Tab 1	**CS/SB 18** by **JU, Flores**; (Similar to CS/H 06523) Relief of "Survivor" and the Estate of "Victim" by the Department of Children and Families

500202 A S RCS AHS, Flores Delete L.153 - 165: 03/22 07:04 PM

Tab 2	**CS/CS/SB 240** by **HP, BI, Lee (CO-INTRODUCERS) Mayfield**; (Similar to CS/H 00161) Direct Primary Care

~~373836~~ A S L WD AHS, Powell Delete L.52 - 58: 03/22 05:23 PM

Tab 3	**CS/SB 430** by **BI, Bean (CO-INTRODUCERS) Flores**; (Similar to CS/H 00577) Discount Plan Organizations

Tab 4	**CS/SB 670** by **BI, Bean (CO-INTRODUCERS) Lee, Mayfield, Broxson**; (Similar to H 00625) Managed Care Plans' Provider Networks

~~433026~~ A S L WD AHS, Bean Delete L.27 - 131: 03/22 05:26 PM

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES
Senator Flores, Chair
Senator Stargel, Vice Chair

MEETING DATE: Tuesday, March 21, 2017
TIME: 2:00—3:30 p.m.
PLACE: *James E. "Jim" King, Jr. Committee Room,* 401 Senate Office Building

MEMBERS: Senator Flores, Chair; Senator Stargel, Vice Chair; Senators Artiles, Baxley, Book, Passidomo, Powell, and Rader

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**CS/SB 18** Judiciary / Flores (Similar CS/H 6523)	Relief of "Survivor" and the Estate of "Victim" by the Department of Children and Families ; Providing for the relief of “Survivor” and the Estate of “Victim”; providing an appropriation to compensate Survivor and the Estate of Victim for injuries and damages sustained as result of the negligence of the Department of Children and Families, formerly known as the Department of Children and Family Services, etc. SM JU 02/21/2017 Fav/CS AHS 03/21/2017 Fav/CS AP	Fav/CS Yeas 8 Nays 0
2	**CS/CS/SB 240** Health Policy / Banking and Insurance / Lee (Similar CS/H 161)	Direct Primary Care; Requiring the Agency for Health Care Administration to provide specified financial assistance to certain Medicaid recipients; authorizing primary care providers or their agents to enter into direct primary care agreements for providing primary care services; providing construction and applicability of the Florida Insurance Code as to direct primary care agreements, etc. BI 02/07/2017 Fav/CS HP 02/21/2017 Fav/CS AHS 03/21/2017 Favorable AP	Favorable Yeas 8 Nays 0
3	**CS/SB 430** Banking and Insurance / Bean (Similar CS/H 577)	Discount Plan Organizations; Requiring third-party entities that contract with providers to administer or provide platforms for discount plans to be licensed as discount plan organizations; specifying periodic charge reimbursement and other requirements for discount plan organizations following membership cancellation requests; requiring discount plan organizations and marketers to provide specified disclosures to prospective members before enrollment, etc. BI 03/06/2017 Fav/CS AHS 03/21/2017 Favorable AP	Favorable Yeas 8 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**CS/SB 670** Banking and Insurance / Bean (Similar H 625)	Managed Care Plans' Provider Networks; Prohibiting a managed care plan from excluding a pharmacy that meets the credentialing requirements and standards established by the Agency for Health Care Administration and that accepts the terms of the plan; requiring a managed care plan to offer the same rate of reimbursement to all pharmacies in the plan's network, etc. BI 03/06/2017 Fav/CS AHS 03/21/2017 Favorable AP	Favorable Yeas 8 Nays 0

Other Related Meeting Documents

THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location
302 Senate Office Building

Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5237

DATE	COMM	ACTION
1/2/17	SM	**Favorable**
2/22/17	JU	**Fav/CS**
3/22/17	AHS	Recommend: Fav/CS
	AP	

January 2, 2017

The Honorable Joe Negron
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

Re: **PCS/CS/SB 18 (521374)** – Appropriations Subcommittee on Health and Human Services; Judiciary Committee and Senator Anitere Flores Relief of "Survivor" and the Estate of "Victim"

SPECIAL MASTER'S FINAL REPORT

THIS IS A SETTLED CLAIM FOR $3.75 MILLION AGAINST THE DEPARTMENT OF CHILDREN AND FAMILIES, WHICH AROSE FROM TWO LAWSUITS AGAINST THE DEPARTMENT, ITS EMPLOYEES, AND OTHER DEFENDANTS. THESE LAWSUITS ALLEGED THAT THE NEGLIGENCE OF AND CIVIL RIGHTS VIOLATIONS BY THE DEPARTMENT, ITS EMPLOYEES, AND OTHER DEFENDANTS RESULTED IN THE SEVERE ABUSE AND NEGLECT OF SURVIVOR AND VICTIM AND THE DEATH OF VICTIM.

INTRODUCTION:

On February 14, 2011, Survivor and Victim were found in a pest control truck owned by their adoptive father, Jorge Barahona, along the side of I-95 in Palm Beach County. Victim was dead, and Survivor was severely injured and covered in chemicals. The adoptive parents, Jorge and Carmen Barahona, tortured the children in numerous ways, likely since gaining custody of them in 2004.

For their conduct, the Barahonas are facing charges for first degree murder and aggravated child abuse. The purpose of this special master report is to determine whether the

Department of Children and Families is also a legal cause of the abuse and neglect of the children.

The evidence on which the recommendation in this report is based was controlled by the claimants and consisted primarily of large volume of documents or records created by the department and its contractors and subcontractors and provided by the claimants. However, in some respects, the evidence available for the special master proceeding was limited because the underlying lawsuits settled before trial and discovery.[1] Had a trial or discovery occurred, transcripts of testimony made under oath by parties and eyewitnesses would have been available during the special master proceeding.[2] Additionally, because of the settlement, the department did not present any mitigating evidence during the special master proceeding or object to evidence presented by the claimants.

As a result of the limited evidence, the extent to which or the specific point in time the actions or omissions of the department and its employees became a legal cause of the abuse and neglect of Survivor and Victim cannot be determined. Similarly, the claimants made no effort and felt no obligation to present evidence showing the relative fault of the department and other defendants. Nevertheless, there is sufficient evidence to show that a jury likely would have found that failures by the department to uncover abuse were a legal cause of prolonging the suffering of Survivor and Victim and of Victim's death.

FINDINGS OF FACT:

The Findings of Fact are organized into three main components. The first component provides a chronological description of the department's interaction with Survivor and Victim. The second component describes other specific types of evidence or descriptions of specific events which was made

[1] The lack of traditional evidence complicates a special master's responsibility to independently determine liability.

> Because governmental agencies occasionally settle cases against them for reasons not directly related to the merits of the claim, consent-based judgments are scrutinized carefully by the special master, by the legislative committees, and by both houses of the legislature, to ensure that independently developed facts exist to support the judgment and to justify the award.

D. Stephen Kahn, former General Counsel for the Florida Senate, *Legislative Claim Bills: A Practical Guide to a Potent(ial) Remedy,* FLA. B.J., Apr. 1988, at 27.

[2] Despite the settlement with the department, the claimants could have taken depositions of the relevant department employees under Senate Rule 4.81, which allows discovery consistent with the Florida Rules of Civil Procedure.

available during the special master proceeding. The last component is a summation of the evidence including reasonable inferences from the evidence.

I. Chronological Events

A. Initial Involvement with the Department, 2000

In May 2000, Survivor and Victim, a brother and sister who were twins, were born. From a few days after their birth until Victim was found dead in February 2000, the department was very involved in their lives. The department's first contact with the newborn children occurred because of their biological mother's substance abuse and Victim's medical condition.[3] In March 2002, before Survivor and Victim turned 2 years old, their biological mother was arrested for domestic violence.[4]

In August 2003, when the children were 3 years old, the biological mother's rights were terminated.[5] A few months later in March 2004, the children were removed from their father by the department after he was charged with sexual battery against a minor not related to him.[6]

B. Placement with the Barahonas, 2004

The department then placed Survivor and Victim in the foster home of Jorge and Carmen Barahona. Two other children that the Barahonas fostered and adopted also resided in the Barahona home at the time.[7] There was no evidence presented during the special master proceeding that the Barahonas had mistreated their other children or were not qualified to foster additional children.

Within days after Survivor and Victim were placed with the Barahonas, the children's uncle in Texas sent a letter to the judge assigned to the case and department staff which expressed his and his wife's desire to obtain custody of Survivor and Victim. The letter stated in part:

We are eager to get the legal custody of those kids, and will like to know what we need to do to be able to do so. We are planning to fly to Miami next Tuesday or Wednesday to follow the necessary legal steps to gain custody of those kids. The

[3] Department of Children and Families, *The Barahona Case: Findings and Recommendations* 2 (Mar. 14, 2011).
[4] *Id.*
[5] *Id.*
[6] *Id.*
[7] These two other children have filed separate lawsuits against the department and its employees.

letter further expressed the willingness of the aunt and uncle to take full responsibility for the financial needs of the children during the adoption process.

As a prerequisite to placing the children with their relatives in Texas, a home study for the suitability of the placement was necessary. Notes from the children's guardian ad litem show that the department expected the home study would take 3 months.[8] However, the home study was not completed for about 15 months.[9] No explanation for the lengthier time period for the Texas home study was provided during the special master proceeding.[10] Accordingly, what the department or others did or did not do with respect to the home study is unknown.

Evidence, however, showed that the lengthy time period for the completion of the Texas home study, at least in part, caused Survivor and Victim to remain with the Barahonas. After a year and a half with the Barahonas, for example, a psychological evaluation of the children by Dr. Vanessa Archer, concluded that Survivor and Victim had bonded with the Barahonas and that sending them to Texas would be "devastatingly detrimental."[11, 12] The evidence presented by the claimants during the special master proceeding did not disclose whether the department or someone else selected Dr. Archer for the multiple psychological evaluations assigned to her.

C. Medical Neglect, 2004

During the hearing, the claimants presented evidence that in December 2004, the department became aware of allegations that the Barahonas were neglecting Victim's medical needs.

[8] Notes of Paul Neumann, guardian ad litem (May 18, 2004) (Bates 4764).
[9] The Department of Children and Families, *The Barahona Case: Findings and Recommendations*, 2 (Mar. 14, 2011).
[10] The third amended complaint in the underlying federal lawsuit alleged that the delay in the completion of the home study was caused by inexcusable delays in processing the relevant paperwork by the department and other defendants including Our Kids and the Center for Family and Child Enrichment. See Third Amended Complaint, paragraphs 69-70, 140-142, 162-164, and 166, *Survivor and Estate of Victim v. Our Kids of Miami/Dade/Monroe, Inc. et al.*, Case No.: 1:11-cv-24611-PAS (S.D. Fla.).
[11] Psychological Evaluation by Dr. Archer, Archer Psychological Services, Inc., Sept. 13, 2005 (Bates 4564-4567).
[12] The third amended complaint in the underlying federal lawsuit named Dr. Archer and Archer Psychological Services, Inc., as a defendant. The general allegations forming the basis of Dr. Archer's liability were that she made her placement recommendation without full information which would have included medical records, school records, and abuse reports. See *Id.* at paragraphs 171-189. The complaint further alleged that the Center for Family and Child Enrichment and one of its employees failed in its duties to provide the relevant information to Dr. Archer. See *Id.*

The evidence was in the form of notes recorded by the Center for Family and Child Enrichment, Inc., (CFCE) a defendant in the underlying federal lawsuit.[13] Victim would have been 4 years old at the time.

The notes show that the nurse for Victim's endocrinologist did not believe that Victim was in a good placement for two reasons.[14] First, Victim had not been to an appointment in nearly a year when Victim needed to see the doctor three times a year. Second, Victim is sent to the doctor by herself, which shows that the foster mother does not care for Victim's well-being. Apparently, the department or one of its contractors transported Victim to medical appointments.

As part of the department's 2011 review of the circumstances leading to the claim bill, the department reviewed the response to the allegations of medical neglect. The department's review found that there was "no documentation of case management follow-up with the foster mother as to the nurse's concerns raised with [Victim's] medical care."[15]

D. Evidence of Sexual Abuse, 2005

During the hearing, the claimants presented evidence that the department became aware that Victim had been sexually molested though a phone call to the Central Abuse Hotline about 10 p.m., January 27, 2005. Victim was 4 years old at the time. A narrative of the call written by DCF staff describes the caller's concerns as follows: "In the past, the foster father (unknown) tickled [Victim's] private area (vagina) with his fingers. This happened more than once, and the incidents occurred in the presence of other adults in the home."[16]

Within 2 hours after the call, a department child protective investigator consulted a psychologist who had seen Victim the day before. The investigator's notes indicate that Victim had made allegations to the psychologist that were similar to those

[13] The Center for Family and Child Enrichment (CFCE) is described in the underlying federal lawsuit as a contractor for Our Kids of Miami-Dade/Monroe, Inc. CFCE's contract with Our Kids, according to the lawsuit, required it to provide case management services to children in foster care and under protective supervision in Miami-Dade County. Our Kids, which was under a contract with the department, was described in the lawsuit as the lead agency for the coordination and delivery of community-based foster care and related services. See Third Amended Complaint, paragraphs 40-42, *Survivor and Estate of Victim v. Our Kids of Miami-Dade/Monroe, Inc. et al.*, Case No.: 1:11-cv-24611-PAS (S.D. Fla.).

[14] Notes recorded by the Center for Family and Child Enrichment, Dec. 15, 2004 (Bates 4856).

[15] The Department of Children and Families, *The Barahona Case: Findings and Recommendations* 6 (Mar. 14, 2011).

[16] Intake Report to Central Abuse Hotline, 10:04 p.m., Jan. 27, 2005 (Bates 4500).

made to the Hotline. The notes further indicate that the psychologist found victim's story questionable and unfounded because of how Victim disclosed the story and because of circumstances around the narration of the story.[17] Finally, the psychologist opined that it would be detrimental to wake the children up and confront them as it was then after midnight.[18]

The morning after the Hotline call, there was a face-to-face meeting by a department child protective investigator with all members of the Barahona household. The Barahonas denied any abuse and suggested that the perpetrator was the biological father. The investigator's notes from the meeting further state in part that Victim and Survivor:

> were interviewed initially separately then together. [Victim] denied fo[ster] father touched her. Both children did make statements as to their biological father. They appeared to call both Daddy when speaking in English but called Papa and Papi when addressing them in Spanish clearly differentiating them.[19]

Apparently, department staff concluded that Victim was confusing her foster father with her biological father.[20] On February 9, 2005, department records state that the court was made aware of the abuse concerns as to the biological father and that there were no further concerns about the Barahonas.[21]

As part of the department's 2011 review of the circumstances leading to the claim bill, the department reviewed the sexual assault allegations against Mr. Barahona. The department's review found that the "Documentation suggests that the interview with [Victim] was not adequate."[22] The review further found that Victim and Survivor should have been interviewed away from the Barahonas to get a more candid understanding of how they viewed their caretakers. This interviewing technique was a "fundamental responsibility" according to the

[17] Notes by David Palachi (Jan. 28, 2005) (Bates 4509).
[18] *Id.*
[19] Notes by David Palachi (Jan. 28, 2005) (Bates 4505-4506).
[20] The Department of Children and Families, *The Barahona Case: Findings and Recommendations* 7 (Mar. 14, 2011).
[21] Notes by David Palachi (Feb. 9, 2005) (Bates 4503).
[22] The Department of Children and Families, *The Barahona Case: Findings and Recommendations* 7 (Mar. 14, 2011).

department, which might not have been well understood due to inadequate training and professional insight.[23]

E. Report of Abuse from School, 2006

During the special master hearing, the claimants presented evidence of several incidents, not described in the claim bill, through which the claimants allege the department and others might have become aware of the abuse perpetrated by the Barahonas. For the sake of brevity, only some of the incidents, not identified in the claim bill, will be described in this report. One of these incidents, however, was based on a call to the Central Abuse Hotline at 2:07 p.m. on February 23, 2006, which described Victim as having a "huge bruise on her chin and neck area."[24] According to the narrative of the call written by department staff, Victim made inconsistent statements about whether the bruises occurred at home or at school. The narrative also noted that Victim had missed several days of school.

The department's records show that by 3:30 p.m. a child protective investigator began investigating the call by obtaining Victim's and Survivor's attendance records and grades.[25] Among the first investigative notes, department staff recorded that between November and February 23, 2006, Victim had 17 absences from school.

Later that day, when the children were interviewed at school, Victim said she had slipped and fallen in class.[26] Both Survivor and Victim denied that anyone had hit Victim. However, the children's teacher said that Victim claimed the injury occurred at home and that Victim sometimes comes to school unclean.

The department's investigator had a face-to-face meeting with the Barahonas on the evening of the call to the Hotline. The Barahonas denied knowing about Victim's bruise. Mr. Barahona further explained that "the child usually gives him a hug before going to school and if the child had a mark, he would have seen it."[27]

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[23] *Id.*
[24] Intake Report to Central Abuse Hotline, 2:07 p.m., Feb. 23, 2006 (Bates 4512-4514).
[25] Chronological Notes Reports, Feb. 23, 2006 (Bates 4527-4528).
[26] Chronological Notes Reports, Feb. 23, 2006 (Bates 4524-4526).
[27] Chronological Notes Reports, Feb. 23, 2006 (Bates 4521).

While department staff were speaking with Ms. Barahona, Victim "jumped in the middle and said she slipped and fell in class."[28] The department's notes further indicate that the Barahona home was clean at the time and well-stocked with food and that the other children in the house were free of bruises.

As part of the department's continued investigation of Victim's bruise, records indicate that a child protection team conducted a specialized interview of Victim about 2 weeks after the call to the Hotline. Child protection teams are a team of professionals who provide specialized diagnostic assessment, evaluation, coordination, consultation, and other supportive services.[29] The child protection team in this case concluded that the bruise was not the result of child abuse and that Victim needed testing for hyperactivity.[30]

During the department's 2011 review of the events leading to the claim bill, the department reviewed its response to the February 2006 call to the Hotline. The department's report expressed concerns that what department staff did to investigate the abuse allegation was not fully documented.[31]

F. Report of Abuse from School, 2007

On March 20, 2007, the principal of Survivor and Victim's elementary school reported potential abuse and neglect to Central Abuse Hotline.[32] The narrative recorded by department staff states:

> For the past five months, [Victim] has been smelling and appearing unkempt. At least 2 or 3 times a week, [Victim] smells. She smells rotten. Her uniform is not clean and her shoes are dirty. On one occasion, [Victim] got applesauce in her hair, the next day she had applesauce still in her hair. [Survivor] also appears unkempt. On 2/20/07, [Victim] had food in her backpack from breakfast and lunch. There is a concern that maybe she is not eating at home. [Victim]

[28] Chronological Notes Reports, Feb. 23, 2006 (Bates 4520-4521).
[29] Section 39.303(1), F.S., (2005).
[30] Chronological Notes Reports, Mar. 13, 2006 (Bates 4515-4516).
[31] The Department of Children and Families, *The Barahona Case: Findings and Recommendations*, 7-8 (Mar. 14, 2011).
[32] Intake Report to the Central Abuse Hotline, 3:46 p.m., Mar. 20, 2007 (Bates 4594-4596).

> is always hungry and she eats a lot at school. [Victim] is afraid to talk.[33]

The department's investigative summary, dated April 12, 2007, of its actions in response to the call to the Hotline concluded: "At this time the risk level is low. No evidence was found to support the allegation of environmental hazards toward the children."[34]

In contrast to the department's conclusion, the children's guardian ad litem felt differently. In an email dated the same date as the department's investigative summary, the guardian ad litem informed his supervisor and a department attorney of the concerns of school staff.[35] The email explained that the reports from school, including the children's approximately 20 absences and failing grades, were causing him to rethink his prior conclusion that the children's placement with the Barahonas was best. In closing his email, the guardian ad litem wrote, "I believe some investigation needs to be done, to determine the very best place for these deserving kids to grow up and lead a healthy, happy life."[36] Whether the guardian ad litem reported his concerns to the dependency court is unknown.[37]

In the department's 2011 review of the events leading to the claim bill, it reviewed its response to the March 2007 Hotline call. The department's review determined that there were "compelling facts" gathered by department staff that should have resulted in "'some indicators' or 'verified' findings for abuse."[38]

G. Survivor and Victim Adopted, May 2009

The Barahonas finalized the adoption of Survivor and Victim in May 2009.

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[33] *Id.*
[34] Investigative Summary (Apr. 12, 2007) (Bates 4616-4618).
[35] Email from Paul Neumann, guardian ad litem, to Cynthia Kline, guardian ad litem supervisor and a copy to Christine Lopez-Acevedo, a department attorney (Apr. 12, 2007) (Bates 4619-4620).
[36] *Id.*
[37] At all times relevant to the events described in the claim bill, s. 39.822(4), F.S., required the guardian ad litem for Survivor and Victim to submit written reports of recommendations to the court. These reports were not made available to the special masters.
[38] The Department of Children and Families, *The Barahona Case: Findings and Recommendations* 8 (Mar. 14, 2011).

H. Final Call to Central Abuse Hotline, 2011

The final call to the Central Abuse Hotline when both Survivor and Victim may have been alive, occurred at 2:22 p.m. on February 10, 2011.[39] The call was made by a therapist for the Barahona's niece. According to excerpts of department records, which the claimants transcribed onto a PowerPoint slide for the special master hearing, the call and the department's response were as follows:

> 2/10/11 2:22 PM Survivor and Victim are tied by their hands and feet with tape and made to stay in bathtub all day and night as a form of punishment tape is taken off to ....RESPONSE TIME 24 HOURS BATES 4684-86--- Transcript of Hotline call:-grandmother cares for her and she has foster children who are being abused…. They are being taped up w/their arms and legs and kept in a bathtub-all day and all night and she undoes their arms to eat… and she has been threatened not to say anything….. ….BATES 4672-73
>
> 2/10/11 6:42 PM CPI to home NO CALL TO POLICE when kids not home. Accepts mother's story that kids are with Foster Dad as they have separated. Bates 4634

According to a recording of a hearing before the Barahona Investigative Team, department staff explained that the Hotline operator and her supervisor misclassified the call as one requiring a response within 24 hours. The call, according, to the department should have resulted in an immediate response.

Similarly, in the department's 2011 review of the events leading to the claim bill, it reviewed its response to the final Hotline call. The department's review concluded that the allegations in the call "suggested criminal child abuse incidents requiring immediate response and outreach to law enforcement."[40]

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[39] This information is based on excerpts of documents provided by the claimants on a PowerPoint presentation. Copies of complete records relating to the final call to the Hotline and the department's response to the call were not provided to the special master by the claimants.

[40] The Department of Children and Families, *The Barahona Case: Findings and Recommendations* 10 (Mar. 14, 2011).

II. Specific Types of Evidence or Categories of Events
This component of the Findings of Fact focuses on the interaction of individuals, other than department staff, with Survivor and Victim and events occurring after Victim's death.

A. Judicial Review Proceedings
While Survivor and Victim were placed with the Barahonas, many individuals or entities were overseeing their care. One of these entities was the dependency court. Florida law required the dependency court to review the placement of Survivor and Victim on a regular basis. The information made available during the special master proceeding indicates that the dependency court knew information about the Barahonas' care of the children that, at least in hindsight, is troubling.

For example, during a hearing in December 2004, the guardian ad litem expressed concerns to the dependency court that "'play therapy' that had been originally suggested, and that the judge ordered several months ago had not begun."[41] The guardian ad litem, according to his notes, believed that therapy was needed because Victim "had begun to touch her sexual areas again" since she started visitation with her biological father.[42] In response to these concerns, "the judge told DCF to have another evaluation, and to begin therapy ASAP."[43]

Later in the dependency process, the department reported to the court that Mr. Barahona prevented the guardian ad litem from visiting Survivor and Victim at home from May to August 2007.[44]

Similarly, in October 2007, a Citizen Review Panel, appointed by the dependency court, issued a report of its findings and recommendations relating to Survivor and Victim.[45] Although the panel found that Survivor and Victim's placement with the Barahonas was "APPROPRIATE and SAFE," the report listed several recent legal events and several other concerns.[46]

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[41] Guardian Ad Litem Case Log, Dec. 14, 2004 (BATES 4914).
[42] *Id.*
[43] *Id.*
[44] Recording of hearing of the Barahona Investigative Team. On this issue, the claimants' PowerPoint presentation to the special masters cited to BATES 4635-36.
[45] Recommendations and Findings of the Citizen Review Panel, In and For the Circuit Court of the 11th Judicial Circuit in and for Miami-Dade County, Florida based on a hearing on Oct. 3, 2007 (BATES 4621—27).
[46] *Id.*

The first legal event described by the panel was that the guardian ad litem had not seen the children in 3 months. The second legal event was an abuse report that had been filed with the dependency court. The panel described the events surrounding the abuse report as follows:

> [The principal] reported that [Victim's] teacher called the foster mother with concerns that there has been an increase in absences and there has not been follow through. Both children doing poorly in school and falling asleep in class. They are scared to go home and is hording food. They are petrified of getting in trouble. The kindergarten teacher for [Survivor] and [Victim] was also present. She reported that she was their teacher for 2 1/2 months. The children were fearful of the mom and was petrified to have the mother called. The court ordered reevaluation of both children. Court order psycho-educational and psychological on the children.[47]

The concerns relevant to the claim bill, which were in the panel's October 2007 report, included a concern that the children's dental exams had not been submitted to the panel for review.[48] The panel also stated that it was concerned that the judicial review social study report was not pre-filed by the Center for Family and Child Enrichment, as required by statute. Finally, the panel expressed a concern that the guardian ad litem had not been able to visit the children at the foster home. Despite the concern, the panel noted the statement of an unidentified foster parent that the guardian ad litem did not show up for visits at the scheduled times and called them at an inconvenient time.

After the Citizen Review Panel issued its October 2007 report and after a hearing in the dependency court, the guardian ad litem supervisor sent an email to the guardian ad litem describing the hearing. The supervisor explained, "the judge was not 'buying' what the foster parents were saying" about the guardian ad litem's access to the Barahona home.[49] The

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[47] *Id.*

[48] *Id. "*On three different occasions, the Citizen's Review Panel held a hearing and found that there was no documentation of the current physical, dental or vision check-ups available for the children, nor were they receiving any required therapy." The Department of Children and Families, *The Barahona Case: Findings and Recommendations* 8 (Mar. 14, 2011).

[49] Email from Cynthia Kline, guardian ad litem supervisor, to Paul Neumann, guardian ad litem, Oct. 23, 2007 (BATES 4658).

supervisor further explained, "it appears everyone (although the Judge did not say so) is under the impression that the foster parents are trying to hide something."[50] It was made very clear, wrote the supervisor, that the guardian ad litem was to be given access to the children in the home.

Nonetheless, the Barahona's complaints about the guardian ad litem were considered. Eventually, the guardian ad litem was "discharged from the case to smooth over relationships with the Barahonas."[51]

B. Psychological Evaluations

During the special master proceeding, the claimants provided the special master with a psychological evaluation written by Dr. Vanessa Archer in September 2005 along with portions of other evaluations written by her.[52] The report from September 2005 concluded that "it would be extremely traumatic, if not devastatingly detrimental to the emotional and psychological well-being of these children if they were removed from their current home to be placed with relatives with whom they have no prior relationship. The effects of such a removal, regardless of what transition phase occurs, would have life-long consequences for these children."[53]

The children were evaluated again by Dr. Archer in 2007 when they were 7 years old. Her report stated that both Survivor and Victim had symptoms of depression and that they had thought of killing themselves.[54] The report further stated that Victim "is sure that terrible things are going to happen to her."[55] Survivor expressed to Dr. Archer that he thought "the purpose of the evaluation was to talk about what his father did to him noting that his father 'tickled' him."[56] Similarly, "[Victim] expressed the belief that the purpose of the evaluation was to talk about what her father said to her and that 'people are lying.'"[57]

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[50] *Id.*
[51] The Department of Children and Families, *The Barahona Case: Findings and Recommendations* 9 (Mar. 14, 2011).
[52] Dr. Archer was a defendant in the underlying lawsuits. She was released, according to one of the claimants' attorneys, because she had no insurance.
[53] Dr. Vanessa Archer, Archer Psychological Solutions, Inc., Psychological Evaluation (Sept. 7, 2005).
[54] Dr. Vanessa Archer, Archer Psychological Services, Inc., Psychological Evaluation (June 11, 2007) (BATES 4631, 4633).
[55] *Id.*
[56] *Id.*
[57] *Id.*

Despite the findings in her previous evaluations, in an excerpt of an evaluation from February 2008, Dr. Archer wrote, "it is astounding how these children have thrived. They clearly have a strong bond with their current care givers." As a result, Dr. Archer concluded that adoption was clearly in the children's best interest and "should be allowed to proceed without further delay."[58]

With respect to the February 2008 evaluation, the Barahona independent investigative panel appointed by the department concluded that Dr. Archer:

> failed to consider critical information presented by the children's principal and school professionals about potential signs of abuse and neglect by the Barahonas. That omission made Dr. Archer's report, at best, incomplete, and should have brought into serious question the reliability of her recommendation of adoption. Several professionals, including the Our Kid's case manager, the GAL, and the Children's Legal Services attorney as well as the judge, were, or should have been, aware of that significant omission, and yet apparently failed to take any steps to rectify that critical flaw in her report.[59]

No evidence was produced for the special master proceeding showing whether the department or someone else selected Dr. Archer to perform the psychological evaluations.

C. Abuse Suffered by Survivor and Victim

During the special master hearing, Dr. Eli Newberger testified about the specific types of abuse and neglect suffered by Survivor and Victim. Dr. Newberger is a pediatrician and an expert in matters relating to child abuse and neglect. His testimony was based on his physical examinations of and interviews with Survivor in February 2013 and September 2015. His testimony is also based on interviews of Survivor's aunt and uncle in Texas, who were finally able to adopt Survivor in May 2012.

Dr. Newberger testified that the Barahonas abused and neglected Survivor and Victim in numerous ways. As explained to Dr. Newberger by Survivor:

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[58] Excerpt of a psychological evaluation reproduced on the claimants' PowerPoint presentation, labeled Vanessa L. Archer PhD Report: 2/12/08 (BATES 4991-95).

[59] *The Nubia Report: The Investigative Panel's Findings and Recommendations*, 5

- Mr. Barahona put hot sauce in Survivor's and Victim's eyes, nose, ears, and private parts, both front and back.
- Mr. Barahona shoved a noisemaker in Survivor's ear.
- Mr. Barahona made Survivor and Victim sleep in the bathtub with ice nearly every day for almost 3 years.
- The Barahonas tied Survivor's and Victim's hands and feet together with tape.
- Mr. Barhahona would hit Survivor with a shoe and a mop, hard enough to cause bleeding.
- Mr. Barahona punched Survivor in the mouth, which resulted in Survivor having corrective surgery.
- Mr. Barahona would place a plastic bag at random times over Survivor and Victim's heads for as long as Mr. Barahona would like.
- Mr. Barahona would give electric shocks to Victim for a minute at a time.
- Mr. Barahona had doused Survivor with chemicals.
- Survivor had gone without eating in the Barahona home for as long as 3 days.
- Before Victim had been found, Mr. Barahona gave Survivor pills that caused Survivor to have seizures.

Dr. Newberger's physical examinations of Survivor found numerous scars across his body which were consistent with the abuse described by Survivor above. On Survivor's forearms and ankles, Survivor had linear healing lacerations from cuts through the lowest level of the skin. These scars, according to Survivor, were from having been bound in the bathtub. On his lower abdomen and back, Survivor had scars that are consistent with chemical burns. Survivor also had scarring on his penis, consistent with chemical burns.

Between Dr. Newberger's first examination of Survivor in 2013 and his examination of Survivor in 2015, some of Survivor's scars faded, but others expanded and became more prominent. How long the scars will last is unknown, but they constantly remind Survivor of the abuse he suffered.

When Dr. Newberger asked Survivor whether he was frightened all the time in the Barahona home, Survivor replied, "At night, in the bathtub, we were scared about what would happen in the morning." Additionally, Survivor told Dr. Newberger that at some point in time near Victim's death, she

told him that she wanted to die because she couldn't take the abuse anymore.

The abuse Survivor suffered in the Barahona home continues to affect him in many ways. Survivor's aunt and uncle explained to Dr. Newberger that soon after Survivor was placed with them, they would find Survivor gasping for air in the middle of the night. He was having nightmares about bags being placed over his head.

Unusual smells tend to trigger memories of abuse. Survivor might suddenly say: "I can't stay here," "It reminds me of the chemicals in the truck," or "it reminds me of what [Victim's] body smelled like after she died." Mr. Barahona operated a pest control business, and Mr. Barahona's truck was carrying pest control chemicals when Survivor and Victim were found.

In school, Dr. Newberger explained, Survivor cannot solve math problems or understand what he is reading without a full-time aide by his side. He cannot take any tests without the presence of an aide. Survivor's grades are poor or failing. According to Survivor, he cannot concentrate because he is constantly thinking about the abuse.

A recent example of how memories of abuse affect Survivor occurred after Survivor met with a prosecutor for one of the Barahonas. After he met with the prosecutor, Survivor was tremendously distressed. He insisted on being treated as an infant for a few days. He wanted to be cuddled and called by various pet names that one would call an infant. In psychological terms, this event was a serious regression and was very unusual for a 15 year old, according to Dr. Newberger.

Dr. Newberger has diagnosed Survivor as having chronic post-traumatic stress disorder, noting that Survivor's entire arc of development has been nothing but deprivation, assaults, witnessing assaults, including a murderous assault on his sister. Dr. Newberger further opined that within a reasonable degree of medical probability, Survivor has suffered a permanent injury because of the abuse in the Barahona home.

Dr. Newberger concludes that Survivor will need psychiatric and psychological care for the rest of his life as he comes into

contact with things that provoke memories and distress. Moreover, Dr. Newberger opined that if Survivor does not have the capacity to learn, his capacity to have a job and provide for himself, his ability to live independently, and his capacity to have a family and conduct himself as an adult are crippled.

D. The Barahona Case: Findings and Recommendations

On February 21, 2011, days after Victim's body was found, the Secretary of the Department of Children and Families established an independent investigative panel to examine issues relating to the Barahonas.[60] The department attached the findings and suggestions from the investigative panel in its report titled *The Barahona Case: Findings and Recommendations.* When available, the department's assessments of its actions are included in the chronological description of its interaction with the children.

During the special master hearing, a member of the investigative panel, David Lawrence, [61] described the panel's activities, information it reviewed, and the findings described in its report titled *The Nubia Report: The Investigative Panel's Findings and Recommendations*.[62] The investigative panel's findings include the following:

- Dr. Archer failed to consider critical information about potential signs of abuse, making her reports incomplete.[63]
- The case manager from Our Kids, the guardian ad litem, and the Children's Legal Services attorney, as well as the judge, were, or should have been, aware of significant omissions in Dr. Archer's reports but failed to take any serious steps to correct the critical flaws.[64]
- There was no centralized system to ensure the dissemination of critical information to all parties overseeing the care of Survivor and Victim.[65]

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[60] David Lawrence Jr., Roberto Martinez, and Dr. James Sewell, *Barahona Investigative Team Report* 4 (Mar. 10, 2011).
[61] Mr. Lawrence was the president of The Early Childhood Initiative Foundation and chair of the Children's Movement of Florida.
[62] *The Nubia Report: The Investigative Panel's Findings and Recommendations* is available at https://www.dcf.state.fl.us/initiatives/barahona/docs/meetings/Nubias%20Story.pdf.
[63] David Lawrence, Jr., et al., *supra* note 60.
[64] *Id.* at 5.
[65] *Id.*

- The guardian ad litem, school personnel, and a nurse practitioner raised serious concerns that should have required "intense and coordinated follow-up."[66]
- There was no person serving as the "system integrator" who ensured that relevant information, including allegations of abuse, was shared and made accessible to others.[67]
- There is evidence of multiple instances in which the Barahonas did not ensure the health of Survivor and Victim.[68]
- During the hearings before the panel, the actions and testimony of the Chief Executive Officers of Our Kids and the Center for Family and Child Enrichment "created suspicions as to what, if anything, they were trying to hide."[69]
- Post-adoption services should have been identified by Our Kids after a post-adoption call to the Hotline in June 2010.[70]
- Much of the necessary information raising red flags about the Barahonas was present within the system, but the individuals involved relied on inadequate technology instead of talking to each other.[71]

E. Letter of Support

The department has provided a letter of support for a claim bill in an amount not to exceed $3.75 million, consistent with the settlement agreement in this matter.

III. Inferential Findings of Fact

The evidence presented, including the guardian ad litem's access to the children, lack of documentation of necessary medical care, the nature of the complaints to the Hotline, and the children's statements to Dr. Archer, show that the department and other defendants to the underlying lawsuits would have had good reason to be suspicious of how the Barahonas were treating Survivor and Victim. Moreover, the shortcomings of the department in its responses to allegations of abuse and neglect, including admissions that its staff failed

[66] *Id.* at 6.
[67] *Id.*
[68] *Id.* at 7.
[69] *Id.* at 8.
[70] *Id.*
[71] *Id.* at 9.

to follow procedures, are credible along with the findings of the independent review panel.

Because the individuals overseeing the care of Survivor and Victim, which included department staff and others, had reason to be suspicious, it seems appropriate to ask, what possible explanation could there be for failing to discover the abuse and neglect? Because this matter settled before discovery and trial and because the individuals involved were not asked to testify for the special master proceeding, they were never asked this question on the record. However, the evidence available suggests that their conduct might be explained by:

- Evidence and allegations of abuse and neglect by the children's biological mother who was a drug addict and their biological father, a child molester.
- The lack of evidence that Barahonas had improperly cared for their other adoptive children.
- The convincing nature of the Barahona's lies and the Barahona's ability to coerce the children into denying the allegations of abuse.
- Wishful thinking, coupled with a belief that the signs of the type of unimaginable abuse perpetrated by the Barahonas would have been more obvious.

Although one might explain the conduct of the department and others as above, the explanations become less and less of an excuse as the signs and allegations of abuse and neglect increase.

CONCLUSIONS OF LAW:

The lawsuits leading to this claim bill were based on allegations of negligence and civils right violations.

I. Negligence

In a negligence action, "a plaintiff must establish the four elements of duty, breach, proximate causation, and damages."[72] Whether a duty of care exists is a question of law.[73] The Department of Children and Families has a duty to reasonably investigate complaints of child abuse and neglect, which is recognized by case law.[74] Once a duty is found to

[72] *Limones v. School Dist. of Lee County*, 161 So. 3d 384, 389 (Fla. 2015).
[73] *McCain v. Fla. Power Corp.*, 593 So. 2d 500, 502 (Fla. 1992).
[74] *Dept. of Health and Rehabilitative Svcs. v. Yamuni*, 498 So. 2d 441, 442-43 (Fla. 3d DCA 1986) (stating that the Dept. of Health and Rehabilitative Services, a precursor to the Dept. of Children and Families, has a statutory

exist, whether a defendant was negligent in fulfilling that duty is a question for the finder of fact.[75] In making that determination, a fact finder must decide whether a defendant exercised the degree of care that an ordinarily prudent person, or caseworker in this instance, would have under the same or similar circumstances.[76]

I find that the claimants provided sufficient evidence in the proceeding to show that, had this case proceeded to trial, a jury would have found that the department and others breached their duties to Survivor and Victim. Juries have done so in somewhat similar lawsuits. However, due to the limited evidence, especially the lack of testimony of any of the various caseworkers, case managers, and child protective investigators, the specific point in time that the department breached its duty cannot be identified with precision.

I also find that the claimants presented sufficient evidence in this matter to show that a jury would have found that actions and inactions by the department proximately caused the suffering of Survivor and Victim to be prolonged and caused Survivor's death. "[T]he issue of proximate cause is generally a question of fact concerned with 'whether and to what extent the defendant's conduct foreseeably and substantially caused the specific injury that actually occurred.'"[77] In cases against the department having some similarities to this matter, the appellate court determined that "[t]he plaintiffs presented evidence that there is a natural, direct, and continuous sequence between DCF's negligence and [a child's] injuries such that it can be reasonably said that but for DCF's negligence, the abuse to [the child] would not have occurred."[78]

Finally, I find that the claimants presented sufficient evidence that a jury would have further found that Survivor and Victim suffered damages because of the department's negligence. No amount of money can compensate for the pain and

duty of care to prevent further harm to children when reports of child abuse are received); *Dept. of Children and Family Svcs. v. Amora*, 944 So. 2d 431 (Fla. 4th DCA 2006).

[75] *Yamuni, 529 So. 2d* at 262.

[76] *Russel v. Jacksonville Gas Corp.*, 117 So. 2d 29, 32 (Fla 1st DCA 1960) (defining negligence as, "the doing of something that a reasonable and prudent person would not ordinarily have done under the same or similar circumstances, or the failure to do that which a reasonable and prudent person would have done under the same or similar circumstances").

[77] *Amora*, 944 So. 2d at 431.

[78] *Id.*

suffering that Survivor and Victim endured. However, the $5 million settlement by the department in this matter is not excessive compared to jury verdicts in similar cases.

II. Federal Civil Rights Violations

The federal lawsuit underlying this claim bill alleged that the department, its employees, Our Kids and its employees, and the Center for Family and Child Enrichment and its employees violated the federal civil rights of Survivor and Victim.

The specific legal standard governing civil rights claims is set forth in 42 U.S.C. s. 1983, which states in relevant part:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State . . . subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress . . . .

In contrast to a negligence action, in a civil rights action, the defense of sovereign immunity or the limits on the collectability of a judgment or the payment of a claim under s. 768.28, F.S., do not apply.[79] For the time periods applicable to the claim bill, s. 768.28, F.S., limited the collectability of a judgment or claim to $100,000 per person and $200,000 for all claims arising out of the same incident.[80]

Case law clearly shows that under 42 U.S.C. s. 1983, state officials and contractors such as Our Kids can be held liable for violations of a foster child's civil rights.[81] The applicable rights protected by statute include the "constitutional right to

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[79] *Howlett v. Rose*, 496 U.S. 356 (1990).

[80] Chapter 2010-26, Laws of Fla., increased the limits on the payment of a claim or judgment to $200,000 per person and $300,000 for all claims arising out of the same incident. The increased limits apply to claims arising on or after October 1, 2011.

[81] *Taylor v. Ledbetter*, 818 F.2d 791 (11th Cir. 1987); *Crispell v. Dept. of Children and Families*, 2012 WL 3599349 (M.D. Fla. 2012) (denying Children's Homes Society of Florida's motion to dismiss a civil rights action because the court found that the entity was not an arm of the state entitled to immunity under the 11th Amendment to the United States Constitution); *Woodburn v. Dept. of Children and Family Svcs.*, 854 F.Supp.2d 1184, 1201 (S.D. Fla. 2011) (finding that the plaintiff "alleged sufficient facts to support a facially plausible claim that her constitutional rights were violated by . . . Our Kids for the purpose of surviving a motion to dismiss").

be free from unnecessary pain and a fundamental right to physical safety."[82]

Proving a civil rights violation is different than proving negligence.[83] In a civil rights action, the plaintiff must show that the defendant was deliberately indifferent to the violation of a federal right. The defendant's knowledge of a risk of harm is key. A state official acts with deliberate indifference only when disregarding a risk of harm of which he or she is actually aware.

Following the guidance above, the Federal 11th Circuit Court of appeals has stated that "in order to establish deliberate indifference, plaintiffs must be able to allege (and prove at trial) that the defendant (1) was objectively aware of a risk of serious harm; (2) recklessly disregarded the risk of harm; and (3) this conduct was more than merely negligent."[84]

The evidence presented during the special master proceeding showed that the actions of the department were negligent, not civil rights violations.[85]

RELATED ISSUES:

A claim bill is an act of legislative grace, not an entitlement.[86] These bills are a "voluntary recognition of its moral obligation by the legislature . . . based on its view of justice and fair treatment of one who ha[s] suffered at the hands of the state."[87] Consistently, the legislative proceedings relating to claim[88] bills are "separate and apart from the constraints of an earlier lawsuit."[89]

For these reasons, special masters inquire into matters that might not be admissible in court but may be relevant to

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[82] *Ray v. Foltz*, 370 F.3d 1079, 1082 (11th Cir. 2004) (citing *Taylor v. Ledbetter*, 818 F.2d 791, 794-95 (11th Cir. 1987) (en banc)).
[83] *Ray v. Foltz*, 370 F.3d 1079, 1083 (11th Cir 2004).
[84] *Id.* (citing *McElligott v. Foley*, 182 F.3d 1248, 1255 (11th Cir. 1999)).
[85] Nonetheless, the department made a payment of $1.25 million, which was in excess of the amounts authorized for negligence actions under s. 768.28, F.S. Perhaps there are facts that are known by the parties that were not presented. When I asked the claimants' attorneys during the special master hearing what facts took the Barahona lawsuits from negligence to a civil rights action, they declined to directly answer the question.
[86] *Searcy Denny Scarola Barnhart & Shipley, P.A. v. State,* 2015 WL 4269031, *5 (Fla. 4th DCA), *review granted*, 2015 WL 6127021 (Fla. Oct. 14, 2015).
[87] *Noel v. Schlesinger*, 984 So. 2d 1265, 1267 Fla. 4th DCA) quoting *Gamble v. Wells*, 450 So. 2d 850, 853 (Fla. 1984).
[88] *Searcy, et al., supra* note 86.
[89] *Id.*

decisions by legislators. These inquires do not affect the recommendation of this report. However, common inquiries include: What is the claimant's criminal history? Is the claimant lawfully present in the United States? Is there any information about the claimant which would cause embarrassment to the Legislature should it enact the claim bill?

Because of the complexity of the department's system to oversee foster care and investigate allegations of abuse and neglect, different questions arise in this matter. These questions relate to the liability of other parties who were also defendants to the underlying lawsuits and were under contract to care for Survivor and Victim.

I. Fault and Damages Collected from Other Defendants

With respect to this claim bill, the most relevant inquiry asks: Who besides the Department of Children and Families was at fault for the abuse and neglect of Survivor and Victim? Of the others at fault, why were they at fault and what was their relative contribution to the damages suffered by Survivor and Victim? Finally, what amounts have been recovered from others?[90]

The claimants declined my request to explain the responsibility of others for the abuse of Survivor and Victim and Victim's death.[91] Nonetheless, there is information suggesting that others bear substantial responsibility, including Dr. Archer, Our Kids, and the Center for Family and Child Enrichment.

According to the settlement agreement in this matter, the department agreed to work cooperatively to reach a settlement with Dr. Archer "as part of which she will agree to take no more court or agency appointments relating to the

[90] If the lawsuit had proceeded to trial after the claimants reached a settlement with other defendants, a court may have found that the settlement agreement could not be used as a basis for offsetting damages owed by the department by damages paid by one of the defendants to the underlying lawsuits. *See Wal-Mart Stores v. Strachan*, 82 So. 3d 1052 (Fla. 4th DCA 2011). With the abolition of joint and several liability, an award against a defendant generally may not be offset by amounts recovered by a settlement with another defendant. *Id.*

[91] The State Constitution permits a legislator to consider any information he or she deems to determine whether a claim bill is in the interests of his or her constituents or the state as a whole. Moreover, because claim bills are a type of appropriation bill, a legislator should have access to information necessary to determine how to rank a claim bill among the state's funding priorities.

foster care or dependency system, or children in it."[92] Further, according to one of the attorneys for the claimants, Dr. Archer was dismissed from the federal court case; she had no insurance, and she made no payment.[93]

The claimants disclosed that they reached a settlement agreement with Our Kids and the Center for Family and Child Enrichment. I asked for the claimants' attorneys for details about the settlement agreement. They refused to make the settlement agreement available or disclose the settlement amount.[94]

Had the claimants fully disclosed information relative to the conduct of the other defendants to the underlying lawsuits and any settlements, the Legislature could independently evaluate whether the department's settlement agreement is in the best interests of the state. Similarly, the lack of disclosure restricts the Legislature from independently determining whether it has a moral obligation to provide compensation in excess of the settlement agreement with the department.

The Supreme Court's opinion in *Fabre v. Marin* shows that, had this matter been presented to a jury, the jury would have apportioned the damages among all the responsible persons.[95] Thus, the department would have been responsible only for that portion of damages equivalent to its percentage of fault.[96, 97]

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[92] Mem. of Settlement, paragraph 5 (Mar. 6, 2013), *Survivor and Estate of Victim v. Our Kids of Miami/Dade/Monroe, Inc. et al.*, Case No.: 1:11-cv-24611-PAS.
[93] Statement of Neal Roth during the special master hearing (Oct. 30, 2015).
[94] The settlement agreement between the claimants and Our Kids and the Center for Family and Child Enrichment should be readily available as a public record, just as the claim bill, investigative reports by the department, and the settlement agreement between the claimants and the department is a public record. *See* ss. 409.1671 (2011), 287.058(1)(c), 119.011(2), and 119.07(1), F.S.; *see also* s. 69.081(8), F.S. The information is also available to the Legislature under s. 11.143, F.S.
[95] *Fabre v. Marin*, 623 So. 2d 1182 (Fla. 1993).
[96] *Id.* at 1185.
[97] Additionally, the lack of disclosure by the claimants' attorneys precludes an analysis of whether the department could be legally responsible for the contractors. According to *Del Pilar v. DHL Customer Solutions, Inc.,* 993 So. 2d 142, 145-46 (Fla. 1st DCA 2008):

> Generally, a principal is not vicariously liable for the negligence of its independent contractor, but the principal is liable for the negligence of its agent. *See generally Fla. Power & Light Co. v. Price*, 170 So.2d 293 (Fla.1964). Whether one laboring on behalf of another is a mere agent or an independent contractor "is a question of fact ... not controlled by descriptive labels employed by the parties themselves." *Parker v. Domino's Pizza, Inc.*, 629 So.2d 1026, 1027 (Fla. 4th DCA 1993) (internal citations omitted); see also *Font v. Stanley Steemer Int'l, Inc.*, 849 So.2d 1214, 1216 (Fla. 5th DCA 2003) (noting that question of status "is normally one for the trier of fact to decide").

II. Distribution of Settlement Proceeds

A second related issue is whether the settlement funds paid by the department have been distributed to Survivor and the Estate of Victim. Pursuant to its settlement agreement with the claimants, the department has made the required payment of $1.25 million. The Memorandum of Settlement, filed in the federal lawsuit, required the department to pay the settlement funds to the claimants' attorneys by the beginning of April 2013.

In October 2015, the claimants successfully terminated any rights the Barahonas may have had to inherit from Victim's estate. However, as of the date of this report, the claimants' attorneys have not provided any information showing that the settlement funds were distributed to their clients.

ATTORNEYS FEES:

Section 768.28(8), F.S., states "[n]o attorney may charge, demand, receive, or collect, for services rendered, fees in excess of 25 percent of any judgment or settlement." In compliance with the statute, Neal Roth, one of the claimants' attorneys, submitted an attorney fee affidavit that states in pertinent part:

> 1. My name is Neal A. Roth and I am a partner of the Law Firm of Grossman Roth . . .
> 2. Grossman Roth, P.A., is counsel for Claimants, Survivor and Richard Milstein, as Personal Representative of the Estate of Victim, deceased.
> 3. As counsel for the Claimants, we have fully complied with all provisions of Section 768.28 (8).
> 4. Insofar as lobbying fees are concerned, the bill as filed provides that any lobbying fees related to the claim bill will be included as part of the statutory cap on attorneys' fees in Section 768.28.

Additionally, closing statements provided by the claimants' attorneys indicate that the contract with the claimants provides for an award of attorney fees in the amount of 25 percent of the $5 million settlement, which is $1.25 million, plus costs.

RECOMMENDATIONS: For the reasons set forth above, I recommend that Senate Bill 18 be reported FAVORABLY.

Respectfully submitted,

Thomas C. Cibula
Senate Special Master

cc: Secretary of the Senate

Recommended PCS/CS by Appropriations Subcommittee on Health and Human Services on March 21, 2017:
The committee substitute directs that the source of funds used for this relief bill be derived from the Federal Grants Trust Fund in the Department of Children and Families rather than from the General Revenue Fund. Also, funds are to be paid over a two year period rather than in a single year as originally specified.

CS by Judiciary:
The committee substitute, in conformity with a recent opinion of the Florida Supreme Court, does not limit the amount of lobbying fees that may be paid from the proceeds of the bill.

500202

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/22/2017	.	
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Appropriations Subcommittee on Health and Human Services (Flores) recommended the following:

Senate Amendment (with title amendment)

Delete lines 153 - 165

and insert:

Section 2. For the relief of Survivor for personal injuries he sustained and to the Estate of Victim for damages related to the death of Victim:

(1) The sum of $1.875 million is appropriated from the Federal Grants Trust Fund to the Department of Children and Families for the 2017-2018 fiscal year; and

500202

(2) The sum of $1.875 million is appropriated from the Federal Grants Trust Fund to the Department of Children and Families for the 2018-2019 fiscal year.

Section 3. The Chief Financial Officer is directed to draw warrants upon the funds appropriated in section 2 of this act to pay such funds, as follows:

(1) No later than August 1, 2017, in favor of the adoptive parents of Survivor, as legal guardians of Survivor, in the amount of $562,500, and to Richard Milstein, as personal representative of the Estate of Victim, in the amount of $1,312,500; and

(2) No later than August 1, 2018, in favor of the adoptive parents of Survivor, as legal guardians of Survivor, in the amount of $562,500, and to Richard Milstein, as personal representative of the Estate of Victim, in the amount of $1,312,500.

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

And the title is amended as follows:

Delete lines 3 - 5

and insert:

"Victim"; providing appropriations to compensate Survivor and the Estate of Victim for injuries and damages sustained as a result of the negligence of the

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 Appropriations Subcommittee on Health and Human Services

BILL:	CS/CS/SB 240
INTRODUCER:	Health Policy Committee; Banking and Insurance Committee; and Senator Lee and others
SUBJECT:	Direct Primary Care
DATE:	March 20, 2017 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.	Lloyd	Stovall	HP	**Fav/CS**
3.	Loe	Williams	AHS	**Recommend: Favorable**
4.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 240 amends the Florida Insurance Code (code) to provide that a direct primary care agreement is not insurance and is not subject to regulation under the code. Direct primary care (DPC) is a primary care medical practice model that eliminates third party payers from the primary care provider-patient relationship. The bill also defines and establishes DPC agreements in chapter 456, Florida Statutes, relating to general provisions for health care practitioners.

Through a contractual agreement, a patient pays a monthly fee, usually between $50 and $100 per individual, to the primary care provider for defined primary care services. As of June 2016, 16 states have adopted DPC laws that define DPC as a medical service outside the scope of state insurance regulation. The bill defines terms and specifies certain provisions, including consumer disclosures, which must be included in a DPC agreement.

The Agency for Health Care Administration (AHCA) is required to submit a waiver to the appropriate federal authorities by January 1, 2018, to provide Medicaid recipients in the Statewide Medicaid Managed Care (SMMC) program the opportunity to select DPC agreements as a delivery service option.

The bill has no fiscal impact on state or local government.

The effective date of the bill is July 1, 2017.

II. Present Situation:

Direct Primary Care

Direct primary care is a primary care medical practice model that eliminates third party payers from the provider-patient relationship. Through a contractual agreement, a patient generally pays a monthly retainer fee, on average $77 per individual,[1] to the primary care provider for defined primary care services, such as office visits, preventive care, annual physical examination, and routine laboratory tests.

After paying the monthly fee, a patient can access all services under the agreement at no extra charge based on the terms of the agreement. Typically, DPC practices provide routine preventive services, screenings, or tests, like lab tests, mammograms, Pap screenings, and vaccinations. A primary care provider DPC model can be designed to address most health care issues, including women's health services, pediatric care, urgent care, wellness education, and chronic disease management.

Some of the potential benefits of the DPC model for providers include reducing patient volume, minimizing administrative and staffing expenses; increasing time with patients; and increasing revenues. In the DPC practice model, the primary care provider eliminates administrative costs associated with filing and resolving insurance claims. Direct primary care practices claim to reduce expenses by more than 40 percent by eliminating administrative staff resources associated with third-party costs.[2]

In 2014, the American Academy of Private Physicians (AAPP) estimated that approximately 5,500 physicians operate under some type of direct financial relationship with their patients, outside of standard insurance coverage. According to the AAPP, that number has increased around 25 percent per year since 2010.[3] The Direct Primary Care Coalition has adopted model state legislation for DPC agreements.[4] As of June 2016, 16 states have adopted DPC legislation, which defines DPC as a medical service outside the scope of state insurance regulation.[5]

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[1] A study of 141 DPC practices found the average monthly retainer fee to be $77.38. Of the 141 practices identified, 116 (82 percent) have cost information available online. When these 116 practices were analyzed, the average monthly cost to the patient was $93.26 (median monthly cost, $75.00; range, $26.67 to $562.50 per month). Of the 116 DPCs noted, 36 charged a one-time enrollment fee and the average enrollment fee was $78. Twenty-eight of 116 DPCs charged a fee for office visits in addition to the retainer fee, and the average visit fee was $16. *See* Phillip M. Eskew and Kathleen Klink, *Direct Primary Care: Practice Distribution and Cost Across the Nation*, Journal of the Amer. Bd. of Family Med. (Nov.-Dec. 2015) Vol. 28, No. 6, p. 797, *available at:* http://www.jabfm.org/content/28/6/793.full.pdf (last viewed Feb. 10, 2017).

[2] Lisa Zamosky, Direct-Pay Medical Practices Could Diminish Payer Headaches, MEDICAL ECONOMICS, (April 24, 2014), http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/concierge-service/direct-pay-medical-practices-could-diminish-payer-h. (last viewed Feb. 10, 2017).

[3] David Twiddy, *Practice Transformation: Taking the Direct Primary Care Route*, Family Practice Management, No. 3, (May-June 2014), *available at:* http://www.aafp.org/fpm/2014/0500/p10.html (last viewed Feb. 10, 2017).

[4] Direct Primary Care Coalition Model State Legislation, *available at:* http://www.dpcare.org/dpcc-model-legislation. (last viewed Feb. 10, 2017).

[5] See http://www.dpcare.org/ (last viewed Feb. 10, 2017).

The DPC practice model is often compared to the concierge practice model. However, while both provide access to primary care services for a periodic fee, the concierge model continues to bill third party payers, such as insurers, in addition to the collection of membership and retainer fees.[6]

Federal Health Care Reform and Direct Primary Care

The federal Patient Protection and Affordable Care Act (PPACA)[7] requires health insurers to make guaranteed issue coverage available to all individuals and employers without exclusions for preexisting conditions and without basing premiums on any health-related factors. The PPACA also mandates that insurers that offer qualified health plans (QHPs) provide 10 categories of essential health benefits,[8] which includes preventive[9] care and other benefits.

The PPACA addresses the DPC practice model as part of health care reform. A QHP may provide coverage through a DPC medical home plan that meets criteria[10] established by the federal Department of Health and Human Services (DHHS), provided the QHP meets all other applicable requirements.[11] Insureds who are enrolled in a DPC medical home plan are compliant with the individual mandate if they have coverage for other services, such as a wraparound catastrophic health policy[12] or high deductible, health insurance plans[13] to provide coverage for severe injuries or chronic conditions.

In Colorado and Washington, qualified health plans offer DPC medical home coverage on the state-based health insurance exchanges.[14] One of those qualified health plans also participates as a managed care plan in Washington and offers access to its DPC medical home provider sites for its Medicaid managed care plan enrollees. The three clinics offer extended office hours and 24/7 access to physicians for the recipients.[15]

In Michigan, for the 2016-2017 state fiscal year, the DHHS through the annual appropriations bill has been tasked to review and consider implementing a pilot program to allow Medicaid enrollees in managed care to participate in a direct primary care provider plan. Outcomes and performance specified in that bill include:

- The number of enrollees in the pilot program by Medicaid eligibility category;
- Direct primary care cost per enrollee; and

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[6] Eskew and Klink, s*upra* note 1, at 793.
[7] Pub. Law No. 111-148 (Mar. 23, 2010) amended by Pub. Law. No. 111-152 (Mar. 30, 2010).
[8] 42 U.S.C. s.18022.
[9] Available at: https://www.hhs.gov/healthcare/about-the-law/preventive-care/index.html#. (last viewed Feb. 13, 2017). Many of these preventive services must be covered without any cost sharing by the patient.
[10] The HHS has not adopted criteria to date.
[11] *See* 42 U.S.C. ss. 18021(a)(3) and 18022.
[12] Catastrophic plans are a form of high deductible plans, which meet the minimum essential coverage requirements. See 42 U.S.C. s. 18021 for eligibility and coverage requirements.
[13] A high deductible health plan (HDHP) has a higher deductible than typical plans and a maximum limit on amount of the annual deductible and out-of-pocket medical expenses that an insured must pay for covered expenses. Out-of-pocket expenses include copayments and other amounts, excluding premiums.
[14] See http://www.akleg.gov/basis/get_documents.asp?session=29&docid=7936 (last visited Feb. 13, 2017).
[15] Qliance, *New Primary Care Model Delivers 20 Percent Lower Overall Healthcare Costs, Increases Patient Satisfaction,* State of Reform (Jan. 15, 2015) http://stateofreform.com/news/industry/healthcare-providers/2015/01/qliance-study-shows-monthly-fee-primary-care-model-saves-20-percent-claims/ (last viewed Feb. 21, 2017).

- Other Medicaid managed care cost savings generated from direct primary care.[16]

While the DHHS regulations do not consider DPC medical homes as insurance,[17] the Internal Revenue Service (IRS) regulations will not permit tax deductions for those individuals with both health savings accounts (HSAs) and DPCs as the tax code considers the DPC a second health plan.[18] The IRS Code additionally does not permit the periodic payments made to primary care physicians under a DPC model to qualify as a medical expense under Section 213(d) of the IRS Code.

State Regulation of Insurance

The Office of Insurance Regulation (OIR) licenses and regulates the activities of insurers, HMOs, and other risk-bearing entities. These specified entities must meet certain requirements for licensure. The AHCA issues regulations regarding the quality of care provided by HMOs and prepaid health clinics under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO and a prepaid health clinic must receive a Health Care Provider Certificate[19] from the AHCA pursuant to part III of ch. 641, F.S.[20]

Currently, Florida law does not address DPC agreements. However, a medical provider offering DPC agreements may be considered to be operating a prepaid health clinic if the medical provider is offering to provide services in exchange for a prepaid fixed fee.[21]

Prepaid Health Clinics

Prepaid health clinics[22] are required to obtain a certificate of authority from the OIR pursuant to part II of chapter 641, F.S. The entity must meet minimum surplus requirements[23] and comply with solvency protections for the benefit of subscribers by securing insurance or filing a surety bond with the OIR.[24] Part II also provides that the procedures for offering basic services and offering and terminating contracts to subscribers may not unfairly discriminate based on age, health, or economic status.[25]

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[16] 2016 Mich. Pub. Acts No. 268; section 1701; (*See:* http://www.legislature.mi.gov/documents/2015-2016/publicact/pdf/2016-PA-0268.pdf).
[17] 45 C.F.R. s. 156.245 (10-1-2016).
[18] 26 U.S. Code s. 223
[19] Section 641.49, F.S.
[20] Section 641.48, F.S., provides that the purpose of part III of ch. 641, F.S., is to ensure that HMOs and prepaid health clinics deliver high-quality care to their subscribers.
[21] Part II of ch. 641, F.S.
[22] Section 641.402, F.S., defines the term, "prepaid health clinic," to mean any organization authorized under part II that provides, either directly or through arrangements with other persons, basic services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis, including those basic services which subscribers might reasonably require to maintain good health. However, no clinic that provides or contracts for, either directly or indirectly, inpatient hospital services, hospital inpatient physician services, or indemnity against the cost of such services shall be a prepaid health clinic.
[23] Section 641.406, F.S. Each prepaid health clinic must maintain minimum surplus in the amount of $150,000 or 10 percent of total liabilities, whichever is greater.
[24] Section 641.409, F.S.
[25] Section 641.406, F.S.

Prepaid Limited Health Service Organizations

Prepaid limited health service organizations provide limited health services to enrollees through an exclusive panel of providers in exchange for a prepayment authorized under ch. 636, F.S. Limited health services include ambulance, dental, vision, mental health, substance abuse, chiropractic, podiatric, and pharmaceutical. Provider arrangements for prepaid limited health service organizations are authorized in s. 636.035, F.S., and must comply with the requirements in that section.

State Regulation of Health Care Practitioners

The Department of Health (DOH) is responsible for the licensure and regulation of most health care practitioners in the state. In addition to the regulatory authority in specific practice acts for each profession or occupation, ch. 456, F.S., provides the general regulatory provisions for health care professions within the DOH, Medical Quality Assurance Division.

Section 456.001, F.S., defines "health care practitioner" as any person licensed under chs. 457, (acupuncture); 458 (medicine); 459 (osteopathic medicine); 460 (chiropractic medicine); 461 (podiatric medicine); 462 (naturopathic medicine); 463 (optometry); 464 (nursing); 465 (pharmacy); 466 (dentistry and dental hygiene); 467 (midwifery); 478 (electrology or electrolysis); 480 (massage therapy); 484 (opticianry and hearing aid specialists); 486 (physical therapy); 490 (psychology); 491 (psychotherapy), F.S., or parts III or IV of ch. 483 (clinical laboratory personnel or medical physics), F.S.

Additionally, the miscellaneous professions and occupations regulated in parts I, II, III, V, X, XIII, or XIV (speech-language pathology and audiology; nursing home administration; occupational therapy; respiratory therapy; dietetics and nutrition practice; athletic trainers; and orthotics, prosthetics, and pedorthics) of ch. 468, F.S., are considered health care practitioners under s. 456.001, F.S.

Statewide Medicaid Managed Care

Florida Medicaid

The Medicaid program is a partnership between the federal government and state governments to provide medical care to low income children, pregnant women, individuals with disabilities, and individuals 65 years of age and older. Each state operates its own Medicaid program under a state plan that must be approved by the federal Centers for Medicare & Medicaid Services (CMS). The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies.

Florida Medicaid is administered by the AHCA and is financed with federal and state funds. The Department of Children and Families (DCF) determines Medicaid eligibility and transmits that information to the AHCA. The AHCA is designated as the single state Medicaid agency and has the lead responsibility for the overall program.[26]

[26] *See* s. 409.963, F.S.

Over 4 million Floridians are currently enrolled in Medicaid.[27] The Medicaid program's estimated expenditures for the 2016-2017 fiscal year are $25.8 billion.[28] The current traditional federal share is 60.99 percent with the state paying 39.01 percent for Medicaid enrollees.[29] Florida has the fourth largest Medicaid population in the country and fifth largest in expenditures.[30]

Medicaid currently covers:

- 47 percent of Florida's children;
- 63 percent of Florida's births; and
- 61 percent of Florida's nursing homes days.[31]

The structures of state Medicaid programs vary from state to state, and each state's share of expenditures also varies and is largely determined by the federal government. Approximately 85 percent of Florida's Medicaid program is enrolled in managed care. Federal law and regulations set the minimum amount, scope, and duration of services offered in the program, among other requirements. State Medicaid benefits are provided in statute under s. 409.903, F.S., (Mandatory Payments for Eligible Persons) and s. 409.904, F.S. (Optional Payments for Eligible Persons).

Applicants for Medicaid must be United States citizens or qualified noncitizens, must be Florida residents, and must provide social security numbers for data matching. While self-attestation is permitted for a number of data elements on the application, most components are matched through the Federal Data Services Hub.[32] Applicants must also agree to cooperate with Child Support Enforcement during the application process and eligibility process.[33]

Minimum eligibility coverage thresholds are established in federal law for certain population groups, such as children and pregnant women, as well as minimum benefits and maximum cost sharing. The minimum benefits include items such as physician services, hospital services, home health services, and family planning.[34] States can add benefits, pending federal approval. Florida has added benefits, including prescription drugs, adult dental services, and dialysis.[35] For children under age 21, the benefits must include the Early and Periodic Screening, Diagnostic

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[27] Agency for Health Care Administration, *Report of Medicaid Eligibles* (Dec. 31, 2016) (on file with the Senate Committee on Health Policy).
[28] Social Services Estimating Conference, *Medicaid Services Expenditures* (Dec. 7, 2016) *available at:* www.edr.state.fl.us/Content/conferences/medicaid/medexp_summary.pdf
[29] Office of Economic and Demographic Research, *Social Services Estimating Conference - Official FMAP Estimate* (November 2016) *available at:* http://edr.state.fl.us/Content/conferences/medicaid/fmap.pdf (last viewed Feb. 20, 2017). The SSEC has also created a "real time" FMAP blend" for the Statewide Medicaid Managed Care Program which is 60.99 percent for SFY 2016-17.
[30] Agency for Health Care Administration, Senate Health and Human Services Appropriations Committee Presentation, *Agency for Health Care Administration - Florida Medicaid* (January 11, 2017), at slide 2, *available at:* http://www.flsenate.gov/PublishedContent/Committees/2016-2018/AHS/MeetingRecords/MeetingPacket_3554.pdf (last viewed Feb. 20, 2017).
[31] Id at 10.
[32] Florida Dep't of Children and Families, *Family-Related Medicaid Programs Fact Sheet*, p. 4 (April 2016) *available at:* http://www.dcf.state.fl.us/programs/access/docs/Family-RelatedMedicaidFactSheet.pdf (last viewed Feb. 21, 2017).
[33] Id.
[34] Section 409.905, F.S.
[35] Section 409.906, F.S.

and Treatment services, which are those health care, diagnostic services, treatment, and measures that may be needed to correct or ameliorate defects or physical and mental illnesses and conditions discovered by screening services consistent with federal law.[36]

Statewide Medicaid Managed Care

Part IV of ch. 409, F.S., was created in 2011 by ch. 2011-134, L.O.F., and governs the Statewide Medicaid Managed Care (SMMC) program. The program, authorized under federal Medicaid waivers, is designed for the AHCA to issue invitations to negotiate[37] and competitively procure contracts with managed care plans in 11 regions of the state to provide comprehensive Medicaid coverage for most of the state's enrollees in the Medicaid program. SMMC has two components: managed medical assistance (MMA) and long-term care managed care (LTCMC).

The LTCMC component began enrolling Medicaid recipients in August 2013 and completed its statewide roll-out in March 2014. The MMA component began enrolling Medicaid recipients in May 2014 and finished its roll-out in August 2014. As of December 2016, there were over 3.2 million Medicaid recipients enrolled in an MMA plan and 94,320 recipients enrolled in an LTC plan.[38]

III. Effect of Proposed Changes:

Direct Primary Care Agreements (Sections 2 and 3)

Section 2 creates s. 456.0625, F.S., to recognize direct primary care agreements within ch. 456, F.S., relating to the general provisions for health care practitioners.

Section 2 defines the following terms within ch. 456, F.S.:

- "Direct primary care agreement" is a contract between a primary care provider and a patient, the patient's legal representative, or an employer which must satisfy certain requirements within the bill and does not indemnify for services provided by a third party.
- "Primary care provider" is a licensed health care practitioner under ch. 458, F.S., (medical doctor or physician assistant); ch. 459, F.S., (osteopathic doctor or physician assistant); ch. 460, F.S., (chiropractic physician); or ch. 464, F.S., (nurses and advanced registered nurse practitioners); or a primary care group practice that provides medical services which are commonly provided without referral from another health care provider.
- "Primary care service" is the screening, assessment, diagnosis, and treatment of a patient for the purpose of promoting health or detecting and managing disease or injury within the competency and training of the primary care provider.

Section 2 authorizes a primary care provider or an agent of the primary care provider to execute a DPC agreement. Section 3 expressly exempts DPC agreements from the Florida Insurance

[36] *See* Section 1905 9(r) of the Social Security Act.
[37] An "invitation to negotiate" is a written or electronically posted solicitation for vendors to submit competitive, sealed replies for the purpose of selecting one or more vendors with which to commence negotiations for the procurement of commodities or contractual services. *See* s. 287.012(17), F.S.
[38] Agency for Health Care Administration, *Supra* note 30, at slide 12.

Code. Additionally, the act of entering into a DPC agreement does not constitute the business of insurance and would not be subject to any chapter of the Florida Insurance Code.

To market, sell, or offer to sell a DPC agreement a primary care provider or agent of a primary care provider is not required to obtain a certification of authority or license under any chapter of the Florida Insurance Code, pursuant to s. 456.0625, F.S.

Section 2 specifies the following minimum requirements and disclosures for DPC agreements:

- Be in writing and signed by the provider or the provider's agent and the patient, the patient's legal representative, or their employer;
- Allow a party to terminate the agreement with 30 days' advance written notice and provide for the immediate termination of the agreement if the physician-patient relationship is violated or a party breaches the terms of the agreement;
- Describe the scope of primary care services covered by the monthly fee;
- Specify the monthly fee and any fees for primary care services not covered by the monthly fee;
- Specify the duration of the agreement and any automatic renewal provisions;
- Offer a refund of monthly fees paid in advance if the provider ceases to offer primary care services for any reason; and
- Contain the following statements in contrasting color and 12-point or larger type on the same page as the applicant's signature:
  - "This agreement is not insurance, and the primary care provider will not file any claims against the patient's health insurance policy or plan for reimbursement of any primary care services covered by this agreement."
  - "This agreement does not qualify as minimum essential coverage to satisfy the individual shared responsibility provision of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148."
  - "This agreement is not workers' compensation insurance and may not replace the employer's obligations under ch. 440, F.S."

Medicaid Managed Care Waiver for Direct Primary Care Agreements (Section 1)

Section 1 amends s. 409.977, F.S., to direct the AHCA to seek a waiver from the appropriate federal authorities to allow Medicaid recipients in the SMMC program the opportunity to participate in direct primary care agreements within the program. Section 1 also clarifies the amount of financial assistance that may be given to recipients who participate and provides a waiver submission deadline of January 1, 2018.

Effective Date

The bill is effective July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

CS/CS/SB 240 removes regulatory uncertainty for health care providers by stating that the direct primary care agreement is not insurance, and as a result, the OIR does not regulate the agreements. This statutory change eliminates a long-standing concern with part II of ch. 641, F.S., which requires licensure and regulation of prepaid health clinics. Currently, that section of the code is unclear about the treatment of these types of arrangements with providers. To date, the OIR has not licensed any direct primary care providers under part II to provide such services.[39]

Additional primary care providers may elect to pursue a direct primary care model and establish direct primary care practices which may increase patients' access to affordable primary care services.

Many individuals have high deductible policies and must meet a significant out of pocket cost to access many types of medical care. The DPC agreements may provide a less expensive option for accessing certain services. For many patients, the greater use of direct primary care agreements may decrease reliance on emergency rooms as a source of routine care.

C. Government Sector Impact:

The establishment of the DPC agreements under ch. 456, F.S., the chapter relating to general provisions for health care practitioners, means that oversight responsibility for the actions of health care practitioners will fall under the Department of Health and the appropriate healthcare professional boards. The department could see an increase in complaint activity to the extent that issues arise between practitioners and patients with DPC agreements.

The AHCA will incur costs related to the submission of the federal waiver or waiver amendment for the SMMC program required under this bill; however, these costs should be absorbed within existing resources.

[39] Office of Insurance Regulation, *Senate Bill 240 Analysis* (Jan. 17, 2017) (on file with the Senate Committee on Banking and Insurance).

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill does not include a provision relating to non-discrimination based on health status. The model bill provides the following:

> Direct primary care practices may not decline to accept new direct primary care patients or discontinue care to existing patients solely because of the patient's health status. A direct practice may decline to accept a patient if the practice has reached its maximum capacity, or if the patient's medical condition is such that the provider is unable to provide the appropriate level and type of primary care services the patient requires.[40]

VIII. Statutes Affected:

This bill substantially amends section 409.977 of the Florida Statutes.

This bill creates the following new sections of the Florida Statutes: 456.0625 and 624.27.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS/CS by Health Policy on February 21, 2017:
The CS/CS retains the exemption of the DPC agreements from the Florida Insurance Code in ch. 624, F.S., and defines and establishes DPC agreements in ch. 456, F.S. The CS/CS also directs the AHCA to submit a Medicaid waiver or waiver amendment to the appropriate federal authorities to provide Medicaid enrollees the opportunity to choose DPC agreements within the Statewide Medicaid Managed Care program.

CS by Banking and Insurance on February 7, 2017:
The CS provides an additional mandatory disclosure to the direct primary care agreement that states that the agreement is not workers' compensation insurance and may not replace the employer's obligation under ch. 440, F.S.

B. Amendments:

None.

[40] *See* http://www.dpcare.org/dpcc-model-legislation (last viewed Feb. 13, 2017.)

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LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/22/2017	.	
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Appropriations Subcommittee on Health and Human Services (Powell) recommended the following:

Senate Amendment (with title amendment)

Delete lines 52 - 58

and insert:

(e) By January 1, 2018, submit an appropriate federal waiver or a waiver amendment to the Centers for Medicare and Medicaid Services, the United States Department of Health and Human Services, or any other designated federal entity to incorporate a pilot program for direct primary care agreements, as defined in s. 456.0625, bundled with a managed care plan for

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Medicaid recipients in Region 6, as described in s. 409.966(2), who are 18 years of age or older and who do not receive supplemental security income, within the Medicaid Managed Assistance component of the Statewide Medicaid Managed Care program. A Medicaid recipient may be offered this opportunity on a voluntary basis and must be given the same rights and responsibilities as other Medicaid recipients enrolled in the Statewide Medicaid Managed Care program. A Medicaid recipient who participates in the pilot program may not be charged a copayment, a premium, coinsurance, or other cost sharing in excess of what is allowed in the Statewide Medicaid Managed Care program. Before seeking a waiver, the agency must provide public notice and the opportunity for public comment in Region 6 and include public feedback in the waiver application. The time period for public comment must end no sooner than 30 days after the completion of the public meeting in Region 6.

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

And the title is amended as follows:

Delete lines 6 - 9

and insert:

the agency to submit, by a specified date, a federal waiver or waiver amendment to one of specified federal entities to incorporate a pilot program for direct primary care agreements bundled with a managed care plan for certain Medicaid recipients in a specified region; providing requirements for the pilot program as to Medicaid recipients; providing that Medicaid recipients in the pilot program may not be charged a

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copayment, premium, coinsurance, or other cost sharing in excess of specified amounts; requiring the agency to provide public notice, receive public comments, and include public feedback in the waiver application; creating s.

By the Committees on Health Policy; and Banking and Insurance; and Senators Lee and Mayfield

588-01932-17 2017240c2

A bill to be entitled

An act relating to direct primary care; amending s. 409.977, F.S.; requiring the Agency for Health Care Administration to provide specified financial assistance to certain Medicaid recipients; requiring the agency to resubmit, by a specified date, certain federal waivers or waiver amendments to specified federal entities to incorporate recipient elections of certain direct primary care agreements; creating s. 456.0625, F.S.; defining terms; authorizing primary care providers or their agents to enter into direct primary care agreements for providing primary care services; providing applicability; specifying requirements for direct primary care agreements; creating s. 624.27, F.S.; providing construction and applicability of the Florida Insurance Code as to direct primary care agreements; providing an exception for primary care providers or their agents from certain requirements under the code under certain circumstances; providing an effective date.

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

Section 1. Subsection (4) of section 409.977, Florida Statutes, is amended to read:

409.977 Enrollment.—

(4) The agency shall:

(a) Develop a process to enable a recipient with access to employer-sponsored health care coverage to opt out of all

588-01932-17 2017240c2

managed care plans and to use Medicaid financial assistance to pay for the recipient's share of the cost in such employer-sponsored coverage.

(b) Contingent upon federal approval, ~~the agency shall also~~ enable recipients with access to other insurance or related products providing access to health care services created pursuant to state law, including any product available under the Florida Health Choices Program, or any health exchange, to opt out.

(c) Provide ~~The amount of~~ financial assistance ~~provided~~ for each recipient in an amount ~~may~~ not to exceed the amount of the Medicaid premium which ~~that~~ would have been paid to a managed care plan for that recipient opting to receive services under this subsection.

(d) ~~The agency shall~~ Seek federal approval to require Medicaid recipients with access to employer-sponsored health care coverage to enroll in that coverage and use Medicaid financial assistance to pay for the recipient's share of the cost for such coverage. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for that recipient.

(e) By January 1, 2018, resubmit an appropriate federal waiver or waiver amendment to the Centers for Medicare and Medicaid Services, the United States Department of Health and Human Services, or any other designated federal entity to incorporate the election by a recipient for a direct primary care agreement, as defined in s. 456.0625, within the Statewide Medicaid Managed Care program.

Section 2. Section 456.0625, Florida Statutes, is created to read:

456.0625 Direct primary care agreements.—

(1) As used in this section, the term:

(a) "Direct primary care agreement" means a contract between a primary care provider and a patient, the patient's legal representative, or an employer which meets the requirements specified under subsection (3) and which does not indemnify for services provided by a third party.

(b) "Primary care provider" means a health care practitioner licensed under chapter 458, chapter 459, chapter 460, or chapter 464 or a primary care group practice that provides medical services to patients which are commonly provided without referral from another health care provider.

(c) "Primary care service" means the screening, assessment, diagnosis, and treatment of a patient for the purpose of promoting health or detecting and managing disease or injury within the competency and training of the primary care provider.

(2) A primary care provider or an agent of the primary care provider may enter into a direct primary care agreement for providing primary care services. Section 624.27 applies to a direct primary care agreement.

(3) A direct primary care agreement must:

(a) Be in writing.

(b) Be signed by the primary care provider or an agent of the primary care provider and the patient, the patient's legal representative, or an employer.

(c) Allow a party to terminate the agreement by giving the other party at least 30 days' advance written notice. The

agreement may provide for immediate termination due to a violation of the physician-patient relationship or a breach of the terms of the agreement.

(d) Describe the scope of primary care services that are covered by the monthly fee.

(e) Specify the monthly fee and any fees for primary care services not covered by the monthly fee.

(f) Specify the duration of the agreement and any automatic renewal provisions.

(g) Offer a refund to the patient of monthly fees paid in advance if the primary care provider ceases to offer primary care services for any reason.

(h) Contain, in contrasting color and in not less than 12-point type, the following statements on the same page as the applicant's signature:

1. This agreement is not health insurance, and the primary care provider will not file any claims against the patient's health insurance policy or plan for reimbursement of any primary care services covered by this agreement.

2. This agreement does not qualify as minimum essential coverage to satisfy the individual shared responsibility provision of the federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148.

3. This agreement is not workers' compensation insurance and may not replace the employer's obligations under chapter 440, Florida Statutes.

Section 3. Section 624.27, Florida Statutes, is created to read:

624.27 Application of code as to direct primary care

agreements.—

(1) A direct primary care agreement, as defined in s. 456.0625, does not constitute insurance and is not subject to any chapter of the Florida Insurance Code. The act of entering into a direct primary care agreement does not constitute the business of insurance and is not subject to any chapter of the Florida Insurance Code.

(2) A primary care provider or an agent of a primary care provider is not required to obtain a certificate of authority or license under any chapter of the Florida Insurance Code to market, sell, or offer to sell a direct primary care agreement pursuant to s. 456.0625.

Section 4. This act shall take effect July 1, 2017.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/21
Meeting Date

240
Bill Number (if applicable)

Topic Direct Primary Care

Amendment Barcode (if applicable)

Name Jarrod Fowler

Job Title Dir. of Healthcare Policy

Address 1430 Piedmont Drive East
Street

Tallahassee FL 32308
City *State* *Zip*

Phone 850-224-6496

Email jfowler@flmedical.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Medical Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3-21-17
Meeting Date

SB 240
Bill Number (if applicable)

Topic DIRECT PRIMARY CARE

Amendment Barcode (if applicable)

Name JACK HEBERT

Job Title

Address 2861 Exec Dr. Suite 100
Street

Clearwater 33762
City *State* *Zip*

Phone 727-560-3323

Email jack@themelland group.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Chiropractic Assn.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

2:00 pm
401 S

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/21/17
Meeting Date

240
Bill Number (if applicable)

Topic Direct Primary Care

Amendment Barcode (if applicable)

Name Stephen Winn

Job Title Executive Director

Address 2544 Blairstone Pines Dr.
Street

Phone 878-7364

Tallahassee FL 32301
City *State* *Zip*

Email winnsr@earthlink.net

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Osteopathic Medical Association

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/21/17
Meeting Date

240
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Nuland

Job Title _____

Address 1000 Riverside Ave #240
Street
Jacksonville FL 32204
City *State* *Zip*

Phone 904-233-3051

Email nulandlaw@aol.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Chapter, American College of Physicians

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/21/2017
Meeting Date

240
Bill Number (if applicable)

Topic Direct Primary Care

Amendment Barcode (if applicable)

Name Sal Nuzzo

Job Title VP of Policy

Address 100 N Duval Street
Street

Phone 850-322-9941

Tallahassee FL 32301
City *State* *Zip*

Email snuzzo@jamesmadison.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing The James Madison Institute

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3-21-17
Meeting Date

240
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic D.P.C.

Name Bill Herrle

Job Title Exec. Director

Address 110 E Jeff
Street

Tallo FL. 01
City *State* *Zip*

Phone 6810416

Email bill.herrle@nfib.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing National Federation of Independent Business

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/21/17
Meeting Date

SB 240
Bill Number (if applicable)

Topic Direct Primary Care

Amendment Barcode (if applicable)

Name Aimee Diaz Lyon

Job Title

Address 119 South Monroe Street, Suite 200
Street

Phone 850-205-9000

Tallahasse FL 32301
City *State* *Zip*

Email aimee.diazlyon@mhdfirm.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Academy of Family Physicians

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

Committee Agenda Request

To: Senator Anitere Flores, Chair
Appropriations Subcommittee on Health and Human Services

Subject: Committee Agenda Request

Date: February 21st, 2017

I respectfully request that **CS/CS/Senate Bill #240**, relating to Direct Primary Care, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Tom Lee
Florida Senate, District 20

File signed original with committee office

S-020 (03/2004)

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 Appropriations Subcommittee on Health and Human Services

BILL:	CS/SB 430
INTRODUCER:	Banking and Insurance Committee and Senator Bean and others
SUBJECT:	Discount Plan Organizations
DATE:	March 20, 2017 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Matiyow	Knudson	BI	**Fav/CS**
2.	Sanders/Forbes	Williams	AHS	**Recommend: Favorable**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 430 amends part II of ch. 636, F.S., relating to Discount Medical Plan Organization. The bill:

- Changes the term "discount medical plan" to "discount plan," changes the title of Part II of chapter 636 from "discount medical plan organizations" to "discount plan organizations, and also changes the terms and allows old terms to be used until June 30, 2018;
- Exempts from licensure requirements those plans that do not charge a fee to plan members;
- Requires third party providers that assist medical providers in offering discounts to their own patients in exchange for consideration to be licensed as a discount plan organization;
- Adds a five year retention of member records requirement and subjects such records to inspection by the Office of Insurance Regulation (OIR) at any time;
- Requires a member to receive a reimbursement of charges if the member cancels a plan in compliance with the rules of an open enrollment period or at any time within 30 days of written notice;
- Allows for an alternate method of providing disclosures and provides disclosure requirements when initial contact is made electronically or by telephone;
- Removes requirements that all discount plan charges must be submitted to the OIR, and that charges greater than $30 per month and $360 per year may only be charged if approved by OIR;
- Removes a standard that charges bear a reasonable relation to the benefits received;
- Removes the requirement that forms must be submitted to the OIR for approval;

- Allows a discount plan organization to delegate functions to its marketers;
- Allows a marketer or discount plan organization to commingle medical services and other services on a single page of forms, advertisements, marketing materials or brochures; and
- Removes the requirement that the fees for the discount medical plan must be provided in writing to the member when a marketer or discount plan organization sells a discount medical plan together with any other product and the fees exceed $30.

The OIR has not identified any fiscal impact on state revenues or expenditures.

The bill is effective upon becoming a law.

II. Present Situation:

Discount medical plans are agreements where membership fees are charged in exchange for the right of the member to receive discounts on certain medical services. Such plans are regulated under part II of ch. 636, F.S., and are not considered insurance. A medical provider who provides discount medical services to his or her own patients is exempt, regardless if a fee is charged.

Under part II, all forms used must first be filed and approved by the OIR. Any amendments to a previously approved form constitute a new form that is subject to OIR approval. Disclosures are required to be made on the first page of advertisements, marketing materials, or brochures. When the initial contract with a prospective member is by telephone, the disclosures are required to be made orally and provided in the initial written materials that describe the benefits under the plan provided to the prospective or new member.

All charges to members are required to be filed with the Office of Insurance Regulation (OIR), any charges greater than $30 per month or $360 per year must be approved by the OIR before the charges can be used. Plan members are guaranteed a refund of periodic charges if cancellation occurs within the first 30 days after the effective date of enrollment. An annual report is required to be filed with the OIR within three months after the end of each organization's fiscal year. Each discount medical plan organization is required to maintain a net worth of at least $150,000 to become or remain eligible for licensure.

III. Effect of Proposed Changes:

CS/SB 430 substantially revises part II of ch. 636, F.S., governing discount medical plans.

Sections 1 and 2 make conforming changes relating to the revised terms in section 3, revising the title to ch. 636, F.S., and the title to part II of ch. 636, F.S.

Section 3 amends s. 636.202, F.S. to change the terms "discount medical plan" to "discount plan" and "discount medical plan organization" to "discount plan organization" within ch. 636, F.S. The old terms will continue to be used until June 30, 2018, allowing time to transition to the new terminology. Furthermore, discount plans that do not charge a fee will be exempt from part II of ch. 636, F.S. Each section of the bill incorporates the new terms.

Section 4 amends s. 636.204, F.S., to require a third party provider that assists medical providers in establishing discounts for medical services to their own patients in exchange for consideration to obtain licensure as a discount plan organization. Providers who provide their patients discounts without a third party remain exempt from Part II of ch. 636, F.S.

Section 5 amends s. 636.206, F.S., to require a discount plan organization to maintain member records for the duration of the agreement and five years thereafter, subject to inspection by the OIR at any time. Records required to be retained include an accurate record of each member, the membership materials provided to each member, the discount plan issued to the members, and the charges billed and paid by the members.

Section 6 amends s. 636.208, F.S., to revise the circumstances under which a member can receive reimbursement for canceling a discount plan. Currently, a member may cancel a discount medical plan within the first 30 days of enrollment, and upon returning the discount card, must be reimbursed all periodic charges. The bill requires the reimbursement if the cancellation is consistent with the open enrollment rules established for such plans and also allows for cancelation in writing at any time within 30 days of notice by the member.

Section 7 amends s. 636.212, F.S., to establish disclosure requirements for written materials, online materials and solicitations over the phone. For written materials, the disclosures must be printed in 12-point font on all advertisements, marketing materials, or brochures relating to the discount plan. For online materials, the disclosures must be printed in a readable size and font on all advertisements, marketing materials, or brochures relating to the discount plan. For telephone solicitations, the disclosure must be given over the phone and must also be sent in writing with any membership or signup materials.

Section 8 amends s. 636.214, F.S., to clarify that an agreement between a discount plan organization and a provider must contain a statement that the provider will not charge members more than the discounted rate.

Section 9 amends s. 636.216, F.S., to remove the requirements that all charges for a discount plan be submitted to the OIR and that charges above $30 per month or $360 per year be approved by the OIR. Also, section 9 removes the requirement that the OIR approve all forms and advertisements. Additionally, this section removes a requirement that a discount plan organization has the burden of proof that the charges bear a reasonable relation to the benefits received by a member.

Section 10 amends s. 636.228, F.S., to allow a discount plan organization to delegate functions to a marketer, but binds the organization for any acts of its marketers within the scope of the delegation.

Sections 11 amends s. 636.230, F.S. to allow a marketer or discount plan organization to commingle medical services and other services on a single page of forms, advertisements, marketing materials, or brochures. This section also deletes the requirement that the fees for the discount medical plan must be provided in writing to the member if the discount medical plan is bundled together with any other product and the fees exceed $30.

Sections 12 amends s. 636.232, F.S., to make a technical change conforming to a change in section 9 and removes the OIR's need to develop rules for form regulation and approval.

Sections 13 – 30 amends ss. 408.9091, 408.910, 627.64731, 636.003, 636.205, 636.207, 636.210, 636.218, 636.220, 636.222, 636.223, 636.224, 636.226, 636.234, 636.236, 636.238, 636.240, and 636.244, F.S., respectively, to make conforming changes relating to the revised terms in section 3.

Section 31 provides the effective date of the bill as becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

Providers currently exempt from licensure but subject to licensure under this bill will be required to pay new fees associated with such licensure.

B. Private Sector Impact:

Providers who are currently exempt from licensure would incur administrative costs of licensing.

C. Government Sector Impact:

The Office of Insurance Regulation has not identified any impact on state revenues or expenditures.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 636.202, 636.204, 636.208, 636.212, 636.214, 636.216, 636.228, 636.230, 408.9091, 408.910, 627.64731, 636.003, 636.205, 636.206, 636.207, 636.210, 636.218, 636.220, 636.222, 636.223, 636.224, 636.226, 636.232, 636.234, 636.236, 636.238, 636.240, and 636.244

IX. Additional Information:

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

CS by Banking and Insurance on March 6, 2017:
The CS clarifies that when a provider pays a third party vendor to provide discounts to their own patients, the third party vendor must be licensed as a discount plan organization. Discount plan organizations must maintain records for five years and such records are subject to examination by the OIR at any time. The CS allows discount plan cancelations outside of an open enrollment plan to occur at any time within 30 days' of written notice. The CS also clarifies how disclosures must be given depending on the type of solicitation.

B. Amendments:

None.

By the Committee on Banking and Insurance; and Senators Bean and Flores

597-02139-17 2017430c1

A bill to be entitled

An act relating to discount plan organizations; revising the titles of ch. 636, F.S., and part II of ch. 636, F.S.; amending s. 636.202, F.S.; revising definitions; amending s. 636.204, F.S.; conforming provisions to changes made by the act; requiring third-party entities that contract with providers to administer or provide platforms for discount plans to be licensed as discount plan organizations; amending s. 636.206, F.S.; conforming provisions to changes made by the act; requiring discount plan organizations to maintain, for a specified timeframe, certain records in a form accessible to the Office of Insurance Regulation during an examination or investigation; amending s. 636.208, F.S.; conforming provisions to changes made by the act; specifying periodic charge reimbursement and other requirements for discount plan organizations following membership cancellation requests; amending s. 636.212, F.S.; requiring discount plan organizations and marketers to provide specified disclosures to prospective members before enrollment; authorizing discount plan organizations and marketers to make other disclosures; requiring prospective members to acknowledge acceptance of disclosures before enrollment; specifying requirements for disclosures made in writing or by electronic means; revising requirements for disclosures made by telephone; amending s. 636.214, F.S.; making a technical change; conforming

597-02139-17 2017430c1

provisions to changes made by the act; amending s. 636.216, F.S.; deleting provisions relating to charge and form filings; conforming a provision to changes made by the act; amending s. 636.228, F.S.; conforming provisions to changes made by the act; authorizing a discount plan organization to delegate functions to its marketers; providing that the discount plan organization is bound by acts of its marketers within the scope of the delegation; amending s. 636.230, F.S.; conforming provisions to changes made by the act; authorizing a marketer or discount plan organization to commingle certain products on a single page of certain documents; deleting a requirement for discount medical plan fees to be provided in writing under certain circumstances; amending s. 636.232, F.S.; conforming a provision to changes made by the act; deleting rulemaking authority of the Financial Services Commission as to the establishment of certain standards; amending ss. 408.9091, 408.910, 627.64731, 636.003, 636.205, 636.207, 636.210, 636.218, 636.220, 636.222, 636.223, 636.224, 636.226, 636.234, 636.236, 636.238, 636.240, and 636.244, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Chapter 636, Florida Statutes, entitled "Prepaid Limited Health Service Organizations and Discount Medical Plan

Organizations," is retitled "Prepaid Limited Health Service Organizations and Discount Plan Organizations."

Section 2. Part II of chapter 636, Florida Statutes, entitled "Discount Medical Plan Organizations," is retitled "Discount Plan Organizations."

Section 3. Section 636.202, Florida Statutes, is amended to read:

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

(1) "Discount ~~medical~~ plan" means a business arrangement or contract in which a person, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. The term ~~"discount medical plan"~~ does not include any product regulated under chapter 627, chapter 641, or part I of this chapter~~;, or~~ any medical services provided through a telecommunications medium that does not offer a discount to the plan member for those medical services; or any plan that does not charge a fee to plan members. Until June 30, 2018, a discount plan may also be referred to as a discount medical plan.

(2) "Discount ~~medical~~ plan organization" means an entity that ~~which~~, in exchange for fees, dues, charges, or other consideration, provides access for plan members to providers of medical services and the right to receive medical services from those providers at a discount. Until June 30, 2018, a discount plan organization may also be referred to as a discount medical plan organization.

(3) "Marketer" means a person or entity that ~~which~~ markets, promotes, sells, or distributes a discount ~~medical~~ plan,

including a private label entity that ~~which~~ places its name on and markets or distributes a discount ~~medical~~ plan but does not operate a discount ~~medical~~ plan.

(4) "Medical services" means any care, service, or treatment of illness or dysfunction of, or injury to, the human body, including, but not limited to, physician care, inpatient care, hospital surgical services, emergency services, ambulance services, dental care services, vision care services, mental health services, substance abuse services, chiropractic services, podiatric care services, laboratory services, and medical equipment and supplies. The term does not include pharmaceutical supplies or prescriptions.

(5) "Member" means any person who pays fees, dues, charges, or other consideration for the right to receive the purported benefits of a discount ~~medical~~ plan.

(6) "Provider" means any person or institution that ~~which~~ is contracted, directly or indirectly, with a discount ~~medical~~ plan organization to provide medical services to members.

(7) "Provider network" means an entity that ~~which~~ negotiates on behalf of more than one provider with a discount ~~medical~~ plan organization to provide medical services to members.

Section 4. Subsections (1), (2), (4), and (6) of section 636.204, Florida Statutes, are amended to read:

636.204 License required.—

(1) Before doing business in this state as a discount ~~medical~~ plan organization, an entity must be a corporation, a limited liability company, or a limited partnership, incorporated, organized, formed, or registered under the laws of

this state or authorized to transact business in this state in accordance with chapter 605, part I of chapter 607, chapter 617, chapter 620, or chapter 865, and must be licensed by the office as a discount ~~medical~~ plan organization or be licensed by the office pursuant to chapter 624, part I of this chapter, or chapter 641.

(2) An application for a license to operate as a discount ~~medical~~ plan organization must be filed with the office on a form prescribed by the commission. Such application must be sworn to by an officer or authorized representative of the applicant and be accompanied by the following, if applicable:

(a) A copy of the applicant's articles of incorporation or other organizing documents, including all amendments.

(b) A copy of the applicant's bylaws.

(c) A list of the names, addresses, official positions, and biographical information of the individuals who are responsible for conducting the applicant's affairs, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire 10 percent or more of the voting securities of the applicant. Such listing must fully disclose the extent and nature of any contracts or arrangements between any individual who is responsible for conducting the applicant's affairs and the discount ~~medical~~ plan organization, including any possible conflicts of interest.

(d) A complete biographical statement~~,~~ on forms prescribed by the commission, an independent investigation report, and a

set of fingerprints, as provided in chapter 624, with respect to each individual identified under paragraph (c).

(e) A statement generally describing the applicant, its facilities and personnel, and the medical services to be offered.

(f) A copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of medical services to members.

(g) A copy of the form of any contract made or arrangement to be made between the applicant and any person listed in paragraph (c).

(h) A copy of the form of any contract made or to be made between the applicant and any person, corporation, partnership, or other entity for the performance on the applicant's behalf of any function, including, but not limited to, marketing, administration, enrollment, investment management, and subcontracting for the provision of health services to members.

(i) A copy of the applicant's most recent financial statements audited by an independent certified public accountant. An applicant that is a subsidiary of a parent entity that is publicly traded and that prepares audited financial statements reflecting the consolidated operations of the parent entity and the subsidiary may petition the office to accept, in lieu of the audited financial statement of the applicant, the audited financial statement of the parent entity and a written guaranty by the parent entity that the minimum capital requirements of the applicant required by this part will be met by the parent entity.

(j) A description of the proposed method of marketing.

(k) A description of the subscriber complaint procedures to be established and maintained.

(l) The fee for issuance of a license.

(m) Such other information as the commission or office may reasonably require to make the determinations required by this part.

(4) Before ~~Prior to~~ licensure by the office, each discount ~~medical~~ plan organization must establish an Internet website so as to conform to the requirements of s. 636.226.

(6) This part does not require ~~Nothing in this part requires~~ a provider who provides discounts to his or her own patients to obtain and maintain a license as a discount ~~medical~~ plan organization. If a provider contracts with a third-party entity to administer or provide a platform for a discount plan, the third-party entity must be licensed as a discount plan organization.

Section 5. Section 636.206, Florida Statutes, is amended to read:

636.206 Examinations and investigations.—

(1) The office may examine or investigate the business and affairs of any discount ~~medical~~ plan organization. The office may order any discount ~~medical~~ plan organization or applicant to produce any records, books, files, advertising and solicitation materials, or other information and may take statements under oath to determine whether the discount ~~medical~~ plan organization or applicant is in violation of the law or is acting contrary to the public interest. The expenses incurred in conducting any examination or investigation must be paid by the discount ~~medical~~ plan organization or applicant. Examinations and

investigations must be conducted as provided in chapter 624. For the duration of the agreement and for 5 years thereafter, every discount plan organization shall maintain, in a form accessible to the office during an examination or investigation, an accurate record of each member, the membership materials provided to the member, the discount plan issued to the member, and the charges billed and paid by the member.

(2) Failure by the discount ~~medical~~ plan organization to pay the expenses incurred under subsection (1) is grounds for denial or revocation.

Section 6. Section 636.208, Florida Statutes, is amended to read:

636.208 Fees; charges; reimbursement.—

(1) A discount ~~medical~~ plan organization may charge a periodic charge as well as a reasonable one-time processing fee for a discount ~~medical~~ plan.

(2)(a) If the member cancels his or her membership in the discount ~~medical~~ plan organization within the first 30 days after the effective date of enrollment in the plan, the member shall receive a reimbursement of all periodic charges upon return of the discount card to the discount ~~medical~~ plan organization.

(b) If the member cancels his or her membership in the discount plan organization consistent with the open enrollment rules established by an employer or association for a plan having an open enrollment period, the member shall receive a pro rata reimbursement of all periodic charges upon return of the discount card to the discount plan organization.

(c) Except for plans enrolled under paragraph (b), if the

member requests in writing the cancellation of his or her membership in the discount plan organization after the first 30 days allowed in paragraph (a), the discount plan organization:

1. Must make the cancellation effective no later than 30 days after receiving the member's cancellation request;

2. May not make future charges to the member after the cancellation has taken effect; and

3. Must provide the member a pro rata reimbursement of periodic charges for all months after the effective date of the cancellation.

(3) If the discount ~~medical~~ plan organization cancels a membership for any reason other than nonpayment of fees by the member, the discount ~~medical~~ plan organization must ~~shall~~ make a pro rata reimbursement of all periodic charges to the member.

(4) In addition to the reimbursement of periodic charges for the reasons stated in subsections (2) and (3), a discount ~~medical~~ plan organization shall also reimburse the member for any portion of a one-time processing fee that exceeds $30 per year.

Section 7. Section 636.212, Florida Statutes, is amended to read:

636.212 Disclosures.—A discount plan organization or marketer shall provide disclosures to a prospective member before his or her enrollment. A discount plan organization or marketer may make disclosures in addition to those described in this part. Before enrollment, a prospective member must acknowledge he or she has accepted the disclosures ~~The following disclosures must be made in writing to any prospective member and must be on the first page of any advertisements, marketing~~

~~materials, or brochures relating to a discount medical plan~~. ~~The disclosures must be printed in not less than 12-point type:~~

(1) The disclosures must include:

(a) That the plan is not insurance.

(b) ~~(2)~~ That the plan provides discounts at certain health care providers for medical services.

(c) ~~(3)~~ That the plan does not make payments directly to the providers of medical services.

(d) ~~(4)~~ That the plan member is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the discount plan organization.

(e) ~~(5)~~ The name and address of the licensed discount ~~medical~~ plan organization.

(2) Written disclosures must include the disclosures in subsection (1) on the first page of any advertisement, marketing material, or brochure relating to a discount plan. The first page is the page that first includes the information describing benefits. The disclosures must be printed in not less than 12-point type.

(3) Disclosures provided by electronic means must include the disclosures in subsection (1) on any advertisement, marketing material, or brochure relating to a discount plan. The disclosures must be viewable in a readable font size and color.

(4) Disclosures made by telephone must include the disclosures in subsection (1), and a written disclosure in accordance with subsection (2) must also be provided with the initial materials sent to the prospective or new member.

~~If the initial contract is made by telephone, the disclosures required by this section shall be made orally and provided in the initial written materials that describe the benefits under the discount medical plan provided to the prospective or new member.~~

Section 8. Section 636.214, Florida Statutes, is amended to read:

636.214 Provider agreements.—

(1) All providers offering medical services to members under a discount ~~medical~~ plan must provide such services pursuant to a written agreement. The agreement may be entered into directly by the provider or by a provider network to which the provider belongs.

(2) A provider agreement between a discount ~~medical~~ plan organization and a provider must provide the following:

(a) A list of the services and products to be provided at a discount.

(b) The amount or amounts of the discounts or, alternatively, a fee schedule which reflects the provider's discounted rates.

(c) A statement that the provider will not charge members more than the discounted rates.

(3) A provider agreement between a discount ~~medical~~ plan organization and a provider network must ~~shall~~ require that the provider network have written agreements with its providers which:

(a) Contain the terms described in subsection (2).

(b) Authorize the provider network to contract with the discount ~~medical~~ plan organization on behalf of the provider.

(c) Require the network to maintain an up-to-date list of its contracted providers and to provide that list on a monthly basis to the discount ~~medical~~ plan organization.

(4) The discount ~~medical~~ plan organization shall maintain a copy of each active provider agreement into which it has entered.

Section 9. Section 636.216, Florida Statutes, is amended to read:

636.216 Written agreement ~~Charge or form filings~~.—

~~(1) All charges to members must be filed with the office and any charge to members greater than $30 per month or $360 per year must be approved by the office before the charges can be used. The discount medical plan organization has the burden of proof that the charges bear a reasonable relation to the benefits received by the member.~~

~~(2)~~ There must be a written agreement between the discount ~~medical~~ plan organization and the member specifying the benefits under the discount ~~medical~~ plan and complying with the disclosure requirements of this part.

~~(3) All forms used, including the written agreement pursuant to subsection (2), must first be filed with and approved by the office. Every form filed shall be identified by a unique form number placed in the lower left corner of each form.~~

~~(4) A charge or form is considered approved on the 60th day after its date of filing unless it has been previously disapproved by the office. The office shall disapprove any form that does not meet the requirements of this part or that is unreasonable, discriminatory, misleading, or unfair. If such~~

~~filings are disapproved, the office shall notify the discount medical plan organization and shall specify in the notice the reasons for disapproval.~~

Section 10. Section 636.228, Florida Statutes, is amended to read:

636.228 Marketing of discount ~~medical~~ plans.—

(1) All advertisements, marketing materials, brochures, and discount cards used by marketers must be approved in writing ~~for such use~~ by the discount ~~medical~~ plan organization.

(2) The discount ~~medical~~ plan organization must ~~shall~~ have an executed written agreement with a marketer before ~~prior to~~ the marketer's marketing, promoting, selling, or distributing the discount ~~medical~~ plan. Such agreement must ~~shall~~ prohibit the marketer from using marketing materials, brochures, and discount cards without the approval in writing by the discount ~~medical~~ plan organization. The discount ~~medical~~ plan organization may delegate functions to its marketers but shall be bound by any acts of its marketers, within the scope of the delegation, which ~~marketers' agency, that~~ do not comply with ~~the provisions of~~ this part.

Section 11. Section 636.230, Florida Statutes, is amended to read:

636.230 Bundling discount ~~medical~~ plans with other products.—A marketer or discount plan organization selling a discount plan with medical services and other services may commingle those products on a single page of forms, advertisements, marketing materials, or brochures ~~When a marketer or discount medical plan organization sells a discount medical plan together with any other product, the fees for the~~

~~discount medical plan must be provided in writing to the member if the fees exceed $30~~.

Section 12. Section 636.232, Florida Statutes, is amended to read:

636.232 Rules.—The commission may adopt rules to administer this part, including rules for the licensing of discount ~~medical~~ plan organizations,~~; establishing standards for evaluating forms, advertisements, marketing materials, brochures, and discount cards;~~ providing for the collection of data,~~;~~ relating to disclosures to plan members,~~;~~ and defining terms used in this part.

Section 13. Paragraph (b) of subsection (5) of section 408.9091, Florida Statutes, is amended to read:

408.9091 Cover Florida Health Care Access Program.—

(5) PLAN PROPOSALS.—The agency and the office shall announce, no later than July 1, 2008, an invitation to negotiate for Cover Florida plan entities to design a Cover Florida plan proposal in which benefits and premiums are specified.

(b) The agency and the office may announce an invitation to negotiate for the design of Cover Florida Plus products to companies that offer supplemental insurance, discount ~~medical~~ plan organizations licensed under part II of chapter 636, or prepaid health clinics licensed under part II of chapter 641.

Section 14. Paragraph (d) of subsection (2) and paragraph (d) of subsection (4) of section 408.910, Florida Statutes, are amended to read:

408.910 Florida Health Choices Program.—

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

(d) "Insurer" means an entity licensed under chapter 624

which offers an individual health insurance policy or a group health insurance policy, a preferred provider organization as defined in s. 627.6471, an exclusive provider organization as defined in s. 627.6472, ~~or~~ a health maintenance organization licensed under part I of chapter 641, or a prepaid limited health service organization or discount ~~medical~~ plan organization licensed under chapter 636.

(4) ELIGIBILITY AND PARTICIPATION.—Participation in the program is voluntary and shall be available to employers, individuals, vendors, and health insurance agents as specified in this subsection.

(d) All eligible vendors who choose to participate and the products and services that the vendors are permitted to sell are as follows:

1. Insurers licensed under chapter 624 may sell health insurance policies, limited benefit policies, other risk-bearing coverage, and other products or services.

2. Health maintenance organizations licensed under part I of chapter 641 may sell health maintenance contracts, limited benefit policies, other risk-bearing products, and other products or services.

3. Prepaid limited health service organizations may sell products and services as authorized under part I of chapter 636, and discount ~~medical~~ plan organizations may sell products and services as authorized under part II of chapter 636.

4. Prepaid health clinic service providers licensed under part II of chapter 641 may sell prepaid service contracts and other arrangements for a specified amount and type of health services or treatments.

5. Health care providers, including hospitals and other licensed health facilities, health care clinics, licensed health professionals, pharmacies, and other licensed health care providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

6. Provider organizations, including service networks, group practices, professional associations, and other incorporated organizations of providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

7. Corporate entities providing specific health services in accordance with applicable state law may sell service contracts and arrangements for a specified amount and type of health services or treatments.

A vendor described in subparagraphs 3.-7. may not sell products that provide risk-bearing coverage unless that vendor is authorized under a certificate of authority issued by the Office of Insurance Regulation and is authorized to provide coverage in the relevant geographic area. Otherwise eligible vendors may be excluded from participating in the program for deceptive or predatory practices, financial insolvency, or failure to comply with the terms of the participation agreement or other standards set by the corporation.

Section 15. Subsection (11) of section 627.64731, Florida Statutes, is amended to read:

627.64731 Leasing, renting, or granting access to a participating provider.—

(11) This section does not apply to a contract between a

contracting entity and a discount ~~medical~~ plan organization licensed or exempt under part II of chapter 636.

Section 16. Paragraph (c) of subsection (7) of section 636.003, Florida Statutes, is amended to read:

636.003 Definitions.—As used in this act, the term:

(7) "Prepaid limited health service organization" means 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. Prepaid limited health service organization does not include:

(c) Any person who is licensed pursuant to part II as a discount ~~medical~~ plan organization.

Section 17. Paragraphs (c) and (d) of subsection (1) of section 636.205, Florida Statutes, are amended to read:

636.205 Issuance of license; denial.—

(1) Following receipt of an application filed pursuant to s. 636.204, the office shall review the application and notify the applicant of any deficiencies contained therein. The office shall issue a license to an applicant who has filed a completed application pursuant to s. 636.204 upon payment of the fees specified in s. 636.204 and upon the office being satisfied that the following conditions are met:

(c) The ownership, control, and management of the entity are competent and trustworthy and possess managerial experience that would make the proposed operation beneficial to the subscribers. The office may ~~shall~~ not grant or continue to grant authority to transact the business of a discount ~~medical~~ plan organization in this state at any time during which the office

has good reason to believe that the ownership, control, or management of the organization includes any person whose business operations are or have been marked by business practices or conduct that is detrimental to the public, stockholders, investors, or creditors.

(d) The discount ~~medical~~ plan organization has a complaint procedure that will facilitate the resolution of subscriber grievances and that includes both formal and informal steps available within the organization.

Section 18. Section 636.207, Florida Statutes, is amended to read:

636.207 Applicability of part.—Except as otherwise provided in this part, discount ~~medical~~ plan organizations are governed by ~~the provisions of~~ this part and are exempt from the Florida Insurance Code unless specifically referenced.

Section 19. Section 636.210, Florida Statutes, is amended to read:

636.210 Prohibited activities of a discount ~~medical~~ plan organization.—

(1) A discount ~~medical~~ plan organization may not:

(a) Use in its advertisements, marketing material, brochures, and discount cards the term "insurance" except as otherwise provided in this part or as a disclaimer of any relationship between discount ~~medical~~ plan organization benefits and insurance;

(b) Use in its advertisements, marketing material, brochures, and discount cards the terms "health plan," "coverage," "copay," "copayments," "preexisting conditions," "guaranteed issue," "premium," "PPO," "preferred provider

organization," or other terms in a manner that could reasonably mislead a person into believing the discount ~~medical~~ plan was health insurance;

(c) Have restrictions on free access to plan providers, including, but not limited to, waiting periods and notification periods; or

(d) Pay providers any fees for medical services.

(2) A discount ~~medical~~ plan organization may not collect or accept money from a member for payment to a provider for specific medical services furnished or to be furnished to the member unless the organization has an active certificate of authority from the office to act as an administrator.

Section 20. Subsection (1), paragraphs (b), (c), and (d) of subsection (2), and subsection (3) of section 636.218, Florida Statutes, are amended to read:

636.218 Annual reports.—

(1) Each discount ~~medical~~ plan organization shall ~~must~~ file with the office, within 3 months after the end of each fiscal year, an annual report.

(2) Such reports must be on forms prescribed by the commission and must include:

(b) If different from the initial application or the last annual report, a list of the names and residence addresses of all persons responsible for the conduct of the organization's affairs, together with a disclosure of the extent and nature of any contracts or arrangements between such persons and the discount ~~medical~~ plan organization, including any possible conflicts of interest.

(c) The number of discount ~~medical~~ plan members in the

state.

(d) Such other information relating to the performance of the discount ~~medical~~ plan organization as is reasonably required by the commission or office.

(3) Every discount ~~medical~~ plan organization that ~~which~~ fails to file an annual report in the form and within the time required by this section shall forfeit up to $500 for each day for the first 10 days during which the neglect continues and shall forfeit up to $1,000 for each day after the first 10 days during which the neglect continues; and, upon notice by the office to that effect, the organization's authority to enroll new members or to do business in this state ceases while such default continues. The office shall deposit all sums collected by the office under this section to the credit of the Insurance Regulatory Trust Fund. The office may not collect more than $50,000 for each report.

Section 21. Section 636.220, Florida Statutes, is amended to read:

636.220 Minimum capital requirements.—

(1) Each discount ~~medical~~ plan organization shall ~~must~~ at all times maintain a net worth of at least $150,000.

(2) The office may not issue a license unless the discount ~~medical~~ plan organization has a net worth of at least $150,000.

Section 22. Section 636.222, Florida Statutes, is amended to read:

636.222 Suspension or revocation of license; suspension of enrollment of new members; terms of suspension.—

(1) The office may suspend the authority of a discount ~~medical~~ plan organization to enroll new members, revoke any

license issued to a discount ~~medical~~ plan organization, or order compliance if the office finds that any of the following conditions exist:

(a) The organization is not operating in compliance with this part.

(b) The organization does not have the minimum net worth as required by this part.

(c) The organization has advertised, merchandised, or attempted to merchandise its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading, or unfair practices with respect to advertising or merchandising.

(d) The organization is not fulfilling its obligations as a ~~medical~~ discount ~~medical~~ plan organization.

(e) The continued operation of the organization would be hazardous to its members.

(2) If the office has cause to believe that grounds for the suspension or revocation of a license exist, the office must ~~shall~~ notify the discount ~~medical~~ plan organization in writing specifically stating the grounds for suspension or revocation and shall pursue a hearing on the matter in accordance with ~~the provisions of~~ chapter 120.

(3) When the license of a discount ~~medical~~ plan organization is surrendered or revoked, such organization must proceed, immediately following the effective date of the order of revocation, to wind up its affairs transacted under the license. The organization may not engage in any further advertising, solicitation, collecting of fees, or renewal of contracts.

(4) The office shall, in its order suspending the authority of a discount ~~medical~~ plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, which must be met by the discount ~~medical~~ plan organization before ~~prior to~~ reinstatement of its license to enroll new members. The order of suspension is subject to rescission or modification by further order of the office before ~~prior to~~ the expiration of the suspension period. Reinstatement may not be made unless requested by the discount ~~medical~~ plan organization; however, the office may not grant reinstatement if it finds that the circumstances for which the suspension occurred still exist or are likely to recur.

Section 23. Section 636.223, Florida Statutes, is amended to read:

636.223 Administrative penalty.—In lieu of suspending or revoking a certificate of authority whenever any discount ~~medical~~ plan organization has been found to have violated any provision of this part, the office may:

(1) Issue and cause to be served upon the organization charged with the violation a copy of such findings and an order requiring such organization to cease and desist from engaging in the act or practice that constitutes the violation.

(2) Impose a monetary penalty of not less than $100 for each violation, but not to exceed an aggregate penalty of $75,000.

Section 24. Section 636.224, Florida Statutes, is amended to read:

636.224 Notice of change of name or address of discount ~~medical~~ plan organization.—Each discount ~~medical~~ plan

organization must provide the office at least 30 days' advance notice of any change in the discount ~~medical~~ plan organization's name, address, principal business address, or mailing address.

Section 25. Section 636.226, Florida Statutes, is amended to read:

636.226 Provider name listing.—Each discount ~~medical~~ plan organization must maintain on an Internet website an up-to-date list of the names and addresses of the providers with which it has contracted~~, on an Internet website page~~, the address of which must ~~shall~~ be prominently displayed on all its advertisements, marketing materials, brochures, and discount cards. This section applies to those providers with whom the discount ~~medical~~ plan organization has contracted directly, as well as those who are members of a provider network with which the discount ~~medical~~ plan organization has contracted.

Section 26. Section 636.234, Florida Statutes, is amended to read:

636.234 Service of process on a discount ~~medical~~ plan organization.—Sections 624.422 and 624.423 apply to a discount ~~medical~~ plan organization as if the discount ~~medical~~ plan organization were an insurer.

Section 27. Section 636.236, Florida Statutes, is amended to read:

636.236 Surety bond or security deposit.—

(1) Each discount ~~medical~~ plan organization licensed pursuant to ~~the provisions of~~ this part shall ~~must~~ maintain in force a surety bond in its own name in an amount not less than $35,000 to be used at the discretion of the office to protect the financial interests of members who may be adversely affected

by the insolvency of a discount ~~medical~~ plan organization. The bond must be issued by an insurance company that is licensed to do business in this state.

(2) In lieu of the bond specified in subsection (1), a licensed discount ~~medical~~ plan organization may deposit and maintain deposited in trust with the department securities eligible for deposit under s. 625.52 having at all times a value of not less than $35,000. If a licensed discount ~~medical~~ plan organization substitutes its deposited securities under this subsection with a surety bond authorized in subsection (1), such deposited securities must ~~shall~~ be returned to the discount ~~medical~~ plan organization no later than 45 days following the effective date of the surety bond.

(3) A ~~No~~ judgment creditor or other claimant of a discount ~~medical~~ plan organization, other than the office or department, does not ~~shall~~ have the right to levy upon any of the assets or securities held in this state as a deposit under subsections (1) and (2).

Section 28. Subsections (2) and (3) of section 636.238, Florida Statutes, are amended to read:

636.238 Penalties for violation of this part.—

(2) A person who operates as or willfully aids and abets another operating as a discount ~~medical~~ plan organization in violation of s. 636.204(1) commits a felony punishable as provided for in s. 624.401(4)(b), as if the unlicensed discount ~~medical~~ plan organization were an unauthorized insurer, and the fees, dues, charges, or other consideration collected from the members by the unlicensed discount ~~medical~~ plan organization or marketer were insurance premium.

(3) A person who collects fees for purported membership in a discount ~~medical~~ plan but purposefully fails to provide the promised benefits commits a theft, punishable as provided in s. 812.014.

Section 29. Subsection (1) of section 636.240, Florida Statutes, is amended to read:

636.240 Injunctions.—

(1) In addition to the penalties and other enforcement provisions of this part, the office may seek both temporary and permanent injunctive relief when:

(a) A discount ~~medical~~ plan is being operated by any person or entity that is not licensed pursuant to this part.

(b) Any person, entity, or discount ~~medical~~ plan organization has engaged in any activity prohibited by this part or any rule adopted pursuant to this part.

Section 30. Section 636.244, Florida Statutes, is amended to read:

636.244 Unlicensed discount ~~medical~~ plan organizations.—

Sections ~~The provisions of ss.~~ 626.901-626.912 apply to the activities of an unlicensed discount ~~medical~~ plan organization as if the unlicensed discount ~~medical~~ plan organization were an unauthorized insurer.

Section 31. This act shall take effect upon becoming a law.

THE FLORIDA SENATE

APPEARANCE RECORD

3-21-2017 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) SB 430

Meeting Date *Bill Number (if applicable)*

Topic Discount Plans *Amendment Barcode (if applicable)*

Name Jack Hebert

Job Title

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Clearwater FL 33762 Email jack@themollardgroup.com
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Chiropractic Assn.

Appearing at request of Chair: ☐ Yes ☑ No Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/21/17
Meeting Date

430
Bill Number (if applicable)

Topic Discount Plans

Amendment Barcode (if applicable)

Name Chris Schoonover

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Consumer Health Alliance

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

Committee Agenda Request

To: Senator Anitere Flores, Chair
Appropriations Subcommittee on Health and Human Services

Subject: Committee Agenda Request

Date: March 9, 2017

I respectfully request that **Senate Bill # 430**, relating to Discount Plan Organizations, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Aaron Bean
Florida Senate, District 4

File signed original with committee office

S-020 (03/2004)

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 Appropriations Subcommittee on Health and Human Services

BILL:	CS/SB 670
INTRODUCER:	Banking and Insurance Committee and Senator Bean and others
SUBJECT:	Managed Care Plans' Provider Networks
DATE:	March 20, 2017 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.	Forbes	Williams	AHS	**Recommend: Favorable**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 670 prohibits a Medicaid managed care plan from excluding any pharmacy from its provider network if the pharmacy meets the credentialing requirements, complies with the Agency for Health Care Administration (agency) standards, and accepts the terms of the plan. The bill requires the managed care plan to offer the same rate of reimbursement to all pharmacies in the plan's network. The bill also authorizes the agency to adopt rules necessary to administer the provisions of the bill, including rules establishing credentialing requirements and quality standards for pharmacies. This bill will allow Medicaid enrollees to access additional pharmacies.

According to the agency, the bill will have an indeterminate fiscal impact on the Medicaid Program.

This bill is effective October 1, 2017.

II. Present Situation:

Many public and private employers and health plans contract with a pharmacy benefit manager (PBM) to help control drug costs. The PBM may provide the employer or plan with access to a nationwide network of pharmacies that will provide services and drugs at a discounted contracted price. The PBMs may negotiate drug prices with retail pharmacies and drug

manufacturers on behalf of health plans or employers and, in addition to other administrative, clinical, and cost containment services, process drug claims for the plans.

Historically, independent pharmacies were anchors in the business community and their pharmacists had long-term relationships with their patients.[1] However, many independent pharmacies have closed in recent years because of the competition resulting from the proliferation of big box and chain retail pharmacies[2] that can negotiate with PBMs at deeply discounted reimbursement levels based on large volume sales. While the big-box and chain retail pharmacies may be able to offset lower prescription reimbursements with other retail sales, it can be difficult for a local independent pharmacy to compete since they derive 90 percent or more of their revenue from prescription sales.[3]

Florida's Statewide Medicaid Managed Care Program

The Florida Medicaid program is a partnership between the federal and state governments. In Florida, the Agency for Health Care Administration (agency) oversees the Medicaid program.[4] The Statewide Medicaid Managed Care (SMMC) program is comprised of the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) managed care program. The agency contracts with managed care plans to provide services to eligible recipients.

Accreditation of Medicaid Managed Care Plans

A managed care plan that is eligible to provide services under the SMMC program must have a contract with the agency to provide services under the Medicaid program. The plan must be a health insurer, an exclusive provider organization, a health maintenance organization (HMO), a provider service network, or an accountable care organization.[5]

Additionally, Medicaid managed care plans are required to be accredited by a nationally recognized accreditation organization or have initiated the accreditation process within 1 year after contract execution.[6] Accreditation is a process of review that healthcare organizations participate in to demonstrate the ability to meet predetermined standards.

Currently, all Florida Medicaid managed care plans are certified by one of three accreditation bodies,[7] which has its own credentialing standards. Each managed care plan must comply with these standards in order to maintain their accreditation. These standards address areas such as quality management and improvement, utilization management, and credentialing. Therefore, in addition to the agency's enrollment and contractually required credentialing requirements,

[1] Independent pharmacies are a type of retail pharmacy with a store-based location—often in rural and underserved areas—that dispense medications to consumers, including both prescription and over-the-counter drugs. See http://www.gao.gov/assets/660/651631.pdf (last viewed Mar. 1, 2017).
[2] Such as Walmart, CVS, Walgreens, Publix or Kroger.
[3] Modern Medicine, *The PBM Squeeze* (Apr. 15, 2013) available at http://drugtopics.modernmedicine.com/drug-topics/news/tags/mac/pbm-squeeze (last viewed Mar. 1, 2017).
[4] Part III of ch. 409, F.S., governs the Medicaid program.
[5] Section 409.962, F.S.
[6] Section 409.967(2)(f)3., F.S.
[7] National Committee for Quality Assurance (NCQA), Joint Commission (JCAHO), or the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC).

managed care plans are responsible for credentialing their providers in accordance with their accreditation standards. A Medicaid managed care plan that fails to attain and maintain accreditation may be subject to liquidated damages for each day of noncompliance.[8]

Provider Credentialing Requirements

Medicaid managed care plans are required by the SMMC contract to conduct credentialing activities of health care providers in accordance with their accreditation requirements to verify a provider's professional qualifications. The process of verifying the credentials of health care providers and facilities helps protect consumers from fraud and poor quality health care by ensuring that providers and facilities have the proper qualifications and licensure to deliver health care services. Most accrediting bodies require health plans to re-credential providers at least every 3 years. Many stakeholders share responsibility for credentialing, and most states and the federal government have laws that affect how credentialing is performed. For example, plans verify with a state or designated certification body that a provider is licensed to practice medicine. Plans also verify a practitioner's Drug Enforcement Agency or Controlled Dangerous Substances certificate, education, and training (including board certification), work history and history of professional liability claims.

Minimum Medicaid Enrollment Requirements

Section 409.912, F.S., authorizes the agency to limit the entities it contracts with or enrolls as Medicaid providers by developing a provider network through provider credentialing. The statute also states that providers are not entitled to enroll in the Medicaid provider network. The agency may limit its provider network based on the following factors:

- Assessment of beneficiary access to care,
- Provider availability,
- Provider quality standards,
- Time and distance standards for access to care,
- The cultural competence of the provider network,
- Demographic characteristics of Medicaid beneficiaries,
- Practice and provider-to-beneficiary standards,
- Appointment wait times,
- Beneficiary use of services,
- Provider turnover,
- Provider profiling,
- Provider licensure history,
- Previous program integrity investigations and findings,
- Peer review,
- Provider Medicaid policy and billing compliance records, and
- Clinical and medical record audits, and other factors.

[8] See http://www.fdhc.state.fl.us/medicaid/statewide_mc/plans.shtml for Florida Medicaid contract provisions (last viewed Mar. 1, 2017).

To receive Medicaid reimbursement, a provider must be enrolled in Medicaid, meet the provider qualifications at the time the service is rendered, and be in compliance with all applicable local, state, and federal laws, rules, regulations, Medicaid bulletins, manuals, handbooks, and statements of policy.[9] Providers rendering services to enrollees through managed care plan contracts currently have several enrollment options including registration only, limited provider enrollment, and full provider enrollment. The registration and limited provider enrollment options do not entitle the provider to serve recipients in the fee-for-service delivery system, but they do meet the federal and state screening standards and allow the issuance of a Medicaid provider identification number. Full provider enrollment allows a provider to serve recipients in the Medicaid fee-for-service delivery system or enrollees in a Medicaid managed care plan, if authorized by the managed care plan of the enrollee. Further, providers seeking limited provider enrollment or full enrollment must execute an agreement with the agency upon successful conclusion of the background screening requirements.[10]

Medicaid Prescription Drug Benefit

The agency maintains coverage policies for most Florida Medicaid services, which are incorporated by reference into ch. 59G-4, F.A.C. Medicaid managed care plans cannot be more restrictive than these policies or the Florida Medicaid State Plan (which is approved by the federal Centers for Medicare and Medicaid Services) in providing services to their enrollees. In addition to prescribing coverage requirements, the coverage policies also set minimum provider qualifications for who may render services to Medicaid recipients.

Florida Medicaid managed care plans serving MMA enrollees are required to provide all prescription drugs listed on the agency's Preferred Drug List (PDL) for at least the first year of operation. At this time, Medicaid managed care plans have not implemented their own plan-specific formulary or PDL. The prior authorization criteria and protocols related to prescription drugs of a Medicaid managed care plan must not be more restrictive than the criteria established by the agency.

The Medicaid fee-for-service system reimburses all Florida Medicaid pharmacy providers at the same rate. Florida Medicaid contracts with a pharmacy benefits manager (PBM) entity to pay for prescription claims. Managed care plans also have a PBM to process their pharmacy claims for all the pharmacies in their networks. For Medicaid managed care plans, the reimbursement of prescribed drugs is based upon negotiated prices between the managed care plan and the pharmacy provider.

Pharmacy Provider Networks in Medicaid Managed Care

Medicaid beneficiaries generally have the right to obtain medical services from any willing provider.[11] However, there is an exception for beneficiaries enrolled in certain managed care

[9] See Rules 59G-5.010 Provider Enrollment and 59G-5.020, F.A.C.
[10] For both limited provider enrollment and full provider enrollment, the agency conducts several basic credentialing functions, including licensure verification, background screening history, criminal history, and federal exclusion database checks. In the case of registered-only providers, the managed care plan is responsible for conducting all credential verifications and background checks.
[11] See CMS Guidance to State Medicaid Directors (Apr. 19, 2016) (on file with Banking and Insurance Committee).

plans (to permit such plans to restrict beneficiaries to providers in the managed care plan networks), except such plans cannot restrict the choice of family planning providers.[12]

Pursuant to s. 409.975(1), F.S., Medicaid managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to s. 409.967(2)(c), F.S. Managed care plans may limit the providers in their networks based on credentials, quality indicators and price, except as specified in the law, and may negotiate rates with pharmacy providers.

Managed care plans must maintain a region-wide network of pharmacy providers in sufficient numbers to meet the access standards for pharmacy and 24-hour pharmacy services for all recipients enrolled in the plan.[13] At a minimum, managed care plans must have pharmacy providers available to enrollees within 30 minutes and 20 miles and 24-hour pharmacy providers available within 60 minutes and 45 miles, regardless of whether in an urban or rural area.[14] At this time, the agency is amending contracts to revise pharmacy network standards to require managed care plans to have pharmacy providers available to the managed care plan's enrollees within 15 minutes and 10 miles, regardless of whether in an urban or rural area. The agency anticipates that this new network standard will be effective upon execution of the June 2017 plan contract amendment.[15]

Managed care plans may assign an enrollee to a specialty pharmacy for specialty medications; however, managed care plans must ensure that members have a choice of available providers in the network of the managed care plan, and members must be notified of this provision.[16] Prior to assigning an enrollee to a specialty pharmacy, the managed care plan must notify the enrollee how to change specialty pharmacies and "opt out" of the assignment, notify the enrollee of their freedom of choice among network providers, and notify the enrollee of rights and protections.[17]

If only one pharmacy distributes a specific product and the provider is not in the plan's network, the managed care plan must take necessary action to provide all medically necessary covered services to enrollees with reasonable promptness, including, but not limited to, the following:

- Utilizing out-of-network providers; and
- Using financial incentives to induce network or out-of-network providers to accept an enrollee as a patient/client and provide all medically necessary covered services with reasonable promptness to the enrollee.[18]

[12] See s. 1902(a)(23(B) of the Social Security Act, 42 C.F.R. s. 431.51(b)(1) and 42 C.F.R. Part 438.
[13] Section 409.967(2)(c)1., F.S.
[14] Pursuant to s. 409.967(2)(c)1., F.S., the managed care plan may use mail-order pharmacies; however, mail-order pharmacies do not count towards the plan's pharmacy network access standards.
[15] Agency for Health Care Administration, 2017 Agency Legislative Bill Analysis of SB 670 (Feb. 6, 2017) (on file with Senate Banking and Insurance Committee).
[16] 42 C.F.R. s. 438.10(f).
[17] 42 C.F.R. s. 438.100.
[18] 42 C.F.R. s. 438.206(b)(4).

Medicare Part D Any Willing Pharmacy Requirements

Federal regulations require a Part D prescription drug plan or sponsor to contract with any willing pharmacy that meets the particular plan's standard terms and conditions.[19] Federal guidance on this requirement provides that the plans standard terms and conditions establish a floor of minimum requirements that all similarly situated pharmacies must abide by while sponsors may modify some of their standard terms and conditions to encourage participation by particular pharmacies. Therefore, plans may negotiate varying payment rates to attract the network participation of certain pharmacies.[20]

Survey of other States

Based on a limited staff survey, approximately 24 states have enacted legislation requiring any willing pharmacy or pharmacist provisions. It is unclear whether these provisions apply to Medicaid or commercial plans or both. In 2015, the State of Maryland issued a report relating to access to Medicaid pharmacy services.[21] In the report, the state contends that encouraging managed care plans to limit their pharmacy networks is an effective strategy for achieving substantial savings without jeopardizing access to prescription drugs. The report cited studies that concluded that allowing insurers to work with PBMs to limit or restrict their pharmacy networks would result in savings[22] while implementing "any willing provider" (AWP) laws may increase pharmacy drug costs.[23]

III. Effect of Proposed Changes:

Section 1 amends s. 409.975, F.S., to prohibit a Medicaid managed care plan from excluding any pharmacy from its provider network if the pharmacy meets the credentialing requirements, complies with the agency standards, and accepts the terms of the plan. The managed care plan must offer the same rate of reimbursement to all pharmacies in the plan's network.

The bill authorizes the agency to adopt rules necessary to administer the provisions of this bill, which includes rules establishing credentialing requirements and quality standards for pharmacies.

Section 2 provides the act will take effect October 1, 2017.

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[19] 42 C.F.R. s. 423.120(a)(8)(i).
[20] Centers for Medicare and Medicaid Services, *Compliance with Any Willing Pharmacy (AWP) Requirements* (Aug. 13, 2015) (on file with Senate Banking and Insurance Committee).
[21] Maryland Department of Health and Mental Hygiene, *Ensuring Maryland Medical Assistance Program Recipients Enrolled in Managed Care Organizations Have Reasonable Access to Pharmacy Services* (Dec. 2015), available at https://mmcp.dhmh.maryland.gov/Documents/JCRs/MCOpharmacynetworksJCRfinal12-15.pdf (last viewed Mar. 1, 2017).
[22] Joanna Shepard, *Selective Contracting in Prescription Drugs: The Benefits for Pharmacy Networks,* 15 MINN. J.L. SCI. & TECH. 1027 (2014) available at http://scholarship.law.umn.edu/cgi/viewcontent.cgi?article=1031&context=mjlst (last viewed Mar. 1, 2017).
[23] Jonathon Klick and Joshua D. Wright, *The Effect of any Willing Provider and Freedom of Choice Laws on Prescription Drug Expenditures*, 17 AM. LAW ECON. REV. 192-213 (Spring 2015), available at http://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=1437&context=faculty_scholarship (last viewed Mar. 1, 2017).

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Requiring Medicaid managed care plans to contract with "any willing pharmacy" that meets certain requirements for participation in Medicaid managed care plans may offer patients greater choice and convenience in the selection of pharmacies.

Absent the promise of exclusivity of network providers, the bargaining power of the larger Medicaid managed care plans may be weakened. Providers may have less incentive to offer substantial discounts to plans, possibly resulting in higher costs to the plans, which may be passed through to the capitation rate setting process.

C. Government Sector Impact:

Impacts on the Credentialing Process[24]

The bill will have an operational and fiscal impact on the Medicaid program, in particular the operations of managed care plans contracted to provide services through the SMMC program.

Medicaid managed care plans will be required to determine if existing pharmacy providers meet and maintain the new credentialing and quality standards. Because this change may result in larger provider networks, the plans may need to deploy additional strategies to monitor against fraud, waste, and abuse. These additional responsibilities may have a fiscal impact on the managed care plans. The fiscal impact of the proposed changes will have an indeterminate impact on managed care plans, but if significant, the

[24] Agency for Health Care Administration, *2017 Agency Legislative Bill Analysis* (Feb. 6, 2017) (on file with Senate Banking and Insurance Committee)

additional administrative costs most likely will be passed through to the capitation rate setting process.

Impacts on Payment Strategies

The bill further requires managed care plans to offer the same rate of reimbursement to all pharmacies in the plan's network. The bill reduces the ability of the plans to negotiate rates for services with pharmacy providers. The bill limits the ability of the plans to control the size of provider networks through cost effective purchasing strategies, which also has the potential to reduce savings opportunities. Currently, managed care plans have the ability to achieve savings by contracting with pharmacies at reduced prices in exchange for volume purchasing. The bill may reduce the managed care plans' bargaining power, resulting in increased costs to the Medicaid program through adjustments that would need to be made in the capitation rates.

VI. Technical Deficiencies:

None.

VII. Related Issues:

According to the agency, the bill creates challenges for plans that want to implement value based purchasing or alternative payment methodologies that are tied to certain plan-specific quality improvement strategies.

VIII. Statutes Affected:

This bill substantially amends section 409.975 of the Florida Statutes.

IX. 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 on March 6, 2017:
The CS clarifies rulemaking authority and changes the effective date from July 1 to October 1, 2017.

B. Amendments:

None.

433026

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/22/2017	.	
	.	
	.	
	.	

Appropriations Subcommittee on Health and Human Services (Bean) recommended the following:

Senate Amendment (with title amendment)

Delete lines 27 - 131
and insert:
(a) A managed care plan may not enter into a contract with a pharmacy benefits manager (PBM) to manage the prescription drug coverage provided under the plan or to control the costs of the prescription drug coverage under such plan unless:
1. The contract prevents the PBM from requiring that a plan enrollee use a retail pharmacy or other pharmacy entity

providing pharmacy services in which the PBM has an ownership interest or which has an ownership interest in the PBM, or the contract provides an incentive to a plan enrollee to encourage the enrollee to use a retail pharmacy, mail order pharmacy, specialty pharmacy, or other pharmacy entity providing pharmacy services in which the PBM has an ownership interest or which has an ownership interest in the PBM, if the incentive is applicable only to such pharmacies; and

2. The contract requires the PBM to update the maximum allowable cost as defined by s. 465.1862(1)(a) every 7 calendar days beginning on January 1 of each year, to accurately reflect the market price of acquiring the drug.

(b) Plans must include all providers in the region which ~~that~~ are classified by the agency as essential Medicaid providers, unless the agency approves, in writing, an alternative arrangement for securing the types of services offered by the essential providers. Providers are essential for serving Medicaid enrollees if they offer services that are not available from any other provider within a reasonable access standard, or if they provided a substantial share of the total units of a particular service used by Medicaid patients within the region during the last 3 years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid patients. The agency may not classify physicians and other practitioners as essential providers. The agency, at a minimum, shall determine which providers in the following categories are essential Medicaid providers:

1. Federally qualified health centers.

2. Statutory teaching hospitals as defined in s. 408.07(45).

3. Hospitals that are trauma centers as defined in s. 395.4001(14).

4. Hospitals located at least 25 miles from any other hospital with similar services.

Managed care plans that have not contracted with all essential providers in the region as of the first date of recipient enrollment, or with whom an essential provider has terminated its contract, must negotiate in good faith with such essential providers for 1 year or until an agreement is reached, whichever is first. Payments for services rendered by a nonparticipating essential provider shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. A rate schedule for all essential providers shall be attached to the contract between the agency and the plan. After 1 year, managed care plans that are unable to contract with essential providers shall notify the agency and propose an alternative arrangement for securing the essential services for Medicaid enrollees. The arrangement must rely on contracts with other participating providers, regardless of whether those providers are located within the same region as the nonparticipating essential service provider. If the alternative arrangement is approved by the agency, payments to nonparticipating essential providers after the date of the agency’s approval shall equal 90 percent of the applicable Medicaid rate. Except for payment for emergency services, if the alternative arrangement is not approved by the agency, payment

to nonparticipating essential providers shall equal 110 percent of the applicable Medicaid rate.

(c) ~~(b)~~ Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks. Statewide essential providers include:

1. Faculty plans of Florida medical schools.

2. Regional perinatal intensive care centers as defined in s. 383.16(2).

3. Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28).

4. Accredited and integrated systems serving medically complex children which comprise separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Except for payments for emergency services, payments to nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that provider

433026

and any other Medicaid managed care plan.

(d) ~~(c)~~ After 12 months of active participation in a plan's network, the plan may exclude any essential provider from the network for failure to meet quality or performance criteria. If the plan excludes an essential provider from the plan, the plan must provide written notice to all recipients who have chosen that provider for care. The notice shall be provided at least 30 days before the effective date of the exclusion. For purposes of this paragraph, the term "essential provider" includes providers determined by the agency to be essential Medicaid providers under paragraph (b) ~~(a)~~ and the statewide essential providers specified in paragraph (c) ~~(b)~~.

(e) ~~(d)~~ The applicable Medicaid rates for emergency services paid by a plan under this section to a provider with which the plan does not have an active contract shall be determined according to s. 409.967(2)(b).

(f) ~~(e)~~ Each managed care plan must offer a network contract to each home medical equipment and supplies provider in the region which meets quality and fraud prevention and detection standards established by the plan and which agrees to accept the lowest price previously negotiated between the plan and another such provider.

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

And the title is amended as follows:

Delete lines 3 - 10

and insert:

networks; amending s. 409.975, F.S.; prohibiting a managed care plan from contracting with a pharmacy

433026

benefits manager to manage the prescription drug coverage provided under the plan unless certain requirements are met; providing an

By the Committee on Banking and Insurance; and Senators Bean, Lee, and Mayfield

597-02144-17 2017670c1

A bill to be entitled

An act relating to managed care plans' provider networks; amending s. 409.975, F.S.; prohibiting a managed care plan from excluding a pharmacy that meets the credentialing requirements and standards established by the Agency for Health Care Administration and that accepts the terms of the plan; requiring a managed care plan to offer the same rate of reimbursement to all pharmacies in the plan's network; authorizing rulemaking; providing an effective date.

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

Section 1. Subsection (1) of section 409.975, Florida Statutes, is amended to read:

409.975 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers participating in the managed medical assistance program shall comply with the requirements of this section.

(1) PROVIDER NETWORKS.—Managed care plans must develop and maintain provider networks that meet the medical needs of their enrollees in accordance with standards established pursuant to s. 409.967(2)(c). Except as provided in this section, managed care plans may limit the providers in their networks based on credentials, quality indicators, and price.

(a) A managed care plan may not exclude any pharmacy that meets the credentialing requirements, complies with agency standards, and accepts the terms of the plan. The managed care plan must offer the same rate of reimbursement to all pharmacies in the plan's network.

(b) Plans must include all providers in the region which ~~that~~ are classified by the agency as essential Medicaid providers, unless the agency approves, in writing, an alternative arrangement for securing the types of services offered by the essential providers. Providers are essential for serving Medicaid enrollees if they offer services that are not available from any other provider within a reasonable access standard, or if they provided a substantial share of the total units of a particular service used by Medicaid patients within the region during the last 3 years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid patients. The agency may not classify physicians and other practitioners as essential providers. The agency, at a minimum, shall determine which providers in the following categories are essential Medicaid providers:

1. Federally qualified health centers.

2. Statutory teaching hospitals as defined in s. 408.07(45).

3. Hospitals that are trauma centers as defined in s. 395.4001(14).

4. Hospitals located at least 25 miles from any other hospital with similar services.

Managed care plans that have not contracted with all essential providers in the region as of the first date of recipient enrollment, or with whom an essential provider has terminated

its contract, must negotiate in good faith with such essential providers for 1 year or until an agreement is reached, whichever is first. Payments for services rendered by a nonparticipating essential provider shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. A rate schedule for all essential providers shall be attached to the contract between the agency and the plan. After 1 year, managed care plans that are unable to contract with essential providers shall notify the agency and propose an alternative arrangement for securing the essential services for Medicaid enrollees. The arrangement must rely on contracts with other participating providers, regardless of whether those providers are located within the same region as the nonparticipating essential service provider. If the alternative arrangement is approved by the agency, payments to nonparticipating essential providers after the date of the agency's approval shall equal 90 percent of the applicable Medicaid rate. Except for payment for emergency services, if the alternative arrangement is not approved by the agency, payment to nonparticipating essential providers shall equal 110 percent of the applicable Medicaid rate.

(c) ~~(b)~~ Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks. Statewide essential providers include:

1. Faculty plans of Florida medical schools.

2. Regional perinatal intensive care centers as defined in s. 383.16(2).

3. Hospitals licensed as specialty children's hospitals as

defined in s. 395.002(28).

4. Accredited and integrated systems serving medically complex children which comprise separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Except for payments for emergency services, payments to nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

(d) ~~(c)~~ After 12 months of active participation in a plan's network, the plan may exclude any essential provider from the network for failure to meet quality or performance criteria. If the plan excludes an essential provider from the plan, the plan must provide written notice to all recipients who have chosen that provider for care. The notice shall be provided at least 30 days before the effective date of the exclusion. For purposes of this paragraph, the term "essential provider" includes providers determined by the agency to be essential Medicaid providers

under paragraph (b) ~~(a)~~ and the statewide essential providers specified in paragraph (c) ~~(b)~~.

(e)~~(d)~~ The applicable Medicaid rates for emergency services paid by a plan under this section to a provider with which the plan does not have an active contract shall be determined according to s. 409.967(2)(b).

(f)~~(e)~~ Each managed care plan must offer a network contract to each home medical equipment and supplies provider in the region which meets quality and fraud prevention and detection standards established by the plan and which agrees to accept the lowest price previously negotiated between the plan and another such provider.

(g) The agency may adopt rules necessary to administer this section, including rules establishing credentialing requirements and quality standards for pharmacies.

Section 2. This act shall take effect October 1, 2017.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/21/17
Meeting Date

SB 670
Bill Number (if applicable)

Topic Managed Care Provider Networks

Amendment Barcode (if applicable)

Name Lawrence (Larry) Gonzalez

Job Title General Counsel

Address 223 S. Gadsden St.
Street

Phone 850-222-0465

Tallahassee, FL 32301
City *State* *Zip*

Email lawgon2@earthlink.net

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Society of Health-System Pharmacists

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/21/17
Meeting Date

670
Bill Number (if applicable)

Topic Pharmacy

Amendment Barcode (if applicable)

Name Cynthia Henderson

Job Title

Address 108 E. Jefferson St. Suite E
Street

Tallahassee FL
City *State* *Zip*

Phone 850 559 0855

Email cyhenderson@me.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Epic Rx

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/21/17
Meeting Date

670
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Pharmacy

Name Claudia Davant

Job Title Lobbyist

Address 205 S. Adams St
Street

Tallahassee 32301
City *State* *Zip*

Phone 8505670979

Email claudia@adamsst.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Pharmacy Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

MARCH 21 2017
Meeting Date

SB 670
Bill Number (if applicable)

Topic PHARMACY

Amendment Barcode (if applicable)

Name MARIANNE GLORIUS

Job Title PHARMACIST

Address 11386 E HWY 316
Street

Phone 352-236-0407

Ft McCoy FL 32134
City *State* *Zip*

Email grandmascountrypharmacy@yahoo.com

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing GRANDMA'S COUNTRY PHARMACY

Appearing at request of Chair: [X] Yes [ ] No

Lobbyist registered with Legislature: [ ] Yes [X] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3-21-17
Meeting Date

SB670
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Pharmacy

Name Mysti Meddox

Job Title Client

Address 15150 NE 111th Ct
Street

Ft McCoy, Fl 32134
City *State* *Zip*

Phone 334-306-4363

Email mimisotired@gmail.com

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against
(The Chair will read this information into the record.)

Representing

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [ ] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3/21/17
Meeting Date

670
Bill Number (if applicable)

Topic SB 670 - ANY WILLING PHARMACY

Amendment Barcode (if applicable)

Name CRAIG HANSEN

Job Title GOVERNMENT AFFAIRS

Address 9670 DEER VALLEY DR
Street

TALLAHASSEE FL 32312
City *State* *Zip*

Phone 850/294/5600

Email craig.hansen@wellcare.com

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing WELLCARE

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3-21-17
Meeting Date

CS/SB 70
Bill Number (if applicable)

Topic Managed care plans provider networks

Amendment Barcode (if applicable)

Name Audrey Brown

Job Title President and CEO

Address 200 W. College Ave
Street

Tallahassee, FL 32301
City *State* *Zip*

Phone 850-386-2904

Email audrey@fahp.net

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Association of Health Plans

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

3-21-17
Meeting Date

Bill Number (if applicable)

Topic Provider Rate

Amendment Barcode (if applicable)

Name Malcolm Harris (Gawdie)

Job Title Self Advocate (SUFL)

Address _____ Phone _____
Street

_____ Email _____
City *State* *Zip*

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing _____

Appearing at request of Chair: [ ] Yes [ ] No

Lobbyist registered with Legislature: [ ] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

Committee Agenda Request

To: Senator Anitere Flores, Chair
Appropriations Subcommittee on Health and Human Services

Subject: Committee Agenda Request

Date: March 6, 2017

I respectfully request that **Senate Bill # 670**, relating to Managed Care Plans, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Aaron Bean

Senator Aaron Bean
Florida Senate, District 4

File signed original with committee office

S-020 (03/2004)

CourtSmart Tag Report

Room: SB 401 **Case No.:** **Type:**
Caption: Senate Appropriation Subcommittee on Health and Human Services **Judge:**

Started: 3/21/2017 2:04:17 PM
Ends: 3/21/2017 3:07:52 PM **Length: 01:03:36**

2:04:19 PM Sen. Flores (Chair)
2:05:28 PM S 18
2:05:38 PM Sen. Stargel
2:05:50 PM Sen. Flores
2:06:25 PM Sen. Stargel
2:06:29 PM Am. 500202
2:06:33 PM Sen. Flores
2:06:50 PM Sen. Stargel
2:07:13 PM Sen. Flores
2:08:07 PM S 430
2:08:10 PM Sen. Bean
2:09:52 PM Sen. Flores
2:10:03 PM Sen. Powell
2:10:19 PM Sen. Bean
2:11:04 PM Sen. Flores
2:11:11 PM Chris Schoonover, Consumer Health Alliance, waives in support
2:11:17 PM Jack Hebert, Florida Chiropractic Association, waives in support
2:12:16 PM S 240
2:12:23 PM Sen. Lee
2:14:27 PM Sen. Flores
2:14:35 PM Sen. Rader
2:14:58 PM Sen. Lee
2:17:03 PM Sen. Rader
2:17:25 PM Sen. Lee
2:18:48 PM Sen. Flores
2:19:06 PM Sen. Rader
2:19:12 PM Sen. Flores
2:19:28 PM Am. 373836
2:19:39 PM Sen. Powell
2:21:02 PM Sen. Flores
2:21:12 PM Sen. Baxley
2:21:41 PM Sen. Flores
2:22:13 PM Sen. Powell
2:22:40 PM Jarrod Fowler, Director of Healthcare Policy, Florida Medical Association, waives in support
2:22:43 PM Jack Hebert, Florida Chiropractic Association, waives in support
2:22:48 PM Stephen Winn, Executive Director, Florida Osteopathic Medical Association, waives in support
2:22:51 PM Chris Nuland, Florida Chapter, American College of Physicians, waives in support
2:22:56 PM Sal Nuzzo, Vice President of Policy, The James Madison Institute, waives in support
2:23:01 PM Bill Herrile, Executive Director, National Federation of Independent Business, waives in support
2:23:06 PM Aimee Diaz Lyon, Florida Academy of Family Physicians, waives in support
2:23:23 PM Sen. Baxley
2:23:59 PM Sen. Powell
2:24:26 PM Sen. Flores
2:24:33 PM Sen. Lee
2:25:24 PM Sen. Flores
2:25:48 PM S 670
2:25:57 PM Sen. Bean
2:31:04 PM Sen. Flores
2:31:06 PM Am. 433026
2:31:22 PM Sen. Passidomo
2:32:24 PM Sen. Bean
2:34:00 PM Sen. Passidomo

2:34:43 PM Sen. Bean
2:35:38 PM Sen. Rader
2:35:46 PM Sen. Bean
2:36:31 PM Sen. Rader
2:37:15 PM Sen. Bean
2:37:41 PM Sen. Powell
2:38:07 PM Sen. Bean
2:38:52 PM Sen. Powell
2:39:06 PM Sen. Bean
2:40:17 PM Sen. Baxley
2:40:50 PM Sen. Bean
2:41:46 PM Sen. Baxley
2:41:52 PM Sen. Bean
2:42:20 PM Sen. Rader
2:42:41 PM Sen. Flores
2:42:51 PM Lawrence Larry Gonzalez, General Counsel, Florida Society of Health System Pharmacists, waives in support
2:42:58 PM Cynthia Henderson, Epic RX, waives in support
2:43:05 PM Claudia Davant, Florida Pharmacy Association, waives in support
2:43:37 PM Marianne Glorius, Pharmacist, Grandma's Country Pharmacy
2:47:09 PM Sen. Flores
2:47:34 PM Mysti Maddox, Client, waives in support
2:49:25 PM Sen. Flores
2:49:39 PM Craig Hansen, Government Affairs, Wellcare
2:52:03 PM Sen. Flores
2:52:19 PM Audrey Brown, President, Florida Association of Health Plans
2:54:21 PM Sen. Flores
2:54:31 PM Sen. Passidomo
2:57:34 PM Sen. Book
2:58:01 PM Sen. Rader
2:59:06 PM Sen. Baxley
3:00:54 PM Sen. Bean
3:02:18 PM Sen. Flores
3:03:04 PM Malcolm Gowdie, Self-Advocate
3:03:52 PM Sen. Flores
3:04:17 PM Jamie Brookwells, Self-Advocate
3:07:32 PM Sen. Artiles
3:07:40 PM Sen. Flores
3:07:44 PM Meeting Adjourned