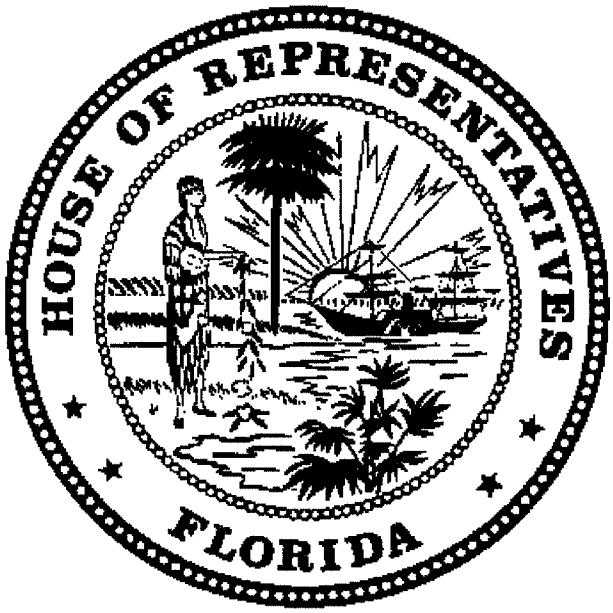


# Health & Human Services Committee

**Tuesday, April 5, 2011**
**9:00 AM**
**Morris Hall (17 HOB)**

**Dean Cannon**
**Speaker**

**Robert C. "Rob" Schenck**
**Chair**

# Committee Meeting Notice

## HOUSE OF REPRESENTATIVES

### Health & Human Services Committee

**Start Date and Time:** Tuesday, April 05, 2011 09:00 am

**End Date and Time:** Tuesday, April 05, 2011 11:00 am

**Location:** Morris Hall (17 HOB)
**Duration:** 2.00 hrs

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

HB 91 Drug-related Overdoses by Bernard
CS/HB 155 Privacy of Firearms Owners by Criminal Justice Subcommittee, Brodeur
CS/HB 1067 Death and Fetal Death Registration by Health & Human Services Quality Subcommittee, Mayfield
HB 4027 Obsolete Health Care Provisions by Horner
CS/HB 4041 Department of Children and Family Services Employees by Government Operations Subcommittee, Diaz
HB 7093 Department of Health by Health & Human Services Quality Subcommittee, Diaz
HB 7179 Vulnerable Children and Adults by Health & Human Services Access Subcommittee, Harrell
HB 7183 Health and Human Services by Health & Human Services Quality Subcommittee, Rooney

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

PCB HHSC 11-05 -- Health Care Coverage
PCB HHSC 11-08 -- Background Screening

Pursuant to Rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m., Monday, April 4, 2011.

By request of the Chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Monday, April 4, 2011.

**NOTICE FINALIZED on 04/01/2011 16:19 by Iseminger.Bobbye**

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 91 Drug-related Overdoses
**SPONSOR(S):** Bernard and others
**TIED BILLS:** None **IDEN./SIM. BILLS:** SB 1146

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Criminal Justice Subcommittee | 12 Y, 1 N | Krol | Cunningham |
| 2) Health & Human Services Committee | | Shaw | Ormley |
| 3) Judiciary Committee | | | |

## SUMMARY ANALYSIS

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

HB 91 creates s. 893.21, F.S., entitled the "911 Good Samaritan Act" and provides that:

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

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

The bill also adds the following to the list of mitigating circumstances a judge may consider when departing from the lowest permissible sentence:

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

The bill does not appear to have a fiscal impact and is effective on July 1, 2011.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

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

Florida Good Samaritan Laws

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

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

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

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

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

Reduction or Suspension of Criminal Sentence

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

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

Mitigating Circumstances

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

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

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

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

Possession of a Controlled Substance

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

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

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

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

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[4] Section 921.0022, F.S.
[5] Section 921.0024, F.S., provides that a defendant's sentence is calculated based on points assigned for factors including: the offense for which the defendant is being sentenced; injury to the victim; additional offenses that the defendant committed at the time of the primary offense; and the defendant's prior record and other aggravating factors,
[6] Section 921.0026, F.S.
[7] *Id.*
[8] Section 893.02(4), F.S., defines controlled substance as "any substance named or described in Schedules I-V of s. 893.03, F.S."
[9] As provided in ss. 775.082, 775.083, or 775.084, F.S.
[10] Section 893.13(6)(a), F.S.
[11] For the purposes of s. 893.13(6)(b), F.S., cannabis is defined as all parts of any plant of the genus Cannabis, whether growing or not, and the seeds thereof.
[12] As provided in ss. 775.082 or 775.083 F.S.
[13] Section 893.13(6)(b), F.S.
[14] As provided in ss. 775.082, 775.083, or 775.084, F.S.
[15] Section 893.13(6)(c), F.S.

911 Good Samaritan Laws in Other States

In New Mexico, the 911 Good Samaritan Act prevents the prosecution for drug possession based on evidence "gained as a result of the seeking of medical assistance" to treat a drug overdose.[16] This law, which took effect in June 2007, was the first of its kind in the country.[17]

While many states have considered similar Good Samaritan immunity legislation, Washington is the only other state to have passed such a law.[18]

**Effect of the Bill**

HB 91 contains the following "whereas clauses:"

- Whereas, some research suggests that in a majority of cases of fatal drug overdose another person was aware of or present during the decedent's fatal drug use and that in one third of the cases someone recognized the decedent's distress,

- Whereas, many people cite fear of police involvement or fear of arrest as their primary reason for not seeking immediate help for a person thought to be experiencing a drug overdose, and

- Whereas, it is in the public interest to encourage a person who is aware of or present during another individual's drug overdose to seek medical assistance for that individual.

The bill provides that a person who in good faith seeks medical assistance for an individual experiencing a drug-related overdose may not be charged, prosecuted, or penalized for possession of a controlled substance if the evidence for possession was obtained as a result of the person's seeking medical assistance.

The bill also provides that a person who experiences a drug-related overdose and is in need of medical assistance may not be not be charged, prosecuted, or penalized for possession of a controlled substance if the evidence for possession was obtained as a result of the overdose and the need for medical assistance.

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

The bill also adds the following to the list of mitigating circumstances a judge may consider when departing from the lowest permissible sentence:

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

B. SECTION DIRECTORY:

**Section 1**. Provides this act may be cited as the "911 Good Samaritan Act."
**Section 2**. Creates s. 893.21, F.S., relating to drug-related overdoses; medical assistance; immunity from prosecution.
**Section 3**. Amends s. 921.0026, F.S., relating to mitigating circumstances.
**Section 4**. Provides an effective date of July 1, 2011.

[16] "Preventing Overdose, Saving Lives." Drug Policy Alliance. March 2009. http://www.drugpolicy.org/library/overdose2009.cfm (Last accessed March 12, 2011.)
[17] *Id.*
[18] SB 5516 entitled "Drug Overdose Prevention." Effective June 2010.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Generally, possession of controlled substances is a felony offense. The bill precludes a person from being charged with possession of controlled substances in specified instances. However, on March 2, 2011, the Criminal Justice Impact Conference (CJIC) determined that this bill would have no impact on the Department of Corrections.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   Possession of less than 20 grams of cannabis is a first degree misdemeanor. The bill could have a positive impact on local jails in that it precludes a person from being charged with possession of cannabis in specified instances. However, since CJIC determined that a similar provision would have "no impact" on prison beds; the jail bed impact will also likely be negligible.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The bill does not appear to require counties or municipalities to spend funds or take any action requiring the expenditure of funds; reduce the authority that municipalities or counties have to raise revenue in the aggregate; or reduce the percentage of a state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to drug-related overdoses; providing a short title; creating s. 893.21, F.S.; providing that a person acting in good faith who seeks medical assistance for an individual experiencing a drug-related overdose may not be charged, prosecuted, or penalized for specified offenses in certain circumstances; providing that a person who experiences a drug-related overdose and needs medical assistance may not be charged, prosecuted, or penalized for specified offenses in certain circumstances; providing that the protections from prosecution for specified offenses are not grounds for suppression of evidence in other prosecutions; amending s. 921.0026, F.S.; amending mitigating circumstances under which a departure from the lowest permissible criminal sentence is reasonably justified to include circumstances in which a defendant was making a good faith effort to obtain or provide medical assistance for an individual experiencing a drug-related overdose; providing an effective date.

WHEREAS, some research suggests that in a majority of cases of fatal drug overdose another person was aware of or present during the decedent's fatal drug use and that in one third of the cases someone recognized the decedent's distress, and

WHEREAS, many people cite fear of police involvement or fear of arrest as their primary reason for not seeking immediate help for a person thought to be experiencing a drug overdose, and

WHEREAS, it is in the public interest to encourage a person who is aware of or present during another individual's drug overdose to seek medical assistance for that individual, NOW, THEREFORE,

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

Section 1. This act may be cited as the "911 Good Samaritan Act."

Section 2. Section 893.21, Florida Statutes, is created to read:

893.21 Drug-related overdoses; medical assistance; immunity from prosecution.—

(1) A person acting in good faith who seeks medical assistance for an individual experiencing a drug-related overdose may not be charged, prosecuted, or penalized pursuant to this chapter for possession of a controlled substance if the evidence for possession of a controlled substance was obtained as a result of the person's seeking medical assistance.

(2) A person who experiences a drug-related overdose and is in need of medical assistance may not be charged, prosecuted, or penalized pursuant to this chapter for possession of a controlled substance if the evidence for possession of a controlled substance was obtained as a result of the overdose and the need for medical assistance.

(3) Protection in this section from prosecution for possession offenses under this chapter may not be grounds for suppression of evidence in other criminal prosecutions.

Section 3. Paragraph (n) is added to subsection (2) of section 921.0026, Florida Statutes, to read:

921.0026 Mitigating circumstances.—This section applies to any felony offense, except any capital felony, committed on or after October 1, 1998.

(2) Mitigating circumstances under which a departure from the lowest permissible sentence is reasonably justified include, but are not limited to:

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

Section 4. This act shall take effect July 1, 2011.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED _____ (Y/N)

ADOPTED AS AMENDED _____ (Y/N)

ADOPTED W/O OBJECTION _____ (Y/N)

FAILED TO ADOPT _____ (Y/N)

WITHDRAWN _____ (Y/N)

OTHER

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Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Bernard offered the following:

**Amendment**

Remove line 68 and insert:

Section 4. This act shall take effect October 1, 2011.

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 155 Privacy of Firearms Owners
**SPONSOR(S):** Criminal Justice Subcommittee; Brodeur and others
**TIED BILLS:** None **IDEN./SIM. BILLS:** CS/SB 432

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Criminal Justice Subcommittee | 9 Y, 6 N, As CS | Cunningham | Cunningham |
| 2) Health & Human Services Committee | | Calamas | Gormley |
| 3) Judiciary Committee | | | |

## SUMMARY ANALYSIS

Florida law contains numerous provisions relating to the regulation of the medical profession, regulation of medical professionals, and the sale, purchase, possession, and carrying of weapons and firearms. However, Florida law does not contain any provision that prohibits physicians or other medical staff from asking a patient whether he or she owns a firearm or whether there is a firearm in the patient's home.

CS/HB 155 creates s. 790.338, F.S., entitled "Medical privacy concerning firearms." Subsection (1) of the statute makes it a noncriminal violation, which is punishable by a $500 fine, for any public or private physician, nurse, or other medical staff to:

- Make a verbal or written inquiry regarding the ownership of a firearm by a patient or the family of a patient or the presence of a firearm in a patient's private home or other domicile.
- Condition receipt of medical treatment or care on a person's willingness or refusal to disclose personal and private information unrelated to medical treatment.
- Enter any intentionally, accidentally, or inadvertently disclosed information concerning firearms into any record, whether written or electronic, or disclose such information to any other source.

The bill authorizes a court to assess specific fines (no less than $10,000 for a first offense, no less than $25,000 for a second offense, no less than $100,000 for third and subsequent offenses) if a court determines that a violation of the above provisions was knowing and willful, or that the person committing the prohibited act, in the exercise of ordinary care, should have known that the act was a violation.

The bill specifies that it is not a violation for specified medical personnel to make an inquiry prohibited by 790.338(1), F.S., if possession of a firearm would pose an imminent danger or threat to the patient or others or if necessary to treat a patient during a medical emergency. The bill also permits medical personnel to enter information obtained from such inquiries into a patient's record, but prohibits this information from being disclosed to any third party not participating in the treatment of the patient other than a law enforcement officer.

CS/HB 155 is effective upon becoming a law and could have both a positive and negative fiscal impact on state government.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Current Situation**

Physicians Inquiring About Firearms

In recent months, there has been media attention surrounding an incident in Ocala, Florida, where, during a routine doctor's visit, a pediatrician asked a patient's mother whether there were firearms in the home. When the mother refused to answer, the doctor advised her that she had 30 days to find a new pediatrician.[1] The doctor stated that he asked all of his patients the same question in an effort to provide safety advice in the event there was a firearm in the home.[2] He further stated that he asked similar questions about whether there was a pool at the home, and whether teenage drivers use their cell phone while driving for similar reasons – to give safety advice to patients. The mother, however, felt that the question invaded her privacy.[3] This incident has led many to question whether it should be an accepted practice for a doctor to inquire about a patient's firearm ownership.

Various professional medical groups have adopted policies that encourage or recommend that physicians ask patients about the presence of a firearm in the home. For example, the American Medical Association (AMA) encourages its members to inquire as to the presence of household firearms as a part of childproofing the home and to educate patients to the dangers of firearms to children.[4] Additionally, the American Academy of Pediatrics recommends that pediatricians incorporate questions about guns into their patient history taking.[5]

Florida law contains numerous provisions relating to the regulation of the medical profession, regulation of medical professionals, and the sale, purchase, possession, and carrying of firearms.[6] However, Florida law does not contain any provision that prohibits physicians or other medical staff from asking a patient whether he or she owns a firearm or whether there is a firearm in the patient's home.

Terminating the Doctor - Patient Relationship

The relationship between a physician and a patient is generally considered a private relationship and contractual in nature. According to the AMA, both the patient and the physician are free to enter into or decline the relationship.[7] Once a physician-patient relationship has been established, patients are free to terminate the relationship at any time.[8] Generally, doctors can only terminate existing relationships after giving the patient notice and a reasonable opportunity to obtain the services of another physician.[9]

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[1] Family and pediatrician tangle over gun question, http://www.ocala.com/article/20100723/news/100729867/1402/news?p=1&tc=pg (last accessed January 27, 2011).

[2] *Id.*

[3] *Id.*

[4] H-145.990 Prevention of Firearm Accidents in Children https://ssl3.ama-assn.org/apps/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fama1%2fpub%2fupload%2fmm%2fPolicyFinder%2fpolicyfiles%2fHnE%2fH-145.990.HTM (last accessed January 28, 2011).

[5] American Academy of Pediatrics: Firearm-Related Injuries Affecting the Pediatric Population. Pediatrics Vol. 105 No. 4, April 2000, pp. 888-895. http://aappolicy.aappublications.org/cgi/content/full/pediatrics;105/4/888 (last accessed January 28, 2011).

[6] *See, e.g.,* Chapters 456, 458, 790, F.S.

[7] AMA Code of Medical Ethics, Opinion 9.12, *Patient-Physician Relationship: Respect for Law and Human Rights*, http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion912.shtml (last accessed February 7, 2011). Doctors who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination.

[8] AMA's Code of Medical Ethics, Opinion 9.06 *Free Choice. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion906.shtml* (last accessed February 7, 2011).

[9] A health care provider owes a duty to the patient to provide the necessary and appropriate medical care to the patient with due diligence and to continue providing those services until: 1) they are no longer needed by the patient; 2) the relationship is ended with

Florida's statutes do not currently contain any provisions that dictate when physicians and patients can terminate a doctor-patient relationship.

Health Insurance Portability and Accountability Act

In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA). HIPAA contains detailed requirements for the use or disclosure of protected health information (PHI). PHI is defined as all "individually identifiable health information" which includes information relating to:

- the individual's past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual,

and that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual.[10] Covered entities may only use and disclose PHI as permitted by HIPAA or more protective state rules.[11] HIPAA establishes both civil monetary penalties and criminal penalties for the knowing use or disclosure of individually identifiable health information in violation of HIPAA.[12]

**Effect of the Bill**

CS/HB 155 creates s. 790.338, F.S., entitled "Medical privacy concerning firearms." Subsection (1) of the statute prohibits any public or private physician, nurse, or other medical staff person from:

- Making a verbal or written inquiry regarding the ownership of a firearm by a patient or the family of a patient or the presence of a firearm in a patient's private home or other domicile. The bill specifies that such inquiries violate the privacy of the patient or the patient's family members.[13]
- Conditioning receipt of medical treatment or care on a person's willingness or refusal to disclose personal and private information unrelated to medical treatment in violation of an individual's privacy, as specified above.
- Entering any intentionally, accidentally, or inadvertently disclosed information concerning firearms into any record, whether written or electronic, or disclose such information to any other source.

The bill provides that a person who violates any of the above provisions commits a noncriminal violation,[14] which is punishable by a $500 fine.[15] However, if a court determines that a violation of the

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the consent of or at the request of the patient; or 3) the health care provider withdraws from the relationship after giving the patient notice and a reasonable opportunity to obtain the services of another health care provider. The relationship typically terminates when the patient's medical condition is cured or resolved, and this often occurs at the last visit when the health care provider notes in his records that the patient is to return as needed. *See Saunders v. Lischkoff*, 188 So. 815 (Fla. 1939). *See also, Ending the Patient-Physician Relationship*, AMA White Paper http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/ending-patient-physician-relationship.shtml (last accessed February 7, 2011); AMA's Code of Medical Ethics, Opinion 8.115 *Termination of the Physician-Patient Relationship. http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8115.shtml* (last accessed February 7, 2011).

[10] 45 C.F.R. s. 160.103

[11] In general, covered entities may use PHI for the purposes of treatment, payment and health care operations (TPO) without any special permission from a patient. Special permission, called an authorization, must be obtained for uses and disclosures other than for TPO. For some uses and disclosures, a covered entity need not obtain an authorization but must give the patient the opportunity to agree or object (e.g., give patients the option to disclose health information to family or friends). Finally, in some situations, such as reporting to public health authorities, emergencies, or in research studies in which a waiver has been obtained from an Institutional Review Board (IRB), a covered entity does not need to obtain an authorization or provide an opportunity to agree or object. *Health Insurance Portability and Accountability Act.* http://hipaa.yale.edu/overview/index.html (last accessed February 4, 2011).

[12] *Health Insurance Portability and Accountability Act.* http://hipaa.yale.edu/overview/index.html (last accessed February 4, 2011). Fines range from $100 to $50,000 per violation with specified annual caps. Criminal penalties include fines ranging from $50,000 to $250,000 and imprisonment of up to 10 years. *HIPAA Violations and Enforcement.* http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/hipaahealth-insurance-portability-accountability-act/hipaa-violations-enforcement.shtml (last accessed February 4, 2011).

[13] Invading someone's privacy is not a criminal act. However, there is a common law tort claim of invasion of privacy. *See Allstate Insurance Company v. Ginsberg*, 863 So.2d 156 (Fla. 2003).

above provisions was knowing and willful, or that the person committing the prohibited act, in the exercise of ordinary care, should have known that the act was a violation, the court may assess the following:

- A fine of not less than $10,000 for the first offense.
- A fine of not less than $25,000 for the second offense.
- A fine of not less than $100,000 for a third or subsequent offense.

Persons found to have committed a violation are personally liable for the payment of all fines, costs, and fees assessed by the court for the noncriminal violation.

The bill requires the state attorney in the circuit where the violation is alleged to have occurred to investigate complaints of noncriminal violations of s. 790.338, F.S., and, where the state attorney determines probable cause that a violation exists, to prosecute violators in circuit court. State attorneys who fail to execute these duties may be held accountable under the appropriate rules of professional conduct. The bill prohibits public funds from being used to defend the unlawful conduct of a person charged with a knowing and willful violation of s. 790.338, F.S., except as provided in the United States and Florida Constitutions.

The bill also requires state attorneys to notify the Attorney General of any fines assessed. The Attorney General must bring a civil action to enforce any fine assessed if the fine is not paid after 90 days.

The bill specifies that it is not a violation of s. 790.338, F.S., for:

- A psychiatrist as defined in s. 394.455, psychologist as defined in s. 490.003, school psychologist as defined in s. 490.003, clinical social worker as defined in s. 491.003, or public or private physician, nurse, or other medical personnel to make an inquiry prohibited by s. 790.338(1), F.S., when the person making the inquiry in good faith believes that the possession or control of a firearm or ammunition by the patient or another member of the patient's household would pose an imminent danger or threat to the patient or others.
- Any public or private physician, nurse, or other medical personnel to make an inquiry prohibited by s. 790.338(1), F.S., if such inquiry is necessary to treat a patient during the course and scope of a medical emergency which specifically includes, but is not limited to, a mental health or psychotic episode where the patient's conduct or symptoms reasonably indicate that the patient has the capacity of causing harm to himself, herself, or others.
- Any public or private physician, nurse, or other medical staff person to enter any of the information disclosed pursuant to the above exceptions into any record, whether written or electronic.

The bill specifies that a patient's response to any inquiry permissible pursuant to the above exceptions is private and prohibits such responses from being disclosed to any third party not participating in the treatment of the patient other than a law enforcement officer conducting an active investigation involving the patient or the events giving rise to a medical emergency. The bill also specifies that the above exceptions do not apply to inquiries made due to a person's general belief that firearms or ammunition are harmful to health or safety.

Medical records created on or before the date the bill becomes law do not violate the bill's provisions, nor is it a violation of the bill's provisions to transfer such records to another health care provider.

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[14] Section 775.08(3), F.S., defines the term "noncriminal violation" as any offense that is punishable under the laws of this state, or that would be punishable if committed in this state, by no other penalty than a fine, forfeiture, or other civil penalty. A noncriminal violation does not constitute a crime, and conviction for a noncriminal violation shall not give rise to any legal disability based on a criminal offense.

[15] *See* ss. 775.082(5) and 775.083(1), F.S. However, the court may impose a higher amount if specifically authorized by statute.

B. SECTION DIRECTORY:

**Section 1**. Creates s. 790.338, F.S., relating to medical privacy concerning firearms.
**Section 2**. The bill takes effect upon becoming a law.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill could have a positive fiscal impact on state government in that it authorizes fines if medical personnel violate s. 790.338, F.S.

2. Expenditures:

   The bill requires state attorneys to investigate complaints of noncriminal violations of s. 790.338, F.S., and to prosecute violators in circuit court. The bill also requires the Attorney General to bring a civil action to enforce any fine assessed if the fine is not paid after 90 days. These requirements could have a negative fiscal impact on state government.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

There could be a negative fiscal impact on public and private physicians, nurses, and other medical staff who violate s. 790.338, F.S., due to the fines authorized by the bill.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   The bill makes it a noncriminal violation, punishable by a fine, for medical personnel to ask a patient whether there is a firearm in the patient's home or whether the patient or the patient's family members own a firearm. This prohibition may be subject to challenge as violating one's First Amendment right to freedom of speech.

The First Amendment to the United States Constitution provides that "Congress shall make no law ...abridging the freedom of speech." The Florida Constitution similarly provides that "[n]o law shall be passed to restrain or abridge the liberty of speech..."[16] Florida courts have equated the scope of the Florida Constitution with that of the Federal Constitution in terms of the guarantees of freedom of speech.[17]

A regulation that abridges speech because of the content of the speech is subject to the strict scrutiny standard of judicial review.[18] However, the state may regulate the content of constitutionally protected speech in order to promote a compelling interest if it chooses the least restrictive means to further the articulated interest.[19]

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

1. The bill creates s. 790.338, F.S., to make it a noncriminal violation for any *public or private physician, nurse, or other medical staff* to do certain acts. The bill does not define these terms, nor are they defined in ch. 790, F.S. Defining these terms, or using a term already defined in Florida law such as "healthcare practitioner," would clarify who the bill's provisions apply to.

2. The bill makes it a noncriminal violation for any public or private physician, nurse, or other medical staff to enter any intentionally, accidentally, or inadvertently disclose information concerning firearms into any record, whether written or electronic, or disclose such information to any other source. If "information concerning firearms" qualifies as PHI, it would appear that HIPAA already prohibits and penalizes such acts.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 8, 2011, the Criminal Justice Subcommittee adopted a strike-all amendment to the bill and reported the bill favorably as a Committee Substitute. The strike-all amendment:

- Specifies that verbal or written inquiries by any public or private physician, nurse, or other medical staff regarding the ownership of a firearm by a patient or the family of a patient or the presence of a firearm in a patient's home or other domicile *are prohibited.*
- Provides that violations of s. 790.338, F.S., are noncriminal violations punishable by specified fines.
- Specifies that state attorneys who fail to investigate and prosecute complaints of violations of s. 790.338, F.S., may be held accountable under the appropriate Florida rules of professional conduct.
- Prohibits public funds from being used to defend the unlawful conduct of a person charged with a knowing and willful violation of s. 790.338, F.S., except as provided in the United States and Florida Constitutions.
- Requires state attorneys to notify the Attorney General of any fines assessed for violations of s. 790.338, F.S., and requires the Attorney General to bring a civil action to enforce any fine assessed if the fine is not paid after 90 days.
- Provides exceptions to the prohibitions in s. 790.338, F.S.
- Specifies that medical records created before the date the bill becomes law and the transfer of such records to another health care provider do not violate s. 790.338, F.S.

This analysis is drafted to the Committee Substitute.

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[16] Art. I, § 4, Fla. Const.

[17] *See, Florida Canners Ass'n v. State, Dep't of Citrus,* 371 So.2d 503 (Fla.1979).

[18] *See, e.g., Reno v. Flores,* 507 U.S. 292, 302 (1993); *Mitchell v. Moore,* 786 So.2d 521, 527 (Fla.2001).

[19] *See United States v. Playboy Entm't Group, Inc.,* 529 U.S. 803, 813 (2000); *Sable Commc'ns of Cal., Inc. v. FCC,* 492 U.S. 115, 126 (1989).

A bill to be entitled

An act relating to the privacy of firearms owners; creating s. 790.338, F.S.; prohibiting physicians or other medical personnel from inquiring, either verbally or in writing, about the ownership of a firearm by a patient or the family of a patient or the presence of a firearm in a patient's private home or other domicile; prohibiting conditioning the receipt of medical treatment or care on a person's willingness or refusal to disclose personal and private information unrelated to medical treatment in violation of an individual's privacy contrary to specified provisions; prohibiting entry of certain information concerning firearms into medical records or disclosure of such information by specified individuals; providing noncriminal penalties; providing for prosecution of violations; requiring informing the Attorney General of prosecution of violations; providing for collection of fines by the Attorney General in certain circumstances; providing exemptions; providing an effective date.

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

Section 1. Section 790.338, Florida Statutes, is created to read:

790.338 Medical privacy concerning firearms; prohibitions; penalties; exceptions.—

(1)(a) A verbal or written inquiry by any public or private physician, nurse, or other medical staff person

regarding the ownership of a firearm by a patient or the family of a patient or the presence of a firearm in a patient's home or other domicile violates the privacy of the patient or the patient's family, respectively, and is prohibited.

(b) Any public or private physician, nurse, or other medical staff person may not condition receipt of medical treatment or medical care on a person's willingness or refusal to disclose personal and private information unrelated to medical treatment in violation of an individual's privacy as specified in this section.

(c) Any public or private physician, nurse, or other medical staff person may not intentionally, accidentally, or inadvertently enter any disclosed information concerning firearms into any record, whether written or electronic, or disclose such information to any other source.

(2)(a) A person who violates a provision of this section commits a noncriminal violation as defined in s. 775.08, punishable as provided in s. 775.082 or s. 775.083.

(b) If the court determines that the violation was knowing and willful or that the person committing the prohibited act, in the exercise of ordinary care, should have known the act was a violation, the court shall assess a fine of not less than $10,000 for the first offense, not less than $25,000 for the second offense, and not less than $100,000 for the third and subsequent offenses. The person found to have committed the violation shall be personally liable for the payment of all fines, costs, and fees assessed by the court for the noncriminal violation.

(3) The state attorney in the circuit where the violation is alleged to have occurred shall investigate complaints of noncriminal violations of this section and, where the state attorney determines probable cause that a violation exists, shall prosecute violators in the circuit court where the violation is alleged to have occurred. Any state attorney who fails to execute his or her duties under this section may be held accountable under the appropriate Florida rules of professional conduct.

(4) The state attorney shall notify the Attorney General of any fines assessed under this section, notwithstanding s. 28.246(6), and if a fine for a violation of this section remains unpaid after 90 days, the Attorney General shall bring a civil action to enforce the fine.

(5) Except as required by s. 16, Art. I of the State Constitution or the Sixth Amendment to the United States Constitution, public funds may not be used to defend the unlawful conduct of any person charged with a knowing and willful violation of this section.

(6) Notwithstanding any other provision of this section, it is not a violation for:

(a) Any psychiatrist as defined in s. 394.455, psychologist as defined in s. 490.003, school psychologist as defined in s. 490.003, clinical social worker as defined in s. 491.003, or public or private physician, nurse, or other medical personnel to make an inquiry prohibited by paragraph (1)(a) if the person making the inquiry in good faith believes that the possession or control of a firearm or ammunition by the patient

or another member of the patient's household would pose an imminent danger or threat to the patient or others.

(b) Any public or private physician, nurse, or other medical personnel to make an inquiry prohibited by paragraph (1)(a) if such inquiry is necessary to treat a patient during the course and scope of a medical emergency which specifically includes, but is not limited to, a mental health or psychotic episode where the patient's conduct or symptoms reasonably indicate that the patient has the capacity of causing harm to himself, herself, or others.

(c) Any public or private physician, nurse, or other medical personnel to enter any of the information disclosed pursuant to paragraphs (a) and (b) into any record, whether written or electronic.

However, a patient's response to any inquiry permissible under this subsection shall be private and may not be disclosed to any third party not participating in the treatment of the patient other than a law enforcement officer conducting an active investigation involving the patient or the events giving rise to a medical emergency. The exceptions provided by this subsection do not apply to inquiries made due to a person's general belief that firearms or ammunition are harmful to health or safety.

(7) Medical records created on or before the effective date of this act do not violate this section, nor is it a violation of this section to transfer such records to another health care provider.

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

Amendment No.

| COMMITTEE/SUBCOMMITTEE ACTION | |
|---|---|
| ADOPTED | __ (Y/N) |
| ADOPTED AS AMENDED | __ (Y/N) |
| ADOPTED W/O OBJECTION | __ (Y/N) |
| FAILED TO ADOPT | __ (Y/N) |
| WITHDRAWN | __ (Y/N) |
| OTHER | _____ |

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative(s) Brodeur offered the following:

**Amendment (with title amendment)**

Remove everything after the enacting clause and insert:

Section 1. Section 790.338, Florida Statutes, is created to read:

790.338 Medical privacy concerning firearms; prohibitions; penalties, exceptions.—

(1) A health care practitioner licensed under chapter 456 or a health care facility licensed under chapter 395 may not intentionally enter any disclosed information concerning firearm ownership into the patient's medical record if the practitioner knows that such information is not relevant to the patient's medical care or safety, or the safety of others.

(2) A health care practitioner licensed under chapter 456 or a health care facility licensed under chapter 395 shall respect a patient's right to privacy and should refrain from

making a written inquiry or asking questions concerning the ownership of a firearm or ammunition by the patient or by a family member of the patient, or the presence of a firearm in a private home or other domicile of the patient or a family member of the patient. Notwithstanding this provision, a health care practitioner or health care facility that in good faith believes that this information is relevant to the patient's medical care or safety, or the safety of others, may make such a verbal or written inquiry.

(3) Any emergency medical technician or paramedic acting under the supervision of an Emergency Medical Services Director under chapter 401 may make an inquiry concerning the possession or presence of a firearm if he or she, in good faith, believes that information regarding the possession of a firearm by the patient or the presence of a firearm in the home or domicile of a patient or a patient's family member is necessary to treat a patient during the course and scope of a medical emergency or that the presence or possession of a firearm would pose an imminent danger or threat to the patient or others.

(4) A patient may decline to answer or provide any information regarding ownership of a firearm by the patient or a family member of the patient, or the presence of a firearm in the domicile of the patient or a family member of the patient. A patient's decision not to answer a question relating to the presence or ownership of a firearm does not alter existing law regarding a physician's authorization to choose his or her patients.

(5) A health care practitioner licensed under chapter 456 or a health care facility licensed under chapter 395 may not discriminate against a patient based solely upon the patient's exercise of the constitutional right to own and possess firearms or ammunition.

(6) A health care practitioner licensed under chapter 456 or a health care facility licensed under chapter 395 shall respect a patient's legal right to own or possess a firearm and should refrain from unnecessarily harassing a patient about firearm ownership during an examination.

(7) An insurer issuing any type of insurance policy pursuant to chapter 627, Florida Statutes, may not deny coverage or increase any premium, or otherwise discriminate against any insured or applicant for insurance, on the basis of or upon reliance upon the lawful ownership or possession of a firearm or ammunition or the lawful use or storage of a firearm or ammunition. Nothing herein shall prevent an insurer from considering the fair market value of firearms or ammunition in the setting of premiums for scheduled personal property coverage.

(8) Violations of the provisions of subsections (1)-(4) constitute grounds for disciplinary action under ss. 456.072(2) and 395.1055.

Section 2. Paragraph (b) of subsection (4) of section 381.026, Florida Statutes, is amended to read:

381.026 Florida Patient's Bill of Rights and Responsibilities.—

(4) RIGHTS OF PATIENTS.—Each health care facility or provider shall observe the following standards:

(b) Information.—

1. A patient has the right to know the name, function, and qualifications of each health care provider who is providing medical services to the patient. A patient may request such information from his or her responsible provider or the health care facility in which he or she is receiving medical services.

2. A patient in a health care facility has the right to know what patient support services are available in the facility.

3. A patient has the right to be given by his or her health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis, unless it is medically inadvisable or impossible to give this information to the patient, in which case the information must be given to the patient's guardian or a person designated as the patient's representative. A patient has the right to refuse this information.

4. A patient has the right to refuse any treatment based on information required by this paragraph, except as otherwise provided by law. The responsible provider shall document any such refusal.

5. A patient in a health care facility has the right to know what facility rules and regulations apply to patient conduct.

6. A patient has the right to express grievances to a health care provider, a health care facility, or the appropriate

state licensing agency regarding alleged violations of patients' rights. A patient has the right to know the health care provider's or health care facility's procedures for expressing a grievance.

7. A patient in a health care facility who does not speak English has the right to be provided an interpreter when receiving medical services if the facility has a person readily available who can interpret on behalf of the patient.

8. A health care provider or health care facility shall respect a patient's right to privacy and should refrain from making a written inquiry or asking questions concerning the ownership of a firearm or ammunition by the patient or by a family member of the patient, or the presence of a firearm in a private home or other domicile of the patient or a family member of the patient. Notwithstanding this provision, a health care provider or health care facility that in good faith believes that this information is relevant to the patient's medical care or safety, or safety or others, may make such a verbal or written inquiry.

9. A patient may decline to answer or provide any information regarding ownership of a firearm by the patient or a family member of the patient, or the presence of a firearm in the domicile of the patient or a family member of the patient. A patient's decision not to answer a question relating to the presence or ownership of a firearm does not alter existing law regarding a physician's authorization to choose his or her patients.

Amendment No.

10. A health care provider or health care facility may not discriminate against a patient based solely upon the patient's exercise of the constitutional right to own and possess firearms or ammunition.

11. A health care provider or health care facility shall respect a patient's legal right to own or possess a firearm and should refrain from unnecessarily harassing a patient about firearm ownership during an examination.

Section 3. Subsection (mm) is added to subsection (1) of section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(mm) Violating any of the provisions of s. 790.338.

Section 4. This act shall take effect upon becoming a law.

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

Remove the entire title and insert:

A bill to be entitled

An act relating to the privacy of firearm owners; creating s. 790.338, F.S.; providing that a licensed medical care practitioner or health care facility may not record information regarding firearm ownership in a patient's medical record; providing an exception for relevance of the information to the patient's medical care or safety or the safety of others;

providing that unless the information is relevant to the patient's medical care or safety or the safety of others, inquiries regarding firearm ownership or possession should not be made by licensed health care practitioners or health care facilities; providing an exception for emergency medical technicians and paramedics; providing that a patient may decline to provide information regarding the ownership or possession of firearms; clarifying that a physician's authorization to choose his or her patients is not altered by the act; prohibiting discrimination by licensed health care practitioners or facilities based solely upon a patient's firearm ownership or possession; prohibiting harassment of a patient regarding firearm ownership by a licensed health care practitioner or facility during an examination; prohibiting denial of insurance coverage, increased premiums, or any other form of discrimination by insurance companies issuing policies on the basis of an insured's or applicant's ownership, possession, or storage of firearms or ammunition; clarifying that an insurer is not prohibited from considering the fair market value of firearms or ammunition in setting personal property coverage premiums; providing for disciplinary action; amending s. 381.026, F.S.; providing that unless the information is relevant to the patient's medical care or safety, or the safety of others, inquiries regarding firearm ownership or possession should not be made by licensed health care providers or health care facilities; providing that a patient may decline to provide information regarding the ownership or possession of firearms; clarifying that a physician's authorization to choose his or her

patients is not altered by the act; prohibiting discrimination by licensed health care providers or facilities based solely upon a patient's firearm ownership or possession; prohibiting harassment of a patient regarding firearm ownership during an examination by a licensed health care provider or facility; amending s. 456.072, F.S.; including the violation of the provisions of s. 790.338, F.S., as grounds for disciplinary action; providing an effective date.

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 1067 Death and Fetal Death Registration
**SPONSOR(S):** Health & Human Services Quality Subcommittee; Mayfield
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 1544

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Health & Human Services Quality Subcommittee | 11 Y, 0 N, As CS | Batchelor | Calamas |
| 2) Health & Human Services Committee | | Batchelor | Gormley |

## SUMMARY ANALYSIS

CS/HB 1067 amends s. 382.008, F.S. relating to death and fetal death registration. The bill provides that Physician's Assistants (PA's) and Advanced Nurse Practitioners (ARNP's) have authority to:

- File a certificate of death or fetal death;
- Provide and complete the medical certification of death, under the supervision of a physician and with written or verbal authorization;
- Provide medical or health information regarding a fetal death.

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

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

*Death Rates in Florida*

In 2009, there were 169,854 Florida resident deaths. This is a 0.4 percent decrease from 2008.[1] The number of Florida resident fetal deaths (stillbirths occurring at 20 or more weeks of gestation)[2] decreased from 1,688 in 2008 to 1,569 in 2009. The ratio of resident fetal deaths to resident live births also decreased from 7.3 per 1,000 live births to 7.1 per 1,000 live births during the same time period.[3]

Heart disease was the leading cause of death of adults in 2009, accounting for 24.3 percent of all deaths.[4] Malignant neoplasm (cancer) was the second leading cause of death in 2009, accounting for almost 24.0 percent of all deaths. Cancer was the leading cause of death for individuals aged 45-84 accounting for 45.4 percent of the total deaths in this age group.[5] In 2009, the major external causes of death (unintentional injury, suicide, and homicide) accounted for 7.5 percent of all resident deaths.[6]

In Florida, the top four leading causes of resident infant deaths in 2009 were: perinatal period conditions, congenital malformations, unintentional Injuries (accidents), and Sudden Infant Death Syndrome (SIDS). These causes accounted for 82.4 percent of all resident infant deaths.[7]

*Office of Vital Statistics*

The Florida Vital Statistics Act[8] authorizes the Department of Health to establish an Office of Vital Statistics, which is responsible for the uniform and efficient registration, compilation, storage, and preservation of all vital records[9] in Florida, including births and fetal deaths.[10] It also permits the Department of Health to appoint a state registrar of vital statistics for each registration district in the state.[11]

*Death and Fetal Death Certificates*

A dead body is defined as a human body or such parts of a human body from the condition of which it reasonably may be concluded that death recently occurred.[12] A fetal death is defined as death prior to the complete expulsion or extraction of a product of human conception from its mother if the 20th week of gestation has been reached and the death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.[13]

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[1] Florida Department of Health, Florida Vital Statistics Standard Report, 2009 Annual Report, *available* at: http://www.flpublichealth.com/VSBOOK/VSBOOK.aspx (last viewed March 18, 2011).
[2] S.382.002(14), F.S.
[3] *See supra*, note 1.
[4] *Id.*
[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] Ch. 382, F.S.
[9] Vital records are certificates or reports of birth, death, fetal death, marriage, dissolution of marriage, or name change.
[10] S.382.003, F.S.
[11] S.382.003(5), F.S.
[12] S.382.002(3), F.S.
[13] S.382.002(6), F.S.

Section 382.008, F.S, sets forth the requirements for certificates of death and fetal death. A certificate for death and fetal death is required to be filed within 5 days of the death and prior to final disposition[14] with the local registrar of the district in which the death occurred so the death may be recorded. [15]

A death certificate must include the decedent's social security number, if available, and aliases or "also known as" names of a decedent in addition to the decedent's name of record.[16]

If the place of death is unknown, the death will be registered in the registration district in which the dead body or fetus is found within 5 days after such occurrence; and if the death occurs in a moving conveyance, the death will be registered in the registration district in which the dead body was first removed from the conveyance.

Current law provides that the funeral director who first assumes custody of a dead body or fetus shall file the certificate of death or fetal death. In the absence of the funeral director, the physician or other person in attendance at or after the death shall file the certificate of death or fetal death.[17]

Physicians or Medical Examiners are responsible for furnishing the medical certification of death. For fetal deaths a physician, midwife or hospital administrator shall provide medical and health information to the funeral director within 72 hours of expulsion or extraction.[18] The physician must within 72 hours after receipt of a death or fetal death, certify the cause of death and make it available to the funeral director. The medical certification is completed by the physician in charge of the decedent's care for the illness or condition which resulted in death, the physician in attendance at the time of death or fetal death or immediately before or after such death or fetal death, or the medical examiner if the provisions of s. 382.011, F.S. apply.[19]

If a funeral director needs an extension of time, the local registrar may grant the extension of time if: [20]

- An autopsy is pending;
- Toxicology, laboratory, or other diagnostic reports have not been completed; or
- The identity of the decedent is unknown and further investigation or identification is required.

If an extension is granted the funeral director is responsible for filing a temporary certificate of death or fetal death containing all available information, including the fact that the cause of death is pending and the estimated date for completion of the permanent certificate, per the physician or medical examiner.[21]

*Determining Cause of Death*

The underlying cause of death is determined from death certificate medical information in accordance with procedures established by the World Health Organization (WHO) and the National Center for Health Statistics (NCHS). The NCHS serves as the WHO Collaborating Center for the Family of International Classifications for North America, and in this capacity is responsible for coordination of all official disease classification activities in the United States relating to the International Classification of Diseases (ICD) and its use, interpretation, and periodic revision.[22] To keep abreast of changes in

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[14] Final disposition is the burial, interment, cremation, removal from the state, or other authorized disposition of a dead body or a fetus. In the case of cremation, dispersion of ashes or cremation residue is considered to occur after final disposition; the cremation itself is considered final disposition.
[15] S.382.008(1), F.S.
[16] S.382.008(1), F.S.
[17] S.382.008(2)(a), F.S.
[18] *Id.*
[19] S.382.008(3), F.S.
[20] S.382.008(3)(a), F.S.
[21] S.382.008(4), F.S.
[22] Centers for Disease Control & Prevention, National Center for Health Statistics, Classification of Diseases, Functioning, and Disability, available at: http://www.cdc.gov/nchs/icd/icd10cm.htm (last viewed March 18, 2011).

medical knowledge, the ICD is revised approximately every 10 to 15 years.[23] The ICD-10, or 10th edition, is the 2011 update of the ICD. The ICD-10 is used to code and classify mortality data from death certificates, having replaced ICD-9 for this purpose as of January 1, 1999.[24]

Current law provides that only physicians can certify cause of death.[25] The Department of Health (DOH) publishes a Vital Records Registration Handbook, outlining physician responsibilities in death registration.[26] Physicians must:

- Attest the facts of death as they relate to date place and time of death;
- Complete the medical certification section of the death certificate, attesting to the cause of death to the best of their knowledge or belief;
- Complete, sign and make the medical certification available to the funeral director/direct disposer within 72 hours after receipt of the record.

Physicians are required to have knowledge of state statutes and the physician handbook regarding medical certifications of death. DOH offers an online tutorial on how to complete a Florida death record.[27]

Current Florida law does not allow physicians assistants or nurses to certify a cause of death. Currently, at least 5 other states[28] provide physicians assistants and advanced registered nurse practitioners with the authority to pronounce death and to certify and sign a death certificate.

**Effect of Proposed Changes**

The bill amends s. 382.008, F.S., to allow PA's and ARNP's to file a certificate of death or fetal death in the absence of a funeral director and to provide any medical or health information to the funeral director within 72 hours of expulsion or extraction.

Additionally, the bill provides that PA's and ARNP's can certify the cause of death under the supervision of a physician and with either written or verbal authorization

B. SECTION DIRECTORY:

**Section 1:** Amends s. 382.008, F.S., relating to death and fetal death registration.
**Section 2:** Provides an effective date.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None

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[23] Florida Department of Health, Florida Vital Statistics Standard Report, 2009 Annual Report, *available* at: http://www.flpublichealth.com/VSBOOK/VSBOOK.aspx (last viewed March 18, 2011).
[24] Centers for Disease Control & Prevention, National Center for Health Statistics, Classification of Diseases, Functioning, and Disability, available at: http://www.cdc.gov/nchs/icd/icd10cm.htm (last viewed March 18, 2011).
[25] S.382.008, F.S.
[26] Vital Records Registration Handbook, Death Edition, December 2009, Department of Health (on file with sub-committee staff).
[27] *Id.*
[28] Conn.Gen.Stat. s 7-62b (2011) (Connecticut), Idaho Code Ann.s.39-620 (2011) (Idaho), Me.Rev.Stat.Ann.tit.22,s 2842 (2011) (Maine), Md.Code Ann., [Certificates of death; notice to medical examiner] s 4-212 (2011) (Maryland), S.D. Codified Laws s. 34-25-18 (2011) (South Dakota).

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 22, 2011, the Health and Human Services Quality Subcommittee adopted a strike-all amendment to House Bill 1067.

The amendment provides that a physician's assistant or advanced nurse practitioner can file a certificate of death or fetal death and that under the supervision of a physician they may also complete a medical certification of death.

This bill was reported favorably as a Committee Substitute. This analysis reflects the Committee Substitute.

A bill to be entitled

An act relating to death and fetal death registration; amending s. 382.008, F.S.; providing for physician assistants and advanced registered nurse practitioners to provide certification of death or fetal death under certain conditions; requiring the supervising physician to verify the certification within a specified timeframe; providing an effective date.

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

Section 1. Paragraph (a) of subsection (2) of section 382.008, Florida Statutes, is amended, and paragraph (c) is added to subsection (3) of that section, to read:

382.008 Death and fetal death registration.—

(2)(a) The funeral director who first assumes custody of a dead body or fetus shall file the certificate of death or fetal death. In the absence of the funeral director, the physician, physician assistant, advanced registered nurse practitioner, or other person in attendance at or after the death shall file the certificate of death or fetal death. The person who files the certificate shall obtain personal data from the next of kin or the best qualified person or source available. The medical certification of cause of death shall be furnished to the funeral director, either in person or via certified mail, by the physician, physician assistant, advanced registered nurse practitioner, or medical examiner responsible for furnishing such information. For fetal deaths, the physician, physician

assistant, midwife, advanced registered nurse practitioner, or hospital administrator shall provide any medical or health information to the funeral director within 72 hours after expulsion or extraction.

(3) Within 72 hours after receipt of a death or fetal death certificate from the funeral director, the medical certification of cause of death shall be completed and made available to the funeral director by the physician in charge of the decedent's care for the illness or condition which resulted in death, the physician in attendance at the time of death or fetal death or immediately before or after such death or fetal death, or the medical examiner if the provisions of s. 382.011 apply. The physician or medical examiner shall certify over his or her signature the cause of death to the best of his or her knowledge and belief.

(c) Notwithstanding any other provision of this section, a physician assistant or advanced registered nurse practitioner, upon specific written or oral authorization from the physician with whom the physician assistant or advanced registered nurse practitioner has a signed protocol or supervisory relationship, may complete the medical certification of cause of death. The physician must sign this certification in writing within 24 hours after the certification of death is completed and place the certification in the decedent's medical records.

Section 2. This act shall take effect July 1, 2011.

Amendment No. 1

| COMMITTEE/SUBCOMMITTEE ACTION | |
|---|---|
| ADOPTED | __ (Y/N) |
| ADOPTED AS AMENDED | __ (Y/N) |
| ADOPTED W/O OBJECTION | __ (Y/N) |
| FAILED TO ADOPT | __ (Y/N) |
| WITHDRAWN | __ (Y/N) |
| OTHER | _____ |

Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative(s) Mayfield offered the following:

**Amendment**

Between lines 52 and 53, insert:

Section 2. Subsection (4) of section 382.025 is amended to read:

382.025 Certified copies of vital records; confidentiality; research.—

(4) CERTIFIED COPIES OF ORIGINAL CERTIFICATES.—Only the state registrar and local registrars are authorized to issue any certificate which purports to be a certified copy of an original certificate of live birth, death, or fetal death. Certified copies issued by a local registrar shall not exceed $10 per copy. Except as provided in this section, preparing or issuing certificates is exempt from the provisions of s. 119.07(1).

Amendment No. 2

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED ____ (Y/N)

ADOPTED AS AMENDED ____ (Y/N)

ADOPTED W/O OBJECTION ____ (Y/N)

FAILED TO ADOPT ____ (Y/N)

WITHDRAWN ____ (Y/N)

OTHER

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Committee/Subcommittee hearing bill: Health & Human Services Committee

Representative Mayfield offered the following:

**Amendment (with directory and title amendments)**

Remove lines 49-52 and insert:

may certify over his or her signature the cause of death to the best of his or her knowledge and belief. The supervising physician shall review each death certificate with the physician assistant or advanced registered nurse practitioner within 15 days after completion of the death certificate. The physician assistant or advanced registered nurse practitioner shall complete training approved by the department.

(4) If the local registrar has granted an extension of time to provide the medical certification of cause of death, the funeral director shall file a temporary certificate of death or fetal death which shall contain all available information, including the fact that the cause of death is pending. The physician, physician assistant, advanced registered nurse

practitioner, or medical examiner shall provide an estimated date for completion of the permanent certificate.

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

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**D I R E C T O R Y A M E N D M E N T**

Remove lines 12-13 and insert:

Section 1. Paragraph (a) of subsection (2) and subsections (4) and (5) of section 382.008, Florida Statutes, are amended, and paragraph (c) is

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

Remove lines 3-8 and insert:

amending s. 382.008, F.S.; providing for the supervising physician to review the death certificate with the physician assistant or advanced registered nurse practitioner within a specified timeframe; requiring a

physician assistant or advanced registered nurse practitioner to complete certain training; providing for a physician assistant or advanced registered nurse practitioner to provide certain information regarding a permanent certificate of death; providing an effective date.

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 4027 Obsolete Health Care Provisions
**SPONSOR(S):** Horner
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 548

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Health & Human Services Quality Subcommittee | 13 Y, 0 N | Holt | Calamas |
| 2) Health & Human Services Committee | | Holt | Gormley |

## SUMMARY ANALYSIS

The bill deletes the following outdated or obsolete provisions:

- Separate restrooms and separate dressing rooms for males and females;
- Florida Healthy People 2010 Program; and
- MedAccess Program

The bill will not affect the funding to any existing programs.

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

The bill takes effect July 1, 2011.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

The effect of this bill is of a technical, non-substantive nature. This bill deletes outdated or obsolete language relating to various health care provisions as follows:

**Separate Male and Female Restrooms**

Created in 1977, section 381.0091, F.S., authorizes private businesses to designate separate restrooms and separate dressing rooms for males and females, and to prohibit any female from using a restroom or dressing room designated for males and vice versa. In addition, if more than one restroom is provided that has occupant capacity for more than one person in any building or facility operated by the state, the restrooms must be separate for males and females and designated as such by appropriate signage. In 1991, this section was amended to transfer and renumber s. 381.523, F.S., to s. 381.0091, F.S., when the Department of Health and Rehabilitative Services was created.

The provision related to private businesses is merely permissive and appears to have little effect. The provision related to government buildings and facilities is outdated and no longer appears to be necessary. In addition, the section does not provide any enforcement provision nor inspection requirements for the Department of Health ("department"). Currently, the department does not inspect entities for compliance with this provision.[1]

The bill repeals s. 381.0091, F.S. The repeal will have no impact on the ability of private businesses and government buildings to designate separate male and female restrooms or dressing rooms.

**Florida Healthy People 2010 Program**

Section 381.736, F.S., requires the department, within existing resources, to monitor and report Florida's status on the Healthy People 2010 goals and objectives currently tracked and available to the Department of Health. The department is required to submit an annual report to the Legislature on the status of health disparities among minorities and non-minorities, using health indicators consistent with those identified by Healthy People 2010. Furthermore, the provision directs the department to work with minority physician networks[2] to develop programs to educate health care professionals about the importance of culture in health status.[3] Moreover, the provision directs the department to promote research on methods to reduce disparities by encouraging local minority students enrolled at colleges and universities[4] to pursue professions in health care.

Healthy People 2010 is a set of federal core public health indicators used for priority-setting and decision-making that reflect major health concerns and that provide guidance to help states, local governments, and private organizations improve the health of their communities. The Florida Healthy People 2010 program has two major program goals: increase quality and years of healthy life; and

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[1] Per telephone conversation with Department of Health staff on February 22, 2010.

[2] A "minority physician network" is a network of primary care physicians with experience managing Medicaid or Medicare recipients that is predominantly owned by minorities as defined in s. 288.703, F.S., which may have a collaborative partnership with a public college or university and a tax-exempt charitable corporation. See s. 409.901, F.S.

[3] Minority physician networks will not be impacted by repealing this section of law. The Agency for Health Care Administration oversees services provided by the minority physician networks. Effective January 1, 2010, minority physician networks were transitioned to health maintenance organizations, thus minority physician networks will no longer be included in the Florida Healthy People 2010 Program report. *See* Florida Healthy People 2010 Program Report: 2009 Office of Minority Health, Executive Summary, *available* at: http://www.doh.state.fl.us/Minority/HealthyPeople.htm (last viewed January 28, 2011).

[4] The statute references colleges and universities that have historically large minority enrollments to include centers of excellence that are identified by the National Center on Minority Health and Disparities.

eliminate health disparities.[5] There are 28 different focus areas in the federal Healthy People 2010 program:[6]

1. Access to Quality Health Services
2. Arthritis, Osteoporosis, and Chronic Back Conditions
3. Cancer
4. Chronic Kidney Disease
5. Diabetes
6. Disability and Secondary Conditions
7. Educational and Community-Based Programs
8. Environmental Health
9. Family Planning
10. Food Safety
11. Health Communication
12. Heart Disease and Stroke
13. HIV
14. Immunization and Infectious Diseases
15. Injury and Violence Prevention
16. Maternal, Infant, and Child Health
17. Medical Product Safety
18. Mental Health and Mental Disorders
19. Nutrition and Overweight
20. Occupational Safety and Health
21. Oral Health
22. Physical Activity and Fitness
23. Public Health Infrastructure
24. Respiratory Diseases
25. Sexually Transmitted Diseases
26. Substance Abuse
27. Tobacco Use
28. Vision and Hearing

The federal Healthy People program goals and objectives are updated every 10 years, thus the existing 2010 goals are obsolete. In December 2010, the U.S. Department of Health and Human Services and the Centers for Disease Control and Prevention unveiled Healthy People 2020 program and objectives.[7]

Currently, the Florida Healthy People 2010 program duplicates other department programs and is not treated as a separate program. Therefore, the intent is being achieved through other statutory directives. This program is not specifically funded. Section 381.736, F.S., requires that the annual report be submitted to the Legislature by December 31 of each year. The last annual report was published in December 2009.[8] The department complies with the reporting requirements of this section by reporting on other programs that receive funding.[9]

The bill repeals s. 381.736, F.S., the Florida Healthy People 2010 goals and reporting requirements. Repealing this provision will only affect the requirement for submitting the annual report to the Legislature, and information available in the annual report will still be collected by the department and made available thru other programs. No funding to any existing programs will be affected.

**MedAccess Program**

Sections 408.90-408.908, F.S., create the MedAccess program.[10] MedAccess was intended to be a state-subsidized program to provide certain health care services to low-income uninsured Floridians who are ineligible for Medicaid or Medicare. The program excludes coverage for preexisting conditions under certain circumstances. The Agency for Health Care Administration ("agency") is the fiscal agent for the program, and is required to develop the provider network, collect premiums and deductibles from enrollees, and make claims payments at Medicaid rates to providers. The program is not subject to state insurance regulation.

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[5] Section 381.736(1), F.S.
[6] In addition, these focus areas are broken down into 467 specific objectives.
[7] U.S. Health and Human Services, About Healthy People 2020, *available* at: http://www.healthypeople.gov/2020/about/default.aspx (last viewed January 28, 2011).
[8] Department of Health, Office of Minority Health, Florida Healthy People 2010, Reports, *available* at: http://www.doh.state.fl.us/Minority/HealthyPeople.htm (last viewed January 28, 2011).
[9] Per telephone call with Department of Health staff on February 22, 2010.
[10] Chapter. 1993-129, L.O.F.

The program was created in 1993 and only the benefits provision[11] was amended since adoption. In 2000, the amount of hospital outpatient services provided to a member was increased from $1000 to $1,500 per calendar year per member and an obsolete cross-reference to licensed abuse treatment centers was deleted.[12] The MedAccess program encompasses nine statutory provisions that provide: Legislative findings and intent; definitions; program creation and title; eligibility; benefits; limitations and exclusions; collection of premiums; and administration.

According to the agency, the program was never funded or implemented. The bill repeals ss. 408.90-408.908, F.S., the MedAccess Program.

B. SECTION DIRECTORY:

**Section 1**. Repeals the following: s. 381.0091, relating to relating to separate restrooms and separate dressing rooms for males and females; s. 381.736, F.S., relating to the Florida Healthy People 2010 Program; s. 408.90, F.S., relating to legislative findings and intent; s. 408.901, F.S., relating to definitions; s. 408.902, F.S., relating to MedAccess program creation and title; s. 408.903, F.S., relating to eligibility; s. 408.904, F.S., relating to benefits; s. 408.905, F.S., relating to limitations and exclusions; s. 408.906, F.S., relating to payment of claims; s. 408.907, F.S., relating to collection of premiums; and s. 408.908, F.S., relating to administration.

**Section 2**. Provides an effective date of July 1, 2011.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Not applicable.

2. Expenditures:

   Not applicable.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   Not applicable.

2. Expenditures:

   Not applicable.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

   Not applicable.

D. FISCAL COMMENTS:

   None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

[11] Section 408.904, F.S.
[12] Chapter 2000-256, L.O.F. and 2000-153, L.O.F.

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

   No rule-making authority is provided in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

   None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

A bill to be entitled

An act relating to obsolete health care provisions; repealing s. 381.0091, F.S., relating to the designation of separate restrooms and separate dressing rooms for males and females; repealing s. 381.736, F.S., relating to the Florida Healthy People 2010 Program; repealing ss. 408.90-408.908, F.S., relating to the MedAccess program within the Agency for Health Care Administration; providing an effective date.

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

Section 1. Sections 381.0091, 381.736, 408.90, 408.901, 408.902, 408.903, 408.904, 408.905, 408.906, 408.907, and 408.908, Florida Statutes, are repealed.

Section 2. This act shall take effect July 1, 2011.

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** CS/HB 4041 Department of Children and Family Services Employees
**SPONSOR(S):** Diaz
**TIED BILLS:** **IDEN./SIM. BILLS:** SB 1362

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| 1) Health & Human Services Access Subcommittee | 15 Y, 0 N | Batchelor | Schoolfield |
| 2) Government Operations Subcommittee | 11 Y, 0 N, As CS | McDonald | Williamson |
| 3) Health & Human Services Committee | | Batchelor | Gormley |

## SUMMARY ANALYSIS

The bill deletes current language in s. 402.35, F.S. that prohibits a federal, state, county or municipal officer from serving as an employee of the Department of Children and Family Services.

The bill has no fiscal impact.

The bill provides an effective date of upon becoming a law.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

**Background**

In 1969, s. 409.015(3)(a),F.S., established the State Board of Social Services, a nine-member board appointed by the Governor and confirmed by the Senate for four-year terms. The last sentence of the subparagraph prohibited a federal, state, county or municipal officer or employee from serving as a member of the board. The exact reason officers were not allowed to serve on the board is unknown.

Since 1969, several changes in statutes have occurred. The Department of Health and Rehabilitative Services (HRS) was created and many boards and councils were abolished or absorbed into the new department. In 1996, HRS was split into two agencies, the Department of Children and Family Services (DCF) and the Department of Health. Throughout these changes, the prohibition for a federal, state, county or municipal officer or employee to serve as a member of the state board was changed to a prohibition to serve as an employee of DCF.[1]

**Effect of Proposed Changes**

The bill eliminates the statutory provision preventing DCF from hiring employees that may be federal, state, county or municipal officers. Removal of the prohibition will allow persons who are currently employed at DCF to seek public office or serve as a local official without leaving DCF. The change will eliminate language from the statute that appears to be obsolete.

B. SECTION DIRECTORY:

**Section 1:** Amends s. 402.35, F.S., removing language prohibiting a federal, state, county or municipal officer from working as an employee of DCF.
**Section 2:** Provides an effective date of upon becoming a law.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

[1] Ch. 70-255, L.O.F., abolished the State Board of Social Services and provided for the creation of the Division of Children Services under the Department of HRS. The chapter law changed the prohibition on serving as a member of the board to serving as an employee of the Division of Children Services. It also was changed to address only officers. The language included in s. 409.135, F.S., was later transferred to s. 402.35, F.S., and amended to refer to the Department of Children and Family Services.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 23, 2011, the Government Operations Subcommittee adopted an amendment that changed the effective date of the bill from July 1, 2011, to upon becoming a law and passed the bill as a committee substitute.

A bill to be entitled

An act relating to Department of Children and Family Services employees; amending s. 402.35, F.S.; removing a provision prohibiting a federal, state, county, or municipal officer from serving as an employee of the department; providing an effective date.

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

Section 1. Section 402.35, Florida Statutes, is amended to read:

402.35 Employees.—All personnel of the Department of Children and Family Services shall be governed by rules and regulations adopted and promulgated by the Department of Management Services relative thereto except the director and persons paid on a fee basis. The Department of Children and Family Services may participate with other state departments and agencies in a joint merit system. ~~No federal, state, county, or municipal officer shall be eligible to serve as an employee of the Department of Children and Family Services.~~

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

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 7093 PCB HSQS 11-01 Department of Health
**SPONSOR(S):** Health & Human Services Quality Subcommittee, Diaz
**TIED BILLS:** **IDEN./SIM. BILLS:**

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| Orig. Comm.: Health & Human Services Quality Subcommittee | 14 Y, 0 N | Batchelor | Calamas |
| 1) Health & Human Services Committee | | Batchelor | Gormley |

## SUMMARY ANALYSIS

PCB HSQS 11-01 repeals the following sections of law:

- Section 381.00325 F.S., relating to the Hepatitis A Awareness program; and
- Section 381.06015, F.S., relating to the Public Cord Blood Tissue Bank

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

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

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

The bill repeals two current sections of law as it relates to the Department of Health (DOH).

Hepatitis A Awareness Program

The bill repeals s. 381.00325, F.S., requiring DOH to develop a Hepatitis A Awareness Program. The purpose of the program is to provide education and information to the public regarding the availability of the Hepatitis A vaccine.

DOH, per s. 381.0011(7), F.S., is to provide information to the public regarding the prevention, control, and cure of diseases and illnesses. Under this authority, the Division of Disease Control, within DOH, currently has a Hepatitis Awareness Program web page that provides necessary information regarding vaccines and educational tools for Hepatitis A, B and C.

Public Cord Blood Tissue Bank

The bill repeals s. 381.06015, F.S., enacted in 2000, which establishes a statewide consortium known as the Public Cord Blood Tissue Bank (consortium). The consortium was intended to be a nonprofit legal entity to collect and screen for infectious and genetic disease, perform tissue typing, cryopreserve and store umbilical cord blood as a resource to the public. Pursuant to s.381.06015 (1), F.S., The University of Florida, University of South Florida, University of Miami and the Mayo Clinic Jacksonville were to make up the consortium. The consortium was never created.

B. SECTION DIRECTORY:

**Section 1**: Repeals s. 381.00325, F.S., related to the Hepatitis A Awareness Program.

**Section 2**: Repeals s. 381.06015, F.S., related to the Public Cord Blood Tissue Bank.

**Section 3**: Provides an effective date.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the Department of Health; repealing s. 381.00325, F.S., relating to the development of a Hepatitis A awareness program; repealing s. 381.06015, F.S., relating to the establishment of the Public Cord Blood Tissue Bank; providing an effective date.

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

Section 1. Section 381.00325, Florida Statutes, is repealed.

Section 2. Section 381.06015, Florida Statutes, is repealed.

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

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 7179 PCB HSAS 11-01 Vulnerable Children and Adults
**SPONSOR(S):** Health & Human Services Access Subcommittee, Harrell
**TIED BILLS:** **IDEN./SIM. BILLS:**

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| Orig. Comm.: Health & Human Services Access Subcommittee | 15 Y, 0 N | Batchelor | Schoolfield |
| 1) Health & Human Services Committee | | Batchelor | Gormley |

## SUMMARY ANALYSIS

The bill repeals the following sections of law, which are outdated, no longer effective, applicable or being implemented:

- s. 39.0015, F.S., relating to child abuse prevention training in the district school system;
- s. 39.305, F.S., relating to the development by the Department of Children and Family Services of a model plan for intervention and treatment in sexual abuse cases;
- ss. 39.311 to 318, F.S., relating to the Family Builders Program;
- s. 39.816, F.S., relating to authorization for pilot and demonstration projects;
- s. 39.817, F.S., relating to a foster care privatization demonstration pilot project;
- s. 383.0115, F.S., relating to the Commission on Marriage and Family Support Initiatives;
- s. 393.22, F.S., relating to financial commitment to community services programs;
- s. 393.503, F.S., relating to respite and family care subsidy expenditures and funding recommendations;
- s. 394.922, F.S., relating to involuntary civil commitments of sexually violent predators;
- s. 402.3045, F.S., relating to a requirement that the Department of Children and Family Services adopt distinguishable definitions of child care programs by rule;
- s. 402.50, F.S., relating to the development of administrative infrastructure standards by the Department of Children and Family Services;
- s. 402.55, F.S., relating to the Management Fellows Program;
- s. 409.1672, F.S., relating to incentives for department employees;
- s. 409.1673, F.S., relating to legislative findings regarding the foster care system and the development of alternate care plans;
- s. 409.1685, F.S., relating to an annual report to the Legislature by the Department of Children and Family Services with respect to children in foster care;
- ss. 409.801 to 803, F.S., relating to the creation of the Family Policy Act;

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

The bill becomes effective on July 1, 2011.

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

The bill repeals the following sections of statute which either are outdated, no longer effective or no longer being implemented:

Child Abuse Prevention Training in the District School System

Repeals s. 39.0015, F.S., which created the "Child Abuse Prevention Training Act of 1985". This Act encouraged the Department of Education to implement abuse prevention training for all school teachers, guidance counselors, parents, and children in the district school system. No rules were created relating to this section and the program was never implemented by the Department of Education (DOE).

Intervention and Treatment in Sexual Abuse Cases; Model Plan

Repeals s. 39.305, F.S., which requires the Department of Children and Family Services (DCF) to develop a model plan for community intervention and treatment of intra-family sexual abuse in conjunction with the Department of Law Enforcement, the Department of Health, Department of Education, the Attorney General, the state Guardian Ad Litem Program, the Department of Corrections, representatives of the judiciary, and professionals and advocates from the mental health and child welfare community. The model plan was never developed. However, other sections of law already provide collaborative efforts including but not limited to child protection teams,[1] agreements with local law enforcement regarding investigations[2] and mandatory notification requirements regarding abuse[3].

Family Builders Program

Repeals s. 39.311, F.S., which establishes the "Family Builders Program" (program). Repeals s. 39.312, F.S., which outlines goals for the program. Repeals s. 39.313, F.S., as it relates to contracting of services for the program. Repeals s. 39.314, F.S., establishing eligibility for the program. Repeals s. 39.315, F.S., regarding delivery of services for the program. Repeals s. 39.316, F.S., regarding qualifications of program workers. Repeals s. 39.317, F.S., relating to outcome evaluation of the program. Repeals s. 39.318, F.S., relating to funding of the program. The program was established in the department to provide family preservation services. The department no longer operates the program and recommended repeal of the program and relating sections of statute during the 2009 legislative session.

Authorization for Pilot and Demonstration Projects

Repeals s. 39.816, F.S., which was enacted in 1998 and requires DCF, contingent on a grant from the federal Adoption Safe Families Act (ASFA), to establish one or more pilots for the purpose of furthering the goals of the Act. It also authorizes DCF to establish demonstration projects to identify barriers to adoption, to address parental substance abuse problems that endanger children, and to address kinship care. It is unknown whether the pilots were ever established. As such, the statutory language for pilots is outdated.

Foster Care Privatization Demonstration Pilot Project

Repeals s. 39.817, F.S., which requires the establishment of a pilot project through The Ounce of Prevention Fund of Florida to contract with a private entity for a foster care privatization demonstration

[1] s. 39.303, F.S.
[2] s. 36.306, F.S.
[3] s. 39.301, F.S.

project. The statute is outdated and foster care and related services are currently privatized statewide through community based care organizations.

The Commission on Marriage and Family Support Initiatives

Repeals s. 383.0115, F.S., which creates the Commission on Marriage and Family Support Initiatives (Commission), which essentially replaced the Commission of Responsible Fatherhood created in 1996. The Commission is authorized to hire an executive director, a researcher, and an administrative assistant and to also create documents related to marriage and family initiatives. The Commission is also required to develop a community awareness campaign related to marriage promotion. The Commission was funded following its inception in 2003, but has not been funded since 2008. As a result, the Commission is no longer operating.

Financial Commitment to Community Services Program

Repeals s. 393.22, F.S., which provides specific guidelines for transferring funds from the institution budget to the community budget when a developmental disabilities center discharges enough persons to close a residential unit. The section also provides that the funds to support at least 80 percent of the direct cost to serve people in the unit that closes must be shifted to community services. The language is not needed as the use of funds which become available from the closing or downsizing of an institution are handled through the Legislative budgeting process. Legislative findings and intent already cover preference of community services instead of services in a developmental disabilities center.[4] This section of law is no longer needed.

Respite and Family Care Subsidy Expenditures

Repeals s. 393.503, F.S., which requires the Agency for Persons with Disabilities (APD) to report to the Family Care Councils and others the annual expenditures for respite care and family care subsidies for individuals living at home. The law also requires the Family Care Council to review the information and make recommendations to APD when new funds become available. This section of law is no longer effective since the Family Care Council no longer needs to submit recommendations to plan for funding of respite care and family care subsidies and APD no longer needs to report the information to the Council each year. Under current law, clients of APD are served based on their assessed need within the funds available.[5] The services are not provided to individuals based on the funding of specific programs such as respite or family care subsidies. Therefore, this section of law is no longer effective and inconsistent with the current Legislative policy.

Constitutional Requirements for Involuntary Civil Commitment

Repeals s. 394.922, which requires the long-term control, care and treatment of a sexually violent predator who is involuntarily civilly committed to conform to constitutional protections. The personal protections afforded to all citizens under the Florida Constitution and the U.S. Constitution are not impeded by involuntary civil commitment. The redundancy of this section is not necessary as the personal protections provided by both Constitutions remain in effect without restating such in statute.

Requirement for distinguishable definitions of child care.

Repeals s. 402.3045, F.S., which requires DCF to adopt by rule a definition for child care. This is redundant language and not needed in statute since the exact same language is contained in s. 402.305(1)(c).

[4] s. 393.062, F.S.
[5] s. 393.0661, F.S.

Administrative Infrastructure; legislative intent; establishment of standards

Repeals s. 402.50, which was enacted in 1991 that requires DCF to develop standards for administrative infrastructure funding and staffing to support the department and contract providers. DCF has undergone several reorganizations since this statute was enacted including a restructuring of administration. This section of statute is outdated and no longer necessary.

Management Fellows Program

Repeals s. 402.55, F.S., which established the Management Fellows Program at DCF and the Department of Health (DOH). The program was enacted in 1991 to identify, train designate and promote employees with high levels of administrative and management potential to fill the needs of the departments. One Career Service employee is to be identified each year and placed in the training program for these purposes. A special pay increase is allowed upon completion of the program. The program is no longer being used by either department.

Incentives for Department Employees

Repeals s. 409.1672, F.S., was enacted in 1994 to authorize DCF to, within existing resources, develop monetary performance incentives such as bonuses, salary increases, and educational enhancements for department employees engaged in positions or activities related to the child welfare system under Chapter 39, relating to dependent children, or Chapter 409, relating to social and economic assistance. It appears this section has never been used due to lack of funds.

Alternative Care Plans; Legislative Findings

Repeals s. 409.1673, F.S., which provides legislative findings related to out-of-home placements for children in the legal custody of the department. It also requires DCF, in collaboration with community service providers, to develop and administer plans for services for dependent children. This section of law was enacted at the early stages of the change to community-based care and it is now outdated as a result of subsequent changes to chapter 39, F.S., and s. 409.1671, F.S.

Annual Report to Legislature relating to Children in Foster Care

Repeals s. 409.1685, F.S., which requires DCF to submit a report each year to the Legislature concerning the status of children in foster care. The report with the specific content referenced in statute is not needed. This section of law is outdated as the information in this report is available from other sources.

Family Policy Act

Repeals s. 409.801, F.S., which creates the "Family Policy Act." Repeals s. 409.802, F.S., which requires the Legislature to seek to provide families certain benefits. Repeals s. 409.803, F.S., which requires DCF to establish a two year pilot program in a rural and an urban county to provide funding and resources for shelters, foster homes, and the children in their care. Provisions regarding these services exist in chapters 39 and 402 and other sections of chapter 409, which more accurately reflect the current philosophy and practice relating to foster children and their parents. This section of statute is outdated.

B. SECTION DIRECTORY:

**Section 1**: Repeals ss. 39.0015, 39.305, 39.311, 39.312, 39.313, 39.314, 39.315, 39.316, 39.317, 39.318, 39.816, 39.817, 383.0115, 393.22, 393.503, 394.922, 402.3045, 402.50, 402.55, 409.1672, 409.1673, 409.1685, 409.801, 409.802, 409.803, F.S.

**Section 2**: Amends s. 39.3031, F.S., relating to rules of implementation for ss. 39.303 and 39.305, F.S.

**Section 3**: Amends s. 390.01114, F.S., relating to parental notice of abortion act.

**Section 4**: Amends s. 753.03, F.S., relating to standards for supervised visitation and supervised exchange programs.

**Section 5**: Provides an effective date of July 1, 2011.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

A bill to be entitled

An act relating to vulnerable children and adults; repealing s. 39.0015, F.S., relating to child abuse prevention training in the district school system; repealing s. 39.305, F.S., relating to the development by the Department of Children and Family Services of a model plan for community intervention and treatment in intrafamily sexual abuse cases; repealing ss. 39.311, 39.312, 39.313, 39.314, 39.315, 39.316, 39.317, and 39.318, F.S., relating to the Family Builders Program; repealing 39.816, F.S., relating to authorization for pilot and demonstration projects; repealing s. 39.817, F.S., relating to a foster care privatization demonstration project; repealing s. 383.0115, F.S., relating to the Commission on Marriage and Family Support Initiatives; repealing s. 393.22, F.S., relating to financial commitment to community services programs; repealing s. 393.503, F.S., relating to respite and family care subsidy expenditures and funding recommendations; repealing s. 394.922, F.S., relating to constitutional requirements regarding long-term control, care, and treatment of sexually violent predators; repealing s. 402.3045, F.S., relating to a requirement that the Department of Children and Family Services adopt distinguishable definitions of child care programs by rule; repealing s. 402.50, F.S., relating to the development of administrative infrastructure standards by the Department of Children and Family Services; repealing

s. 402.55, F.S., relating to the management fellows program; repealing s. 409.1672, F.S., relating to performance incentives for department employees with respect to the child welfare system; repealing s. 409.1673, F.S., relating to legislative findings regarding the foster care system and the development of alternate care plans; repealing s. 409.1685, F.S., relating to an annual report to the Legislature by the Department of Children and Family Services with respect to children in foster care; repealing ss. 409.801 and 409.802, F.S., relating to the Family Policy Act; repealing s. 409.803, F.S., relating to pilot programs to provide shelter and foster care services to dependent children; amending ss. 20.195, 39.00145, 39.0121, 39.301, 39.3031, 49.011, 381.006, 381.0072, 390.01114, 409.1685, 411.01013, 753.03, and 877.22, F.S.; conforming references to changes made by the act; providing an effective date.

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

Section 1. Sections 39.0015, 39.305, 39.311, 39.312, 39.313, 39.314, 39.315, 39.316, 39.317, 39.318, 39.816, 39.817, 383.0115, 393.22, 393.503, 394.922, 402.3045, 402.50, 402.55, 409.1672, 409.1673, 409.1685, 409.801, 409.802, and 409.803, Florida Statutes, are repealed.

Section 2. Paragraph (a) of subsection (4) of section 20.195, Florida Statutes, is amended to read:

20.195 Department of Children and Family Services; trust

funds.—The following trust funds shall be administered by the Department of Children and Family Services:

(4) Domestic Violence Trust Fund.

(a) Funds to be credited to and uses of the trust fund shall be administered in accordance with the provisions of s. 28.101, part XII ~~XIII~~ of chapter 39, and chapter 741.

Section 3. Subsection (1) of section 39.00145, Florida Statutes, is amended to read:

39.00145 Records concerning children.—

(1) The case record of every child under the supervision of or in the custody of the department, the department's authorized agents, or providers contracting with the department, including community-based care lead agencies and their subcontracted providers, must be maintained in a complete and accurate manner. The case record must contain, at a minimum, the child's case plan required under part VII ~~VIII~~ of this chapter and the full name and street address of all shelters, foster parents, group homes, treatment facilities, or locations where the child has been placed.

Section 4. Subsection (10) of section 39.0121, Florida Statutes, is amended to read:

39.0121 Specific rulemaking authority.—Pursuant to the requirements of s. 120.536, the department is specifically authorized to adopt, amend, and repeal administrative rules which implement or interpret law or policy, or describe the procedure and practice requirements necessary to implement this chapter, including, but not limited to, the following:

(10) The ~~Family Builders Program, the~~ Intensive Crisis

Counseling Program~~,~~ and any other early intervention programs and kinship care assistance programs.

Section 5. Paragraph (a) of subsection (15) of section 39.301, Florida Statutes, is amended to read:

39.301 Initiation of protective investigations.—

(15)(a) If the department or its agent determines that a child requires immediate or long-term protection through:

1. Medical or other health care; or

2. Homemaker care, day care, protective supervision, or other services to stabilize the home environment, including intensive family preservation services through ~~the Family Builders Program or~~ the Intensive Crisis Counseling Program, ~~or both,~~

such services shall first be offered for voluntary acceptance unless there are high-risk factors that may impact the ability of the parents or legal custodians to exercise judgment. Such factors may include the parents' or legal custodians' young age or history of substance abuse or domestic violence.

Section 6. Section 39.3031, Florida Statutes, is amended to read:

39.3031 Rules for implementation of s. ~~ss.~~ 39.303 ~~and 39.305~~.—The Department of Health, in consultation with the Department of Children and Family Services, shall adopt rules governing the child protection teams ~~and the sexual abuse treatment program~~ pursuant to s. ~~ss.~~ 39.303 ~~and 39.305~~, including definitions, organization, roles and responsibilities,

eligibility, services and their availability, qualifications of staff, and a waiver-request process.

Section 7. Subsection (13) of section 49.011, Florida Statutes, is amended to read:

49.011 Service of process by publication; cases in which allowed.—Service of process by publication may be made in any court on any party identified in s. 49.021 in any action or proceeding:

(13) For termination of parental rights pursuant to part VIII ~~IX~~ of chapter 39 or chapter 63.

Section 8. Subsection (18) of section 381.006, Florida Statutes, is amended to read:

381.006 Environmental health.—The department shall conduct an environmental health program as part of fulfilling the state's public health mission. The purpose of this program is to detect and prevent disease caused by natural and manmade factors in the environment. The environmental health program shall include, but not be limited to:

(18) A food service inspection function for domestic violence centers that are certified and monitored by the Department of Children and Family Services under part XII ~~XIII~~ of chapter 39 and group care homes as described in subsection (16), which shall be conducted annually and be limited to the requirements in department rule applicable to community-based residential facilities with five or fewer residents.

The department may adopt rules to carry out the provisions of this section.

Section 9. Paragraph (b) of subsection (1) of section 381.0072, Florida Statutes, is amended to read:

381.0072 Food service protection.—It shall be the duty of the Department of Health to adopt and enforce sanitation rules consistent with law to ensure the protection of the public from food-borne illness. These rules shall provide the standards and requirements for the storage, preparation, serving, or display of food in food service establishments as defined in this section and which are not permitted or licensed under chapter 500 or chapter 509.

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

(b) "Food service establishment" means detention facilities, public or private schools, migrant labor camps, assisted living facilities, adult family-care homes, adult day care centers, short-term residential treatment centers, residential treatment facilities, homes for special services, transitional living facilities, crisis stabilization units, hospices, prescribed pediatric extended care centers, intermediate care facilities for persons with developmental disabilities, boarding schools, civic or fraternal organizations, bars and lounges, vending machines that dispense potentially hazardous foods at facilities expressly named in this paragraph, and facilities used as temporary food events or mobile food units at any facility expressly named in this paragraph, where food is prepared and intended for individual portion service, including the site at which individual portions are provided, regardless of whether consumption is on or off the premises and regardless of whether there is a charge for the

food. The term does not include any entity not expressly named in this paragraph; nor does the term include a domestic violence center certified and monitored by the Department of Children and Family Services under part XII ~~XIII~~ of chapter 39 if the center does not prepare and serve food to its residents and does not advertise food or drink for public consumption.

Section 10. Paragraph (b) of subsection (2) of section 390.01114, Florida Statutes, is amended to read:

390.01114 Parental Notice of Abortion Act.—

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

(b) "Child abuse" means abandonment, abuse, harm, mental injury, neglect, physical injury, or sexual abuse of a child as those terms are defined in ss. 39.01, 827.04, and 984.03 ~~has the same meaning as s. 39.0015(3)~~.

Section 11. Section 409.1685, Florida Statutes, is amended to read:

409.1685 Children in foster care; annual report to Legislature.—The Department of Children and Family Services shall submit a written report to the Governor and the Legislature concerning the status of children in foster care and the judicial review mandated by part IX ~~X~~ of chapter 39. The report shall be submitted by May 1 of each year and must include the following information for the prior calendar year:

(1) The number of 6-month and annual judicial reviews completed during that period.

(2) The number of children in foster care returned to a parent, guardian, or relative as a result of a 6-month or annual judicial review hearing during that period.

(3) The number of termination of parental rights proceedings instituted during that period, including:

(a) The number of termination of parental rights proceedings initiated pursuant to former s. 39.703; and

(b) The total number of terminations of parental rights ordered.

(4) The number of foster care children placed for adoption.

Section 12. Paragraph (a) of subsection (3) of section 411.01013, Florida Statutes, is amended to read:

411.01013 Prevailing market rate schedule.—

(3) The prevailing market rate schedule, at a minimum, must:

(a) Differentiate rates by type, including, but not limited to, a child care provider that holds a Gold Seal Quality Care designation under s. 402.281, a child care facility licensed under s. 402.305, a public or nonpublic school exempt from licensure under s. 402.3025, a faith-based child care facility exempt from licensure under s. 402.316 that does not hold a Gold Seal Quality Care designation, a large family child care home licensed under s. 402.3131, or a family day care home licensed or registered under s. 402.313~~, or an after-school program that is not defined as child care under rules adopted pursuant to s. 402.3045~~.

Section 13. Paragraph (j) of subsection (2) of section 753.03, Florida Statutes, is redesignated as paragraph (i), and present paragraph (i) of that subsection is amended to read:

753.03 Standards for supervised visitation and supervised

exchange programs.—

(2) The clearinghouse shall use an advisory board to assist in developing the standards. The advisory board must include:

~~(i) A representative of the Commission on Marriage and Family Support Initiatives.~~

Section 14. Subsection (4) of section 877.22, Florida Statutes, is amended to read:

877.22 Minors prohibited in public places and establishments during certain hours; penalty; procedure.—

(4) If a minor violates a curfew and is taken into custody, the minor shall be transported immediately to a police station or to a facility operated by a religious, charitable, or civic organization that conducts a curfew program in cooperation with a local law enforcement agency. After recording pertinent information about the minor, the law enforcement agency shall attempt to contact the parent of the minor and, if successful, shall request that the parent take custody of the minor and shall release the minor to the parent. If the law enforcement agency is not able to contact the minor's parent within 2 hours after the minor is taken into custody, or if the parent refuses to take custody of the minor, the law enforcement agency may transport the minor to her or his residence or proceed as authorized under part IV ~~V~~ of chapter 39.

Section 15. This act shall take effect July 1, 2011.

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** HB 7183 PCB HSQS 11-02 Health and Human Services
**SPONSOR(S):** Health & Human Services Quality Subcommittee, Rooney, Jr.
**TIED BILLS:** **IDEN./SIM. BILLS:**

| REFERENCE | ACTION | ANALYST | STAFF DIRECTOR or BUDGET/POLICY CHIEF |
|---|---|---|---|
| Orig. Comm.: Health & Human Services Quality Subcommittee | 11 Y, 2 N | Guzzo | Calamas |
| 1) Health & Human Services Committee | | Guzzo | Gormley |

## SUMMARY ANALYSIS

The bill repeals ss. 408.18, 408.185, 402.164-167, and 408.036(3)(m)(3), F.S., which are either outdated, no longer effective, or no longer being implemented.

Section 408.18, F.S., the Health Care Antitrust Guidance Act, was created to provide instruction to the health care community to help resolve antitrust uncertainty that may deter health care business activities. This section authorizes the Office of the Attorney General (OAG) to issue antitrust no-action letters, which state the intention of the OAG not to take antitrust enforcement actions with respect to the requesting party. Since the statute was enacted in 1996, the OAG has only issued four no-action letters. Section 408.185, F.S., makes information held by the OAG submitted by a member of the health care community pursuant to a request for an antitrust no-action letter confidential and exempt from chapter 119, F.S., public records requirements.

Sections 402.164-167, F.S., relate to the Statewide Advocacy Council and the Florida local advocacy councils, which consist of citizen volunteers who monitor, investigate, and determine the presence of conditions or individuals that pose a threat to the rights, health, safety, or welfare of people who receive services from state agencies. Funding and positions for the Statewide Advocacy Council were eliminated in 2010.

Section 408.036(3)(m)(3), F.S., requires the Agency for Health Care Administration (AHCA) to provide an annual report to the Legislature listing the number of certificate of need exemption requests for open-heart services received during the calendar year. The Legislature can request this information from AHCA at any time.

The bill does not appear to have a fiscal impact.

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

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

*Current Situation*

Antitrust Issues

Sections 408.18, and 408.185, F.S., relate to the Health Care Community Antitrust Guidance Act and antitrust no-action letters. These sections were created in 1996 to provide instruction to the health care community, to help resolve the problem of antitrust uncertainty that may deter health care business activities that can improve the delivery of health care.

Antitrust no-action letters state the intention of the Office of the Attorney General (OAG) not to take antitrust enforcement actions with respect to the requesting party. In order to receive an antitrust no-action letter, a member of the health care community must submit a request in writing to the OAG. In addition to the request for the antitrust no-action letter, requesting parties must provide the OAG with any additional information or documents the OAG requests for its review. Section 408.185, F.S., makes information held by the OAG submitted by a member of the health care community pursuant to a request for an antitrust no-action letter confidential and exempt from chapter 119, F.S., public records requirements. The information submitted by a member of a health care community is held by the OAG and exempt from public records for one year.

Statewide Advocacy Council

Sections 402.164-167, F.S., relate to the Florida Statewide Advocacy Council (SAC) and the Florida local advocacy councils. In 2000 the Legislature created a system that includes the SAC and local advocacy councils to serve as a consumer protection mechanism without interference by an executive agency for people receiving services from four state agencies, the Agency for Health Care Administration (AHCA), the Agency for Persons with Disabilities, the Department of Children and Families, and the Department of Elder Affairs. The types of programs and facilities monitored and investigated by the volunteer network include group homes for people with developmental disabilities, adult day training programs, inpatient and outpatient mental health and substance abuse facilities, economic self-sufficiency offices, Baker Act facilities, child care facilities, and licensed foster homes.

The SAC is under the direction of the Executive Office of the Governor and has 15 volunteer members appointed by the Governor. The SAC's primary role is to oversee and supervise the operation of 25 local advocacy councils and serve as the appellate body for complaints that the local advocacy councils have not been able to resolve. Local advocacy councils are located throughout the state and organized into 15 service areas.

Statutes authorize the Governor to assign the SAC to any executive agency for administrative support services.[1] In fiscal year 2004-05, the Governor assigned this role to AHCA. The Legislature appropriated AHCA $555,437 in fiscal year 2009-10 from general revenue, including $349,566 for salaries and benefits and $137,450 for expenses, and five full time employees for SAC.[2] However, in 2010 all funding and positions were eliminated.

Certificate of Need Exemption Request Report

Section 408.036(3)(m)(3), F.S., requires AHCA to submit an annual report to the Legislature providing information concerning the number of certificate of need (CON) exemption requests for adult open-heart services it has received during the calendar year. CONs are written statements issued by AHCA

[1] S. 402.165, F.S.

[2] "Statewide Advocacy Council Activities Overlap with Other Entities, but Duplication is Minimal", Office of Program Policy Analysis and Government Accountability, Research Memorandum. October 13, 2009.

evidencing community need for new, converted, expanded or otherwise significantly modified health care facility, health service or hospice.[3] In 2004, the Legislature created an exemption from CON review for open-heart surgery services provided by hospitals meeting certain criteria.[4] Such hospitals are required to document or certify certain information to AHCA in their applications for exemption.

*Effects of the Bill*

The bill repeals s. 408.18, F.S., which created the Health Care Community Antitrust Guidance Act. Since the statute was enacted in 1996, the OAG has only issued four no-action letters.

The bill repeals s. 408.185, F.S., relating to a public records exemption for certain documents submitted for OAG review in regards to a request for a no-action letter. The repeal of this section will not result in these documents becoming available to the public. Section 119.15(7), F.S., provides that records made before the date of a repeal of an exemption may not be made public unless otherwise provided by law.

The bill repeals ss. 402.164-167, F.S., relating to the Statewide Advocacy Council and local advocacy councils. The SAC is currently defunct, as funding and positions were eliminated from the council in 2010.

Finally, the bill repeals s. 408.036 (3)(m)(3), F.S., relating to adult open-heart CON exemption reports submitted by AHCA. The Legislature can request this information from AHCA at any time.

B. SECTION DIRECTORY:

**Section 1:** Repeals ss. 408.18, 408.185, 402.164-167, and 408.036, F.S., relating to the Health Care Community Antitrust Guidance Act; Information submitted for review of antitrust issues; Legislative intent, definitions; Florida Statewide Advocacy Council; Florida local advocacy councils; Duties of state agencies that provide client services relating to the Florida Statewide Advocacy Council and the Florida local advocacy councils; and projects subject to review.

**Section 2.** Provides an effective date of July 1, 2011.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

[3] S. 408.032(3), F.S.
[4] S. 408.036(3)(m), Ch. 2004-383, Laws of Florida.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

A bill to be entitled

An act relating to health and human services; repealing s. 394.4595, F.S., relating to access to patients and their records by Florida statewide and local advocacy councils; repealing s. 402.164, F.S., relating to legislative intent and definitions applicable to advocacy councils; repealing s. 402.165, F.S., relating to the establishment of the Florida Statewide Advocacy Council; repealing s. 402.166, F.S., relating to the establishment of the Florida local advocacy councils; repealing s. 402.167, F.S., relating to the duties of state agencies that provide client services relating to the Florida Statewide Advocacy Council and the Florida local advocacy councils; amending s. 408.036, F.S.; eliminating an annual report submitted to the Legislature by the Agency for Health Care Administration; repealing s. 408.18, F.S., relating to the Health Care Community Antitrust Guidance Act; repealing s. 408.185, F.S., relating to confidentiality of information submitted for review of antitrust issues; amending ss. 39.001, 39.0011, 39.202, 39.302, 394.459, 394.4597, 394.4598, 394.4599, 394.4615, 400.0065, 400.141, 415.1034, 415.104, 415.1055, 415.106, 415.107, 429.19, 429.28, and 429.34, F.S.; conforming references; providing an effective date.

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

Section 1. Sections 394.4595, 402.164, 402.165, 402.166, 402.167, 408.18, and 408.185, Florida Statutes, are repealed.

Section 2. Paragraph (a) of subsection (8) of section 39.001, Florida Statutes, is amended to read:

39.001 Purposes and intent; personnel standards and screening.—

(8) PLAN FOR COMPREHENSIVE APPROACH.—

(a) The office shall develop a state plan for the promotion of adoption, support of adoptive families, and prevention of abuse, abandonment, and neglect of children and shall submit the state plan to the Speaker of the House of Representatives, the President of the Senate, and the Governor no later than December 31, 2008. The Department of Children and Family Services, the Department of Corrections, the Department of Education, the Department of Health, the Department of Juvenile Justice, the Department of Law Enforcement, the Agency for Persons with Disabilities, and the Agency for Workforce Innovation shall participate and fully cooperate in the development of the state plan at both the state and local levels. Furthermore, appropriate local agencies and organizations shall be provided an opportunity to participate in the development of the state plan at the local level. Appropriate local groups and organizations shall include, but not be limited to, community mental health centers; guardian ad litem programs for children under the circuit court; the school boards of the local school districts; ~~the Florida local advocacy councils;~~ community-based care lead agencies; private or public organizations or programs with recognized expertise in working with child abuse prevention programs for children and families; private or public organizations or programs with recognized

expertise in working with children who are sexually abused, physically abused, emotionally abused, abandoned, or neglected and with expertise in working with the families of such children; private or public programs or organizations with expertise in maternal and infant health care; multidisciplinary child protection teams; child day care centers; law enforcement agencies; and the circuit courts, when guardian ad litem programs are not available in the local area. The state plan to be provided to the Legislature and the Governor shall include, as a minimum, the information required of the various groups in paragraph (b).

Section 3. Subsection (2) of section 39.0011, Florida Statutes, is amended to read:

39.0011 Direct-support organization.—

(2) The number of members on the board of directors of the direct-support organization shall be determined by the Chief Child Advocate. Membership on the board of directors of the direct-support organization shall include, but not be limited to, a guardian ad litem; ~~a member of a local advocacy council;~~ a representative from a community-based care lead agency; a representative from a private or public organization or program with recognized expertise in working with child abuse prevention programs for children and families; a representative of a private or public organization or program with recognized expertise in working with children who are sexually abused, physically abused, emotionally abused, abandoned, or neglected and with expertise in working with the families of such children; an individual working at a state adoption agency; and

the parent of a child adopted from within the child welfare system.

Section 4. Paragraph (k) of subsection (2) of section 39.202, Florida Statutes, is amended to read:

39.202 Confidentiality of reports and records in cases of child abuse or neglect.—

(2) Except as provided in subsection (4), access to such records, excluding the name of the reporter which shall be released only as provided in subsection (5), shall be granted only to the following persons, officials, and agencies:

(k) ~~Any appropriate official of a Florida advocacy council investigating a report of known or suspected child abuse, abandonment, or neglect;~~ The Auditor General or the Office of Program Policy Analysis and Government Accountability for the purpose of conducting audits or examinations pursuant to law~~;~~ or the guardian ad litem for the child.

Section 5. Subsections (5) through (7) of section 39.302, Florida Statutes, are renumbered as subsections (4) through (6), respectively, and present subsection (4) of that section is amended to read:

39.302 Protective investigations of institutional child abuse, abandonment, or neglect.—

~~(4) The department shall notify the Florida local advocacy council in the appropriate district of the department as to every report of institutional child abuse, abandonment, or neglect in the district in which a client of the department is alleged or shown to have been abused, abandoned, or neglected, which notification shall be made within 48 hours after the~~

~~department commences its investigation.~~

Section 6. Paragraph (c) of subsection (5) and subsection (12) of section 394.459, Florida Statutes, are amended to read:

394.459 Rights of patients.—

(5) COMMUNICATION, ABUSE REPORTING, AND VISITS.—

(c) Each facility must permit immediate access to any patient, subject to the patient's right to deny or withdraw consent at any time, by the patient's family members, guardian, guardian advocate, representative, ~~Florida statewide or local advocacy council,~~ or attorney, unless such access would be detrimental to the patient. If a patient's right to communicate or to receive visitors is restricted by the facility, written notice of such restriction and the reasons for the restriction shall be served on the patient, the patient's attorney, and the patient's guardian, guardian advocate, or representative; and such restriction shall be recorded on the patient's clinical record with the reasons therefor. The restriction of a patient's right to communicate or to receive visitors shall be reviewed at least every 7 days. The right to communicate or receive visitors shall not be restricted as a means of punishment. Nothing in this paragraph shall be construed to limit the provisions of paragraph (d).

(12) POSTING OF NOTICE OF RIGHTS OF PATIENTS.—Each facility shall post a notice listing and describing, in the language and terminology that the persons to whom the notice is addressed can understand, the rights provided in this section. This notice shall include a statement that provisions of the federal Americans with Disabilities Act apply and the name and

telephone number of a person to contact for further information. This notice shall be posted in a place readily accessible to patients and in a format easily seen by patients. This notice shall include the telephone number ~~numbers~~ of the ~~Florida local advocacy council and~~ Advocacy Center for Persons with Disabilities, Inc.

Section 7. Paragraph (d) of subsection (2) of section 394.4597, Florida Statutes, is amended to read:

394.4597 Persons to be notified; patient's representative.—

(2) INVOLUNTARY PATIENTS.—

(d) When the receiving or treatment facility selects a representative, first preference shall be given to a health care surrogate, if one has been previously selected by the patient. If the patient has not previously selected a health care surrogate, the selection, except for good cause documented in the patient's clinical record, shall be made from the following list in the order of listing:

1. The patient's spouse.

2. An adult child of the patient.

3. A parent of the patient.

4. The adult next of kin of the patient.

5. An adult friend of the patient.

~~6. The appropriate Florida local advocacy council as provided in s. 402.166.~~

Section 8. Subsection (1) of section 394.4598, Florida Statutes, is amended to read:

394.4598 Guardian advocate.—

(1) The administrator may petition the court for the appointment of a guardian advocate based upon the opinion of a psychiatrist that the patient is incompetent to consent to treatment. If the court finds that a patient is incompetent to consent to treatment and has not been adjudicated incapacitated and a guardian with the authority to consent to mental health treatment appointed, it shall appoint a guardian advocate. The patient has the right to have an attorney represent him or her at the hearing. If the person is indigent, the court shall appoint the office of the public defender to represent him or her at the hearing. The patient has the right to testify, cross-examine witnesses, and present witnesses. The proceeding shall be recorded either electronically or stenographically, and testimony shall be provided under oath. One of the professionals authorized to give an opinion in support of a petition for involuntary placement, as described in s. 394.4655 or s. 394.467, must testify. A guardian advocate must meet the qualifications of a guardian contained in part IV of chapter 744, except that a professional referred to in this part, an employee of the facility providing direct services to the patient under this part, a departmental employee, or a facility administrator~~, or member of the Florida local advocacy council~~ shall not be appointed. A person who is appointed as a guardian advocate must agree to the appointment.

Section 9. Paragraph (b) of subsection (2) of section 394.4599, Florida Statutes, is amended to read:

394.4599 Notice.—

(2) INVOLUNTARY PATIENTS.—

(b) A receiving facility shall give prompt notice of the whereabouts of a patient who is being involuntarily held for examination, by telephone or in person within 24 hours after the patient's arrival at the facility, unless the patient requests that no notification be made. Contact attempts shall be documented in the patient's clinical record and shall begin as soon as reasonably possible after the patient's arrival. ~~Notice that a patient is being admitted as an involuntary patient shall be given to the Florida local advocacy council no later than the next working day after the patient is admitted.~~

Section 10. Subsection (5) of section 394.4615, Florida Statutes, is amended to read:

394.4615 Clinical records; confidentiality.—

(5) Information from clinical records may be used by the Agency for Health Care Administration and~~,~~ the department~~, and the Florida advocacy councils~~ for the purpose of monitoring facility activity and complaints concerning facilities.

Section 11. Paragraphs (h) and (i) of subsection (2) of section 400.0065, Florida Statutes, are redesignated as paragraphs (g) and (h), respectively, and present paragraph (g) of that subsection is amended to read:

400.0065 State Long-Term Care Ombudsman; duties and responsibilities.—

(2) The State Long-Term Care Ombudsman shall have the duty and authority to:

~~(g) Enter into a cooperative agreement with the Statewide Advocacy Council for the purpose of coordinating and avoiding duplication of advocacy services provided to residents.~~

Section 12. Paragraph (m) of subsection (1) of section 400.141, Florida Statutes, is amended to read:

400.141 Administration and management of nursing home facilities.—

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(m) Publicly display a poster provided by the agency containing the names, addresses, and telephone numbers for the state's abuse hotline, the State Long-Term Care Ombudsman, the Agency for Health Care Administration consumer hotline, the Advocacy Center for Persons with Disabilities, ~~the Florida Statewide Advocacy Council,~~ and the Medicaid Fraud Control Unit, with a clear description of the assistance to be expected from each.

Section 13. Paragraph (m) of subsection (3) of section 408.036, Florida Statutes, is amended to read:

408.036 Projects subject to review; exemptions.—

(3) EXEMPTIONS.—Upon request, the following projects are subject to exemption from the provisions of subsection (1):

(m)1. For the provision of adult open-heart services in a hospital located within the boundaries of a health service planning district, as defined in s. 408.032(5), which has experienced an annual net out-migration of at least 600 open-heart-surgery cases for 3 consecutive years according to the most recent data reported to the agency, and the district's population per licensed and operational open-heart programs exceeds the state average of population per licensed and operational open-heart programs by at least 25 percent. All

hospitals within a health service planning district which meet the criteria reference in sub-subparagraphs 2.a.-h. shall be eligible for this exemption on July 1, 2004, and shall receive the exemption upon filing for it and subject to the following:

a. A hospital that has received a notice of intent to grant a certificate of need or a final order of the agency granting a certificate of need for the establishment of an open-heart-surgery program is entitled to receive a letter of exemption for the establishment of an adult open-heart-surgery program upon filing a request for exemption and complying with the criteria enumerated in sub-subparagraphs 2.a.-h., and is entitled to immediately commence operation of the program.

b. An otherwise eligible hospital that has not received a notice of intent to grant a certificate of need or a final order of the agency granting a certificate of need for the establishment of an open-heart-surgery program is entitled to immediately receive a letter of exemption for the establishment of an adult open-heart-surgery program upon filing a request for exemption and complying with the criteria enumerated in sub-subparagraphs 2.a.-h., but is not entitled to commence operation of its program until December 31, 2006.

2. A hospital shall be exempt from the certificate-of-need review for the establishment of an open-heart-surgery program when the application for exemption submitted under this paragraph complies with the following criteria:

a. The applicant must certify that it will meet and continuously maintain the minimum licensure requirements adopted by the agency governing adult open-heart programs, including the

most current guidelines of the American College of Cardiology and American Heart Association Guidelines for Adult Open Heart Programs.

b. The applicant must certify that it will maintain sufficient appropriate equipment and health personnel to ensure quality and safety.

c. The applicant must certify that it will maintain appropriate times of operation and protocols to ensure availability and appropriate referrals in the event of emergencies.

d. The applicant can demonstrate that it has discharged at least 300 inpatients with a principal diagnosis of ischemic heart disease for the most recent 12-month period as reported to the agency.

e. The applicant is a general acute care hospital that is in operation for 3 years or more.

f. The applicant is performing more than 300 diagnostic cardiac catheterization procedures per year, combined inpatient and outpatient.

g. The applicant's payor mix at a minimum reflects the community average for Medicaid, charity care, and self-pay patients or the applicant must certify that it will provide a minimum of 5 percent of Medicaid, charity care, and self-pay to open-heart-surgery patients.

h. If the applicant fails to meet the established criteria for open-heart programs or fails to reach 300 surgeries per year by the end of its third year of operation, it must show cause why its exemption should not be revoked.

~~3. By December 31, 2004, and annually thereafter, the agency shall submit a report to the Legislature providing information concerning the number of requests for exemption it has received under this paragraph during the calendar year and the number of exemptions it has granted or denied during the calendar year.~~

Section 14. Paragraph (a) of subsection (1) of section 415.1034, Florida Statutes, is amended to read:

415.1034 Mandatory reporting of abuse, neglect, or exploitation of vulnerable adults; mandatory reports of death.—

(1) MANDATORY REPORTING.—

(a) Any person, including, but not limited to, any:

1. Physician, osteopathic physician, medical examiner, chiropractic physician, nurse, paramedic, emergency medical technician, or hospital personnel engaged in the admission, examination, care, or treatment of vulnerable adults;

2. Health professional or mental health professional other than one listed in subparagraph 1.;

3. Practitioner who relies solely on spiritual means for healing;

4. Nursing home staff; assisted living facility staff; adult day care center staff; adult family-care home staff; social worker; or other professional adult care, residential, or institutional staff;

5. State, county, or municipal criminal justice employee or law enforcement officer;

6. An employee of the Department of Business and Professional Regulation conducting inspections of public lodging

establishments under s. 509.032; or

~~7. Florida advocacy council member or long-term care ombudsman council member; or~~

7.~~8.~~ Bank, savings and loan, or credit union officer, trustee, or employee,

who knows, or has reasonable cause to suspect, that a vulnerable adult has been or is being abused, neglected, or exploited shall immediately report such knowledge or suspicion to the central abuse hotline.

Section 15. Subsection (1) of section 415.104, Florida Statutes, is amended to read:

415.104 Protective investigations of cases of abuse, neglect, or exploitation of vulnerable adults; transmittal of records to state attorney.—

(1) The department shall, upon receipt of a report alleging abuse, neglect, or exploitation of a vulnerable adult, begin within 24 hours a protective investigation of the facts alleged therein. If a caregiver refuses to allow the department to begin a protective investigation or interferes with the conduct of such an investigation, the appropriate law enforcement agency shall be contacted for assistance. If, during the course of the investigation, the department has reason to believe that the abuse, neglect, or exploitation is perpetrated by a second party, the appropriate law enforcement agency and state attorney shall be orally notified. The department and the law enforcement agency shall cooperate to allow the criminal investigation to proceed concurrently with, and not be hindered

by, the protective investigation. The department shall make a preliminary written report to the law enforcement agencies within 5 working days after the oral report. The department shall, within 24 hours after receipt of the report, notify the ~~appropriate Florida local advocacy council, or~~ long-term care ombudsman council~~, when appropriate,~~ that an alleged abuse, neglect, or exploitation perpetrated by a second party has occurred. Notice to the ~~Florida local advocacy council or~~ long-term care ombudsman council may be accomplished orally or in writing and shall include the name and location of the vulnerable adult alleged to have been abused, neglected, or exploited and the nature of the report.

Section 16. Subsection (8) of section 415.1055, Florida Statutes, is amended to read:

415.1055 Notification to administrative entities.—

(8) At the conclusion of a protective investigation at a facility, the department shall notify ~~either~~ the ~~Florida local advocacy council or~~ long-term care ombudsman council of the results of the investigation. This notification must be in writing.

Section 17. Subsection (2) of section 415.106, Florida Statutes, is amended to read:

415.106 Cooperation by the department and criminal justice and other agencies.—

(2) To ensure coordination, communication, and cooperation with the investigation of abuse, neglect, or exploitation of vulnerable adults, the department shall develop and maintain interprogram agreements or operational procedures among

appropriate departmental programs and the State Long-Term Care Ombudsman Council~~, the Florida Statewide Advocacy Council,~~ and other agencies that provide services to vulnerable adults. These agreements or procedures must cover such subjects as the appropriate roles and responsibilities of the department in identifying and responding to reports of abuse, neglect, or exploitation of vulnerable adults; the provision of services; and related coordinated activities.

Section 18. Paragraph (g) of subsection (3) of section 415.107, Florida Statutes, is amended to read:

415.107 Confidentiality of reports and records.—

(3) Access to all records, excluding the name of the reporter which shall be released only as provided in subsection (6), shall be granted only to the following persons, officials, and agencies:

(g) Any appropriate official of the ~~Florida advocacy council or~~ long-term care ombudsman council investigating a report of known or suspected abuse, neglect, or exploitation of a vulnerable adult.

Section 19. Subsection (9) of section 429.19, Florida Statutes, is amended to read:

429.19 Violations; imposition of administrative fines; grounds.—

(9) The agency shall develop and disseminate an annual list of all facilities sanctioned or fined for violations of state standards, the number and class of violations involved, the penalties imposed, and the current status of cases. The list shall be disseminated, at no charge, to the Department of

Elderly Affairs, the Department of Health, the Department of Children and Family Services, the Agency for Persons with Disabilities, the area agencies on aging, ~~the Florida Statewide Advocacy Council,~~ and the state and local ombudsman councils. The Department of Children and Family Services shall disseminate the list to service providers under contract to the department who are responsible for referring persons to a facility for residency. The agency may charge a fee commensurate with the cost of printing and postage to other interested parties requesting a copy of this list. This information may be provided electronically or through the agency's Internet site.

Section 20. Subsection (2) of section 429.28, Florida Statutes, is amended to read:

429.28 Resident bill of rights.—

(2) The administrator of a facility shall ensure that a written notice of the rights, obligations, and prohibitions set forth in this part is posted in a prominent place in each facility and read or explained to residents who cannot read. This notice shall include the name, address, and telephone numbers of the local ombudsman council and central abuse hotline and, when applicable, the Advocacy Center for Persons with Disabilities, Inc., ~~and the Florida local advocacy council,~~ where complaints may be lodged. The facility must ensure a resident's access to a telephone to call the local ombudsman council, central abuse hotline, and Advocacy Center for Persons with Disabilities, Inc.~~, and the Florida local advocacy council.~~

Section 21. Section 429.34, Florida Statutes, is amended to read:

429.34 Right of entry and inspection.—In addition to the requirements of s. 408.811, any duly designated officer or employee of the department, the Department of Children and Family Services, the Medicaid Fraud Control Unit of the Office of the Attorney General, the state or local fire marshal, or a member of the state or local long-term care ombudsman council shall have the right to enter unannounced upon and into the premises of any facility licensed pursuant to this part in order to determine the state of compliance with the provisions of this part, part II of chapter 408, and applicable rules. Data collected by the state or local long-term care ombudsman councils ~~or the state or local advocacy councils~~ may be used by the agency in investigations involving violations of regulatory standards.

Section 22. This act shall take effect July 1, 2011.

A bill to be entitled

An act relating to health care coverage; repealing s. 408.50, F.S., relating to prospective payment arrangements between hospitals and health insurers; repealing s. 408.70, F.S., relating to managed competition in the state health care markets; repealing s. 408.9091, F.S., relating to the Cover Florida Health Care Access Program; amending s. 627.6699, F.S., relating to the Employee Health Care Access Act; repealing s. 1004.29, F.S., relating to the university health services support organizations; repealing s. 1004.30, F.S., relating to confidential and exempt records and information maintained by university health services support organizations; amending ss. 112.363, 408.07, 627.6475, 945.603, and 1001.76, F.S.; conforming references to changes made by the act; providing an effective date.

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

Section 1. Sections 408.50, 408.70, 408.9091, 1004.29 and 1004.30, Florida Statutes, are repealed.

Section 2. Subsections (2), (5), and (7) of section 627.6475, Florida Statutes, are amended to read:

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

(a) ~~"Board," "carrier,"~~ "Carrier" and "health benefit plan" have the same meaning ascribed in s. 627.6699(3).

(b) "Health insurance issuer," "issuer," and "individual health insurance" have the same meaning ascribed in s. 627.6487(2).

~~(c) "Reinsuring carrier" means a health insurance issuer that elects to comply with the requirements set forth in subsection (7).~~

(d) "Risk-assuming carrier" means a health insurance issuer that elects to comply with the requirements set forth in subsection (6).

(e) "Eligible individual" has the same meaning ascribed in s. 627.6487(3).

(5) ISSUER'S ELECTION TO BECOME A RISK-ASSUMING CARRIER.—

(a) Each health insurance issuer that offers individual health insurance must elect to become a risk-assuming carrier ~~or a reinsuring carrier~~ for purposes of this section. Each such issuer must make an initial election, binding through December 31, 1999. The issuer's initial election must be made no later than October 31, 1997. By October 31, 1997, all issuers must file a final election, which is binding for 2 years, from January 1, 1998, through December 31, 1999, after which an election shall be binding for a period of 5 years. The office may permit an issuer to modify its election at any time for good cause shown, after a hearing.

~~(b) The office shall establish an application process for issuers seeking to change their status under this subsection.~~

(b) ~~(c)~~ An election to become a risk-assuming carrier is subject to approval under this subsection.

~~(d) An issuer that elects to cease participating as a reinsuring carrier and to become a risk-assuming carrier may not reinsure or continue to reinsure any individual health benefits plan under subsection (7) once the issuer becomes a risk-assuming carrier, and the issuer must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured. An issuer that elects to cease participating as a risk-assuming carrier and to become a reinsuring carrier may reinsure individual health insurance under the terms set forth in subsection (7) and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.~~

(7) INDIVIDUAL HEALTH REINSURANCE PROGRAM.—

~~(a) The individual health reinsurance program shall operate subject to the supervision and control of the board of the small employer health reinsurance program established pursuant to s. 627.6699(11). The board shall establish a separate, segregated account for eligible individuals reinsured pursuant to this section, which account may not be commingled with the small employer health reinsurance account.~~

~~(b) A reinsuring carrier may reinsure with the program coverage of an eligible individual, subject to each of the following provisions:~~

~~1. A reinsuring carrier may reinsure an eligible individual within 60 days after commencement of the coverage of the eligible individual.~~

~~2. The program may not reimburse a participating carrier with respect to the claims of a reinsured eligible individual until the carrier has paid incurred claims of at least $5,000 in a calendar year for benefits covered by the program. In addition, the reinsuring carrier is responsible for 10 percent of the next $50,000 and 5 percent of the next $100,000 of incurred claims during a calendar year, and the program shall reinsure the remainder.~~

~~3. The board shall annually adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment may not be less than the annual change in the medical component of the "Commerce Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the United States Department of Labor, unless the board proposes and the office approves a lower adjustment factor.~~

~~4. A reinsuring carrier may terminate reinsurance for all reinsured eligible individuals on any plan anniversary.~~

~~5. The premium rate charged for reinsurance by the program to a health maintenance organization that is approved by the Secretary of Health and Human Services as a federally qualified health maintenance organization pursuant to 42 U.S.C. s. 300e(c)(2)(A) and that, as such, is subject to requirements that limit the amount of risk that may be ceded to the program, which requirements are more restrictive than subparagraph 2., shall be reduced by an amount equal to that portion of the risk, if any,~~

~~which exceeds the amount set forth in subparagraph 2., which may not be ceded to the program.~~

~~6. The board may consider adjustments to the premium rates charged for reinsurance by the program or carriers that use effective cost-containment measures, including high-cost case management, as defined by the board.~~

~~7. A reinsuring carrier shall apply its case management and claims handling techniques, including, but not limited to, utilization review, individual case management, preferred provider provisions, other managed care provisions, or methods of operation consistently with both reinsured business and nonreinsured business.~~

~~(c)1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring eligible individuals pursuant to this section. The methodology must include a system for classifying individuals which reflects the types of case characteristics commonly used by carriers in this state. The methodology must provide for the development of basic reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the office, and shall be set at levels that reasonably approximate gross premiums charged to eligible individuals for individual health insurance by health insurance issuers. The premium rates set by the board may vary by geographical area, as determined under this section, to reflect differences in cost. An eligible~~

~~individual may be reinsured for a rate that is five times the rate established by the board.~~

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

~~(d) If individual health insurance for an eligible individual is entirely or partially reinsured with the program pursuant to this section, the premium charged to the eligible individual for any rating period for the coverage issued must be the same premium that would have been charged to that individual if the health insurance issuer elected not to reinsure coverage for that individual.~~

~~(e)1. Before March 1 of each calendar year, the board shall determine and report to the office the program net loss in the individual account for the previous year, including administrative expenses for that year and the incurred losses for that year, taking into account investment income and other appropriate gains and losses.~~

~~2. Any net loss in the individual account for the year shall be recouped by assessing the carriers as follows:~~

~~a. The operating losses of the program shall be assessed in the following order subject to the specified limitations. The first tier of assessments shall be made against reinsuring carriers in an amount that may not exceed 5 percent of each reinsuring carrier's premiums for individual health insurance. If such assessments have been collected and additional moneys are~~

~~needed, the board shall make a second tier of assessments in an amount that may not exceed 0.5 percent of each carrier's health benefit plan premiums.~~

~~b. Except as provided in paragraph (f), risk-assuming carriers are exempt from all assessments authorized pursuant to this section. The amount paid by a reinsuring carrier for the first tier of assessments shall be credited against any additional assessments made.~~

~~c. The board shall equitably assess reinsuring carriers for operating losses of the individual account based on market share. The board shall annually assess each carrier a portion of the operating losses of the individual account. The first tier of assessments shall be determined by multiplying the operating losses by a fraction, the numerator of which equals the reinsuring carrier's earned premium pertaining to direct writings of individual health insurance in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of all such premiums earned by reinsuring carriers in the state during that calendar year. The second tier of assessments shall be based on the premiums that all carriers, except risk assuming carriers, earned on all health benefit plans written in this state. The board may levy interim assessments against reinsuring carriers to ensure the financial ability of the plan to cover claims expenses and administrative expenses paid or estimated to be paid in the operation of the plan for the calendar year prior to the association's anticipated receipt of annual assessments for that calendar year. Any interim assessment is due and payable~~

~~within 30 days after receipt by a carrier of the interim assessment notice. Interim assessment payments shall be credited against the carrier's annual assessment. Health benefit plan premiums and benefits paid by a carrier that are less than an amount determined by the board to justify the cost of collection may not be considered for purposes of determining assessments.~~

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

~~3. Before March 1 of each year, the board shall determine and file with the office an estimate of the assessments needed to fund the losses incurred by the program in the individual account for the previous calendar year.~~

~~4. If the board determines that the assessments needed to fund the losses incurred by the program in the individual account for the previous calendar year will exceed the amount specified in subparagraph 2., the board shall evaluate the operation of the program and report its findings and recommendations to the office in the format established in s. 627.6699(11) for the comparable report for the small employer reinsurance program.~~

~~(f) Notwithstanding paragraph (e), the administrative expenses of the program shall be recouped by assessing risk-assuming carriers and reinsuring carriers, and such amounts may not be considered part of the operating losses of the plan for~~

~~the purposes of this paragraph. Each carrier's portion of such administrative expenses shall be determined by multiplying the total of such administrative expenses by a fraction, the numerator of which equals the carrier's earned premium pertaining to direct writing of individual health benefit plans in the state during the calendar year for which the assessment is levied, and the denominator of which equals the total of such premiums earned by all carriers in the state during such calendar year.~~

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

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

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

~~3. Interest for late payment of assessments.~~

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

~~5. Limited immunity from legal actions or carriers.~~

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

~~7. Monitoring compliance by carriers with this section.~~

Section 3. Section 627.6699, Florida Statutes, is amended to read:

627.6699 Employee Health Care Access Act.-

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

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

(a) "Actuarial certification" means a written statement, by a member of the American Academy of Actuaries or another person acceptable to the office, that a small employer carrier is in compliance with subsection (6), based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the carrier in establishing premium rates for applicable health benefit plans.

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

~~(c) "Board" means the board of directors of the program.~~

(c) ~~(d)~~ "Carrier" means a person who provides health benefit plans in this state, including an authorized insurer, a health maintenance organization, a multiple-employer welfare arrangement, or any other person providing a health benefit plan that is subject to insurance regulation in this state. However, the term does not include a multiple-employer welfare arrangement, which multiple-employer welfare arrangement operates solely for the benefit of the members or the members and the employees of such members, and was in existence on January 1, 1992.

(d) ~~(e)~~ "Case management program" means the specific supervision and management of the medical care provided or prescribed for a specific individual, which may include the use of health care providers designated by the carrier.

(e) ~~(f)~~ "Creditable coverage" has the same meaning ascribed in s. 627.6561.

(f) ~~(g)~~ "Dependent" means the spouse or child of an eligible employee, subject to the applicable terms of the health benefit plan covering that employee.

(g) ~~(h)~~ "Eligible employee" means an employee who works full time, having a normal workweek of 25 or more hours, and who has met any applicable waiting-period requirements or other requirements of this act. The term includes a self-employed individual, a sole proprietor, a partner of a partnership, or an independent contractor, if the sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include a part-time, temporary, or substitute employee.

(h) ~~(i)~~ "Established geographic area" means the county or counties, or any portion of a county or counties, within which the carrier provides or arranges for health care services to be available to its insureds, members, or subscribers.

(i) ~~(j)~~ "Guaranteed-issue basis" means an insurance policy that must be offered to an employer, employee, or dependent of the employee, regardless of health status, preexisting conditions, or claims history.

(j) ~~(k)~~ "Health benefit plan" means any hospital or medical policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. The term does not include accident-only, specified disease, individual hospital indemnity, credit, dental-only, vision-only, Medicare supplement, long-term care, or disability income insurance; similar supplemental plans provided under a separate policy, certificate, or contract of insurance, which cannot duplicate coverage under an underlying health plan and are specifically designed to fill gaps in the underlying health plan, coinsurance, or deductibles; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

(k) ~~(l)~~ "Late enrollee" means an eligible employee or dependent as defined under s. 627.6561(1)(b).

(l) ~~(m)~~ "Limited benefit policy or contract" means a policy or contract that provides coverage for each person insured under the policy for a specifically named disease or diseases, a specifically named accident, or a specifically named limited

market that fulfills an experimental or reasonable need, such as the small group market.

(m) ~~(n)~~ "Modified community rating" means a method used to develop carrier premiums which spreads financial risk across a large population; allows the use of separate rating factors for age, gender, family composition, tobacco usage, and geographic area as determined under paragraph (5)(j); and allows adjustments for: claims experience, health status, or duration of coverage as 2permitted under subparagraph (6)(b)5.; and administrative and acquisition expenses as 2permitted under subparagraph (6)(b)5.

(n) ~~(o)~~ "Participating carrier" means any carrier that issues health benefit plans in this state except a small employer carrier that elects to be a risk-assuming carrier.

~~(p) "Plan of operation" means the plan of operation of the program, including articles, bylaws, and operating rules, adopted by the board under subsection (11).~~

~~(q) "Program" means the Florida Small Employer Carrier Reinsurance Program created under subsection (11).~~

(o) ~~(r)~~ "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

~~(s) "Reinsuring carrier" means a small employer carrier that elects to comply with the requirements set forth in subsection (11).~~

(p) ~~(t)~~ "Risk-assuming carrier" means a small employer carrier that elects to comply with the requirements set forth in subsection (10).

(q) ~~(u)~~ "Self-employed individual" means an individual or sole proprietor who derives his or her income from a trade or business carried on by the individual or sole proprietor which results in taxable income as indicated on IRS Form 1040, schedule C or F, and which generated taxable income in one of the 2 previous years.

(r) ~~(v)~~ "Small employer" means, in connection with a health benefit plan with respect to a calendar year and a plan year, any person, sole proprietor, self-employed individual, independent contractor, firm, corporation, partnership, or association that is actively engaged in business, has its principal place of business in this state, employed an average of at least 1 but not more than 50 eligible employees on business days during the preceding calendar year the majority of whom were employed in this state, employs at least 1 employee on the first day of the plan year, and is not formed primarily for purposes of purchasing insurance. In determining the number of eligible employees, companies that are an affiliated group as defined in s. 1504(a) of the Internal Revenue Code of 1986, as amended, are considered a single employer. For purposes of this section, a sole proprietor, an independent contractor, or a self-employed individual is considered a small employer only if all of the conditions and criteria established in this section are met.

(s) ~~(w)~~ "Small employer carrier" means a carrier that offers health benefit plans covering eligible employees of one or more small employers.

~~(9) SMALL EMPLOYER CARRIER'S ELECTION TO BECOME A RISK-ASSUMING CARRIER OR A REINSURING CARRIER.—~~

~~(a) A small employer carrier must elect to become either a risk assuming carrier or a reinsuring carrier. By October 31, 1993, all small employer carriers must file a final election, which is binding for 2 years, from January 1, 1994, through December 31, 1995, after which an election shall be binding for a period of 5 years. Any carrier that is not a small employer carrier and intends to become a small employer carrier must file its designation when it files the forms and rates it intends to use for small employer group health insurance; such designation shall be binding for 2 years after the date of approval of the forms and rates, and any subsequent designation is binding for 5 years. The office may permit a carrier to modify its election at any time for good cause shown, after a hearing.~~

~~(b) The commission shall establish an application process for small employer carriers seeking to change their status under this subsection.~~

~~(c) An election to become a risk assuming carrier is subject to approval under subsection (10).~~

~~(d) A small employer carrier that elects to cease participating as a reinsuring carrier and to become a risk-assuming carrier is prohibited from reinsuring or continuing to reinsure any small employer health benefits plan under subsection (11) as soon as the carrier becomes a risk assuming carrier and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured. A small employer carrier that elects~~

~~to cease participating as a risk-assuming carrier and to become a reinsuring carrier is permitted to reinsure small employer health benefit plans under the terms set forth in subsection (11) and must pay a prorated assessment based upon business issued as a reinsuring carrier for any portion of the year that the business was reinsured.~~

(9) ~~(10)~~ ELECTION PROCESS TO BECOME A RISK-ASSUMING CARRIER.—

(a)1. A small employer carrier may become a risk-assuming carrier by filing with the office a designation of election under subsection (9) in a format and manner prescribed by the commission. The office shall approve the election of a small employer carrier to become a risk-assuming carrier if the office finds that the carrier is capable of assuming that status pursuant to the criteria set forth in paragraph (b).

2. The office must approve or disapprove any designation as a risk-assuming carrier within 60 days after filing.

(b) In determining whether to approve an application by a small employer carrier to become a risk-assuming carrier, the office shall consider:

1. The carrier's financial ability to support the assumption of the risk of small employer groups.

2. The carrier's history of rating and underwriting small employer groups.

3. The carrier's commitment to market fairly to all small employers in the state or its service area, as applicable.

~~4. The carrier's ability to assume and manage the risk of enrolling small employer groups without the protection of the reinsurance program provided in subsection (11).~~

~~(c) A small employer carrier that becomes a risk assuming carrier pursuant to this subsection is not subject to the assessment provisions of subsection (11).~~

~~(d) The office shall provide public notice of a small employer carrier's designation of election under subsection (9) to become a risk assuming carrier and shall provide at least a 21-day period for public comment prior to making a decision on the election. The office shall hold a hearing on the election at the request of the carrier.~~

(c) ~~(e)~~ The office may rescind the approval granted to a risk-assuming carrier under this subsection if the office finds that the carrier no longer meets the criteria of paragraph (b).

~~(11) SMALL EMPLOYER HEALTH REINSURANCE PROGRAM.~~

~~(a) There is created a nonprofit entity to be known as the "Florida Small Employer Health Reinsurance Program."~~

~~(b)1. The program shall operate subject to the supervision and control of the board.~~

~~2. Effective upon this act becoming a law, the board shall consist of the director of the office or his or her designee, who shall serve as the chairperson, and 13 additional members who are representatives of carriers and insurance agents and are appointed by the director of the office and serve as follows:~~

~~a. Five members shall be representatives of health insurers licensed under chapter 624 or chapter 641. Two members~~

~~shall be agents who are actively engaged in the sale of health insurance. Four members shall be employers or representatives of employers. One member shall be a person covered under an individual health insurance policy issued by a licensed insurer in this state. One member shall represent the Agency for Health Care Administration and shall be recommended by the Secretary of Health Care Administration.~~

~~b. A member appointed under this subparagraph shall serve a term of 4 years and shall continue in office until the member's successor takes office, except that, in order to provide for staggered terms, the director of the office shall designate two of the initial appointees under this subparagraph to serve terms of 2 years and shall designate three of the initial appointees under this subparagraph to serve terms of 3 years.~~

~~3. The director of the office may remove a member for cause.~~

~~4. Vacancies on the board shall be filled in the same manner as the original appointment for the unexpired portion of the term.~~

~~(c)1. The board shall submit to the office a plan of operation to assure the fair, reasonable, and equitable administration of the program. The board may at any time submit to the office any amendments to the plan that the board finds to be necessary or suitable.~~

~~2. The office shall, after notice and hearing, approve the plan of operation if it determines that the plan submitted by the board is suitable to assure the fair,~~

~~reasonable, and equitable administration of the program and provides for the sharing of program gains and losses equitably and proportionately in accordance with paragraph (j).~~

~~3. The plan of operation, or any amendment thereto, becomes effective upon written approval of the office.~~

~~(d) The plan of operation must, among other things:~~

~~1. Establish procedures for handling and accounting for program assets and moneys and for an annual fiscal reporting to the office.~~

~~2. Establish procedures for selecting an administering carrier and set forth the powers and duties of the administering carrier.~~

~~3. Establish procedures for reinsuring risks.~~

~~4. Establish procedures for collecting assessments from participating carriers to provide for claims reinsured by the program and for administrative expenses, other than amounts payable to the administrative carrier, incurred or estimated to be incurred during the period for which the assessment is made.~~

~~5. Provide for any additional matters at the discretion of the board.~~

~~(e) The board shall recommend to the office market conduct requirements and other requirements for carriers and agents, including requirements relating to:~~

~~1. Registration by each carrier with the office of its intention to be a small employer carrier under this section;~~

~~2. Publication by the office of a list of all small employer carriers, including a requirement applicable to agents~~

~~and carriers that a health benefit plan may not be sold by a carrier that is not identified as a small employer carrier;~~

~~3. The availability of a broadly publicized, toll-free telephone number for access by small employers to information concerning this section;~~

~~4. Periodic reports by carriers and agents concerning health benefit plans issued; and~~

~~5. Methods concerning periodic demonstration by small employer carriers and agents that they are marketing or issuing health benefit plans to small employers.~~

~~(f) The program has the general powers and authority granted under the laws of this state to insurance companies and health maintenance organizations licensed to transact business, except the power to issue health benefit plans directly to groups or individuals. In addition thereto, the program has specific authority to:~~

~~1. Enter into contracts as necessary or proper to carry out the provisions and purposes of this act, including the authority to enter into contracts with similar programs of other states for the joint performance of common functions or with persons or other organizations for the performance of administrative functions.~~

~~2. Sue or be sued, including taking any legal action necessary or proper for recovering any assessments and penalties for, on behalf of, or against the program or any carrier.~~

~~3. Take any legal action necessary to avoid the payment of improper claims against the program.~~

~~4. Issue reinsurance policies, in accordance with the requirements of this act.~~

~~5. Establish rules, conditions, and procedures for reinsurance risks under the program participation.~~

~~6. Establish actuarial functions as appropriate for the operation of the program.~~

~~7. Assess participating carriers in accordance with paragraph (j), and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses. Interim assessments shall be credited as offsets against any regular assessments due following the close of the calendar year.~~

~~8. Appoint appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the program, and in any other function within the authority of the program.~~

~~9. Borrow money to effect the purposes of the program. Any notes or other evidences of indebtedness of the program which are not in default constitute legal investments for carriers and may be carried as admitted assets.~~

~~10. To the extent necessary, increase the $5,000 deductible reinsurance requirement to adjust for the effects of inflation.~~

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

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

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

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

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

~~5. The board annually shall adjust the initial level of claims and the maximum limit to be retained by the carrier to reflect increases in costs and utilization within the standard market for health benefit plans within the state. The adjustment~~

~~shall not be less than the annual change in the medical component of the "Consumer Price Index for All Urban Consumers" of the Bureau of Labor Statistics of the Department of Labor, unless the board proposes and the office approves a lower adjustment factor.~~

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

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

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

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

~~(h)1. The board, as part of the plan of operation, shall establish a methodology for determining premium rates to be charged by the program for reinsuring small employers and individuals pursuant to this section. The methodology shall include a system for classification of small employers that reflects the types of case characteristics commonly used by small employer carriers in the state. The methodology shall provide for the development of basic reinsurance premium rates, which shall be multiplied by the factors set for them in this paragraph to determine the premium rates for the program. The basic reinsurance premium rates shall be established by the board, subject to the approval of the office, and shall be set at levels which reasonably approximate gross premiums charged to small employers by small employer carriers for health benefit plans with benefits similar to the standard and basic health benefit plan. The premium rates set by the board may vary by geographical area, as determined under this section, to reflect differences in cost. The multiplying factors must be established as follows:~~

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

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

~~2. The board periodically shall review the methodology established, including the system of classification and any rating factors, to assure that it reasonably reflects the claims experience of the program. The board may propose~~

~~changes to the rates which shall be subject to the approval of the office.~~

~~(i) If a health benefit plan for a small employer issued in accordance with this subsection is entirely or partially reinsured with the program, the premium charged to the small employer for any rating period for the coverage issued must be consistent with the requirements relating to premium rates set forth in this section.~~

~~(j)1. Before July 1 of each calendar year, the board shall determine and report to the office the program net loss for the previous year, including administrative expenses for that year, and the incurred losses for the year, taking into account investment income and other appropriate gains and losses.~~

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

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

~~first tier of assessments shall be credited against any additional assessments made.~~

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

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

~~3. Before July 1 of each year, the board shall determine and file with the office an estimate of the assessments needed to fund the losses incurred by the program in the previous calendar year.~~

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

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

~~6. Each carrier's proportion of the assessment shall be determined annually by the board, based on annual statements and other reports considered necessary by the board and filed by the carriers with the board.~~

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

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

~~(k) Neither the participation in the program as reinsuring carriers, the establishment of rates, forms, or~~

~~procedures, nor any other joint or collective action required by this act, may be the basis of any legal action, criminal or civil liability, or penalty against the program or any of its carriers either jointly or separately.~~

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

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

~~(n) Notwithstanding paragraph (j), the administrative expenses of the program shall be recouped by assessment of risk~~

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

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

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

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

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

~~4. Meet at least three times each year. One meeting shall be held to hear reports and to secure public comment on the health insurance market, to develop any legislation needed~~

~~to address health insurance market issues, and to provide comments on health insurance legislation proposed by the office.~~

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

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

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

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

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

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

subparagraph 1. to submit recommended modifications to the office for approval.

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

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

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

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

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

a. A preferred provider arrangement or exclusive provider organization or any combination thereof, in which a small employer carrier enters into a written agreement with the provider to provide services at specified levels of reimbursement or to provide reimbursement to specified providers. Any such written agreement between a provider and a

small employer carrier must contain a provision under which the parties agree that the insured individual or covered member has no obligation to make payment for any medical service rendered by the provider which is determined not to be medically necessary. A carrier may use preferred provider arrangements or exclusive provider arrangements to the same extent as allowed in group products that are not issued to small employers.

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

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

4. The standard health benefit plan shall include:

a. Coverage for inpatient hospitalization;

b. Coverage for outpatient services;

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

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

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

f. Coverage for mammograms pursuant to s. 627.6613;

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

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

i. Coverage for services provided by a hospice licensed under s. 400.602 in cases where such coverage would be the most appropriate and the most cost-effective method for treating a covered illness.

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

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

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

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

9. Each small employer carrier that provides for inpatient and outpatient services by allopathic hospitals may provide as an option of the insured similar inpatient and outpatient services by hospitals accredited by the American Osteopathic Association when such services are available and the osteopathic hospital agrees to provide the service.

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

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

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

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

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

Such disclosure statement must be presented in a clear and understandable form and format and must be separate from the policy or certificate or evidence of coverage provided to the employer group.

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

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

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

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

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

A copy of such written statement shall be provided to the prospective policyholder no later than at the time of delivery of the policy or contract, and the original of such written statement shall be retained in the files of the small employer carrier for the period of time that the policy or contract remains in effect or for 5 years, whichever period is longer.

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

4. Each marketing communication that is intended to be used in the marketing of a health benefit plan in this state must be submitted for review by the office prior to use and must contain the disclosures stated in this subsection.

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

(13) STANDARDS TO ASSURE FAIR MARKETING.—

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

status or claims experience of the small employer or its employees or dependents, the small employer carrier shall offer the small employer the opportunity to purchase a basic health benefit plan and a standard health benefit plan. Beginning January 1, 1994, small employer carriers must offer and issue all plans on a guaranteed-issue basis.

(b) No small employer carrier or agent shall, directly or indirectly, engage in the following activities:

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

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

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

(d) No small employer carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an agent that provides for or results in the compensation paid to an agent for the sale of a health benefit plan to be varied because of the health status, claims experience, industry, occupation, or geographic location of the small

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

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

(f) No small employer carrier shall terminate, fail to renew, or limit its contract or agreement of representation with an agent for any reason related to the health status, claims experience, occupation, or geographic location of the small employers placed by the agent with the small employer carrier unless the agent consistently engages in practices that violate this section or s. 626.9541.

(g) No small employer carrier or agent shall induce or otherwise encourage a small employer to separate or otherwise exclude an employee from health coverage or benefits provided in connection with the employee's employment.

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

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

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

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

(16) APPLICABILITY OF OTHER STATE LAWS.—

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

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

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

2. Imposes any restriction on a small employer carrier's ability to negotiate with providers regarding the level or method of reimbursing care or services provided under a health benefit plan; or

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

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

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

Section 4. Sub-subsection (d) of subsection (2) of section 112.363, Florida Statutes, is amended to read:

(2) ELIGIBILITY FOR RETIREE HEALTH INSURANCE SUBSIDY.—

(d) Payment of the retiree health insurance subsidy shall be made only after coverage for health insurance for the retiree or beneficiary has been certified in writing to the Department of Management Services. Participation in a former employer's group health insurance program is not a requirement for eligibility under this section. ~~Coverage issued pursuant to s. 408.9091 is considered health insurance for the purposes of this section.~~

Section 5. Subsections (42) through (45) are renumbered and subsection (41) of section 408.07, Florida Statutes, is amended to read:

~~(41) "Prospective payment arrangement" means a financial agreement negotiated between a hospital and an insurer, health maintenance organization, preferred provider organization, or other third-party payor which contains, at a minimum, the elements provided for in s. 408.50.~~

(41) ~~(42)~~ "Rate of return" means the financial indicators used to determine or demonstrate reasonableness of the financial requirements of a hospital. Such indicators shall include, but not be limited to: return on assets, return on equity, total margin, and debt service coverage.

(42) ~~(43)~~ "Rural hospital" means an acute care hospital licensed under chapter 395, having 100 or fewer licensed beds and an emergency room, and which is:

(a) The sole provider within a county with a population density of no greater than 100 persons per square mile;

(b) An acute care hospital, in a county with a population density of no greater than 100 persons per square mile, which is

at least 30 minutes of travel time, on normally traveled roads under normal traffic conditions, from another acute care hospital within the same county;

(c) A hospital supported by a tax district or subdistrict whose boundaries encompass a population of 100 persons or fewer per square mile;

(d) A hospital with a service area that has a population of 100 persons or fewer per square mile. As used in this paragraph, the term "service area" means the fewest number of zip codes that account for 75 percent of the hospital's discharges for the most recent 5-year period, based on information available from the hospital inpatient discharge database in the Florida Center for Health Information and Policy Analysis at the Agency for Health Care Administration; or

(e) A critical access hospital.

Population densities used in this subsection must be based upon the most recently completed United States census. A hospital that received funds under s. 409.9116 for a quarter beginning no later than July 1, 2002, is deemed to have been and shall continue to be a rural hospital from that date through June 30, 2015, if the hospital continues to have 100 or fewer licensed beds and an emergency room, or meets the criteria of s. 395.602(2)(e)4. An acute care hospital that has not previously been designated as a rural hospital and that meets the criteria of this subsection shall be granted such designation upon application, including supporting documentation, to the Agency for Health Care Administration.

(43) ~~(44)~~ "Special study" means a nonrecurring data-gathering and analysis effort designed to aid the agency in meeting its responsibilities pursuant to this chapter.

(44) ~~(45)~~ "Teaching hospital" means any Florida hospital officially affiliated with an accredited Florida medical school which exhibits activity in the area of graduate medical education as reflected by at least seven different graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education or the Council on Postdoctoral Training of the American Osteopathic Association and the presence of 100 or more full-time equivalent resident physicians. The Director of the Agency for Health Care Administration shall be responsible for determining which hospitals meet this definition.

Section 6. Subsection (10) of section 945.603, Florida Statutes, is amended to read:

945.603 Powers and duties of authority.—The purpose of the authority is to assist in the delivery of health care services for inmates in the Department of Corrections by advising the Secretary of Corrections on the professional conduct of primary, convalescent, dental, and mental health care and the management of costs consistent with quality care, by advising the Governor and the Legislature on the status of the Department of Corrections' health care delivery system, and by assuring that adequate standards of physical and mental health care for inmates are maintained at all Department of Corrections institutions. For this purpose, the authority has the authority to:

~~(10) Coordinate the development of prospective payment arrangements as described in s. 408.50 when appropriate for the acquisition of inmate health care services.~~

Section 7. Sub-subsection (c) of subsection (3) of section 1001.706, Florida Statutes, is amended to read:

(3) POWERS AND DUTIES RELATING TO ORGANIZATION AND OPERATION OF STATE UNIVERSITIES.—

(a) The Board of Governors, or the board's designee, shall develop guidelines and procedures related to data and technology, including information systems, communications systems, computer hardware and software, and networks.

(b) The Board of Governors shall develop guidelines relating to divisions of sponsored research, pursuant to the provisions of s. 1004.22, to serve the function of administration and promotion of the programs of research.

(c) The Board of Governors shall prescribe conditions for direct-support organizations ~~and university health services support organizations~~ to be certified and to use university property and services. Conditions relating to certification must provide for audit review and oversight by the Board of Governors.

(d) The Board of Governors shall develop guidelines for supervising faculty practice plans for the academic health science centers.

(e) The Board of Governors shall ensure that students at state universities have access to general education courses as provided in the statewide articulation agreement, pursuant to s. 1007.23.

(f) The Board of Governors shall approve baccalaureate degree programs that require more than 120 semester credit hours of coursework prior to such programs being offered by a state university. At least half of the required coursework for any baccalaureate degree must be offered at the lower-division level, except in program areas approved by the Board of Governors.

(g) The Board of Governors, or the board's designee, shall adopt a written antihazing policy, appropriate penalties for violations of such policy, and a program for enforcing such policy.

(h) The Board of Governors, or the board's designee, may establish a uniform code of conduct and appropriate penalties for violations of its regulations by students and student organizations, including regulations governing student academic honesty. Such penalties, unless otherwise provided by law, may include reasonable fines, the withholding of diplomas or transcripts pending compliance with regulations or payment of fines, and the imposition of probation, suspension, or dismissal.

Section 8. This act shall take effect July 1, 2011.

# HOUSE OF REPRESENTATIVES STAFF ANALYSIS

**BILL #:** PCB HHSC 11-08 Background Screening
**SPONSOR(S):** Health & Human Services Committee
**TIED BILLS:** **IDEN./SIM. BILLS:**

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

## SUMMARY ANALYSIS

In 2010, the Legislature substantially rewrote the requirements and procedures for background screening of the individuals and businesses that deal primarily with vulnerable populations. A Level 2 background screening requirement was created for direct services providers who provide services through a contractual relationship with the Department of Elderly Affairs (DOEA). A direct service provider is defined as a person who pursuant to a program to provide services to the elderly, has direct, face-to-face contact with a client while providing services to the client or has access to the client's living areas or to the client's funds or personal property. Volunteers are specifically included as "direct service providers".

PCB HHSC 11-08 amends the definition of direct service provider to include individuals who have direct, face-to-face contact with a client and have access to the client's living areas or to the client's funds or personal property.

The bill creates an exemption from background screening for the following direct care providers:

- Volunteers who assist on an intermittent basis for less than 20 hours of direct, face-to-face contact with a client per month.
- Individuals who are related by blood to the client.
- The client's spouse.

The bill also creates an exemption from additional screening for an individual who becomes a direct care provider who has previously been screened as a condition of licensure by the Agency for Health Care Administration.

The bill provides time frames for DOEA to stagger the implementation of the background screening requirements. The bill also provides that direct care providers must be screened every 5 years unless their finger prints are continuously retained and monitored by the Department of Law Enforcement in the federal fingerprint retention program.

Rule-making authority is granted to DOEA to establish the staggered implementation schedule.

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

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

## FULL ANALYSIS

## I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background Screening

Currently, Florida has one of the largest vulnerable populations in the country with over 25% of the state's population over the age of 65, and many more children and disabled adults. These vulnerable populations require special care because they are at an increased risk of abuse.

In 1995, the Legislature created standard procedures for the screening of prospective employees where the Legislature had determined it necessary to conduct criminal history background screenings to protect vulnerable persons. Chapter 435, F.S., outlines the employment screening requirements. The Florida Department of Law Enforcement (FDLE) provides criminal history checks to the employer.

In 2010, the Legislature substantially rewrote the requirements and procedures for background screening of the persons and businesses that deal primarily with vulnerable populations.[1] Major changes made by the act include:

- No person who is required to be screened may begin work until the screening has been completed.
- All Level 1[2] screenings were increased to Level 2[3].
- By August 1, 2012, all fingerprints submitted to FDLE must be submitted electronically.
- Certain personnel that were not being screened were required to begin Level 2 screening.
- The addition of serious crimes that disqualify an individual from employment working with vulnerable populations.
- Agencies were authorized to request the retention of fingerprints by the Florida Department of Law Enforcement.
- An exemption for a disqualifying felony may not be granted until at least three years after the completion of all sentencing sanctions for that felony.
- All exemptions from disqualification may be granted only by the agency head.

Level 2 background screenings cost $43.25 (the $24 state fee, plus an additional $19.25 for electronic fingerprints) or $30.25 ($24 plus $6.25 for hard copy fingerprints).[4]

The Department of Elderly Affairs

In 1988, the Department of Elderly Affairs ("DOEA" or "the department") was created by the passage of a constitutional amendment. In 1991, the department was codified in s. 40.41, F.S., and organized pursuant to Chapter 430, F.S. The department began operation in January 1992.

The department is the designated state unit on aging as defined in the Older Americans Act (OAA) of 1965.[5] As such, the department's role is to administer the state's OAA allotment and grants, and to

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[1] Ch. 2010-114, L.O.F.

[2] Section 435.03, F.S. Level 1 screenings are name-based demographic screenings that must include, but are not limited to, employment history checks and statewide criminal correspondence checks through FDLE. Level 1 screenings may also include local criminal records checks through local law enforcement agencies. A person undergoing a Level 1 screening must not have been found guity of any of the listed offenses.

[3] Section 435.04, F.S. A Level 2 screening consists of a fingerprint-based search of FDLE and the Federal Bureau of Investigations (FBI) databases for state and national criminal arrest records. Any person undergoing a Level 2 screening must not have been found guilty of any of the listed offenses.

[4] *Criminal History Record Checks/Background Checks Fact Sheet* January 4, 2011. Available at http://www.fdle.state.fl.us/Content/getdoc/39b8f116-6d8b-4024-9a70-5d8cd2e34aa5/FAQ.aspx (last visited April 1, 2011).

[5] s. 305(a)(1)(C), Older Americans Act

advocate, coordinate, and plan all elder services.[6] The OAA requires states to provide elder services through a coordinated service delivery system through designated Area Agencies on Aging (AAAs). There are 11 AAAs – 1 in each of the state's 11 planning and service areas—that are responsible to the department to provide services.

In addition, ch. 430, F.S., requires that the department fund service delivery "lead agencies" that coordinate and provide a variety of oversight and elder support services at the consumer level in the counties within each planning and service area.

The department is 94 percent privatized through contracts with local entities and utilizes over 45,000 volunteers to deliver information and services to elders.[7] Many of the volunteers are elders themselves.[8]

Direct Service Providers

The 2010 revision of the background screening laws created s. 430.0402, F.S., requiring Level 2 background screenings for direct services providers who provide services through a contractual relationship with the Department of Elderly Affairs. A direct service provider is defined as a person who pursuant to a program to provide services to the elderly, has direct, face-to-face contact with a client while providing services to the client or has access to the client's living areas or to the client's funds or personal property. Volunteers are specifically included as "direct service providers".

The statute contains no exception from background screenings for a volunteer who has occasional or limited hours. There are exceptions for volunteers who are in brief or occasional contact with vulnerable populations other than elders. For example, s. 393.0655(1), F.S., exempts from screening a volunteer who assist with persons with developmental disabilities if the volunteer assists less than 10 hours per month and a person who has been screened is always present and has the volunteer within his or her line of sight.[9]

Section 430.0402, F.S., also provides that in addition to the offenses listed in s.435.04, F.S., direct service provides must also be screened for offenses prohibited under the following:

- Any authorizing statutes, if the offense was a felony.
- Section 409.920, relating to Medicaid provider fraud.
- Section 409.9201, relating to Medicaid fraud.
- Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.
- Section 817.234, relating to false and fraudulent insurance claims.
- Section 817.505, relating to patient brokering.
- Section 817.568, relating to criminal use of personal identification information.
- Section 817.60, relating to obtaining a credit card through fraudulent means.
- Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.
- Section 831.01, relating to forgery.
- Section 831.02, relating to uttering forged instruments.
- Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.
- Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

[6] s. 430.04(1), F.S.
[7] Department of Elder Affairs, Summary of Programs and Services (2010)
[8] *Id.*
[9] *See e.g.* s. 394.4572(1)(a), F.S. (contact with persons held for mental health treatment) and s. 409.175(2), F.S. (contact with children).

Area Agencies on Aging and Elder Care Services are entities who contract with the Department of Elderly Affairs to provide services to elders. Representatives of several of these entities report that the requirement of Level 2 background screening of volunteers has dramatically reduced the number of volunteers potentially impacting the availability of services to elders.[10] The Meals on Wheels program is dependent on volunteers, and the program is currently losing volunteers who cannot afford to pay for the cost of a level 2 background screening. Senior centers, congregate meal sites, and health and wellness programs are also dependent on volunteers.

The provisions of the 2010 legislation also impacts Home Care for the Elderly (HCE)[11] caregivers. Many HCE caregivers are family members. These family members receive a monthly stipend of $106 to help care for family member at home. The stipend is used to pay for incontinence products, nutritional supplements, respite care, and other needed products and services. The new Level 2 background screening requirement is applicable to these family members who act as caregivers.

Effect of the Bill

PCB HHSC 11-08 amends the definition of direct service provider to include individuals who have direct, face-to-face contact with a client and have access to the client's living areas or to the client's funds or personal property. Current law defines a direct services provider as having client contact or living area/property access.

The bill creates an exemption from background screening for the following:
- Volunteers who assist on an intermittent basis for less than 20 hours of direct, face-to-face contact with a client per month.
- Individuals who are related by blood to the client.
- The client's spouse.

The bill provides an exemption from additional background screening for an individual who becomes a direct care provider and provides services within the scope of his or her license. The exemption applies to a person who was previously screened by the Agency for Health Care Administration as a condition of licensure. Such individuals would include owners, administrators, and employees of such entities as nursing homes, assisted living facilities, home health agencies, and adult day cares.[12]

The bill provides time frames for screenings by the Department of Elderly Affairs:
- Individuals serving as direct service providers on July 31, 2010, must be screened by July 1, 2012.
- DOEA may adopt rules to establish a schedule to stagger the implementation of the required screenings over a 1-year period, beginning July 1, 2011, through July 1, 2012.
- Individuals shall be rescreened every 5 years following the date of his or her last background screening unless the individual's fingerprints are continuously retained and monitored by the Department of Law Enforcement in the federal fingerprint retention program.

The bill removes "any authorizing statutes, if the offense was a felony" for the list of disqualifying offenses for direct services providers. The term "authorizing statue" in not defined by Chapter 430. The term is defined in s. 408.803, F.S., and relates to entities regulated by the Agency for Health Care Administration. Its inclusion in s. 430.0402, F.S, appears to be a scrivener's error.

B. SECTION DIRECTORY:

**Section 1**: Amends s. 430.0402, F.S., relating to screening of direct service providers.
**Section 2**: Provides an effective date of July 1, 2011.

[10] Meetings with Health and Human Services Committee staff in November and December of 2010, and correspondence on file with the Committee.
[11] Department of Elder Affairs, Summary of Programs and Services (2010)
[12] For a complete list of entities see s. 408.802, F.S.

## II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will reduce the number of persons who will need to undergo background screening prior to working with vulnerable persons. The Level 2 screenings cost $43.25 (the $24 state fee, plus an additional $19.25 for electronic fingerprints) or $30.25 ($24 plus $6.25 for hard copy fingerprints).[13]

D. FISCAL COMMENTS:

None.

## III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The Department of Elderly Affairs is given rule-making authority to establish a schedule to stagger the implementation of the required background screenings over a 1-year period, beginning July 1, 2011, through July 1, 2012.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

## IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[13] See note 4, supra.

A bill to be entitled

An act relating to background screening; amending s. 430.0402, F.S.; including volunteers within the definition of the term "direct service provider" for purposes of required background screening; exempting a volunteer who meets certain criteria and a client's relative or spouse from the screening requirement; excepting certain licensed professionals and persons screened as a licensure requirement from further screening under certain circumstances; requiring direct service providers working as of a certain date to be screened within a specified period; providing a phase-in for screening direct service providers; providing rule-making authority to the Department of Elderly Affairs to implement the phase-in; requiring that employers of direct service providers and certain other individuals be rescreened every 5 years unless fingerprints are retained electronically by the Department of Law Enforcement; removing an offense from the list of disqualifying offenses for purposes of background screening; providing an effective date.

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

Section 1. Section 430.0402, Florida Statutes, is amended to read:

430.0402 Screening of direct service providers.—

(1)(a) Level 2 background screening pursuant to chapter 435 is required for direct service providers. Background screening includes employment history checks as provided in s.

435.03(1) and local criminal records checks through local law enforcement agencies.

(b) For purposes of this section, the term "direct service provider" means a person 18 years of age or older, including a volunteer, who, pursuant to a program to provide services to the elderly, has direct, face-to-face contact with a client while providing services to the client and ~~or~~ has access to the client's living areas or to the client's funds or personal property. The term does not include ~~includes coordinators, managers, and supervisors of residential facilities and~~ volunteers who assist on an intermittent basis for less than 20 hours of direct, face-to-face contact with a client per month, individuals who are related by blood to the client, or the client's spouse.

(2) Licensed physicians, nurses, or other professionals licensed by the Department of Health are not subject to background screening if they are providing a service that is within the scope of their licensed practice.

(3) Individuals qualified for employment by the Agency for Health Care Administration pursuant to the agency's background screening standards for licensure or employment contained in s. 408.809 are not subject to subsequent or additional Level 2 screening pursuant to chapter 435, or to the unique screening requirements of this section, by virtue of their employment as a direct service provider if they are providing a service that is within the scope of their licensed practice.

(4) ~~(3)~~ Refusal on the part of an employer to dismiss a manager, supervisor, or direct service provider who has been

found to be in noncompliance with standards of this section shall result in the automatic denial, termination, or revocation of the license or certification, rate agreement, purchase order, or contract, in addition to any other remedies authorized by law.

(5) Individuals serving as direct service providers on July 31, 2010, must be screened by July 1, 2012. The department may adopt rules to establish a schedule to stagger the implementation of the required screening over a 1-year period, beginning July 1, 2011, through July 1, 2012.

(6) An employer of a direct service provider who previously qualified for employment or volunteer work under Level 1 screening standards or an individual who is required to be screened according to the Level 2 screening standards contained in chapter 435, pursuant to this section, shall be rescreened every 5 years following the date of his or her last background screening or exemption, unless such individual's fingerprints are continuously retained and monitored by the Department of Law Enforcement in the federal fingerprint retention program according to the procedures specified in s. 943.05.

(7) ~~(4)~~ The background screening conducted pursuant to this section must ensure that, in addition to the disqualifying offenses listed in s. 435.04, no person subject to the provisions of this section has an arrest awaiting final disposition for, has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, or has been adjudicated delinquent and the record has not been

sealed or expunged for, any offense prohibited under any of the following provisions of state law or similar law of another jurisdiction:

~~(a) Any authorizing statutes, if the offense was a felony.~~

(a) ~~(b)~~ Section 409.920, relating to Medicaid provider fraud.

(b) ~~(c)~~ Section 409.9201, relating to Medicaid fraud.

(c) ~~(d)~~ Section 817.034, relating to fraudulent acts through mail, wire, radio, electromagnetic, photoelectronic, or photooptical systems.

(d) ~~(e)~~ Section 817.234, relating to false and fraudulent insurance claims.

(e) ~~(f)~~ Section 817.505, relating to patient brokering.

(f) ~~(g)~~ Section 817.568, relating to criminal use of personal identification information.

(g) ~~(h)~~ Section 817.60, relating to obtaining a credit card through fraudulent means.

(h) ~~(i)~~ Section 817.61, relating to fraudulent use of credit cards, if the offense was a felony.

(i) ~~(j)~~ Section 831.01, relating to forgery.

(j) ~~(k)~~ Section 831.02, relating to uttering forged instruments.

(k) ~~(l)~~ Section 831.07, relating to forging bank bills, checks, drafts, or promissory notes.

(l) ~~(m)~~ Section 831.09, relating to uttering forged bank bills, checks, drafts, or promissory notes.

Section 2. This act shall take effect July 1, 2011.

Amendment No. 1

| COMMITTEE/SUBCOMMITTEE ACTION | |
|---|---|
| ADOPTED | __ (Y/N) |
| ADOPTED AS AMENDED | __ (Y/N) |
| ADOPTED W/O OBJECTION | __ (Y/N) |
| FAILED TO ADOPT | __ (Y/N) |
| WITHDRAWN | __ (Y/N) |
| OTHER | _____ |

Committee/Subcommittee hearing PCB: Health & Human Services Committee

Representative(s) Holder offered the following:

**Amendment**

Remove line 111 and insert:

Section 2. Subsection (1) of section 464.203, Florida Statutes, is amended to read:

464.203 Certified nursing assistants; certification requirement.—

(1) The board shall issue a certificate to practice as a certified nursing assistant to any person who demonstrates a minimum competency to read and write and successfully passes the required background screening pursuant to s. 400.215. If the person has successfully passed the required background screening pursuant to s. 400.215 or s. 408.809 within 90 days prior to the application for a certificate to practice, the board shall waive the requirement that the applicant successfully pass an

additional background screening pursuant to 400.215. The person must also meet ~~and meets~~ one of the following requirements:

(a) Has successfully completed an approved training program and achieved a minimum score, established by rule of the board, on the nursing assistant competency examination, which consists of a written portion and skills-demonstration portion approved by the board and administered at a site and by personnel approved by the department.

(b) Has achieved a minimum score, established by rule of the board, on the nursing assistant competency examination, which consists of a written portion and skills-demonstration portion, approved by the board and administered at a site and by personnel approved by the department and:

1. Has a high school diploma, or its equivalent; or

2. Is at least 18 years of age.

(c) Is currently certified in another state; is listed on that state's certified nursing assistant registry; and has not been found to have committed abuse, neglect, or exploitation in that state.

(d) Has completed the curriculum developed under the Enterprise Florida Jobs and Education Partnership Grant and achieved a minimum score, established by rule of the board, on the nursing assistant competency examination, which consists of a written portion and skills-demonstration portion, approved by the board and administered at a site and by personnel approved by the department.

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