STORAGE NAME: h0591s2z.hcl ****AS PASSED BY THE LEGISLATURE****
DATE: July 1, 2000 **CHAPTER** #:2000-318, Laws of Florida

HOUSE OF REPRESENTATIVES
AS FURTHER REVISED BY THE COMMITTEE ON
HEALTH CARE LICENSING & REGULATION
FINAL ANALYSIS

BILL #: CS/CS/HB 591, Third Engrossed

RELATING TO: Health Care

SPONSOR(S): Committee on Governmental Rules & Regulations, Committee on Health Care Licensing & Regulation, and Representatives Minton, Fasano, and others

TIED BILL(S): None.

ORIGINATING COMMITTEE(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH CARE LICENSING & REGULATION YEAS 10 NAYS 3
(2) GOVERNMENTAL RULES & REGULATIONS YEAS 6 NAYS 1
(3) HEALTH AND HUMAN SERVICES APPROPRIATIONS YEAS 11 NAYS 0
(4)
(5)

I. SUMMARY:

CS/CS/HB 591:

- Addresses the issue of unlicensed assisted living facilities by establishing local coordinating workgroups, by requiring reporting by health care providers of unlicensed facilities, by prohibiting the discharge of patients to unlicensed facilities, and by requiring paramedics, emergency medical technicians, and public lodging inspectors to report abuse and neglect;
- Amends the Certificate of Need (CON) statutes by identifying an additional type of project subject to expedited rather than competitive CON review and by identifying several other types of currently reviewable projects that would become exempt from CON review. The bill also proposes a significant reduction and clarification of the review criteria used to evaluate applications for a CON and removes other obsolete provisions. Furthermore, this bill authorizes a certificate of need workgroup to study issues regarding the CON program;
- Appropriates $230,000 for continuation of the 1999 kidney dialysis study;
- Amends several general administrative provisions relating to the regulation of the health care professions by the Department of Health;
- Clarifies that only the licensing board, or the department when there is no board, may grant an exemption from disqualification from employment to a person under the jurisdiction of the board, or department, as applicable;
- Sets minimum mandatory penalties for the unlicensed practice of health care;
- Provides statutory construction relating to the sale, use, or recommendation of the use of a dietary supplement, as defined under federal law, to clarify that nothing herein shall be construed to limit or restrict such sale, use, or recommendation of the use so long as the person selling, using, or recommending the use of the dietary supplement does so in compliance with federal and state laws;
- Creates temporary physician certificates for visiting physicians to train at the Moffitt Cancer Center on cancer treatment techniques; allows physicians teaching at FSU Medical School and the Mayo Medical School at the Mayo Clinic, Jacksonville, to receive medical faculty temporary certificates like other Florida medical schools; and waives fees for physicians willing to practice for free in areas of critical need under a temporary certificate;
- Requires registration of remaining residents training in teaching hospitals;
- Mandates that protocols for hair removal or reduction require direct supervision by an allopathic or osteopathic physician when lasers are used by non-physicians;
- Clarifies duties of Council on Physician Assistants relating to licensure;
- Updates terminology and requirements relating to acupuncture;
- Clarifies clinical laboratory director qualifications for licensure;
- Prevents HMOs from delaying medically necessary ophthalmology examinations; and
- Modifies other provisions relating to health care practitioners, insurance providers, and facilities.

Please see Section II.D, Section-by-Section Analysis, for details.

The bill takes effect July 1, 2000, except as otherwise specified.

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1. Less Government Yes [X] No [] N/A []
2. Lower Taxes Yes [X] No [] N/A []
3. Individual Freedom Yes [X] No [] N/A []
4. Personal Responsibility Yes [X] No [] N/A []
5. Family Empowerment Yes [X] No [] N/A []

B. PRESENT SITUATION:

CERTIFICATE OF NEED

Section 408.032(2), F.S., defines "certificate of need" as a written statement issued by the Agency for Health Care Administration (agency) evidencing community need for a new, converted, expanded or otherwise significantly modified health care facility, health service, or hospice. The purpose of the CON process is to avoid costly duplication of services and unnecessary capital expenditures as it relates to hospitals, nursing homes, acute care hospital services, psychiatric or rehabilitative beds, and tertiary health services. As part of the CON review process, the financial feasibility of a project is assessed, the under served population group is determined, and the overall reasonableness of proposed revenues and expenses is evaluated. Applicants generally propose a specified level of care to indigent and Medicaid patients as a condition placed upon the award of a CON. These activities are consistent with the agency's mission to champion accessible, affordable, quality health care for all Floridians. The agency is charged with carrying out the CON review process on the applicable facilities.

Hospitals - Currently, s. 408.036, F.S., requires hospitals to make application for the establishment of new hospitals and the addition of beds to existing hospitals. The agency publishes a need for acute care hospital beds twice a year for the 11 planning districts. Hospitals can respond to published need, or demonstrate special circumstances unique to their hospital and the service area. In order to determine future bed need, the agency has to establish a complete inventory of acute care beds and look at the current and projected utilization of each hospital in the respective service area. All proposals are evaluated against statutory, rule, and local health plan CON review criteria.

Overall, most Floridians have adequate geographical access to acute care hospital services. The statewide average acute care bed occupancy rate remains low at 50%. The CON program lacks authority to de-license underutilized beds. However, in some areas of the state a few hospitals have experienced increasing occupancy rates especially during the winter season.

Over the past five years, the agency reviewed 37 proposals to add general acute care beds to existing hospitals. A total of 1,214 new acute care beds were proposed, at a cost of $306 million. During the same time period, the agency reviewed 17 proposals for new

acute care hospitals excluding replacement facilities. A total of 815 new acute care beds were proposed, at a cost of $826 million.

According to the agency, the CON review for acute care beds was originally implemented when reimbursement for acute care services was cost-based and fears of over utilization were prevalent. These market conditions have clearly changed, and better cost control mechanisms have been implemented. However, nearly 60% of all hospital care is funded by Medicare and Medicaid, and the CON program ensures public input into the allocation of resources.

Nursing Homes - Section 408.036, F.S., requires CON review of proposals to establish new nursing homes, and proposals to add beds to existing nursing homes. The agency publishes a need for nursing home beds twice a year for 38 planning areas. Nursing home applicants generally respond to published need. In order to determine future bed need, the agency has to establish a complete inventory of nursing home beds and look at the current and projected utilization of all nursing homes in the respective service area. Future bed need is primarily determined based on population growth in each respective service area. Since it takes about three years to establish a new facility, bed need is projected three years into the future. All proposals are evaluated against statutory, rule, and local health plan CON review criteria. The construction of state veterans' nursing homes is exempted from CON review provided certain conditions are met.

The primary rationale for nursing home market controls is to contain capacity, ensure access to care regardless of income, promote the location of nursing homes in areas with need, ensure efficient occupancy levels, and avoid costs associated with duplicative services and facilities. Additionally, the CON program allows the state to assess the financial soundness of a potential provider and to evaluate his/her past quality of care record.

According to the agency, Florida's CON program for nursing homes has been one of the most effective CON programs. Most Floridians have adequate geographic access to nursing home care. At the same time, Florida has maintained one of the lowest nursing home bed-to-population ratios in the country, while several other states had to resort to moratoria to contain the bed supply. Florida has approximately 29 beds per 1,000 65+ population compared to the national average of 50 beds.

It is in the interest of most growing states to control the nursing home bed supply, since nearly 50% of all nursing home care is funded by Medicaid and another 15% by Medicare. Florida's annual Medicaid nursing home budget exceeds $1 billion even with the low bed ratio and an overall low nursing home utilization rate.

Over 330 nursing homes have received CONs predicated on the condition that they provide a specified level of care to Medicaid patients. This is an important program feature in view of recent events in Florida when a nursing home attempted to evict Medicaid patients.

Over the past 5 years, the agency has reviewed 220 proposals for new freestanding nursing homes. A total of 20,998 new nursing home beds were proposed, at a cost of $1.4 billion. During the same period, there were 216 proposals to add beds to existing nursing homes. A total of 8,220 new nursing home beds were proposed, at a cost of $454 million. Thus, there were 5,844 new nursing home beds proposed in an average year.

Other current provisions - Current statutes specifically require review of any increase in the number of psychiatric or rehabilitation beds at hospitals. Also, a review of the

establishment of tertiary health services is required. Currently, tertiary health services with dedicated inpatient beds include Level II neonatal intensive care, Level III neonatal intensive care, specialty burn units, and comprehensive rehabilitation.

Except for proposals from rural hospitals under specified circumstances, the agency also reviews proposals to establish or expand hospital-based skilled nursing units (SNUs).

KIDNEY DIALYSIS STUDY

In 1999, the Florida Legislature requested that the Agency for Health Care Administration investigate the relationship between dialysis centers, the centers' medical directors, and the laboratories that serve dialysis patients. The agency issued a report on February 1, 2000, on that investigation which concluded that additional review and resources were necessary to complete the study. The estimated cost to contract with a state university to complete the study is $230,000.

HEALTH CARE PRACTITIONERS

Social Security Numbers:

Under s. 455.564(1), F.S., all applicants are required to provide their social security number at the time of initial application for license. This creates a "catch-22" for applicants who cannot obtain a work visa without a license, cannot obtain a license without a social security number, and cannot obtain a social security number without a work visa. This problem was discovered during 1999 and the Department of Health requested an Attorney General Opinion regarding the interpretation of this law. An opinion was issued which allowed the department to begin processing these applications but advised the department that legislative clarification was needed. According to the department, this issue is important due to the current shortage of nurses in this state. Nurses are being recruited from Canada to help alleviate this shortage.

Profiling/Background Screening:

Currently, allopathic, osteopathic, chiropractic, and podiatric physicians are required to be profiled and to submit other information, including fingerprints, necessary to conduct national and statewide criminal background checks as a condition of licensure or licensure renewal. The physician must pay the full cost of the background screening, which is $43. If the physician is also a Medicaid provider, then the physician is required to undergo background screening as part of the Medicaid provider application process. Furthermore, if the physician practices in certain facilities or settings, such as a county health department or a nursing home, or is an employee of the Department of Children and Family Services or the Department of Juvenile Justice, the physician must also undergo background screening as part of the employment process. These redundant background checks create duplicative work for the Florida Department of Law Enforcement, are time-consuming and expensive for the physician, and add little protection for the public when conducted in such short and overlapping time periods.

The Department of Health reports that during the first six months that practitioner profiles were available to the public on the Internet, approximately 304,451 searches were conducted. The average was over 50,000 searches per month. It is unknown how many of

these licensure inquiries and verifications would have been conducted through written or telephone requests had the Internet site not been available.

Practitioner Misconduct Provisions:

Sexual Misconduct: Practitioners are currently prohibited from engaging in sexual activity with patients, clients, and immediate family members of the patient or client. However, there are also foster families and other legal guardianship relationships where the guardian or representative of the patient is equally vulnerable. Those legal guardians and representatives are not currently afforded equal protection from a practitioner who may use his or her position to engage or attempt to engage in sexual activity to the detriment of the patient.

Impairment or Use of Drugs: Any practitioner who tests positive for any drug, as defined in s. 112.0455, F.S., on any confirmed preemployment or employer-ordered drug screening when the practitioner does not have a lawful prescription and legitimate medical reason for using the drug, may be suspended by an emergency suspension order issued by the Secretary of Health. However, there is no corresponding ground for discipline. The Administrative Procedures Act, chapter 120, F.S., requires the Department of Health to initiate formal disciplinary proceedings following the issuance of an emergency suspension order. Since there is no corresponding ground for discipline at the present time for any profession other than nursing, the department must charge the licensee with being unable to practice with reasonable skill and safety or other related provision. However, a licensee may have used drugs and been a potential danger to patients at the time of the positive drug test but may not be using drugs during a subsequent hearing. At hearing on the ground for discipline for being unable to practice with reasonable skill and safety, the department must prove that the licensee used drugs at the time of the positive drug test and is still a danger to the public at the time of the hearing. Although this is very difficult to prove, the members of the regulatory boards have repeatedly stated that a licensee who uses drugs illegally has poor judgment and cannot be trusted to prescribe, administer, and dispense drugs to patients with reasonable skill and safely.

Additionally, under current law, if there is an allegation that a practitioner is using drugs, the department or the board may attempt to refer the practitioner into one of the two existing impaired practitioner programs for a mental and physical examination to determine if there is any merit to the allegation of impairment. Most practitioners assent to be evaluated to determine current fitness to practice. However, on occasion, a practitioner may refuse to be evaluated. When that occurs, and the practitioner is a physician or one of several other types of practitioners, the Secretary of Health may compel the practitioner to undergo an evaluation if the Secretary finds probable cause to exist that the practitioner is impaired. Not all of the health care practice acts contain this provision. Most notably, the pharmacy practice act is missing this procedure. Pharmacy has a high rate of impairment due to the easy access of pharmacists to controlled substances.

Penalties for Misconduct: One of the penalties that the boards and department may impose on a practitioner for misconduct is a restriction of practice. For instance, a practitioner may be restricted to practicing in certain settings or under certain conditions. Presently, pursuant to ch. 455, F.S., only the practice can be restricted, not the license.

In lieu of the full disciplinary process set forth in s. 455.621, F.S., the boards or department may issue a citation in accordance with s. 455.617, F.S. However, in order to issue a citation, the board or department must designate by rule which grounds for discipline have no substantial threat to the public health, safety, and welfare. Because the bulk of the grounds for discipline involve protecting the public health, safety, and welfare, very few grounds for discipline have been designated by the boards as suitable for citations. Those that have been designated as citation violations are very narrowly tailored and thus do not provide much relief to the overburdened regulatory system. Practitioners who have committed relatively minor offenses must go through the entire disciplinary process which can take several years and cost thousands of dollars.

Presuit notices are required to be filed with the state at the time a patient is considering filing a medical malpractice lawsuit, pursuant to section 766.106, F.S. The Agency for Health Care Administration reviews these presuit notices to determine legal sufficiency to open an independent investigation of the health care practitioner. A large percentage of these presuit notice cases never result in the actual filing of a lawsuit. Therefore, the agency is using considerable resources to review situations which frequently do not result in the filing of a lawsuit. These resources would be better spent on cases which are non-frivolous. Oftentimes, the attorney representing the plaintiff in the civil action is not cooperative with the agency at this stage and is unwilling to share evidence with the state. Thus, the agency finds it difficult if not impossible to pursue an investigation of these cases without the cooperation of the patient and plaintiff's lawyer since a patient release is necessary to obtain patient records and patient testimony is almost always crucial to the state prevailing against the license of a health care practitioner. The patient and plaintiff's lawyer usually become more cooperative and willing to assist in the state's investigation once the actual lawsuit is filed.

Licensure Status Changes:

Sections 455.711, F.S., and 455.714, F.S., set forth the conditions and requirements for licensees to change their licensure status from active to inactive or from inactive to active. Under current law, the ability of the licensee to change status is limited. Also, with regard to the fees to be charged in certain circumstances, because the language is unclear, different boards have interpreted these provisions differently resulting in confusion and inconsistencies for the department in carrying out the ministerial functions relating to licensure status changes.

Requests for Exemption from Disqualification from Employment or Contracting:

Currently, the state agency with disciplinary jurisdiction over the licensee is the board, or department when there is no board, and the jurisdiction to grant exemptions from disqualification lies with the department even when there is a board. To complicate matters further, while the department must handle all requests for exemption from certified nursing assistants regardless of practice location, the department only handles requests for exemption from other health care practitioners if the practitioner has applied to practice in certain settings. The remaining exemptions are handled by the Agency for Health Care Administration. This has led to much confusion in the health care industry and has resulted in discrepancies between the findings of the various jurisdictional bodies.

Unlicensed Activity:

Florida law requires persons wishing to provide health care services to patients in Florida to prove that they have the requisite education, training, and knowledge to practice that profession. Florida law provides avenues for licensure by examination or by endorsement if the health care practitioner has already been licensed in another jurisdiction. The purpose of licensure and regulation is to protect the public health, safety, and welfare from unsafe and incompetent practitioners.

The Florida Legislature has recognized in passing laws setting forth practice parameters that the practice of medicine and other health care professions is potentially dangerous. The primary legislative purpose in enacting the medical and health care practice acts is to ensure that every health care practitioner who wishes to practice in Florida meets minimum requirements for safe practice.

The Legislature has set forth certain acts which constitute criminal violations. Among the prohibited acts is practicing medicine without a license, a felony of the third degree. If a person is found guilty of practicing medicine in Florida without a license, criminal penalties may be imposed, including incarceration. However, according to information received from the Department of Health, these cases are rarely prosecuted because the crimes are listed on the Offense Severity Ranking Chart in s. 921.0022(3), F.S., as level 1 crimes. Level 1 crimes are considered to be the least serious and if prosecuted at all, almost never result in a prison sentence. Other crimes listed in level 1 include molesting a crab trap, poaching an alligator, and tampering with an odometer.

During the past year, the Department of Health and the Office of the Attorney General have worked together to form the Office of Unlicensed Activity in Ft. Lauderdale. This special investigative unit consisting of 2 investigators, 1 attorney, and 1 support staff was created to focus attention on the ever-growing problem of unlicensed activity. This unit was set up as a pilot project to focus on the 4 South Florida counties in which most of the unlicensed activity in this state occurs. This unit investigates complaints of unlicensed activity and then presents the case to local law enforcement and the appropriate prosecutor in order to facilitate the criminal investigation and prosecution. This pilot project has been successful in getting more unlicensed persons arrested than in past years due to its narrow focus.

Recent newspaper articles have further focused attention on the rise in unlicensed activity and the great potential for harm to patients from unqualified practitioners practicing in unsanitary locations.

Nursing/ Nursing Assistants:

The federal government has created guidelines pursuant to the Code of Federal Regulation, Title 42, ss. 483.150-158, which establish basic requirements regarding nurses aides that must be met by states. All state policies relating to certified nursing assistants (CNAs) must comply with the federal guidelines. These federal regulations outline the required training programs and competency evaluations for CNAs, require states to establish a registry of CNAs, and set up procedures by which states may receive federal reimbursement for some costs associated with CNA programs.

Certified nursing assistants are currently regulated in Florida by the Department of Health. The department oversees the discipline and certification of all CNAs. The Department of Health indicates that there is confusion among individuals who supervise and employ CNAs regarding the mechanism for their discipline. The department also asserts that the Board of Nursing is recognized and accepted by nurses and employers as an effective disciplinary body.

The department is responsible for ensuring that a statewide registry of certified nursing assistants is maintained. The Department of Health contracts with the Agency for Health Care Administration (AHCA) to maintain this registry.

In order to become certified as a CNA an individual must:

1. Successfully complete an approved training program and achieve a minimum score on the nursing assistant competency examination; or

2. Be at least 18 years of age, hold a high school diploma or its equivalent, and achieve a minimum score on the nursing assistant competency examination.

The Department of Education approves certified nursing assistant education programs.

In Florida, profiling and credentialing of allopathic, osteopathic, chiropractic, and podiatric physicians are required. Advanced registered nurse practitioners (ARNPs) are not required to be credentialed or profiled.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

Chapter 641, F.S., relates to health care services programs. Part I of this chapter, consisting of ss. 641.17-641.3923, F.S., is the "Health Maintenance Organization Act," under which the Department of Insurance regulates the business aspects of HMOs. The Department of Insurance issues a certificate of authority to do business in Florida if the organization applying meets the requirements of s. 641.22, F.S. Specifically, the department reviews the financial and business aspects of HMOs such as actuarial soundness, minimum surplus, insurance and reinsurance, and blanket fidelity bond requirements, as well as managerial aspects of HMOs such as non-discriminatory practices and subscriber grievance procedures.

As a condition of receiving a certificate of authority to do business from the Department of Insurance, an HMO must receive a health care provider certificate from the Agency for Health Care Administration. Part III of chapter 641, F.S., consisting of ss. 641.47-641.75, F.S., authorizes the Agency for Health Care Administration to regulate HMO quality of care by issuing health care provider certificates to HMOs which meet certain requirements. Any entity that is issued a health care provider certificate under part III of chapter 641 and that is otherwise in compliance with the certificate of authority to do business provisions under part I may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services to subscribers in exchange for a prepaid per capita sum or prepaid aggregate fixed sum.

Section 641.31, F.S., sets certain requirements HMOs must meet when contracting with subscribers and provides for certain coverage that must be included in the contract. Among the provisions included are those relating to rates charged, contract amendments, services, subscriber grievances, dependent coverage, including adoption, emergency services and care, preexisting conditions, open enrollment, disease-specific conditions, and point-of-service provisions.

Requirements for contracts and billings between an HMO and its contract and non-contract providers are established in s. 641.315, F.S. Among the provisions included are those relating to obligations for fees, liability for covered services, collection of money for services, contract terms, notice of cancellation, provider-patient communication, exclusive provider contracting, and contract termination.

Section 641.3155, F.S., relates to HMO provider contracts and payment of claims. Specifically addressed are time frames for payment of uncontested claims, contesting of claims, prompt payment, and payment reconciliation.

MANDATED HEALTH BENEFITS

State laws frequently require private health insurance policies and health maintenance organization (HMO) contracts to include specific coverages for particular treatments, conditions, persons, or providers. These are commonly referred to as "mandated [health] benefits." These mandated benefits affect plans covering an estimated 33 percent of all Floridians and 40 percent of insured Floridians. The nearly one-half of all Floridians who either are uninsured or covered under Medicare or Medicaid are not affected. Self-funded plans provided by employers also are similarly unaffected because the federal Employee Retirement Income Security Act of 1974 (ERISA) [29 U.S.C. s. 1001, et. seq.] generally preempts state regulation of these plans.

Recognizing that "most mandated benefits" contribute to the cost of health insurance yet acknowledging the social and health benefits of many of these mandates, the Legislature in 1987 called for a "systematic review of current and proposed" mandated benefits. At that point, the Legislature had approved 16 mandated benefits. In the 13 years since, the Legislature has approved an additional 35 mandated benefits. With a total of 51 mandated health benefits applicable either to private insurer or HMO health plans, Florida now has one of the nation's most extensive set of coverage requirements. The lone procedural requirement established for reviewing mandated benefits--that proponents submit an impact analysis for any proposed mandated benefit prior to consideration--has been largely ignored. Staff could confirm only 4 instances since 1987 in which the required study was completed for a mandated benefit.

In 1998, nearly a quarter of non-elderly Floridians were uninsured. According to the 1998 Health Confidence Survey sponsored by the Employee Benefit Research Institute, 48 percent of the uninsured nationwide cited cost as the primary reason for being uninsured. Costs would have to be "cut in half " to entice one-third of these respondents back into the marketplace, according to at least one study.

Number of Mandated Health Benefits - By some measures, Florida has more mandated benefits than nearly every other state. In preparing this report, committee staff identified 51 mandated health benefits applicable either to private insurer or HMO plans. Of the 51 mandated benefits, 40 apply to either private individual or group policies provided by insurers. Individual policies are subject to 34 and group policies to 39. Health maintenance organizations must comply with 39 mandated benefits.

In a separate count, BlueCross BlueShield Association placed the number of mandates in Florida statutes at 44--the second highest in the nation, compared to an average of 25 among all states [BlueCross BlueShield Association, State Legislative Health Care and Insurance Issues: 1998 Survey of Plans.]

The Reach of Mandated Health Benefits: Floridians Affected - An estimated 33 percent of all Floridians are covered under health plans subject to mandated health benefits. These Floridians are covered under a private insurer or HMO plan, other than a basic or standard small employer group plan. The other 67 percent are unaffected by mandated health benefits because they either are uninsured or covered under plans not subject to these mandates. These include Medicare or Medicaid plans, and self-funded ERISA plans

provided by certain employers. Among insured Floridians, 40 percent are in plans subject to mandated health benefits.

Health Plans	Insured Floridians	% of all Floridians	Mandates applicable?
Insurer/HMO	40%	33%	Yes
Self-Funded Employer	26%	21%	No
Medicare	22%	18%	No
Medicaid	12%	10%	No
No health plan/uninsured	N/A	17%	N/A

In 1992, in the Florida Employee Health Care Access Act [s. 627.6699, F.S.], the Legislature authorized insurers and HMOs to offer "basic" and "standard" small employer group plans and exempted these 2 plan types from mandated coverages not expressly made applicable to these plans in law. For the period ending December 31, 1998, these 2 plan types accounted for only $139 million in earned premium or just over 8 percent of the more than $1.7 billion in premium earned for all small employer group plans, according to figures provided by the Department of Insurance. According to the Department of Insurance small employer enrollment report for the period ending June 30, 1999, the number of lives covered under a basic or standard plan was 276,000 of over 1.7 million individuals covered under a small employer group plan.

It is not always apparent in statute which health plans are subject to which state-mandated health benefits. The statutes can be inconsistent and confusing. For instance, the statute may refer to "an insurer" but then in describing those covered refer to "subscriber," a term associated with HMOs.

Availability of Generally-comparable Benefits - Although mandated health benefits apply only to private insurer and HMO health plans, committee staff found in many instances Floridians are receiving comparable benefits either under an exempt self-funded ERISA plan, or through Medicaid or Medicare.[1] However, these plans are either paid for by the general public, as in the case of Medicaid and Medicare, or funded voluntarily by those with the freedom to design a plan with benefits they are willing to purchase, such as an employer with a self-funded plan. In contrast, insurer and HMO plans are paid for by those securing the coverage, regardless of whether or not they want to purchase all of the mandated benefits.

The Cost of Mandated Health Benefits - The Legislature has recognized in legislative intent that "most mandates contribute to the increasing cost of health insurance premiums." Insurers and HMOs contend mandated benefits increase costs by: 1) increasing utilization of health care services; 2) giving providers of certain benefits pricing leverage; and 3) requiring them to include additional benefits.

By stating that "most" mandates increase costs, that same legislative intent recognizes that some mandates may not increase premium costs. These could be of at least two types: one, a preventative care mandate, such as mammogram screening or well-child care; and two, a mandated treatment or provider substituting for a more expensive alternative.

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[1]Note: The actual terms of the coverage may vary. Committee staff did not analyze the details of the specific coverages or compare deductibles or co-payments, or determine the extent to which the coverages meet the letter of the benefit mandated on insurers and HMOs operating in the private market place. This information should therefore be considered only as a starting point in any comparison of benefits among the different sources of coverage.

Certain mandated benefits may not necessarily reduce premium costs but may reduce the costs borne by the general public.

Calculating the cost of mandated health benefits can be difficult. Cost determinations are complicated by a lack of reported data, difficulty in calculating costs avoided, and failure to account for the cost of mandated benefits which would today be provided in the absence of a specific mandate.

Studies of the cost of mandated health benefits

Florida - Staff could not identify any comprehensive study of the cumulative cost of mandated health benefits in Florida.

Other States - Several states have calculated these costs. A 1996 U.S. General Accounting Office report on claims costs in 6 states cited studies as far back as 1988, revealing claims costs ranging from 5.4 percent in Iowa to 22 percent in Maryland. Costs vary based on the number and type of mandated benefits.

In Virginia, a state with extensive cost reporting requirements for insurers and HMOs, the average claim cost per group certificate for the 1997 reporting period was $263, accounting for 16.62 percent of total claims costs. The premium impact on group certificates for family coverage was 29.17 percent of overall average premium on a full cost (as opposed to marginal cost) basis. Virginia had 33 mandated benefits according to the 1998 BlueCross BlueShield report.

In Maryland, mandates were priced on a full cost and marginal cost basis. On a full cost basis, the estimated annual cost per policy for a group insurance policy was $604. The marginal cost came in at $148. This represents 15.4 percent and 3.8 percent of the average premium per policy. Maryland has 47 mandated benefits according to the 1998 BlueCross BlueShield report.

Maine calculates the cost impact of proposed mandated health benefits and also determines the cumulative costs of mandated benefits. As part of a December 22, 1999, report, the Maine Bureau of Insurance estimated the cumulative premium impact of 19 currently mandated benefits on group policies covering more than 20 employees to be 7.54 percent for fee-for-service plans, and 7.12 percent for managed care plans. For comparison purposes, the 1998 BlueCross BlueShield report showing Florida with 44 mandated benefits shows Maine with 31.

Mandated Benefits Review Process

Florida -The Legislature has established requirements specific to consideration of legislation proposing mandated health benefits.[2] Proponents of a particular mandated health benefit must prepare a report assessing the social and financial impacts of the proposal and submit the report to the Agency for Health Care Administration and the relevant legislative committees. These include an assessment of the extent to which:

- The treatment or service is used by a significant portion of the population;
- The insurance coverage is generally available;
- Any general lack of availability of coverage causes persons to forego necessary treatment;
- Any general lack of availability of coverage results in unreasonable financial hardship;
- There is public demand for the treatment or service;
- The coverage is included in collective bargaining negotiations;
- Cost increase or decrease results from the treatment or service;
- Coverage will increase the appropriate uses of the treatment or service;
- The coverage will be a substitute for a more expensive treatment or service;
- The coverage will increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders; and
- The coverage will impact the total cost of health care.

Although the Legislature has enacted approximately 35 mandated benefits since 1987, staff could only identify 4 reports submitted for mandated health benefits since that time.

Other States - A survey conducted by the committee staff found 20 states have special statutory provisions for managing mandated benefits legislation and 28 do not.

Impact analyses

The most common response of states has been to have an impact analysis conducted to assess the financial impact, social impact, and/or medical efficacy of the proposal. This is the case in 18 states. States typically require either a designated state agency or special review panel to conduct the review. In Maine, the review panel may contract with a private actuarial firm to complete the analysis. However, 7 states, including Florida, direct the proponents or sponsor of a mandates proposal to complete the analysis. One state, Pennsylvania, permits both proponents and opponents to submit information. Two states, Louisiana and Tennessee, direct fiscal committee staff to conduct the review. For the most part, states call for a similar impact analysis. All include a financial component. Fourteen, including Florida, must include an analysis of the social impact of the proposal. Seven require the analysis to consider the medical efficacy of the mandate as well. Virtually all states include a laundry list of specific criteria to examine in conducting the analysis.

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[2]With other types of legislation, special constitutional or statutory requirements exist. These include legislation proposing changes in the state retirement system, creation of a public records exemption or specialty license plate, and approval of a local bill or local government mandate. The Legislature uses an estimating conference to consider fiscal impacts on the state employees group health plan. Both the Senate and the House of Representatives adopt rules, jointly and separately, defining the process for considering certain types of legislation--for example, legislation affecting appropriations--or conducting other legislative business. Special requirements can also be found in policy statements of several standing committees specific to legislative consideration of certain types of legislation.

Time frames for submitting an impact analysis vary among states: at the time the proposal is filed (e.g., Oregon); within 30 days after analysis is requested (e.g., South Carolina); 90 days prior to session (e.g., Washington); timely manner (e.g., Maine); or before being heard or before final passage by committee (e.g., Kentucky).

Only 5 states directly attempt to limit the prerogative of the legislature to act on mandates legislation based on whether or not an impact analysis has been submitted. Maine is the most direct: "a proposed mandate may not be enacted into law unless [the] review and evaluation . . . has been completed."

Review entities

Only 11 of the 48 states responding reported having either an ongoing permanent body or a state agency specifically charged with reviewing proposed mandated benefits.

Virginia and Maryland have standing commissions; Pennsylvania's Health Care Cost Containment Council must convene a Mandated Benefits Review Panel of 4 senior researchers to develop independently certified documentation for proposed mandates. The remaining states designate a state agency such as the Department of Insurance to review a proposed mandate if requested by either the appropriate legislative committee or, in some states, by the Governor's office. In Georgia, the Clerk of the House and the Secretary of the Senate must deliver any health insurance mandates bills to the Insurance Commissioner for a fiscal review within 5 days after first reading. Several state legislatures, Texas for one, have enacted legislation creating a temporary committee to study the costs and benefits of proposed mandated benefits. Missouri, likewise, approved legislation for a one-time study of mandated benefits.

Limitations on enactment

Maryland and Oregon are 2 states with distinct limitations on legislative approval of mandated benefits legislation.

Maryland, at least in the small group market, is the only state staff could identify that has attempted to limit the cumulative cost of all mandated benefits to a specific dollar amount. In Maryland, insurance carriers can only sell one insurance product to small employers--the product developed by the Health Care Access and Cost Commission (HCACC). In 1993, the Maryland General Assembly enacted an "affordability" cap on mandates costs for the small group plan. The cap is set at 12 percent of the average wage in the state. If the HCACC finds the cumulative cost of approved mandates exceeds this amount, the HCACC must adjust the level of benefits or cost sharing arrangements under the plan so the cap is not exceeded in the future.

In 1999, the Maryland General Assembly considered a similar approach for the large group market by requiring a comparison of mandates costs to the average annual wage in Maryland and to health insurance premiums. However, an actual cap was not imposed and benefits adjustments were not provided for. Instead, the calculations are used as the basis for triggering further review by the HCACC. If the HCACC finds the full cost of mandated benefits exceeds 2.2 percent of the average wage in the state, then it must evaluate the social, medical, and financial impacts of each existing mandated benefit and report its findings to the General Assembly. The General Assembly can then use this information to decide whether or not to enact proposed mandates or repeal existing mandates.

The Oregon Legislature appears to be the only state which sunsets mandated benefits. Since 1985, Oregon law has provided for the automatic repeal of mandated benefits statutes 6 years from the effective date of the particular mandate. According to Oregon legislative staff, several mandates have expired under this law.

EMPLOYEE HEALTH CARE ACCESS

Florida's Small Group Insurance Reform -- The Employee Health Care Access Act- In 1992, the Legislature enacted reforms to the small group insurance market, called the Employee Health Care Access Act (the Act). An express purpose of the Act is to promote the availability of health insurance coverage to small employers regardless of their claims experience or their employees' health status. The Act has three key components. These are:

- *Modified Community Rating* - Community rating is a method of developing health insurance rates which takes into account the medical and hospital costs in the entire community or area to be covered. Individual characteristics of the insured employer are not considered. Florida utilizes a variation on this method, which allows carriers to consider a limited set of individual characteristics relating to the individuals actually covered. These factors include age, gender, family composition, tobacco usage, and geographic location.[3] Florida's "modified community rating" method does not allow carriers to adjust premiums for an employer based on any other factors, including an employee's claims experience or health status.

- *Guarantee-Issue Requirements* - Under the Act, carriers are required to offer and renew certain health insurance plans, including basic and standard plans, for small employers regardless of claims experience or health status. For employers with one or two employees, Florida law requires carriers to offer, at a minimum, "standard" and "basic" plans. The "standard" policy is generally intended to be comparable to a major medical policy typically sold in the group market, with cost containment features intended to make the policy affordable. The "basic" policy includes certain standard policy benefits with certain restrictions on the benefits and utilization, as well as other features designed to lower the cost of this coverage. For employers with 3 to 50 employees, Florida law requires each carrier to offer, not only the standard and basic plans, but any other small employer group plans sold by that carrier.[4]

- *Exemption from Mandates* - Certain small employer policies are exempt from "mandated health benefits" (i.e., laws which require private insurer and HMO health plans to provide certain coverages) unless made applicable by the Legislature.

Non-Elderly Uninsured Rate: Florida vs. U.S., 1989 - 1997 - According to the Employee Benefit Research Institute,[5] the uninsured rate within Florida's non-elderly population

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[3] Section 627.6699(3)(n), F.S.

[4] In addition to the basic and standard plans, small employer carriers typically offer additional plans with variations such as higher benefit levels or additional coverages.

[5] Established in 1978, the Employee Benefit Research Institute is a nonprofit, nonpartisan organization which conducts policy research on economic security and employee benefits.

(ages 0-64) was higher in 1997 than it was in 1989. Florida's non-elderly uninsured rate also exceeded the national average.

	1989	1993	1997
Florida	20.5%	23.1%	23.7%
United States	15.7%	17.3%	18.2%

Carriers Offering Small Group Insurance in Florida - According to the Department of Insurance, as of the first quarter of 2000, there are 59 carriers offering small employer health benefit plans. This number reflects a continuing drop in recent years in the number of carriers offering small employer benefit plans. In 1997 there were 116 carriers, and in 1998 there were 90 carriers, offering small employer benefit plans in Florida.

MEDICAID ISSUES

Medicaid is a medical assistance program that pays for health care for the poor and disabled. The program is jointly funded by the federal government, the state, and the counties. The federal government, through law and regulations, has established extensive requirements for the Medicaid Program. The Agency for Health Care Administration is the single state agency responsible for administering the Florida Medicaid Program. The statutory provisions for the Medicaid Program appear in ss. 409.901 through 409.9205, F.S. The state budget for the program for the current fiscal year is $7,416,045,061, and the program anticipates serving 1,607,144 clients this year.

Medicaid Prepaid Health Care Services - Section 409.912(2), F.S., authorizes AHCA to enter comprehensive risk contracts serving the general Medicaid population with entities certified by the Department of Insurance (DOI) under part I of ch. 641, F.S. By contrast, s. 409.912(4)(b), F.S., authorizes AHCA to contract with entities that only serve Medicaid members, and which entities are exempt from regulation by DOI under the provisions of part I of ch. 641, F.S. This exemption dates back to early attempts by Medicaid to contract with any entity willing to provide prepaid plan services to Medicaid recipients, and more recent Medicaid attempts to contract with specific publicly-funded entities for such services, namely a consortium of federally-funded community health centers. In the recent past, AHCA has concluded that Medicaid recipients should have the benefit of the protections afforded every other citizen of Florida under part I of ch. 641, F.S., regardless of whether their health plan of choice offers commercial products or not.

Part I, ch. 641, F.S., encompasses a number of requirements which AHCA regards as critical to any sound and responsible risk-based contractor. These requirements include surplus requirements to promote fiscally sound plans, and requirements for subcontractors and regulations on marketers and marketing practices (historically a source of many complaints from Medicaid members).

The Department of Insurance is also tasked, through part I, ch. 641, F.S., with specific responsibilities in the event a health plan becomes insolvent. Those responsibilities include the provision of administrative supervision, rehabilitation, and potentially liquidation of an insolvent health plan. The Department of Insurance has the expertise and resources for these activities; AHCA does not. Dealing with insolvent contractors has presented problems for AHCA in the past since AHCA does not have the staff or experience necessary to competently administer the post-closure affairs of an insolvent plan.

Prior to the adoption of the requirements of s. 409.912(2), F.S., AHCA contracted with a number of Medicaid prepaid health plans that were not certified under part I, ch. 641, F.S. AHCA had two difficult experiences where AHCA was forced to terminate the contract due to the inability of the contractor to meet its current financial obligations. There were several other instances where only "last minute" mergers or acquisitions prevented the similar demise of health plans. Since AHCA began dealing only with DOI certified plans, AHCA has not had the frequency of this phenomenon, and with the cooperative working relationship between AHCA and DOI, AHCA has been much better able to deal with the consequences of the financial failure of contracted plans.

C. EFFECT OF PROPOSED CHANGES:

Please see Section II.D., Section-by-Section Analysis, for more details.

CERTIFICATE OF NEED

This bill amends the Certificate of Need (CON) statutes by identifying additional types of projects subject to **expedited** rather than competitive CON review. These projects include conversion of mental health services beds or hospital-based distinct part skilled nursing unit beds to acute care beds, conversion between or among the categories of mental health services beds, and conversion of acute care beds to mental health services beds.

It identifies several other types of currently reviewable projects that will become **exempt** from CON review. These include combination within one nursing home of the beds authorized by two or more CONs within the same planning subdistrict; division into two or more nursing homes in the same planning subdistrict of the beds authorized by a CON; addition of hospital beds in a number not to exceed 10 beds or 10 percent of the licensed capacity of the service being expanded, except beds for specialty burn units, neonatal intensive care units, or comprehensive rehabilitation, and provided there was a prior 12-month occupancy of at least 80 percent in that service or at least 96 percent for hospital-based distinct part skilled nursing units; and addition of nursing home beds in a number not exceeding 10 beds or 10 percent of the licensed capacity of beds at the nursing home, whichever is greater, provided that the facility has been designated as a Gold Seal nursing home pursuant to s. 400.235, F.S., and there was a prior 12-month occupancy of at least 96 percent.

CON oversight is **eliminated** by this bill for provision of respite care, expenditure for outpatient services, Medicare certified home health agencies, acquisitions, and cost overruns. The bill also proposes a significant reduction and clarification of the review criteria used to evaluate applications for a CON and removes other obsolete provisions.

The bill creates a CON workgroup consisting of 30 members, including representatives from health care provider organizations, health care facilities, individual health care practitioners, local health councils, consumer organizations, and persons with health care market expertise as a private-sector consultant. The workgroup is to study issues pertaining to the CON program, including the impact of trends in health care delivery and financing. The workgroup is to submit an interim report by December 31, 2001, and a final report by December 31, 2002. The workgroup is abolished on July 1, 2003.

KIDNEY DIALYSIS STUDY

This bill appropriates $230,000 from the Agency for Health Care Administration Tobacco Settlement Trust Fund to fund a contract with the University of South Florida to conduct a review of quality and effectiveness of kidney dialysis treatment as well as the utilization and business arrangements related to kidney dialysis centers.

HEALTH CARE PRACTITIONERS

Social Security Numbers:

This bill eliminates the “catch-22" for applicants without social security numbers by allowing applications to be processed and temporary licenses to be granted for 30 days. Once the social security number is obtained and provided to the Department of Health, a regular license may be granted.

This change in process will allow active recruitment of nurses and other health care practitioners from foreign countries such as Canada to help alleviate the shortage of nurses and other health care practitioners in Florida. This bill is consistent with the policy of eliminating unnecessary barriers to licensure.

Profiling/Background Screening:

This bill establishes that once an allopathic, osteopathic, chiropractic, or podiatric physician, licensed under chapters 458, 459, 460, or 461, F.S., has submitted a set of fingerprints as a condition of initial licensure or licensure renewal, the practitioner need not submit another set of fingerprints to any other state agency as a condition of employment or licensure. Furthermore, it requires other state agencies to access the criminal history information via the Department of Health’s limited access practitioner credentialing system known as CoreSTAT. The state agencies affected by this provision include the Department of Health, the Agency for Health Care Administration, the Department of Juvenile Justice, and the Department of Children and Family Services. The Florida Department of Law Enforcement is also affected since duplicate requests for criminal background checks will be eliminated.

Physicians benefit from this bill because redundant and burdensome fingerprinting requirements are eliminated. State agencies benefit from this bill because they will be able to access criminal history information for health care practitioners quickly and cost-effectively. By requiring other state agencies to rely upon the limited-access practitioner credentialing system of the Department of Health, there is minimal administrative burden placed upon the department to respond to requests for licensure information.

There may be some administrative cost savings to the affected state agencies; however, the exact amount is unknown. The Florida Department of Law Enforcement may experience some initial loss of revenue with the reduction in the number of duplicative criminal checks required of physicians. However, the initial reduction in revenue should be more than offset by the profiling law now being implemented which requires ongoing statewide criminal checks as a condition of licensure renewal.

Practitioner Misconduct Provisions:

Sexual Misconduct: This bill adds legal guardians to the prohibition against sexual misconduct to close a loophole in the current law. It protects parents and children of non-traditional custodial and familial relationships, such as foster families. This bill recognizes that a practitioner could abuse the practitioner-patient relationship to influence a guardian or representative of this already vulnerable population in the same manner as traditional family members of the patient or client. It also conforms s. 455.624(1)(u), F.S., regarding discipline for sexual misconduct, to s. 455.567(1), F.S., the definition of sexual misconduct.

Impairment or Use of Drugs: This bill creates a ground for discipline in ch. 455, F.S., to conform to the provision passed in 1999 that allows the Secretary of Health to suspend a licensee on an emergency basis for testing positive for a drug on a confirmed drug screen when the licensee does not have a lawful prescription and legitimate medical reason for using such drug.

This bill allows the Secretary of Health, upon a finding of probable cause, to compel a health care practitioner to undergo a mental or physical examination to determine current fitness to practice. By placing this provision in ch. 455, F.S., consistency will be created for all health care practitioners and enable the department to adequately assess any practitioner's ability to safely practice when an allegation has been made that they are a danger to the public. The provision will mainly impact impaired pharmacists, but will also impact impaired optometrists, midwives, dietitians and nutritionists, athletic trainers, orthotists, prothetists, and pedorthists, nursing assistants, opticians, and hearing aid specialists.

Penalties for Misconduct: This provision corrects terminology to allow the appropriate regulatory board, or the department when there is no board, to restrict a license instead of restricting the practice of a profession when the restriction is more a condition of licensure than a condition of practice. The bill also clarifies that a practitioner may be disciplined or denied licensure in Florida for any health care profession if that person has had any professional license disciplined in any jurisdiction. For example, if a physician has his or her license to practice medicine revoked or suspended, that action may be taken into consideration if the person applies for another type of health care license in Florida, such as a license to practice nursing or pharmacy. This will correct the glitch in the law that allows a dangerous practitioner to obtain a license to practice a different but related profession when they have their original license revoked, suspended, or otherwise disciplined.

This bill also provides that first-time violations of a practice act, which has an express ground for discipline, for unprofessional conduct shall be handled by citation. The four chapters that contain this particular ground for discipline are chapters 464, 467, 468, and 478, F.S. This is consistent with the requirement that passed in 1999 requiring all first-time violations of the continuing education requirements to be handled by citations. Citations can be issued quickly and reduce the expense of investigating and prosecuting a disciplinary case considerably. Citations benefit the practitioner because the matter is resolved quickly, allowing them to pay a fine or other penalty similar to a traffic citation issued to a licensed driver who violates the law. Citations are considered disciplinary action and will remain on the licensee's permanent record, and therefore, the public is protected.

Furthermore, the bill modifies the presuit notice process in that a copy of the presuit notice is no longer required to be filed with the state. Instead, a copy of the actual civil complaint must be filed with the state at the time the civil lawsuit is filed. This will reduce the number of potential malpractice suits that the state will review and instead allow the limited state resources to be focused on those malpractice cases which actually result in a lawsuit. This will reduce investigation costs being spent on frivolous allegations.

Licensure Status Changes:

This bill provides flexibility to licensees by deleting language which prohibits a licensee who has elected active status licensure at the time of renewal from changing to inactive status during the biennium. Licensees will be affected positively by this change as additional costs involved with maintaining an active license for the remainder of the biennium will not be incurred. Such additional costs include maintaining malpractice insurance.

Other technical terminology is amended to create consistent interpretations among the boards and the department with regard to which fees apply in which circumstances. The term “status” is removed from “delinquent” licensees to clarify that delinquency is not a status, rather it is a label as to how the license became inactive instead of active. Delinquent licenses are those that have not been renewed on time.

Requests for Exemption from Disqualification from Employment or Contracting:

This bill eliminates dual and duplicative jurisdiction over health care practitioners wishing to practice in certain settings. Eliminating the duplicative jurisdiction will result in a streamlined and consistent procedure for health care practitioners. Potential conflicts of opinion between the Department of Health, the Agency for Health Care Administration, and the applicable regulatory board will be avoided. By requiring the board, or the department if there is no board, to make the decision regarding restrictions of practice settings for both licensure and employment purposes, the licensee will only have to undergo scrutiny one time. Both the licensee and the state will benefit from the coordination of these processes. There will not be any lengthening of the time to process these requests since the law already provides that all requests for exemption must be decided upon within 30 days.

Unlicensed Activity:

The bill focuses attention on the ever-increasing problem of unlicensed activity and gives new tools to prosecutors to enforce the law for the protection of the public. It emphasizes that vigorous enforcement of licensure regulation for all health care professions is a state priority and creates a new violation for the unlicensed practice of a health care profession.

Specifically, this bill sets minimum criminal penalties of a $1,000 criminal fine and a minimum mandatory period of incarceration of 1 year for practicing without a license. It allows the state to impose administrative and civil fines to help stop the occurrence of unlicensed activity. It also clarifies that it is a violation to practice with an inactive or delinquent license and distinguishes the penalties for practicing with an inactive or delinquent license for a period up to 12 months and over 12 months.

If the unlicensed practice of a health care profession results in serious bodily injury, this bill upgrades that crime to a second degree felony. It defines “serious bodily injury” as death, brain or spinal damage, disfigurement, fracture or dislocation of bones or joints, any

limitation of neurological, physical, or sensory function, or any other condition which was serious enough to require subsequent surgical repair.

This bill proactively protects patients from harm by prohibiting an unlicensed person from holding himself or herself out as able to practice a regulated profession unless that person holds a valid, active license to do so. This provision allows the state to protect the public before actual physical injury occurs.

Acupuncture:

This bill expands the definition of "acupuncture," and requires applicants for licensure to be at least 21 years old and be able to communicate in English. It updates the content areas of the licensure examination and reduces the fee cap for renewing a license from $700 to $500.

Physicians:

In addition to the changes to chapter 455, F.S., which apply to all health care practitioners, this bill modifies chapters 458 and 459, F.S., relating to allopathic and osteopathic physicians. Specifically, this bill establishes temporary certificates for visiting physicians to practice in approved cancer centers, adds the newly-created medical school at Florida State University and the Mayo Medical School at the Mayo Clinic, Jacksonville, to the list of schools that may receive medical faculty teaching certificates for visiting professors, waives certain fees for physicians who volunteer to work in areas of critical need, and requires the registration of resident physicians under certain circumstances.

The bill also requires direct supervision by a licensed physician when lasers are used for hair removal purposes by non-physicians, including electrologists, nurses, medical assistants, or others. Additionally, this bill clarifies duties of the Council on Physician Assistants with regard to licensure of physician assistants.

Nursing/ Nursing Assistants:

The bill transfers part XV, ch. 468, F.S., to ch. 464, F.S., consolidating and placing the regulation of certified nursing assistants under the Board of Nursing. It also transfers authority to approve certified nursing assistant education programs to the Board of Nursing from the Department of Education. It transfers the responsibility for the maintenance of the state registry of CNAs from the department to the board.

The bill creates a 5-member Council on Certified Nursing Assistants and specifies its duties. It revises requirements for CNA certification and application procedures.

The bill includes advanced registered nurse practitioners under the credentialing and profiling programs administered by the Department of Health. ARNPs are required upon applying for initial licensure, or upon seeking renewal of a license to submit certain information to the department including a set of fingerprints.

Home Health Agencies:

The bill revises certain portions of the Home Health Services Act. This bill requires that AHCA take responsibility for conducting the abuse registry background check required for those applying for licensure or registration as a home health agency, nurse registry, or companion homemaker service. The bill also requires AHCA to develop a home health

aide competency test that may be taken in lieu of the required training. AHCA is granted authority to establish by rule the criteria for onsite licensure surveys and to determine what information must be kept in patients' records.

The bill deletes the requirement that home health agencies have a service provision plan. Instead, the services provided by a home health agency must be covered in an agreement between the agency and the patient or the patient's legal representative. The agreement must include the specific services to be provided, the rates or charges for services paid for with private funds, and the method of payment. A home health agency must still obtain treatment orders when required by the provisions of chapter 464, F.S., part I, part III, or part V of chapter 468, F.S., or chapter 486, F.S. Also, a home health agency must arrange for supervisory visits by a registered nurse to the home of a patient receiving home health aide services in accordance with the patient's direction and approval.

The bill allows AHCA to assess against any home health agency, nurse registry, or companion homemaker service, in addition to any other penalties allowed under law, the costs related to an investigation that results in a successful prosecution.

HEALTH MAINTENANCE ORGANIZATIONS

This bill requires HMOs to allow a licensed family practitioner or other physician to refer a patient directly to an ophthalmologist if the physician determines that an ophthalmologic examination or treatment is necessary. The HMO must pay for such examination if the examination is a covered benefit. This eliminates the need for a second examination by an optometrist, thereby eliminating the costs of the second examination and eliminating the delay to the patient in obtaining necessary eye care.

This bill also amends the Florida Insurance Code and requires federal solvency standards to be applied to managed care organizations rather than state solvency standards.

MANDATED HEALTH BENEFITS

CS/HB 2339 appropriated $200,000 from the Insurance Commissioner's Regulatory Trust Fund to the Office of Legislative Services for the purpose of implementing the legislative intent expressed in s. 624.215(1) for a "systematic review of current ... mandated coverages. The review consisted of an assessment of the impact of current mandated coverages using the guidelines provided in s. 624.215(2). The bill required the establishment of the aggregate cost of mandated health coverages. However, subsection (1) of section 69 of this bill nullified the provisions of CS/HB 2339 and reverted the appropriation. In lieu of the study of current mandates, section 77 of this bill, provides an appropriation for a study of proposed mandates.

EMPLOYEE HEALTH CARE ACCESS

Modified Community Rating - The "modified community rating" component of the Act would be revised to permit small employer carriers to adjust premium rates based on additional factors such as employees' claims experience, health status, or duration of coverage. Rate adjustments made pursuant to these factors would be subject to the following limitations:

Per employer	Up to 15% deviation from carrier's approved rate; Up to 10% change annually on renewal; and Must be applied uniformly to all employees and dependents
All employers	Up to 5% deviation (in the aggregate) from carrier's approved rate

Small employer carriers would also be permitted to credit a small employer's premiums based on certain administrative and acquisition expense savings realized by the carrier.

Instead of being required to use one rating category for all dependent children, small employer carriers would be permitted to use rating methodologies that include separate rating categories depending on the number of dependent children.

Guarantee-Issue Requirements - The guarantee-issue requirements of the Act would also be revised so that, instead of needing 3 employees, employers with only 2 employees would have access to all small employer health plans offered by small employer carriers. For employers with only one employee, carriers would only be required to offer the basic and standard plans during a one-month open enrollment period in August. A person, his or her spouse, and his or her dependent children would count as a single employee if such person and spouse are employed by the same employer.

MEDICAID ISSUES

This bill directs the Agency for Health Care Administration to seek federal waivers and develop a competitive procurement package for managed care plans for HIV and AIDS patients. A status report on the waiver is due February 1, 2001.

OTHER PROVISIONS

This bill establishes an annual Florida Alzheimer's Disease Day. It allows disbursement of funds relating to the Indigent Care and Trauma Center Surtax to hospitals with trauma centers in large urban counties. Also, the bill directs the agency to conduct a cost and feasibility study regarding the federal Ticket to Work and Work Incentives Act due December 1, 2000.

D. SECTION-BY-SECTION ANALYSIS:

UNLICENSED ASSISTED LIVING FACILITIES

Section 1. Amends s. 400.408, F.S., requiring AHCA field offices to establish local coordinating workgroups to assist in identifying unlicensed facilities. Requires health care providers to report the operation of unlicensed facilities and provides for sanctions.

MANDATORY REPORTING OF ABUSE, NEGLECT, OR EXPLOITATION OF DISABLED ADULTS OR ELDERLY PERSONS

Section 2. Amends s. 415.1034, F.S., to add paramedics, emergency medical technicians, and employees of public lodging establishments (hotels) to the list of those required to report suspected abuse to the Department of Children and Families.

CERTIFICATE OF NEED

Section 3. Amends s. 400.471, F.S., to delete the requirement for CON approval as a prerequisite for licensure of a Medicare certified home health agency.

Section 4. Amends s. 408.032, F.S., providing definitions of "exemption" and "mental health services," and deleting the definitions of "home health agency," "institutional health service," "intermediate care facility," "multifacility project," and "respite care."

Section 5. Amends s. 408.033, F.S., deleting references to the state health plan.

Section 6. Amends s. 408.034, F.S., deleting a reference to Medicare certified home health agencies.

Section 7. Amends s. 408.035, F.S., deleting obsolete review criteria and clarifying other criteria.

Section 8. Amends s. 408.036, F.S., clarifying "capacity," specifying types of beds subject to review, and eliminating CON review for Medicare certified home health agencies, acquisitions, and cost overruns. Deletes review of cost overruns, combination of nursing home certificates of need, and creates new category of review. Exempts three new categories from review and amends 5 current exemptions. Provides for procedures and fees.

(See subsection (2) of **section 69** of this bill which reestablishes the CON process that was eliminated in CS/HB 2339 for specialty hospital establishment.)

Section 9. Amends s. 408.037, F.S., to delete a reference to the state health plan.

Section 10. Amends s. 408.038, F.S., to replace "department" with "agency."

Section 11. Amends s. 408.039, F.S., to replace "department" with "agency" and to clarify procedures to intervene in administrative hearing.

Section 12. Amends s. 408.040, F.S., to require conditions imposed on CON to be stated on face of CON. Deletes obsolete reference to psychiatric or rehabilitation beds. Modifies Medicaid patient condition from percentage of beds to percentage of days.

Section 13. Amends s. 408.044, F.S., to replace "department" with "agency."

Section 14. Amends s. 408.045, F.S., to replace "department" with "agency."

Section 15. Creates a CON workgroup consisting of 30 members, to study issues pertaining to the CON program. Requires the workgroup to submit an interim report by

December 31, 2001, and a final report by December 31, 2002. Abolishes the workgroup effective July 1, 2003.

Section 16. Amends s. 651.118, F.S., to provide that the five-year limit does not apply to up to five sheltered beds designated for inpatient hospice care as part of a contract with a licensed hospice.

Section 17. Repeals s. 400.464(3), F.S., relating to home health agency licenses provided to CON exempt entities.

Section 18. Provides statement of applicability of changes to CON process.

KIDNEY DIALYSIS STUDY

Section 19. Appropriates $230,000 from the Agency for Health Care Administration Tobacco Settlement Trust Fund to fund a contract with the University of South Florida to conduct a review of quality and effectiveness of kidney dialysis treatment as well as the utilization and business arrangements related to kidney dialysis centers.

HEALTH CARE PRACTITIONERS

Section 20. Amends s. 455.564(1), F.S., to allow the Department of Health to process licensure applications for persons who are not citizens or residents of this country, and therefore, do not have social security numbers at the time of initial licensure application but are otherwise qualified for licensure. Provides for issuance of a temporary license for 30 days so that the applicant may obtain a social security number. Provides that temporary license expires automatically after 30 days unless a social security number is obtained and provided to the department in writing. Provides that upon receipt of the social security number, the department shall issue a regular license to the applicant.

This section also amends subsection (3) of s. 455.564, F.S., to toll the time period in which a licensure application must be granted or denied until 15 days after the receipt of the final results of an investigation or prosecution of the applicant in any jurisdiction. Further, this section allows the board, or department when there is no board, to require applicants with criminal histories to prove that the applicant's civil rights have been restored prior to granting a license. Lastly, this section tolls for 30 days or for the next two regularly scheduled board meetings the time period in which a licensure application must be granted or denied to allow an applicant to personally appear before the board to explain why the license should be granted.

Section 21. Amends s. 455.565, F.S., to eliminate duplicate fingerprinting submissions by a health care practitioner to other state agencies for employment or licensure if the applicant has undergone a criminal history check as a condition of initial licensure or licensure renewal as a health care practitioner. Requires the Agency for Health Care Administration, the Department of Juvenile Justice, and the Department of Children and Family Services to obtain criminal history information for employment or licensure purposes from the Department of Health's health care practitioner credentialing system.

Section 22. Amends s. 455.5651, F.S., to delete obsolete language and to conform cross-references and profession-specific terminology.

Section 23. Amends s. 455.5653, F.S., to delete obsolete provision requiring the department to provide a schedule for profiling the remaining professions and conforms cross-references and profession-specific terminology.

Section 24. Restates s. 455.5654, F.S., relating to profiling. (See chapters 2000-153 and 2000-160, L.O.F.)

Section 25. Amends s. 455.567(1), F.S., to add patient guardians and patient representatives to the sexual misconduct prohibition law.

Section 26. Amends s. 455.624(1)(f), F.S., to clarify that discipline against any professional license may be considered at the time of application or may be grounds for discipline. Amends s. 455.624(1)(u), F.S., to delete unnecessary language and conform to s. 455.567(1), F.S.

Adds s. 455.624(1)(y), F.S., to provide grounds for discipline or denial of licensure for being unable to practice with reasonable skill and safety to patients by reason of impairment, and provides method to compel licensees to submit to a mental or physical examination when probable cause exists that the licensee is unable to practice with reasonable skill and safety to patients by reason of impairment. Provides for summary proceedings in circuit court to enforce order compelling mental or physical examination.

Adds s. 455.624(1)(z), F.S., to provide grounds for discipline or denial of licensure for testing positive for any drug, as defined in s. 112.0455, F.S., on any confirmed preemployment or employer-ordered drug screening when the practitioner does not have a lawful prescription and legitimate medical reason for using such drug. This section provides that the board, or the department when there is no board, may restrict a license when the licensee is found guilty of violating any of the grounds for discipline found in s. 455.624(1), F.S. Lastly, this section requires the board, or department when there is no board, to issue citations for first-time violations of unprofessional conduct as set forth as grounds for discipline in ss. 464.018(1)(h), 467.203(1)(f), 468.365(1)(f), and 478.52(1)(f), F.S.

Section 27. Reenacts ss. 455.577, 455.631, 455.651, 455.712, 458.347, 459.022, 468.1755, 468.719, 468.811, and 484.056, F.S., with cross-references to s. 455.624, F.S.

Section 28. Repeals s. 455.704, F.S., to eliminate the obsolete Impaired Practitioners Committee.

Section 29. Amends s. 455.707, F.S., to correct terminology and delete references to the Impaired Practitioners Committee. Clarifies when impairment becomes a ground for discipline.

Section 30. Amends s. 310.102, F.S., to delete reference to the Impaired Practitioners Committee.

Section 31. Amends s. 455.711, F.S., to correct terminology relating to licensure status and to provide licensees with the ability to change licensure status at any time, notwithstanding any other provision. Clarifies which fees are supposed to be paid at the time of change of status and at the time of renewal. Provides specific rulemaking authority to the boards, or the department when there is no board, to adopt rules necessary to implement this section.

Section 32. Amends s. 455.587(3), F.S., to correct and conform terminology relating to licensure status.

Section 33. Amends s. 455.714, F.S., to correct and conform terminology relating to licensure status.

Section 34. Creates s. 455.719, F.S., to provide that only the appropriate regulatory board, or the Department of Health when there is no board, may grant an exemption from disqualification from employment or contracting as provided in s. 435.07, F.S., when the person applying for employment or contracting is a person under the licensing jurisdiction of the board or department, as applicable.

Section 35. Amends s. 455.637, F.S., to emphasize that vigorous enforcement of licensure regulation for all health care professions is a state priority in order to protect Florida residents and visitors from the potentially serious and dangerous consequences of receiving medical and health care services from unlicensed persons whose professional education and training and other relevant qualifications have not been approved through the issuance of a license. Provides administrative, civil, and criminal penalties for practicing without a license. Establishes minimum and maximum penalties. Reenacts authority for the Department of Health to collect a special fee of $5 per licensee to fund efforts to combat unlicensed activity.

Section 36. Creates s. 458.3135, F.S., to establish temporary certificates for visiting physicians to practice in approved cancer centers.

Section 37. Amends s. 458.3145, F.S., to add the new medical school at Florida State University and the Mayo Medical School at the Mayo Clinic, Jacksonville, to the list of medical schools which are able to obtain faculty teaching certificates for their visiting professors.

Section 38. Creates s. 458.315(5), F.S., to waive certain fees for physicians who volunteer to work for free in areas of critical need.

Section 39. Amends s. 458.345, F.S., to require residents, interns, and fellows to register with the state under certain circumstances.

Section 40. Creates s. 458.348(3), F.S., to require the direct supervision by a licensed physician when lasers are used by non-physicians for hair removal purposes.

Section 41. Amends s. 459.021, F.S., to require residents, interns, and fellows to register with the state under certain circumstances.

Section 42. Amends s. 458.437, F.S., to clarify duties of the Council on Physician Assistants relating to licensure.

Section 43. Amends s. 459.022, F.S., to clarify duties of the Council on Physician Assistants relating to licensure.

Section 44. Clarifies that the amendments to s. 455.637, F.S., only apply to offenses committed on or after the effective date.

Section 45. Repeals s. 455.641, F.S., relating to unlicensed activities. The provisions of this section are relocated within s. 455.637, F.S., as set forth above.

Section 46. Reenacts ss. 455.574, 468.1295, 484.014, and 484.056, F.S., with cross-references to s. 455.637, F.S.

Section 47. Amends s. 921.0022, F.S., to delete the crimes of unlicensed practice of medicine and unlicensed practice of dentistry or dental hygiene from level 1 and insert them in level 7 of the Offense Severity Ranking Chart along with the crimes created by this bill and other existing crimes of unlicensed practice of individual health care professions.

Sections 48-61. Republishes existing statutes for the violation of practicing without a license for the following professions: medicine, osteopathic medicine, chiropractic medicine, podiatric medicine, naturopathy, optometry, nursing, pharmacy, dentistry, dental hygiene, midwifery, respiratory care, clinical laboratory care, medical physics, and hearing aid dispensing.

Section 62. Amends s. 457.102, F.S., revising definition of “acupuncture.”

Section 63. Amends s. 457.105, F.S., revising licensure qualifications for acupuncturists.

Section 64. Amends s. 457.107, F.S., lowering fee cap for acupuncturist license renewal from $700 to $500.

Section 65. Amends s. 483.824, F.S., revising the qualifications for licensure as a clinical laboratory director.

Nursing

Section 79. Renumbers ss. 468.821 - 468.829, F.S., as ss. 464.201 - 464.209, F.S., and designates them as part II of ch. 464, F.S.; amends said sections to transfer regulatory authority of certified nursing assistants (CNAs) from the Department of Health to the Board of Nursing; and replaces “department” with “board.” The contract providers are directed to accept CNA applications via the Internet and complete testing within 5 calendar days and provide test scores within 2 calendar days after the test date.

Section 80. Creates s. 464.2085, F.S., to establish a 5-member Council on Certified Nursing Assistants under the Board of Nursing within the Department of Health, which will recommend policies and procedures for the certification of nursing assistants to the department, develop rules regulating the education, training, and certification process for nursing assistants, and address concerns and problems of CNAs to improve safety in their practice; provides for membership.

Section 81. Amends s. 20.43, F.S., to place nursing assistants in the correct numerical sequence in the list of boards and professionals under the oversight of the Division of Medical Quality Assurance.

Sections 82-94. Amend ss. 39.01, 39.304, 110.131, 232.46, 240.4075, 246.081, 310.102, 381.0302, 384.30, 384.31, 394.455, 395.0191, and 400.021, F.S., to make

technical changes inserting “part I of” before “chapter 464" to reflect that ch. 464, F.S., is divided into two parts, where part I addresses licensed nurses and part II addresses nursing assistants.

Section 95. Amends s. 400.211, F.S., to require that any individual who works as a nursing assistant in a nursing home must be certified under part II of ch. 464, F.S. Makes technical changes to reflect that ch. 464, F.S., has two parts.

Section 96. Amends s. 400.215, F.S., to provide jurisdiction to allow the appropriate board within the Department of Health to grant exemptions from disqualification from employment to certain individuals, such as nurses and nursing assistants, instead of such exemption being granted by the Agency for Health Care Administration.

Section 97. Amends s. 400.23, F.S., to authorize licensed practical nurses in nursing homes to supervise the activities of other licensed practical nurses, certified nursing assistants, and other unlicensed personnel working in such facilities in accordance with such rules as the Department of Health adopts.

Sections 98-104. Amend ss. 400.402, 400.407, 400.4255, 400.426, 400.462, 400.464, and 400.506, F.S., to make technical changes inserting “part I of” and “part II of chapter 464" to reflect that ch. 464, F.S., is divided into two parts, where part I addresses licensed nurses and part II addresses nursing assistants.

Section 105. Amends s. 400.512, F.S., to revise the manner in which exemptions from disqualification from employment are granted for certain individuals. Provides that the appropriate regulatory board, or department when there is no board, has jurisdiction to grant exemptions for its licensees instead of the Agency for Health Care Administration. Applies to all health care licensees, including nurses and nursing assistants.

Sections 106-118. Amend ss. 400.6105, 401.23, 401.252, 408.706, 409.908, 415.1085, 455.597, 455.604, 455.667, 455.677, 455.694, 455.707, and 458.348, F.S., to make technical changes inserting “part I of” and “part II of chapter 464" to reflect that ch. 464, F.S., is divided into two parts, where part I addresses licensed nurses and part II addresses nursing assistants.

Sections 119-129. Amend ss. 464.001, 464.002, 464.003, 464.006, 464.009, 464.016, 464.018, 464.019, 464.022, 464.023, and 464.027, F.S., to make technical changes dividing ch. 464, F.S., into two parts.

Sections 130-150. Amend ss. 466.003, 467.003, 467.0125, 467.203, 468.505, 483.041, 483.801, 491.0112, 550.24055, 627.351, 627.357, 627.9404, 641.31, 766.101, 766.110, 766.1115, 877.111, 945.602, 960.28, 984.03, and 985.03, F.S., to make technical changes inserting “part I of” before “chapter 464" to reflect that ch. 464, F.S., is divided into two parts, where part I addresses licensed nurses and part II addresses nursing assistants.

Section 151. Amends s. 455.557, F.S., to revise provisions regarding the credentialing of health care practitioners, to delete obsolete language referring to the Credentials Advisory Council, and to add ARNPs to the list of health care practitioners required to participate in the credentialing program.

Section 152. Creates s. 455.56503, F.S., to require ARNPs to submit certain information when applying for certification or recertification renewal including a set of fingerprints for profiling purposes.

Section 153. Amends s. 455.5651, F.S., to allow the department to publish certain information relating to ARNPs in practitioner profiles, beginning July 1, 2001.

Section 154. Amends s. 455.5653, F.S., to remove obsolete language relating to the development of a schedule for practitioner profiles for other health care professionals, and to allow the Department of Health to access information about ARNPs that is compiled by the Agency for Health Care Administration.

Section 155. Amends s. 455.5654, F.S., to grant the department authority, by rule, to create a form for ARNPs to use when submitting profiling information.

Home Health Agencies

Section 156. Repeals s. 400.462(20), F.S., to delete the definition of "screening" under the Home Health Services Act.

Section 157. Amends s. 400.471, F.S., to provide that AHCA conduct abuse registry background checks of applicants for provisional licenses.

Section 158. Amends s. 400.484, F.S., to provide that in addition to other penalties imposed against any home health agency pursuant to this section, AHCA may assess costs related to an investigation that results in a successful prosecution.

Section 159. Amends s. 400.487, F.S., to require home health agencies to develop a home health service agreement with each patient, to revise the requirements for physician's treatment orders, and to provide for supervisory visits by a registered nurse to a patient's home in accordance with the patient's directions and approval. Deletes provisions relating to service provision plans.

Section 160. Amends s. 400.497, F.S., to require AHCA to develop a home health aide competency test, which when passed successfully may substitute for the training required under this section to become a home health aide. Requires AHCA to develop rules regarding the criteria for onsite licensure surveys and regarding information to be included in patients' records.

Section 161. Amends s. 400.506, F.S., to revise provisions relating to nurse registries to provide that AHCA conduct abuse registry background checks of applicants for provisional licenses, providing that in addition to other penalties imposed pursuant to this section, AHCA may assess costs related to an investigation that results in a successful prosecution, and providing that the renewal of a license is contingent upon payment or agreement for payment of any unpaid assessment.

Section 162. Amends s. 400.509, F.S., to revise provisions relating to companion or homemaker service organizations to provide that AHCA conduct abuse registry background checks of applicants for provisional licenses, to provide that in addition to other penalties imposed pursuant to this section, AHCA may assess costs related to an investigation that results in a successful prosecution, and to provide that the renewal of

a license is contingent upon payment or agreement for payment of any unpaid assessment.

Section 163. Amends s. 400.512, F.S., to revise provisions relating to the screening of home health agency, nurse registry, and companion and homemaker service personnel, to require AHCA to conduct searches for reports of confirmed abuse, and to provide an exemption form liability under certain conditions for providing opinions on the job performance of former employees.

Section 164. Amends s. 455.587, F.S., to provide requirements for funding the regulation of professions by the Department of Health. Provides legislative intent that each profession operate within its anticipated fees.

Section 165. Appropriates from the Medical Quality Assurance Trust Fund to the Department of Health $280,000 to implement the provisions of this act.

Section 166. Amends s. 766.106, F.S., to require copies of civil lawsuits to be filed with the state at the time of filing instead of requiring a copy of the presuit notice to be filed with the state.

HEALTH MAINTENANCE ORGANIZATIONS

Section 67. Amends s. 641.51, F.S., to allow a licensed physician to refer a patient directly to an ophthalmologist under certain circumstances.

Sections 71-76. Amends and creates various provisions in chapter 641, F.S., relating to the Florida Insurance Code and the regulation of the solvency of managed care organizations.

MANDATED HEALTH BENEFITS

Section 69. Subsection (1) of this section provides that any funds appropriated by CS/HB 2339 are reverted back and that such reviews of existing mandates not be conducted.

Section 77. Appropriates $200,000 to the Office of Legislative Services to study the cost of future proposed mandated health coverages, if proposed.

EMPLOYEE HEALTH CARE ACCESS

Section 70. Amends s. 627.6699, F.S., revising the requirements for benefit plans, redefining terminology, and revising the rating methodology to determine premiums.

INDIGENT CARE SURTAX

Section 78. Amends s. 212.055, F.S., relating to the Indigent Care and Trauma Center Surtax. Revises disbursement eligibility and amends procedures.

MEDICAID ISSUES

Section 169. Directs AHCA to secure a federal waiver and develop competitive procurement package for managed care plans for HIV and AIDS patients. A report is due to the Legislature by February 1, 2001.

OTHER PROVISIONS

Section 66. Designates February 6th of each year as Florida Alzheimer's Disease Day.

Section 68. Provides statement of legislative intent that nothing in this bill shall prohibit anyone from seeking medical information on the Internet. This clarifies that persons may still conduct research of medical information now that most publications are available electronically and not just in medical libraries in book form. However, this does not allow a diagnosis to be made or treatment to be provided without the practitioner who is providing the medical information being licensed in Florida and complying with all laws and rules relating to the practice of medicine or one of the other health care professions.

Section 167. Directs AHCA to conduct a cost and feasibility study regarding the federal Ticket to Work and Work Incentives Act of 1999. A report is due to the Legislature no later than December 1, 2000.

Section 168. Amends s. 240.241, F.S., relating to the allocation of funds in the University of Florida Division of Sponsored Research.

Section 170. Provides an effective date of July 1, 2000, except as otherwise provided.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

	FY 00-01	FY 01-02
Agency for Health Care Administration		
CON Fees	($320,000)	($320,000)
Citation Issuance	54,123	48,824
Department of Health		
Nursing/CNAs	38,700	387,000
Resident Registration	1,000	1,000
Cancer Center Physicians	1,000	1,000
Volunteer Physicians	(9,050)	(9,050)
Total Revenues:	**($234,227)**	**$108,774**

2. Expenditures:

		FY 00-01	FY 01-02
Agency for Health Care Administration			
CON		($260,719)	($260,719)
Citation Issuance		54,123	48, 824
Kidney Dialysis Study		230,000	0
Department of Health			
Nursing/CNAs	196,538	1,079,257	
Resident Registration	1,000	1,000	
Cancer Center Physicians	1,000	1,000	
Volunteer Physicians	6,500	6,500	
Total Expenditures:	**$228,442**	**$875,862**	

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The private sector will have savings of approximately $320,000 annually because of the additional exemptions provided by this bill. Instead of incurring CON application fees ranging from $5,000 to $22,000, applicants who are subject to a CON exemption review will be required to submit an exemption request fee of $250. Additionally, the private sector will benefit from reduced consultant fees and costs of litigation.

Health care practitioners will no longer have to pay duplicative fees to have multiple background screenings performed but they will have to pay to be fingerprinted and background screened for licensure purposes. Allopathic, osteopathic, podiatric, and chiropractic physicians were recently required to undergo background screening prior to renewal of their licenses and were required to pay the cost of the screening in an amount of $43. Once they have paid this fee and are screened for licensure purposes, they will not have to be screened again and pay $43 each time they apply for a position in a facility or program that requires background screening. Thus, while some practitioners will incur this cost for the first time, many practitioners will ultimately benefit from not having to pay this $43 multiple times for licensure or employment purposes. It is unknown how many of the approximately 55,000 physicians will save money by not having to pay duplicative criminal background screening fees.

Health care practitioners can eliminate paying the costs to maintain medical malpractice insurance if they are not practicing and place their license on inactive status.

D. FISCAL COMMENTS:

The agency estimates an increased workload to its consumer and investigative services staff in order to issue additional citations. However, this process will offset the number of cases which are reviewed by the legal staff, heard by the probable cause panel, and heard by the board for final action. Thus, there should be a slight decrease in workload for the agency's legal staff.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

The bill does not require a county or municipality to expend funds or to take any action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not reduce the authority that municipalities or counties have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

None.

B. RULE-MAKING AUTHORITY:

Rules will need to be promulgated, amended, and repealed as a result of this bill with regard to CON, home health agencies, and health care practitioner regulation.

C. OTHER COMMENTS:

Comments by the Committee on Health Care Licensing & Regulation

During the 1999 legislative session, HB 1517 by Representative Minton was introduced to revise the CON review process. The bill as amended by the Health Care Licensing & Regulation Committee created a 12-member Florida Commission on Quality Hospital Services. Although the bill failed to pass the Legislature, the Executive Director of the Agency for Health Care Administration appointed a 28-member Certificate of Need Work Group to assist the agency in "making better policy decisions for the program." The agency released a report to the Legislature in December 1999 proposing to exempt from the review process many of the health care facilities, health services, and hospice presently subject to CON review.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

The original bill only expressed the intent of the Legislature to revise laws relating to the issuance of certificates of need (CON) by the Agency for Health Care Administration. On February 8, 2000, the Committee on Health Care Licensing & Regulation adopted a "strike everything" amendment and reported the bill favorably as a committee substitute.

On March 23, 2000, the Committee on Governmental Rules & Regulations adopted several amendments and reported the bill favorably as a committee substitute for committee substitute. The amendments made the following changes:

Clarified that obstetric services are not considered health services for the purposes of this section; allowed the addition of temporary acute care beds to address high seasonal demand, emergencies, or exigent circumstances; revised and clarified membership and duties of CON workgroup; allowed for a sheltered nursing home to continue to use beds designated for hospice beyond the 5-year limit allowed for community usage; clarified requirements necessary for a nursing home to add beds; and deleted the sunset date for review of the establishment of a hospice program or hospice inpatient facility.

On April 18, 2000, the Committee on Health and Human Services Appropriations adopted the following amendments and reported the bill favorably:

Amended section 408.036, F.S., relating to projects subject to review, removing the word exigent.

Amended section 401.25, F.S., relating to licensure as a basic life support or an advanced life support services, removing language regarding municipalities with a population greater than 30,000.

Eliminated 4 positions and $260,719 from the Health Care Trust Fund in the Agency for Health Care Administration as a result of reductions in workload.

The bill was then substantially amended on the Senate floor to include all of the health care issues described herein.

VII. SIGNATURES:

COMMITTEE ON HEALTH CARE LICENSING & REGULATION:

Prepared by:	Staff Director:
Wendy Smith Hansen	Lucretia Shaw Collins

AS REVISED BY THE COMMITTEE ON GOVERNMENTAL RULES AND REGULATIONS:

Prepared by:	Staff Director:
Shari Z. Whittier	David M. Greenbaum

AS FURTHER REVISED BY THE COMMITTEE ON HEALTH AND HUMAN SERVICES APPROPRIATIONS:

Prepared by:	Staff Director:
Tom Weaver	Lynn Dixon

FINAL ANALYSIS PREPARED BY THE COMMITTEE ON HEALTH CARE LICENSING & REGULATION:

Prepared by:	Staff Director:
Wendy Smith Hansen	Lucretia Shaw Collins