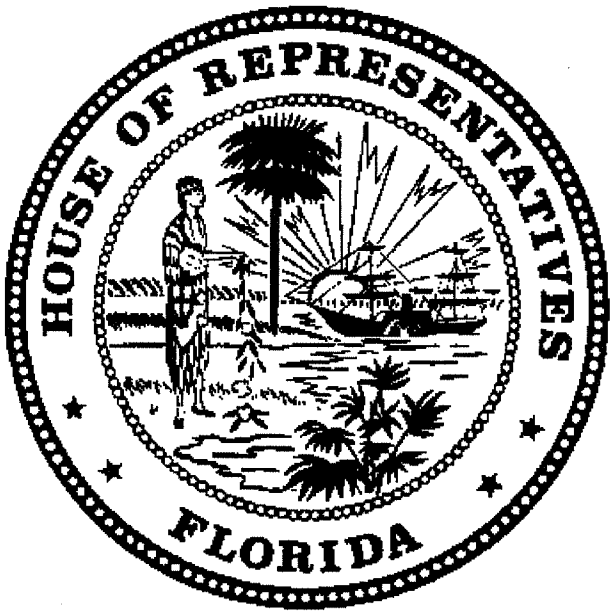

Health & Human Services Quality Subcommittee

Wednesday, January 25, 2012
11:00 AM – 1:30 PM
306 HOB

Dean Cannon
Speaker

John Wood
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health & Human Services Quality Subcommittee

Start Date and Time:	Wednesday, January 25, 2012 11:00 am
End Date and Time:	Wednesday, January 25, 2012 01:30 pm
Location:	306 HOB
Duration:	2.50 hrs

Consideration of the following bill(s):

HB 509 Pharmacy by Logan
HB 1313 Dental Hygienists by Corcoran
HB 1329 Health Care Consumer Protection by Corcoran

Consideration of the following proposed committee bill(s):

PCB HSQS 12-01 -- Health Information Systems Council
PCB HSQS 12-02 -- Developmental Disabilities Compact Workgroup

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m., Tuesday, January 24, 2012.

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., Tuesday, January 24, 2012.

NOTICE FINALIZED on 01/23/2012 16:11 by Iseminger.Bobbye

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 509 Pharmacy
SPONSOR(S): Logan
TIED BILLS: **IDEN./SIM. BILLS:** SB 850

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Quality Subcommittee		Holt	Calamas
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

In 2007, pharmacists were granted the authority to administer influenza vaccines (flu shots) to an adults under a written protocol with a supervising physician. A pharmacist who wishes to administer the flu shot must complete a 20-hour influenza immunization certification program (certification program) approved by the Board of Medicine and the Board of Osteopathic Medicine.

The bill expands the authorized vaccines to include the varicella zoster and pneumococcal vaccines. Moreover, the bill also grants authority to administer epinephrine auto-injector system, commonly referred to as an EpiPen, to a person if they have an anaphylaxis reaction.

The bill also grants pharmacy interns the authority to administer vaccines and epinephrine auto-injectors upon passage of the 20-hour certification program. A pharmacy intern is a person who is enrolled at an accredited school of pharmacy or a certified graduate of an accredited school of pharmacy, but is not a Florida-licensed pharmacist. A pharmacist may only supervise one pharmacy intern and the pharmacy intern is not permitted to perform any acts relating to the filing, compounding, or dispensing of medicinal drugs unless it is done under the direct and immediate personal supervision of a licensed pharmacist.

The bill has an insignificant fiscal impact to the Medical Quality Assurance Trust Fund (See Fiscal Analysis).

The bill take effect July 1, 2012.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Influenza Vaccine Certification Program

In 2007, the Florida Legislature granted pharmacists the authority to administer influenza vaccines (flu shots).[1] Section 465.189, F.S., sets out the terms and conditions under which a pharmacist may administer a flu shot to an adult.[2] Florida is the only state that uses the terminology "adult" instead of specifying a numerical age, such as 18 years or older. Fifteen states and territories limit the administration to 18 years or older.[3] Thirteen states authorize administration to individuals at any age.[4]

A pharmacist who wishes to administer the flu shot must enter into a written protocol with a supervising physician licensed under chapter 458 or chapter 459, F.S.[5] However, the pharmacist may not enter into a protocol while acting as an employee without the written approval of the owner of the pharmacy.[6]

Through the protocol the supervising physician dictates which types and categories of patients to whom the pharmacist may administer the flu shot.[7] The terms, scope, and conditions set forth in the protocol must be appropriate to the pharmacist's training and certification.[8] The pharmacist is required to provide the Board of Pharmacy a copy of the protocol.[9]

The pharmacist is required for 5 years to maintain and make available patient records using the same standards for confidentiality and maintenance required of other healthcare practitioners. The pharmacist must forward all immunization records to the DOH for inclusion in the state immunization registry.[10] The pharmacist is required to maintain at least $200,000 of professional liability insurance.[11]

Additionally, the pharmacist must successfully complete a certification program, which includes 20 hours of coursework in the form of continuing education hours that require the successful passage of a cognitive examination and proficient demonstration of administration technique.[12] The pharmacist is required to provide the Board of Pharmacy proof of possessing a current certification to administer the flu shot.[13] The coursework must include instruction in the following:[14]

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[1] Ch. 2007-152, L.O.F.
[2] Section 465.189, F.S.
[3] The states and territories are: Connecticut, District of Columbia, Hawaii, Iowa, Massachusetts, North Carolina, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico, South Carolina, Vermont, and West Virginia. *See* American Pharmacist Association, Pharmacist Immunization Center, States authorizing pharmacists to administer influenza vaccine & pharmacists trained to administer vaccines , *available at*: http://www.pharmacist.com/AM/Template.cfm?Section=Pharmacist_Immunization_Center1 (last viewed January 19, 2012).
[4] The states are: Alabama, Alaska, California, Colorado, Michigan, Mississippi, Nebraska, New England, New Mexico, Oklahoma, Tennessee, Texas, Virginia, and Washington. *See* American Pharmacist Association, Pharmacist Immunization Center, States authorizing pharmacists to administer influenza vaccine & pharmacists trained to administer vaccines , *available at*: http://www.pharmacist.com/AM/Template.cfm?Section=Pharmacist_Immunization_Center1 (last viewed January 19, 2012).
[5] Section 465.189(1), F.S.
[6] Section 465.189(4), F.S.
[7] Section 465.189(6), F.S.
[8] *Id.*
[9] Section 465.189(7), F.S.
[10] Section 465.189(4), F.S.
[11] Section 465.189(2), F.S.
[12] Chapter 64B16-26.1031, F.A.C.
[13] Section 465.189(6), F.S.
[14] Chapter 64B16-26.1031(2), F.A.C.

- Mechanisms of action for vaccines, contraindications, drug interactions, and monitoring after vaccine administration;
- Immunization schedules;
- Immunization screening questions, provision of risk/benefit information, informed consent, recordkeeping, and electronic reporting into the statewide immunization registry maintained by DOH;
- Vaccine storage and handling;
- Bio-hazardous waste disposal and sterile technique;
- Entering, negotiating, and performing pursuant to physician oversight protocols;
- Community immunization resources and programs;
- Identifying, managing and responding to adverse incidents including but not limited to potential allergic reactions associated with vaccine administration;
- Procedures and policies for reporting adverse incidents to the Vaccine Adverse Event Reporting System;
- Reimbursement procedures and vaccine coverage by federal, state, and local governmental jurisdictions and private third party payors;
- Administration techniques;
- Current influenza immunization guidelines and recommendations of the CDC published in the Morbidity Weekly Report;
- Review of the current law permitting pharmacist to administer influenza vaccine (s. 465.189, F.S.); and
- CPR training.

The certification program is approved by the Board of Medicine and the Board of Osteopathic Medicine, as required by law.[15]

As of June 2009, all states allow pharmacists to immunize patients.[16] However, there is variability by states as to what vaccines pharmacists are authorized to administer. Thirty-seven states and territories[17] allow pharmacists to administer any vaccine, of which, 15 require a prescription.[18] Florida, Maine, and Puerto Rico are more restrictive and only allow pharmacist to administer the flu shot.[19]

In addition to Florida-licensed medical physicians, osteopathic physicians, physician assistants, and nurses, paramedics may administer immunizations. Section 401.272, F.S., authorizes a paramedic to administer immunizations after his or her medical director has verified and documented that the paramedic has received sufficient training and experience to administer immunizations.

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[15] Section 465.189(7), F.S.

[16] American Pharmacist Association, States Where Pharmacists Can Immunize, *See* map available at: http://www.pharmacist.com/AM/TemplateRedirect.cfm?Template=/CM/ContentDisplay.cfm&ContentID=21623 (last viewed January 19, 2012).

[17] Alabama*, Alaska*, Arizona*, Arkansas*, California, Colorado, District of Columbia*, Delaware*, Georgia*, Hawaii*, Idaho, Illinois, Indiana*, Iowa*, Kansas, Kentucky, Louisiana*, Michigan*, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Jersey*, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina*, Tennessee, Texas, Vermont, Virginia*, Washington, and Wisconsin *(*states that require a prescription)*.

[18] American Pharmacist Association, Pharmacist Immunization Center, States authorizing pharmacists to administer influenza vaccine & pharmacists trained to administer vaccines , *available at*: http://www.pharmacist.com/AM/Template.cfm?Section=Pharmacist_Immunization_Center1 (last viewed January 19, 2012).

[19] *Id.*

Pneumococcal Disease and Immunization

According to the American Pharmacist Association, Florida is one of three states and Puerto Rico that do not authorize pharmacist to administer the pneumococcal vaccine.[20]

Pneumococcal disease is an infection caused by the bacteria called *Streptococcus pneumoniae*.[21] Pneumococcal disease is the leading cause of serious illness in children and adults throughout the world.[22] Bacteria can invade different organs of the body, causing pneumonia in the lungs, bacteremia in the bloodstream, meningitis in the brain, middle ear infections, and sinusitis.[23] There are more than 90 known pneumococcal types; the ten most common types cause 62 percent of invasive disease worldwide.[24]

Each year in the U.S., there are 175,000 cases of pneumococcal pneumonia, more than 50,000 cases of bacteremia, and between 3,000 and 6,000 cases of meningitis.[25] According to the Centers for Disease Control and Prevention, invasive pneumococcal disease causes 6,000 deaths each year.[26]

Symptoms of pneumococcal infection, depending on the location of the infection, include fever, cough, shortness of breath and chest pain; stiff neck, fever, mental confusion, disorientation and sensitivity to light (meningitis); joint pains and chills (bacteremia); and a painful ear, a red or swollen eardrum, sleeplessness, fever and irritability (middle ear infection).[27] Pneumococcal disease can result in long term damage, such as hearing loss, loss of a limb, and brain damage; pneumococcal disease can also result in death.[28]

The best way to protect against pneumococcal disease is through vaccination. The vaccination is very good at preventing severe pneumococcal disease, but it is not guaranteed to protect against infection and symptoms in all people.[29] Persons aged 65 years or older are considered to be at high risk for pneumococcal disease or its complications. It is recommended that persons 65 years old or older be vaccinated against pneumococcal disease.[30]

Varicella Zoster Virus and Immunization

According to the American Pharmacist Association, Florida is one of four states and Puerto Rico that do not authorize pharmacist to administer the varicella zoster vaccine.[31]

Varicella zoster virus (VZV) causes chickenpox and shingles. Chickenpox is a common childhood disease, characterized by a blister-like rash over the torso and face, itching, tiredness, and fever. Before a vaccine was developed, approximately 10,600 persons were hospitalized and 100 to 150 died

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[20] The 3 states are: Florida, Massachusetts, and South Carolina. *See*, American Pharmacist Association, Pharmacist Immunization Center, States authorizing pharmacists to administer influenza vaccine & pharmacists trained to administer vaccines , *available at*: http://www.pharmacist.com/AM/Template.cfm?Section=Pharmacist_Immunization_Center1 (last viewed January 19, 2012).

[21] Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases, Pneumococcal Disease In-Short, *available at*: http://www.cdc.gov/vaccines/vpd-vac/pneumo/in-short-both.htm (last viewed January 19, 2012).

[22] National Foundation for Infectious Diseases, Pneumococcal Disease, *available at:* http://www.nfid.org/factsheets/pneumofacts.shtml (last viewed January 19, 2012).

[23] *Id.*

[24] *Id.*

[25] *Id.*

[26] *Id.*

[27] *Id.*

[28] *Id.*

[29] *Id.*

[30] *Id.*

[31] The 4 states are: Florida, Massachusetts, New York, and West Virginia. *See*, American Pharmacist Association, Pharmacist Immunization Center, States authorizing pharmacists to administer influenza vaccine & pharmacists trained to administer vaccines , *available at*: http://www.pharmacist.com/AM/Template.cfm?Section=Pharmacist_Immunization_Center1 (last viewed January 19, 2012).

each year in the U.S. as a result of contracting chickenpox.[32] Since the development of a vaccine, the occurrence rate and severity of chickenpox has decreased.[33]

Shingles, a painful localized skin rash often with blisters, is caused by the reactivation of the VZV in the body of a person who contracted chickenpox, often years after suffering from the disease. Almost one out of every three people in the U.S. will develop shingles.[34] There are 1 million estimated cases of shingles every year in the U.S., and half of those cases occur in persons over the age of 60.[35] The only way to reduce the risk of developing shingles is to get vaccinated.[36]

Anaphylaxis Epinephrine Auto-Injectors

Currently, a pharmacist who is eligible to administer the flu vaccine is not authorized to administer an epinephrine auto-injector system, commonly referred to as an EpiPen, to a person if they have an anaphylaxis reaction to the vaccine.

Many individuals with severe allergies that have resulted in, or can result in, anaphylaxis carry an EpiPen. The EpiPen consists of a syringe prefilled with an appropriate dose of epinephrine and a retractable needle that is protected by a safety guard to prevent injury or reuse. There are two dosages available for the EpiPen- for children weighing between 33 and 66 pounds, the dosage is .15 mg; for children and adults weighing more than 66 pounds, the dosage is .30 mg.[37] When injected into the top of the thigh, epinephrine eases the symptoms of anaphylaxis until professional medical treatment is obtained.

Anaphylaxis is a severe, whole body allergic reaction to a chemical that has become an allergen.[38] The human body releases chemicals during anaphylaxis that can cause shock, resulting in a sudden drop in blood pressure and the release of histamines, which restrict breathing.[39] Symptoms of anaphylaxis include a rapid, weak pulse, skin rash, nausea and vomiting.[40] Common causes include drug allergies, food allergies, insect bites or stings and exposure to latex.[41] The severely allergic population has increased significantly during that last ten years, with the current incidence rate estimated to be 49.8 per 100,000 person-years.[42]

Anaphylaxis is an emergency situation that requires immediate medical attention. If anaphylaxis is not treated, it will lead to unconsciousness and possible death. Initial treatment of anaphylaxis includes the administration of epinephrine, also known as adrenaline, to improve breathing by relaxing muscles in the airways, stimulate the heart, and tighten the blood vessels to reduce swelling. Epinephrine is classified as a sympathomimetic drug, meaning its effects mimic those of the stimulated sympathetic nervous system, which stimulates the heart and narrows the blood vessels. It is available through a prescription from a physician.

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[32] Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases, Varicella Disease Questions & Answers, *available at*: http://www.cdc.gov/vaccines/vpd-vac/varicella/default.htm (last viewed January 19, 2012).
[33] *Id.*
[34] Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases, Division of Viral Diseases, Shingles-Overview, *available at*: http://www.cdc.gov/vaccines/vpd-vac/shingles/default.htm (last viewed January 20, 2012).
[35] *Id.*
[36] Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases, Shingles-Prevention & Treatment, *available at:* http://www.cdc.gov/shingles/about/prevention-treatment.html (last viewed January 19, 2012).
[37] Dey Pharma, L.P., EpiPen Prescribing Information, *available at:* http://files.epipen.gethifi.com/footer-pdfs/patient-packaging-insert-pdf/Prescribing-Information.pdf. (last viewed January 20, 2012).
[38] U.S. National Institute of Health, U.S. National Library of Medicine, National Center for Biotechnology Information, Anaphylaxis, *available at*: http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0001847/ (last viewed January 19, 2012).
[39] Mayo Foundation for Medical Education and Research, First Aid: Anaphylaxis, *available at*: http://www.mayoclinic.com/health/first-aid-anaphylaxis/FA00003 (last viewed January 20,, 2012).
[40] *Id.*
[41] *Id.*
[42] Stephanie Guerlain, PhD, et al., *A comparison of 4 epinephrine autoinjector delivery systems: usability and patient preference*, NIH Public Access Author Manuscript, available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2892620/. , citing Decker WW, Campbell, RL, Luke A, et al., *The etiology and incidence of anaphylaxis in Rochester, Minnesota: a report from the Rochester Epidemiology Project,* J Allergy Clin Immunol., 2008;122:1161-1165.

Practice of Pharmacy

Section 465.003(13), F.S., defines the "practice of the profession of pharmacy" to include compounding, dispensing, and consulting concerning contents, therapeutic values, and uses of any medicinal drug; consulting concerning therapeutic values and interactions of patent and proprietary preparations, whether pursuant to prescriptions or in the absence and entirely independent of such prescriptions or orders; and other pharmaceutical services. The practice of pharmacy also includes any other act, service, operation, research, or transaction incidental to, or forming a part of, any of the foregoing acts, requiring, involving, or employing the science or art of any branch of the pharmaceutical profession, study, or training, and expressly permits a pharmacist to transmit information from persons authorized to prescribe medicinal drugs to their patients.

Pharmacy Intern

To become a pharmacy intern, a person must be certified by the Board as enrolled in an intern program at an accredited school or college of pharmacy or certified as a graduate of an accredited school or college of pharmacy and not yet licensed as a pharmacist in Florida.[43] The Board may refuse to certify, or revoke the registration of, any intern for good cause, including acts or omissions deemed grounds for disciplinary action against licensed pharmacists included in s. 465.016, F.S.[44] The Board has developed detailed rules for the registration of pharmacy interns and internship program requirements for U.S. pharmacy students or graduates and foreign pharmacy graduates.[45]

A pharmacy intern may not engage in any act that constitutes the "practice of the profession of pharmacy". A pharmacy intern must perform all delegated act under the direct supervision of a licensed pharmacist.[46] No intern is permitted to perform any acts relating to the filing, compounding, or dispensing of medicinal drugs unless it is done under the direct and immediate personal supervision of a licensed pharmacist.[47] No pharmacist may be responsible for the supervision of more than one intern at any one time.[48]

In every pharmacy, the pharmacist shall retain the professional and personal responsibility for any delegated act performed by registered pharmacy interns in the licensee's employ or under the licensee's supervision.[49] Therefore, the pharmacist's professional liability insurance will likely cover the acts or omissions of the pharmacy intern. However, this rule does not shield a pharmacy intern from the possibility of being named as a defendant in a negligence lawsuit. Several insurance companies offer professional liability insurance policies designed for student pharmacists and pharmacy interns.[50]

According to the American Pharmacists Association, Florida is one of 18 states and territories that do not authorize pharmacy interns to administer vaccines.[51]

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[43] S. 465.003(12), F.S.
[44] *Id.*
[45] *See* Rule 64B16-26.2032, F.A.C. (U.S. pharmacy students/graduates); *see also* Rule 64B16-26.2033, F.A.C. (foreign pharmacy graduates).
[46] S. 465.014(1), F.S.
[47] 64B16-26.2032, F.A.C.
[48] *Id.*
[49] 64B16-27.1001, F.A.C.
[50] *See, e.g.,* Pharmacists Mutual Insurance Company, at http://www.phmic.com/phmc/productlines/personal/Pages/IndividualPharmacistProfessionalLiability.aspx
[51] The states and territories are: Arkansas, Colorado, Connecticut, Delaware, Florida, Indiana, Maine, Massachusetts, Minnesota, North Dakota, New Hampshire, New Jersey, Pennsylvania, Puerto Rico, South Carolina, South Dakota, and West Virginia.

Effect of Proposed Changes

The bill expands the current pharmacist's flu vaccine administration certification program by authorizing a pharmacist and a pharmacy intern to administer:

- Varicella zoster vaccine to adults 60 years of age or older;
- Pneumococcal vaccine to adults 65 years of age or older; and
- Epinephrine using an autoinjector delivery system (EpiPen) to an adult 18 years of age or older who is suffering an anaphylactic reaction.

The bill expands the certification program allowing a pharmacy intern to administer the vaccines or the EpiPen if the he or she successfully completes the 20 hour certification program.

The bill also clears an ambiguity in current law that provides pharmacist the authority to administer the influenza vaccine to an adult by specifying a numeric age of 18 years or older, but also leaves in the term "adult". It may be advantageous to remove the term "adult" and replace it with "person."

The bill makes conforming changes the section to add the pharmacy intern and restructures the language to incorporate the additional vaccines and epinephrine autoinjector authorized by the bill.

B. SECTION DIRECTORY:

Section 1. Amends s. 465.189, F.S., relating to administration of vaccines and epidephrine auto injection.
Section 2. Amends s. 465.003, F.S., relating to definitions.
Section 3. Provides an effective date of July 1, 2012.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None identified.

2. Expenditures:

   None identified.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   See Fiscal Comments.

2. Expenditures:

   See Fiscal Comments.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Pharmacies that opt to allow its pharmacists and pharmacy interns to administer the vaccines specified in the bill will realize positive fiscal impact from the revenue generated from offering vaccinations.

D. FISCAL COMMENTS:

The DOH will experience a recurring increase in workload to certify pharmacy interns to administer vaccines and epinephrine following completion certification program. Also, DOH will incur non-recurring costs associated with rule adoption and reconfiguring the COMPAS licensure system to accommodate the pharmacy intern certificate. DOH has promulgated a rule requiring applicants for the

influenza immunization certificate program to pay a non-refundable $55 fee to the Board of Pharmacy.[52] However, s. 465.189, F.S., does not authorize DOH to charge a fee for the certification program.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

   None identified.

B. RULE-MAKING AUTHORITY:

DOH has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Subsection (6) states that the written protocol is between the pharmacist and the supervising physician. It is unclear how the pharmacy intern will interact with the written protocol. It may be advantageous to require the pharmacy intern to be included in the written protocol with the supervising physician since the pharmacy intern is delegated the authority to administer by the supervising physician. By not including the pharmacy intern in the written protocol, it is unclear how the supervising physician will know to whom he has delegated his authority.

On lines 28-36, uses the term adult and specifies a numeric age. It may be advantageous to remove the term "adult" and replace it with "person."

The bill authorizes a pharmacist or pharmacy intern to administer an EpiPen in the event of an anaphylactic reaction. This could be construed to mean such a reaction from anything or specifically due to the administration of an authorized vaccine. It may be advantageous to clarify under what circumstances an EpiPen may be administered (i.e. due to the administration of a vaccine).

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[52] 64B16-26.1001, F.A.C.

A bill to be entitled

An act relating to pharmacy; amending s. 465.189, F.S.; revising the types of vaccines that pharmacists may administer; authorizing pharmacy interns to administer certain vaccines under certain circumstances; authorizing pharmacists and pharmacy interns to administer an epinephrine autoinjection under certain circumstances; revising protocol requirements for vaccine administration and the duties of supervising physicians under such protocols; revising requirements for training programs, certifications, and patient records related to vaccine administration; amending s. 465.003, F.S.; conforming terminology; providing an effective date.

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

Section 1. Section 465.189, Florida Statutes, is amended to read:

465.189 Administration of vaccines and epinephrine autoinjection ~~influenza virus immunizations~~.—

(1) A pharmacist, and a certified pharmacy intern working under the pharmacist's supervision, ~~Pharmacists~~ may administer the following ~~influenza virus immunizations to adults~~ within the framework of an established protocol under a supervising ~~supervisory practitioner who is a~~ physician licensed under chapter 458 or chapter 459:

(a) Influenza vaccine to an adult 18 years of age or

older.

(b) Varicella zoster vaccine to an adult 60 years of age or older.

(c) Pneumococcal vaccine to an adult 65 years of age or older.

(d) Epinephrine using an autoinjector delivery system to an adult 18 years of age or older who is suffering an anaphylactic reaction.

The ~~Each~~ protocol must ~~shall~~ contain specific procedures for addressing any unforeseen adverse ~~allergic~~ reaction to the vaccine or epinephrine autoinjection ~~influenza virus immunizations~~.

(2) A pharmacist may not enter into a protocol unless he or she maintains at least $200,000 of professional liability insurance and has completed training on administration of the vaccines and epinephrine autoinjection ~~in influenza virus immunizations~~ as provided in this section.

(3) A pharmacist, or his or her intern, who administers a vaccine or epinephrine autoinjection must ~~administering influenza virus immunizations shall~~ maintain and make available patient records using the same standards for confidentiality and maintenance of such records as those that are imposed on health care practitioners under s. 456.057. These records must ~~shall~~ be maintained for a minimum of 5 years.

(4) The decision by a supervising physician ~~supervisory practitioner~~ to enter into a protocol under this section is a professional decision on the part of the physician ~~practitioner~~,

and a person may not interfere with a supervising physician's ~~supervisory practitioner's~~ decision to enter ~~as to entering~~ into such a protocol. A pharmacist or his or her intern may not enter into a protocol that is to be performed while acting as an employee without the written approval of the owner of the pharmacy. Pharmacists shall forward immunization records to the department for inclusion in the state registry of immunization information.

(5) Any pharmacist or pharmacy intern seeking to administer a vaccine or epinephrine autoinjection ~~influenza virus immunizations to adults~~ under this section must be certified to administer the vaccine or epinephrine autoinjection ~~influenza virus immunizations~~ pursuant to a certification program approved by the Board of Pharmacy in consultation with the Board of Medicine and the Board of Osteopathic Medicine. The certification program shall, at a minimum, require that the pharmacist or pharmacy intern attend at least 20 hours of continuing education classes approved by the board. The program shall have a curriculum of instruction concerning the safe and effective administration of the vaccines and epinephrine autoinjection listed in subsection (1) ~~influenza virus immunizations~~, including, but not limited to, potential adverse ~~allergic~~ reactions to the vaccines or epinephrine autoinjection ~~influenza virus immunizations~~.

(6) The written protocol between the pharmacist and supervising physician must include particular terms and conditions imposed by the supervising physician upon the pharmacist relating to the administration of a vaccine or

epinephrine autoinjection ~~influenza virus immunizations~~ by the pharmacist or his or her intern. The written protocol must ~~shall~~ include, at a minimum, specific categories and conditions among patients for whom the supervising physician authorizes the pharmacist or pharmacy intern to administer a vaccine or epinephrine autoinjection ~~influenza virus immunizations~~. The terms, scope, and conditions set forth in the written protocol between the pharmacist and the supervising physician must be appropriate to the pharmacist's or pharmacy intern's training and certification for the vaccine or epinephrine autoinjection ~~immunization~~. A pharmacist or his or her intern ~~Pharmacists~~ who is ~~have been~~ delegated the authority to administer a vaccine or epinephrine autoinjection ~~influenza virus immunizations~~ by the supervising physician must ~~shall~~ provide evidence of current certification by the Board of Pharmacy to the supervising physician. A supervising physician must ~~physicians shall~~ review the administration of the vaccine or epinephrine autoinjection ~~influenza virus immunizations~~ by the pharmacist or his or her intern ~~pharmacists~~ under such physician's supervision pursuant to the written protocol, and this review shall take place as outlined in the written protocol. The process and schedule for the review shall be outlined in the written protocol between the pharmacist and the supervising physician.

(7) The pharmacist shall submit to the Board of Pharmacy a copy of his or her protocol or written agreement to administer the vaccine or epinephrine autoinjection ~~influenza virus immunizations~~.

Section 2. Subsection (13) of section 465.003, Florida Statutes, is amended to read:

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

(13) "Practice of the profession of pharmacy" includes compounding, dispensing, and consulting concerning contents, therapeutic values, and uses of any medicinal drug; consulting concerning therapeutic values and interactions of patent or proprietary preparations, whether pursuant to prescriptions or in the absence and entirely independent of such prescriptions or orders; and other pharmaceutical services. For purposes of this subsection, "other pharmaceutical services" means the monitoring of the patient's drug therapy and assisting the patient in the management of his or her drug therapy, and includes review of the patient's drug therapy and communication with the patient's prescribing health care provider as licensed under chapter 458, chapter 459, chapter 461, or chapter 466, or similar statutory provision in another jurisdiction, or such provider's agent or such other persons as specifically authorized by the patient, regarding the drug therapy. However, ~~nothing in~~ this subsection does not ~~may be interpreted to~~ permit an alteration of a prescriber's directions, the diagnosis or treatment of any disease, the initiation of any drug therapy, the practice of medicine, or the practice of osteopathic medicine, unless otherwise permitted by law. The term "practice of the profession of pharmacy" ~~also~~ includes any other act, service, operation, research, or transaction incidental to, or forming a part of, any of the foregoing acts, requiring, involving, or employing the science or art of any branch of the pharmaceutical

profession, study, or training, and shall expressly permit a pharmacist to transmit information from persons authorized to prescribe medicinal drugs to their patients. The term ~~practice of the profession of pharmacy~~ also includes the administration of certain vaccines and epinephrine autoinjection ~~influenza virus immunizations~~ to adults pursuant to s. 465.189.

Section 3. This act shall take effect July 1, 2012.

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 Quality Subcommittee

Representative Logan offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Section 465.189, Florida Statutes, is amended to read:

465.189 Administration of vaccines and epinephrine autoinjection ~~influenza virus immunizations~~.—

(1) A pharmacist ~~Pharmacists~~ may administer the following ~~influenza virus immunizations to adults~~ within the framework of an established protocol under a supervising ~~supervisory practitioner who is a~~ physician licensed under chapter 458 or chapter 459:

(a) Influenza vaccine to an adult 18 years of age or older.

(b) Shingles vaccine to an adult 60 years of age or older.

(c) Pneumococcal vaccine to an adult 65 years of age or older.

(d) Epinephrine using an autoinjector delivery system to an adult 18 years of age or older who is suffering an anaphylactic reaction.

The ~~Each~~ protocol must ~~shall~~ contain specific procedures for addressing any unforeseen adverse ~~allergic~~ reaction to the vaccine or epinephrine autoinjection ~~influenza virus immunizations~~.

(2) A pharmacist may not enter into a protocol unless he or she maintains at least $200,000 of professional liability insurance and has completed training on administration of the vaccines and epinephrine autoinjection ~~in influenza virus immunizations~~ as provided in this section.

(3) A pharmacist who administers a vaccine or epinephrine autoinjection must ~~administering influenza virus immunizations shall~~ maintain and make available patient records using the same standards for confidentiality and maintenance of such records as those that are imposed on health care practitioners under s. 456.057. These records must ~~shall~~ be maintained for a minimum of 5 years.

(4) The decision by a supervising physician ~~supervisory practitioner~~ to enter into a protocol under this section is a professional decision on the part of the physician ~~practitioner~~, and a person may not interfere with a supervising physician's ~~supervisory practitioner's~~ decision to enter ~~as to entering~~ into such a protocol. A pharmacist may not enter into a protocol that

is to be performed while acting as an employee without the written approval of the owner of the pharmacy. Pharmacists shall forward immunization records to the department for inclusion in the state registry of immunization information.

(5) Any pharmacist seeking to administer a vaccine or epinephrine autoinjection ~~influenza virus immunizations to adults~~ under this section must be certified to administer the vaccine or epinephrine autoinjection ~~influenza virus immunizations~~ pursuant to a certification program approved by the Board of Pharmacy in consultation with the Board of Medicine and the Board of Osteopathic Medicine. The certification program shall, at a minimum, require that the pharmacist attend at least 20 hours of continuing education classes approved by the board. The program shall have a curriculum of instruction concerning the safe and effective administration of the vaccines and epinephrine autoinjection listed in subsection (1) ~~influenza virus immunizations~~, including, but not limited to, potential adverse ~~allergic~~ reactions to the vaccines or epinephrine autoinjection ~~influenza virus immunizations~~.

(6) The written protocol between the pharmacist and supervising physician must include particular terms and conditions imposed by the supervising physician upon the pharmacist relating to the administration of a vaccine or epinephrine autoinjection ~~influenza virus immunizations~~ by the pharmacist. The written protocol must ~~shall~~ include, at a minimum, specific categories and conditions among patients for whom the supervising physician authorizes the pharmacist to administer a vaccine or epinephrine autoinjection ~~influenza~~

~~virus immunizations~~. The terms, scope, and conditions set forth in the written protocol between the pharmacist and the supervising physician must be appropriate to the pharmacist's training and certification for the vaccine or epinephrine autoinjection ~~immunization~~. A pharmacist ~~Pharmacists~~ who is ~~have been~~ delegated the authority to administer a vaccine or epinephrine autoinjection ~~influenza virus immunizations~~ by the supervising physician must ~~shall~~ provide evidence of current certification by the Board of Pharmacy to the supervising physician. A supervising physician must ~~physicians shall~~ review the administration of the vaccine or epinephrine autoinjection ~~influenza virus immunizations~~ by the pharmacist ~~pharmacists~~ under such physician's supervision pursuant to the written protocol, and this review shall take place as outlined in the written protocol. The process and schedule for the review shall be outlined in the written protocol between the pharmacist and the supervising physician.

(7) The pharmacist shall submit to the Board of Pharmacy a copy of his or her protocol or written agreement to administer the vaccine or epinephrine autoinjection ~~influenza virus immunizations~~.

Section 2. Subsection (13) of section 465.003, Florida Statutes, is amended to read:

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

(13) "Practice of the profession of pharmacy" includes compounding, dispensing, and consulting concerning contents, therapeutic values, and uses of any medicinal drug; consulting concerning therapeutic values and interactions of patent or

proprietary preparations, whether pursuant to prescriptions or in the absence and entirely independent of such prescriptions or orders; and other pharmaceutical services. For purposes of this subsection, "other pharmaceutical services" means the monitoring of the patient's drug therapy and assisting the patient in the management of his or her drug therapy, and includes review of the patient's drug therapy and communication with the patient's prescribing health care provider as licensed under chapter 458, chapter 459, chapter 461, or chapter 466, or similar statutory provision in another jurisdiction, or such provider's agent or such other persons as specifically authorized by the patient, regarding the drug therapy. However, ~~nothing in~~ this subsection does not ~~may be interpreted to~~ permit an alteration of a prescriber's directions, the diagnosis or treatment of any disease, the initiation of any drug therapy, the practice of medicine, or the practice of osteopathic medicine, unless otherwise permitted by law. The term "practice of the profession of pharmacy" ~~also~~ includes any other act, service, operation, research, or transaction incidental to, or forming a part of, any of the foregoing acts, requiring, involving, or employing the science or art of any branch of the pharmaceutical profession, study, or training, and shall expressly permit a pharmacist to transmit information from persons authorized to prescribe medicinal drugs to their patients. The term ~~practice of the profession of pharmacy~~ also includes the administration of certain vaccines and epinephrine autoinjection ~~influenza virus immunizations~~ to adults pursuant to s. 465.189.

Section 3. This act shall take effect July 1, 2012.

Amendment No.1

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 pharmacy; amending s. 465.189, F.S.; revising the types of vaccines that pharmacists may administer; authorizing pharmacists to administer an epinephrine autoinjection under certain circumstances; revising protocol requirements for vaccine administration and the duties of supervising physicians under such protocols; revising requirements for training programs, certifications, and patient records related to vaccine administration; amending s. 465.003, F.S.; conforming terminology; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1313 Dental Hygienists
SPONSOR(S): Corcoran
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Quality Subcommittee		Holt	Calamas
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

A dental hygienist practices under the supervision of a licensed dentist and may be delegated various remediable tasks – intraoral treatment tasks which are reversible and do not cause an increased risk to the patient. Dental hygienists may not perform any irremediable tasks – intraoral treatment tasks which are irreversible or cause an increased risk to the patient. The administration of anesthetics other than topical anesthetics is considered to be an irremediable task. A dentist may not delegate irremediable tasks unless granted specific authority in law.

The bill grants dental hygienists the specific authority to administer local anesthesia, which includes intraoral block and soft tissue infiltration anesthesia. A dental hygienist who wishes to administer anesthesia must complete an approved 60-hour course in the administration of local anesthesia and maintain a certification in basic or advanced CPR.

DOH is directed to issue a certificate to a dental hygienist who meets all criteria for a certificate. The certificate is not subject to the licensure renewal process and is considered part of the dental hygienists permanent record. The certificate must be prominently displayed at the location where the dental hygienist is administering local anesthesia.

The bill has an indeterminate, but likely minimal, fiscal impact to the Medical Quality Assurance Trust Fund within the Department of Health. (See Fiscal Analysis).

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Medical Quality Assurance

The Department of Health (DOH), Division of Medical Quality Assurance (MQA), regulates health care practitioners to ensure the health, safety and welfare of the public. Currently, MQA supports licensure and disciplinary activities for 43 professions and 37 types of facilities/establishments, and works with 22 boards and 6 councils.

Boards

A board is a statutorily created entity that is authorized to exercise regulatory or rulemaking functions within the MQA.[1] Boards are responsible for approving or denying applications for licensure and making disciplinary decisions on whether a practitioner practices within the authority of their practice act. Practice acts refer to the legal authority in state statute that grants a profession the authority to provide services to the public. The range of disciplinary actions taken by a board includes citations, suspensions, reprimands, probations, and revocations.

Dental Hygienists

Dental hygienists are governed by chapter 466, F.S., the Dentistry, Dental Hygiene, and Dental Laboratories practice act (Dental Practice Act). Dental hygiene is defined as the rendering of educational, preventative, and therapeutic dental services and any related extra-oral procedures within the scope and practice area of a dental hygienist.[2] Currently, there are 4,208 individuals who hold an active in-state license to practice as a dental hygienist in Florida.[3]

Dental hygienists practice under the supervision of dentists and may be delegated various remediable and irremediable tasks. The administration of anesthetics other than topical anesthetics is considered to be an irremediable task.[4] Dentists are responsible for any delegated procedures or tasks.[5]

Delegated Tasks

There are two types of tasks within the practice of dentistry that specify delegation parameters for dentists: irremediable and remediable tasks.[6]

"Irremediable tasks" are those intraoral treatment tasks which, when performed, are irreversible and create unalterable changes within the oral cavity or the contiguous structures or which cause an increased risk to the patient. The administration of anesthetics other than topical anesthesia and the use of a laser or laser device of any type are considered to be "irremediable tasks".[7] A dentist may not delegate irremediable tasks unless granted specific authority in law.[8]

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[1] Section 456.001, F.S.
[2] Section 466.003(4), F.S.
[3] Florida Department of Health, Division of Medical Quality Assurance, 2010-2011 MQA Annual Report, *available at*: http://doh.state.fl.us/mqa/reports.htm (last viewed January 17, 2012).
[4] Section 466.003, F.S.
[5] Section 466.024(9), F.S.
[6] Dental hygienists are regulated by ss. 466.023, 466.0235, and 466.024, F.S.
[7] S. 466.003(11), F.S. and 64B5-16.001, F.A.C.
[8] Section 466.024(1), F.S.

"Remediable tasks" are those intraoral treatment tasks which are reversible and do not create unalterable changes within the oral cavity or the contiguous structures and which do not cause an increased risk to the patient.[9] A dentist may delegate remediable tasks to a dental hygienist when the tasks pose no risk to the patient. The board is granted the authority to designate tasks that are remediable and delegable, except for the following tasks that are designated in law:[10]

- Taking impressions for study casts but not for the purpose of fabricating any intraoral restorations or orthodontic appliance;
- Placing periodontal dressings;
- Removing periodontal or surgical dressings;
- Removing sutures;
- Placing or removing rubber dams;
- Placing or removing matrices;
- Placing or removing temporary restorations;
- Applying cavity liners, varnishes, or bases;
- Polishing amalgam restorations;
- Polishing clinical crowns of the teeth for the purpose of removing stains but not changing the existing contour of the tooth; and
- Obtaining bacteriological cytological specimens not involving cutting of the tissue.

A dentist may only delegate remediable tasks to a dental assistant or a dental hygienist when the tasks pose no risk to the patient. Section 466.024(8), F.S., prohibits dentists from delegating the writing of a prescription drug order and determining a diagnosis for treatment or a treatment plan.

Supervision

There are three levels of supervision within the practice of dentistry: direct, indirect, and general. Under "direct supervision", a dentist diagnoses the condition to be treated, a dentist authorizes the procedure to be performed, a dentist remains on the premises while the procedures are performed, and a dentist approves the work performed before dismissal of the patient.[11] Under "indirect supervision", a dentist examines a patient, diagnoses a condition to be treated, authorizes the procedure, and a dentist is on the premises while the procedures are performed.[12]

Under "general supervision[13]", a dentist authorizes the procedure being carried out but is not required to be present when the authorized procedure is being performed.[14] The authorized procedure may be performed at a place other than the dentist's usual place of practice. Furthermore, general supervision requires that a dentist examine the patient, diagnose the condition to be treated, and then authorize a procedure to be performed.[15] Any authorization for remediable tasks to be performed under general supervision is valid for a maximum of 13 months; after which, no further treatment under general supervision can be performed without another clinical exam by a licensed dentist.[16]

All levels of supervision require that a dental hygienist or dental assistant receive the appropriate formal training or on-the job training to be qualified to perform delegated tasks.[17]

Anesthesia in Dentistry

Currently, only licensed dentists may administer general or local anesthetics within the practice of dentistry.[18] The anesthesia modalities authorized for use in dentistry are:[19]

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[9] S. 466.003(12), F.S.
[10] Section 466.024(1), F.S.
[11] S. 466.003(8), F.S.
[12] S. 466.003(9), F.S. and 64B5-16.001(5), F.A.C.
[13] The issuance of a written work authorization to a commercial dental laboratory by a dentist does not constitute general supervision.
[14] S. 466.003(10), F.S.
[15] 64B5-16.001(6), F.A.C.
[16] 64B5-16.001(7), F.A.C.
[17] 64B5-16.005 and 64B5-16.006, F.A.C.

- Local anesthesia, which leads to diminished pain sensation in a specific area of the body without loss of consciousness, usually achieved with a topically-applied or superficially-injected numbing agent.
- General anesthesia, which is a controlled state of pharmacologically-induced unconsciousness accompanied by a partial or complete loss of protective reflexes.
- Conscious sedation, which is a depressed level of consciousness produced by a pharmacologic substance in which the patient's ability to independently maintain an airway and respond appropriately to physical and verbal stimulation is retained.
- Nitrous-oxide inhalation anesthesia, which is produced by the inhalation of a combination of nitrous-oxide and oxygen and causes an altered level of consciousness while retaining the patient's ability to independently maintain an airway and respond appropriately to physical stimulation or verbal commands.

Moreover, dentists who administer anesthesia are required to maintain certification in cardiopulmonary resuscitation (CPR) and either Advanced Cardiac Life Support (ACLS) or Advanced Trauma Life Support.[20]

Oral medications may not be used for sedation unless the dentist holds a conscious sedation permit, and the administration of propofol, methohexital, thiopental, or etomidate is prohibited without a general anesthesia permit.[21] A dentist who performs conscious sedation in a dental office may only induce on patient at a time.[22] A second patient may not be induced until the first patient is awake, alert, conscious, spontaneously breathing, has stable vital signs, is ambulatory with assistance, is under the care of a responsible adult, and the portion of the procedure requiring the participation of the dentist is complete.[23]

The only agents authorized for inhalation analgesia is nitrous-oxide.[24] To perform nitrous-oxide inhalation anesthesia, a dentist must complete a 2-day training course described in the American Dental Association's "Guidelines for Teaching and Comprehensive Control of Pain and Anxiety in Dentistry" or an equivalent program and have adequate equipment with fail-safe features.[25] Alternatively, a dentist who holds any type of anesthesia permit is also authorized to perform nitrous-oxide inhalation anesthesia.[26]

Dental Hygienists and Anesthesia

The presence of at least one assistant is required for all general anesthesia, conscious sedation, and pediatric conscious sedation procedures. Dental hygienists may assist with such procedures under the direct supervision of a permitted dentist if they possess a valid basic CPR certificate.[27] Dental hygienists may monitor nitrous-oxide inhalation analgesia under the direct supervision of a permitted dentist if they complete a 2-day training course as described in the American Dental Association's "Guidelines for Teaching and Comprehensive Control of Pain and Anxiety in Dentistry" or an equivalent program.[28]

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[18] Section 466.017(1), F.S.
[19] Rule 64B5-14.001, F.A.C.
[20] Section 466.017(4), F.S.
[21] Rule 64B5-14.002, F.A.C.
[22] 64B5-14.004, F.A.C.
[23] *Id.*
[24] 64B5-14.002, F.A.C.
[25] 64B5-14.003, F.A.C.
[26] *Id.*
[27] Rule 64B5-14.003, F.A.C.
[28] Rule 64B5-14.004(2), F.A.C.

Effect of Proposed Changes

The bill grants dental hygienists the specific authority to administer local anesthesia, which includes intraoral block and soft tissue infiltration anesthesia. This authority is limited to patients 18 years or older. Currently, the administration of anesthetics other than topical anesthetics is considered to be an irremediable task and dental hygienists are not authorized to perform irremediable tasks unless granted specific authority in law.

The bill "notwithstands" s. 466.003, F.S., which is the definition section for the Dentistry and Dental Hygiene Practice Act. The effect of the notwithstanding clause is unclear.

A dental hygienist who wishes to administer local anesthesia must meet the following criteria:

- Hold a current certification in basic or advanced cardiac life support;
- Apply for a certificate authorizing administration of local anesthesia; and
- Complete a 60-hour course in the administration of local anesthesia offered by a dental or dental hygiene program approved by the board or a program accredited by the Commission on Dental Accreditation of the American Dental Association. The course must be comprised of 30-hours of didactic instruction and 30-hours of clinical experience. The didactic instruction must include the following areas of study:
    - Anatomy;
    - Infection control;
    - Local anesthesia medical emergencies;
    - Neurophysiology;
    - Pharmacology of local anesthetics and vasoconstrictors;
    - Psychological aspects of pain control;
    - Selection of pain control modalities;
    - Systemic complications;
    - Techniques of mandibular anesthesia; and
    - Theory of pain control.

The bill directs DOH to issue a certificate to a dental hygienist who meets the eligibility criteria. The certificate is not subject to the licensure renewal process and is considered part of the dental hygienist's permanent record. The certificate must be prominently displayed where the dental hygienist is administering local anesthesia.

B. SECTION DIRECTORY:

Section 1. Amends s. 466.017, F.S., relating to prescription of drugs and anesthesia.
Section 2. Amends s. 466.023, F.S., relating to dental hygienists scope of practice.
Section 3. Provides an effective date of becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None identified.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None identified.

2. Expenditures:

None identified.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None identified.

D. FISCAL COMMENTS:

The bill does not provide a fee to cover the regulatory cost DOH will incur to verify if a dental hygienist has meets the criteria to administer local anesthesia and issue a certificate.

Section 216.0236, F.S., provides that regulatory services or programs are to be borne solely by those who receive the service or who are subject to regulation. A regulatory program should be totally self-sufficient or is required to demonstrate that the service or program provides substantial benefits to the public in order to justify a partial subsidy from other state funds.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill does not provide DOH or the Board of Dentistry any authority to promulgate rules to implement the provisions of the bill and there is not sufficient authority in chapter 466, F.S., the Dental Practice Act.

C. DRAFTING ISSUES OR OTHER COMMENTS:

On line 18, the bill notwithstands s. 466.003, F.S. This section of law is the definitions section to the dentistry practice act. It not clear what the notwithstanding clause is trying to do.

Subsection (5) of the bill states that the dentist may administer intraoral block and soft tissue infiltration anesthesia. This is the only part of the bill were these procedures are mentioned. It is unclear if these are the types of local anesthesia the bill is authorizing. It may be advantageous to provide a definition of local anesthesia.

Currently, chapter 466, F.S., does not provide the board sufficient authority to implement the provisions of the bill, nor does the bill provide this authority.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to dental hygienists; amending s. 466.017, F.S.; authorizing dental hygienists to administer certain local anesthesia under the direct supervision of a licensed dentist if certain educational requirements are met; amending s. 466.023, F.S.; revising the scope and area of practice for dental hygienists, to conform to changes made by this act; providing an effective date.

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

Section 1. Present subsections (5) and (6) of section 466.017, Florida Statutes, are renumbered as subsections (7) and (8), respectively, and new subsections (5) and (6) are added to that section to read:

466.017 Prescription of drugs; anesthesia.—

(5) Notwithstanding s. 466.003, a dental hygienist under the direct supervision of a licensed dentist may administer intraoral block and soft tissue infiltration anesthesia to a nonsedated patient 18 years of age or older, if the following criteria are met:

(a) The dental hygienist has successfully completed a course in the administration of local anesthesia offered by a dental or dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association or approved by the board. A course involving local anesthesia administration must contain a minimum of 30 hours of didactic

instruction and 30 hours of clinical experience. In the case of local anesthesia, the course of instruction shall include the following:

1. Anatomy.

2. Infection control.

3. Local anesthesia medical emergencies.

4. Neurophysiology.

5. Pharmacology of local anesthetics.

6. Pharmacology of vasoconstrictors.

7. Psychological aspects of pain control.

8. Selection of pain control modalities.

9. Systemic complications.

10. Techniques of mandibular anesthesia.

11. Techniques of maxillary anesthesia.

12. Theory of pain control.

(b) The dental hygienist maintains and presents evidence of current certification in basic or advanced cardiac life support.

(6) Application for certification in the administration of local anesthesia under subsection (5) is at the discretion of the dental hygienist. The department shall issue a certificate to a dental hygienist who meets the criteria in subsection (5) after the initial completion of the requirements to administer local anesthesia. The certificate is not subject to renewal but is part of the dental hygienist's permanent record and must be prominently displayed where the dental hygienist is administering local anesthesia.

Section 2. Subsection (6) of section 466.023, Florida Statutes, is renumbered as subsection (7), and a new subsection (6) is added to that section to read:

466.023 Dental hygienists; scope and area of practice.—

(6) Dental hygienists may administer local anesthesia as provided in s. 466.017.

Section 3. This act shall take effect upon becoming a law.

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 Quality Subcommittee
Representative Corcoran offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Present subsection (4) of section 466.017, Florida Statutes, is amended, subsections (5) and (6) are renumbered as (7) and (8), respectively, and new subsections (5), and (6) are added to read:

466.017 Prescription of drugs; anesthesia.—

(4) A dentist or dental hygienist who administers or employs the use of any form of anesthesia must possess a certification in either basic cardiopulmonary resuscitation for health professionals or advanced cardiac life support approved by the American Heart Association or the American Red Cross or an equivalent agency-sponsored course with recertification every 2 years. Each dental office which uses any form of anesthesia must have immediately available and in good working order such

resuscitative equipment, oxygen, and other resuscitative drugs as are specified by rule of the board in order to manage possible adverse reactions.

(5) A dental hygienist under the direct supervision of a dentist may administer local anesthesia, including intraoral block and soft tissue infiltration anesthesia, including both intraoral block and soft tissue infiltration anesthesia, to a nonsedated patient who is 18 years of age or older, if the following criteria are met:

(a) The dental hygienist has successfully completed a course in the administration of local anesthesia which is offered by a dental or dental hygiene program accredited by the Commission on Dental Accreditation of the American Dental Association or approved by the board. The course must include a minimum of 30 hours of didactic instruction and 30 hours of clinical experience, and instruction in:

1. Theory of pain control;
2. Selection-of-pain-control modalities;
3. Anatomy;
4. Neurophysiology;
5. Pharmacology of local anesthetics;
6. Pharmacology of vasoconstrictors;
7. Psychological aspects of pain control;
8. Systematic complications;
9. Techniques of maxillary anesthesia;
10. Techniques of mandibular anesthesia;
11. Infection Control; and
12. Medical emergencies involving local anesthesia.

(b) The dental hygienist presents evidence of current certification in basic or advanced cardiac life support.

(c) The dental hygienist possesses a valid certificate issued under subsection (6).

(6) Any dental hygienist seeking a certificate to administer local anesthesia must apply to the department, remit an application fee, and submit proof of completion of successfully completed a course in the administration of local anesthesia pursuant to subsection (5). The board shall certify, and the department shall issue a certificate to, any dental hygienist who fulfills the qualifications of subsection (5). The board shall establish a one-time application fee not to exceed $35. The certificate is not subject to renewal but is part of the dental hygienist's permanent record and must be prominently displayed at the location where the dental hygienist is authorized to administer local anesthesia. The board shall adopt rules pursuant to ss.120.536(1) and 120.54 necessary to administer subsections (5)-(6).

Section 2. Subsection (7) is added to section 466.023, Florida Statutes, to read:

466.023 Dental hygienists; scope and area of practice. —

(7) A dental hygienist may administer local anesthesia as provided in ss. 466.017 and 466.024.

Section 3. Subsection (1) of section 466.024, Florida Statutes, is amended to read:

466.024 Delegation of duties; expanded functions.—

(1) A dentist may not delegate irremediable tasks to a dental hygienist or dental assistant, except as provided by law.

Amendment No.1

A dentist may delegate remediable tasks to a dental hygienist or dental assistant when such tasks pose no risk to the patient. A dentist may only delegate remediable tasks so defined by law or rule of the board. The board by rule shall designate which tasks are remediable and delegable, except that the following are by law found to be remediable and delegable:

(a) Taking impressions for study casts but not for the purpose of fabricating any intraoral restorations or orthodontic appliance.

(b) Placing periodontal dressings.

(c) Removing periodontal or surgical dressings.

(d) Removing sutures.

(e) Placing or removing rubber dams.

(f) Placing or removing matrices.

(g) Placing or removing temporary restorations.

(h) Applying cavity liners, varnishes, or bases.

(i) Polishing amalgam restorations.

(j) Polishing clinical crowns of the teeth for the purpose of removing stains but not changing the existing contour of the tooth.

(k) Obtaining bacteriological cytological specimens not involving cutting of the tissue.

(l) Administering local anesthesia pursuant to s. 466.017(5).

This subsection does not limit delegable tasks to those specified herein.

Section 4. This section shall take effect July 1, 2012.

Amendment No.1

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

Remove the entire title and insert:

A bill entitled

An act relating to dental hygienists; amending s. 466.017, F.S.; authorizing dental hygienists to administer certain local anesthesia under the direct supervision of a licensed dentist if certain educational requirements are met; requires dental hygienists to maintain current certification in basic or advanced cardiopulmonary resuscitation or advanced cardiac life support with recertification every 2 years; amending s. 466.023, F.S.; revising the scope and area of practice for dental hygienists, to conform to changes made by this act; amending s. 466.024, F.S.; revising the delegated duties that are found to be remediable and delegable, to conform to changes made by this act; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1329 Health Care Consumer Protection
SPONSOR(S): Corcoran
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health & Human Services Quality Subcommittee		Poche	Calamas
2) Insurance & Banking Subcommittee			
3) Health Care Appropriations Subcommittee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

HB 1329 amends s. 395.107, F.S., to require ambulatory surgical centers and diagnostic-imaging centers to publish and post a schedule of medical charges for the 50 most frequently provided services and treatments at each center. The prices for medical service and treatment must be those charged to uninsured patients who pay for service or treatment by cash, check, credit card or debit card. The posting must be in a conspicuous place in the reception area of the center and comply with size and content requirements. The bill provides for a $1,000 fine, per day, for failure to comply with the law.

The bill requires certain medical practitioners to publish and distribute, in writing, a schedule of medical charges that meets the same requirements as those imposed on the centers, above. The schedule must be distributed to patients at every visit. Failure to distribute the schedule as required by law is grounds for discipline under the medical practice acts and pursuant to s. 456.072, F.S.

The bill prohibits "balance billing" by a provider for emergency care and services rendered to an insured patient if the insured patient is transported to a facility by emergency medical transportation services. "Balance billing" is also prohibited for nonemergency medical care and services if it was provided in a facility licensed under chapter 395, F.S., that has a contract with the patient's health insurer and the care or service was delivered by a provider who does not have a contract with the patient's health insurer, and the patient did not have the ability and opportunity to choose an alternate provider who has a contract with the patient's health insurer.

The bill requires specific disclosures by health insurers, facilities licensed under chapter 395, F.S., and medical professionals who provide medical care and services in those facilities to insured patients regarding contractual relationships between and among the entities and whether or not those entities will bill the insured patient directly for services rendered within the facility. The bill provides for fines and other penalties for failing to provide the requisite disclosure.

The bill makes conforming changes to statutes consistent with proposed law.

The bill has an indeterminate, possibly significant, fiscal impact on state government.

The bill provides an effective date of July 1, 2012.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Regulation of Health Insurers and HMOs

The Office of Insurance Regulation (OIR) regulates health insurance contracts and rates under part VI of chapter 627, F.S., and health maintenance organization (HMO) contracts and rates under part I of chapter 641, F.S. The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of chapter 641, F.S.

Before receiving a certificate of authority from OIR, an HMO must receive a Health Care Provider Certificate from AHCA. Any entity that is issued a certificate of authority and that is otherwise in compliance with the licensure provisions under part I of chapter 641, F.S., may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services to subscribers.

Florida Patient's Bill of Rights and Responsibilities

In 1991, Florida enacted the Florida Patient's Bill of Rights and Responsibilities as s. 381.026, F.S.[1] The statute established the right of patients to expect medical providers to observe standards of care in providing medical treatment and communicating with their patients.[2] The standards of care include, but are not limited to, the following aspects of medical treatment and patient communication:

- Individual dignity
- Provision of information
- Financial information and the disclosure of financial information
- Access to health care
- Experimental research
- Patient's knowledge of rights and responsibilities

Pursuant to the section relating to financial information and disclosure of financial information, a patient has the right to request certain financial information from health care providers and facilities.[3] Specifically, upon request, a health care provider or health care facility must provide a person with a reasonable estimate of the cost of medical treatment prior to the provision of treatment.[4] Estimates are required to be written in language "comprehensible to an ordinary layperson."[5] The reasonable estimate does not preclude the health care provider or health care facility from exceeding the estimate or making additional charges as the patient's needs or medical condition warrant.[6] A patient has the right to receive a copy of an itemized bill upon request and to receive an explanation of charges upon request.[7]

Health Care Price Transparency

In 2011, the Legislature passed CS/CS/HB 935, which was signed by the Governor.[8] The law requires an urgent care center[9] to publish and post a schedule of medical services provided and the cost of

[1] S. 1, Ch. 91-127, Laws of Fla. (1991).
[2] S. 381.026(3), F.S.
[3] S. 381.026(4)(c), F.S.
[4] S. 381.026(4)(c)3., F.S.
[5] *Id.*
[6] *Id.*
[7] S. 381.026(4)(c)5., F.S.
[8] *See* Chapter 2011-122, Laws of Fla.

each service, grouped into three pricing levels.[10] The charges posted must be those fees charged to an uninsured patient who is paying for medical treatment by cash, check, credit card or debit card.[11] The schedule must be posted in a conspicuous place in the reception area of the office in an area of 15 square feet or more.[12] The schedule must list the 50 most frequently performed services provided by the urgent care center.[13] A primary care provider[14] (PCP) may post the same schedule of medical services provided.[15] If a PCP chooses to post a schedule of medical services, the schedule is subject to the same size and text requirements as an urgent care center.[16]

A health care provider or health care facility is required to provide a reasonable estimate of charges for non-emergency medical treatment to a patient.[17] The law also requires that the estimate comply with posted charges for medical treatment.[18]

Section 408.05, F.S. requires the AHCA to establish the Florida Center for Health Information and Policy Analysis (the Center).[19] The Center was required to create "a comprehensive health information system to provide for the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of both purposefully collected and extant health-related data and statistics."[20] Specifically, the Center makes available to consumers health care quality measures and financial data of physicians, health care facilities, and other entities to enable the comparison of health care services.[21] The database includes certain health care quality measures such as average patient charges, the average of undiscounted charges on frequently performed procedures and preventive diagnostic procedures, and a range of charges for procedures from highest to lowest.[22]

Balance Billing

"Balance billing" is the term given to the practice of a provider of medical care or treatment, such as a physician or hospital, seeking to collect payment from an insured patient or HMO subscriber, the amount of which is beyond the co-payment and deductible outlined in the health insurance plan or HMO contract. Essentially, the provider seeks to collect the total fee charged to a patient from the patient after the terms of the insurance plan or contract is applied to the total fee. Florida law prohibits balance billing of HMO subscribers.[23] Florida law also provides that AHCA may impose a fine on a hospital for balance billing an HMO subscriber[24], the amount of which is to be determined under section 641.52(5), F.S.[25].

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[9] S. 395.002(30), F.S., defines "urgent care center" as a facility or clinic that provides immediate but not emergent ambulatory medical care to patients with or without an appointment. It does not include the emergency department of a hospital.
[10] S. 395.107, F.S.
[11] *Id.*
[12] *Id.*
[13] *Id.*
[14] S. 381.026(2)(d), F.S., defines "primary care provider" as a health care provider licensed under chapter 458, chapter 459, or chapter 464 who provides medical services to patients which are commonly provided without referral from another health care provider, including family and general practice, general pediatrics, and general internal medicine.
[15] S. 381.026(4)(c)3., F.S.
[16] *Id.*
[17] S. 381.026(4)(c)5., F.S.
[18] *Id.*
[19] S. 408.05, F.S.
[20] S. 408.05(1), F.S.
[21] S. 408.05(3)(k), F.S.
[22] S. 408.05(3)(k)1., F.S.; *see also* 2009 Hospital Financial Data, AHCA, data compiled September 2, 2010- available at http://ahca.myflorida.com/MCHQ/CON_FA/Publications/index.shtml (includes the most recent financial data for hospitals, including costs of daily hospital services, ambulatory services, and other total patient charges); *see also* http://www.floridahealthfinder.gov/CompareCare/CompareFacilities.aspx (provides the range of charges for specific procedures at various facilities throughout Florida, broken down by category, condition or procedure, and age group).
[23] S. 641.3154, F.S.
[24] S. 395.1065(2)(c), F.S.
[25] S. 641.52(5), F.S. ,provides AHCA with the authority to suspend an HMO's authority to enroll new members, revoke the health care provider certificate, and assess fines for willful and non-willful violations not to exceed $2,500 and $20,000, respectively, with caps on the aggregate amount of fines assessed.

There is no prohibition against balance billing of a patient covered by a health insurer subject to regulation under chapter 627, F.S.

Effect of Proposed Changes

Price Transparency

The bill requires an ambulatory surgical center[26] and a diagnostic-imaging center[27] to comply with the provisions of s. 395.107, F.S. Each center is required to post a schedule of charges for the 50 most frequently provided medical services in a conspicuous location in the reception area of the center. The schedule must include the price charged to an uninsured patient paying for the service by cash, check, credit card or debit card. Prices for medical services may be grouped into three pricing levels. The posted scheduled must be at least 15 square feet in size.

The schedule of charges for medical services posted by an urgent care center, ambulatory surgical center, and a diagnostic-imaging center must describe each medical service in language comprehensible to a layperson. This provision prevents a center from using medical or billing codes, Latin phrases, or technical medical jargon as the only description of each medical service. The bill also requires the text of the schedule of medical charges to fill at least 12 square feet of the total 15 square feet area of the posted schedule.

In situations in which the care center is affiliated with a facility licensed under chapter 395, F.S.,[28] the schedule of medical charges must include a statement, in a font which is the same size as other text on schedule, explaining whether charges for medical care received at the care center will be the same as charges for medical care received at the facility licensed under chapter 395. This statement regarding medical charges must be included in all advertisements for the care facility and must be in language comprehensible to a layperson. This provision provides for transparency of medical facility charges so that a consumer, who may choose to seek treatment at a care center rather than the emergency room assuming that the cost of care at the care center is lower than the cost of care at an emergency room, can expect the charges for care received and choose the option for medical care that best fits the consumer's budget.

The bill requires allopathic physicians, osteopathic physicians, chiropractors, and podiatrists to publish, in writing, a schedule of medical charges, as required of urgent care centers and other specified facilities. The schedule must meet all of the requirements contained in s. 395.107, F.S. The schedule must be given to patients at each visit.

The bill imposes a fine of $1,000, per day, on an urgent care center, ambulatory surgical center, or diagnostic-imaging center that fails to post the schedule of medical charges. The failure of a practitioner to publish and distribute a schedule of medical charges is deemed grounds for discipline under s. 456.072(1), F.S., and subjects the offending practitioner to discipline under the applicable practice act and s. 456.072(2), F.S.[29]

Balance Billing Prohibition

The bill prohibits provider balance billing of an insured by a provider for emergency care and services if the insured was transported to a facility by emergency medical transportation services, as defined by s.

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[26] S. 395.002(3), F.S., defines "ambulatory surgical center", in part, as a "facility the primary purpose of which is to provide elective surgical care, in which the patient is admitted to and discharged from such facility within the same working day and is not permitted to stay overnight, and which is not part of a hospital."

[27] "Diagnostic-imaging center" is defined in section 1 of the bill as a free-standing outpatient facility that provides specialized services for diagnosis of a disease by examination and also provides radiological services.

[28] S. 395.002(12), F.S., (hospital); s. 395.002(3), F.S., (ambulatory surgical center); s. 395.002(21), F.S., (mobile surgical facility); s. 395.002(28), F.S., (specialty hospital).

[29] Possible disciplinary action includes, but is not limited to, suspension or revocation of license, administrative fine, license probation, or other corrective action.

945.6041(1)(a), F.S.[30] Further, provider balance billing of an insured by a provider for nonemergency medical care and services is prohibited if the care or service is provided in a facility licensed under chapter 395, F.S., which has a contract with the health insurer and the care or service is provided by a provider who does not have a contract with the health insurer, and the insured had no ability and opportunity to choose an alternate provider who has a contract with the health insurer. This provision addresses the situation in which a patient maintains health insurance, seeks treatment from a covered hospital entity, is treated by providers within the hospital who do not have a contract with the patient's insurer, and the patient has no ability to choose a contracted provider. The patient is negatively impacted by a contractual situation, or lack thereof, over which he or she has no control or input. This provision allows the patient to avoid charges for medical care over and above that which is covered by the patient's health insurance coverage.

Balance Billing Transparency

The bill creates s. 627.6385, F.S., requiring health insurers, hospitals, and medical providers to disclose contractual relationships among the parties and to disclose, in advance of the provision of medical care or service, whether or not the patient will be balance billed as a result of the contractual relationship, or lack thereof, among the insurer, hospital, and medical provider. The bill provides transparency in the billing process and allows the health care consumer to make an informed choice regarding his or her medical treatment.

The bill requires each health insurer operating within the state to disclose to the insured if a facility licensed under chapter 395, F.S., contracts with medical providers that do not have a contractual relationship with the insurer. This information must be available on the insurer website and must be distributed to each insured.

The bill then requires a facility licensed under chapter 395, F.S., to disclose to a patient, at the time the patient is admitted or schedules medical care or treatment, which providers will treat the patient and which of those providers do not have a contractual relationship with the patient's insurer. The disclosure must include notice to the patient that the providers without a contractual relationship with the patient's insurer may bill the patient directly for services rendered within the facility. The notice must:

- Be limited to the providers reasonably expected to treat the insured, based on the medical care or treatment scheduled by the insured. For example, if the insured is scheduled to undergo a heart catheterization, the notice will apply to the anesthesiologist and the cardiologist scheduled to treat the insured. The notice will not apply to an oncologist or obstetrician, as those providers cannot be reasonably expected to provide treatment to the insured undergoing a cardiac procedure;
- Be in writing;
- Include the name, address, and telephone number of each provider; and
- Direct the insured to contact each provider to determine if the insured will be billed directly by the provider.

Failure to provide disclosure to the insured as required by this provision of the bill results in a $500 fine, per occurrence, to be imposed by the AHCA, pursuant to the provisions of s. 408.813, F.S.[31]

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[30] S. 945.6041(1)(a), F.S., defines "emergency medical transportation services" as including, but not limited to, services rendered by ambulances, emergency medical services vehicles, and air ambulances as those terms are defined in s. 401.23, F.S.; within that section, an "ambulance" or "emergency medical services vehicle" is defined as any privately or publicly owned land or water vehicle that is designed, constructed, reconstructed, maintained, equipped, or operated for, and is used for, or intended to be used for, land or water transportation of sick or injured persons requiring or likely to require medical attention during transport; an "air ambulance" is defined as any fixed-wing or rotary-wing aircraft used for, or intended to be used for, air transportation of sick or injured persons requiring or likely to require medical attention during transport.

[31] S. 408.813, F.S., authorizes AHCA to impose administrative fines as a penalty for violations of the Health Care Licensing Procedures Act (Part II of Chapter 408, F.S.), authorizing statutes, or applicable rules.

Lastly, a medical provider, treating patients in a hospital entity, who is not under contract with an insured's health insurer must disclose in writing, prior to providing care, whether the insured will be billed directly by the provider for care or treatment rendered in the facility. Failure to provide the written disclosure to the insured exempts the insured from liability for any charges for services rendered by the provider. The bill does specify that the insured will be responsible for any applicable co-payments or deductibles as outlined by his or her health insurance plan.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.002, F.S., relating to definitions.
Section 2: Amends s. 395.107, F.S., relating to urgent care centers; publishing and posting schedule of charges.
Section 3: Amends s. 456.072, F.S., relating to grounds for discipline; penalties; enforcement.
Section 4: Amends s. 627.6131, F.S., relating to payment of claims.
Section 5: Creates s. 627.6385, F.S., relating to hospital and provider transparency; duty to inform.
Section 6: Amends s. 383.50, F.S., relating to treatment of surrendered newborn infant.
Section 7: Amends s. 390.011, F.S., relating to definitions.
Section 8: Amends s. 394.4787, F.S., relating to definition; ss. 394.4786, 394.4787, 394.4788, and 394.4789.
Section 9: Amends s. 395.003, F.S., relating to licensure; denial, suspension, and revocation.
Section 10: Amends s. 395.602, F.S., relating to rural hospitals.
Section 11: Amends s. 395.701, F.S., relating to annual assessments on net operating revenues for inpatient and outpatient services to fund public medical assistance; administrative fines for failure to pay assessments when due; exemption.
Section 12: Amends s. 408.051, F.S., relating to Florida Electronic Health Records Exchange Act.
Section 13: Amends s. 409.905, F.S., relating to mandatory Medicaid services.
Section 14: Amends s. 409.97, F.S., relating to state and local Medicaid partnerships.
Section 15: Amends s. 409.975, F.S., relating to managed care plan accountability.
Section 16: Amends s. 468.505, F.S., relating to exemptions; exceptions.
Section 17: Amends s. 627.736, F.S., relating to required personal injury protection benefits; exclusions; priority; claims.
Section 18: Amends s. 766.118, F.S., relating to determination of noneconomic damages.
Section 19: Amends s. 766.316, F.S., relating to notice to obstetrical patients of participation in the plan.
Section 20: Amends s. 812.014, F.S., relating to theft.
Section 21: Provides an effective date of July 1, 2012.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The AHCA may collect fines from urgent care centers, ambulatory surgical centers, and diagnostic-imaging centers which fail to publish and post the schedule of medical charges provided to patients at the center. The Department of Health (DOH) may collect fines from medical practitioners who fail to publish and distribute a schedule of medical charges to patients. Lastly, AHCA may also collect fines from facilities licensed under chapter 395, F.S., that fail to provide the requisite disclosure to an insured regarding whether or not providers may bill the insured directly for care and service rendered within the facility. The amount of fines that will be collected will not be known until compliance with the law by all parties can be determined. As a result, the impact of the collection of fines on revenue is indeterminate at this time. Such fines will likely offset the increased workload to enforce the provisions of the bill.

2. Expenditures:

AHCA will be responsible for confirming compliance with the law by urgent care centers, ambulatory surgical centers, diagnostic-imaging centers, and facilities licensed under chapter 395, F.S., and for imposing and collecting applicable fines. AHCA may experience a recurring increase in workload associated with confirming compliance with the law by urgent care centers, ambulatory surgical centers, and diagnostic-imaging centers. AHCA may also experience a recurring increase in workload associated with confirming that facilities licensed under chapter 395, F.S., are complying with the disclosure provisions of the bill. It is anticipated that current resources are adequate to absorb the increase in workload.[32] AHCA will incur non-recurring costs for rulemaking, which current budget authority is adequate to absorb.[33] The budgetary impact on AHCA for the increase in workload, if it exists, is indeterminate at this time.

Medical practitioner boards housed within DOH, or DOH itself, will be responsible for confirming compliance with the law by the specified medical practitioners subject to the statute proposed in the bill, and for imposing and collecting applicable fines. DOH may experience a recurring increase in workload associated with additional complaints and investigations due to non-compliance. It is anticipated that current resources are adequate to absorb the increase in workload.[34] DOH will incur non-recurring costs for rulemaking, which current budget authority is adequate to absorb.[35] The budgetary impact on the DOH for the increase in workload, if it exists, is indeterminate at this time.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Urgent care centers, ambulatory surgical centers, diagnostic-imaging centers, facilities licensed under chapter 395, F.S., and certain medical professional, all of which are subject to the statutes proposed by this bill, may be required to pay fines for failing to comply with the law. The fines could be, in some cases, significant.

The centers will incur costs associated with publishing and posting the schedule of medical charges. Licensed facilities under chapter 395, F.S., and medical providers will incur costs associated with preparing and distributing the requisite disclosures to patients regarding the status of contractual relationships among each other and with insurers. Health insurers will incur costs associated with posting information on their websites regarding the contractual relationships between hospitals within the insurer's network and the medical professionals that provide care and services at those hospitals, as well as the costs associated with ensuring that the information on the website is up to date. Lastly, insurers may incur costs associated with distributing the information to their insureds in a manner other than through the website.

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[32] Telephone conference between AHCA staff and Health and Human Services Quality Subcommittee staff on January 23, 2012.
[33] *Id.*
[34] E-mail correspondence between DOH staff and Health and Human Services Quality Subcommittee staff on January 23, 2012 (on file with the Subcommittee).
[35] *Id.*

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 AHCA and the DOH have appropriate rule-making authority sufficient to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Lines 85-86 requires a "care center" affiliated with a facility licensed under chapter 395, F.S., to include text in its posted schedule of medical charges advising consumers that the charges for services provided at the center will be the same as the charges for services provided at the licensed facility. The bill refers to an urgent care center, ambulatory surgical center, and diagnostic-imaging center. Reasonable interpretation of the provision leads to the conclusion that it applies to an "urgent care center", however, for clarity, an amendment to include the word "urgent" will avoid any misunderstanding of the application of the law.

Line 100-101 requires certain medical practitioners to publish and distribute, in writing, a schedule of medical charges, subject to the same requirements as the urgent care centers and other specified facilities. The phrase "...distribute it to patients upon each visit[.]" can be clarified by amendment to read "...distribute it to each patient upon each visit", signifying that the law requires that all patients receive the schedule of charges each time they are seen by the medical professional.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to health care consumer protection; amending s. 395.002, F.S.; defining the term "diagnostic-imaging center"; conforming cross-references; amending s. 395.107, F.S.; requiring certain health care practitioners, urgent care centers, ambulatory surgical centers, and diagnostic-imaging centers to publish and post a schedule of charges for services provided to patients; specifying text size; requiring the schedule to be in language comprehensible to a layperson; requiring certain practitioners to distribute charge schedules to patients; providing for fines; providing that a practitioner's failure to comply is grounds for discipline; amending s. 456.072, F.S.; adding failure to comply with the provisions of s. 395.107, F.S., to the grounds for discipline of a practitioner licensed under certain chapters; amending s. 627.6131, F.S.; prohibiting a provider of emergency medical care and services from billing a patient under certain circumstances; prohibiting certain providers of nonemergency medical care and services from billing a patient under certain circumstances; creating s. 627.6385, F.S.; requiring insurers to inform insureds of certain providers who may bill the insured for medical services; requiring hospitals to disclose to certain patients which of its contracted providers will treat the patients and which of those may bill

the patient directly; requiring hospitals to provide contact information for those providers to the patient; requiring certain providers in a hospital to inform certain patients in writing whether the patients will be billed directly by the providers; releasing a patient from liability if a provider fails to disclose billing information; amending ss. 383.50, 390.011, 394.4787, 395.003, 395.602, 395.701, 408.051, 409.905, 409.97, 409.975, 468.505, 627.736, 766.118, 766.316, and 812.014, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Subsections (6) through (33) of section 395.002, Florida Statutes, are renumbered as subsections (7) through (34), respectively, present subsections (10) and (28) of that section are amended, and a new subsection (6) is added to that section, to read:

395.002 Definitions.—As used in this chapter:

(6) "Diagnostic-imaging center" means a freestanding outpatient facility that provides specialized services for the diagnosis of a disease by examination and also provides radiological services.

(11) ~~(10)~~ "General hospital" means any facility which meets the provisions of subsection (13) ~~(12)~~ and which regularly makes its facilities and services available to the general population.

(29) ~~(28)~~ "Specialty hospital" means any facility which

meets the provisions of subsection (13) ~~(12)~~, and which regularly makes available either:

(a) The range of medical services offered by general hospitals, but restricted to a defined age or gender group of the population;

(b) A restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders; or

(c) Intensive residential treatment programs for children and adolescents as defined in subsection (16) ~~(15)~~.

Section 2. Section 395.107, Florida Statutes, is amended to read:

395.107 Practitioners, urgent care centers, ambulatory surgical centers, and diagnostic-imaging centers; publishing and posting schedule of charges; distribution; penalties.—

(1) An urgent care center, an ambulatory surgical center, and a diagnostic-imaging center must publish a schedule of charges for the medical services offered to patients. The schedule must describe the medical services in language comprehensible to a layperson. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule must be posted in a conspicuous place in the reception area ~~of the urgent care center~~ and must include, but is not limited to, the 50 services most frequently provided ~~by the urgent care center~~. The schedule may group services by three price levels, listing services in each price level. The posting must be at least 15 square feet in size. The text describing the medical services

must fill at least 12 square feet of the posting. If a care center is affiliated with a facility licensed under chapter 395, the schedule must include text that notifies the insured whether the charges for medical services received at the center will be the same as charges for medical services received at a hospital. The text notifying the insured must be in a font size equal to or greater than the font size used for prices and must be in a contrasting color. Such text must be included in all advertisements for the center and in language comprehensible to a layperson ~~The failure of an urgent care center to publish and post a schedule of charges as required by this section shall result in a fine of not more than $1,000, per day, until the schedule is published and posted~~.

(2) A practitioner licensed under chapter 458, chapter 459, chapter 460, or chapter 461 must publish in writing a schedule of charges as described in subsection (1) and distribute it to patients upon each visit.

(3) The failure of an urgent care center, an ambulatory surgical center, or a diagnostic-imaging center to comply with this section shall result in a fine of not more than $1,000, per day, until compliance. Failure of a practitioner licensed under chapter 458, chapter 459, chapter 460, or chapter 461 to comply with this section is grounds for discipline pursuant to s. 456.072(2).

Section 3. Paragraph (oo) 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:

(oo) Failure to comply with the provisions of s. 395.107.

Section 4. Subsections (20) and (21) are added to section 627.6131, Florida Statutes, to read:

627.6131 Payment of claims.—

(20) If any insurer is liable for emergency services and care, as defined in s. 395.002, regardless of whether a contract exists between the insurer and the provider of emergency services and care, the insurer is solely liable for payment of fees to the provider, and the insured is not liable for payment of fees to the provider, other than applicable copayments and deductibles, if the insured is transported to the facility by emergency medical transportation services, as defined in s. 945.6041(1)(a).

(21) An insurer is solely liable for payment of fees to the provider and the insured is not liable for payment of fees to the provider, other than applicable copayments and deductibles, for medical services and care that are:

(a) Nonemergency services and care as defined in s. 395.002;

(b) Provided in a facility licensed under chapter 395 which has a contract with the insurer; and

(c) Provided by a provider that does not have a contract with the insurer where the patient has no ability and opportunity to choose an alternative provider having a contract with the insurer.

Section 5. Section 627.6385, Florida Statutes, is created

to read:

627.6385 Hospital and provider transparency; duty to inform.—

(1) Each insurer issuing a health insurance policy insuring against loss or expense due to medical and related services provided within a facility licensed under chapter 395 shall disclose to its insured whether the facility contracts with providers who are not under contract with the insurer. Such disclosure shall be included in the insurer's member website and distributed by the insurer to each insured.

(2) Each facility licensed under chapter 395 shall disclose to each patient upon scheduling services or nonemergency admission which providers will treat the patient and which of those providers is not under contract with the patient's insurer. The disclosure shall include notification to the insured that such providers may bill the insured directly for services rendered within the facility. The disclosure shall be limited to the providers that are reasonably expected to provide specific medical services and treatment scheduled to be received by the insured, shall be in writing, and shall include the name, professional address, and telephone number of all such providers. The disclosure shall advise all patients to contact providers prior to delivery of medical services to determine whether or not providers will bill the patient directly for medical services rendered within the facility. Failure to make such a disclosure shall result in a fine of $500 per occurrence pursuant to s. 408.813.

(3) For a patient scheduled or admitted for nonemergency

services to a facility licensed under chapter 395 and receiving medical services from a provider not under contract with the patient's insurer, that provider shall disclose to the patient in writing, prior to the provision of medical services, whether the patient will be billed directly for medical services rendered within the facility. The patient is not liable for any charges, other than applicable copayments or deductibles, billed to the patient by the provider who failed to make the disclosure.

Section 6. Subsection (4) of section 383.50, Florida Statutes, is amended to read:

383.50 Treatment of surrendered newborn infant.—

(4) Each hospital of this state subject to s. 395.1041 shall, and any other hospital may, admit and provide all necessary emergency services and care, as defined in s. 395.002~~(9)~~, to any newborn infant left with the hospital in accordance with this section. The hospital or any of its licensed health care professionals shall consider these actions as implied consent for treatment, and a hospital accepting physical custody of a newborn infant has implied consent to perform all necessary emergency services and care. The hospital or any of its licensed health care professionals is immune from criminal or civil liability for acting in good faith in accordance with this section. Nothing in this subsection limits liability for negligence.

Section 7. Subsection (5) of section 390.011, Florida Statutes, is amended to read:

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

(5) "Hospital" means a facility as defined in s. 395.002(13) ~~395.002(12)~~ and licensed under chapter 395 and part II of chapter 408.

Section 8. Subsection (7) of section 394.4787, Florida Statutes, is amended to read:

394.4787 Definitions; ss. 394.4786, 394.4787, 394.4788, and 394.4789.—As used in this section and ss. 394.4786, 394.4788, and 394.4789:

(7) "Specialty psychiatric hospital" means a hospital licensed by the agency pursuant to s. 395.002(29) ~~395.002(28)~~ and part II of chapter 408 as a specialty psychiatric hospital.

Section 9. Paragraph (b) of subsection (2) of section 395.003, Florida Statutes, is amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(2)

(b) The agency shall, at the request of a licensee that is a teaching hospital as defined in s. 408.07(45), issue a single license to a licensee for facilities that have been previously licensed as separate premises, provided such separately licensed facilities, taken together, constitute the same premises as defined in s. 395.002~~(23)~~. Such license for the single premises shall include all of the beds, services, and programs that were previously included on the licenses for the separate premises. The granting of a single license under this paragraph shall not in any manner reduce the number of beds, services, or programs operated by the licensee.

Section 10. Paragraph (c) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

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

(c) "Inactive rural hospital bed" means a licensed acute care hospital bed, as defined in s. 395.002~~(13)~~, that is inactive in that it cannot be occupied by acute care inpatients.

Section 11. Paragraph (c) of subsection (1) of section 395.701, Florida Statutes, is amended to read:

395.701 Annual assessments on net operating revenues for inpatient and outpatient services to fund public medical assistance; administrative fines for failure to pay assessments when due; exemption.—

(1) For the purposes of this section, the term:

(c) "Hospital" means a health care institution as defined in s. 395.002(13) ~~395.002(12)~~, but does not include any hospital operated by the agency or the Department of Corrections.

Section 12. Subsection (3) of section 408.051, Florida Statutes, is amended to read:

408.051 Florida Electronic Health Records Exchange Act.—

(3) EMERGENCY RELEASE OF IDENTIFIABLE HEALTH RECORD.—A health care provider may release or access an identifiable health record of a patient without the patient's consent for use in the treatment of the patient for an emergency medical condition, as defined in s. 395.002~~(8)~~, when the health care provider is unable to obtain the patient's consent or the consent of the patient representative due to the patient's condition or the nature of the situation requiring immediate medical attention. A health care provider who in good faith releases or accesses an identifiable health record of a patient

in any form or medium under this subsection is immune from civil liability for accessing or releasing an identifiable health record.

Section 13. Subsection (8) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(8) NURSING FACILITY SERVICES.—The agency shall pay for 24-hour-a-day nursing and rehabilitative services for a recipient in a nursing facility licensed under part II of chapter 400 or in a rural hospital, as defined in s. 395.602, or in a Medicare certified skilled nursing facility operated by a hospital, as defined by s. 395.002(11) ~~395.002(10)~~, that is licensed under part I of chapter 395, and in accordance with provisions set forth in s. 409.908(2)(a), which services are

ordered by and provided under the direction of a licensed physician. However, if a nursing facility has been destroyed or otherwise made uninhabitable by natural disaster or other emergency and another nursing facility is not available, the agency must pay for similar services temporarily in a hospital licensed under part I of chapter 395 provided federal funding is approved and available. The agency shall pay only for bed-hold days if the facility has an occupancy rate of 95 percent or greater. The agency is authorized to seek any federal waivers to implement this policy.

Section 14. Paragraph (a) of subsection (4) of section 409.97, Florida Statutes, is amended to read:

409.97 State and local Medicaid partnerships.—

(4) HOSPITAL RATE DISTRIBUTION.—

(a) The agency is authorized to implement a tiered hospital rate system to enhance Medicaid payments to all hospitals when resources for the tiered rates are available from general revenue and such contributions pursuant to subsection (1) as are authorized under the General Appropriations Act.

1. Tier 1 hospitals are statutory rural hospitals as defined in s. 395.602, statutory teaching hospitals as defined in s. 408.07(45), and specialty children's hospitals as defined in s. 395.002(29) ~~395.002(28)~~.

2. Tier 2 hospitals are community hospitals not included in Tier 1 that provided more than 9 percent of the hospital's total inpatient days to Medicaid patients and charity patients, as defined in s. 409.911, and are located in the jurisdiction of a local funding source pursuant to subsection (1).

3. Tier 3 hospitals include all community hospitals.

Section 15. Paragraph (b) of subsection (1) of section 409.975, Florida Statutes, is amended to read:

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

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

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

1. Faculty plans of Florida medical schools.

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

3. Hospitals licensed as specialty children's hospitals as defined in s. 395.002(29) ~~395.002(28)~~.

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

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

Section 16. Paragraph (l) of subsection (1) of section 468.505, Florida Statutes, is amended to read:

468.505 Exemptions; exceptions.—

(1) Nothing in this part may be construed as prohibiting or restricting the practice, services, or activities of:

(l) A person employed by a nursing facility exempt from licensing under s. 395.002(13) ~~395.002(12)~~, or a person exempt from licensing under s. 464.022.

Section 17. Paragraph (c) of subsection (4) and paragraph (a) of subsection (5) of section 627.736, Florida Statutes, are amended to read:

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(4) BENEFITS; WHEN DUE.—Benefits due from an insurer under ss. 627.730-627.7405 shall be primary, except that benefits received under any workers' compensation law shall be credited

against the benefits provided by subsection (1) and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under ss. 627.730-627.7405. When the Agency for Health Care Administration provides, pays, or becomes liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, benefits under ss. 627.730-627.7405 shall be subject to the provisions of the Medicaid program.

(c) Upon receiving notice of an accident that is potentially covered by personal injury protection benefits, the insurer must reserve $5,000 of personal injury protection benefits for payment to physicians licensed under chapter 458 or chapter 459 or dentists licensed under chapter 466 who provide emergency services and care, as defined in s. 395.002~~(9)~~, or who provide hospital inpatient care. The amount required to be held in reserve may be used only to pay claims from such physicians or dentists until 30 days after the date the insurer receives notice of the accident. After the 30-day period, any amount of the reserve for which the insurer has not received notice of a claim from a physician or dentist who provided emergency services and care or who provided hospital inpatient care may then be used by the insurer to pay other claims. The time periods specified in paragraph (b) for required payment of personal injury protection benefits shall be tolled for the period of time that an insurer is required by this paragraph to hold payment of a claim that is not from a physician or dentist

who provided emergency services and care or who provided hospital inpatient care to the extent that the personal injury protection benefits not held in reserve are insufficient to pay the claim. This paragraph does not require an insurer to establish a claim reserve for insurance accounting purposes.

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

(a)1. Any physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment, if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. In no event, however, may such a charge be in excess of the amount the person or institution customarily charges for like services or supplies. With respect to a determination of whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, and reimbursement levels in the community and various federal and state medical fee schedules applicable to automobile and other insurance coverages, and other information relevant to the

reasonableness of the reimbursement for the service, treatment, or supply.

2. The insurer may limit reimbursement to 80 percent of the following schedule of maximum charges:

a. For emergency transport and treatment by providers licensed under chapter 401, 200 percent of Medicare.

b. For emergency services and care provided by a hospital licensed under chapter 395, 75 percent of the hospital's usual and customary charges.

c. For emergency services and care as defined by s. 395.002~~(9)~~ provided in a facility licensed under chapter 395 rendered by a physician or dentist, and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community.

d. For hospital inpatient services, other than emergency services and care, 200 percent of the Medicare Part A prospective payment applicable to the specific hospital providing the inpatient services.

e. For hospital outpatient services, other than emergency services and care, 200 percent of the Medicare Part A Ambulatory Payment Classification for the specific hospital providing the outpatient services.

f. For all other medical services, supplies, and care, 200 percent of the allowable amount under the participating physicians schedule of Medicare Part B. However, if such services, supplies, or care is not reimbursable under Medicare Part B, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as

determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. Services, supplies, or care that is not reimbursable under Medicare or workers' compensation is not required to be reimbursed by the insurer.

3. For purposes of subparagraph 2., the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect at the time the services, supplies, or care was rendered and for the area in which such services were rendered, except that it may not be less than the allowable amount under the participating physicians schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.

4. Subparagraph 2. does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 2. must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider would be entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes.

5. If an insurer limits payment as authorized by subparagraph 2., the person providing such services, supplies, or care may not bill or attempt to collect from the insured any amount in excess of such limits, except for amounts that are not covered by the insured's personal injury protection coverage due

to the coinsurance amount or maximum policy limits.

Section 18. Subsection (4) of section 766.118, Florida Statutes, is amended to read:

766.118 Determination of noneconomic damages.—

(4) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF PRACTITIONERS PROVIDING EMERGENCY SERVICES AND CARE.—Notwithstanding subsections (2) and (3), with respect to a cause of action for personal injury or wrongful death arising from medical negligence of practitioners providing emergency services and care, as defined in s. 395.002~~(9)~~, or providing services as provided in s. 401.265, or providing services pursuant to obligations imposed by 42 U.S.C. s. 1395dd to persons with whom the practitioner does not have a then-existing health care patient-practitioner relationship for that medical condition:

(a) Regardless of the number of such practitioner defendants, noneconomic damages shall not exceed $150,000 per claimant.

(b) Notwithstanding paragraph (a), the total noneconomic damages recoverable by all claimants from all such practitioners shall not exceed $300,000.

The limitation provided by this subsection applies only to noneconomic damages awarded as a result of any act or omission of providing medical care or treatment, including diagnosis that occurs prior to the time the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in

which case the limitation provided by this subsection applies to any act or omission of providing medical care or treatment which occurs prior to the stabilization of the patient following the surgery.

Section 19. Section 766.316, Florida Statutes, is amended to read:

766.316 Notice to obstetrical patients of participation in the plan.—Each hospital with a participating physician on its staff and each participating physician, other than residents, assistant residents, and interns deemed to be participating physicians under s. 766.314(4)(c), under the Florida Birth-Related Neurological Injury Compensation Plan shall provide notice to the obstetrical patients as to the limited no-fault alternative for birth-related neurological injuries. Such notice shall be provided on forms furnished by the association and shall include a clear and concise explanation of a patient's rights and limitations under the plan. The hospital or the participating physician may elect to have the patient sign a form acknowledging receipt of the notice form. Signature of the patient acknowledging receipt of the notice form raises a rebuttable presumption that the notice requirements of this section have been met. Notice need not be given to a patient when the patient has an emergency medical condition as defined in s. 395.002(9)(b) ~~395.002(8)(b)~~ or when notice is not practicable.

Section 20. Paragraph (b) of subsection (2) of section 812.014, Florida Statutes, is amended to read:

812.014 Theft.—

(2)

(b)1. If the property stolen is valued at $20,000 or more, but less than $100,000;

2. The property stolen is cargo valued at less than $50,000 that has entered the stream of interstate or intrastate commerce from the shipper's loading platform to the consignee's receiving dock;

3. The property stolen is emergency medical equipment, valued at $300 or more, that is taken from a facility licensed under chapter 395 or from an aircraft or vehicle permitted under chapter 401; or

4. The property stolen is law enforcement equipment, valued at $300 or more, that is taken from an authorized emergency vehicle, as defined in s. 316.003,

the offender commits grand theft in the second degree, punishable as a felony of the second degree, as provided in s. 775.082, s. 775.083, or s. 775.084. Emergency medical equipment means mechanical or electronic apparatus used to provide emergency services and care as defined in s. 395.002~~(9)~~ or to treat medical emergencies. Law enforcement equipment means any property, device, or apparatus used by any law enforcement officer as defined in s. 943.10 in the officer's official business. However, if the property is stolen within a county that is subject to a state of emergency declared by the Governor under chapter 252, the theft is committed after the declaration of emergency is made, and the perpetration of the theft is facilitated by conditions arising from the emergency, the theft

is a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. As used in this paragraph, the term "conditions arising from the emergency" means civil unrest, power outages, curfews, voluntary or mandatory evacuations, or a reduction in the presence of or response time for first responders or homeland security personnel. For purposes of sentencing under chapter 921, a felony offense that is reclassified under this paragraph is ranked one level above the ranking under s. 921.0022 or s. 921.0023 of the offense committed.

Section 21. This act shall take effect July 1, 2012.

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 Quality Subcommittee
Representative Corcoran offered the following:

Amendment (with title amendment)

Remove everything after the enacting clause and insert:

Section 1. Paragraph (c) 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:

(c) *Financial information and disclosure.*—

1. A patient has the right to be given, upon request, by the responsible provider, his or her designee, or a representative of the health care facility full information and necessary counseling on the availability of known financial resources for the patient's health care.

2. A health care provider or a health care facility shall, upon request, disclose to each patient who is eligible for Medicare, before treatment, whether the health care provider or the health care facility in which the patient is receiving medical services accepts assignment under Medicare reimbursement as payment in full for medical services and treatment rendered in the health care provider's office or health care facility.

3.a. A practitioner licensed under chapter 458 or chapter 459 must ~~primary care provider may~~ publish a schedule of charges for the medical services that the practitioner ~~provider~~ offers to patients and distribute the schedule to each patient upon each visit. The schedule must describe the medical services in language comprehensible to a layperson. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card.

b. The schedule may ~~must~~ be posted in a conspicuous place in the reception area of the practitioner's ~~provider's~~ office and must include, but need ~~is~~ not be limited to, the 50 services most frequently provided by the practitioner ~~primary care provider~~. The schedule may group services by three price levels, listing services in each price level. The posting must be at least 15 square feet in size. The text describing the medical services must fill at least 12 square feet of the posting. A primary care provider who voluntarily published and maintained ~~publishes and maintains~~ a schedule of charges for medical services from July 1, 2011, through June 30, 2012, in accordance with chapter 2011-122, Laws of Florida, is exempt from the license fee requirements for a single period of renewal of a

professional license under chapter 456 for that licensure term and is exempt from the continuing education requirements of chapter 456 and the rules implementing those requirements for a single 2-year period.

4. If a primary care provider publishes a schedule of charges pursuant to subparagraph 3., he or she must continually post it at all times for the duration of active licensure in this state when primary care services are provided to patients. If a primary care provider fails to post the schedule of charges in accordance with this subparagraph, the provider shall be required to pay any license fee and comply with any continuing education requirements for which an exemption was received.

5. A health care provider or a health care facility shall, upon request, ~~furnish a person,~~ before the provision of medical services, furnish a reasonable estimate of charges for such services. The health care provider or the health care facility shall provide an uninsured person, before the provision of a planned nonemergency medical service, a reasonable estimate of charges for such service and information regarding the provider's or facility's discount or charity policies for which the uninsured person may be eligible. Such estimates ~~by a primary care provider~~ must be consistent with the schedule posted under subparagraph 3. Estimates shall, to the extent possible, be written in a language comprehensible to an ordinary layperson. Such reasonable estimate does not preclude the health care provider or health care facility from exceeding the estimate or making additional charges based on changes in the patient's condition or treatment needs.

6. Each licensed facility not operated by the state shall make available to the public on its Internet website or by other electronic means a description of and a link to the performance outcome and financial data that is published by the agency pursuant to s. 408.05(3)(k). The facility shall place a notice in the reception area that such information is available electronically and the website address. The licensed facility may indicate that the pricing information is based on a compilation of charges for the average patient and that each patient's bill may vary from the average depending upon the severity of illness and individual resources consumed. The licensed facility may also indicate that the price of service is negotiable for eligible patients based upon the patient's ability to pay.

7. A patient has the right to receive a copy of an itemized bill upon request. A patient has a right to be given an explanation of charges upon request.

Section 2. Subsections (6) through (33) of section 395.002, Florida Statutes, are renumbered as subsections (7) through (34), respectively, present subsections (10), (28), and (30) of that section are amended, and a new subsection (6) is added to that section, to read:

395.002 Definitions.—As used in this chapter:

(6) "Diagnostic-imaging center" means a freestanding outpatient facility that provides specialized services for the diagnosis of a disease by examination and also provides radiological services.

(11)~~(10)~~ "General hospital" means any facility which meets the provisions of subsection (13) ~~(12)~~ and which regularly makes its facilities and services available to the general population.

(29)~~(28)~~ "Specialty hospital" means any facility which meets the provisions of subsection (13) ~~(12)~~, and which regularly makes available either:

(a) The range of medical services offered by general hospitals, but restricted to a defined age or gender group of the population;

(b) A restricted range of services appropriate to the diagnosis, care, and treatment of patients with specific categories of medical or psychiatric illnesses or disorders; or

(c) Intensive residential treatment programs for children and adolescents as defined in subsection (16) ~~(15)~~.

(31)~~(30)~~ "Urgent care center" means a facility or clinic that provides immediate but not emergent ambulatory medical care to patients with or without an appointment. It includes a facility or clinic organization that maintains three or more locations using the same or similar name, does not require a patient to make an appointment, and holds itself out to the general public in any manner as a facility or clinic where immediate but not emergent medical care is provided.

Section 3. Section 395.107, Florida Statutes, is amended to read:

395.107 ~~Urgent care centers;~~ Ppublishing and posting schedule of charges; penalties.—

(1) An urgent care center, an ambulatory surgical center, and a diagnostic-imaging center must publish and post a schedule of charges for the medical services offered to patients.

(2) The schedule of charges must describe the medical services in language comprehensible to a layperson. The schedule must include the prices charged to an uninsured person paying for such services by cash, check, credit card, or debit card. The schedule must be posted in a conspicuous place in the reception area ~~of the urgent care center~~ and must include, but is not limited to, the 50 services most frequently provided ~~by the urgent care center~~. The schedule may group services by three price levels, listing services in each price level. The posting must be at least 15 square feet in size. If an urgent care center is affiliated with a facility licensed under chapter 395, the schedule must include text that notifies the insured whether the charges for medical services received at the center will be the same as, or more than, charges for medical services received at a hospital. The text notifying the patient shall be in a font size equal to or greater than the font size used for prices and must be in a contrasting color. Such text shall be included in all advertisements for the center and in language comprehensible to a layperson.

(3) The posted text describing the medical services must fill at least 12 square feet of the posting. A center may use an electronic device to post the schedule of charges. Such a device must measure at least 22″ by 33″ in size and patients must be able to access the schedule during all hours of operation.

(4) An urgent care center that is operated and used exclusively for employees and the dependents of employees of the business that owns or contracts for the urgent care center is exempt from this section.

(5) A fine of up to $1,000, per day shall be imposed on an urgent care center, an ambulatory surgical center, or a diagnostic-imaging center that fails to comply with this section until the center comes into compliance. ~~The failure of an urgent care center to publish and post a schedule of charges as required by this section shall result in a fine of not more than $1,000, per day, until the schedule is published and posted~~.

Section 4. Paragraph (oo) 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:

(oo) Failure to comply with the provisions of s. 381.026.

Section 5. Subsections (20) and (21) are added to section 627.6131, Florida Statutes, to read:

627.6131 Payment of claims.—

(20) If any insurer is liable for emergency services and care, as defined in s. 395.002, regardless of whether a contract exists between the insurer and the provider of emergency services and care, the insurer is solely liable for payment of fees to the provider, and the insured is not liable for payment of fees to the provider, other than applicable copayments and deductibles, for the first 24 hours if the insured is

transported to the facility by emergency medical transportation services, as defined in s. 945.6041(1)(a).

(21) An insurer is solely liable for payment of fees to the provider and the insured is not liable for payment of fees to the provider, other than applicable copayments and deductibles, for medical services and care that are:

(a) Nonemergency services and care as defined in s. 395.002;

(b) Provided in a facility licensed under chapter 395 which has a contract with the insurer; and

(c) Provided by a provider that does not have a contract with the insurer where the patient has no ability and opportunity to choose an alternative provider having a contract with the insurer.

Section 6. Section 627.6385, Florida Statutes, is created to read:

627.6385 Hospital and provider transparency; duty to inform.—

(1) Each insurer issuing a health insurance policy insuring against loss or expense due to medical and related services provided within a facility licensed under chapter 395 shall disclose to its insured whether the facility contracts with providers who are not under contract with the insurer. Such disclosure must be included in the insurer's member website and distributed by the insurer to each insured.

(2) Each facility licensed under chapter 395 shall disclose to each patient upon scheduling services or nonemergency admission which providers will treat the patient

and which of those providers is not under contract with the patient's insurer. The disclosure must include notification to the insured that such providers may bill the insured directly for services rendered within the facility. The disclosure must be limited to the providers that are reasonably expected to provide specific medical services and treatment scheduled to be received by the insured, must be in writing, and must include the name, professional address, and telephone number of all such providers. Failure to make such a disclosure shall result in a fine of $500 per occurrence pursuant to s. 408.813. If during an episode of care the patient's condition becomes emergent the disclosure provision of this subsection does not apply.

(3) For a patient scheduled or admitted for nonemergency services to a facility licensed under chapter 395 and receiving medical services from a provider not under contract with the patient's insurer, that provider shall disclose to the patient in writing, prior to the provision of medical services, whether the patient will be billed directly for medical services rendered within the facility and provide an estimate of the amount to be billed directly to the patient. The patient is not liable for any charges, other than applicable copayments or deductibles, billed to the patient by the provider who failed to make the disclosure. If the actual amount billed directly to the patient is 200 percent above the estimate required by this subsection, or greater, that provider may not bill the patient directly for any charges for services rendered within the facility. If during an episode of care the patient's condition

becomes emergent the disclosure provision of this subsection does not apply.

Section 7. Subsection (4) of section 383.50, Florida Statutes, is amended to read:

383.50 Treatment of surrendered newborn infant.—

(4) Each hospital of this state subject to s. 395.1041 shall, and any other hospital may, admit and provide all necessary emergency services and care, as defined in s. 395.002~~(9)~~, to any newborn infant left with the hospital in accordance with this section. The hospital or any of its licensed health care professionals shall consider these actions as implied consent for treatment, and a hospital accepting physical custody of a newborn infant has implied consent to perform all necessary emergency services and care. The hospital or any of its licensed health care professionals is immune from criminal or civil liability for acting in good faith in accordance with this section. Nothing in this subsection limits liability for negligence.

Section 8. Subsection (5) of section 390.011, Florida Statutes, is amended to read:

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

(5) "Hospital" means a facility as defined in s. 395.002(13) ~~395.002(12)~~ and licensed under chapter 395 and part II of chapter 408.

Section 9. Subsection (7) of section 394.4787, Florida Statutes, is amended to read:

394.4787 Definitions; ss. 394.4786, 394.4787, 394.4788, and 394.4789.—As used in this section and ss. 394.4786, 394.4788, and 394.4789:

(7) "Specialty psychiatric hospital" means a hospital licensed by the agency pursuant to s. 395.002(29) ~~395.002(28)~~ and part II of chapter 408 as a specialty psychiatric hospital.

Section 10. Paragraph (b) of subsection (2) of section 395.003, Florida Statutes, is amended to read:

395.003 Licensure; denial, suspension, and revocation.—

(2)

(b) The agency shall, at the request of a licensee that is a teaching hospital as defined in s. 408.07(45), issue a single license to a licensee for facilities that have been previously licensed as separate premises, provided such separately licensed facilities, taken together, constitute the same premises as defined in s. 395.002~~(23)~~. Such license for the single premises shall include all of the beds, services, and programs that were previously included on the licenses for the separate premises. The granting of a single license under this paragraph shall not in any manner reduce the number of beds, services, or programs operated by the licensee.

Section 11. Paragraph (c) of subsection (2) of section 395.602, Florida Statutes, is amended to read:

395.602 Rural hospitals.—

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

(c) "Inactive rural hospital bed" means a licensed acute care hospital bed, as defined in s. 395.002~~(13)~~, that is inactive in that it cannot be occupied by acute care inpatients.

Section 12. Paragraph (c) of subsection (1) of section 395.701, Florida Statutes, is amended to read:

395.701 Annual assessments on net operating revenues for inpatient and outpatient services to fund public medical assistance; administrative fines for failure to pay assessments when due; exemption.—

(1) For the purposes of this section, the term:

(c) "Hospital" means a health care institution as defined in s. 395.002(13) ~~395.002(12)~~, but does not include any hospital operated by the agency or the Department of Corrections.

Section 13. Subsection (3) of section 408.051, Florida Statutes, is amended to read:

408.051 Florida Electronic Health Records Exchange Act.—

(3) EMERGENCY RELEASE OF IDENTIFIABLE HEALTH RECORD.—A health care provider may release or access an identifiable health record of a patient without the patient's consent for use in the treatment of the patient for an emergency medical condition, as defined in s. 395.002~~(8)~~, when the health care provider is unable to obtain the patient's consent or the consent of the patient representative due to the patient's condition or the nature of the situation requiring immediate medical attention. A health care provider who in good faith releases or accesses an identifiable health record of a patient in any form or medium under this subsection is immune from civil liability for accessing or releasing an identifiable health record.

Section 14. Subsection (8) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(8) NURSING FACILITY SERVICES.—The agency shall pay for 24-hour-a-day nursing and rehabilitative services for a recipient in a nursing facility licensed under part II of chapter 400 or in a rural hospital, as defined in s. 395.602, or in a Medicare certified skilled nursing facility operated by a hospital, as defined by s. 395.002(11) ~~395.002(10)~~, that is licensed under part I of chapter 395, and in accordance with provisions set forth in s. 409.908(2)(a), which services are ordered by and provided under the direction of a licensed physician. However, if a nursing facility has been destroyed or otherwise made uninhabitable by natural disaster or other emergency and another nursing facility is not available, the agency must pay for similar services temporarily in a hospital

licensed under part I of chapter 395 provided federal funding is approved and available. The agency shall pay only for bed-hold days if the facility has an occupancy rate of 95 percent or greater. The agency is authorized to seek any federal waivers to implement this policy.

Section 15. Paragraph (a) of subsection (4) of section 409.97, Florida Statutes, is amended to read:

409.97 State and local Medicaid partnerships.—

(4) HOSPITAL RATE DISTRIBUTION.—

(a) The agency is authorized to implement a tiered hospital rate system to enhance Medicaid payments to all hospitals when resources for the tiered rates are available from general revenue and such contributions pursuant to subsection (1) as are authorized under the General Appropriations Act.

1. Tier 1 hospitals are statutory rural hospitals as defined in s. 395.602, statutory teaching hospitals as defined in s. 408.07(45), and specialty children's hospitals as defined in s. 395.002(29) ~~395.002(28)~~.

2. Tier 2 hospitals are community hospitals not included in Tier 1 that provided more than 9 percent of the hospital's total inpatient days to Medicaid patients and charity patients, as defined in s. 409.911, and are located in the jurisdiction of a local funding source pursuant to subsection (1).

3. Tier 3 hospitals include all community hospitals.

Section 16. Paragraph (b) of subsection (1) of section 409.975, Florida Statutes, is amended to read:

409.975 Managed care plan accountability.—In addition to the requirements of s. 409.967, plans and providers

participating in the managed medical assistance program shall comply with the requirements of this section.

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

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

1. Faculty plans of Florida medical schools.

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

3. Hospitals licensed as specialty children's hospitals as defined in s. 395.002(29) ~~395.002(28)~~.

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

Managed care plans that have not contracted with all statewide essential providers in all regions as of the first date of recipient enrollment must continue to negotiate in good faith. Payments to physicians on the faculty of nonparticipating

Florida medical schools shall be made at the applicable Medicaid rate. Payments for services rendered by regional perinatal intensive care centers shall be made at the applicable Medicaid rate as of the first day of the contract between the agency and the plan. Payments to nonparticipating specialty children's hospitals shall equal the highest rate established by contract between that provider and any other Medicaid managed care plan.

Section 17. Paragraph (l) of subsection (1) of section 468.505, Florida Statutes, is amended to read:

468.505 Exemptions; exceptions.—

(1) Nothing in this part may be construed as prohibiting or restricting the practice, services, or activities of:

(l) A person employed by a nursing facility exempt from licensing under s. 395.002(13) ~~395.002(12)~~, or a person exempt from licensing under s. 464.022.

Section 18. Paragraph (c) of subsection (4) and paragraph (a) of subsection (5) of section 627.736, Florida Statutes, are amended to read:

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(4) BENEFITS; WHEN DUE.—Benefits due from an insurer under ss. 627.730-627.7405 shall be primary, except that benefits received under any workers' compensation law shall be credited against the benefits provided by subsection (1) and shall be due and payable as loss accrues, upon receipt of reasonable proof of such loss and the amount of expenses and loss incurred which are covered by the policy issued under ss. 627.730-627.7405. When the Agency for Health Care Administration provides, pays, or

becomes liable for medical assistance under the Medicaid program related to injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle, benefits under ss. 627.730-627.7405 shall be subject to the provisions of the Medicaid program.

(c) Upon receiving notice of an accident that is potentially covered by personal injury protection benefits, the insurer must reserve $5,000 of personal injury protection benefits for payment to physicians licensed under chapter 458 or chapter 459 or dentists licensed under chapter 466 who provide emergency services and care, as defined in s. 395.002~~(9)~~, or who provide hospital inpatient care. The amount required to be held in reserve may be used only to pay claims from such physicians or dentists until 30 days after the date the insurer receives notice of the accident. After the 30-day period, any amount of the reserve for which the insurer has not received notice of a claim from a physician or dentist who provided emergency services and care or who provided hospital inpatient care may then be used by the insurer to pay other claims. The time periods specified in paragraph (b) for required payment of personal injury protection benefits shall be tolled for the period of time that an insurer is required by this paragraph to hold payment of a claim that is not from a physician or dentist who provided emergency services and care or who provided hospital inpatient care to the extent that the personal injury protection benefits not held in reserve are insufficient to pay the claim. This paragraph does not require an insurer to establish a claim reserve for insurance accounting purposes.

(5) CHARGES FOR TREATMENT OF INJURED PERSONS.—

(a)1. Any physician, hospital, clinic, or other person or institution lawfully rendering treatment to an injured person for a bodily injury covered by personal injury protection insurance may charge the insurer and injured party only a reasonable amount pursuant to this section for the services and supplies rendered, and the insurer providing such coverage may pay for such charges directly to such person or institution lawfully rendering such treatment, if the insured receiving such treatment or his or her guardian has countersigned the properly completed invoice, bill, or claim form approved by the office upon which such charges are to be paid for as having actually been rendered, to the best knowledge of the insured or his or her guardian. In no event, however, may such a charge be in excess of the amount the person or institution customarily charges for like services or supplies. With respect to a determination of whether a charge for a particular service, treatment, or otherwise is reasonable, consideration may be given to evidence of usual and customary charges and payments accepted by the provider involved in the dispute, and reimbursement levels in the community and various federal and state medical fee schedules applicable to automobile and other insurance coverages, and other information relevant to the reasonableness of the reimbursement for the service, treatment, or supply.

2. The insurer may limit reimbursement to 80 percent of the following schedule of maximum charges:

a. For emergency transport and treatment by providers licensed under chapter 401, 200 percent of Medicare.

b. For emergency services and care provided by a hospital licensed under chapter 395, 75 percent of the hospital's usual and customary charges.

c. For emergency services and care as defined by s. 395.002~~(9)~~ provided in a facility licensed under chapter 395 rendered by a physician or dentist, and related hospital inpatient services rendered by a physician or dentist, the usual and customary charges in the community.

d. For hospital inpatient services, other than emergency services and care, 200 percent of the Medicare Part A prospective payment applicable to the specific hospital providing the inpatient services.

e. For hospital outpatient services, other than emergency services and care, 200 percent of the Medicare Part A Ambulatory Payment Classification for the specific hospital providing the outpatient services.

f. For all other medical services, supplies, and care, 200 percent of the allowable amount under the participating physicians schedule of Medicare Part B. However, if such services, supplies, or care is not reimbursable under Medicare Part B, the insurer may limit reimbursement to 80 percent of the maximum reimbursable allowance under workers' compensation, as determined under s. 440.13 and rules adopted thereunder which are in effect at the time such services, supplies, or care is provided. Services, supplies, or care that is not reimbursable

under Medicare or workers' compensation is not required to be reimbursed by the insurer.

3. For purposes of subparagraph 2., the applicable fee schedule or payment limitation under Medicare is the fee schedule or payment limitation in effect at the time the services, supplies, or care was rendered and for the area in which such services were rendered, except that it may not be less than the allowable amount under the participating physicians schedule of Medicare Part B for 2007 for medical services, supplies, and care subject to Medicare Part B.

4. Subparagraph 2. does not allow the insurer to apply any limitation on the number of treatments or other utilization limits that apply under Medicare or workers' compensation. An insurer that applies the allowable payment limitations of subparagraph 2. must reimburse a provider who lawfully provided care or treatment under the scope of his or her license, regardless of whether such provider would be entitled to reimbursement under Medicare due to restrictions or limitations on the types or discipline of health care providers who may be reimbursed for particular procedures or procedure codes.

5. If an insurer limits payment as authorized by subparagraph 2., the person providing such services, supplies, or care may not bill or attempt to collect from the insured any amount in excess of such limits, except for amounts that are not covered by the insured's personal injury protection coverage due to the coinsurance amount or maximum policy limits.

Section 19. Subsection (4) of section 766.118, Florida Statutes, is amended to read:

766.118 Determination of noneconomic damages.—

(4) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF PRACTITIONERS PROVIDING EMERGENCY SERVICES AND CARE.— Notwithstanding subsections (2) and (3), with respect to a cause of action for personal injury or wrongful death arising from medical negligence of practitioners providing emergency services and care, as defined in s. 395.002~~(9)~~, or providing services as provided in s. 401.265, or providing services pursuant to obligations imposed by 42 U.S.C. s. 1395dd to persons with whom the practitioner does not have a then-existing health care patient-practitioner relationship for that medical condition:

(a) Regardless of the number of such practitioner defendants, noneconomic damages shall not exceed $150,000 per claimant.

(b) Notwithstanding paragraph (a), the total noneconomic damages recoverable by all claimants from all such practitioners shall not exceed $300,000.

The limitation provided by this subsection applies only to noneconomic damages awarded as a result of any act or omission of providing medical care or treatment, including diagnosis that occurs prior to the time the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the limitation provided by this subsection applies to any act or omission of providing medical care or treatment which

occurs prior to the stabilization of the patient following the surgery.

Section 20. Section 766.316, Florida Statutes, is amended to read:

766.316 Notice to obstetrical patients of participation in the plan.—Each hospital with a participating physician on its staff and each participating physician, other than residents, assistant residents, and interns deemed to be participating physicians under s. 766.314(4)(c), under the Florida Birth-Related Neurological Injury Compensation Plan shall provide notice to the obstetrical patients as to the limited no-fault alternative for birth-related neurological injuries. Such notice shall be provided on forms furnished by the association and shall include a clear and concise explanation of a patient's rights and limitations under the plan. The hospital or the participating physician may elect to have the patient sign a form acknowledging receipt of the notice form. Signature of the patient acknowledging receipt of the notice form raises a rebuttable presumption that the notice requirements of this section have been met. Notice need not be given to a patient when the patient has an emergency medical condition as defined in s. 395.002(9)(b) ~~395.002(8)(b)~~ or when notice is not practicable.

Section 21. Paragraph (b) of subsection (2) of section 812.014, Florida Statutes, is amended to read:

812.014 Theft.—

(2)

(b)1. If the property stolen is valued at $20,000 or more, but less than $100,000;

2. The property stolen is cargo valued at less than $50,000 that has entered the stream of interstate or intrastate commerce from the shipper's loading platform to the consignee's receiving dock;

3. The property stolen is emergency medical equipment, valued at $300 or more, that is taken from a facility licensed under chapter 395 or from an aircraft or vehicle permitted under chapter 401; or

4. The property stolen is law enforcement equipment, valued at $300 or more, that is taken from an authorized emergency vehicle, as defined in s. 316.003,

the offender commits grand theft in the second degree, punishable as a felony of the second degree, as provided in s. 775.082, s. 775.083, or s. 775.084. Emergency medical equipment means mechanical or electronic apparatus used to provide emergency services and care as defined in s. 395.002~~(9)~~ or to treat medical emergencies. Law enforcement equipment means any property, device, or apparatus used by any law enforcement officer as defined in s. 943.10 in the officer's official business. However, if the property is stolen within a county that is subject to a state of emergency declared by the Governor under chapter 252, the theft is committed after the declaration of emergency is made, and the perpetration of the theft is facilitated by conditions arising from the emergency, the theft is a felony of the first degree, punishable as provided in s.

775.082, s. 775.083, or s. 775.084. As used in this paragraph, the term "conditions arising from the emergency" means civil unrest, power outages, curfews, voluntary or mandatory evacuations, or a reduction in the presence of or response time for first responders or homeland security personnel. For purposes of sentencing under chapter 921, a felony offense that is reclassified under this paragraph is ranked one level above the ranking under s. 921.0022 or s. 921.0023 of the offense committed.

Section 22. This act shall take effect on July 1, 2012.

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 health care consumer protection; amending s. 381.026, F.S.; revising the Florida Patient's Bill of Rights to require certain health care practitioners to publish and distribute a schedule of charges for services provided by patients; specifying text size; providing that a primary care provider who voluntarily published and maintained a schedule of charges within specified dates is exempt from certain requirements; amending s. 395.002, F.S.; defining the term "diagnostic-imaging center"; amending the term "urgent care center"; conforming cross-references; amending s. 395.107, F.S.; requiring that urgent care centers, ambulatory surgical centers, and diagnostic-imaging centers publish and post a schedule of

charges for services provided to patients; specifying text size; requiring the schedule to be in language comprehensible to a layperson; specifying posted size and allowing for electronic posting; providing an exception; providing for fines; amending s. 456.072, F.S.; adding failure to comply with the provisions of s. 395.107, F.S., to the grounds for discipline of a practitioner licensed under certain chapters; amending s. 627.6131, F.S.; prohibiting a provider of emergency medical care and services from billing a patient under certain circumstances; prohibiting certain providers of nonemergency medical care and services from billing a patient under certain circumstances; creating s. 627.6385, F.S.; requiring insurers to inform insureds of certain providers who may bill the insured for medical services; requiring hospitals to disclose to certain patients which of its contracted providers will treat the patients and which of those may bill the patient directly; providing an exception; requiring hospitals to provide contact information for those providers to the patient; requiring certain providers in a hospital to inform certain patients in writing whether the patients will be billed directly by the providers; requiring certain providers in a hospital to provide to the patient an estimate of the amount to be billed directly by the provider; prohibiting certain providers from directly billing a patient if the actual charges are 200 percent greater than the estimate provided to the patient; releasing a patient from liability if a provider fails to disclose billing information; providing an exception; amending ss. 383.50, 390.011, 394.4787, 395.003, 395.602, 395.701, 408.051, 409.905,

409.97, 409.975, 468.505, 627.736, 766.118, 766.316, and 812.014, F.S.; conforming cross-references; providing an effective date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HSQS 12-01 Health Information Systems Council
SPONSOR(S): Health & Human Services Quality Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health & Human Services Quality Subcommittee		Poche	Calamas

SUMMARY ANALYSIS

PCB HSQS 12-01 eliminates the Florida Health Information Systems Council (Council), established by s. 381.90, F.S. The purpose of the Council is to facilitate the collection, analysis, and sharing of health-related data among federal, state, local and private entities. The Council has not taken any official action since 2003. The Council has received no funding in recent years. No new appointments have been made to the Council in the last two years.

The bill appears to have an insignificant, but indeterminate, positive fiscal impact on state government.

The bill provides an effective date of July 1, 2012.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

The Florida Health Information Systems Council (Council) was created in the Department of Health by the Information Resource Management Reform Act of 1997.[1] The purpose of the Council is to coordinate, and provide for, the identification, collection, standardization, and sharing of health-related data among federal, state, local, and private entities.[2] Members of the Council include:

- The State Surgeon General;
- The Executive Director of the Department of Veterans' Affairs;
- The Secretary of Children and Family Services;
- The Secretary of Health Care Administration;
- The Secretary of Corrections;
- The Attorney General;
- The Executive Director of the Corrections Medical Authority;
- One member representing a small county health department and one member representing a large county health department, both appointed by the Governor;
- A representative from the Florida Association of Counties;
- The Chief Financial Officer;
- A representative from the Florida Health Kids Corporation;
- A representative from a school of public health chosen by the Commissioner of Education;
- The Commissioner of Education;
- The Secretary of Elder Affairs; and
- The Secretary of Juvenile Justice.

Representatives from the federal government may also serve on the Council, but do not have voting rights.[3] The Council is required to meet at least quarterly, but may also meet at the call of its chair, at the request of a majority of the membership, or at the request of a department.[4]

According to the Department of Health, the Council has continued to meet as required, but takes no official action.[5] The last meeting of the Council at which any official action was taken occurred on October 22, 2003.[6] At that meeting, the Council adopted revisions to its Strategic Plan for FY 2004-05 through 2008-09.[7] However, none of the recommendations contained in the Plan have been implemented over the last 8 years. Lastly, the Council has not received any recent funding, nor have any appointments to the Council been made in the last two years.[8]

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[1] *See* s. 27, ch. 97-286, Laws of Fla.
[2] S. 381.90(2), F.S.
[3] S. 381.90(3), F.S.
[4] S. 381.90(5), F.S.
[5] Telephone conference between Department of Health legislative affairs staff and Health and Human Services Quality Subcommittee staff.
[6] Florida Department of Health, Florida Health Information Systems Council, *Meeting Minutes, October 22, 2003*, available at http://www.doh.state.fl.us/floridahisc/Meetings/102203mts.html (last viewed on January 21, 2012).
[7] Department of Health, Florida Health Information Systems Council, *Strategic Plan-Fiscal Years 2004-05 through 2008-09*, May 15, 2003 (revised October 22, 2003), available at http://www.doh.state.fl.us/floridahisc/Plan/FHISCSP_2003_approved_revision_10_22_2003.pdf (last viewed January 22, 2012).
[8] *See supra* at FN 7.

Effect of Proposed Changes

PCB HSQS 12-01 eliminates the Council. Elimination of the Council will have little or no effect on the Department of Health because the Council is defunct.

B. SECTION DIRECTORY:

Section 1: Repeals s. 381.90, F.S., relating to Health Information Systems Council; legislative intent; creation, appointment, duties.
Section 2: Provides an effective date of July 1, 2012.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

Members of the Council are entitled to reimbursement for per diem and travel expenses pursuant to s. 112.061, F.S.[9] Elimination of the Council ends these reimbursements, resulting in an insignificant, but indeterminate, savings to the Department of Health.

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.

[9] S. 381.90(6), F.S.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

PCB HSQS 12-01 ORIGINAL YEAR

A bill to be entitled

An act relating to health information systems; repealing s. 381.90, F.S., relating to Health Information Systems Council; providing an effective date.

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

Section 1. Section 381.90, Florida Statutes, is repealed.

Section 2. This act shall take effect July 1, 2012.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

V

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HSQS 12-02 Developmental Disabilities Compact Workgroup
SPONSOR(S): Health & Human Services Quality Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health & Human Services Quality Subcommittee		Poche	Calamas

SUMMARY ANALYSIS

PCB HSQS 12-02 repeals s. 624.916, F.S., relating to the Developmental Disabilities Compact. The statute required the Office of Insurance Regulation (OIR) to convene a workgroup to negotiate a binding agreement among participants (large group health insurers and health maintenance organizations) to provide coverage of evaluation and treatment for developmental disabilities. Participants in the agreement would be exempt from the provisions of the Steven A. Geller Autism Act because the agreement covered autism spectrum disorder, as well as other developmental disabilities.

One company became a participant in the agreement prior to the April 1, 2009 deadline. The company had no claims for evaluation or treatment of developmental disabilities. The company subsequently lost its certificate of authority to operate in Florida and no longer exists. As a result, there are no signatories to the compact, which is now moot.

The bill has an insignificant, but indeterminate, positive fiscal impact on state government.

The bill provides an effective date of July 1, 2012.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Section 624.916, F.S., called the "Window of Opportunity Act"[1], required the Office of Insurance Regulation (OIR) to convene a workgroup for the purpose of developing and executing a compact including a binding agreement among the participants relating to insurance and access to services for persons with developmental disabilities.[2] Members of the workgroup included:

- Representatives from all health insurers licensed under chapter 624;
- Representatives from all health maintenance organizations licensed under part I of chapter 641;
- Representatives of employers with self-insured health benefit plans;
- Two designees of the Governor, one of whom must be a consumer advocate;
- A designee of the President of the Senate; and
- A designee of the Speaker of the House of Representatives.

The agreement was to include:

- A requirement that each participant agree to increase coverage for behavior analysis and assistant services[3], speech therapy, physical therapy, and occupational therapy as medically necessary to treat a developmental disability;
- Procedures for notice to policyholders setting out the amount, scope, and conditions under which coverage is provided for the specified therapies and treatments;
- Penalties for documented cases of denial of claims for medically necessary treatment for a developmental disability; and
- Proposals for new insurance products that may be offered with traditional insurance coverage to more effectively spread risk and costs associated with providing coverage for developmental disabilities.

The Window of Opportunity Act was enacted concurrently with the Steven A. Geller Autism Coverage Act (the Act).[4] The Act establishes insurance coverage mandates for group health insurers and health maintenance organizations for evaluation and treatment of autism spectrum disorder. The Act requires coverage of well-baby and well-child screening for autism spectrum disorder[5] and speech therapy, occupational therapy, physical therapy, and applied behavior analysis.[6] Participants who signed on to the compact would be exempt from the coverage mandates, beginning on April 1, 2009. Provisions of the Act prohibit enforcement of its terms against an insurer or health maintenance organization that is a signatory to the compact no later than April 1, 2009.[7]

OIR was required to provide the results of negotiations for the compact to the Governor, the President of the Senate, and the Speaker of the House of Representatives and, beginning in February 2009, to

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[1] S. 624.916(1), F.S.
[2] S. 624.916(2), F.S.
[3] S. 624.916(4)(a) and (b), F.S., refers to s. 409.815(2)(r), F.S., for the definition of the terms "behavior analysis" and "behavior assistant services". However, that section of law sets a lifetime maximum coverage amount for health benefits for covered children under the Florida KidCare Act of $1,000,000. The term "applied behavior analysis" is defined within the Steven A. Geller Autism Act. The term "behavior assistant services" is not defined in Florida Statutes.
[4] S. 627.6686, F.S., and s. 641.31098, F.S.
[5] S. 627.6686(3)(a), F.S., and s. 641.31098(3)(a), F.S.
[6] S. 627.6686(3)(b), F.S. and s. 641.31098(3)(b), F.S.
[7] S. 627.6686(1), F.S., and s. 641.31098(9), F.S.

report yearly on the implementation of the agreement.[8] Lastly, OIR is required to monitor participation in the agreement, compliance with the terms of the agreement, and the effectiveness of the agreement, and report its findings on an annual basis.[9]

On December 17, 2008, the Developmental Disabilities Compact Workgroup adopted the Developmental Disabilities Compact.[10] Total Health Choice, Inc., a health maintenance organization that operated in Broward and Dade counties, was the only signatory to the compact, signing it on March 24, 2009.[11] Total Health Choice, Inc., had 160 eligible lives enrolled in large group coverage which were subject to the terms of the agreement.[12] OIR reviewed the claims submitted by those eligible individuals and determined that none of them had been diagnosed with a developmental disability at 8 years of age or younger, resulting in no services provided and no claims denied for services.[13]

According to OIR, effective April 30, 2010, the certificate of authority of Total Health Choice, Inc., was suspended and the company was winding down its commercial operation.[14] The company no longer operates in Florida.[15] As a result, there are no signatories to the Developmental Disabilities Compact.

Effect of Proposed Changes

PCB HSQS 12-02 repeals the Developmental Disabilities Compact and deletes applicable cross-references found in the Act. There are no signatories to the compact. For the brief time period during which Total Health Choice, Inc., was the sole signatory, there were no claims for service pursuant to the terms of the compact. Because there is no signatory to the compact that has availed itself of the provisions exempting it from the coverage mandates contained in the Act, the compact is moot.

The bill has no impact on the coverage mandates contained in the Act.

B. SECTION DIRECTORY:

Section 1: Repeals s. 624.916, F.S., relating to developmental disabilities compact.
Section 2: Amends s. 627.6686, F.S., relating to coverage for individuals with autism spectrum disorder required; exception.
Section 3: Amends s. 641.31098, F.S., relating to coverage for individuals with developmental disabilities.
Section 4: Provides an effective date of July 1, 2012.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

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[8] S. 624.916(5), F.S.
[9] S. 624.916(6), F.S.
[10] The Developmental Disabilities Compact can be found at http://www.floir.com/siteDocuments/DDCProposal-A.pdf.
[11] Florida Office of Insurance Regulation, *2010 Developmental Disabilities Compact Annual Report*, page 1 (February 15, 2010)(available at http://www.floir.com/siteDocuments/DDCWGReport02152010.pdf).
[12] *Id.* at page 2.
[13] *Id.* at page 3.
[14] Florida Office of Insurance Regulation, *2011 Developmental Disabilities Compact Annual Report*, page 2 (February 14, 2011)(available at http://www.floir.com/siteDocuments/DDCWGReport02142011.pdf).
[15] Telephone conference between Michelle Robleto, Deputy Insurance Commissioner of Life and Health Insurance, Florida Office of Insurance Regulation, and Health and Human Services Quality Subcommittee staff on January 11, 2012.

2. Expenditures:

Repeal of s. 624.916, F.S., would eliminate the reporting requirement for OIR[16], resulting in an insignificant, but indeterminate, positive fiscal impact on OIR.

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:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[16] *See supra* at FN 7.

A bill to be entitled

An act relating to Developmental Disabilities Compact Workgroup; repealing s. 624.916, F.S., relating to developmental disabilities compact; amending s. 627.6686, F.S.; conforming a cross-reference; amending s. 641.31098, F.S.; conforming a cross-reference; providing an effective date.

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

Section 1. Section 624.916, Florida Statutes, is repealed.

Section 2. Subsection (10) of section 627.6686, Florida Statutes, is amended to read:

627.6686 Coverage for individuals with autism spectrum disorder required; exception.—

~~(10) The Office of Insurance Regulation may not enforce this section against an insurer that is a signatory no later than April 1, 2009, to the developmental disabilities compact established under s. 624.916. The Office of Insurance Regulation shall enforce this section against an insurer that is a signatory to the compact established under s. 624.916 if the insurer has not complied with the terms of the compact for all health insurance plans by April 1, 2010.~~

Section 3. Subsection (9) of section 641.31098, Florida Statutes, is amended to read:

641.31098 Coverage for individuals with developmental disabilities.—

~~(9) The Office of Insurance Regulation may not enforce~~

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

~~this section against a health maintenance organization that is a signatory no later than April 1, 2009, to the developmental disabilities compact established under s. 624.916. The Office of Insurance Regulation shall enforce this section against a health maintenance organization that is a signatory to the compact established under s. 624.916 if the health maintenance organization has not complied with the terms of the compact for all health maintenance contracts by April 1, 2010.~~

Section 4. This act shall take effect July 1, 2012.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

V