a civil cause of action in some situations.

[6] *Estate of Canavan v. National Healthcare Corp.*, 889 So.2d 825, 826 (Fla. 2d DCA 1994).
[7] *Estate of Canavan v. National Healthcare Corp.*, 889 So.2d 825, 826-827 (Fla. 2d DCA 1994)(citations omitted).

Section 415.1111, F.S., provides a cause of action where a vulnerable adult[8] who has been abused, neglected, or exploited has a cause of action and can recover damages, punitive damages, and attorney fees. However, any action brought against a licensee or entity that establishes, controls, manages, or operates a nursing home must be brought under s. 400.023, F.S.

One court has specifically held that no civil cause of action exists for failing to report abuse of vulnerable adult pursuant to s. 415.111, F.S. The court explained:

> It is evident that the legislature considered both civil and criminal penalties under this statute, but subjected only actual perpetrators of abuse to civil penalties. This is strong evidence of a legislative intent not to provide a civil cause of action for victims against those who fail to report the abuse as required by this act.[9]

Election of Damages

Section 400.023, F.S., requires that in cases where the action alleges a claim for resident's rights or for negligence that caused the death of the resident, a claimant must elect either survival damages[10] or wrongful death damages.[11] The statute does not provide a time certain for a claimant to make an election. In *In re Estate of Trollinger*, 9 So.3d 667 (Fla. 2d DCA 2009), the trial court forced a claimant to make an election at the time of the initial complaint and the appellate court held that certiorari review was not available because any error could be corrected by a subsequent appeal. The court noted that s. 400.023(1), F.S., is "silent as to whether the election of remedies must be made at the pleading stage or at the end of trial."[12]

Judge Altenbernd argued that the claimant should not have to make an election with the initial pleading:

> [The statute] requires the personal representative to elect to receive only one of the two different measures of damages that are available in such a case. The statute does not require the personal representative to choose to pursue only one of the two different causes of action available to the personal representative. It certainly does not state that the election must be made in the complaint...
>
> Even if one assumes that section 400.023(1) requires a plaintiff to elect one cause of action, this election of a claim would not logically occur at the pleading stage. If the plaintiff is required to elect one measure of damages, there is little reason why this

[8] "Vulnerable adult" means "means a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging." s. 415.102(27), F.S.
[9] *Mora v. South Broward Hosp. Dist.*, 710 So.2d 633, 634 (Fla. 4th DCA 1998).
[10] Section 46.021, F.S., provides that no cause of action dies with the person. Accordingly, if a resident brings a claim for a violation of resident's rights or negligence and dies during the pendency of the claim, the action may continue and the resident's estate may recover the damages that the resident could have recovered if the resident had lived until the end of the litigation.
[11] Section 768.21, F.S., provides for damages that may be recovered by the estate of a resident and the resident's family in a wrongful death action.
[12] *In re Estate of Trollinger*, 9 So.3d 667, 668 (Fla. 2d DCA 2009).

> election cannot take place after the jury returns its verdict. Election of remedies is a somewhat complex theory, but it is generally designed to prevent a double recovery, which can be avoided in this case even if the jury is presented with a verdict form containing both theories.
>
> The personal representative's two theories are factually and legally distinct. One theory requires proof that negligence caused only injury and the other theory requires proof that negligence caused death. In Florida, a standard verdict form asks the jury to decide whether there was negligence on the part of the defendant which was a legal cause of damage to the plaintiff. If the jury is instructed on only one of the causes of action and the damages appropriate under that theory, there is nothing in the verdict form to demonstrate that the verdict forecloses an action on the other theory for the damages available under the other theory. In other words, if a jury were to find that an act of negligence did not cause wrongful death damages, that verdict would not prevent another jury from finding that an act of negligence caused survivorship damages. Thus, whichever theory is tried first, the trial court is likely to be called upon to try the second theory later.[13] (internal citations omitted).

Cap on Noneconomic Damages

Current law provides no cap on the recovery of noneconomic damages in wrongful death actions brought under s. 400.023, F.S. "Economic" damages are damages such as loss of earnings, loss of net accumulations, medical expenses, and funeral expenses.[14] "Noneconomic damages" are damages for which there is no exact standard for fixing compensation such as mental pain and suffering and loss of companionship or protection.[15]

Attorney Fees in Actions for Injunctive Relief

A resident may bring an action seeking injunctive relief in court or bring an administrative action to force a licensee to take an action or cease taking some action. Current law provides that a resident is entitled to attorney fees not to exceed $25,000, plus costs, if the resident prevails when seeking injunctive relief.

Elements in a Civil Actions Under s. 400.023, F.S.

Section 400.023(2), F.S., provides that in any claim alleging a violation of resident's rights or alleging that negligence caused injury to or the death of a resident, the claimant must prove, by a preponderance of the evidence:

- The defendant owed a duty to the resident;
- The defendant breached the duty to the resident;
- The breach of the duty is a legal cause of loss, injury, death, or damage to the resident; and
- The resident sustained loss, injury, death, or damage as a result of the breach.

[13] *In re Estate of Trollinger*, 9 So.3d 667, 669 (Fla. 2d DCA 2009)(Altenbernd, J., concurring).
[14] *See generally* Florida Standard Jury Instructions in Civil Cases, s. 502.2. (accessed at http://www.floridasupremecourt.org/civ_jury_instructions/instructions.shtml#500).
[15] *See generally* Florida Standard Jury Instructions in Civil Cases, s. 502.2. (accessed at http://www.floridasupremecourt.org/civ_jury_instructions/instructions.shtml#500).

The Florida Supreme Court has set forth the elements of a negligence action:

> 1. A duty, or obligation, recognized by the law, requiring the [defendant] to conform to a certain standard of conduct, for the protection of others against unreasonable risks.
>
> 2. A failure on the [defendant's] part to conform to the standard required: a breach of the duty...
>
> 3. A reasonably close causal connection between the conduct and the resulting injury. This is what is commonly known as "legal cause," or "proximate cause," and which includes the notion of cause in fact.
>
> 4. **Actual loss** or damage...[16] (emphasis added).

Current law provides in any claim brought pursuant to s. 400.023, F.S., a licensee, person, or entity has the duty to exercise "reasonable care" and nurses have the duty to exercise care "consistent with the prevailing professional standard of care."[17] Standards of care are set forth in current law. Section 400.023(3), F.S., provides that a licensee, person, or entity shall have a duty to exercise reasonable care.[18] Nurses have the duty to "exercise care consistent with the prevailing professional standard of care for a nurse."[19]

Punitive Damages

Current law provides for recovery of punitive damages by a claimant. Punitive damages "are not compensation for injury. Instead, they are private fines levied by civil juries to punish reprehensible conduct and to deter its future occurrence."[20] Punitive damages are generally limited to three times the amount of compensatory damages or $1 million, whichever is greater.[21] Damages can exceed $1 million if the jury finds that the wrongful conduct was motivated primarily by unreasonable financial gain and determines that the unreasonably dangerous nature of the conduct, together with the high likelihood of injury resulting from the conduct, was actually known by the managing agent, director, officer, or other person responsible for making policy decisions on behalf of the defendant.[22] If the jury finds that the defendant had a specific intent to harm the claimant and determines that the defendant's conduct did in fact harm the claimant, there is be no cap on punitive damages.[23]

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[16] *United States v. Stevens*, 994 So.2d 1062, 1066 (Fla. 2008).
[17] *See* s. 400.023(1), F.S.
[18] "Reasonable care" is defined as "that degree of care which a reasonably careful licensee, person, or entity would use under like circumstances." s. 400.023(3), F.S.
[19] "The prevailing professional standard of care for a nurse shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar nurses." s. 400.023(4), F.S.
[20] *Gertz v. Robert Welch, Inc.*, 418 U.S. 323, 350 (1974).
[21] *See* s. 400.0238(1)(a), F.S.
[22] *See* s. 400.0238(1)(b), F.S.
[23] *See* s. 400.0238(1)(c), F.S.

Evidentiary Requirements to Bring a Punitive Damages Claims

Section 400.0237(1), F.S., provides:

> In any action for damages brought under this part, no claim for punitive damages shall be permitted unless there is a reasonable showing by evidence in the record or proffered by the claimant which would provide a reasonable basis for recovery of such damages. The claimant may move to amend her or his complaint to assert a claim for punitive damages as allowed by the rules of civil procedure. The rules of civil procedure shall be liberally construed so as to allow the claimant discovery of evidence which appears reasonably calculated to lead to admissible evidence on the issue of punitive damages. No discovery of financial worth shall proceed until after the pleading concerning punitive damages is permitted.

A court discussed how a claimant can make a proffer to assert a punitive damage claim:

> [A] a 'proffer' according to traditional notions of the term, connotes merely an 'offer' of evidence and neither the term standing alone nor the statute itself calls for an adjudication of the underlying veracity of that which is submitted, much less for countervailing evidentiary submissions. Therefore, a proffer is merely a representation of what evidence the defendant proposes to present and is not actual evidence. A reasonable showing by evidence in the record would typically include depositions, interrogatories, and requests for admissions that have been filed with the court. Hence, an evidentiary hearing where witnesses testify and evidence is offered and scrutinized under the pertinent evidentiary rules, as in a trial, is neither contemplated nor mandated by the statute in order to determine whether a reasonable basis has been established to plead punitive damages.[24],[25]

Punitive damages claims are often raised after the initial complaint has been filed. Once a claimant has discovered enough evidence that the claimant believes justifies a punitive damage claim, the claimant files a motion to amend the complaint to add a punitive damage action. The trial judge considers the evidence presented and proffered by the claimant to determine whether the claim should proceed.

Individual Liability for Punitive Damages

Section 400.0237(2), F.S., provides:

> A defendant may be held liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds that the defendant was personally guilty of intentional misconduct[26] or gross negligence.[27]

[24] *Estate of Despain v. Avante Group, Inc.*, 900 So.2d 637, 642 (Fla. 5th DCA 2005)(internal citations omitted).
[25] The *Despain* court was discussing a prior version of the punitive damages statute relating to nursing home litigation but the language in that statute is the same in that statute and current law.
[26] "Intentional misconduct" is actual knowledge of the wrongfulness of the conduct and the high probability that injury or damage to the claimant will result and, despite that knowledge, intentionally pursuing a course of conduct that results in injury or damage. *See* s. 400.0237(2)(a), F.S.

Vicarious Liability for Punitive Damages

Punitive damages claims are sometimes brought under a theory of vicarious liability where an employer is held responsible for the acts of an employee. Section 400.0273(3), F.S., provides:

> In the case of an employer, principal, corporation, or other legal entity, punitive damages may be imposed for the conduct of an employee or agent only if the conduct of the employee or agent meets the criteria specified in subsection (2)[28] and:
> (a) The employer, principal, corporation, or other legal entity actively and knowingly participated in such conduct;
> (b) The officers, directors, or managers of the employer, principal, corporation, or other legal entity condoned, ratified, or consented to such conduct; or
> (c) The employer, principal, corporation, or other legal entity engaged in conduct that constituted gross negligence and that contributed to the loss, damages, or injury suffered by the claimant.

Attorney Fees in Punitive Damages Actions

Current law provides that to the extent a claimant's attorney's fees are based on punitive damages, the attorney fees are calculated based on the final judgment for punitive damages.[29],[30] The amount of punitive damages awarded is divided equally between the Quality of Long-Term Care Facility Improvement Trust Fund[31] and the claimant.[32] The statute also provides for a split of any settlement by the parties that is reached after the verdict.[33]

Current law does require that any portion of a punitive damages settlement that is reached before a verdict to be divided with the Quality of Long-Term Care Facility Improvement Trust Fund. According to the AHCA, no money has been collected for the Fund pursuant to s. 400.0238, F.S.

Nursing Home Surveys

Section 400.23, F.S., requires the AHCA to promulgate and enforce rules relating to the safety and care of nursing home residents. The AHCA is required to evaluate all facilities at least every 15 months.[34] The AHCA is specifically required to adopt rules relating to minimum staffing requirements.[35] Such requirements include a minimum weekly average of certified nursing assistants and licensed nursing staff, a minimum daily staffing of certified nursing assistants, specified staffing ratios, and specific amounts of care per resident per day.[36]

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[27] "Gross negligence" is conduct that is reckless or wanting in care such that it constitutes a conscious disregard or indifference to the life, safety, or rights of persons exposed to such conduct. *See* s. 400.0237(2)(b), F.S.
[28] Criteria are whether the defendant was personally guilty of intentional misconduct or gross negligence.
[29] Section 400.0238(2), F.S.
[30] A final judgment is an order entered by the trial judge after a jury verdict or a trial before the judge.
[31] Section 400.0239(1), F.S., creates the "Quality of Long-Term Care Facility Improvement Trust Fund." The Fund supports activities and programs directly related to improvement of the care of nursing home and assisted living facility residents.
[32] Section 400.0238(4), F.S.
[33] Section 400.0238(4)(b), F.S.
[34] Section 400.23(7), F.S.
[35] Section 400.23(3), F.S.
[36] Section 400.23(3), F.S.

When the AHCA does a survey to determine whether a nursing home is violating statutes or rules, it is required to classify the deficiencies according to the nature and scope of the deficiency.[37] The classifications are as follows:

- A class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility.
- A class II deficiency is a deficiency that the agency determines has compromised the resident's ability to maintain or reach his or her highest practicable physical, mental, and psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
- A class III deficiency is a deficiency that the agency determines will result in no more than minimal physical, mental, or psychosocial discomfort to a resident or has the potential to compromise a resident's ability to maintain or reach his or her highest practical physical, mental, or psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services.
- A class IV deficiency is a deficiency that the agency determines has the potential for causing no more than a minor negative impact on the resident. If the class IV deficiency is isolated, no plan of correction is required.[38]

The AHCA can cite violators and impose penalties including fines or revocation of licenses for violations. Evidence of understaffing is sometimes used to show negligence and show an entitlement to punitive damages.[39]

III. Effect of Proposed Changes:

Section 1 amends s. 400.023, F.S., as follows:

Named Defendants and Causes of Action in Nursing Home Cases

The bill provides that any resident who alleges negligence or a violation of rights has a cause of action against the "licensee or its management company, as specifically identified in the application for nursing home licensure" and its direct caregiver employees.

Current law in ss. 400.023 - 400.0238, F.S., provides the exclusive remedy for a cause of action for personal injury or death of a nursing home resident or a violation of the resident's rights statute. Current law further provides that s. 400.023, F.S., "does not preclude theories of recovery not arising out of negligence or s. 400.022, F.S., which are available to the resident or

[37] Section 400.023(8), F.S.
[38] Section 400.023(8), F.S.
[39] *See e.g. Estate of Despain v. Avante Group, Inc.*, 900 So.2d 637, 645 (Fla. 5th DCA 2005) ("As to the vicarious liability of the corporate entities, the record evidence and proffer shows that the facility was not adequately staffed, which contributed to the inability to provide the decedent with proper care, and that numerous records regarding the decedent's care were incomplete, missing, or had been fabricated, which made assessment, treatment, and referrals of the decedent much more difficult. We believe that this showing established a reasonable basis to conclude that the corporate entities were negligent." Accordingly, Despain established a reasonable basis to plead a claim for punitive damages based on the theory of vicarious liability).

to the agency." The bill removes that provision. The bill provides that ss. 400.023 - 400.0238, F.S., set forth the exclusive remedy in resident rights cases and cases involving the personal injury or wrongful death of resident. Any other claims would have to be brought outside of ss. 400.023 - 400.0238, F.S.

Liability of Employees, Officers, Directors, or Owners

The bill provides that a cause of action cannot be asserted against an "employee, officer, director, owner, including any designated as having a 'controlling interest'[40] on the application for nursing home licensure, or agent of licensee or management company" unless the court determines there is a reasonable basis that:

- The officer, director, owner, or agent breached, failed to perform, or acted outside the scope of duties as an officer, director, owner, or agent; and
- The breach, failure to perform, or conduct outside the scope of duties is a legal cause of the damage.

The court must make this finding at an evidentiary hearing after considering evidence in the record and evidence proffered by the claimant.

"Scope of duties as an officer, director, owner, or agent" is not defined by The bill. The parties would have to present evidence on what the "scope of duties" as an officer, director, owner, or agent are in each case and the trial judge would have to determine whether there is a reasonable basis for the jury to conclude that there was a breach of duty and damage to the claimant.

Limitations on Causes of Action for Violations of Criminal Statutes

The bill provides that if a cause of action is brought by or on behalf of a resident under Part II of ch. 400, F.S., then a cause of action may not be asserted under s. 415.111, F.S., against an employee, officer, director, owner, or agent of the licensee or management company.

Election of Damages

The bill amends s. 400.023(1), F.S., to require the claimant to choose between survival damages under s. 46.021, F.S., or wrongful death damages under s. 768.21, F.S., at the end of discovery but not later than 60 days before trial. As *Trollinger* indicates, current law is unclear. It might allow such an election to be made at the end of trial or might allow the trial court to require an election be made with the complaint.[41] The bill requires that the election be made by a time certain before trial.

[40] Section 400.071, F.S., governs applications for licensure for nursing homes. It references s. 408.803, F.S., where "controlling interest" is defined. "Controlling interest" means: "(a) The applicant or licensee; (b) A person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the applicant or licensee; or (c) A person or entity that serves as an officer of, is on the board of directors of, or has a 5-percent or greater ownership interest in the management company or other entity, related or unrelated, with which the applicant or licensee contracts to manage the provider. The term does not include a voluntary board member." s. 408.803(7), F.S.

[41] The *Trollinger* court did not hold that the election must be made at the pleading stage. It held that certiorari review, a high standard, was not available. There is no subsequent appellate court decision resolving the issue left open in *Trollinger*.

Cap on Noneconomic Damages

The bill provides a cap of $250,000 on noneconomic damages in any claim for wrongful death brought under s. 400.023, F.S., regardless of the number of claimants or defendants. The bill does not cap noneconomic damages in negligence cases that do not involve a wrongful death brought under s. 400.023, F.S.

Attorney Fees in Actions for Injunctive Relief

The bill provides that a resident "may" recover attorney fees and costs if the resident prevails.

Elements in a Civil Actions Under s. 400.023, F.S.

The bill provides that in any claim brought pursuant to this part alleging a violation of resident's rights or negligence causing injury to or the death of a resident, the claimant shall have the burden of proving, by a preponderance of the evidence, that:

- The defendant breached the applicable standard of care; and
- The breach is a legal cause of actual loss, injury, death, or damage to the resident. (emphasis added).

The bill provides that a claimant bringing a claim pursuant to ch. 400, F.S., must show the defendant breached the applicable standard of care and that the breach is the legal cause of actual loss, injury, death, or damage. The "actual" loss addition to the statute is from Florida Supreme Court case law.

Section 2 amends s. 400.0237, F.S., as follows:

Evidentiary Requirements to Bring a Punitive Damages Claims

The bill provides that a claimant may not bring a claim for punitive damages unless there is a showing of admissible evidence proffered by the parties that provides a reasonable basis for recovery of punitive damages. The bill requires the trial judge to conduct an evidentiary hearing where both sides present evidence. The trial judge must find there is reasonable basis to believe the claimant will be able to demonstrate, by clear and convincing evidence, that the recovery of punitive damages is warranted. The effect of these requirements is: (1) to limit the trial judge's consideration to admissible evidence. Current law does not require a showing of admissibility at this stage of the proceedings; and (2) to provide that the claimant and defendant may present evidence and have the trial judge weigh the evidence to make its determination. Current law contemplates that the claimant will proffer evidence and the court, considering the proffer in the light most favorable to the claimant, will determine whether there is a reasonable basis to allow the claimant's punitive damages case to proceed.[42]

Current law provides that the rules of civil procedure are to be liberally construed to allow the claimant discovery of admissible evidence on the issue of punitive damages. The bill removes that provision from statute. Discovery in civil cases is governed by the Florida Rules of Civil

[42] *See Estate of Despain v.Avante Group, Inc.*, 900 So.2d 637, 644 (Fla. 5th DCA 2005).

Procedure. Since the rules govern discovery, it is not clear what effect, if any, removing this provision from statute would have on current practice.

Individual Liability for Punitive Damages

The bill provides that a defendant, including the licensee or management company against whom punitive damages is sought, may be held liable for punitive damages only if the trier of fact, based on clear and convincing evidence, finds that "a specific individual or corporate defendant actively and knowingly participated in intentional misconduct or engaged in conduct that constituted gross negligence and contributed to the loss, damages, or injury" suffered by the claimant.

The current standard jury instructions provide for punitive damages if the defendant was "personally guilty of intentional misconduct."[43] The bill requires that the defendant "actively and knowingly participated in intentional misconduct."

Vicarious Liability for Punitive Damages

The bill provides that in the case of vicarious liability of an employer, principal, corporation, or other legal entity, punitive damages may not be imposed for the conduct of an employee or agent unless:

- A specifically identified employee or agent actively and knowingly participated in intentional misconduct or engaged in conduct that constituted gross negligence and contributed to the loss, damages, or injury suffered by the claimant; and
- An officer, director, or manager of the actual employer, corporation, or legal entity condoned, ratified, or consented to the specific conduct alleged.

Use of Survey Reports in Punitive Damages Actions

The bill provides that state or federal survey reports may not be used to establish an entitlement to punitive damages.

Section 3 amends s. 400.0238, F.S., as follows:

Attorney Fees in Punitive Damages Actions

The bill changes how attorney fees are calculated in punitive damages actions. It requires that attorney fees be calculated based on the claimant's share of punitive damages rather than the final judgment for punitive damages. The bill provides that if a claimant receives a final judgment for punitive damages or settles a case in which the claimant was granted leave to amend the complaint to add a punitive damages claim, the punitive award is divided equally between the claimant and the Quality of Long-Term Care Facility Improvement Trust Fund. The award is divided before any distribution to the claimant or claimant's counsel.

[43] Standard Jury Instructions in Civil Cases, 503.1, Punitive Damages - Bifurcated Procedure.

The bill further provides that if the parties enter into a settlement agreement at any point after the claimant is allowed to amend the agreement to add a count for punitive damages, 50 percent of the total settlement amount is considered to be the punitive award. The bill provides that the punitive award is divided equally between the claimant and the Quality of Long-Term Care Facility Improvement Trust Fund before any distribution for attorney fees and costs. The bill prohibits the parties from altering the allocation by agreement.

The bill provides that settlement of a claim after the claimant has been allowed to amend the complaint to add a punitive damages count is not an admission of liability and is not governed by s. 400.0238, F.S.

Section 4 amends s. 400.23, F.S., as follows:

Evidence of Relating to Compliance with Staffing Requirements

The bill provides that if the licensee demonstrates compliance with the minimum staffing requirements, the licensee is entitled to a presumption that appropriate staffing was provided and the claimant is not permitted to present any testimony or other evidence of understaffing. The testimony or other evidence is only permissible for days which it can be demonstrated that the licensee was not in compliance with the minimum staffing requirements.

The bill further provides that evidence that the licensee was staffed by an insufficient number of nursing assistants or licensed nurses may not be qualified or admitted on behalf of a resident who makes a claim, unless the licensee received a class I, class II, or uncorrected class III deficiency from AHCA for failure to comply with the minimum staffing requirements and the claimant resident was identified by AHCA as having suffered actual harm because of that failure.

Deficiencies Found in Nursing Home Surveys

The bill provides that a deficiency identified by the agency in a nursing home survey is generally not admissible in nursing home negligence litigation. However, the bill also provides two exceptions and allows the introduction of a survey if:

- The survey cites the resident on whose behalf the action is brought and AHCA determines the resident sustained actual harm as a result of the deficiency, or
- After an evidentiary hearing to determine its relevance, if the deficiency is found to have caused actual harm to residents and was widespread or if the deficiency is determined by the AHCA to be an uncorrected pattern of activity related to the injury sustained by the claimant.

The bill also provides that a survey may be admitted by the defendant if a claimant was a member of a survey resident roster or otherwise was the subject of any survey by AHCA and AHCA did not allege or determine that any deficiency occurred with respect to that claimant during that survey. The absence of a deficiency may be used by the licensee to refute an allegation of neglect or noncompliance with regulatory standards.

Section 5 provides an effective date for the bill of July 1, 2011.

Other Potential Implications:

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of the bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

D. Other Constitutional Issues:

Section 4 of the bill contains provisions related the admissibility of evidence such as evidence of understaffing and evidence of survey deficiencies. The Florida Supreme Court has held that portions of the Florida Evidence Code are substantive and portions are procedural. To the extent the exclusion of evidence in this bill is procedural, a court could hold that the restriction violates Art. V, s. 2(a) of the Florida Constitution.

Lines 69-71 of the bill provide a cap on noneconomic damages in wrongful death actions brought under section 400.023, F.S. Caps on noneconomic damages are subject to review under Art. I, s. 21 of the Florida Constitution. The constitution provides that the courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay. In *Kluger v. White*, 281 So.2d 1 (Fla. 1973), the Florida Supreme Court held that:

> [w]here a right of access to the courts for redress for a particular injury has been provided…the Legislature is without power to abolish such a right without providing a reasonable alternative to protect the rights of the people of the State to redress for injuries, unless the Legislature can show an overpowering public necessity for the abolishment of such right, and no alternative method of meeting such public necessity can be shown.[44]

The Florida Supreme Court in *Kluger* invalidated a statute that required a minimum of $550 in property damages arising from an automobile accident before a lawsuit could be brought. Based upon the *Kluger* test, the Florida Supreme Court has also invalidated a portion of a tort reform statute that placed a cap on all noneconomic damages because the statute did not provide claimants with a commensurate benefit.[45] Thus, the Legislature

[44] *Kluger v. White*, 281 So2d 1, 4 (Fla. 1973).
[45] *See Smith v. Dept. of Insurance*, 507 So.2d 1080 (Fla. 1987).

cannot restrict damages by either enacting a minimum damage amount or a monetary cap on damages without meeting the *Kluger* test.

The caps on noneconomic damages in medical malpractice cases, found in ss. 766.207 and 766.209, F.S., have been found by the Florida Supreme Court to meet the *Kluger* test and are not violative of the access to courts provision in the Florida Constitution. In *University of Miami v. Echarte,* 618 So.2d 189 (Fla. 1993), the court ruled that the arbitration scheme met both prongs of the *Kluger* test. First, the court held that the arbitration scheme provided claimants with a commensurate benefit for the loss of the right to fully recover noneconomic damages as the claimant has the opportunity to receive prompt recovery without the risk and uncertainty of litigation or having to prove fault in a civil trial. Additionally, the claimant benefits from: reduced costs of attorney and expert witness fees which would be required to prove liability; joint and several liability of multiple defendants; prompt payment of damages after determination by the arbitration panel; interest penalties against the defendant for failure to promptly pay the arbitration award; and limited appellate review of the arbitration award.

Second, the court in *Echarte* ruled that, even if the medical malpractice arbitration statutes did not provide a commensurate benefit, the statutes satisfied the second prong of *Kluger* which requires a legislative finding that an overpowering public necessity exists, and further that no alternative method of meeting such public necessity can be shown. The court found that the Legislature's factual and policy findings of a medical malpractice crisis constituted an overpowering public necessity. The court also ruled that the record supported the conclusion that no alternative or less onerous method existed for meeting the public necessity of ending the medical malpractice crisis. The court explained, "…it is clear that both the arbitration statute, with its conditional limits on recovery of noneconomic damages, and the strengthened regulation of the medical profession are necessary to meet the medical malpractice insurance crisis."[46]

The bill limits the recovery of noneconomic damages. If the cap is challenged, the court would scrutinize this limitation based on the rulings in *Kluger* and its progeny. Accordingly, the court would have to determine whether this bill provided a claimant with a reasonable alternative to the right to recover full noneconomic damages. If not, the courts would look to see whether this bill was a response to an overpowering public necessity and that no alternative method of meeting such public necessity could have been shown.

Article I, s. 22 of the Florida Constitution provides for right to a trial by jury. The bill contains provisions that limit the admissibility of certain evidence unless AHCA has made certain findings. Specifically, lines 292 and 293 provide that evidence of understaffing cannot be admitted unless AHCA makes a finding that the claimant suffered harm due to a deficiency and lines 321 and 322 provide that certain evidence cannot be admitted unless AHCA finds that the claimant suffered actual harm. In *National Airlines, Inc. v. Florida Equipment Co. of Miami,* 71 So.2d 741, 744 (Fla. 1954), the Florida Supreme Court warned that it is "peculiarly within the province of the

[46] *University of Miami v. Echarte,* 618 So.2d 189, 195-197 (Fla. 1993).

jury" to draw inferences from facts and determine the ultimate facts. It could be argued that these provisions make AHCA, rather than the jury, the ultimate finder of fact if the issue in the case is whether the claimant suffered actual harm.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Due to the greater portion of settlements in punitive damages cases being distributed to the Quality of Long-Term Care Facility Improvement Trust Fund, claimants could see smaller awards in settlements. Attorneys could see lower attorney fees in such punitive damage cases.

C. Government Sector Impact:

The AHCA advises:
The fiscal impact to the Agency will arise out of the use of survey deficiencies to prove adequate staffing issues (see pages 10-11, lines 278-293 of bill) and the use of survey results to prove or rebute negligence (see pages 11-12, lines 316-337). Currently, the Agency already experiences complaints filed to bolster claims. Under this bill, Agency findings are a prerequisite to staffing claims and evidence for or against other negligence. It can be easily anticipated that complaints requiring surveyor time and expense will be filed for litigation purposes. It is also certain that in the case where such deficiencies might be settled by the Agency without formal hearing, litigating parties will require discovery and testimony in the civil actions from Agency surveyors to substantiate the survey findings. Additionally, virtually all presuit investigation will include a public records request. These will result in expense to the Agency. The fiscal impact cannot be determined at this time. If the bill were amended to require that the agency's survey findings must be accepted as written and prohibit the ability to depose agency staff, the impact to the agency would be reduced.[47]

VI. Technical Deficiencies:

None.

VII. Related Issues:

In Section 1 of the bill, lines 41-54 indicate that a cause of action may not be asserted individually against an "employee" unless the "officer, director, owner, or agent breached, failed to perform, or acted outside the scope of duties as an officer, director, owner, or agent," and when such behavior is the legal cause of loss, injury, death, or damage to the resident. This

[47] Agency for Health Care Administration, "2011 Bill Analysis and Economic Impact Statement: SB 1396," on file with Senate Health Regulation Committee staff.

seems to limit causes of action against an employee to situations in which another party has caused the harm.

In Section 3 of the bill, lines 258-262 provide that the settlement of a claim before a verdict is not an admission of liability and "is not governed" by s. 400.0238, F.S. Much of Section 3 of the bill provides for allocation of punitive damages in cases that settle before a verdict. The intent and effect of lines 261-262 are unclear.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

452902

LEGISLATIVE ACTION

Senate . House

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The Committee on Health Regulation (Altman) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 514.0315, Florida Statutes, is created to read:

514.0315 Required safety features for public swimming pools and spas.—

(1) A public swimming pool or spa must be equipped with an anti-entrapment system or device that complies with ASME/ANSI standard A112.19.8, or any successor standard.

(2) A public swimming pool or spa with a single main drain,

452902

other than an unblockable drain, must be equipped with at least one of the following features that complies with any ASME, ANSI, ASTM, or other applicable consumer product safety standard for such system or device:

(a) A safety vacuum release system that ceases operation of the pump, reverses the circulation flow, or otherwise provides a vacuum release at a suction outlet when a blockage is detected and that has been tested by an independent third party and found to conform to ASME/ANSI standard A112.19.17, ASTM standard F2387, or any successor standard.

(b) A suction-limiting vent system with a tamper-resistant atmospheric opening.

(c) A gravity drainage system that uses a collector tank.

(d) An automatic pump shut-off system.

(e) A device or system that disables the drain.

(3) The determination and selection of a feature under subsection (2) for a public swimming pool or spa constructed before January 1, 1993, is at the sole discretion of the owner or operator of the public swimming pool or spa.

Section 2. This act shall take effect July 1, 2011.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to public swimming pools and spas; creating s. 514.0315, F.S.; requiring public swimming pools and spas to be equipped with certain safety

452902

features; providing an effective date.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1480
INTRODUCER:	Senator Evers
SUBJECT:	Public Swimming Pools and Spas
DATE:	April 8, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Stovall	HR	**Pre-meeting**
2.			RI	
3.			CM	
4.			BC	
5.				
6.				

I. Summary:

The bill creates a new section of Florida Statutes relating to required safety features for public swimming pools and spas. The bill requires that a public swimming pool or spa be equipped with an anti-entrapment system or device. If a public pool or spa has one main drain, the bill requires that the owner or operator of the pool choose one of the following:

- A safety vacuum release system;
- A suction-limiting vent system;
- A gravity drainage system;
- An automatic pump system; or
- A device that disables the drain.

This bill creates the following sections of the Florida Statutes: 514.0315.

II. Present Situation:

Virginia Graeme Baker Pool and Spa Safety Act

In 2007, the Virginia Graeme Baker Pool and Spa Safety Act was passed by the U.S. Congress.[1] The act was named for the 7-year-old granddaughter of the former Secretary of State who drowned after being trapped under water by the suction of a hot tub drain. The act created federal requirements for suction entrapment avoidance in pools and spas. Specifically, a pool is required to have a compliant drain cover and one of the following five devices that would prevent entrapment:

[1] 15 U.S.C. s. 8001.

- Safety vacuum release system;
- Suction-limiting vent system;
- Gravity drainage system;
- Automatic pump shut off system;
- Drain disablement; or
- Another system approved by the U.S. Consumer Product Safety Commission (CPSC).[2]

Florida Department of Health Rule and Statutory Authority

Public pools and spas are regulated in Florida by the Department of Health (DOH) pursuant to chapter 514, F.S. The DOH has rulemaking authority to protect the health, safety, and welfare of bathers in public pools and spas.[3] By rule, the DOH has required gravitational drainage systems with collector tanks since 1977 for public pools and since 1993 for public spas.[4] DOH rule requires gravitational drainage systems despite the federal law's allowance for other options. In 2008, the DOH promulgated rules and a timetable to require retrofitting to gravitational drainage systems and collector tanks for pools and spa pools not already fitted with such a system.[5] For spa pools, the following implementation schedule applies:

- Built before 1977, retrofit by July 1, 2010,
- Built between 1977 and 1986, retrofit by July 1, 2011,
- Built between 1986 and 1995, retrofit by July 1, 2012.[6]

It is estimated there are approximately 37,000 pools in Florida and approximately 6,000 still require collector tanks to be installed to bring them into compliance with 64E-9.007(10), F.A.C.[7] DOH has a regulatory mechanism[8] that allows the department to grant a variance from the rule to pool owners who demonstrate that they cannot comply.

Exemptions

Section 514.0115, F.S., provides exemptions from chapter 514 requirements for pools that are associated with hospitals, medical facilities, child caring agencies, private pools for instructional purposes, and condominiums with no more than 32 units. For condominiums with 32 units or fewer, the DOH has authority to regulate water quality. If there are more than 32 units, the DOH inspects the pool annually for water quality and life saving equipment.[9]

[2] 15 U.S.C. s. 8004(c)(1)(A).
[3] Section 514.021, F.S.
[4] Department of Health, *Bill Analysis, Economic Statement and Fiscal Note: SB 1480,* March 21, 2011.
[5] Ch. 64E-9.007, F.A.C., Recirculation and Treatment System Requirements.
[6] *Id.*
[7] Email from the Florida Pool Association to Senate Committee on Health Regulation, April 8, 2011, at 6:29 p.m.
[8] Ch. 64E-9.016, F.A.C.
[9] Section 514.0115 (2) (b), F.S.

Pool Industry Standards

The American Society of Mechanical Engineers (AMSE), the American National Standards Institute (ANSI), and the American Standard for Testing and Materials (ASTM) provide industry standards and establish materials, testing, and marking requirements for suction outlet fittings in swimming pools, wading pools, spas, hot tubs, and other aquatic facilities. Suction outlet fittings include all components including the body, cover, grate, and hardware. Skimmers and vacuum connection covers are excluded from the standards.[10]

III. Effect of Proposed Changes:

Section 1 creates s. 514,0315, F.S., relating to required safety features for public swimming pools and spas. The bill requires all public pools and spas to be fitted with an anti-entrapment device that complies with AMSE, ANSI[11] standard A112.19.8, or ASTM standard F2387.[12] This departs from current DOH rule 64E-9.007(10), F.A.C., which requires that the only anti-entrapment device allowed is a gravity drainage system that uses a collector tank. The bill provides other anti-entrapment options for public pools and spas.

The bill provides that a single-drain pool or spa, other than an unblockable drain, to be equipped with at least one of the following:

- A safety vacuum release system that conforms with ASME/ANSI standard A112.19.17 or American Society for Testing and Materials (ASTM) standard F2387, or any successor standard;
- A suction-limiting vent system with a tamper-resistant atmospheric opening;
- A gravity drainage system that uses a collector tank;
- An automatic pump shut-off system; or
- A device that disables the drain.

The bill provides that the selection of the anti-entrapment device is the sole discretion of the owner or operator of the public pool or spa.

Section 2 provides an effective date for the bill of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

[10] AMSE Standard A112.19.8, vii.
[11] AMSE standards provide guidance to the industry and policy makers, and are to promote understanding in an industry. They are intended to represent the consensus of concerned parties, and are open to public comment. AMSE Standard A112.19.8, vii.
[12] ASTM is a voluntary standards organization that promulgates consensus driven industry benchmarks that are designed to improve product quality, enhance safety, facilitate market access and trade, and build consumer confidence. ASTM Standard F2387.

B. Public Records/Open Meetings Issues:

The provisions of the bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The DOH advises the following:

> Apart from statutory exemptions, all public swimming pools and spas are required to comply with the Federal law, so facilities should have already installed anti-entrapment systems or devices. These facilities should have already incurred the cost to comply. However, some public pools and spas are exempted from regulation under Florida law and might not have been retrofitted. Currently, there are 1,561 exempt pools with 32 or fewer units that are not inspected and do not require a permit. However, the statutory exemption allows for a complaint investigation for water quality. There are 1,009 exempt facilities over 32 units. These facilities are inspected once a year for water quality and life-saving equipment only. If Florida begins enforcing a state law that mimics the Federal law in total, facilities that are not in compliance will incur costs to comply or face state enforcement.

C. Government Sector Impact:

The DOH advises the following:

> There will be staff resources spent notifying the impacted facility owners, design engineers, and contractors of the statutory change and rule revisions. If the installation of anti-entrapment systems or devices is required at currently exempted facilities, there will be staff resources needed to notify these facilities of the statutory change and to perform follow-through with compliance enforcement. For those currently exempted facilities, DOH engineering offices would need to verify proper installation and testing required of those systems or devices not currently allowed to ensure compliance. Enforcement at all public swimming pools and spas would be performed by DOH. Current appropriations and existing staff will be utilized to provide the notification to facilities of statutory change and to enforce compliance.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

231150

LEGISLATIVE ACTION

Senate . House

. . . . .

The Committee on Health Regulation (Sobel) recommended the following:

Senate Amendment (with title amendment)

Delete line 25
and insert:
(MDPV).

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:
Delete lines 4 - 18
and insert:
possession of methylenedioxypyrovalerone (MDPV).

231150

WHEREAS, methylenedioxypyrovalerone (MDPV) is a psychoactive drug with stimulant properties and has no history of FDA-approved medical use, and

WHEREAS, MDPV acts as a stimulant and has been reported to have amphetamine-like or cocaine-type effects, which include physical rapid heartbeat, vasoconstriction, sweating, euphoria, anxiety, agitation, perception of a diminished requirement for food and sleep, and increases in alertness, awareness, wakefulness, arousal, and blood pressure and

WHEREAS, Florida's Attorney General has issued an emergency order banning the sale of substances containing MDPV in the state for a limited period, and

WHEREAS, federal action is needed to control MDPV and keep

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SM 1762
INTRODUCER:	Senator Smith
SUBJECT:	Memorial to ban MDPV
DATE:	April 8, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Fernandez	Stovall	HR	**Pre-meeting**
2.				
3.				
4.				
5.				
6.				

I. Summary:

Senate Memorial 1762 urges the Congress of the United States to ban the sale, distribution, and possession of methylenedioxypyrovalerone (MDPV). The memorial requests for immediate action to be taken to prevent MDPV from entering the state to avoid an imminent hazard to the public safety.

Approval of this Senate Memorial will have no fiscal impact on the state or local governments.

This Senate Memorial does not amend, create, or repeal any provisions of the Florida Statutes.

II. Present Situation:

Methylenedioxypyrovalerone (MDPV)

MDPV is a psychoactive drug with stimulant properties and has no history of FDA-approved medical use. MDPV is a central nervous system stimulant that was first seized in Germany in 2007.[1] MDPV has been identified in products called "bath salts" and are known by a variety of street names.[2] Bath salts are abused as recreational drugs typically by injection, smoking, snorting, and, less often, by the use of an atomizer.[3] Both the law enforcement community and

[1] Methylenedioxypyrovalerone (MDPV). Drug Enforcement Administration. March 2011. (http://www.deadiversion.usdoj.gov/drugs_concern/mdpv.pdf), (Last visited on April 8, 2011).

[2] Bath salts are known by a variety of names including but not limited to: "Ivory Wave", "Vanilla Sky", "Pure Ivory", "Whack", "Bolivian Bath", "Sextacy", "Gloom", "Purple Rain", "Hurricane Charlie", "Fly", "Purple Wave", "Charge+", "Ocean Burst", "Crush", and "White Rush".

[3] National Drug Intelligence Center. U.S. Department of Justice. DRUG WATCH: Increasing abuse of bath salts. December 2010. A copy of this document is on file with the Senate Health Regulation Committee.

medical professionals indicate that "bath salts" are becoming increasingly popular due to the perception that they pose a seemingly safer alternative to illegal methods of getting "high" and can easily be obtained.[4]

These "bath salts" are among the latest in a series of currently legal synthetic substances that, when used improperly, offer alternatives to illegal drugs.[5] The acute side effects of MDPV include tachycardia, hypertension, vasoconstriction, and sweating. Higher doses of MDPV have caused intense, prolonged panic attacks in stimulant-intolerant users.[6] The duration of the subjective effects is about 3 to 4 hours and the side effects continuing a total of 6 to 8 hours after administration.[7] In most extreme cases, powdered "bath salt" products have been linked to self-mutilation and drug induced deaths to include an increased risk of suicide.[8]

Suspected as being produced as legal substitutes for ecstasy, cocaine, and amphetamines, "bath salts" are powerful stimulant drugs that are suspected to have been designed to avoid legal prosecution. [9] These products are readily available at convenience stores, discount tobacco outlets, gas stations, pawnshops, tattoo parlors, and truck stops, among other locations.[10] While it is unclear as to the population of MDPV users, there have been reports that MDPV being used predominantly by the youth population.[11]

Florida Law

There are currently no Florida Statutes that regulate the sale, purchase, possession, or manufacture of "bath salts". However, current law authorizes the Attorney General, by means of an emergency rule,[12] to schedule a substance on a temporary basis if it is found that scheduling the substance is necessary to avoid an imminent hazard to the public safety.[13]

On January 26, 2011, Attorney General Pam Bondi issued an emergency rule to add "bath salts" to Schedule I of Florida's controlled substance schedule.[14] Attorney General Bondi stated that, "due to the violent nature of the side effects involved in taking these drugs, the emergency rule will provide law enforcement with the tools necessary to take this dangerous substance off the shelves and protect the abusers from themselves as well as others. These are dangerous drugs

[4] Florida Fusion Center Brief: "Bath Salts" Receive Emergency Drug Scheduling, The Florida Department of Law Enforcement (January 26, 2011). A copy of this document is on file with the Senate Health Regulation Committee.
[5] *Id.*
[6] *Supra* note 1.
[7] *Id.*
[8] *Supra* note 4.
[9] *Id.*
[10] *Supra* note 3.
[11] *Supra* note 1.
[12] *See* s. 120.54, F.S.
[13] *See* s. 893.035(7), F.S.
[14] Office of the Attorney General of Florida Pam Bondi, News Release: *Attorney General Bondi Files Emergency Rule Banning the Dangerous Synthetic Drug Marketed as "Bath Salts".* January 26, 2011. Available at: http://www.myfloridalegal.com/newsrel.nsf/newsreleases/81CC463863D88DC4852578240077FD45, (Last visited on April 8, 2011).

that should not be confused with any type of common bath product."[15] If the Legislature fails to take legislative action, the emergency rule scheduling "bath salts" will expire on June 30, 2011.[16] While MDPV is not scheduled under the Federal Controlled Substances Act, many states,[17] counties, cities and local municipalities have taken action to ban the drug.[18]

III. Effect of Proposed Changes:

Senate Memorial 1762 urges the Congress of the United States to ban the sale, distribution, and possession of methylenedioxypyrovalerone (MDPV). The memorial requests for immediate action to be taken to prevent MDPV from entering the state to avoid an imminent hazard to the public safety.

Copies of the memorial are to be dispatched to the President of the United States, the President of the United States Senate, the Speaker of the United States House of Representatives, and each member of the Florida delegation to the United States Congress.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this CS have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this CS have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this CS have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

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[15] *Id.*
[16] *See* s. 893.035(9), F.S. SB 1866 (2011) and HB 1039 (2011) contain provisions to schedule MDPV as a Schedule I controlled substance in Florida.
[17] Hawaii, Michigan, Louisiana, Kentucky, and North Dakota have all introduced legislation to ban MDPV.
[18] Nora D. Volkow, M.S., National Institute of Drug Abuse, Message from the Director on "Bath Salts". Available at: http://www.nida.nih.gov/about/welcome/MessageBathSalts211.html, (Last visited on April 7, 2011).

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

The memorial uses an incorrect acronym for the substance on lines 4, 16, 18, and 25. The correct acronym is MDPV.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1778
INTRODUCER:	Senator Bogdanoff
SUBJECT:	Clove Cigarettes
DATE:	April 8, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Stovall	HR	**Pre-meeting**
2.				
3.				
4.				
5.				
6.				

I. Summary:

The bill repeals the statutory prohibition against the sale, use, possession, transfer, or otherwise disposing of clove cigarettes or similar products.

This bill repeals the following sections of the Florida Statutes: 859.058.

II. Present Situation:

Clove Cigarette Ban

Clove cigarettes, also called kreteks, generally contain 60 percent to 80 percent tobacco and 40 percent to 20 percent ground clove.[1]

Clove cigarettes are statutorily banned in Florida under s. 859.058, F.S., which states that "No person shall sell, use, possess, give away, or otherwise dispose of cigarettes or similar products designed or intended for smoking, made in whole or in part from, or containing, cloves, clove oil, or eugenol,[2] or any derivative thereof."

The provisions of s. 859.058, F.S., were adopted in 1985 as an amendment to HB 1365, which also enacted a tax on smokeless tobacco products and loose smoking tobacco.[3] This bill repeals only the statutory ban on clove cigarettes.

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[1] *See* http://www.nlm.nih.gov/medlineplus/druginfo/natural/251.html (last visited April 8, 2011)
[2] *Id.* Eugenol, one of the chemicals in clove, acts like menthol to reduce the harshness of tobacco smoke.
[3] *See* ch. 85-141, L.O.F.

On August 10, 2003, the St. Petersburg Times published an article on the prohibition of clove cigarettes.[4] The article contained a history of the statutory ban, including the issuance of an injunction prohibiting the Division of Alcoholic Beverages and Tobacco within what is now the Department of Business and Professional Regulation from enforcing the statute. This injunction was reportedly issued weeks after the law was passed in 1985.[5] The judge issuing the injunction was concerned because the law did not specify if the infraction was a civil or criminal violation or the level of such a violation but rather was silent as to how violators should be punished.[6]

Despite the injunction prohibiting the enforcement of the clove cigarette ban, the statute was never amended or repealed.

The Florida Department of Law Enforcement (FDLE) reports, as of February 15, 2011, no arrests have been entered in the FDLE Computerized Criminal History database for a violation of s. 859.058, F.S. For an arrest to be entered into the database, a person would have to be arrested and fingerprinted on a criminal charge. Similarly, the FDLE reports no convictions under this statute.

III. Effect of Proposed Changes:

Section 1 repeals the clove cigarette ban, removing the provision from Florida Statutes. The bill will align the statutes with state practice and with the judicial injunction prohibiting the enforcement of the ban.

Section 2 provides an effective date for the bill of July 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of the bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

[4] http://www.sptimes.com/2003/08/10/Pasco/History_clouds_case_o.shtml (last visited April 8, 2011)
[5] *Id*.
[6] *Id*.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 2168
INTRODUCER:	Health Regulation Committee
SUBJECT:	Ratification of Rules
DATE:	April 6, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Stovall	Stovall	HR	**Pre-meeting**
2.				
3.				
4.				
5.				
6.				

I. Summary:

The bill ratifies two rules relating to the maximum number of prescriptions for certain controlled substances that may be written in a registered pain management clinic during any 24-hour period. These two rules were filed for adoption by the Department of Health, Board of Medicine and Board of Osteopathic Medicine.

This bill does not amend, create, or repeal any section of the Florida Statutes.

II. Present Situation:

Current Law

Chapter 2010-279, Laws of Florida (L.O.F.), became effective on November 17, 2010,[1] when the Legislature over-rode the Governor's Veto of CS/CS/HB 1565, which was passed during the 2010 Regular Session. This law requires a proposed administrative rule that has an adverse impact or regulatory costs that exceed certain thresholds to be submitted to the Legislature for ratification before the rule can take effect. The Legislature provided for a statement of estimated regulatory costs (SERC) as the tool to assess a proposed rule's impact.

[1] House Joint Resolution 9-A passed during the 2010A Special Session on November 16, 2010.

An agency proposing a rule is required to prepare a SERC of the proposed rule if the proposed rule:[2]

- Will have an adverse impact on small business; or

- Is likely to directly or indirectly increase regulatory costs in excess of $200,000 in the aggregate in this state within 1 year after the implementation of the rule.

A SERC is required to include:[3]

- An economic analysis showing whether the rule directly or indirectly:
  - Is likely to have an adverse impact on economic growth, private sector job creation or employment, or private sector investment in excess of $1 million in the aggregate within 5 years after the implementation of the rule;

  - Is likely to have an adverse impact on business competitiveness, including the ability of persons doing business in the state to compete with persons doing business in other states or domestic markets, productivity, or innovation in excess of $1 million in the aggregate within 5 years after the implementation of the rule; or

  - Is likely to increase regulatory costs, including any transactional costs, in excess of $1 million in the aggregate within 5 years after the implementation of the rule.

If the adverse impact or regulatory costs of the rule exceed any of these criteria, then the rule may not take effect until it is ratified by the Legislature;

- A good faith estimate of the number of individuals and entities likely to be required to comply with the rule, together with a general description of the types of individuals likely to be affected by the rule;

- A good faith estimate of the cost to the agency, and to any other state and local government entities, of implementing and enforcing the proposed rule, and any anticipated effect on state or local revenues;

- A good faith estimate of the transactional costs likely to be incurred by individuals and entities, including local government entities, required to comply with the requirements of the rule. "Transactional costs" are direct costs that are readily ascertainable based upon standard business practices, and include filing fees, the cost of obtaining a license, the cost of equipment required to be installed or used or procedures required to be employed in complying with the rule, additional operating costs incurred, the cost of monitoring and reporting, and any other costs necessary to comply with the rule;

- An analysis of the impact on small businesses,[4] and an analysis of the impact on small counties and small cities.[5] The impact analysis for small businesses must include the basis for

[2] *See* s. 120.54(3)(b)1., F.S.
[3] *See* s. 120.541(2), F.S.
[4] "Small business" is defined to mean an independently owned and operated business concern that employs 200 or fewer permanent full-time employees and that, together with its affiliates, has a net worth of not more than $5 million or any firm

the agency's decision not to implement alternatives that would reduce adverse impacts on small businesses;

- Any additional information that the agency determines may be useful; and

- A description of any regulatory alternative submitted by a substantially affected person and a statement adopting the alternative or a statement of the reasons for rejecting the alternative in favor of the proposed rule.

Regulation of Pain Management Clinics

The 2010 Legislature enacted CS/CS/SB 2272 and CS/CS/SB 2722[6] to help address the prescription drug abuse epidemic that is fueled by "pill mills." This law created ss. 458.3265 and 459.0137, F.S., to enhance a registration and inspection program for pain management clinics in which allopathic physicians and osteopathic physicians who primarily engage in the treatment of pain by prescribing or dispensing controlled substance medications may practice. These two sections of law are similar for the respective practice acts.

Among other things, this law requires each board to adopt a rule establishing the maximum number of prescriptions for Schedule II or Schedule III controlled substances or the controlled substance Alprazolam, which may be written at any one registered pain-management clinic during any 24-hour period.[7]

The two boards initiated rulemaking by publishing the Notice of Rule Development in the Florida Administrative Weekly on October 29, 2010. After completing the statutory requirements for rulemaking, the rules were filed for adoption with the Department of State on March 25, 2011.

The rules set the maximum number of prescriptions for Schedule II or Schedule III controlled substances or the controlled substance Alprazolam, which may be written at any one registered pain-management clinic during any 24-hour period at no more than an average of three prescriptions per patient per physician working at the pain-management clinic, up to a maximum of 150 prescriptions per physician. If a physician is working less than 8 hours per day in the pain-management clinic, the maximum number that may be written is pro-rated for the number of hours worked. The rule also provides that "do not fill before dated" prescription will not be counted toward the daily limit until the first date the prescription is eligible to be filled.

based in this state which has a Small Business Administration 8(a) certification. As applicable to sole proprietorships, the $5 million net worth requirement shall include both personal and business investments.

[5] "Small county" and "small city" are defined to mean any county that has an un-incarcerated population of 75,000 or less and any municipality that has an un-incarcerated population of 10,000 or less, respectively, according to the most recent decennial census.

[6] Ch. 2010-211, L.O.F.

[7] *See* s. 458.3265(4)(c), F.S., and s. 459.0137(4)(c), F.S.

SERC for Rule 64B8-9.0131

The Center for Economic Forecasting and Analysis (CEFA), part of the Florida State University Institute of Science and Public Affairs, was engaged to estimate the costs for the Department of Health and the pain-management clinics for proposed rules 64B8-9.0134 and 64B15-14.0054, for the Board of Medicine and the Board of Osteopathic Medicine, respectively. For purposes of determining whether the proposed rule requires Legislative ratification, the SERC indicates the proposed rule "is likely to increase regulatory costs, including any transactional costs, in excess of $1 million in the aggregate within 5 years after the implementation of the rule."[8]

Specifically, the SERCs indicate a total estimated statewide cost of $932,000 per year. This cost is arrived at by estimating $20 per clinic per week (for a 50-week year), for one hour of administrative time per week tracking the number of controlled substance prescriptions, including accounting for any "do not fill before" prescriptions, written by each physician practicing in the pain-management clinic. That equals $1,000 per clinic and when multiplied by the 932 clinics (as of December 9, 2010) totals $932,000 per year.

Controlled Substances

Chapter 893, F.S., sets forth the Florida Comprehensive Drug Abuse Prevention and Control Act. This chapter classifies controlled substances into five schedules in order to regulate the manufacture, distribution, preparation, and dispensing of the substances.

- A Schedule I substance has a high potential for abuse and no currently accepted medical use in treatment in the United States and its use under medical supervision does not meet accepted safety standards. Examples: heroin and methaqualone.

- A Schedule II substance has a high potential for abuse, a currently accepted but severely restricted medical use in treatment in the United States, and abuse may lead to severe psychological or physical dependence. Examples: cocaine and morphine.

- A Schedule III substance has a potential for abuse less than the substances contained in Schedules I and II, a currently accepted medical use in treatment in the United States, and abuse may lead to moderate or low physical dependence or high psychological dependence or, in the case of anabolic steroids, may lead to physical damage. Examples: lysergic acid; ketamine; and some anabolic steroids.

- A Schedule IV substance has a low potential for abuse relative to the substances in Schedule III, a currently accepted medical use in treatment in the United States, and abuse may lead to limited physical or psychological dependence relative to the substances in Schedule III. Examples: alprazolam; diazepam; and phenobarbital.

[8] *See* The SERC of Proposed Rules in Regulation of Pain Management Clinics in Florida, BOM 64B8-9.0134, Maximum Number of Prescriptions in Registered PMC, January 18, 2011, page 10, paragraph (a)3 and The SERC of Proposed Rules in Regulation of Pain Management Clinics in Florida, BOOM 64B15-14.0054, Maximum Number of Prescriptions in Registered PMC, January 18, 2011, page 10, paragraph (a)3. A copy of each SERC is on file in the Senate Health Regulation Committee.

- A Schedule V substance has a low potential for abuse relative to the substances in Schedule IV, a currently accepted medical use in treatment in the United States, and abuse may lead to limited physical or psychological dependence relative to the substances in Schedule IV. Examples: low dosage levels of codeine; certain stimulants; and certain narcotic compounds.

A prescription for a controlled substance listed in Schedule II may be dispensed only upon a written prescription of a practitioner, except that in an emergency situation, as defined by department rule, it may be dispensed upon oral prescription but is limited to a 72-hour supply. A prescription for a controlled substance listed in Schedule II may not be refilled.[9] 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.[10]

III. Effect of Proposed Changes:

The bill provides for Legislative ratification of the Board of Medicine's Rule 64B8-9.0134, Maximum Number of Prescriptions in Registered Pain Management Clinics and the Board of Osteopathic Medicine's Rule 64B15-14.0054, Maximum Number of Prescriptions in Registered Pain Management Clinics.

The act shall take effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

[9] s. 893.04(1)(f), F.S.
[10] s. 893.04(2)(e), F.S.

B. Private Sector Impact:

The SERC estimates that an average annual cost per clinic to track the number of prescriptions dispensed is $1,000. This takes into account tracking "do not fill before dated" prescriptions which are counted toward the daily limit on the first date the prescription is eligible to be filled.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

PAM BONDI
ATTORNEY GENERAL
STATE OF FLORIDA

OFFICE OF THE ATTORNEY GENERAL
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March 25, 2011

The Honorable Mike Haridopolos, Senate President
Florida Senate
409, The Capitol
404 South Monroe Street
Tallahassee, Florida 32399

Re: Rule 64B8-9.0134 (Board of Medicine)
Rule 64B15-14.0054 (Board of Osteopathic Medicine)

Honorable Senator Haridopolos:

On behalf of the Florida Boards of Medicine and Osteopathic Medicine (Boards), the above-referenced pain management clinic rules relating to the maximum number of controlled substance prescriptions that may be written at a pain management clinic during a 24-hour period have been submitted today for final adoption with the Department of State. These rules are presented to the Legislature for consideration and ratification during the 2011 legislative session, pursuant to section 120.541(3), Florida Statutes. Because the proposed rules relate to issues of great importance for the protection of the health, safety, and welfare of the citizens of the State of Florida, the Boards have requested that the proposed rules be ratified by both the House and the Senate and have asked that after ratification they be sent to Governor Scott for his signature. Copies of the Statements of Estimated Regulatory Costs (SERCs) and copies of the rule adoption packets are enclosed.

We appreciate your consideration to this matter of great public importance. Should you have any questions, please feel free to contact us at your convenience.

Sincerely,

Edward A. Tellechea
Counsel to the Florida Board of Medicine

Donna C. McNulty
Donna Canzano McNulty
Counsel to the
Florida Board of Osteopathic Medicine

Enclosures

cc: Michael Chizner, M.D., Chair, Florida Board of Medicine
Joel Rose, D.O., Chair, Florida Board of Osteopathic Medicine
Sue Foster, Acting Executive Director, Florida Board of Medicine
Anthony Jusevitch, Executive Director, Florida Board of Osteopathic Medicine
Marjorie Holladay, Senior Attorney, Joint Administrative Procedures Committee

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March 25, 2011

The Honorable Dean Cannon, Speaker of the House
Florida House of Representatives
420, The Capitol
402 South Monroe Street
Tallahassee, Florida 32399

Re: Rule 64B8-9.0134 (Board of Medicine)
Rule 64B15-14.0054 (Board of Osteopathic Medicine)

Honorable Speaker Cannon:

On behalf of the Florida Boards of Medicine and Osteopathic Medicine (Boards), the above-referenced pain management clinic rules relating to the maximum number of controlled substance prescriptions that may be written at a pain management clinic during a 24-hour period have been submitted today for final adoption with the Department of State. These rules are presented to the Legislature for consideration and ratification during the 2011 legislative session, pursuant to section 120.541(3), Florida Statutes. Because the proposed rules relate to issues of great importance for the protection of the health, safety, and welfare of the citizens of the State of Florida, the Boards have requested that the proposed rules be ratified by both the House and the Senate and have asked that after ratification they be sent to Governor Scott for his signature. Copies of the Statements of Estimated Regulatory Costs (SERCs) and copies of the rule adoption packets are enclosed.

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Florida Board of Osteopathic Medicine

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March 25, 2011

Governor's Office of Fiscal Accountability
And Regulatory Reform
400 S. Monroe Street
Tallahassee, Florida 32399-0001

Re: Rule 64B8-9.0134 (Board of Medicine)
Rule 64B15-14.0054 (Board of Osteopathic Medicine)

Dear Sir or Madam,

On behalf of the Florida Boards of Medicine and Osteopathic Medicine (Boards), the above-referenced pain management clinic rules relating to the maximum number of controlled substance prescriptions that may be written at a pain management clinic during a 24-hour period have been submitted today for final adoption with the Department of State. These rules are presented to the Legislature for consideration and ratification during the 2011 legislative session, pursuant to section 120.541(3), Florida Statutes. Because the proposed rules relate to issues of great importance for the protection of the health, safety, and welfare of the citizens of the State of Florida, the Boards have requested that the proposed rules be ratified by both the House and the Senate and have asked that after ratification they be sent to Governor Scott for his signature. Copies of the Statements of Estimated Regulatory Costs (SERCs) and copies of the rule adoption packets are enclosed.

We appreciate your consideration to this matter of great public importance. Should you have any questions, please feel free to contact us at your convenience.

Sincerely,

Edward A. Tellechea
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Donna Canzano McNulty
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Florida Board of Osteopathic Medicine

Enclosures

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Marjorie Holladay, Senior Attorney, Joint Administrative Procedures Committee

Center for Economic Forecasting and Analysis
Florida State University
3200 Commonwealth Blvd. Suite 153
Tallahassee, Florida 32303-2770

A Statement of Estimated Regulatory Cost (SERC) of Proposed Rules in Regulation of Pain Management Clinics in Florida

BOM 64B8-9.0134

Maximum Number of Prescriptions in Registered PMC

Florida Department of Health

January 18, 2011

Center for Economic Forecasting and Analysis
Florida State University
3200 Commonwealth Blvd.
Tallahassee, Fl. 32303

Project Timeline

12/15/2010 to 1/18/2011

Institutional Capacity

The Center for Economic Forecasting and Analysis (CEFA) is part of the Florida State University Institute of Science and Public Affairs (ISPA), which is a multi-disciplinary research institute. CEFA specializes in applying advanced, computer-based economic models and techniques to examine and help resolve pressing public policy issues across a spectrum of research areas. CEFA provides advanced research and training to students in the areas of health care, education, high technology, energy, and environmental economics, economic impact analysis, among others.

Scope and Deliverable

CEFA has estimated the costs for both the agencies and the Pain Management Clinics (PMC) that are required to comply with the following rules:

- BOM Rule: 64B8-9.0131 Standards of Practice for Physicians Practicing in PMC
- BOM Rule: 64B8-9.0132 Requirement for PMC Registration; Inspection or Accreditation
- BOM: 64B8-9.0131(Subparagraph (2)(n): Training Requirements
- BOM/BOOM: 64B8-9.0134/64B15-14.0054 Maximum Number of Prescriptions in Registered PMC.
- BOM/BOOM: 64B8-9.0133/64B15-14.0053 Approval of Nationally Recognized Pain Management Accrediting Organizations
- DOH: 64B-7.001: Pain Management Clinic Registration Requirements
- DOH: 64B-7.003: Counterfeit-Resistant Prescription Blanks

CEFA has estimated for each of the rules:

1. The number of individuals that are likely to be required to comply with the rule and a general description of the types of individuals likely to be affected by the rule.
2. The cost to state and local government entities of implementing and enforcing the proposed rules and their anticipated effect on state and local revenues.
3. The transaction costs likely to be incurred by individuals and government agencies, required to comply with the rules

The Florida Pain Management Clinic Industry Overview

Sections 458.3265, and 459.0137, F.S., created the registration and inspection of pain management clinics with the Department of Health and required the Boards of Medicine and Osteopathic Medicine to promulgate rules for the standards of practice of physicians practicing in pain management clinics and rules to implement certain other pain management clinic provisions. The Allopathic Medical Practice Act, Chapter 458, F.S. (MD) and the Osteopathic Medical Practice Act, Chapter 459, F.S. (DO) are similar and the proposed pain management clinic rules of both of these physician boards are also similar. Pain management clinics may have MD or DO licensed Florida physicians or a combination of both practicing at the clinic at any one time. The Board of Osteopathic Medicine has in effect a standards of practice rule, a training rule and a registration/inspection or accreditation rule which are similar to the proposed Board of Medicine rules being addressed in this SERC.

Below is an overview of the Pain Management Clinics in Florida. The data is from a December 9, 2010 download of the "Application Status" file from the Florida Department of Health. No changes since 12/09/2010 have been considered – therefore if an additional clinic was approved, or a clinic lost its "clear" status after December 9, 2010, they have not been accounted for in this study.
This data includes records for clinics adding locations, adding new physicians and some are in progress and haven't been approved as of December 9, 2010. Others are listed as withdrawn, "admin. revoked", closed, denied or under emergency suspension. The records that were not listed as "clear" were deleted. Then, all multiples for any clinic were deleted to give the final number of clinics with clear status as 932 on the December 9, 2010 date.

Clinic Locations: this table shows the number of registered Pain Management Clinics, ranked from largest to smallest, by county, for the top 10 counties as of 12/09/2010.

County	Clinics
BROWARD	117
HILLSBOROUGH	113
PALM BEACH	108
MIAMI-DADE	89
DUVAL	51
ORANGE	49
PINELLAS	47
PASCO	31
VOLUSIA	30
LEE	29

Density: To estimate the density of Pain Management Clinics by county, the number of clinics was divided by the population, 18 and over, in the county. This yields the following density figures, from highest to lowest for the top 10 counties.

County	Clinics/100k pop.
HILLSBOROUGH	12.52
PALM BEACH	10.68
FRANKLIN	10.63
BROWARD	8.61
PASCO	8.34
DUVAL	7.88
SARASOTA	7.74
VOLUSIA	7.50
NASSAU	7.31
HERNANDO	7.27
PUTNAM	7.15
MANATEE	7.14

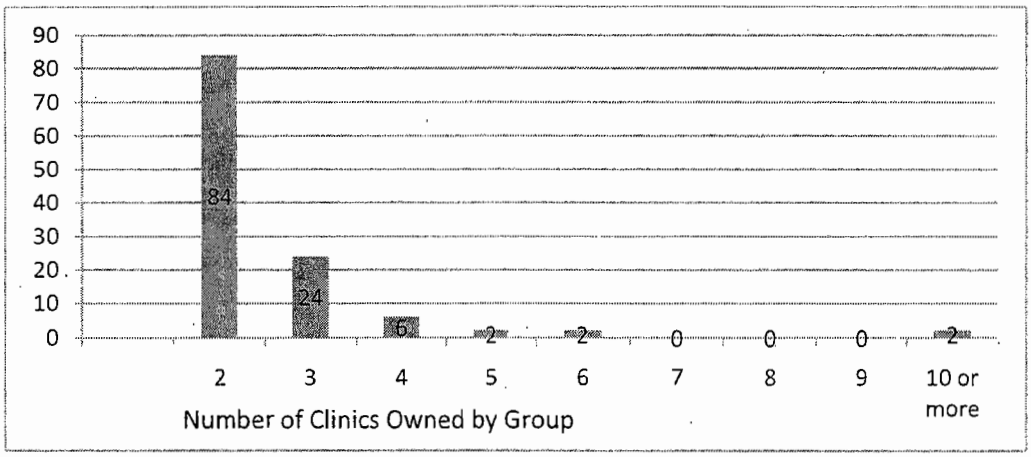
Appendix 1 shows the total for all counties that have at least 1 registered Pain Management Clinic.

Many of the clinics have physicians who are registered to dispense medication on the premises of the clinic. To do this, the physician must register with the Florida Department of Health and pay a $100 fee. The following table shows available data on the number of clinics whose Designated Physician is registered to dispense medication for the top 10 counties in Florida.

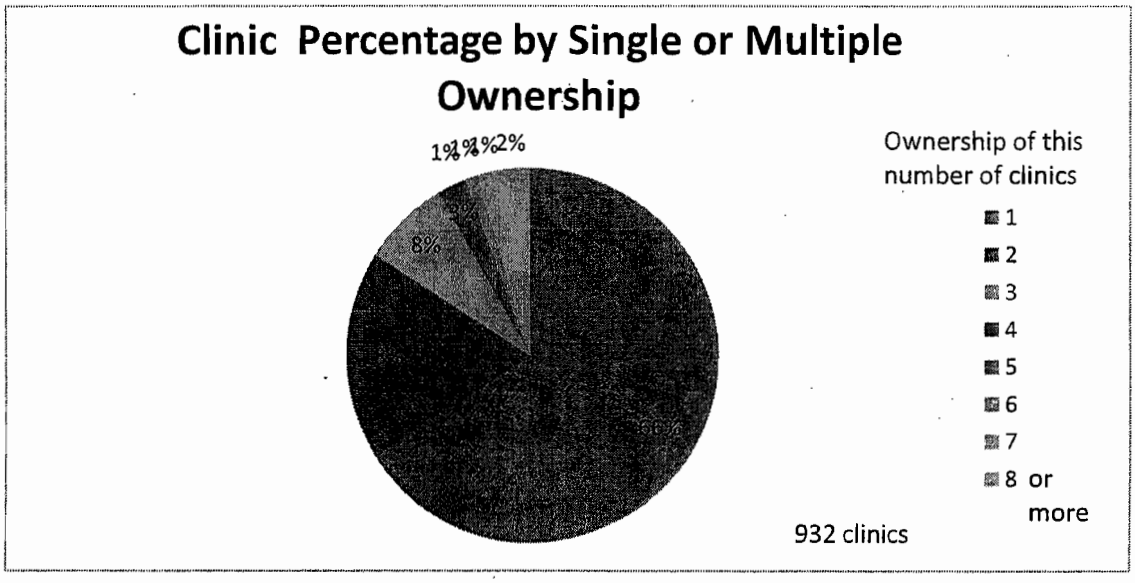
County	Clinics	Dispensing
PALM BEACH	108	77
BROWARD	117	73
MIAMI-DADE	89	50
HILLSBOROUGH	113	45
PINELLAS	47	32
DUVAL	51	31
ORANGE	49	29
PASCO	31	18
SARASOTA	24	18
LEE	29	16

Appendix 1 shows the total for the whole state.

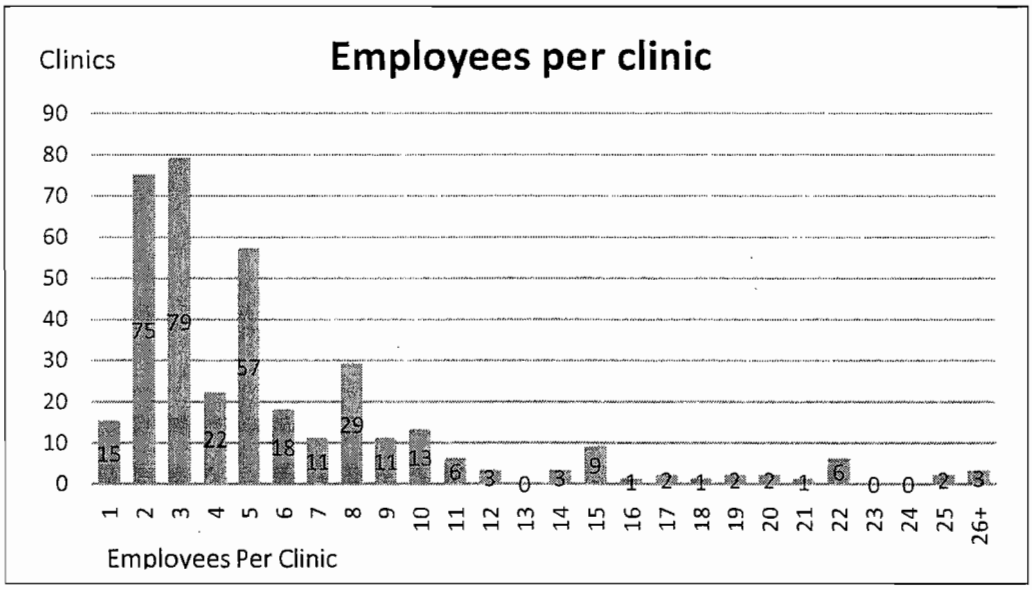
To check for concentration of ownership, the data was analyzed to see how many groups own more than one Pain Management Clinic in Florida. The number of clinics that are owned as an individual clinic is 615 clinics (66%). Of the remaining 317 clinics, the below graph shows that there are 84 groups that own 2 clinics, 24 that own 3 clinics, 6 that own 4 clinics, 2 that own 5 clinics, 2 that own 6 clinics and then one group that owns 10 clinics and one that appears to own 21 clinics. Checking the concentration, the clinics owned by groups that own four or less Pain Management Clinics compose 94.31% of the clinics. These were found by analyzing the data for common listed owners and common mailing addresses and are shown in the graph below.



The graph below shows the same information, by percentage of the total clinics.



To check for concentration in any given county or group of counties, the ownership groups were analyzed to see which counties they operated in. Appendix 2 shows the list of those groups owning three or more pain clinics and the counties that they operate in.
Data from the same database as above, as well as additional data from Dun & Bradstreet's Selectory database was obtained and analyzed. Cross-referencing the DOH data and the current Selectory database, 371 of the 932 clinics were found on the database. Information on the number of employees was recorded and analyzed. The median number of employees was 4 for this sample. The employee number was derived using Selectory data for total sales and sales per employee.



A majority, 248 of the 371 (66.8%) of the clinics found in the Selectory database have 5 employees or less. Those that have 3 or less employees (169 of 371) account for 45.5% of these clinics.

Estimating the Number of Physicians

Establishing an upper and lower bound: Physicians are allowed work at more than one clinic at a time, including working part-time at a Pain Management Clinic and having a separate practice. There is no requirement for all physicians working at a PMC to register with DOH. However, each clinic must register a Designated Physician that is responsible for the clinic.
To establish an upper and lower bound for the "actual number of physicians working" to estimate things like the number of patients seen and the number of prescriptions written, the lower bound will be 932 for physicians, one for each Pain Management Clinic.
Since data is not available, other methods are used to estimate physicians working in Pain Management Clinics. Data was obtained from an advertising website and analyzed. The number of clinics found on one marketing website was 366, showing 574 physicians. That website is Ucomparehealthcare.com.
Their data was analyzed and it showed the doctors per clinic in the below percentages:

Clinics with	Percentage
1 physician	74.90%
2 physicians	13.10%
3 physicians	7.10%
4 physicians	1.40%
5 physicians	1.40%
6 or more	0.02%

Although we cannot identify how similar this sample is to the rest of the population, the analysis of the above data yields 1.57 physicians per clinic. That would lead us to an estimate of 1462 physicians as an upper bound. This data is possibly skewed upward for a couple of reasons. First, it might be more likely that the larger businesses would seek opportunities to advertise. Most importantly, one of the groups in this sample shows 20 physicians working at their clinic. The clinic is, indeed registered as a Pain Management Clinic in Florida, yet having 20 physicians shown working at one clinic likely skews this sample upward.

Using this sample, there are 566 physicians that are known, although one cannot be sure what percentage of time each physician is working at that clinic. If one uses the minimum (one physician at the clinic) for the unknown clinics in addition to this number, one obtains a lower-bound estimate of 1140.

To estimate the actual number of physicians working at pain management clinics in Florida, a normal distribution was set up, with a 90% confidence interval between the lower and upper bounds. This resulted in a distribution with a mean of 1314 physicians and a standard deviation of 106.4.

The estimate that will be used for the number of physicians working full-time at registered Pain Management Clinics in Florida is a normal probability distribution function with a mean of 1314 and a standard deviation of 106.4. This yields an expectation of a 90% probability of the actual physician number being between 1140 and 1462.

Small business and number of PMCs affected: Most of the 932 registered PMCs in Florida will qualify as a small businesses under Florida 288.703.

Methods Used in this Study

Data was requested, purchased and gathered from various sources and then confirmed with physicians and industry professionals. Data that had a significant amount of uncertainty was estimated at upper and lower bounds, and then by statistical means. This study estimates some items and costs by the Monte Carlo method, where probability distributions are developed to use in the analysis. During each of the iterations of the model, values are drawn from the input probability distribution and used in calculating the range of the outputs.

Full-time is defined as 250 work days per year. When used, calculations use 40 hour work weeks and 50-week years.

Summary of Proposed Rule 64B8-9.0134/64B15-14.0054. Maximum Number of Prescriptions in Registered PMC.

This rule outlines the maximum number of prescriptions per physician at a Pain Management Clinic for Schedule II and Schedule III controlled substances and Alprazolam which may be written during a 24-hour period.

A copy of the complete proposed rule is shown below.

Total Estimated Statewide Cost: Estimated Statewide cost of $932,000 per year. On a per clinic basis, estimated $1,000 per clinic per year.

The proposed Rule 64B8-9.0134 is:
The maximum number of prescriptions for Schedule II or Schedule III controlled substances or the controlled substance Alprazolam, which may be written at any one registered pain management clinic during any 24-hour period shall be no more than an average of three prescriptions per patient per physician working at the pain management clinic up to a maximum of 150 prescriptions per physician. In the event that the physician is working less than 8 hours per day in the pain management clinic, the maximum number of prescriptions per physician shall be based upon the following formula: the number of hours worked divided by 8, then multiplied by 150 [(# of hours/8) X 150 = maximum # of prescriptions]. A "do not fill before dated" prescription will not be counted toward the daily limit until the first date the prescription is eligible to be filled.

To analyze the economic impact of this rule, one would need the actual number of prescriptions written by each physician working in a Pain Management Clinic (PMC) and the number of hours they worked. Neither piece of actual data is available.

To derive whether limiting a physician to prescribing 150 prescriptions per day is likely to be a limiting factor, and what the expected costs would be, one can start with an assumed number of patients per day. The average number of patients per week for all Florida physicians is 74[1]. One should note that number includes those physicians working less than fulltime. That number includes physicians that see from 0-25 patients per week up through those that see more than 200 per week.

Given that any physician practicing in a PMC, under statute, is required to do the physical examination of the patient on the same day he or she dispenses or prescribes a controlled substance, it is unlikely that physicians in Pain Management Clinics can comfortably see more than 30-35 patients per day. Given the maximum "no more than an average of three

[1] http://www.doh.state.fl.us/Workforce/Physicians_Workforce_Annual_Rpt_2009.pdf

prescriptions per patient", it is unlikely that most physicians will be affected by the 150 daily maximum.

Looking at "no more than an average of three prescriptions per patient" perhaps yields a different result. Physicians and clinic owners indicate that in some cases, a patient is prescribed a short-acting pain killer, a long-acting pain killer and a muscle relaxer.
Physicians are also allowed to write "do not fill before dated" prescriptions and the rule indicates that those prescriptions will count on the first day the prescriptions are eligible to be filled. Therefore, a physician who writes "do not fill before dated" prescriptions will have to be noted and accounted for on the date they are available to be filled.

It would appear that a PMC physician who is near the limits of an average of 3 controlled substance prescriptions per patient will have to track his or her numbers more closely than physicians at an average PMC. It would be the physicians with high patient count, the ones who use mostly pills and not interventional therapies, and ones that often write "do not fill before" prescriptions that would be in this category.

One possible result of this rule is that physicians will reduce the number of "do not fill before dated" prescriptions. This may occur because the physician or the clinic would not want to undertake tracking the hours each physician worked in the clinic, the number of patients seen, the number of prescriptions and the number of "do not fill before dated" prescriptions. This could also have the effect of requiring patients to visit the clinics more often and pay more in physician visit fees. This possible cost is not included in the study because the numbers vary widely depending on the type of practice, and are likely to affect only a small and unknown number of clinics.

To estimate the costs to an average clinic for this rule, the assumption will be that all clinics spend one additional hour of administrative time per week tracking the number of controlled substance prescriptions, including accounting for any "do not fill before" prescriptions. There are, no doubt, some clinics that will spend less time or more time than that. Some clinics will be nowhere near the limit and will spend little time tracking this and others will be near the limit and be required to spend more time. The following estimate uses one hour per week in additional time for the average clinic, at the previously noted $20 per hour, including benefits.

The calculation of $20 per clinic per week (for a 50-week year), for the 932 Pain Management Clinics in Florida equals: $932,000 per year. On a per-clinic basis, this is $1,000 per clinic per year.

Statement of Estimated Regulatory Costs:

a) **The above economic analysis shows that the proposed rule, directly or indirectly:**

1. Is not likely to have an adverse impact on economic growth, private-sector job creation of employment, or private-sector investment in excess of $1 million in the aggregate within 5 years after the implementation of the rule.
2. Is not likely to have an adverse impact on business competitiveness, including the ability of persons doing business in the state to compete with persons doing business in other states or domestic markets, productivity, or innovation in excess of $1 million in the aggregate within 5 years after the implementation of the rule.
3. Is likely to increase regulatory costs, including any transactional costs, in excess of $1 million in the aggregate within 5 years after the implementation of the rule.

b) **A good faith estimate of the number of individuals and entities likely to be required to comply with the rule, together with a general description of the types of individuals likely to be affected by the rule.**

This proposed rule would affect the estimated 1314 physicians and clinic owners of the estimated 932 Pain Management Clinics.

c) **A good faith estimate of the cost to the agency, and to any other state and local government entities, of implementing and enforcing the proposed rule, and any anticipated effect on state or local revenues.**

The Board has advised that the Department of Health, Division of Medical Quality Assurance, prepared a good faith estimate in its original SERC dated October 27, 2010 as follows:

> There will be no fiscal impact on this agency or other governmental entities.
> Enforcement costs are reimbursed by the Respondent when disciplined.

d) **A good faith estimate of the transactional costs likely to be incurred by individuals and entities, including government entities, required to comply with this rule.**

An estimated $1,000 per Pain Management Clinic per year, for a statewide total of $932,000 per year.

e) **An analysis of the impact on small businesses as defined by s. 288.703, and an analysis of the impact on small counties and small cities as defined in by s. 120.52. The impact analysis for small businesses must include the basis for the agency's decision not to implement alternatives that would reduce adverse impacts on small businesses.**

Most of the estimated 932 Pain Management Clinics are small businesses.
There are no expected costs to small counties or small cities.
In response to this inquiry, the Board has advised that during the course of all of its rule meetings and rule hearings it considered alternatives and suggested rule language by interested persons in arriving at the proposed rule language.

Appendix 1 – Clinic totals, density and dispensing, by county

County	Total Clinics	Clinics/100k population*	Dispensing**	% Dispensing***
ALACHUA	5	2.51	3	60.0%
BAY	4	3.14	2	50.0%
BREVARD	16	3.73	8	50.0%
BROWARD	117	8.61	73	62.4%
CHARLOTTE	7	5.23	4	57.1%
CITRUS	8	6.80	4	50.0%
CLAY	9	6.56	4	44.4%
COLLIER	15	5.91	9	60.0%
COLUMBIA	3	5.60	3	100.0%
DUVAL	51	7.88	31	60.8%
ESCAMBIA	10	4.22	2	20.0%
FLAGLER	3	4.07	2	66.7%
FRANKLIN	1	10.63	0	0.0%
HERNANDO	10	7.27	4	40.0%
HIGHLANDS	2	2.49	1	50.0%
HILLSBOROUGH	113	12.52	45	39.8%
INDIAN RIVER	5	4.58	3	60.0%
JACKSON	1	2.46	1	100.0%
LAKE	11	4.37	9	81.8%
LEE	29	6.21	16	55.2%
LEON	5	2.34	1	20.0%
LEVY	1	3.26	1	100.0%
MANATEE	18	7.14	12	66.7%
MARION	12	4.57	7	58.3%
MARTIN	6	5.27	5	83.3%
MIAMI-DADE	89	4.62	50	56.2%
MONROE	1	1.62	0	0.0%
NASSAU	4	7.31	3	75.0%
OKALOOSA	4	2.92	2	50.0%
OKEECHOBEE	2	6.64	1	50.0%
ORANGE	49	5.98	29	59.2%
OSCEOLA	13	6.60	5	38.5%
PALM BEACH	108	10.68	77	71.3%
PASCO	31	8.34	18	58.1%
PINELLAS	47	6.33	32	68.1%
POLK	13	2.94	5	38.5%
PUTNAM	4	7.15	2	50.0%
SANTA ROSA	8	6.90	4	50.0%
SARASOTA	24	7.74	18	75.0%
SEMINOLE	17	5.36	10	58.8%
ST. JOHNS	9	6.17	3	33.3%
ST. LUCIE	12	5.82	8	66.7%
SUMTER	3	4.48	2	66.7%
VOLUSIA	30	7.50	11	36.7%
WALTON	1	2.28	1	100.0%
WASHINGTON	1	5.34	0	0.0%

* Population over 18, U.S. Census Bureau estimate for 2008

** Dispensing means registered physician that is qualified to dispense

*** Percentage of clinics that have registered physician who is qualified to dispense

Appendix 2 – Groups owning 3 or more PMC, by common owners, partners, and/or billing addresses.

Clinic Name	# of Clinics	Counties of Clinics
Total Medical Express	3	Palm Beach
Physicians Group Services	4	Clay, Duval(2), Nassau
Gulf-to-Bay Anesthesiology	5	Pinellas, Hillsborough(4)
Neurological Testing Centers of America	5	Broward(2), Miami-Dade(2)
Frank R. Collier, Jr. M.D., P.A.	3	Duval(2), Clay
Edwin Colon, M.D., P.A.	3	Pasco
Robert B. Dehgan, M.D., P.A.	3	Putnam, St. Johns, Duval
Southeastern Integrated Medical	5	Levy, Marion, Lake, Alachua, Columbia
Various Names (Dubravetz, owner)	4	Orange, Broward(2), St. Lucie
International Rehab/Comprehensive Pain Medicine/ Anesthesiology Assoc.	21	Miami-Dade(4), Broward(8), Palm Beach(3) Leon, Okaloosa, Escambia, Santa Rosa(2), Martin
Lescobar, P.A.	3	Broward(2), Miami-Dade
Physician Providers Group	3	Marion, Lake, Citrus
Premier Pain Care	3	Broward, Miami-Dade(2)
Institute of Pain Management	3	Duval(2), Clay
Spine Diagnostics Interventional Center	3	Collier(2), Hillsborough
Pain Care Management of....(Clearwater, Melbourne, Orlando)	3	Pinellas, Brevard, Orange
CMG, LLC	3	Martin, Palm Beach(2)
Laudan Partners, Inc.	3	Miami-Dade
West Coast Anesthesiology Associates, Inc.	3	Sarasota, Seminole, Lee
Comprehensive Pain Management Partners	6	Pasco(3), Sarasota, Hillsborough, Pinellas
Hess Spinal & Medical Centers	10	Hillsborough(4), Polk, Pinellas(3), Pasco, Manatee
Center for Quality Pain Care	3	Miami-Dade(2), Broward
Glory Medclinic, LLC	4	Pasco(2), Polk, Hillsborough
Yili Zhou, LLC	3	Marion(2), Columbia
A Pain Clinic of....(Boca Raton, Delray Beach, Ft. Lauderdale, WPB)	4	Broward, Palm Beach(3)
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Vidya P. Kini, M.D., P.L.	3	Lee
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Sunshine Spine and Pain, P.A.	4	Duval
James D. Shortt, M.D., P.A.	4	Duval
Jose A. Torres, M.D., P.A.	3	Orange(2), Osceola
West Florida Pain Management, P.A.	3	Pinellas

As of 9 December, 2010

References:

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Center for Economic Forecasting and Analysis
Florida State University
3200 Commonwealth Blvd. Suite 153
Tallahassee, Florida 32303-2770

A Statement of Estimated Regulatory Cost (SERC) of Proposed Rules in Regulation of Pain Management Clinics in Florida

BOOM 64B15-14.0054

Maximum Number of Prescriptions in Registered PMC

Florida Department of Health

January 18, 2011

Center for Economic Forecasting and Analysis
Florida State University
3200 Commonwealth Blvd.
Tallahassee, Fl. 32303

Project Timeline

12/15/2010 to 1/18/2011

Institutional Capacity

The Center for Economic Forecasting and Analysis (CEFA) is part of the Florida State University Institute of Science and Public Affairs (ISPA), which is a multi-disciplinary research institute. CEFA specializes in applying advanced, computer-based economic models and techniques to examine and help resolve pressing public policy issues across a spectrum of research areas. CEFA provides advanced research and training to students in the areas of health care, education, high technology, energy, and environmental economics, economic impact analysis, among others.

Scope and Deliverable

CEFA has estimated the costs for both the agencies and the Pain Management Clinics (PMC) that are required to comply with the following rules:

- BOM Rule: 64B8-9.0131 Standards of Practice for Physicians Practicing in PMC
- BOM Rule: 64B8-9.0132 Requirement for PMC Registration; Inspection or Accreditation
- BOM: 64B8-9.0131(Subparagraph (2)(n): Training Requirements
- BOM/BOOM: 64B8-9.0134/64B15-14.0054 Maximum Number of Prescriptions in Registered PMC.
- BOM/BOOM: 64B8-9.0133/64B15-14.0053 Approval of Nationally Recognized Pain Management Accrediting Organizations
- DOH: 64B-7.001: Pain Management Clinic Registration Requirements
- DOH: 64B-7.003: Counterfeit-Resistant Prescription Blanks

CEFA has estimated for each of the rules:

1. The number of individuals that are likely to be required to comply with the rule and a general description of the types of individuals likely to be affected by the rule.
2. The cost to state and local government entities of implementing and enforcing the proposed rules and their anticipated effect on state and local revenues.
3. The transaction costs likely to be incurred by individuals and government agencies, required to comply with the rules

The Florida Pain Management Clinic Industry Overview

Sections 458.3265, and 459.0137, F.S., created the registration and inspection of pain management clinics with the Department of Health and required the Boards of Medicine and Osteopathic Medicine to promulgate rules for the standards of practice of physicians practicing in pain management clinics and rules to implement certain other pain management clinic provisions. The Allopathic Medical Practice Act, Chapter 458, F.S. (MD) and the Osteopathic Medical Practice Act, Chapter 459, F.S. (DO) are similar and the proposed pain management clinic rules of both of these physician boards are also similar. Pain management clinics may have MD or DO licensed Florida physicians or a combination of both practicing at the clinic at any one time. The Board of Osteopathic Medicine has in effect a standards of practice rule, a training rule and a registration/inspection or accreditation rule which are similar to the proposed Board of Medicine rules being addressed in this SERC.

Below is an overview of the Pain Management Clinics in Florida. The data is from a December 9, 2010 download of the "Application Status" file from the Florida Department of Health. No changes since 12/09/2010 have been considered – therefore if an additional clinic was approved, or a clinic lost its "clear" status after December 9, 2010, they have not been accounted for in this study.
This data includes records for clinics adding locations, adding new physicians and some are in progress and haven't been approved as of December 9, 2010. Others are listed as withdrawn, "admin. revoked", closed, denied or under emergency suspension. The records that were not listed as "clear" were deleted. Then, all multiples for any clinic were deleted to give the final number of clinics with clear status as 932 on the December 9, 2010 date.

Clinic Locations: this table shows the number of registered Pain Management Clinics, ranked from largest to smallest, by county, for the top 10 counties as of 12/09/2010.

County	Clinics
BROWARD	117
HILLSBOROUGH	113
PALM BEACH	108
MIAMI-DADE	89
DUVAL	51
ORANGE	49
PINELLAS	47
PASCO	31
VOLUSIA	30
LEE	29

Density: To estimate the density of Pain Management Clinics by county, the number of clinics was divided by the population, 18 and over, in the county. This yields the following density figures, from highest to lowest for the top 10 counties.

County	Clinics/100k pop.
HILLSBOROUGH	12.52
PALM BEACH	10.68
FRANKLIN	10.63
BROWARD	8.61
PASCO	8.34
DUVAL	7.88
SARASOTA	7.74
VOLUSIA	7.50
NASSAU	7.31
HERNANDO	7.27
PUTNAM	7.15
MANATEE	7.14

Appendix 1 shows the total for all counties that have at least 1 registered Pain Management Clinic.

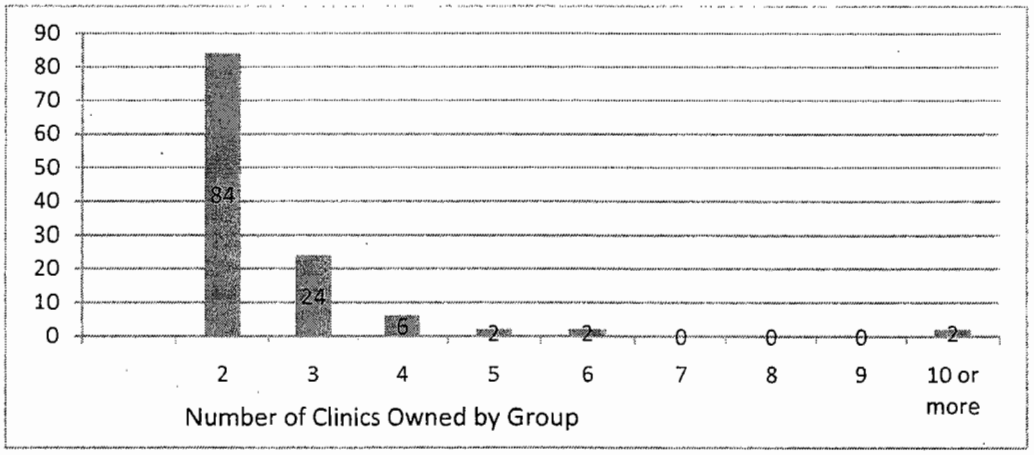
Many of the clinics have physicians who are registered to dispense medication on the premises of the clinic. To do this, the physician must register with the Florida Department of Health and pay a $100 fee. The following table shows the number of clinics whose Designated Physician is registered to dispense medication for the top 10 counties in Florida.

County	Clinics	Dispensing
PALM BEACH	108	77
BROWARD	117	73
MIAMI-DADE	89	50
HILLSBOROUGH	113	45
PINELLAS	47	32
DUVAL	51	31
ORANGE	49	29
PASCO	31	18
SARASOTA	24	18
LEE	29	16

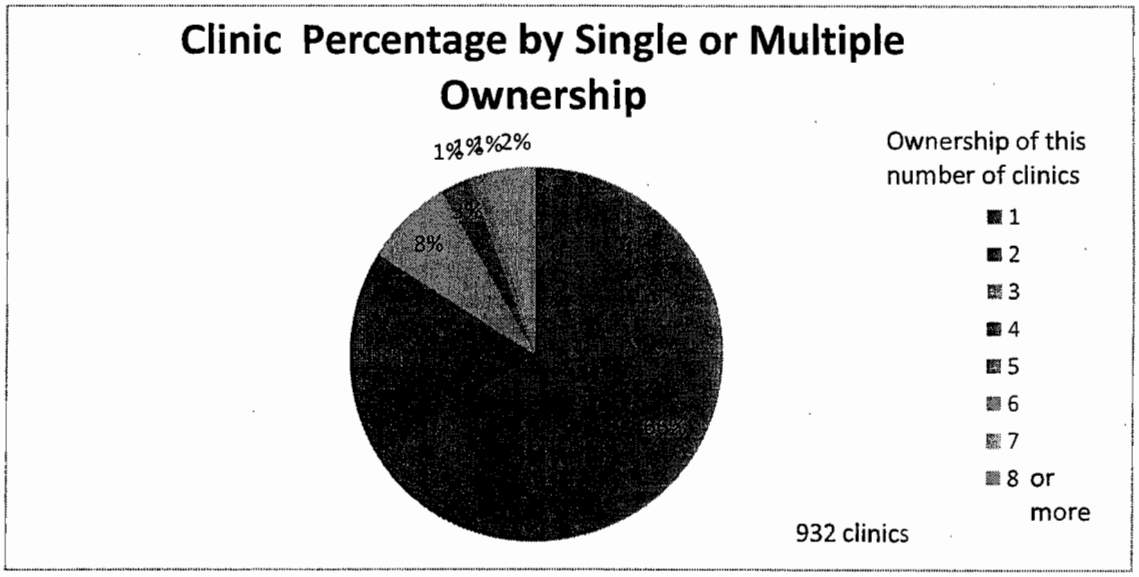
Appendix 1 shows the total for the whole state.

To check for concentration of ownership, the data was analyzed to see how many groups own more than one Pain Management Clinic in Florida. The number of clinics that are owned as an individual clinic is 615 clinics (66%). Of the remaining 317 clinics, the below graph shows that there are 84 groups that own 2 clinics, 24 that own 3 clinics, 6 that own 4 clinics, 2 that own 5 clinics, 2 that own 6 clinics and then one group that owns 10 clinics and one that appears to own 21 clinics. Checking the concentration, the clinics owned by groups that four or less Pain

Management Clinics compose 94.31% of the clinics. These were found by analyzing the data for common listed owners and common mailing addresses and are shown in the graph below.

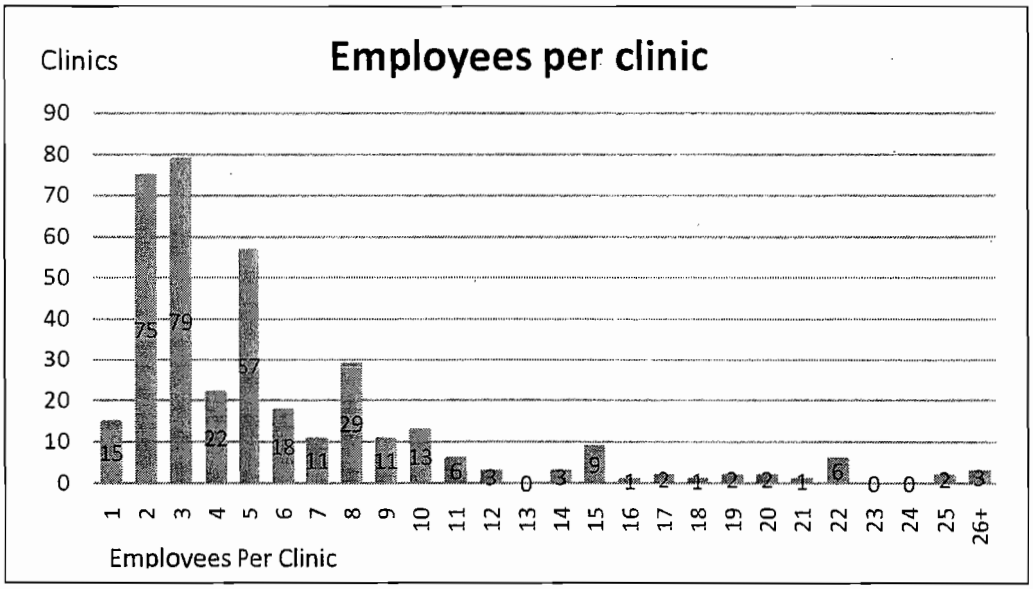


The graph below shows the same information, by percentage of the total clinics



To check for concentration in any given county or group of counties, the ownership groups were analyzed to see which counties they operated in. Appendix 2 shows the list of those groups owning three or more pain clinics and the counties that they operate in.
Data from the same database as above, as well as additional data from Dun & Bradstreet's Selectory database was obtained and analyzed. Cross-referencing the DOH data and the current Selectory database, 371 of the 932 clinics were found on the database. Information on the number of employees was recorded and analyzed. The median number of employees was 4 for

this sample. The employee number was derived using Selectory data for total sales and sales per employee.



A majority, 248 of the 371 (66.8%) of the clinics found in the Selectory database have 5 employees or less. Those that have 3 or less employees (169 of 371) account for 45.5% of these clinics.

Estimating the Number of Physicians

Establishing an upper and lower bound: Physicians are allowed work at more than one clinic at a time, including working part-time at a Pain Management Clinic and having a separate practice. There is no requirement for all physicians to register with DOH. However, each clinic must register a Designated Physician that is responsible for the clinic.

To establish an upper and lower bound for the "actual number of physicians working" to estimate things like the number of patients seen and the number of prescriptions written, the lower bound will be 932 for physicians, one for each Pain Management Clinic.

Since data is not available, other methods are used to estimate physicians working in Pain Management Clinics. Data was obtained from an advertising website and analyzed. The number of clinics found on one marketing website was 366, showing 574 physicians. That website is Ucomparehealthcare.com.

Their data was analyzed and it showed the doctors per clinic in the below percentages:

Clinics with	Percentage
1 physician	74.90%
2 physicians	13.10%
3 physicians	7.10%
4 physicians	1.40%
5 physicians	1.40%
6 or more	0.02%

Although we cannot identify how similar this sample is to the rest of the population, the analysis of the above data yields 1.57 physicians per clinic. That would lead us to an estimate of 1462 physicians as an upper bound. This data is possibly skewed upward for a couple of reasons. First, it might be more likely that the larger businesses would seek opportunities to advertise. Most importantly, one of the groups in this sample shows 20 physicians working at their clinic. The clinic is, indeed registered as a Pain Management Clinic in Florida, yet having 20 physicians shown working at one clinic likely skews this sample upward.

Using this sample, there are 566 physicians that are known, although one cannot be sure what percentage of time each physician is working at that clinic. If one uses the minimum (one physician at the clinic) for the unknown clinics in addition to this number, one obtains a lower-bound estimate of 1140.

To estimate the actual number of physicians working at Pain Management Clinics in Florida, a normal distribution was set up, with a 90% confidence interval between the lower and upper bounds. This resulted in a distribution with a mean of 1314 physicians and a standard deviation of 106.4.

The estimate that will be used for the number of physicians working full-time at registered Pain Management Clinics in Florida is a normal probability distribution function with a mean of 1314 and a standard deviation of 106.4. This yields an expectation of a 90% probability of the actual physician number being between 1140 and 1462.

Small business and number of PMCs affected: Most of the 932 registered PMCs in Florida will qualify as a small businesses under Florida 288.703.

Methods Used in this Study

Data was requested, purchased and gathered from various sources and then confirmed with physicians and industry professionals. Data that had a significant amount of uncertainty was estimated at upper and lower bounds, and then by statistical means. This study estimates some items and costs by the Monte Carlo method, where probability distributions are developed to use in the analysis. During each of the iterations of the model, values are drawn from the input probability distribution and used in calculating the range of the outputs.

Full-time is defined as 250 work days per year. When used, calculations use 40 hour work weeks and 50-week years.

Summary of Proposed Rule 64B8-9.0134/64B15-14.0054. Maximum Number of Prescriptions in Registered PMC.

This rule outlines the maximum number of prescriptions per physician at a Pain Management Clinic for Schedule II and Schedule III controlled substances and Alprazolam which may be written during a 24-hour period.

A copy of the complete proposed rule is shown below.

Total Estimated Statewide Costs: Estimated Statewide cost of $932,000 per year. On a per clinic basis, estimated $1,000 per clinic per year.

Proposed Rule 64B15-14.0054 states:
The maximum number of prescriptions for Schedule II or Schedule III controlled substances or the controlled substance Alprazolam, which may be written at any one registered pain management clinic during any 24-hour period shall be no more than an average of three prescriptions per patient per physician working at the pain management clinic up to a maximum of 150 prescriptions per physician. In the event that the physician is working less than 8 hours per day in the pain management clinic, the maximum number of prescriptions per physician shall be based upon the following formula: the number of hours worked divided by 8, then multiplied by 150 [(# of hours/8) X 150 = maximum # of prescriptions]. A "do not fill before dated" prescription will not be counted toward the daily limit until the first date the prescription is eligible to be filled.

To analyze the statewide cost of this rule, one would need the actual number of prescriptions written by each physician working in a Pain Management Clinic (PMC) and the number of hours they worked. Neither piece of actual data is available.

To derive whether limiting a physician to prescribing 150 prescriptions per day is likely to be a limiting factor, and what the expected costs would be, one can start with an assumed number of patients per day. The average number of patients per week for all Florida physicians is 74[1]. One should note that number includes those physicians working less than fulltime. That number includes physicians that see from 0-25 patients per week up through those that see more than 200 per week.

Given that any physician practicing in a PMC, under statute, is required to do the physical examination of the patient on the same day he or she dispenses or prescribes a controlled substance, it is unlikely that physicians in Pain Management Clinics can comfortably see more than 30-35 patients per day. Given the maximum "no more than an average of three

[1] http://www.doh.state.fl.us/Workforce/Physicians_Workforce_Annual_Rpt_2009.pdf

prescriptions per patient", it is unlikely that most physicians will be affected by the 150 daily maximum.

Looking at "no more than an average of three prescriptions per patient" perhaps yields a different result. Physicians and clinic owners indicate that in some cases, a patient is prescribed a short-acting pain killer, a long-acting pain killer and a muscle relaxer.
Physicians are also allowed to write "do not fill before dated" prescriptions and the rule indicates that those prescriptions will count on the first day the prescriptions are eligible to be filled. Therefore, a physician who writes "do not fill before dated" prescriptions will have to be noted and accounted for on the date they are available to be filled.

It would appear that a PMC physician who is near the limits of an average of 3 controlled substance prescriptions per patient will have to track his or her numbers more closely than physicians at an average PMC. It would be the physicians with high patient count, the ones who use mostly pills and not interventional therapies, and ones that often write "do not fill before" prescriptions that would be in this category.

One possible result of this rule is that physicians will reduce the number of "do not fill before dated" prescriptions. This may occur because the physician or the clinic would not want to undertake tracking the hours each physician worked in the clinic, the number of patients seen, the number of prescriptions and the number of "do not fill before dated" prescriptions. This could also have the effect of requiring patients to visit the clinics more often and pay more in physician visit fees. This possible cost is not included in the study because the numbers vary widely depending on the type of practice, and are likely to affect only a small and unknown number of clinics.

To estimate the costs to an average clinic for this rule, the assumption will be that all clinics spend one additional hour of administrative time per week tracking the number of controlled substance prescriptions, including accounting for any "do not fill before" prescriptions. There are, no doubt, some clinics that will spend less time or more time than that. Some clinics will be nowhere near the limit and will spend little time tracking this and others will be near the limit and be required to spend more time. The following estimate uses one hour per week in additional time for the average clinic, at the previously noted $20 per hour, including benefits.

The calculation of $20 per clinic per week (for a 50-week year), for the 932 Pain Management Clinics in Florida equals: $932,000 per year. On a per-clinic basis, this is $1,000 per clinic per year.

Statement of Estimated Regulatory Costs:

a) The above economic analysis shows that the proposed rule, directly or indirectly:

1. Is not likely to have an adverse impact on economic growth, private-sector job creation of employment, or private-sector investment in excess of $1 million in the aggregate within 5 years after the implementation of the rule.
2. Is not likely to have an adverse impact on business competitiveness, including the ability of persons doing business in the state to compete with persons doing business in other states or domestic markets, productivity, or innovation in excess of $1 million in the aggregate within 5 years after the implementation of the rule.
3. Is likely to increase regulatory costs, including any transactional costs, in excess of $1 million in the aggregate within 5 years after the implementation of the rule.

b) A good faith estimate of the number of individuals and entities likely to be required to comply with the rule, together with a general description of the types of individuals likely to be affected by the rule.

An estimated 1314 physicians and clinic owners of the estimated 932 Pain Management Clinics would be required to comply with this rule.

c) A good faith estimate of the cost to the agency, and to any other state and local government entities, of implementing and enforcing the proposed rule, and any anticipated effect on state or local revenues.

The Department has advised that there will be no fiscal impact on this agency or other governmental entities. Enforcement costs are reimbursed by the Respondent when disciplined.

d) A good faith estimate of the transactional costs likely to be incurred by individuals and entities, including government entities, required to comply with this rule.

An estimated $1,000 per Pain Management Clinic per year, for a statewide total of $932,000 per year.

e) An analysis of the impact on small businesses as defined by s. 288.703, and an analysis of the impact on small counties and small cities as defined in by s. 120.52. The impact analysis for small businesses must include the basis for the agency's decision not to implement alternatives that would reduce adverse impacts on small businesses.

Most of the estimated 932 Pain Management Clinics are small businesses.
There are no expected costs to small counties or small cities.
In response to this inquiry, the Department has advised that during the course of all of the rule meetings and rule hearings the Board considered alternatives and suggested rule language by interested persons in arriving at the proposed rule language.

Appendix 1 – Clinic totals, density and dispensing, by county

County	Total Clinics	Clinics/100k population*	Dispensing**	% Dispensing***
ALACHUA	5	2.51	3	60.0%
BAY	4	3.14	2	50.0%
BREVARD	16	3.73	8	50.0%
BROWARD	117	8.61	73	62.4%
CHARLOTTE	7	5.23	4	57.1%
CITRUS	8	6.80	4	50.0%
CLAY	9	6.56	4	44.4%
COLLIER	15	5.91	9	60.0%
COLUMBIA	3	5.60	3	100.0%
DUVAL	51	7.88	31	60.8%
ESCAMBIA	10	4.22	2	20.0%
FLAGLER	3	4.07	2	66.7%
FRANKLIN	1	10.63	0	0.0%
HERNANDO	10	7.27	4	40.0%
HIGHLANDS	2	2.49	1	50.0%
HILLSBOROUGH	113	12.52	45	39.8%
INDIAN RIVER	5	4.58	3	60.0%
JACKSON	1	2.46	1	100.0%
LAKE	11	4.37	9	81.8%
LEE	29	6.21	16	55.2%
LEON	5	2.34	1	20.0%
LEVY	1	3.26	1	100.0%
MANATEE	18	7.14	12	66.7%
MARION	12	4.57	7	58.3%
MARTIN	6	5.27	5	83.3%
MIAMI-DADE	89	4.62	50	56.2%
MONROE	1	1.62	0	0.0%
NASSAU	4	7.31	3	75.0%
OKALOOSA	4	2.92	2	50.0%
OKEECHOBEE	2	6.64	1	50.0%
ORANGE	49	5.98	29	59.2%
OSCEOLA	13	6.60	5	38.5%
PALM BEACH	108	10.68	77	71.3%
PASCO	31	8.34	18	58.1%
PINELLAS	47	6.33	32	68.1%
POLK	13	2.94	5	38.5%
PUTNAM	4	7.15	2	50.0%
SANTA ROSA	8	6.90	4	50.0%
SARASOTA	24	7.74	18	75.0%
SEMINOLE	17	5.36	10	58.8%
ST. JOHNS	9	6.17	3	33.3%
ST. LUCIE	12	5.82	8	66.7%
SUMTER	3	4.48	2	66.7%
VOLUSIA	30	7.50	11	36.7%
WALTON	1	2.28	1	100.0%
WASHINGTON	1	5.34	0	0.0%

* Population over 18, U.S. Census Bureau estimate for 2008

** Dispensing means registered physician that is qualified to dispense

*** Percentage of clinics that have registered physician who is qualified to dispense

Appendix 2 – Groups owning 3 or more PMC, by common owners, partners, and/or billing addresses.

Clinic Name	# of Clinics	Counties of Clinics
Total Medical Express	3	Palm Beach
Physicians Group Services	4	Clay, Duval(2), Nassau
Gulf-to-Bay Anesthesiology	5	Pinellas, Hillsborough(4)
Neurological Testing Centers of America	5	Broward(2), Miami-Dade(2)
Frank R. Collier, Jr. M.D., P.A.	3	Duval(2), Clay
Edwin Colon, M.D., P.A.	3	Pasco
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Deborah H. Tracy, M.D., M.B.A. Pain Management Physician, solo practitioner

CERTIFICATE OF

BOARD OF OSTEOPATHIC MEDICINE ADMINISTRATIVE RULES

FILED WITH THE DEPARTMENT OF STATE

I hereby certify:

[xx] (1) That all statutory rulemaking requirements of Chapter 120, F.S., and all rulemaking requirements of the Department of State have been complied with; and

[xx] (2) That there is no administrative determination under subsection 120.56(2), F.S., pending on any rule covered by this certification; and

[xx] (3) All rules covered by this certification are filed within the prescribed time limitations of paragraph 120.54(3)(e), F.S. They are filed not less than 28 days after the notice required by paragraph 120.54(3)(a), F.S., and;

[xx] (a) Are filed not more than 90 days after the notice; or

[ ] (b) Are filed more than 90 days after the notice, but not more than 60 days after the administrative law judge files the final order with the clerk or until 60 days after subsequent judicial review is complete; or

[ ] (c) Are filed more than 90 days after the notice, but not less than 21 days nor more than 45 days from the date of publication of the notice of change; or

[ ] (d) Are filed more than 90 days after the notice, but not less than 14 nor more than 45 days after the adjournment of the final public hearing on the rule; or

[ ] (e) Are filed more than 90 days after the notice, but within 21 days after the date of receipt of all material authorized to be submitted at the hearing; or

[ ] (f) Are filed more than 90 days after the notice, but within 21 days after the date the transcript was received by this agency; or

[ ] (g) Are filed not more than 90 days after the notice, not including the days the adoption of the rule was postponed following notification from the Joint Administrative Procedures Committee that an objection to the rule was being considered; or

[ ] (h) Are filed more than 90 days after the notice, but within 21 days after a good faith written proposal for a lower cost regulatory alternative to a proposed rule is submitted which substantially accomplishes the objectives of the law being implemented; or

[ ] (i) Are filed more than 90 days after the notice, but within 21 days after a regulatory alternative is offered by the Small Business Regulatory Advisory Committee.

Attached are the original and two copies of each rule covered by this certification. The rules are hereby adopted by the undersigned agency by and upon their filing with the Department of State.

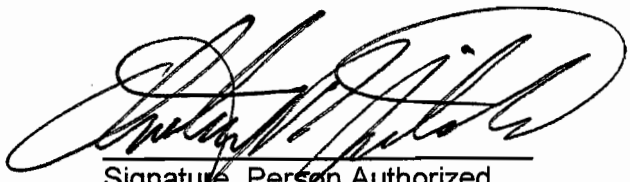
Rule No(s).

64B15-14.0054

Under the provision of subparagraph 120.54(3)(e)6., F.S., the rules take effect 20 days from the date filed with the Department of State or a later date as set out below:

Effective: _____

(Month) (Day) (Year)



Signature, Person Authorized
To Certify Rules

Executive Director
Title

1
Number of Pages Certified

DEPARTMENT OF HEALTH

BOARD OF OSTEOPATHIC MEDICINE

ADDITIONAL STATEMENT TO THE SECRETARY OF STATE

RULE TITLE: RULE NO.:

Maximum Number of Prescriptions

In Registered Pain Management Clinics 64B15-14.0054

SUMMARY: The proposed rule sets forth 150 as the maximum number of prescriptions which may be written by a physician for Schedule II or III controlled substances, or the controlled substance Alprazolam, at a pain management clinic during any 24-hour period. The rule additionally sets forth a formula for calculating the maximum number of prescriptions for those physicians who practice less than 8 hours a day in the pain management clinic.

SUMMARY OF THE HEARING ON THE RULE:

No timely request for a hearing was received and no hearing was held.

STATEMENT OF FACTS AND CIRCUMSTANCES JUSTIFYING RULE PROPOSAL:

The proposed rule is necessary to comply with the legislative mandate set forth in subsection 459.0137(4)(c), Florida Statutes, requiring the Board to set forth the maximum number of prescriptions for Schedule II or Schedule III controlled substances or the controlled substance Alprazolam which may be written at any one registered pain management clinic during any 24-hour period.

THE FULL TEXT OF THE PROPOSED RULE IS:

64B15-14.0054 Maximum Number of Prescriptions in Registered Pain Management Clinics. THE LIMIT ON THE MAXIMUM NUMBER OF PRESCRIPTIONS SET FORTH IN THIS RULE DOES NOT SUPERSEDE THE STANDARD OF CARE FOR THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF PAIN.

The maximum number of prescriptions for Schedule II or Schedule III controlled substances or the controlled substance Alprazolam, which may be written at any one registered pain management clinic during any 24-hour period shall be no more than an average of three prescriptions per patient per physician working at the pain management clinic up to a maximum of 150 prescriptions per physician. In the event that the physician is working less than 8 hours per day in the pain management clinic, the maximum number of prescriptions per physician shall be based upon the following formula: the number of hours worked divided by 8, then multiplied by 150 [(# of hours/8) X 150 = maximum # of prescriptions]. A "do not fill before dated" prescription will not be counted toward the daily limit until the first date the prescription is eligible to be filled.

Rulemaking Authority: 459.0137(4)(c), F.S.

Law Implemented: 459.0137(4)(c), F.S.

History -- New _____.

CERTIFICATE OF

BOARD OF MEDICINE ADMINISTRATIVE RULES

FILED WITH THE DEPARTMENT OF STATE

I hereby certify:

[xx] (1) That all statutory rulemaking requirements of Chapter 120, F.S., and all rulemaking requirements of the Department of State have been complied with; and

[xx] (2) That there is no administrative determination under subsection 120.56(2), F.S., pending on any rule covered by this certification; and

[xx] (3) All rules covered by this certification are filed within the prescribed time limitations of paragraph 120.54(3)(e), F.S. They are filed not less than 28 days after the notice required by paragraph 120.54(3)(a), F.S., and;

[xx] (a) Are filed not more than 90 days after the notice; or

[ ] (b) Are filed more than 90 days after the notice, but not more than 60 days after the administrative law judge files the final order with the clerk or until 60 days after subsequent judicial review is complete; or

[ ] (c) Are filed more than 90 days after the notice, but not less than 21 days nor more than 45 days from the date of publication of the notice of change; or

[ ] (d) Are filed more than 90 days after the notice, but not less than 14 nor more than 45 days after the adjournment of the final public hearing on the rule; or

[ ] (e) Are filed more than 90 days after the notice, but within 21 days after the date of receipt of all material authorized to be submitted at the hearing; or

[ ] (f) Are filed more than 90 days after the notice, but within 21 days after the date the transcript was received by this agency; or

[ ] (g) Are filed not more than 90 days after the notice, not including the days the adoption of the rule was postponed following notification from the Joint Administrative Procedures Committee that an objection to the rule was being considered; or

[ ] (h) Are filed more than 90 days after the notice, but within 21 days after a good faith written proposal for a lower cost regulatory alternative to a proposed rule is submitted which substantially accomplishes the objectives of the law being implemented; or

[ ] (i) Are filed more than 90 days after the notice, but within 21 days after a regulatory alternative is offered by the Small Business Regulatory Advisory Committee.

Attached are the original and two copies of each rule covered by this certification. The rules are hereby adopted by the undersigned agency by and upon their filing with the Department of State.

Rule No(s).

64B8-9.0134

Under the provision of subparagraph 120.54(3)(e)6., F.S., the rules take effect 20 days from the date filed with the Department of State or a later date as set out below:

Effective: _____

(Month) (Day) (Year)

Signature, Person Authorized
To Certify Rules

Acting Executive Director
Title

1
Number of Pages Certified

DEPARTMENT OF HEALTH

BOARD OF MEDICINE

ADDITIONAL STATEMENT TO THE SECRETARY OF STATE

RULE TITLE:	RULE NO.:
Maximum Number of Prescriptions In Registered Pain Management Clinics	64B8-9.0134

SUMMARY: The proposed rule sets forth 150 as the maximum number of prescriptions which may be written by a physician for Schedule II or III controlled substances , or the controlled substance Alprazolam, at a pain management clinic during any 24-hour period. The rule additionally sets forth a formula for calculating the maximum number of prescriptions for those physicians who practice less than 8 hours a day in the pain management clinic.

SUMMARY OF THE HEARING ON THE RULE:

No timely request for a hearing was received and no hearing was held.

STATEMENT OF FACTS AND CIRCUMSTANCES JUSTIFYING RULE PROPOSAL:

The proposed rule is necessary to comply with the legislative mandate set forth in subsection 458.3265(4)(c), Florida Statutes, requiring the Board to set forth the maximum number of prescriptions for Schedule II or Schedule III controlled substances or the controlled substance Alprazolam which may be written at any one registered pain management clinic during any 24-hour period.

THE FULL TEXT OF THE PROPOSED RULE IS:

64B8-9.0134 Maximum Number of Prescriptions in Registered Pain Management Clinics. THE LIMIT ON THE MAXIMUM NUMBER OF PRESCRIPTIONS SET FORTH IN THIS RULE DOES NOT SUPERSEDE THE STANDARD OF CARE FOR THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF PAIN. The maximum number of prescriptions for Schedule II or Schedule III controlled substances or the controlled substance Alprazolam, which may be written at any one registered pain management clinic during any 24-hour period shall be no more than an average of three prescriptions per patient per physician working at the pain management clinic up to a maximum of 150 prescriptions per physician. In the event that the physician is working less than 8 hours per day in the pain management clinic, the maximum number of prescriptions per physician shall be based upon the following formula: the number of hours worked divided by 8, then multiplied by 150 [(# of hours/8) X 150 = maximum # of prescriptions]. A "do not fill before dated" prescription will not be counted toward the daily limit until the first date the prescription is eligible to be filled.

Rulemaking Authority: 458.3265(4)(c), F.S.

Law Implemented: 458.3265(4)(c), F.S.

History -- New _____.

685560

LEGISLATIVE ACTION

Senate . House

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The Committee on Health Regulation (Garcia) recommended the following:

Senate Amendment (with title amendment)

Delete lines 74 - 123
and insert:
Section 1. Subsection (9) is added to section 390.011, Florida Statutes, to read:
390.011 Definitions.—As used in this chapter, the term:
(9) "Viability" means that stage of fetal development when the life of the unborn child may, with a reasonable degree of medical probability, be continued indefinitely outside the womb.
Section 2. Subsections (1), (2), (4), (7), and (10) of section 390.0111, Florida Statutes, are amended, and subsection

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(12) is added to that section, to read:

390.0111 Termination of pregnancies.—

(1) TERMINATION IN THIRD TRIMESTER OR AFTER VIABILITY; WHEN ALLOWED.—

(a) A ~~No~~ termination of pregnancy may not ~~shall~~ be performed after the period at which, in the best medical judgment of the physician, the fetus has attained viability, as defined in s. 390.011, or on any person ~~human being~~ in the third trimester of pregnancy unless:

1.~~(a)~~ Two physicians certify in writing to the fact that, to a reasonable degree of medical probability, the termination of pregnancy is necessary to prevent the death of the pregnant woman or the substantial and irreversible impairment of a major bodily function of the pregnant woman ~~save the life or preserve the health of the pregnant woman~~; or

2.~~(b)~~ The physician certifies in writing to the existence of a medical emergency, as defined in s. 390.01114(2)(d) ~~medical necessity for legitimate emergency medical procedures for termination of pregnancy in the third trimester~~, and another physician is not available for consultation.

(b) An abortion clinic must provide conspicuous notice on any form or medium of advertisement that the abortion clinic is prohibited from performing abortions in the third trimester or after viability.

(2) PHYSICIAN, LOCATION, AND CLINIC LICENSURE AND OWNERSHIP REQUIREMENTS ~~PERFORMANCE BY PHYSICIAN REQUIRED~~.—

(a) A ~~No~~ termination of pregnancy may not ~~shall~~ be performed at any time except by a physician as defined in s. 390.011. A physician who offers to perform or who performs

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terminations of pregnancy in an abortion clinic must annually complete a minimum of 3 hours of continuing education related to ethics.

(b) Except for procedures that must be conducted in a hospital or in emergency-care situations, a termination of pregnancy may not be performed in a location other than in a validly licensed hospital, abortion clinic, or physician's office.

(c) A person may not establish, conduct, manage, or operate an abortion clinic without a valid current license.

(d) A person may not perform or assist in performing an abortion on a person in the third trimester or after viability, other than in a hospital.

(e) Other than an abortion clinic licensed before October 1, 2011, an abortion clinic must be wholly owned and operated by a physician who has received training during residency in performing a dilation-and-curettage procedure or a dilation-and-evacuation procedure.

(f) A person who willfully violates paragraph (c), paragraph (d), or paragraph (e) commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(4) STANDARD OF MEDICAL CARE TO BE USED DURING VIABILITY.—If a termination of pregnancy is performed during viability, no person who performs or induces the termination of pregnancy shall fail to use that degree of professional skill, care, and diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not

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aborted. ~~"Viability" means that stage of fetal development when the life of the unborn child may with a reasonable degree of medical probability be continued indefinitely outside the womb.~~ Notwithstanding the provisions of this subsection, the woman's life and health shall constitute an overriding and superior consideration to the concern for the life and health of the fetus when such concerns are in conflict.

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

And the title is amended as follows:

Delete lines 2 - 26

and insert:

An act relating to abortions; amending s. 390.011, F.S.; defining the term "viability" as it relates to the termination of a pregnancy; amending s. 390.0111, F.S.; restricting the circumstances in which an abortion may be performed in the third trimester or after viability; requiring an abortion clinic to provide conspicuous notice on any form or medium of advertisement that the abortion clinic is prohibited from performing abortions in the third trimester or after viability; providing certain physician, location, and clinic licensure and ownership requirements; requiring a physician who offers to perform or who performs terminations of pregnancy to complete continuing education related to ethics; prohibiting a termination of pregnancy from being performed in a location other than a validly licensed hospital, abortion clinic, or physician's office;


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prohibiting a person from establishing, conducting, managing, or operating an abortion clinic without a valid, current license; prohibiting a person from performing or assisting in performing an abortion on a person in the third trimester or after viability, in a location other than a hospital; requiring an abortion clinic to be owned and operated by a physician who has received training during residency in performing a dilation-and-curettage procedure or a dilation-and-evacuation procedure; providing a penalty; deleting the definition of the term "viability"; providing

450940

LEGISLATIVE ACTION

Senate . House

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The Committee on Health Regulation (Garcia) recommended the following:

Senate Amendment (with title amendment)

Delete lines 172 - 174
and insert:
(1) The director of any medical facility or physician's office in which any pregnancy is terminated shall submit a ~~monthly~~ report each month to the agency on a

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:
Delete lines 43 - 45
and insert:

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390.0112, F.S.; requiring the director of a medical facility or physician's office to submit a monthly report to the agency on

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LEGISLATIVE ACTION

Senate . House

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The Committee on Health Regulation (Garcia) recommended the following:

Senate Amendment (with title amendment)

Delete line 177

and insert:

Centers for Disease Control and Prevention. The submitted report must not contain any personal identifying information ~~which contains the~~

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

And the title is amended as follows:

Delete line 49

and insert:

795534

Prevention; requiring that the submitted report not contain any personal identifying information; requiring the agency to submit reported

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Health Regulation Committee

BILL:	SB 1748
INTRODUCER:	Senator Flores
SUBJECT:	Abortions
DATE:	March 25, 2011
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	O'Callaghan	Stovall	HR	**Pre-meeting**
2.			CJ	
3.			BC	
4.				
5.				
6.				

I. Summary:

This bill prohibits abortions from being performed while a woman is in her third trimester of pregnancy or after a fetus has attained viability unless a medical emergency exists.

The bill provides that any abortion clinic that advertises its services must also advertise that the clinic is prohibited from performing abortions in the third trimester or after viability and requires the Agency for Health Care Administration (AHCA) to adopt rules to regulate such advertisements.

The bill requires any physician who performs abortions in an abortion clinic to annually complete at least 3 hours of continuing education that relate to ethics. The bill also provides for restrictions as to where an abortion may be performed.

This bill also provides that it is a misdemeanor of the second-degree if:

- A person establishes, conducts, manages, or operates an abortion clinic without a valid current license.
- A person performs or assists in performing an abortion on a person in the third trimester or after viability in a place other than in a hospital.
- After October 1, 2011, an abortion clinic is not wholly owned and operated by a physician who has received certain training during residency.

This bill increases the penalty for failure to properly dispose of fetal remains from a second-degree to a first-degree misdemeanor. It is also a misdemeanor of the first-degree for a person to advertise or facilitate an advertisement of services or drugs for the purpose of performing an

abortion in violation of ch. 390, F.S. A licensed health care practitioner who is guilty of a felony for providing unlawful abortion services is subject to licensure revocation.

This bill also requires a director of a medical facility or physician's office where abortions are performed to report to the AHCA specific information, which the AHCA must then submit to the Centers for Disease Control and Prevention (CDC) and make available on the AHCA website prior to each general legislative session. Additionally, the AHCA must provide an annual report to the Governor and Legislature, which contains such information. None of the reported or published information is to contain any personal indentifying information.

The bill transfers provisions concerning abortion from the Florida Criminal Code, under ch. 797, F.S., into ch. 390, F.S., and the bill contains a severability clause.

The effective date of the act is October 1, 2011.

This bill substantially amends the following sections of the Florida Statutes: 390.0111, 390.0112, 390.012, and 456.013.

This bill repeals the following sections of the Florida Statutes: 797.02 and 797.03.

This bill also creates an undesignated section of the Florida Statutes.

II. Present Situation:

Background

Under Florida law the term "abortion" means the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.[1] "Viability" means that stage of fetal development when the life of the unborn child may, with a reasonable degree of medical probability, be continued indefinitely outside the womb.[2] Induced abortion can be elective (performed for nonmedical indications) or therapeutic (performed for medical indications). An abortion can be performed by surgical or medical means (medicines that induce a miscarriage).[3]

An abortion in Florida must be performed by a physician licensed to practice medicine or osteopathic medicine who is licensed under ch. 458, F.S., or ch. 459, F.S., or a physician practicing medicine or osteopathic medicine in the employment of the United States.[4] No person who is a member of, or associated with, the staff of a hospital, or any employee of a hospital or physician in which, or by whom, the termination of a pregnancy has been authorized or performed, who states an objection to the procedure on moral or religious grounds is required to

[1] Section 390.011, F.S.
[2] Section 390.0111(4), F.S.
[3] Suzanne R. Trupin, M.D., *Elective Abortion*, December 21, 2010, *available at* http://www.emedicine.com/med/TOPIC3312.HTM (last visited Mar. 23, 2011).
[4] Section 390.0111(2) and s. 390.011(7), F.S.

participate in the procedure. The refusal to participate may not form the basis for any disciplinary or other recriminatory action.[5]

According to the AHCA, for the calendar year 2009, a total of 81,916 abortions were performed by licensed physicians. During calendar year 2010, a total of 79,908 abortions were performed by licensed physicians.[6]

Abortion Clinics

Abortion clinics are licensed and regulated by the AHCA under ch. 390, F.S., and part II of ch. 408, F.S. The AHCA has adopted rules in Chapter 59A-9, Florida Administrative Code, related to abortion clinics. Section 390.012, F.S., requires these rules to address the physical facility, supplies and equipment standards, personnel, medical screening and evaluation of patients, abortion procedures, recovery room standards, and follow-up care. The rules relating to the medical screening and evaluation of each abortion clinic patient, at a minimum, shall require:

- A medical history, including reported allergies to medications, antiseptic solutions, or latex; past surgeries; and an obstetric and gynecological history;
- A physical examination, including a bimanual examination estimating uterine size and palpation of the adnexa;
- The appropriate laboratory tests, including:
  - For an abortion in which an ultrasound examination is not performed before the abortion procedure, urine or blood tests for pregnancy performed before the abortion procedure,
  - A test for anemia,
  - Rh typing, unless reliable written documentation of blood type is available, and
  - Other tests as indicated from the physical examination;
- An ultrasound evaluation for patients who elect to have an abortion after the first trimester. If a person who is not a physician performs the ultrasound examination, that person must have documented evidence that he or she has completed a course in the operation of ultrasound equipment. If a patient requests, the physician, registered nurse, licensed practical nurse, advanced registered nurse practitioner, or physician assistant must review the ultrasound evaluation results and the estimate of the probable gestational age of the fetus with the patient before the abortion procedure is performed; and
- The physician to estimate the gestational age of the fetus based on the ultrasound examination and obstetric standards in keeping with established standards of care regarding the estimation of fetal age and write the estimate in the patient's medical history. The physician must keep original prints of each ultrasound examination in the patient's medical history file.

Section 390.0111(4), F.S., provides for the standard of medical care to be used during viability. If a termination of pregnancy is performed during viability, a person who performs or induces the termination of pregnancy may not fail to use that degree of professional skill, care, and diligence to preserve the life and health of the fetus which the person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted.

[5] Section 390.0111(8), F.S.
[6] Agency for Health Care Administration, *2011 Bill Analysis & Economic Impact Statement for SB 1748*, on file with the Senate Health Regulation Committee.

The biennial license fee for an abortion clinic is $514. The administrator responsible for the day to day operations of the abortion clinic and the chief financial officer are required to submit to a level 2 (statewide and nationwide) background screening.[7]

Relevant Case Law

In 1973, the landmark case of *Roe v. Wade* established that restrictions on a woman's access to secure an abortion are subject to a strict scrutiny standard of review.[8] In *Roe*, the U.S. Supreme Court determined that a woman's right to have an abortion is part of the fundamental right to privacy guaranteed under the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution, justifying the highest level of review.[9] Specifically, the Court concluded that: (1) during the first trimester, the state may not regulate the right to an abortion; (2) after the first trimester, the state may impose regulations to protect the health of the mother; and (3) after viability, the state may regulate and proscribe abortions, except when it is necessary to preserve the life or health of the mother.[10] Therefore, a state regulation limiting these rights may be justified only by a compelling state interest, and the legislative enactments must be narrowly drawn to express only legitimate state interests at stake.[11]

In 1992, in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the U.S. Supreme Court relaxed the standard of review in abortion cases involving adult women from strict scrutiny to unduly burdensome, while still recognizing that the right to an abortion emanates from the constitutional penumbra of privacy rights.[12] In *Planned Parenthood*, the Court determined that, prior to fetal viability, a woman has the right to an abortion without being unduly burdened by government interference.[13] The Court concluded that the state may regulate the abortion as long as the regulation does not impose an undue burden on a woman's decision to choose an abortion.[14] If the purpose of a provision of law is to place substantial obstacles in the path of a woman seeking an abortion before viability, it is invalid; however, after viability the state may restrict abortions if the law contains exceptions for pregnancies endangering a woman's life or health.[15]

The unduly burdensome standard as applied in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, which is generally considered to be a hybrid between strict scrutiny and intermediate level scrutiny, shifted the Court's focus to whether a restriction creates a substantial obstacle to access. This is the prevailing standard today applied in cases in which abortion access is statutorily restricted.

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[7] Agency for Health Care Administration, *Abortion Clinic*, *available at* http://www.fdhc.state.fl.us/mchq/health_facility_regulation/hospital_outpatient/abortion.shtml (Last visited on March 23, 2011).
[8] 410 U.S. 113 (1973).
[9] 410 U.S. 113, 154 (1973).
[10] 410 U.S. 113, 162-65 (1973).
[11] 410 U.S. 113, 152-56 (1973).
[12] 505 U.S. 833, 876-79 (1992).
[13] *Id.*
[14] *Id*.
[15] *Id.*

However, the undue burden standard was held not to apply in Florida. The 1999 Legislature passed a parental notification law, the Parental Notice of Abortion Act, requiring a physician to give at least 48 hours of actual notice to one parent or to the legal guardian of a pregnant minor before terminating the pregnancy of the minor. Although a judicial waiver procedure was included, the act was never enforced.[16] In 2003, the Florida Supreme Court[17] ruled this legislation unconstitutional on the grounds that it violated a minor's right to privacy, as expressly protected under Article I, s. 23 of the Florida Constitution.[18] Citing the principle holding of *In re T.W.*,[19] the Court reiterated that, as the privacy right is a fundamental right in Florida, any restrictions on privacy warrant a strict scrutiny review, rather than that of an undue burden. Here, the Court held that the state failed to show a compelling state interest and therefore, the Court permanently enjoined the enforcement of the Parental Notice of Abortion Act.[20]

Centers for Disease Control and Prevention (CDC)

The CDC began collecting abortion data (abortion surveillance) in 1969 to document the number and characteristics of women obtaining "legal induced" abortions. The CDC's surveillance system counts legal induced abortions only. For the CDC's surveillance purposes, legal abortion is defined as a procedure performed by a licensed physician, or a licensed advanced practice clinician acting under the supervision of a licensed physician, to induce the termination of a pregnancy.[21]

States and other territories voluntarily report data to the CDC for inclusion in its annual Abortion Surveillance Report.[22] The CDC's Division of Reproductive Health prepares surveillance reports as data becomes available. There is no national requirement for data submission or reporting.[23]

Those states requiring the reporting of information on induced abortions use various methods to collect the data. Some states include induced abortion reporting as a part of their fetal death reporting system, while a majority of states use a separate form, usually called Report of Induced Termination of Pregnancy, for the reporting of induced abortions. Regardless of the reporting system used, all states with reporting systems require the reporting of all induced abortions regardless of length of gestation.[24]

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[16] *See* s. 390.01115, F.S. (repealed by s. 1, ch. 2005-52, Laws of Florida). Ch. 2005-52, Laws of Florida created s. 390.01114, F.S., the revised Parental Notice of Abortion Act.

[17] *North Florida Women's Health and Counseling Services, Inc., et al., v. State of Florida*, 866 So. 2d 612, 619-20 (Fla. 2003)

[18] The constitutional right of privacy provision reads: "Every natural person has the right to be let alone and free from governmental intrusion into the person's private life except as otherwise provided herein. This section shall not be construed to limit the public's right of access to public records and meetings as provided by law." FLA. CONST. art. I, s. 23.

[19] 551 So. 2d 1186, 1192 (Fla. 1989).

[20] *North Florida Women's Health and Counseling Services, supra* note 16, at 622 and 639-40.

[21] Centers for Disease Control and Prevention, *CDC's Abortion Surveillance System FAQs*, available at: http://www.cdc.gov/reproductivehealth/Data_Stats/Abortion.htm (Last visited on March 23, 2011).

[22] Florida does not report abortion data to the CDC. *Supra* fn. 6.

[23] *Supra* fn. 21.

[24] Centers for Disease Control and Prevention, *Handbook on the Reporting of Induced Termination of Pregnancy*, April 1998, available at: http://www.cdc.gov/nchs/data/misc/hb_itop.pdf (Last visited on March 23, 2011).

The CDC has developed a Standard Report of Induced Termination of Pregnancy to serve as a model for use by states. The model report suggests that the state's report should include the:[25]

- Facility name where the induced termination of pregnancy occurred.
- City, town, or location where the pregnancy termination occurred.
- County where the pregnancy termination occurred.
- Hospital, clinic, or other patient identification number, which would enable the facility or physician to access the medical file of the patient.
- Age of the patient in years at her last birthday.
- Marital status of the patient.
- Date of the pregnancy termination.
- Place the patient actually and physically lives or resides, which is not necessarily a patient's home state, voting residence, mailing address, or legal residence.
- Name of the state, county, and city where the patient lives.
- Number of the ZIP code where the patient lives.
- Origin of the patient, if Hispanic.
- Ancestry of the patient.
- Race of the patient.
- Highest level of education completed by the patient.
- Date the patient's last normal menstrual period began.
- Length of gestation as estimated by the attending physician.
- Number of previous pregnancies, including live births and other terminations.
- Type of termination procedure used.
- Name of the attending physician.
- Name of the person completing the report.

The CDC reports that its surveillance data is used to:[26]

- Identify characteristics of women who are at high risk of unintended pregnancy.
- Evaluate the effectiveness of programs for reducing teen pregnancies and unintended pregnancy among women of all ages.
- Calculate pregnancy rates based on the number of pregnancies ending in abortion in conjunction with birth data and fetal loss estimates.
- Monitor changes in clinical practice patterns related to abortion, such as changes in the types of procedures used, and weeks of gestation at the time of abortion.

Additionally, demographers use information in the report to calculate pregnancy rates, which are combined estimates of births and fetal loss and managers of public health programs use this data to evaluate the programs' effectiveness to prevent unintended pregnancy. There have historically been other data uses; such as, the calculation of the mortality rate of specific abortion procedures.

The CDC reports that in 2007,[27] there were 827,609 legal induced abortions reported to the CDC from 49 reporting areas. This is a 2 percent decrease from the 846,181 abortions in 2006. The

[25] *Id.*
[26] *Supra* fn. 21.

abortion rate for 2007 was 16.0 abortions per 1,000 women aged 15 through 44 years. This also is a 2 percent decrease from 2006. The abortion ratio was 231 abortions per 1,000 live births in 2007. This is a 3 percent decrease from 2006. During 1998 through 2007, the reported abortion numbers, rates, and ratios decreased 6 percent, 7 percent, and 14 percent, respectively. During 1997 through 2006, women aged 20 to 29 years accounted for the majority of abortions. The majority (62.3 percent) of abortions in 2007 were performed at 8 weeks' gestation or less and 92 percent were performed at 13 weeks' gestation or less; 13.1 percent of all abortions were medical abortions.[28]

III. Effect of Proposed Changes:

Section 1 amends s. 390.0111, F.S., to prohibit abortions from being performed after the period at which, in the physician's best medical judgment, the fetus has attained viability or during the third trimester of pregnancy. However, an abortion may be performed after viability or during the third trimester of pregnancy if two physicians certify in writing as to the existence of a medical emergency[29] or one physician certifies in writing to the existence of a medical emergency and another physician is not available for consultation.

This section also requires:

- An abortion clinic that advertises its services to provide conspicuous notice on its advertisements that it is prohibited from performing abortions in the third trimester or after viability.
- Physicians who offer to perform or perform abortions in abortion clinics to annually complete at least 3 hours of continuing education that relate to ethics.
- Abortions to be performed in a validly licensed hospital, abortion clinic, or physician's office, unless the law specifically requires the abortion to be performed in a hospital or an emergency care situation exists.

This section provides that it is a misdemeanor of the second-degree punishable as provided in s. 775.082, F.S., or s. 775.083, F.S., (maximum imprisonment of 60 days or maximum fine of $500) if a person willfully:

- Establishes, conducts, manages, or operates an abortion clinic without a valid current license.
- Performs or assists in performing an abortion on a person in the third trimester or after viability in a place other than in a hospital.
- After October 1, 2011, operates or owns an abortion clinic and is not a physician who has received training during residency in performing a dilation-and-curettage procedure[30] or a dilation-and-evacuation procedure.[31]

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[27] This is the most recent data available on the CDC website, which is available at: http://www.cdc.gov/reproductivehealth/Data_Stats/Abortion.htm (Last visited on March 23, 2011).
[28] *Supra* fn. 21.
[29] Section 390.01114(2)(d), F.S., defines a "medical emergency" as a condition that, on the basis of a physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate termination of her pregnancy to avert her death, or for which a delay in the termination of her pregnancy will create serious risk of substantial and irreversible impairment of a major bodily function.
[30] Dilation-and-curettage is a medical procedure in which the uterine cervix is dilated and a curette is inserted into the uterus to scrape away the endometrium, also known as a D&C. Merriam-Webster, MedlinePlus Medical Dictionary, available at: http://www.merriam-webster.com/medlineplus/dilation-and-curettage (Last visited on March 23, 2011).

This section also increases the penalty for a person who fails to dispose of fetal remains in an appropriate manner. The penalty is increased from a misdemeanor of a second-degree to a misdemeanor of a first-degree, punishable as provided in s. 775.082, F.S., or s. 775.083, F.S. (maximum imprisonment of 1 year or maximum fine of $1,000). In addition, it is a misdemeanor of the first-degree for a person to advertise or facilitate an advertisement of services or drugs for the purpose of performing an abortion in violation of ch. 390, F.S.

The Department of Health is required to permanently revoke the license of a licensed health care practitioner who has been convicted or found guilty of, or entered a plea of guilty or nolo contendre to, regardless of adjudication, a felony criminal act for willfully performing an unlawful abortion.

The AHCA is required to report, prior to each general legislative session, aggregate statistical data that relates to abortions and does not contain any personal identifying information, which has been reported to the Division of Reproductive Health within the CDC, on its website. In addition, the AHCA must submit such information in an annual report the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 2 amends s. 390.0112, F.S., to require the director of any medical facility or physician's office in which an abortion is performed to submit a report to AHCA following each abortion. The report must be on a form developed by the AHCA which is consistent with the U.S. Standard Report of Induced Termination of Pregnancy from the CDC. The AHCA is required to submit this reported information to the Division of Reproductive Health within the CDC.

Section 3 amends s. 390.012, F.S., to require the AHCA to adopt rules to prescribe standards for advertisements used by an abortion clinic by requiring the clinic to provide conspicuous notice on its advertisement that it is prohibited from performing abortions in the third trimester or after viability.

Section 4 amends s. 456.013, F.S., to require physicians who offer to perform or perform abortions in an abortion clinic to annually complete a 3-hour course related to ethics as part of the licensure and renewal process as required in section 1 of the bill. This section clarifies that the 3-hour course must count toward the total number of continuing education hours required for the profession and the applicable board, or department if there is no board, must approve of the course.

Section 5 repeals s. 797.02, F.S., the provisions of which are transferred to ch. 390, F.S., in section 1 of the bill.

Section 6 repeals s. 797.03, F.S., the provisions of which are transferred to ch. 390, F.S., in section 1 of the bill.

[31] Dilation-and-evacuation is a surgical abortion that is typically performed midway during the second trimester of pregnancy and in which the uterine cervix is dilated and fetal tissue is removed using surgical instruments and suction, also called a D&E. Merriam-Webster, MedlinePlus Medical Dictionary, available at: http://www.merriam-webster.com/medlineplus/dilation-and-evacuation%20 (Last visited on March 23, 2011).

Section 7 is an undesignated section that provides for the severability of any provision in the bill that is held invalid.

Section 8 provides an effective date of October 1, 2011.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Article I, Section 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

D. Other Constitutional Issues:

If the bill, should it become law, is challenged as an invasion of privacy, it will be subject to a strict scrutiny review, rather than that of an undue burden test pursuant to *North Florida Women's Health and Counseling Services, Inc., et al., v. State of Florida*,[32] as discussed above under the subheading, "Relevant Case Law." Otherwise, any challenge that does not impinge on a constitutional fundamental right, will be subject to the "undue burden" standard announced in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.[33]

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Abortion clinics may incur an indeterminate amount of costs associated with complying with the advertisement requirements, ownership requirements, and report requirements provided for in the bill.

[32] 866 So. 2d 612 (Fla. 2003).
[33] 505 U.S. 833 (1992).

C. Government Sector Impact:

Because the bill requires the director of any medical facility or physician's office to submit a report after each abortion, instead of monthly, the AHCA has estimated that it will receive approximately 80,000 reports annually. The AHCA estimates that it will incur costs of approximately $50,000 in order to contract for services to develop a database to collect the additional data elements required by the bill.[34]

VI. Technical Deficiencies:

The term "viability" is defined in s. 390.0111(4), F.S. Lines 78, 82, 98, 114 and 217 of the bill use the term viability. However, the definition is not provided in a manner so that it applies to the whole chapter. In order for the definition of the term to apply to the whole chapter, including the use of the term in the aforementioned lines, the definition of viability should be moved to s. 390.011, F.S.

Line 131 of the bill should read "Except as provided in paragraph (f) of subsection (2) and subsections (3) and (7)" because paragraph (f) of subsection (2) contains misdemeanor penalties that should also be excluded from the felony provisions of subsection (10).

VII. Related Issues:

None.

VIII. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

[34] *Supra* fn. 6.