

Tab 1	SB 1568 by Brodeur; Identical to H 01297 Electronic Prescribing						
Tab 2	SB 1606 by Grall; Identical to H 01083 Patient Access to Records						
900268	A	S	FAV	HP, Grall	Delete L.463 - 474.	03/25	03:33 PM
Tab 3	SB 656 by Rodriguez; Similar to H 00547 Health Care Billing and Collection Activities						
967282	D	S	RCS	HP, Rodriguez	Delete everything after	03/26	09:25 AM
Tab 4	SB 68 by Martin; Similar to CS/H 00229 Health Facilities Authorities						
534268	A	S	RCS	HP, Martin	Delete L.26:	03/26	09:26 AM
Tab 5	SB 1690 by McClain; Similar to CS/CS/H 00791 Surrendered Infants						
Tab 6	SB 1346 by Polksky; Similar to H 01195 Fentanyl Testing						
609278	A	S	RCS	HP, Polksky	Delete L.30:	03/26	09:28 AM
Tab 7	SB 1224 by Harrell; Similar to CS/H 00519 Administration of Controlled Substances						
375076	A	S	RCS	HP, Harrell	Delete L.18 - 20:	03/26	09:29 AM
Tab 8	SB 524 by Harrell; Identical to H 01089 Newborn Screenings						
Tab 9	SB 172 by Burton (CO-INTRODUCERS) Passidomo; Similar to H 01341 Health Care Practitioner Specialty Titles and Designations						
310092	A	S	RCS	HP, Burton	Delete L.55 - 221:	03/26	09:40 AM
Tab 10	SPB 7028 by HP; Cancer						
Tab 11	SB 1842 by Burton; Similar to H 01101 Out-of-network Providers						
371962	D	S	RCS	HP, Burton	Delete everything after	03/26	09:42 AM
505022	AA	S	RCS	HP, Burton	Delete L.10:	03/26	09:42 AM

The Florida Senate
COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY

Senator Burton, Chair
Senator Harrell, Vice Chair

MEETING DATE: Tuesday, March 25, 2025

TIME: 1:30—3:30 p.m.

PLACE: *Pat Thomas Committee Room, 412 Knott Building*

MEMBERS: Senator Burton, Chair; Senator Harrell, Vice Chair; Senators Berman, Calatayud, Davis, Gaetz, Leek, Osgood, Passidomo, and Trumbull

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	SB 1568 Brodeur (Identical H 1297)	<p>Electronic Prescribing; Revising health care practitioners who may only electronically transmit prescriptions for certain drugs; revising exceptions, etc.</p> <p>HP 03/25/2025 Favorable AHS RC</p>	<p>Favorable Yea 7 Nays 3</p>
2	SB 1606 Grall (Identical H 1083)	<p>Patient Access to Records; Requiring a service provider to furnish and provide access to records within a specified timeframe after receiving a request for such records; revising provisions relating to the appropriate disclosure of patient records without consent; revising the timeframe within which a nursing home facility must provide access to and copies of resident records after receiving a request for such records; authorizing a provider to impose reasonable terms necessary to preserve such records, etc.</p> <p>HP 03/25/2025 Pending reconsideration (Unfavorable) AHS RC</p>	<p>Unfavorable Yea 4 Nays 4 -Pending Reconsideration</p>
3	SB 656 Rodriguez (Similar H 547)	<p>Health Care Billing and Collection Activities; Authorizing the furnishing of paid or settled medical debt information to consumer reporting agencies; authorizing the furnishing of certain information relating to medical debt payment plans to consumer reporting agencies under certain circumstances; requiring consumer reporting agencies and credit scoring service providers to adopt certain procedures for the use of positive consumer credit information, etc.</p> <p>HP 03/25/2025 Fav/CS CM RC</p>	<p>Fav/CS Yea 10 Nays 0</p>

COMMITTEE MEETING EXPANDED AGENDA

Health Policy

Tuesday, March 25, 2025, 1:30—3:30 p.m.

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	SB 68 Martin (Similar CS/H 229)	Health Facilities Authorities; Revising the definition of the term "health facility" to include other entities and associations organized not for profit; revising the powers of health facilities authorities to include the power to issue certain loans and execute related loan agreements; specifying requirements for projects financed by loan agreements issued by a health facilities authority, etc. CA 03/03/2025 Favorable HP 03/25/2025 Fav/CS RC	Fav/CS Yea 10 Nays 0
5	SB 1690 McClain (Similar CS/CS/H 791)	Surrendered Infants; Revising the definition of the term "infant"; defining the term "infant safety device"; authorizing certain hospitals, emergency medical services stations, and fire stations to use infant safety devices to accept surrendered infants if the device meets specified criteria; requiring such hospitals, emergency medical services stations, and fire stations to monitor the inside of the device 24 hours per day and physically check and test the devices at specified intervals, etc. HP 03/25/2025 Favorable JU RC	Favorable Yea 6 Nays 1
6	SB 1346 Polsky (Similar H 1195)	Fentanyl Testing; Creating "Gage's Law"; requiring hospitals and hospital-based off-campus emergency departments to test for fentanyl as part of any urine testing they conduct to treat individuals for possible drug overdose or poisoning; requiring such facilities to perform further laboratory and toxicology screenings if the urine test results are positive for fentanyl; requiring that the results of such tests and screenings be preserved as part of the patient's clinical record in accordance with the facility's current recordkeeping practices, etc. HP 03/25/2025 Fav/CS JU RC	Fav/CS Yea 10 Nays 0
7	SB 1224 Harrell (Similar CS/H 519)	Administration of Controlled Substances; Authorizing a practitioner to cause a controlled substance to be administered by a certified paramedic, etc. HP 03/25/2025 Fav/CS CA RC	Fav/CS Yea 10 Nays 0

COMMITTEE MEETING EXPANDED AGENDA

Health Policy

Tuesday, March 25, 2025, 1:30—3:30 p.m.

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
8	SB 524 Harrell (Identical H 1089)	Newborn Screenings; Beginning on a specified date, requiring that the Department of Health's rules require that newborns be screened for Duchenne muscular dystrophy at the appropriate age, etc. HP 03/25/2025 Favorable AHS FP	Favorable Yea 10 Nays 0
9	SB 172 Burton (Similar H 1341)	Health Care Practitioner Specialty Titles and Designations; Prohibiting the use of specified titles and designations by health care practitioners not licensed as physicians or osteopathic physicians, as applicable, with an exception; specifying the manner in which health care practitioners may represent their specialty practice areas; specifying specialist titles and designations that physicians and osteopathic physicians, respectively, are prohibited from using unless they have received formal recognition by the appropriate recognizing agency for such specialty certifications, etc. HP 03/25/2025 Fav/CS RC	Fav/CS Yea 7 Nays 3
Consideration of proposed bill:			
10	SPB 7028	Cancer; Revising the definitions of the terms "cancer center" and "Florida-based"; defining the term "Cancer Connect Collaborative" or "collaborative"; requiring the collaborative to review all submitted Cancer Innovation Fund grant applications using certain parameters; requiring the Department of Health to appoint peer review panels for a specified purpose; creating the Cancer Connect Collaborative Research Incubator within the department, and overseen by the collaborative, to provide funding for a specified purpose over a specified timeframe, etc.	Submitted and Reported Favorably as Committee Bill Yea 10 Nays 0
11	SB 1842 Burton (Similar H 1101)	Out-of-network Providers; Requiring a health care practitioner to notify a patient in writing upon referring the patient to certain providers; requiring certain health insurers to apply payments for services provided by nonpreferred providers toward insureds' deductibles and out-of-pocket maximums if specified conditions are met, etc. HP 03/25/2025 Fav/CS AHS FP	Fav/CS Yea 8 Nays 2

COMMITTEE MEETING EXPANDED AGENDA

Health Policy

Tuesday, March 25, 2025, 1:30—3:30 p.m.

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
Other Related Meeting Documents			

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL: SB 1568

INTRODUCER: Senator Brodeur

SUBJECT: Electronic Prescribing

DATE: March 24, 2025

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Smith	Brown	HP	Favorable
2.		AHS	
3.		RC	

I. Summary:

SB 1568 revises exceptions to Florida's electronic prescribing (e-prescribing) requirement. Authorized prescribers who prescribe a medicinal drug in their capacity as an owner, employee, or contractor of a health care facility or practice that maintains an electronic health records system must electronically transmit prescriptions instead of issuing written prescriptions, unless they meet an exception.

The bill lists exceptions for prescribers who:

- Prescribe fewer than 100 prescriptions annually.
- Are located in an area where a state of emergency has been declared.
- Have been issued a waiver by the Department of Health due to circumstances beyond their control.

The bill removes seven exceptions from current law. Prescribers who no longer qualify for an exception would be required to establish compliance with the e-prescribing requirement upon their next scheduled license renewal or by July 1, 2026, whichever occurs first.

The bill purports to align Florida's exceptions to e-prescribing requirements for *all* prescription drugs with federal exceptions that apply only to controlled substances under Medicare Part D.¹ However, federal law includes additional provisions, such as a compliance threshold of 70 percent, which the federal Centers for Medicare & Medicaid Services (CMS) is expected to review and revise.²

¹ Medicare Part D is the voluntary federal prescription drug benefit for seniors and individuals with disabilities.

² If a prescriber issues 70% or more of their Part D controlled substance prescriptions electronically, they are considered in compliance with the federal Electronic Prescribing of Controlled Substances (EPCS) requirement. CMS has not yet finalized a move to raise the threshold beyond 70 percent, but the language used in Federal Register notices and CMS guidance suggests that eventual increases are likely.

A prescriber prescribing in a personal capacity and not as an owner, employee, or contractor of a facility or practice that maintains an electronic health records system remains exempt from e-prescribing requirements under the bill.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

E-prescribing

E-prescribing refers to the transmission of prescription information in electronic format from a prescriber at the point of care to a pharmacy. It is widely adopted as a method to improve the accuracy and legibility of prescriptions, reduce medication errors associated with handwritten or phoned-in orders, prevent prescription fraud and forgery, and streamline the medication dispensing process. In provider settings, e-prescribing integrates with electronic health records (EHRs), allowing prescribers to view patient medication histories, check for drug interactions, and access formulary information in real time. On the pharmacy side, electronic receipt of prescriptions reduces transcription errors, accelerates processing time, and facilitates more accurate patient counseling and verification procedures. The number of e-prescribers in Florida continues to increase annually.³

Federal Medicare E-Prescribing Requirements

The federal *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act* (SUPPORT Act), enacted in 2018, mandated that prescriptions for controlled substances covered under Medicare Part D be transmitted electronically beginning January 1, 2021.⁴ CMS is responsible for enforcing this mandate and has established the Electronic Prescribing for Controlled Substances (EPCS) Program to oversee compliance.⁵

The Secretary of the U.S. Department of Health and Human Services *may* waive the requirements for a Medicare Part D covered schedule II, III, IV, and V controlled substance to be electronically transmitted in the case of a prescription issued:

- When the practitioner and dispensing pharmacy are the same entity;
- That cannot be transmitted electronically under the most recently implemented version of the National Council for Prescription Drug Programs' Stanford Computerized Researcher Information Profile Technique (SCRIPT) Standard;
- By a practitioner who received a waiver or a renewal for a period of time, not to exceed one year, from the requirement to use electronic prescribing due to economic hardship, technological limitations outside the control of the practitioner, or other exceptional circumstances;

³ Agency for Health Care Administration, 2023 Electronic Prescribing Annual Report (Jan. 2024); available at https://ahca.myflorida.com/content/download/25388/file/2023eRxAnnualReport_Final.pdf (last visited Mar. 23, 2025).

⁴ Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act, Pub. L. No. 115-271, 132 Stat. 3894 (2018); available at <https://www.congress.gov/115/plaws/publ271/PLAW-115publ271.pdf> (last visited Mar. 23, 2025).

⁵ Centers for Medicare & Medicaid Services, Electronic Prescribing for Controlled Substances (EPCS) Program, available at <https://www.cms.gov/medicare/e-health/eprescribing/cms-eprescribing-for-controlled-substances-program> (last visited Mar. 23, 2025).

- By a practitioner under circumstances in which it would be impractical for the individual to obtain the substances prescribed by electronic prescription in a timely manner, and such delay would adversely impact the individual's medical condition;
- By a practitioner prescribing a drug under a research protocol;
- By a practitioner for a drug for which the FDA requires a prescription to contain elements that are not able to be included in e-prescribing, such as a drug with risk evaluation and mitigation strategies that include elements to assure safe use;
- By a practitioner for an individual receiving hospice care that is not covered under the hospice Medicare benefit or a resident of a nursing facility dually eligible for Medicaid and Medicare.⁶

The Secretary has authority to revise these exceptions and generally does so annually through the Medicare physician fee schedules.⁷

Additionally, CMS established a 70 percent compliance threshold by rule. To be considered compliant, prescribers must electronically transmit at least 70 percent of their Schedule II through V controlled substance prescriptions under Medicare Part D during each measurement year.⁸

Florida E-Prescribing Requirements

Florida law generally requires prescriptions for *all* medicinal drugs, not just controlled substances, to be electronically transmitted, subject to specific exceptions. Section 456.42, F.S., governs written and electronic prescriptions for medicinal drugs. Under current law, a health care practitioner who is licensed to prescribe medicinal drugs and who maintains an electronic health record system or who is prescribing medicinal drugs in his or her capacity as an owner, an employee, or a contractor of a licensed health care facility or practice that maintains such a system, must electronically transmit prescriptions. This requirement also applies to practitioners prescribing on behalf of a licensed facility or practice that maintains such a system.

However, several exceptions exist in Florida law that allow prescribers to write paper prescriptions. For example, the requirement for e-prescribing does not apply if the practitioner issues fewer than 100 prescriptions annually, is located in an area under a declared state of emergency, or determines it is in the best interest of the patient to compare prescription drug prices among area pharmacies. Additional exceptions include prescribing under research protocols, for patients in hospice or nursing home care, or when a prescription cannot be electronically transmitted under the current SCRIPT standard. These exceptions are not uniformly defined in federal laws mandating the e-prescribing of controlled substances, and some have been eliminated at the federal level.

Section 456.43, F.S., authorizes the Department of Health to issue waivers from the electronic prescribing requirement for up to one year, based on demonstrated economic hardship,

⁶ 42 U.S.C. § 1395w-104(e)(7)(B); available at <https://www.govinfo.gov/app/details/USCODE-2021-title42/USCODE-2021-title42-chap7-subchapXVIII-partD-subpart1-sec1395w-104> (last visited Mar. 23, 2025).

⁷ See "Effect of Proposed Changes" to compare Florida's exceptions for all prescription drugs with the EPCS exceptions.

⁸ 42 C.F.R. § 423.160(a)(5)(i); available at <https://www.ecfr.gov/current/title-42/section-423.160> (last visited Mar. 23, 2025).

technological limitations, or other exceptional circumstances. It also authorizes the Department to adopt rules and coordinate with professional boards to implement and enforce the e-prescribing requirements. Electronic prescribing may not interfere with a patient's freedom to choose a pharmacy.⁹

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 456.42, F.S., to require health care practitioners who are licensed by law to prescribe a medicinal drug and who are prescribing medicinal drugs in their capacity as an owner, an employee, or a contractor of a licensed health care facility or practice that maintains a system of electronic health records¹⁰ to electronically transmit prescriptions for such drugs. The bill creates two exceptions, retains one in current law, and removes seven, as follows.

The bill creates the following two exceptions:

- *(a) The practitioner prescribes fewer than 100 such prescriptions annually;*

This is intended to mirror the "Small Prescriber Exception" from EPCS requirements which CMS automatically provides to prescribers who issue 100 or fewer qualifying Medicare Part D controlled substance prescriptions in the measurement year.¹¹

- *(b) The practitioner is located in an area for which a state of emergency is declared pursuant to s. 252.36, F.S.;*

This is intended to mirror the "Declared Disaster Exception" from EPCS requirements which CMS automatically provides to prescribers located in the geographic area of an emergency or disaster declared by a federal, state, or local government entity.¹²

The bill retains the following exception in current law:

- *(c) The practitioner has been issued a waiver by the department, not to exceed one year in duration, from the requirement to use electronic prescribing due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the practitioner, or another exceptional circumstance demonstrated by the practitioner;*

This is similar to the "CMS-Approved Waiver" exception. CMS provides this exception to prescribers who submit and receive a CMS-approved waiver because the prescriber is unable to meet the CMS EPCS Program requirement due to circumstances beyond the prescriber's control.¹³

⁹ Section 456.43, F.S.

¹⁰ "Electronic health record" means a record of a person's medical treatment which is created by a licensed health care provider and stored in an interoperable and accessible digital format. Section 408.051, F.S.

¹¹ *Supra* note 5.

¹² *Id.*

¹³ *Id.*

The bill deletes all other exceptions listed in current law, including all of the following:

- *(a) The practitioner and the dispenser are the same entity;*

This was intended to mirror a similar federal requirement which has since been removed. On November 16, 2023, CMS published the 2024 Physician Fee Schedule final rule (CMS-1784-F)¹⁴ which removed the exception to the EPCS requirement for prescriptions where the prescriber and dispensing pharmacy are the same legal entity. Effective January 1, 2025, all prescriptions for controlled substances under Medicare Part D must be transmitted electronically, regardless of whether the prescriber and dispenser are part of the same legal entity.

- *(b) The prescription cannot be transmitted electronically under the most recently implemented version of the National Council for Prescription Drug Programs SCRIPT Standard;*

This was intended to mirror federal authority given to the Secretary of HHS that was never exercised. The 2021 Physician Fee Schedule final rule (CMS-1734-F),¹⁵ published on December 28, 2020, mandated that prescribers use the NCPDP SCRIPT Standard Version 2017071 for EPCS transmissions. By adopting this standard, CMS did not include exceptions for prescriptions that could not be transmitted electronically under the most recent SCRIPT standard, thereby eliminating any previous allowances for such limitations.

- *(d) The practitioner reasonably determines that it would be impractical for the patient in question to obtain a medicinal drug prescribed by electronic prescription in a timely manner and such delay would adversely impact the patient's medical condition;*

This was intended to mirror a similar federal requirement which has since been removed. On November 18, 2022, CMS published the 2023 Physician Fee Schedule final rule (CMS-1770-F),¹⁶ which removed the exception to the EPCS requirement for prescriptions issued when it would be impractical for the patient to obtain the prescribed substance electronically and a delay would adversely impact the patient's medical condition.

- *(e) The practitioner is prescribing a drug under a research protocol;*

This was intended to mirror a similar federal requirement which has since been removed. The exception permitting practitioners to issue non-electronic prescriptions for controlled substances when prescribing under a research protocol was removed in the Calendar Year (CY) 2022

¹⁴ Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Final Rule, 88 Fed. Reg. 81280 (Nov. 16, 2023), available at <https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other> (last visited Mar. 23, 2025).

¹⁵ Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Final Rule, 85 Fed. Reg. 84472 (Dec. 28, 2020); available at <https://www.govinfo.gov/content/pkg/FR-2020-12-28/pdf/2020-26815.pdf>. (last visited Mar. 23, 2025).

¹⁶ Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Final Rule, 87 Fed. Reg. 69404 (Nov. 18, 2022); available at <https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf>. (last visited Mar. 23, 2025).

Medicare Physician Fee Schedule final rule (CMS-1751-F),¹⁷ which was published on November 19, 2021. In this rule, CMS finalized specific exceptions to the EPCS requirement, and the exception for prescriptions under a research protocol was not included among them, effectively removing it.

- *(f) The prescription is for a drug for which the federal Food and Drug Administration requires the prescription to contain elements that may not be included in electronic prescribing;*

This was intended to mirror a similar federal requirement which has since been removed. The exception allowing practitioners to issue non-electronic prescriptions for drugs requiring specific elements by the FDA that could not be included in electronic prescriptions was also removed in the Calendar Year (CY) 2022 Medicare Physician Fee Schedule final rule (CMS-1751-F).¹⁸ In this rule, CMS finalized specific exceptions to the Electronic Prescribing for Controlled Substances (EPCS) requirement, and the exception for prescriptions requiring FDA-mandated elements not supported by electronic prescribing was not included among them, effectively removing it.

- *(g) The prescription is issued to an individual receiving hospice care or who is a resident of a nursing home facility; or*

The exemption for individuals receiving hospice care from the federal electronic prescribing requirements for controlled substances under Medicare Part D was removed with the publication of the 2024 Physician Fee Schedule final rule (CMS-1784-F) by CMS on November 16, 2023.¹⁹

However, the exemption for residents of long-term care (LTC) facilities (which generally include nursing home facilities in Florida law) from the federal electronic prescribing requirements for controlled substances under Medicare Part D has been extended by three years, from 2025 to 2028.²⁰ The CMS finalized a policy to delay compliance actions against prescribers who do not meet the EPCS requirement for prescriptions written for beneficiaries in LTC facilities until January 1, 2028.²¹ This extension aligns the timeline for EPCS compliance in LTC facilities with the adoption of updated electronic prescribing standards that include improved communication functionalities between pharmacies and LTC facilities.²²

¹⁷ Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Final Rule, 86 Fed. Reg. 64996 (Nov. 19, 2021); available at <https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf>. (last visited Mar. 23, 2025).

¹⁸ *Id.*

¹⁹ Centers for Medicare & Medicaid Services, Medicare Program: CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Final Rule, 88 Fed. Reg. 81280, 82539 (Nov. 16, 2023) (to be codified at 42 C.F.R. pt. 423).

²⁰ American Medical Association, Summary of Final CY 2025 Medicare Physician Fee Schedule (PFS) Rule, at 8 (2023); available at <https://www.ama-assn.org/system/files/ama-2025-mpfs-summary.pdf> (last visited Mar. 23, 2025).

²¹ Centers for Medicare & Medicaid Services, Electronic Prescribing for Controlled Substances (EPCS) Program, available at <https://www.cms.gov/medicare/e-health/eprescribing/cms-eprescribing-for-controlled-substances-program> (last visited Mar. 23, 2025).

²² American Medical Association, Summary of Final CY 2025 Medicare Physician Fee Schedule (PFS) Rule, at 8 (2023); available at <https://www.ama-assn.org/system/files/ama-2025-mpfs-summary.pdf> (last visited Mar. 23, 2025).

- *(h) The practitioner determines that it is in the best interest of the patient, or the patient determines that it is in his or her own best interest, to compare prescription drug prices among area pharmacies. The practitioner must document such determination in the patient's medical record.*

This exception is unique to Florida law and is consistent with s. 456.24, F.S., which establishes that electronic prescribing may not interfere with a patient's freedom to choose a pharmacy.

Prescribers who no longer qualify for an exception would be required to establish compliance with the bill's e-prescribing requirement upon their next scheduled license renewal or by July 1, 2026, whichever occurs first.

By deleting the exceptions in current law, the bill would increase the number of prescriptions that prescribers must submit electronically. Prescribers who no longer meet an exception would be required to establish compliance with the e-prescribing requirement upon their next scheduled practitioner license renewal or by July 1, 2026, whichever occurs first.

The DOH, in consultation with the Board of Medicine, the Board of Osteopathic Medicine, the Board of Podiatric Medicine, the Board of Dentistry, the Board of Nursing, and the Board of Optometry, is authorized, but not required to, adopt rules to implement this subsection encompassing the e-prescribing requirement. With this rulemaking authority, the DOH has incorporated a Request for Waiver form by reference, which would need to be updated to conform with changes made by the bill in its introductory paragraph.²³

Sections 2 and 3 of the bill amend ss. 458.347 and 459.022, F.S., respectively, to conform a cross-reference to subsection (1) of s. 456.42, F.S., which is redesignated as subsection (2) in section 1 of the bill.

Section 4 of the bill provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

²³ Rule 64B-3.009, F.A.C. (2025).

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:²⁴

The DOH reports that both the department and the Board of Pharmacy would need to update rules²⁵ that reference subsections of statute that are renumbered by the bill. Additionally, the DOH would need to communicate the revised requirements to all prescribing practitioners through the customer contact center virtual agent (ELI), board websites, and email notifications. The DOH indicates that current resources and budget authority are sufficient to absorb the associated non-recurring costs and the expected temporary increase in workload.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 456.42, 458.347, and 459.022.

²⁴ Department of Health, Senate Bill 1568 Legislative Analysis (Mar. 11, 2025) (on file with the Senate Committee on Health Policy).

²⁵ Rules 64B-3.009 and 64B16-27.831(5), F.A.C. (2025).

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

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

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By Senator Brodeur

10-01056A-25

20251568

A bill to be entitled

An act relating to electronic prescribing; amending s. 456.42, F.S.; revising health care practitioners who may only electronically transmit prescriptions for certain drugs; revising exceptions; amending ss. 458.347 and 459.022, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Present subsections (1) and (2) of section 456.42, Florida Statutes, are redesignated as subsections (2) and (3), respectively, and present subsection (3) of that section is redesignated as subsection (1) and amended, to read:

456.42 ~~written~~ Prescriptions for medicinal drugs.—

(1)-(3) A health care practitioner licensed by law to prescribe a medicinal drug who maintains a system of electronic health records as defined in s. 408.051(2)(c), or who prescribes medicinal drugs as an owner, an employee, or a contractor of a licensed health care facility or practice that maintains such a system of electronic health records as defined in s.

408.051(2)(c) and who is prescribing in his or her capacity as such an owner, an employee, or a contractor, may only electronically transmit prescriptions for such drugs. This requirement applies to such a health care practitioner upon renewal of the health care practitioner's license or by July 1, 2026 2021, whichever is earlier, but does not apply if:

(a) The practitioner prescribes fewer than 100 such prescriptions annually;

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30 (b) The practitioner is located in an area for which a
31 state of emergency is declared pursuant to s. 252.36; or
32 (a) The practitioner and the dispenser are the same entity;
33 (b) The prescription cannot be transmitted electronically
34 under the most recently implemented version of the National
35 Council for Prescription Drug Programs SCRIPT Standard;
36 (c) The practitioner has been issued a waiver by the
37 department, not to exceed 1 year in duration, from the
38 requirement to use electronic prescribing due to demonstrated
39 economic hardship, technological limitations that are not
40 reasonably within the control of the practitioner, or another
41 exceptional circumstance demonstrated by the practitioner;
42 (d) The practitioner reasonably determines that it would be
43 impractical for the patient in question to obtain a medicinal
44 drug prescribed by electronic prescription in a timely manner
45 and such delay would adversely impact the patient's medical
46 condition;
47 (e) The practitioner is prescribing a drug under a research
48 protocol;
49 (f) The prescription is for a drug for which the federal
50 Food and Drug Administration requires the prescription to
51 contain elements that may not be included in electronic
52 prescribing;
53 (g) The prescription is issued to an individual receiving
54 hospice care or who is a resident of a nursing home facility; or
55 (h) The practitioner determines that it is in the best
56 interest of the patient, or the patient determines that it is in
57 his or her own best interest, to compare prescription drug
58 prices among area pharmacies. The practitioner must document

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59 ~~such determination in the patient's medical record.~~

60

61 The department, in consultation with the Board of Medicine, the
62 Board of Osteopathic Medicine, the Board of Podiatric Medicine,
63 the Board of Dentistry, the Board of Nursing, and the Board of
64 Optometry, may adopt rules to implement this subsection.

65 Section 2. Paragraph (e) of subsection (4) of section
66 458.347, Florida Statutes, is amended to read:

67 458.347 Physician assistants.—

68 (4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

69 (e) A supervising physician may delegate to a fully
70 licensed physician assistant the authority to prescribe or
71 dispense any medication used in the supervising physician's
72 practice unless such medication is listed on the formulary
73 created pursuant to paragraph (f). A fully licensed physician
74 assistant may only prescribe or dispense such medication under
75 the following circumstances:

76 1. A physician assistant must clearly identify to the
77 patient that he or she is a physician assistant.

78 2. The supervising physician must notify the department of
79 his or her intent to delegate, on a department-approved form,
80 before delegating such authority and of any change in
81 prescriptive privileges of the physician assistant. Authority to
82 dispense may be delegated only by a supervising physician who is
83 registered as a dispensing practitioner in compliance with s.
84 465.0276.

85 3. A fully licensed physician assistant may procure medical
86 devices and drugs unless the medication is listed on the
87 formulary created pursuant to paragraph (f).

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88 4. The physician assistant must complete a minimum of 10
89 continuing medical education hours in the specialty practice in
90 which the physician assistant has prescriptive privileges with
91 each licensure renewal. Three of the 10 hours must consist of a
92 continuing education course on the safe and effective
93 prescribing of controlled substance medications which is offered
94 by a statewide professional association of physicians in this
95 state accredited to provide educational activities designated
96 for the American Medical Association Physician's Recognition
97 Award Category 1 credit, designated by the American Academy of
98 Physician Assistants as a Category 1 credit, or designated by
99 the American Osteopathic Association as a Category 1-A credit.

100 5. The prescription may be in paper or electronic form but
101 must comply with ss. 456.0392(1) and 456.42(2) ~~456.42(1)~~ and
102 chapter 499 and must contain the physician assistant's name,
103 address, and telephone number and the name of each of his or her
104 supervising physicians. Unless it is a drug or drug sample
105 dispensed by the physician assistant, the prescription must be
106 filled in a pharmacy permitted under chapter 465 and must be
107 dispensed in that pharmacy by a pharmacist licensed under
108 chapter 465.

109 6. The physician assistant must note the prescription or
110 dispensing of medication in the appropriate medical record.

111 Section 3. Paragraph (e) of subsection (4) of section
112 459.022, Florida Statutes, is amended to read:

113 459.022 Physician assistants.—

114 (4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

115 (e) A supervising physician may delegate to a fully
116 licensed physician assistant the authority to prescribe or

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117 dispense any medication used in the supervising physician's
118 practice unless such medication is listed on the formulary
119 created pursuant to s. 458.347. A fully licensed physician
120 assistant may only prescribe or dispense such medication under
121 the following circumstances:

122 1. A physician assistant must clearly identify to the
123 patient that she or he is a physician assistant.

124 2. The supervising physician must notify the department of
125 her or his intent to delegate, on a department-approved form,
126 before delegating such authority and of any change in
127 prescriptive privileges of the physician assistant. Authority to
128 dispense may be delegated only by a supervising physician who is
129 registered as a dispensing practitioner in compliance with s.
130 465.0276.

131 3. A fully licensed physician assistant may procure medical
132 devices and drugs unless the medication is listed on the
133 formulary created pursuant to s. 458.347(4)(f).

134 4. The physician assistant must complete a minimum of 10
135 continuing medical education hours in the specialty practice in
136 which the physician assistant has prescriptive privileges with
137 each licensure renewal. Three of the 10 hours must consist of a
138 continuing education course on the safe and effective
139 prescribing of controlled substance medications which is offered
140 by a provider that has been approved by the American Academy of
141 Physician Assistants and which is designated for the American
142 Medical Association Physician's Recognition Award Category 1
143 credit, designated by the American Academy of Physician
144 Assistants as a Category 1 credit, or designated by the American
145 Osteopathic Association as a Category 1-A credit.

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20251568

146 5. The prescription may be in paper or electronic form but
147 must comply with ss. 456.0392(1) and 456.42(2) ~~456.42(1)~~ and
148 chapter 499 and must contain the physician assistant's name,
149 address, and telephone number and the name of each of his or her
150 supervising physicians. Unless it is a drug or drug sample
151 dispensed by the physician assistant, the prescription must be
152 filled in a pharmacy permitted under chapter 465, and must be
153 dispensed in that pharmacy by a pharmacist licensed under
154 chapter 465.

155 6. The physician assistant must note the prescription or
156 dispensing of medication in the appropriate medical record.

157 Section 4. This act shall take effect July 1, 2025.



The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 17, 2025

I respectfully request that **Senate Bill #1568**, relating to Electronic Prescribing, be placed on the:

- committee agenda at your earliest possible convenience.
- next committee agenda.



Senator Jason Brodeur
Florida Senate, District 10

3-25-25

The Florida Senate

APPEARANCE RECORD

Tab 1

1568

Bill Number or Topic

Meeting Date

Health Policy

Committee

Name Jerrod Fowler

Phone _____

Address 1426 Pecan Dr. E Email Jfowler - at - mrsnow.org
Flagstaff AZ 86303

City

State

Zip

Speaking: For

Against

Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without compensation or sponsorship.

I am a registered lobbyist, representing:

I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

Florida Medical Association

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf \(flsenate.gov\)](https://flsenate.gov/2020-2022JointRules.pdf)

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

S-001 (08/10/2021)

3-25-25

Meeting Date

Health Policy

Committee

Name Blake Buchanan, MD

Address 3608 Shadow Arbor Way
Street

Lutz

FL

33548

City

State

Zip

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

SB 1568

Bill Number or Topic

Amendment Barcode (if applicable)

(863) 255-2315

Email BlakeBuchanan87@gmail.com

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without compensation or sponsorship.

I am a registered lobbyist, representing:

I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

Florida College of Emergency Physicians

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf](https://flsenate.gov/2020-2022JointRules.pdf) (flsenate.gov)

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

S-001 (08/10/2021)

March 25, 2025

Meeting Date

Health Policy

Committee

Name **Jason Winn**

Address **106 E. College Ave, Suite 1500**

Street

Tallahassee

FL

32301

City

State

Zip

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without compensation or sponsorship.

I am a registered lobbyist, representing:

Florida Osteopathic Medical Association

I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf](https://flsenate.gov/2020-2022JointRules.pdf) (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL: SB 1606

INTRODUCER: Senator Grall

SUBJECT: Patient Access to Records

DATE: March 24, 2025

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Smith	Brown	HP	Pre-meeting
2.		AHS	
3.		RC	

I. Summary:

Under current Florida law, hospitals, ambulatory surgical centers, and health care practitioners are required to provide requested patient health records to patients, residents, and their legal representatives in a “timely” manner. In the absence of a specific statutory deadline, the federal Health Insurance Portability and Accountability Act (HIPAA) standard of 30 calendar days applies. For electronic health information, the federal Information Blocking Rule also generally applies, requiring access without unreasonable delay.

SB 1606 standardizes the timeframe for responding to patient records requests for patients, residents, and their legal representatives. The bill amends various sections of the Florida Statutes to require health care providers and practitioners to furnish requested records within 14 working days of a request. Providers and practitioners who maintain electronic health record systems must deliver the records in the format chosen by the requester.

In addition, the bill requires providers and practitioners to allow access for the inspection of original records, or suitable reproductions such as microforms, within 10 working days of receiving a request. Providers may impose reasonable conditions to protect the integrity of the records.

The bill creates s. 408.833, F.S., to establish uniform record access and delivery standards for clients of health care providers (including facilities) that are licensed, registered, or certified by the Agency for Health Care Administration (AHCA), that are not otherwise addressed in specific statutory provisions. These standards are also applied to licensed health care practitioners regulated by the Department of Health (DOH), as well as to mental health service providers and substance abuse treatment providers.

Florida law currently requires nursing homes to provide requested records within 14 working days. The bill revises this requirement to align with federal Medicare and Medicaid Conditions

of Participation, mandating that inspection be allowed within 24 hours (excluding weekends and holidays) and copies be furnished within two working days of the request.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

Federal Right of Access to Records Under HIPAA

The federal Health Insurance Portability and Accountability Act (HIPAA) establishes national standards for the protection of individually identifiable health information. The HIPAA Privacy Rule¹, implements these protections and sets forth the individual right of access to medical records.² The U.S. Department of Health and Human Services' Office for Civil Rights (OCR) is responsible for implementing and enforcing the HIPAA Privacy Rule.³

Under the Privacy Rule, individuals have the right to inspect or obtain a copy of their *protected health information* (PHI) maintained by a *covered entity*. Covered entities include:

- Health care providers who transmit health information electronically in connection with certain administrative transactions,
- Health plans such as insurers and health maintenance organizations (HMOs), and
- Health care clearinghouses.⁴

Most licensed health care providers and health care practitioners in Florida qualify as covered entities under these definitions. Business associates of covered entities, such as third-party billing companies or cloud storage providers, must also comply with HIPAA's access provisions when they handle protected health information on behalf of the covered entity.⁵

The Privacy Rule requires covered entities to provide access to PHI contained in what is known as a *designated record set*. A designated record set is defined⁶ as a group of records maintained by or for a covered entity that is used, in whole or in part, to make decisions about individuals. These records include:

- Medical and billing records maintained by or for a health care provider,
- Enrollment, payment, claims adjudication, and case or medical management records maintained by or for a health plan, and
- Any other records used to make decisions about the individual.⁷

Records not used to make treatment or coverage decisions—such as peer review files or internal administrative documents—are not considered to be included in the designated record set.

¹ 45 C.F.R. Part 160 and Subparts A and E of Part 164.

² 45 C.F.R. § 164.524.

³ U.S. Department of Health and Human Services, Office for Civil Rights, *Summary of the HIPAA Privacy Rule*, available at: <https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html> (last visited Mar. 22, 2025).

⁴ 45 C.F.R. § 160.103.

⁵ 45 C.F.R. §§ 160.103, 164.502(e).

⁶ 45 C.F.R. § 164.501.

⁷ *Id.*

The Privacy Rule requires covered entities to respond to a request for access within *30 calendar days*. One 30-day extension is permitted if the individual is notified in writing of the delay and the expected response date.⁸ If PHI is maintained electronically, and the individual requests an electronic copy, the entity must provide it in the requested form and format if it is readily producible.⁹

Covered entities may charge only a *reasonable, cost-based fee* for access. This fee may include the cost of labor for copying, supplies, and postage, if applicable, but may not include retrieval fees or other administrative charges.¹⁰ In guidance issued by the OCR, covered entities are prohibited from imposing barriers to access, such as requiring patients to submit requests in person or through proprietary forms when such requirements are not necessary.¹¹

Interaction of HIPAA with State Law¹²

HIPAA establishes a national baseline for the privacy and security of health information but permits states to enact laws that provide greater protections or access rights. A state law is only preempted by HIPAA if it is contrary to HIPAA—that is, if it is impossible to comply with both the state and federal requirements, or if the state law stands as an obstacle to the full purposes and objectives of HIPAA.

However, if a state law is more protective of patient privacy or provides greater access to health information than HIPAA, it is not preempted and remains enforceable. In practice, this means states may adopt laws that expand individual rights of access, shorten response times, or add safeguards, so long as they do not authorize disclosures or impose barriers that conflict with HIPAA's requirements.

Federal Information Blocking Prohibition

The 21st Century Cures Act¹³ prohibits certain actors from engaging in “*information blocking*,” which is broadly defined as any practice that is likely to interfere with access, exchange, or use of *electronic health information* (EHI), unless the practice is required by law or covered by a regulatory exception.¹⁴ The Office of the National Coordinator for Health Information

⁸ 45 C.F.R. § 164.524(b)(2).

⁹ 45 C.F.R. § 164.524(c)(2).

¹⁰ 45 C.F.R. § 164.524(c)(4).

¹¹ U.S. Department of Health and Human Services, Office for Civil Rights, *Individuals' Right under HIPAA to Access their Health Information* 45 CFR § 164.524, available at: <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html> (last visited Mar. 22, 2025).

¹² U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, When a state or federal law or regulation (such as the HIPAA Privacy Rule) requires that EHI be released, is it ever information blocking not to release it?, available at: <https://www.healthit.gov/faq/when-state-or-federal-law-or-regulation-such-hipaa-privacy-rule-requires-ehi-be-released-no> (last visited Mar. 22, 2025).

¹³ Pub. L. No. 114-255.

¹⁴ 42 U.S.C. § 300jj-52.

Technology (ONC) is responsible for implementing the rule,¹⁵ and the U.S. Department of Health and Human Services Office of Inspector General (OIG) is charged with enforcement.¹⁶

The federal Information Blocking Rule¹⁷, adopted by ONC in 2020, applies to three categories of actors:

- Health care providers,
- Developers of certified health information technology (health IT), and
- Health information networks or health information exchanges.¹⁸

Most licensed health care providers and health care practitioners in Florida fall within the rule's definition of a "health care provider."¹⁹

The rule prohibits these actors from engaging in practices that are "likely to interfere" with access, exchange, or use of EHI, unless one of eight specified exceptions applies.²⁰ EHI is defined to include all electronic protected health information (ePHI) that would be part of a designated record set under HIPAA.²¹ Examples of information blocking may include imposing unnecessary delays, refusing to provide records in electronic format, charging unreasonable fees, or using technology in a way that restricts access or interoperability.

Unlike HIPAA, which allows covered entities to respond to access requests within 30 calendar days, the Information Blocking Rule requires that access to EHI be provided *without unreasonable delay*, subject to specified exceptions where the EHI is protected.²² These include exceptions for preventing harm, protecting privacy, ensuring security, managing infeasible requests, maintaining health IT performance, complying with licensing restrictions, and limiting the manner of access.²³

Enforcement of the Information Blocking Rule is governed by 42 U.S.C. § 300jj-52(b). OIG may impose civil monetary penalties of up to \$1 million per violation on health IT developers and health information networks or exchanges. While ONC and OIG have finalized enforcement regulations for non-provider actors, enforcement policies for health care providers are still forthcoming as of early 2025.

Interaction of the Information Blocking Rule with State Law

The federal law preempts state law only to the extent of a direct conflict.

¹⁵ U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, *Information Blocking Overview*, available at: <https://www.healthit.gov/topic/information-blocking> (last visited Mar. 22, 2025).

¹⁶ U.S. Department of Health and Human Services, Office of Inspector General, *Information Blocking Enforcement*, available at: <https://oig.hhs.gov/reports/featured/information-blocking/> (last visited Mar. 22, 2025).

¹⁷ 45 C.F.R. Part 171.

¹⁸ 45 C.F.R. § 171.102.

¹⁹ "Health care provider" for purposes of the Information Blocking Rule has the same meaning as "health care provider" in 42 U.S.C. § 300jj.

²⁰ 45 C.F.R. § 171.103.

²¹ See 45 C.F.R. § 171.102, referencing 45 C.F.R. § 164.501.

²² 45 C.F.R. §§ 171.200–171.303.

²³ *Id.*

“The information blocking provisions of the Cures Act establish a floor for permissible practices and do not preempt State laws that are more stringent.”
— 85 Fed. Reg. 25810 (May 1, 2020).

The Information Blocking Rule does not prohibit state laws that impose stricter or faster access obligations but does preempt state laws that would require or permit practices that interfere with access to EHI in ways that federal law would otherwise prohibit.

The ONC has clarified that compliance with state law is not a defense to information blocking if the delay or interference is not required by the state law. This is central to understanding how federal and state requirements interact:

“The fact that an actor covered by the information blocking regulations meets its obligations under another law applicable to them or its circumstances (such as the maximum allowed time an actor has under that law to respond to a patient’s request) will not automatically demonstrate that the actor’s practice does not implicate the information blocking definition.”
— ONC Information Blocking FAQ.²⁴

This means that a state statute may impose a 14-day deadline, but if a provider routinely waits 14 days to respond when it could have provided access sooner, that practice may still constitute information blocking.

Due to the many provider types affected by changes made by the bill, pertinent background information regarding Florida law is provided within the Effect of Proposed Changes section of this analysis for the reader’s convenience.

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 394.4615, F.S., to require a **mental health service provider**²⁵ to furnish copies of clinical records²⁶ within 14 working days of receiving a request, if:

- The patient or the patient’s guardian²⁷ or legal custodian authorizes the release;

²⁴ U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, *When a state or federal law or regulation (such as the HIPAA Privacy Rule) requires that EHI be released, is it ever information blocking not to release it?*, available at: <https://www.healthit.gov/faq/when-state-or-federal-law-or-regulation-such-hipaa-privacy-rule-requires-ehi-be-released-no> (last visited Mar. 22, 2025).

²⁵ “Service provider” means a receiving facility, a facility licensed under ch. 397, F.S., a treatment facility, an entity under contract with the Department of Children and Families to provide mental health or substance abuse services, a community mental health center or clinic, a psychologist, a clinical social worker, a marriage and family therapist, a mental health counselor, a physician, a psychiatrist, an advanced practice registered nurse, a psychiatric nurse, or a qualified professional as defined in s. 39.01, F.S. Section 394.455(45), F.S.

²⁶ “Clinical record” means all parts of the record required to be maintained and includes all medical records, progress notes, charts, and admission and discharge data, and all other information recorded by facility staff which pertains to the patient’s hospitalization or treatment. Section 394.455(6), F.S.

²⁷ “Guardian” means the natural guardian of a minor, or a person appointed by a court to act on behalf of a ward’s person if the ward is a minor or has been adjudicated incapacitated. Section 394.455(18), F.S.

- The patient is represented by counsel and the records are needed by the patient's counsel for adequate representation; or
- The court orders the release.

Under the bill, a service provider may furnish the requested clinical records in paper form or, upon request, in an electronic format. If the service provider maintains an electronic health record system, the service provider must furnish the clinical records in the format chosen by the requester, which must include electronic format, access through a web-based patient portal, or submission through a patient's electronic personal health record.

Section 2 of the bill amends s. 395.3025, F.S., to remove the requirement that **licensed hospitals and ambulatory surgical centers** timely provide patient records only after a patient's discharge, thereby aligning state law with federal access rights under HIPAA.

Section 2 also changes the term "agency" (as in the Agency for Health Care Administration) to "Department of Health" and "department" to clarify²⁸ and correct²⁹ that the DOH has the authority to issue subpoenas for patient records from entities regulated under ch. 395, F.S., for the purposes of investigating a health care practitioner.

To conform to changes made by the bill this section also deletes language requiring a licensed hospital or ambulatory surgical center to allow a person to examine original records in its possession, or microforms or other suitable reproductions of the records. The requirements in the deleted text would instead be applied to licensed hospitals and ambulatory surgical centers in s. 408.833, F.S., as created in section 5 of the bill, on lines 215-221.

As a federal condition of a hospital's participation in Medicare or Medicaid, a hospital must provide access to requested patient records "within a reasonable time frame" and to "seek to fulfill requests as quickly as their recordkeeping system permits."³⁰ This requirement exists in conjunction with Florida law and would continue to apply under the bill.

Section 3 of the bill amends s. 397.501, F.S., to require **substance abuse service providers** to furnish copies of records within 14 working days after receiving a *written* request from an individual or the individual's legal representative.³¹

If the service provider maintains an electronic health record system, the service provider must furnish the requested records in the format chosen by the requester, which must include electronic format, access through a web-based patient portal, or submission through a patient's electronic personal health record.

²⁸ Department of Health, Senate Bill 1606 Legislative Analysis (Mar. 20, 2025) (on file with the Senate Committee on Health Policy).

²⁹ Agency for Health Care Administration, Senate Bill 1606 Legislative Analysis (Mar. 19, 2025) (on file with the Senate Committee on Health Policy).

³⁰ See 42 CFR § 482.24(b)(3) and 42 C.F.R. § 482.13(d)(2).

³¹ For purposes of this section, the term "legal representative" has the same meaning as in s. 408.833(1), F.S., as created in section 5 of the bill.

The service provider must, within 10 working days after receiving such a written request from an individual or his or her legal representative, provide access to examine the original records in the service provider's possession, or microforms, or other suitable reproductions of the records. The service provider may impose any reasonable terms necessary to ensure that the records will not be damaged, destroyed, or altered.

Section 4 of the bill amends s. 400.145, F.S., to revise the timeframe within which **nursing home facilities** must provide access to and copies of resident records upon written request.³² Current law requires a nursing home facility to provide the requested records within 14 working days after receiving a written request relating to current resident. Under the bill, for current residents, access must be provided within 24 hours (excluding weekends and holidays), and copies must be provided within two working days, of receipt of the written request. This change would align Florida law with federal law for nursing home facilities that receive Medicare or Medicaid funding.³³

For former residents, copies must be provided within 30 working days. The bill does not make changes to the timeline for requests from former residents.

Section 5 of the bill creates s. 408.833, F.S., within the Health Care Licensing Procedures Act³⁴ to establish uniform standards for record access by clients³⁵ of **health care providers**,³⁶ including facilities, that are licensed, registered, or certified by the AHCA and not otherwise addressed in statute. Records maintained by psychiatric hospitals, substance abuse treatment providers, or nursing homes are exempt from this section pursuant to subsection (4).

The section defines the term "legal representative" as an attorney who has been designated by a client to receive copies of the client's medical, care and treatment, or interdisciplinary records; a legally recognized guardian of the client; a court-appointed representative of the client; or a person designated by the client or by a court of competent jurisdiction to receive copies of the client's medical, care and treatment, or interdisciplinary records.

The bill requires providers to furnish records within 14 working days after receiving a *written* request from a client or his or her legal representative. A provider must furnish *all* records in the

³² Note that access to assisted living facility resident records is also governed by this section in current law. See changes made to s. 429.294, F.S., in section 11 of the bill.

³³ 42 C.F.R. § 483.10(g)(2)(ii) requires Medicare- or Medicaid-certified long-term care facilities to provide residents or their legal representatives the opportunity to inspect all records, including clinical records, within 24 hours (excluding weekends and holidays) of an oral or written request.

³⁴ Chapter 408, Part II, F.S. See also s. 408.801(1), F.S.

³⁵ "Client" means any person receiving services from a provider listed in s. 408.802. Section 408.803(6), F.S.

³⁶ The Act applies to all of the following facilities: Laboratories authorized to perform testing under the Drug-Free Workplace Act; birth centers; abortion clinics; crisis stabilization units; short-term residential treatment facilities; residential treatment facilities; residential treatment centers for children and adolescents; hospitals; ambulatory surgical centers; nursing homes; assisted living facilities; home health agencies; nurse registries; companion services or homemaker services providers; adult day care centers; hospices; adult family-care homes; homes for special services; transitional living facilities; prescribed pediatric extended care centers; home medical equipment providers; intermediate care facilities for persons with developmental disabilities; health care services pools; health care clinics; and organ, tissue, and eye procurement organizations. Section 408.802, F.S. See also s. 408.803(12), F.S.

provider's possession, including, but not limited to: medical, care and treatment, and interdisciplinary records.

A provider may furnish the requested records in paper form or, upon request, in an electronic format. If the health care practitioner maintains an electronic health record system, the service provider must furnish the requested records in the format chosen by the requester, which must include electronic format, access through a web-based patient portal, or submission through a patient's electronic personal health record.

The health care provider must, within 10 working days after receiving a request from an individual or his or her legal representative, provide access to examine the original records in the service provider's possession, or microforms, or other suitable reproductions of the records. The health care provider may impose any reasonable terms necessary to ensure that the records will not be damaged, destroyed, or altered.

A **hospice** would be required to follow this section of law. However, pursuant to s. 400.611(4), F.S., a hospice may not release a patient's interdisciplinary record or any portion of it, unless the person requesting the information provides a patient authorization or other satisfactory documentation in compliance with that section.

Section 6 of the bill amends s. 456.057, F.S., to require **any health care practitioner**³⁷ licensed by the DOH who is not exempt under subsection (2)³⁸ to furnish copies of requested records within 14 working days after the request is received, rather than "in a timely manner, without delays for legal review" as written in current law. This creates a specific timeframe in which health care practitioners must remit the requested records to the patient or his or her legal representative.

For health care practitioners, records include any report or record relating to examination or treatment of the patient.

If the health care practitioner maintains an electronic health record system, the service provider must furnish the requested records in the format chosen by the requester, which must include electronic format, access through a web-based patient portal, or submission through a patient's electronic personal health record.

³⁷ Acupuncturists; allopathic physicians, physician assistants, anesthesiologist assistants, and medical assistants; osteopathic physicians, physician assistants, and anesthesiologist assistants; chiropractic physicians and physician assistants; podiatric physicians; naturopathic physicians; optometrists; autonomous advanced practice registered nurses, advanced practice registered nurses, registered nurses, licensed practical nurses, and certified nursing assistants; pharmacists, pharmacy interns, and pharmacy technicians; dentists, dental hygienists, and dental laboratories; midwives; speech and language pathologists; audiologists; occupational therapists and occupational therapy assistants; respiratory therapists; dieticians and nutritionists; athletic trainers; orthotists, prosthetists, and pedorthists; electrologists; massage therapists; clinical laboratory personnel; medical physicists; genetic counselors; opticians; hearing aid specialists; physical therapists; psychologists and school psychologists; and clinical social workers, mental health counselors, and marriage and family therapists.

³⁸ The following persons are not included for purposes of that section: certified nursing assistants, pharmacists and pharmacies, dental hygienists, nursing home administrators, respiratory therapists, athletic trainers, electrologists, clinical laboratory personnel, medical physicists, opticians and optical establishments, and persons or entities practicing under s. 627.736(7), F.S.

The bill creates a definition for the term “legal representative” that is similar to the definition created for health care providers earlier in the bill. Under the bill and for this section, “legal representative” means a *patient’s* attorney who has been designated by the patient to receive copies of the patient’s medical records, a legally recognized guardian of the patient, a court-appointed representative of the patient, or any other person designated by the patient or by a court of competent jurisdiction to receive copies of the patient’s medical records.

The health care practitioner provider must, within 10 working days after receiving a *written* request from an individual or his or her legal representative, provide access to examine the original records in the service provider’s possession, or microforms, or other suitable reproductions of the records. The health care practitioner may impose any reasonable terms necessary to ensure that the records will not be damaged, destroyed, or altered.

Section 10 of the bill amends s. 400.0234, F.S., to revise a cross-reference so that requests for nursing home resident records are now governed by s. 408.833, F.S., as created in section 5 of the bill, rather than s. 400.145, F.S., for certain purposes. *See* “Technical Deficiencies” section of this analysis.

Section 11 of the bill amends s. 429.294, F.S., to conform a cross-reference to changes made in the bill so that access to assisted living facility resident records is governed by s. 408.833, F.S., as created in section 5 of the bill, rather than s. 400.145, F.S.

Sections 7, 8, 9, 12, and 13 of the bill amend ss. 316.1932, 316.1933, 395.4025, 440.185, and 456.47, F.S., respectively to revise cross-references to conform to the renumbering of subsections within s. 395.3025, F.S., in section 2 of the bill.

Section 14 of the bill provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

While a 10- or 14-day deadline for responding to records requests is not necessarily in conflict with the federal Information Blocking Rule, compliance with that statutory deadline alone may not be enough to shield a provider from liability under federal law if the delay is otherwise unreasonable.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

On line 230 of the bill, records of a resident of a nursing home facility are expressly exempt from the requirements governing client access to medical records that apply to other health care providers. However, section 10 of the bill erroneously conforms a cross-reference to reflect changes elsewhere in the bill, with the unintended effect of subjecting access to nursing home facility records to the provisions of newly created section 408.833, F.S.—the very section from which they are explicitly exempted. Because this section was mistakenly included, staff recommends that an amendment be considered to delete section 10 of the bill.

VII. Related Issues:

Lines 154 and 205 respectively require that substance abuse service providers and health care providers furnish a true and correct copy of all records in the possession of the provider rather than a true and correct copy of all *requested* records in the possession of the provider. If this is unintended, an amendment should be considered to add the word “requested” before “records.”

The bill also requires health care providers, health care practitioners, mental health service providers, and substance abuse service providers that maintain an electronic health record system to furnish clinical records in a format chosen by the requester. Formatting options must include “electronic format, access through a web-based patient portal, or submission through a patient’s electronic personal health record.” If a requester chooses an electronic file format that is contrary to the manner in which the provider maintains the files, this formatting requirement may be unnecessarily burdensome on the provider or practitioner. It is unclear if the bill as written intends to limit the formatting options to these three options.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 394.4615, 395.3025, 397.501, 400.145, 456.057, 316.1932, 316.1933, 395.4025, 400.0234, 429.294, 440.185, and 456.47.

This bill creates section 408.833 of the Florida Statutes.

IX. Additional Information:**A. Committee Substitute – Statement of Changes:**

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

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.



LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
03/25/2025	.	
	.	
	.	
	.	

The Committee on Health Policy (Grall) recommended the following:

1 **Senate Amendment (with title amendment)**

2

3 Delete lines 463 - 474.

4

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

6 And the title is amended as follows:

7 Delete line 42

8 and insert:

9 amending ss. 316.1932, 316.1933, 395.4025,

By Senator Grall

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30 reasonable terms necessary to preserve such records;
31 providing exceptions; amending s. 456.057, F.S.;
32 requiring certain licensed health care practitioners
33 to furnish and provide access to copies of reports and
34 records within a specified timeframe after receiving a
35 request from a patient or the patient's legal
36 representative; requiring that certain licensed health
37 care practitioners furnish such reports and records in
38 the manner chosen by the requester; defining the term
39 "legal representative"; authorizing such licensed
40 health care practitioners to impose reasonable terms
41 necessary to preserve such reports and records;
42 amending ss. 316.1932, 316.1933, 395.4025, 400.0234,
43 429.294, 440.185, and 456.47, F.S.; conforming cross-
44 references; providing an effective date.

45
46 Be It Enacted by the Legislature of the State of Florida:

47
48 Section 1. Subsections (3) through (12) of section
49 394.4615, Florida Statutes, are renumbered as subsections (4)
50 through (13), respectively, and a new subsection (3) is added to
51 that section, to read:

52 394.4615 Clinical records; confidentiality.—

53 (3) Within 14 working days after receiving a request made
54 in accordance with paragraphs (2)(a)-(c), a service provider
55 must furnish clinical records in its possession. A service
56 provider may furnish the requested records in paper form or,
57 upon request, in an electronic format. A service provider who
58 maintains an electronic health record system shall furnish the

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59 requested records in the manner chosen by the requester which
60 must include electronic format, access through a web-based
61 patient portal, or submission through a patient's electronic
62 personal health record.

63 Section 2. Subsections (4) through (11) of section
64 395.3025, Florida Statutes, are renumbered as subsections (2)
65 through (9), respectively, and subsections (1), (2), and (3),
66 paragraph (e) of present subsection (4), paragraph (a) of
67 present subsection (7), and present subsection (8) of that
68 section, are amended to read:

69 395.3025 Patient and personnel records; copy costs copies;
70 examination.—

71 (1) Any licensed facility shall, upon written request, and
72 only after discharge of the patient, furnish, in a timely
73 manner, without delays for legal review, to any person admitted
74 therein for care and treatment or treated thereat, or to any
75 such person's guardian, curator, or personal representative, or
76 in the absence of one of those persons, to the next of kin of a
77 decedent or the parent of a minor, or to anyone designated by
78 such person in writing, a true and correct copy of all patient
79 records, including x rays, and insurance information concerning
80 such person, which records are in the possession of the licensed
81 facility, provided the person requesting such records agrees to
82 pay a charge. The exclusive charge for copies of patient records
83 may include sales tax and actual postage, and, except for
84 nonpaper records that are subject to a charge not to exceed \$2,
85 may not exceed \$1 per page. A fee of up to \$1 may be charged for
86 each year of records requested. These charges shall apply to all
87 records furnished, whether directly from the facility or from a

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copy service providing these services on behalf of the facility. However, a patient whose records are copied or searched for the purpose of continuing to receive medical care is not required to pay a charge for copying or for the search. ~~The licensed facility shall further allow any such person to examine the original records in its possession, or microforms or other suitable reproductions of the records, upon such reasonable terms as shall be imposed to assure that the records will not be damaged, destroyed, or altered.~~

~~(2) This section does not apply to records maintained at any licensed facility the primary function of which is to provide psychiatric care to its patients, or to records of treatment for any mental or emotional condition at any other licensed facility which are governed by the provisions of s. 394.4615.~~

~~(3) This section does not apply to records of substance abuse impaired persons, which are governed by s. 397.501.~~

~~(2) (4) Patient records are confidential and must not be disclosed without the consent of the patient or his or her legal representative, but appropriate disclosure may be made without such consent to:~~

~~(e) The Department of Health agency upon subpoena issued pursuant to s. 456.071, but the records obtained thereby must be used solely for the purpose of the department agency and the appropriate professional board in its investigation, prosecution, and appeal of disciplinary proceedings. If the department agency requests copies of the records, the facility shall charge no more than its actual copying costs, including reasonable staff time. The records must be sealed and must not~~

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117 be available to the public pursuant to s. 119.07(1) or any other
118 statute providing access to records, nor may they be available
119 to the public as part of the record of investigation for and
120 prosecution in disciplinary proceedings made available to the
121 public by the department ~~agency~~ or the appropriate regulatory
122 board. However, the department ~~agency~~ must make available, upon
123 written request by a practitioner against whom probable cause
124 has been found, any such records that form the basis of the
125 determination of probable cause.

126 (5) ~~(a)~~ (7) ~~(a)~~ If the content of any record of patient
127 treatment is provided under this section, the recipient, ~~if~~
128 ~~other than the patient or the patient's representative,~~ may use
129 such information only for the purpose provided and may not
130 further disclose any information to any other person or entity,
131 unless expressly permitted by the written consent of the
132 patient. A general authorization for the release of medical
133 information is not sufficient for this purpose. The content of
134 such patient treatment record is confidential and exempt from
135 the provisions of s. 119.07(1) and s. 24(a), Art. I of the State
136 Constitution.

137 (6) ~~(8)~~ Patient records at hospitals and ambulatory surgical
138 centers are exempt from disclosure under s. 119.07(1), except as
139 provided by subsections (2) and (3) ~~(1)~~ —(5).

140 Section 3. Paragraphs (a) through (j) of subsection (7) of
141 section 397.501, Florida Statutes, are redesignated as
142 paragraphs (c) through (l), respectively, and new paragraphs (a)
143 and (b) are added to that subsection, to read:

144 397.501 Rights of individuals.—Individuals receiving
145 substance abuse services from any service provider are

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146 guaranteed protection of the rights specified in this section,
147 unless otherwise expressly provided, and service providers must
148 ensure the protection of such rights.

149 (7) RIGHT TO ACCESS AND CONFIDENTIALITY OF INDIVIDUAL
150 RECORDS.—

151 (a) Within 14 working days after receiving a written
152 request from an individual or an individual's legal
153 representative, a service provider shall furnish a true and
154 correct copy of all records in the possession of the service
155 provider. The service provider may furnish the requested records
156 in paper form or, upon request, in an electronic format. A
157 service provider that maintains an electronic health record
158 system shall furnish the requested records in the manner chosen
159 by the requester which must include electronic format, access
160 through a web-based patient portal, or submission through a
161 patient's electronic personal health record. For purposes of
162 this section, the term "legal representative" has the same
163 meaning as provided in s. 408.833(1).

164 (b) Within 10 working days after receiving such a request
165 from an individual or an individual's legal representative, a
166 service provider shall provide access to examine the original
167 records in its possession, or microforms or other suitable
168 reproductions of the records. The service provider may impose
169 any reasonable terms necessary to ensure that the records will
170 not be damaged, destroyed, or altered.

171 Section 4. Subsection (1) of section 400.145, Florida
172 Statutes, is amended to read:

173 400.145 Copies of records of care and treatment of
174 resident.—

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192 Section 5. Section 408.833, Florida Statutes, is created to
193 read:

408.833 Client access to medical records.—

195 (1) For purposes of this section, the term "legal
196 representative" means an attorney who has been designated by a
197 client to receive copies of the client's medical, care and
198 treatment, or interdisciplinary records; a legally recognized
199 guardian of the client; a court-appointed representative of the
200 client; or a person designated by the client or by a court of
201 competent jurisdiction to receive copies of the client's
202 medical, care and treatment, or interdisciplinary records.

(2) Within 14 working days after receiving a written

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204 request from a client or client's legal representative, a
205 provider shall furnish a true and correct copy of all records,
206 including medical, care and treatment, and interdisciplinary
207 records, as applicable, in the possession of the provider. A
208 provider may furnish the requested records in paper form or,
209 upon request, in an electronic format. A provider that maintains
210 an electronic health record system shall furnish the requested
211 records in the manner chosen by the requester which must include
212 electronic format, access through a web-based patient portal, or
213 submission through a patient's electronic personal health
214 record.

215 (3) Within 10 working days after receiving a request from a
216 client or a client's legal representative, a provider shall
217 provide access to examine the original records in its
218 possession, or microforms or other suitable reproductions of the
219 records. A provider may impose any reasonable terms necessary to
220 ensure that the records will not be damaged, destroyed, or
221 altered.

222 (4) This section does not apply to:

223 (a) Records maintained at a licensed facility, as defined
224 in s. 395.002, the primary function of which is to provide
225 psychiatric care to its patients, or to records of treatment for
226 any mental or emotional condition at any other licensed facility
227 which are governed by s. 394.4615;

228 (b) Records of substance abuse impaired persons which are
229 governed by s. 397.501; or

230 (c) Records of a resident of a nursing home facility.

231 Section 6. Subsection (6) of section 456.057, Florida
232 Statutes, is amended to read:

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233 456.057 Ownership and control of patient records; report or
234 copies of records to be furnished; disclosure of information.—

235 (6) (a) Any health care practitioner licensed by the
236 department or a board within the department who makes a physical
237 or mental examination of, or administers treatment or dispenses
238 legend drugs to, any patient person shall, upon request of such
239 patient person or the patient's person's legal representative,
240 furnish, within 14 working days after such request in a timely
241 manner, without delays for legal review, copies of all reports
242 and records relating to such examination or treatment, including
243 X rays and insurance information. A health care practitioner may
244 furnish the requested reports and records in paper form or, upon
245 request, in an electronic format. A health care practitioner who
246 maintains an electronic health record system shall furnish the
247 requested reports and records in the manner chosen by the
248 requester which must include electronic format, access through a
249 web-based patient portal, or submission through a patient's
250 electronic personal health record. For purposes of this section,
251 the term "legal representative" means a patient's attorney who
252 has been designated by the patient to receive copies of the
253 patient's medical records, a legally recognized guardian of the
254 patient, a court-appointed representative of the patient, or any
255 other person designated by the patient or by a court of
256 competent jurisdiction to receive copies of the patient's
257 medical records.

258 (b) Within 10 working days after receiving a written
259 request by a patient or a patient's legal representative, a
260 healthcare practitioner must provide access to examine the
261 original reports and records, or microforms or other suitable

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262 reproductions of the reports and records in the healthcare
263 practitioner's possession. The healthcare practitioner may
264 impose any reasonable terms necessary to ensure that the reports
265 and records will not be damaged, destroyed, or altered.

266 (c) However, When a patient's psychiatric, chapter 490
267 psychological, or chapter 491 psychotherapeutic records are
268 requested by the patient or the patient's legal representative,
269 the health care practitioner may provide a report of examination
270 and treatment in lieu of copies of records. Upon a patient's
271 written request, complete copies of the patient's psychiatric
272 records shall be provided directly to a subsequent treating
273 psychiatrist. The furnishing of such report or copies may shall
274 not be conditioned upon payment of a fee for services rendered.

275 Section 7. Paragraph (f) of subsection (1) of section
276 316.1932, Florida Statutes, is amended to read:

277 316.1932 Tests for alcohol, chemical substances, or
278 controlled substances; implied consent; refusal.—

279 (1)

280 (f)1. The tests determining the weight of alcohol in the
281 defendant's blood or breath shall be administered at the request
282 of a law enforcement officer substantially in accordance with
283 rules of the Department of Law Enforcement. Such rules must
284 specify precisely the test or tests that are approved by the
285 Department of Law Enforcement for reliability of result and ease
286 of administration, and must provide an approved method of
287 administration which must be followed in all such tests given
288 under this section. However, the failure of a law enforcement
289 officer to request the withdrawal of blood does not affect the
290 admissibility of a test of blood withdrawn for medical purposes.

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291 2.a. Only a physician, certified paramedic, registered
292 nurse, licensed practical nurse, other personnel authorized by a
293 hospital to draw blood, or duly licensed clinical laboratory
294 director, supervisor, technologist, or technician, acting at the
295 request of a law enforcement officer, may withdraw blood for the
296 purpose of determining its alcoholic content or the presence of
297 chemical substances or controlled substances therein. However,
298 the failure of a law enforcement officer to request the
299 withdrawal of blood does not affect the admissibility of a test
300 of blood withdrawn for medical purposes.

301 b. Notwithstanding any provision of law pertaining to the
302 confidentiality of hospital records or other medical records, if
303 a health care provider, who is providing medical care in a
304 health care facility to a person injured in a motor vehicle
305 crash, becomes aware, as a result of any blood test performed in
306 the course of that medical treatment, that the person's blood-
307 alcohol level meets or exceeds the blood-alcohol level specified
308 in s. 316.193(1) (b), the health care provider may notify any law
309 enforcement officer or law enforcement agency. Any such notice
310 must be given within a reasonable time after the health care
311 provider receives the test result. Any such notice shall be used
312 only for the purpose of providing the law enforcement officer
313 with reasonable cause to request the withdrawal of a blood
314 sample pursuant to this section.

315 c. The notice shall consist only of the name of the person
316 being treated, the name of the person who drew the blood, the
317 blood-alcohol level indicated by the test, and the date and time
318 of the administration of the test.

319 d. Nothing contained in s. 395.3025(2) ~~s. 395.3025(4)~~, s.

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320 456.057, or any applicable practice act affects the authority to
321 provide notice under this section, and the health care provider
322 is not considered to have breached any duty owed to the person
323 under s. 395.3025(2) ~~s. 395.3025(4)~~, s. 456.057, or any
324 applicable practice act by providing notice or failing to
325 provide notice. It shall not be a breach of any ethical, moral,
326 or legal duty for a health care provider to provide notice or
327 fail to provide notice.

328 e. A civil, criminal, or administrative action may not be
329 brought against any person or health care provider participating
330 in good faith in the provision of notice or failure to provide
331 notice as provided in this section. Any person or health care
332 provider participating in the provision of notice or failure to
333 provide notice as provided in this section shall be immune from
334 any civil or criminal liability and from any professional
335 disciplinary action with respect to the provision of notice or
336 failure to provide notice under this section. Any such
337 participant has the same immunity with respect to participating
338 in any judicial proceedings resulting from the notice or failure
339 to provide notice.

340 3. The person tested may, at his or her own expense, have a
341 physician, registered nurse, other personnel authorized by a
342 hospital to draw blood, or duly licensed clinical laboratory
343 director, supervisor, technologist, or technician, or other
344 person of his or her own choosing administer an independent test
345 in addition to the test administered at the direction of the law
346 enforcement officer for the purpose of determining the amount of
347 alcohol in the person's blood or breath or the presence of
348 chemical substances or controlled substances at the time

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349 alleged, as shown by chemical analysis of his or her blood or
350 urine, or by chemical or physical test of his or her breath. The
351 failure or inability to obtain an independent test by a person
352 does not preclude the admissibility in evidence of the test
353 taken at the direction of the law enforcement officer. The law
354 enforcement officer shall not interfere with the person's
355 opportunity to obtain the independent test and shall provide the
356 person with timely telephone access to secure the test, but the
357 burden is on the person to arrange and secure the test at the
358 person's own expense.

359 4. Upon the request of the person tested, full information
360 concerning the results of the test taken at the direction of the
361 law enforcement officer shall be made available to the person or
362 his or her attorney. Full information is limited to the
363 following:

364 a. The type of test administered and the procedures
365 followed.

366 b. The time of the collection of the blood or breath sample
367 analyzed.

368 c. The numerical results of the test indicating the alcohol
369 content of the blood and breath.

370 d. The type and status of any permit issued by the
371 Department of Law Enforcement which was held by the person who
372 performed the test.

373 e. If the test was administered by means of a breath
374 testing instrument, the date of performance of the most recent
375 required inspection of such instrument.

376
377 Full information does not include manuals, schematics, or

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378 software of the instrument used to test the person or any other
379 material that is not in the actual possession of the state.
380 Additionally, full information does not include information in
381 the possession of the manufacturer of the test instrument.

382 5. A hospital, clinical laboratory, medical clinic, or
383 similar medical institution or physician, certified paramedic,
384 registered nurse, licensed practical nurse, other personnel
385 authorized by a hospital to draw blood, or duly licensed
386 clinical laboratory director, supervisor, technologist, or
387 technician, or other person assisting a law enforcement officer
388 does not incur any civil or criminal liability as a result of
389 the withdrawal or analysis of a blood or urine specimen, or the
390 chemical or physical test of a person's breath pursuant to
391 accepted medical standards when requested by a law enforcement
392 officer, regardless of whether or not the subject resisted
393 administration of the test.

394 Section 8. Paragraph (a) of subsection (2) of section
395 316.1933, Florida Statutes, is amended to read:

396 316.1933 Blood test for impairment or intoxication in cases
397 of death or serious bodily injury; right to use reasonable
398 force.—

399 (2) (a) Only a physician, certified paramedic, registered
400 nurse, licensed practical nurse, other personnel authorized by a
401 hospital to draw blood, or duly licensed clinical laboratory
402 director, supervisor, technologist, or technician, acting at the
403 request of a law enforcement officer, may withdraw blood for the
404 purpose of determining the alcoholic content thereof or the
405 presence of chemical substances or controlled substances
406 therein. However, the failure of a law enforcement officer to

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407 request the withdrawal of blood shall not affect the
408 admissibility of a test of blood withdrawn for medical purposes.

409 1. Notwithstanding any provision of law pertaining to the
410 confidentiality of hospital records or other medical records, if
411 a health care provider, who is providing medical care in a
412 health care facility to a person injured in a motor vehicle
413 crash, becomes aware, as a result of any blood test performed in
414 the course of that medical treatment, that the person's blood-
415 alcohol level meets or exceeds the blood-alcohol level specified
416 in s. 316.193(1)(b), the health care provider may notify any law
417 enforcement officer or law enforcement agency. Any such notice
418 must be given within a reasonable time after the health care
419 provider receives the test result. Any such notice shall be used
420 only for the purpose of providing the law enforcement officer
421 with reasonable cause to request the withdrawal of a blood
422 sample pursuant to this section.

423 2. The notice shall consist only of the name of the person
424 being treated, the name of the person who drew the blood, the
425 blood-alcohol level indicated by the test, and the date and time
426 of the administration of the test.

427 3. Nothing contained in s. 395.3025(2) ~~s. 395.3025(4)~~, s.
428 456.057, or any applicable practice act affects the authority to
429 provide notice under this section, and the health care provider
430 is not considered to have breached any duty owed to the person
431 under s. 395.3025(2) ~~s. 395.3025(4)~~, s. 456.057, or any
432 applicable practice act by providing notice or failing to
433 provide notice. It shall not be a breach of any ethical, moral,
434 or legal duty for a health care provider to provide notice or
435 fail to provide notice.

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436 4. A civil, criminal, or administrative action may not be
437 brought against any person or health care provider participating
438 in good faith in the provision of notice or failure to provide
439 notice as provided in this section. Any person or health care
440 provider participating in the provision of notice or failure to
441 provide notice as provided in this section shall be immune from
442 any civil or criminal liability and from any professional
443 disciplinary action with respect to the provision of notice or
444 failure to provide notice under this section. Any such
445 participant has the same immunity with respect to participating
446 in any judicial proceedings resulting from the notice or failure
447 to provide notice.

448 Section 9. Subsection (13) of section 395.4025, Florida
449 Statutes, is amended to read:

450 395.4025 Trauma centers; selection; quality assurance;
451 records.—

452 (13) Patient care, transport, or treatment records or
453 reports, or patient care quality assurance proceedings, records,
454 or reports obtained or made pursuant to this section, s.
455 395.3025(2)(f) s. 395.3025(4)(f), s. 395.401, s. 395.4015, s.
456 395.402, s. 395.403, s. 395.404, s. 395.4045, s. 395.405, s.
457 395.50, or s. 395.51 must be held confidential by the department
458 or its agent and are exempt from the provisions of s. 119.07(1).
459 Patient care quality assurance proceedings, records, or reports
460 obtained or made pursuant to these sections are not subject to
461 discovery or introduction into evidence in any civil or
462 administrative action.

463 Section 10. Subsection (1) of section 400.0234, Florida
464 Statutes, is amended to read:

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465 400.0234 Availability of facility records for investigation
466 of resident's rights violations and defenses; penalty.—

467 (1) Failure to provide complete copies of a resident's
468 records, including, but not limited to, all medical records and
469 the resident's chart, within the control or possession of the
470 facility in accordance with s. 408.833 ~~s. 400.145~~ shall
471 constitute evidence of failure of that party to comply with good
472 faith discovery requirements and shall waive the good faith
473 certificate and presuit notice requirements under this part by
474 the requesting party.

475 Section 11. Subsection (1) of section 429.294, Florida
476 Statutes, is amended to read:

477 429.294 Availability of facility records for investigation
478 of resident's rights violations and defenses; penalty.—

479 (1) Failure to provide complete copies of a resident's
480 records, including, but not limited to, all medical records and
481 the resident's chart, within the control or possession of the
482 facility in accordance with s. 408.833 ~~s. 400.145~~, shall
483 constitute evidence of failure of that party to comply with good
484 faith discovery requirements and shall waive the good faith
485 certificate and presuit notice requirements under this part by
486 the requesting party.

487 Section 12. Subsection (4) of section 440.185, Florida
488 Statutes, is amended to read:

489 440.185 Notice of injury or death; reports; penalties for
490 violations.—

491 (4) Additional reports with respect to such injury and of
492 the condition of such employee, including copies of medical
493 reports, funeral expenses, and wage statements, shall be filed

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494 by the employer or carrier to the department at such times and
495 in such manner as the department may prescribe by rule. In
496 carrying out its responsibilities under this chapter, the
497 department or agency may by rule provide for the obtaining of
498 any medical records relating to medical treatment provided
499 pursuant to this chapter, notwithstanding the provisions of ss.
500 90.503 and 395.3025(2) ~~395.3025(4)~~.

501 Section 13. Subsection (3) of section 456.47, Florida
502 Statutes, is amended to read:

503 456.47 Use of telehealth to provide services.—

504 (3) RECORDS.—A telehealth provider shall document in the
505 patient's medical record the health care services rendered using
506 telehealth according to the same standard as used for in-person
507 services. Medical records, including video, audio, electronic,
508 or other records generated as a result of providing such
509 services, are confidential pursuant to ss. 395.3025(2) and
510 456.057 ~~ss. 395.3025(4) and 456.057~~.

511 Section 14. This act shall take effect July 1, 2025.



The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 6, 2025

I respectfully request that **Senate Bill #1606**, relating to Patient Access to Records, be placed on the:

- committee agenda at your earliest possible convenience.
- next committee agenda.

Erin K. Grall

Senator Erin Grall
Florida Senate, District 29

March 25, 2025

Meeting Date

Health Policy

Committee

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32301

City

State

Zip

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without compensation or sponsorship.

I am a registered lobbyist, representing:

AARP Florida

I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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S-001 (08/10/2021)

Tab 2

3/25/25

Meeting Date

Health policy

Committee

APPEARANCE RECORDDeliver both copies of this form to
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1606

Bill Number or Topic

Amendment Barcode (if applicable)

Name Mackenna DavisPhone 863-608-6658Address 300 W. pensacola st.
StreetEmail Mackenna@converge
public.comCity Tallahassee State FL Zip 32301Speaking: For Against Information**OR** Waive Speaking: In Support Against**PLEASE CHECK ONE OF THE FOLLOWING:** I am appearing without
compensation or sponsorship. I am a registered lobbyist,
representing:Alliance for Health
Information Operations
and Standards I am not a lobbyist, but received
something of value for my appearance
(travel, meals, lodging, etc.),
sponsored by:

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S-001 (08/10/2021)

3/25/25

Meeting Date

APPEARANCE RECORD

SB 1606

Bill Number or Topic

Health Policy

Committee

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Name

Kyle Probst (Datavant)

Phone

Address

2222 W. Dunlap St.

Email

Street

Phoenix

AZ

Zip

Speaking: For Against Information**OR**Waive Speaking: In Support Against**PLEASE CHECK ONE OF THE FOLLOWING:** I am appearing without compensation or sponsorship. I am a registered lobbyist, representing: I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf \(flsenate.gov\)](https://www.flsenate.gov/2020-2022JointRules.pdf)

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S-001 (08/10/2021)

3/25/25

Meeting Date

Health Policy

Committee

Name

Adrienne Morrell VP, Government Affairs
MRO

Phone

Address

1000 Madison Avenue

Email

Street

Norristown PA

19403

City

State

Zip

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without compensation or sponsorship.

I am a registered lobbyist, representing:

I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf](https://flsenate.gov/2020-2022JointRules.pdf) (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL: CS/SB 656

INTRODUCER: Health Policy Committee and Senator Rodriguez

SUBJECT: Health Care Billing and Collection Activities

DATE: March 26, 2025

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Looke	Brown	HP	<u>Fav/CS</u>
2.		CM	
3.		RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 656 amends s. 395.3011, F.S., to extend protections from “extraordinary collection actions” by hospitals and ambulatory surgical centers (ASC) to all actions relating to payments of a bill for care. Current protections, created in 2024, apply only to bills for care covered under the hospital’s or ASC’s financial assistance policy. The bill also allows a hospital or ASC to sell an individual’s debt without a 30-day notification to the patient if the hospital or ASC meets specified requirements.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

Medical Debt

Medical debt, or personal debt incurred from unpaid medical bills, is a leading cause of bankruptcy in the United States. Two-thirds of medical debts are the result of a one-time or short-term medical expense arising from an acute medical need.¹ Many medical collections on consumer credit reports are low-dollar accounts. Data from the federal Consumer Financial Protection Bureau’s Consumer Credit Panel show that in 2020, the median medical collection

¹ Hamel, Liz et al. “The Burden of Medical Debt: January 2016 Results from the Kaiser Family Foundation/New York Times Medical Bills Survey.” Kaiser Family Foundation. January 2016. [The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey \(kff.org\)](https://www.kff.org/report-section/the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey-kfforg/) (last visited Mar. 24, 2025).

was \$310, the mean medical collection was \$773, and 62 percent of medical collections were under \$490.² In Florida, approximately 6.6 percent of the population has medical debt in collection.³ The median amount of medical debt in collections is \$1593.⁴ The percentage of persons without health insurance coverage is 11.1 percent.⁵

Medical Debt Collection in Florida

Debt Collection in General

Florida law provides a court process for the collection of lawful debts, including medical debts. A creditor may sue a debtor and, if the creditor prevails, the creditor may receive a final judgment awarding monetary damages. If the debtor does not voluntarily pay the judgment, the creditor has several legal means to collect on the debt, including:

- Wage garnishment.
- Garnishment of money in a bank account.
- Directing the sheriff to seize assets, sell them, and give the proceeds to the creditor.

In order to protect debtors from being destitute, current state law provides that certain property is exempt from being taken by a creditor. The Florida Constitution provides that the debtor's homestead and \$1,000 of personal property is exempt.⁶ Statutory law provides numerous categories of exempt property, and federal law also provides certain exemptions applicable in all states.⁷

In addition to the protection from creditors contained in the State Constitution, ch. 222, F.S., protects other personal property from certain claims of creditors and legal process: garnishment of wages for a head of family;⁸ proceeds from life insurance policies;⁹ wages or unemployment compensation payments due certain deceased employees;¹⁰ disability income benefits;¹¹ assets in qualified tuition programs; medical savings accounts; Coverdell education savings accounts; hurricane savings accounts;¹² \$1,000 interest in a motor vehicle; professionally prescribed health aids; certain refunds or credits from financial institutions; and \$4,000 interest in personal property, if the debtor does not claim or receive the benefits of a homestead exemption under the State Constitution.¹³

Changes Specific to Medical Debt

Chapter 2024-183, L.O.F., made significant changes to how a hospital or ASC is allowed to collect on debt owed to it. Specifically, the law:

² [Medical Debt Burden in the United States \(consumerfinance.gov\)](#). (last visited Mar. 24, 2025).

³ Debt in America 2024, Urban Data Catalog, *Debt in America State-Level Medical Debt*, Sep. 12, 2024, available at [Debt in America 2024 | Urban Data Catalog](#), (last visited Mar. 24, 2025).

⁴ *Id.*

⁵ *Id.*

⁶ Art. X, s. 4(a), Fla. Const.

⁷ For example, the federal ERISA law provides that most retirement plans are exempt from creditor claims.

⁸ Section 222.11, F.S.

⁹ Section 222.13, F.S.

¹⁰ Section 222.15, F.S.

¹¹ Section 222.18, F.S.

¹² Section 222.22, F.S.

¹³ Section 222.25, F.S.

- Prohibits hospitals and ASCs from filing an extraordinary collection action for medical debt;
- Establishes a new three-year statute of limitation period for medical debt collections which begins on the date the hospital or ASC refers the medical debt to a third party;
- Exempts up to \$10,000 of a debtor's property from attachment, garnishment, or other legal action by a hospital or ASC to recover a medical debt; and
- Prohibits a hospital or ASC from engaging in extraordinary action to collect a medical debt while a patient's eligibility for, enrollment in, or grievance about other coverages are pending.

Part of the 2024 law created s. 395.3011, F.S., which prohibits a hospital or ASC from engaging in certain billing and collection activities relating to medical debt. The section defines "extraordinary collection actions" to mean any of the following actions taken by a licensed facility against an individual in relation to obtaining payment of a bill for care covered under the facility's financial assistance policy:

- Selling the individual's debt to another party.
- Reporting adverse information about the individual to consumer credit reporting agencies.
- Deferring, denying, or requiring a payment before providing medically necessary care because of the individual's nonpayment of one or more bills for previously provided care covered under the facility's financial assistance policy.
- Actions that require a legal or judicial process, including, but not limited to:
 - Placing a lien on the individual's property;
 - Foreclosing on the individual's real property;
 - Attaching or seizing the individual's bank account or any other personal property;
 - Commencing a civil action against the individual;
 - Causing the individual's arrest; or
 - Garnishing the individual's wages.

The 2024 law prohibits a hospital or ASC from engaging in an extraordinary collection action to obtain payment for services in the following circumstances:

- Before the facility has made reasonable efforts to determine whether the individual is eligible for assistance under its financial assistance policy for the care provided and, if eligible, before a decision is made by the facility on the patient's application for such financial assistance;
- Before the facility has provided the individual with an itemized statement or bill;
- During an ongoing grievance process as described in s. 395.301(6), F.S., or an ongoing appeal of a claim adjudication;
- Before billing any applicable insurer or HMO and allowing the insurer or HMO to adjudicate a claim;
- For 30 days after notifying the patient in writing, by certified mail, or by other traceable delivery method, that a collection action will commence absent additional action by the patient; or
- While the individual:
 - Negotiates in good faith the final amount of a bill for services rendered; or
 - Complies with all terms of a payment plan with the facility.

III. Effect of Proposed Changes:

CS/SB 656 amends s. 395.3011, F.S., to:

- Expand the scope of “extraordinary collection action” to include actions taken in relation to obtaining payment for any bill of care, rather than only bills of care that are covered under a hospital’s or ASC’s financial assistance policy.
- Allow a hospital or ASC to sell a patient’s debt without 30-day notice to the patient if the debt:
 - Is not subject to interest, fees, or actions that require a legal or judicial process; and
 - Is returned to the facility if it is determined that the debt qualifies for charity care under the facility’s financial assistance policy.

The bill provides an effective date of July 1, 2025.

IV. Constitutional Issues:**A. Municipality/County Mandates Restrictions:**

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 395.3011 of the Florida Statutes.

IX. Additional Information:**A. Committee Substitute – Statement of Substantial Changes:**

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

CS by Health Policy on March 25, 2025:

The committee substitute eliminates all provisions from the underlying bill except expanding the definition of “extraordinary collection action” to apply to all bills for care and allowing a hospital or ASC to sell a patient’s debt without a 30-day notice to the patient under certain circumstances.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill’s introducer or the Florida Senate.



LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/26/2025	.	
	.	
	.	
	.	

The Committee on Health Policy (Rodriguez) recommended the following:

1 **Senate Amendment (with title amendment)**

2
3 Delete everything after the enacting clause
4 and insert:

5 Section 1. Subsection (1) and paragraph (e) of subsection
6 (2) of section 395.3011, Florida Statutes, are amended to read:

7 395.3011 Billing and collection activities.—

8 (1) As used in this section, the term "extraordinary
9 collection action" means any of the following actions taken by a
10 licensed facility against an individual in relation to obtaining



11 payment of a bill for care ~~covered under the facility's~~
12 ~~financial assistance policy~~:

13 (a) Selling the individual's debt to another party.

14 (b) Reporting adverse information about the individual to
15 consumer credit reporting agencies or credit bureaus.

16 (c) Deferring, denying, or requiring a payment before
17 providing medically necessary care because of the individual's
18 nonpayment of one or more bills for previously provided care
19 covered under the facility's financial assistance policy.

20 (d) Actions that require a legal or judicial process,
21 including, but not limited to:

22 1. Placing a lien on the individual's property;

23 2. Foreclosing on the individual's real property;

24 3. Attaching or seizing the individual's bank account or
25 any other personal property;

26 4. Commencing a civil action against the individual;

27 5. Causing the individual's arrest; or

28 6. Garnishing the individual's wages.

29 (2) A facility may not engage in an extraordinary
30 collection action against an individual to obtain payment for
31 services:

32 (e) For 30 days after notifying the patient in writing, by
33 certified mail, or by other traceable delivery method, that a
34 collection action will commence absent additional action by the
35 patient. However, a facility may engage in an extraordinary
36 collection action without providing 30 days' notice if both of
37 the following conditions are met:

38 1. The facility contracts to sell an individual's debt to
39 another party, provided that the debt may not incur interest or



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40 fees and that no other extraordinary actions are taken, as
41 described in subsection (1).

42 2. If the debt is later determined to qualify for charity
43 care under the facility's financial assistance policy, such debt
44 is returned to the licensed facility.

45 Section 2. This act shall take effect July 1, 2025.

46

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

48 And the title is amended as follows:

49 Delete everything before the enacting clause
50 and insert:

51 A bill to be entitled

52 An act relating to health care billing and collection
53 activities; amending s. 395.3011, F.S.; revising the
54 definition of the term "extraordinary collection
55 action"; authorizing facilities to engage in an
56 extraordinary collection action under certain
57 circumstances; providing an effective date.

By Senator Rodriguez

40-01084-25

2025656

A bill to be entitled

An act relating to health care billing and collection activities; amending s. 395.3011, F.S.; revising the definition of the term "extraordinary collection action"; defining the terms "furnisher of medical debt information" and "medical debt"; authorizing the furnishing of paid or settled medical debt information to consumer reporting agencies; authorizing the furnishing of certain information relating to medical debt payment plans to consumer reporting agencies under certain circumstances; requiring consumer reporting agencies and credit scoring service providers to adopt certain procedures for the use of positive consumer credit information; providing an effective date.

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

Section 1. Subsection (1) of section 395.3011, Florida Statutes, is amended, and subsection (3) is added to that section, to read:

395.3011 Billing and collection activities.—

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

(a) "Extraordinary collection action" means any of the following actions taken by a licensed facility against an individual in relation to obtaining payment of a bill for care ~~covered under the facility's financial assistance policy:~~

1.(a) Selling the individual's debt to another party,
unless the debt is not subject to interest, fees, or actions

40-01084-25

2025656

30 that require a legal or judicial process under subparagraph 4.,
31 and provided the debt is returned to the licensed facility if it
32 is determined that the debt qualifies for charity care under the
33 facility's financial assistance policy.

34 2.(b) Reporting adverse information about the individual to
35 consumer credit reporting agencies or credit bureaus.

36 3.(c) Deferring, denying, or requiring a payment before
37 providing medically necessary care because of the individual's
38 nonpayment of one or more bills for previously provided care
39 covered under the facility's financial assistance policy.

40 4.(d) Actions that require a legal or judicial process,
41 including, but not limited to, any of the following:

- a.1. Placing a lien on the individual's property.
- b.2. Foreclosing on the individual's real property.
- c.3. Attaching or seizing the individual's bank account or
any other personal property.
- d.4. Commencing a civil action against the individual.
- e.5. Causing the individual's arrest.
- f.6. Garnishing the individual's wages.

49 (b) "Furnisher of medical debt information" means an entity
50 that owns the medical debt account and provides to a consumer
51 reporting agency information pertaining to transactions,
52 accounts, balances, repayment terms, repayment history, and
53 other similar information relating to medical debts.

54 (c) "Medical debt" means a debt arising from the receipt of
55 medical services, products, or devices.

56 (3) (a) Information relating to medical debt that has been
57 paid or settled by a consumer may be furnished to a consumer
58 reporting agency.

40-01084-25

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59 (b) Information relating to a consumer's satisfaction of
60 the obligations of a payment plan may be furnished to a consumer
61 reporting agency if:

62 1. The medical debt owner and the consumer have entered
63 into a payment plan, including a deferred payment agreement or a
64 debt forgiveness program with respect to medical debt; and
65 2. The consumer is meeting the obligations of the payment
66 plan, as determined by the medical debt owner.

67 (c) Consumer reporting agencies and credit scoring service
68 providers shall adopt reasonable procedures to use positive
69 consumer credit information from furnishers of medical debt
70 information so that such positive consumer credit information
71 is:

72 1. Included in a consumer report used, in whole or in part,
73 for the purpose of serving as a factor in establishing a
74 consumer's eligibility for credit, employment purposes, and
75 other purposes authorized by this part;

76 2. Used in the generation of any credit score; and
77 3. Provided in a manner that is fair to the consumer, with
78 regard for the confidentiality, accuracy, relevancy, and proper
79 use of such information in accordance with the requirements of
80 this part.

81 Section 2. This act shall take effect July 1, 2025.



The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: February 26, 2025

I respectfully request that **Senate Bill #656**, relating to Health Care Billing and Collection Activities, be placed on the:

- committee agenda at your earliest possible convenience.
- next committee agenda.

A handwritten signature in black ink, appearing to read "Ana Rodriguez".

Senator Ana Maria Rodriguez
Florida Senate, District 40

3/25/25

Meeting Date

Health Policy

Committee

Name Ron LaFace

Address 121 W Jefferson St

Street

Tallahassee

FL

32311

City

State

Zip

The Florida Senate

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Senate professional staff conducting the meeting

656

Bill Number or Topic

967282

Amendment Barcode (if applicable)

Phone 850 445 7258

Email _____

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Capio

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

S-001 (08/10/2021)

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL: CS/SB 68

INTRODUCER: Health Policy Committee and Senator Martin

SUBJECT: Health Facilities Authorities

DATE: March 26, 2025

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Shuler	Fleming	CA	Favorable
2. Smith	Brown	HP	Fav/CS
3. _____	_____	RC	_____

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 68 amends multiple provisions of Part III of ch. 154, F.S., related to health facilities authorities (authorities). The bill expands the definition of “health facility” to include other entities and associations organized not for profit, including, but not limited to, limited liability companies that are organized as not-for-profit organizations and controlled directly or indirectly by one or more not-for-profit organizations. The bill expands the powers of authorities related to loans, bonds, and other debts used for the purpose of acquiring, constructing, financing, and refinancing projects and specifies requirements for agreements executed for such financing tools.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

Health Facilities Authorities

Generally

The Health Facilities Authorities Law¹ (the Law) was enacted in 1974, to provide health facilities in each local agency (defined as a county or municipality²) with a measure of assistance and an alternate method to enable the health facilities to provide the facilities and structures that

¹ Part III of ch. 154, F.S.

² Section 154.205(9), F.S.

are determined to be needed by the community to improve the development and maintenance of the public health.³

Health facilities include any private corporation organized not-for-profit and authorized by law to provide:

- Hospital services in accordance with ch. 395, F.S., related to hospital licensing and regulation;
- Nursing home care services in accordance with ch. 400, F.S., related to nursing home and related health care facilities;
- Life care services in accordance with ch. 651, F.S., related to continuing care contracts;
- Services for the developmentally disabled under ch. 393, F.S., related to developmental disabilities;
- Services for the mentally ill under ch. 394, F.S., related to mental health;
- Assisted living services in accordance with ch. 429, F.S., related to assisted care communities;
- Hospice services in accordance with ch. 400, F.S., related to nursing homes and related health care facilities; and
- Independent living facilities and services as part of a retirement community that provides nursing home care services or assisted living services on the same campus.⁴

The Law authorizes a local agency to create an authority if the governing body⁵ of the local agency determines there is a need for an authority by adopting an ordinance or resolution.⁶ An authority is a public corporation created by s. 154.207, F.S.; or a board, body, commission, or department of a local agency succeeding to the principal functions of the public corporation or to whom the powers and responsibilities authorized by the Law are given by the local agency.⁷ The governing body of the local agency is required to appoint five persons, who must be residents of the local agency, as members of the authority to serve staggered terms of 4 years each.⁸ Members of the authority are eligible for reappointment and serve without compensation, but are paid for necessary expenses incurred while engaged in the performance of the authority's duties.⁹ Costs of employing professionals, staff, and other costs of operating the authority must be paid from funds obtained under the Law.¹⁰

Any member of the authority who is employed by, or receives income from, a health facility under consideration by the authority may not vote on any matter related to that facility.¹¹ All meetings of the authority, and its records, books, documents, and papers are open and available to the public in accordance with the Public Meetings Law in s. 286.011, F.S.¹²

³ Section 154.203, F.S.

⁴ Section 154.205(8), F.S.

⁵ The governing body means the board, commission, or other governing body of any local agency in which the general legislative powers of such local agency are vested. Section 154.205(7), F.S.

⁶ Section 154.207(1), F.S.

⁷ Section 154.205(2), F.S.

⁸ Section 154.207(4), F.S.

⁹ Section 154.207(8), F.S.

¹⁰ See s. 154.211, F.S.

¹¹ Section 154.207(9), F.S.

¹² Section 154.207(7), F.S.

Purpose and Powers of the Authority

The purpose of the authority is to assist health facilities in the acquisition, construction, financing, and refinancing of projects within the geographical limits of the local agency.¹³ However, if an authority finds that there will be a benefit or a cost savings to a health facility located within its jurisdiction, it may issue bonds for the health facility to finance projects for the health facility or for another not-for-profit corporation under common control with a health facility that is located outside the geographical limits of the local agency or outside the state.¹⁴

A “project” is defined¹⁵ as any structure, facility, machinery, equipment, or other property suitable for use by a health facility in connection with its operations or proposed operations, including without limitation:

- Real property;
- A clinic, computer facility, dining hall, firefighting facility, fire prevention facility, food service and preparation facility, health care facility, long-term care facility, hospital, interns’ residence, laboratory, laundry, maintenance facility, nurses’ residence; nursing home, nursing school, office, parking area, pharmacy, recreational facility, research facility, storage facility, utility, or X-ray facility, or any combination of these; and
- Other structures or facilities related, required, or useful for health care purposes, research, or the operation of a health facility, including facilities or structures essential or convenient for the orderly conduct of the health facility and other similar items necessary or convenient for the operation of a particular facility or structure in the manner for which its use is intended; and excluding fuel, supplies, or other items customarily charged as current operating expenses.

The Law also provides in s. 154.209(18), F.S., that an accounts receivable program constitutes a project.

The authority is authorized and empowered, among other things, to:

- Sue and be sued;
- Purchase, lease, receive by gift or otherwise, or obtain options for the acquisition of, any real or personal property for the acquisition, construction, operation, or maintenance of any project;
- Construct, acquire, own, lease, repair, maintain, extend, expand, improve, rehabilitate, renovate, furnish, and equip projects and to pay all or any part of these costs from the proceeds of bonds of the authority or from any other funds made available to the authority for such purpose;
- Make and execute agreements of lease, contracts, deeds, mortgages, notes, and other instruments necessary or convenient in the exercise of its powers and functions;
- Sell, lease, exchange, mortgage, transfer, or otherwise dispose of, or to grant options for any such purposes with respect to any project, any real or personal property or interest therein;

¹³ Section 154.209, F.S.

¹⁴ Section 154.247, F.S.

¹⁵ Section 154.205(10), F.S.

- Pledge or assign any money, rents, charges, fees, or other revenues and any proceeds derived from sales of property, insurance, or condemnation awards;
- Fix, charge, and collect rents, fees, and charges for the use of any project;
- Issue bonds for the purpose of providing funds to pay all or any part of the cost of any project and to issue refunding bonds;
- Employ consulting engineers, architects, surveyors, attorneys, accountants, financial experts, and such other employees and agents as may be necessary and to fix their compensation;
- Acquire existing projects, reimburse any health facility for the cost of such project, and refund outstanding obligations, mortgages, or advances issued, made, or given by a health facility for the cost of the project;
- Mortgage any project and site for the benefit of the holders of the bonds issued to finance that project;
- Participate in and to issue bonds for the purpose of establishing and maintaining a self-insurance pool, as provided under the state Insurance Code, on behalf of a health facility or a group of health facilities in order to resolve issues related to an act or omission of the health facility, its employees, or agents in the performance of health care or health-care-related functions;
- Issue special obligation revenue bonds for the purpose of establishing and maintaining the self-insurance pool and related reserve funds;
- Participate in and issue bonds and other forms of indebtedness for the purpose of establishing and maintaining an accounts receivable program on behalf of a health facility or group of health facilities;
- Issue and renew its negotiable notes; and
- Issue revenue bonds for the purpose of paying all or any part of the cost of any project or for acquiring existing or completed health facilities projects and negotiable bond anticipation notes payable out of revenues derived by the authority from the sale, operation, or leasing of any project.¹⁶

Revenue bonds issued by an authority under the Law are not a debt, liability, obligation, or a pledge of the faith and credit of the local agency, the state, or any political subdivision but are payable solely from the revenues of the project.¹⁷

The Law provides that if a project is subject to review under the Health Facility and Services Development Act in ss. 408.031 – 408.045, F.S., a certificate of need (CON) is required before revenue bonds are validated for a project.¹⁸ A CON is a written statement issued by the Agency for Health Care Administration (Agency) evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility or hospice.¹⁹ Currently, a CON is required for the addition of beds in community nursing homes or intermediate care facilities for the developmentally disabled, the new construction or establishment of additional health care

¹⁶ See ss. 154.209, 154.217, and 154.219, F.S.

¹⁷ Section 154.223, F.S.

¹⁸ Section 154.245, F.S. See also s. 154.213, F.S.

¹⁹ Section 408.032(3), F.S.

facilities²⁰ the conversion from one type of health care facility to another, and the establishment of a hospice, certain hospice inpatient facilities.²¹ A CON issued by the Agency is not required for certain projects upon request.²²

Currently there are 22 Health Facilities Authorities throughout the state.²³

III. Effect of Proposed Changes:

CS/SB 68 revises the definition of a health facility to include other entities and associations organized not for profit, including, but not limited to, limited liability companies that are organized as not-for-profit organizations and controlled directly or indirectly by one or more not-for-profit organizations.

The bill revises the powers of authorities to include the power to make and execute loan agreements; to refund outstanding bonds; to refund certain debts issued, made, or given on behalf of a health facility; to make mortgage or other secured or unsecured loans to or for the benefit of any health facility for the cost of a project or to refund or refinance outstanding bonds, obligations, loans, indebtedness, or advances.

The bill requires that mortgage or other secured or unsecured loans be made pursuant to an agreement between an authority and a health facility and allows such loans to be made to an entity affiliated with a health facility that undertakes such financing, refunding, or refinancing, if the loan proceeds are made available to or applied for the benefit of the health facility.

The bill applies the existing requirements for lease agreements in current law to loan agreements and specifies additional requirements for loan agreements. Specifically, the bill requires that a loan agreement govern projects financed or refinanced by the authority with the proceeds of bonds. Such a loan agreement may be between an authority and a health facility or between an authority and an entity affiliated with a health facility that undertakes such financing if the loan proceeds are made available to or applied for the benefit of the health facility.

The bill provides an effective date of July 1, 2025.

²⁰ Except for a replacement health care facility when the proposed project site is located on the same site as or within 1 mile of the existing health care facility if the number of beds in each licensed bed category will not increase.

Section 408.036(1)(b), F.S.

²¹ Section 408.036(1), F.S.

²² See s.408.036(3), F.S.

²³ FLORIDA DEPARTMENT OF COMMERCE, Official List of Special Districts, <https://www.floridajobs.org/community-planning-and-development/special-districts/special-district-accountability-program/official-list-of-special-districts>, (last visited on Mar 21, 2025). They include the Alachua County Health Facilities Authority, Altamonte Springs Health Facilities Authority, Brevard County Health Facilities Authority, City of Cape Coral Health Facilities Authority, City of Miami Health Facilities Authority, City of South Miami Health Facilities Authority, City of St. Petersburg Health Facilities Authority, Collier County Health Facilities Authority, Escambia Health Facilities Authority, Highlands County Health Facilities Authority, Jacksonville Health Facilities Authority, Martin County Health Facilities Authority, Miami Beach Health Facilities Authority, Miami-Dade County Health Facilities Authority, Mount Dora Health Facilities Authority, Orange County Health Facilities Authority, Osceola County Health Facilities Authority, Palm Beach County Health Facilities Authority, Pasco County Health Facilities Authority, Pinellas County Health Facilities Authority, Santa Rosa County Health Facilities Authority, and Sarasota County Health Facilities Authority. *Id.*

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill expands the available options for authorities to assist private entities in acquiring, constructing, financing, and refinancing projects supporting the provision of health care services.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 154.205, 154.209, 154.213, 154.219, 154.221, 154.225, 154.235, and 154.247.

IX. Additional Information:

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

CS by Health Policy on March 25, 2025:

The committee substitute clarifies that a limited liability company that has been organized as a not-for-profit entity may receive financing from a health facilities authority.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.



LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/26/2025	.	
	.	
	.	
	.	

The Committee on Health Policy (Martin) recommended the following:

1 **Senate Amendment**

2

3 Delete line 26

4 and insert:

5 but not limited to, a limited liability company that is
6 organized as a not-for-profit organization and controlled

By Senator Martin

33-00198-25

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A bill to be entitled

An act relating to health facilities authorities; amending s. 154.205, F.S.; revising the definition of the term "health facility" to include other entities and associations organized not for profit; amending s. 154.209, F.S.; revising the powers of health facilities authorities to include the power to issue certain loans and execute related loan agreements; amending s. 154.213, F.S.; specifying requirements for projects financed by loan agreements issued by a health facilities authority; specifying provisions that may be included in such loan agreements; amending ss. 154.219, 154.221, 154.225, 154.235, and 154.247, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Subsection (8) of section 154.205, Florida Statutes, is amended to read:

154.205 Definitions.—The following terms, whenever used in this part, shall have the following meanings unless a different meaning clearly appears from the context:

(8) "Health facility" means any private corporation or other entity or association organized not for profit, including, but not limited to, a limited liability company controlled directly or indirectly by one or more not-for-profit organizations, and authorized by law to provide:

(a) Hospital services in accordance with chapter 395;

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30 (b) Nursing home care services in accordance with chapter
31 400;
32 (c) Life care services in accordance with chapter 651;
33 (d) Services for the developmentally disabled under chapter
34 393;
35 (e) Services for the mentally ill under chapter 394;
36 (f) Assisted living services in accordance with chapter
37 429; or
38 (g) Hospice services in accordance with chapter 400.

40 The term also includes any private corporation or other entity
41 or association organized not for profit which offers independent
42 living facilities and services as part of a retirement community
43 that provides nursing home care services or assisted living
44 services on the same campus.

45 Section 2. Present subsection (19) of section 154.209,
46 Florida Statutes, is redesignated as subsection (21), a new
47 subsection (19) and subsection (20) are added to that section,
48 and subsections (6), (8), (9), (13), and (18) of that section
49 are amended, to read:

50 154.209 Powers of authority.—The purpose of the authority
51 shall be to assist health facilities in the acquisition,
52 construction, financing, and refinancing of projects in any
53 incorporated or unincorporated area within the geographical
54 limits of the local agency. For this purpose, the authority is
55 authorized and empowered:

56 (6) To make and execute agreements of lease, contracts,
57 deeds, loan agreements, mortgages, notes, and other instruments
58 necessary or convenient in the exercise of its powers and

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59 functions under this part.

60 (8) To pledge or assign any money, rents, loan payments,
61 charges, fees, or other revenues and any proceeds derived from
62 sales of property, insurance, or condemnation awards.

63 (9) To fix, charge, and collect rents, loan payments, fees,
64 and charges for the use of any project.

65 (13) To acquire existing projects and to refund outstanding
66 bonds, obligations, mortgages, or advances issued, made, or
67 given by or on behalf of a health facility for the cost of such
68 project.

69 (18) To participate in and issue bonds and other forms of
70 indebtedness for the purpose of establishing and maintaining an
71 accounts receivable program on behalf of a health facility or
72 group of health facilities. Notwithstanding any other provisions
73 of this part, the structuring and financing of an accounts
74 receivable program pursuant to this subsection shall constitute
75 a project and may be structured for the benefit of health
76 facilities within or outside the geographical limits of the
77 local agency. An accounts receivable program may include the
78 financing of accounts receivable acquired by a health facility
79 from other not-for-profit health care organizations
80 ~~corporations~~, whether or not controlled by or affiliated with
81 the health facility and regardless of location within or outside
82 the geographical limits of this state.

83 (19) To make mortgage or other secured or unsecured loans
84 to or for the benefit of any health facility for the cost of a
85 project in accordance with an agreement between the authority
86 and the health facility. Such loans may be made to any entity
87 affiliated with a health facility that undertakes such

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88 financing, if the proceeds of such loan are made available to or
89 applied for the benefit of such health facility.

90 (20) To make mortgage or other secured or unsecured loans
91 to or for the benefit of a health facility in accordance with an
92 agreement between the authority and the health facility to
93 refund or refinance outstanding bonds, obligations, loans,
94 indebtedness, or advances issued, made, given, or incurred by or
95 for the benefit of such health facility for the cost of a
96 project. Such loans may be made to any entity affiliated with a
97 health facility that undertakes such refunding or refinancing,
98 if the proceeds of such loan are made available to or applied
99 for the benefit of such health facility.

100 Section 3. Section 154.213, Florida Statutes, is amended to
101 read:

102 154.213 Agreements of lease; loan agreements.—In
103 undertaking any project pursuant to this part, the authority
104 shall first obtain a valid certificate of need evidencing need
105 for the project and a statement that the project serves a public
106 purpose by advancing the commerce, welfare, and prosperity of
107 the local agency and its people. A ~~No~~ project financed under ~~the~~
108 ~~provisions of this part~~ may not ~~shall~~ be operated by the
109 authority or any other governmental agency; however, the
110 authority may temporarily operate or cause to be operated all or
111 any part of a project to protect its interest therein pending
112 any leasing of such project in accordance with ~~the provisions of~~
113 this part. The authority may lease a project or projects to a
114 health facility for operation and maintenance in such manner as
115 to effectuate the purposes of this part under an agreement of
116 lease in form and substance not inconsistent herewith. Projects

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117 financed or refinanced by the authority with the proceeds of
118 bonds issued for the benefit of a health facility pursuant to s.
119 154.209(19) or (20) shall be governed by one or more loan
120 agreements made between the authority and a health facility, or
121 between the authority and an entity affiliated with a health
122 facility that undertakes such financing, if the proceeds of such
123 loan are made available to or applied for the benefit of such
124 health facility.

125 (1) Any such agreement of lease or loan agreement may
126 provide, among other provisions, that:

127 (a) The lessee under an agreement of lease or an obligor
128 under a loan agreement shall at its own expense operate, repair,
129 and maintain the project or projects financed or refinanced
130 leased thereunder.

131 (b) The rent payable under the agreement of lease or the
132 loan payments made pursuant to the loan agreement shall in the
133 aggregate be not less than an amount sufficient to pay all of
134 the interest, principal, and redemption premiums, if any, on the
135 bonds that are ~~shall~~ be issued by the authority to pay the cost
136 of the project or projects financed or refinanced leased
137 thereunder.

138 (c) The lessee under an agreement of lease or the obligor
139 under a loan agreement shall pay all costs incurred by the
140 authority in connection with the acquisition, financing,
141 construction, and administration of the project or projects
142 financed or refinanced leased, except as may be paid out of the
143 proceeds of bonds or otherwise, including, but not ~~without~~ being
144 limited to, ~~÷~~ insurance costs, the cost of administering the bond
145 resolution authorizing such bonds and any trust agreement

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146 securing the bonds, and the fees and expenses of trustees,
147 paying agents, attorneys, consultants, and others.

148 (d) The terms of the agreement of lease or loan agreement
149 shall terminate not earlier than the date on which all such
150 bonds and all other obligations incurred by the authority in
151 connection with the project or projects financed or refinanced
152 ~~leased~~ thereunder are shall be paid in full, including interest,
153 principal, and redemption premiums, if any, or adequate funds
154 for such payment are shall be deposited in trust.

155 (e) The lessee's obligation to pay rent under the agreement
156 of lease and the obligor's obligation to make loan payments
157 under a loan agreement may shall not be subject to cancellation,
158 termination, or abatement by the lessee or the obligor until
159 such payment of the bonds or provision for such payment is shall
160 be made.

161 (2) Such agreement of lease or loan agreement may contain
162 such additional provisions as in the determination of the
163 authority are necessary or convenient to effectuate the purposes
164 of this part, including provisions for extensions of the term
165 and renewals of the lease or loan agreement and vesting in the
166 lessee an option to purchase the project leased thereunder
167 pursuant to such terms and conditions consistent with this part
168 as shall be prescribed in the lease. Except as may otherwise be
169 expressly stated in the agreement of lease or loan agreement, to
170 provide for any contingencies involving the damaging,
171 destruction, or condemnation of the project financed or
172 refinanced ~~leased~~ or any substantial portion thereof, such
173 option to purchase may not be exercised unless all bonds issued
174 for such project, including all principal, interest, and

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175 redemption premiums, if any, and all other obligations incurred
176 by the authority in connection with such project, shall have
177 been paid in full or sufficient funds shall have been deposited
178 in trust for such payment. The purchase price of such project
179 shall not be less than an amount sufficient to pay in full all
180 of the bonds, including all principal, interest, and redemption
181 premiums, if any, issued for the project then outstanding and
182 all other obligations incurred by the authority in connection
183 with such project.

184 Section 4. Paragraph (b) of subsection (4) of section
185 154.219, Florida Statutes, is amended to read:

186 154.219 Revenue bonds.—

187 (4) Any resolution or resolutions authorizing any revenue
188 bonds or any issue of revenue bonds may contain provisions which
189 shall be a part of the contract with the holders of the revenue
190 bonds to be authorized, as to:

191 (b) The rentals, loan payments, fees, and other charges to
192 be charged, the amounts to be raised in each year thereby, and
193 the use and disposition of the revenues.

194 Section 5. Section 154.221, Florida Statutes, is amended to
195 read:

196 154.221 Security of bondholders.—In the discretion of the
197 authority, any bonds issued under ~~the provisions of~~ this part
198 may be secured by a trust agreement by and between the authority
199 and a corporate trustee, which may be any trust company or bank
200 having the powers of a trust company within or outside ~~without~~
201 the state. Such trust agreement or resolution providing for the
202 issuance of such bonds may pledge or assign the fees, rents,
203 charges, or proceeds from the sale of any project or part

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204 thereof, insurance proceeds, condemnation awards, and other
205 funds and revenues to be received therefor, and may provide for
206 the mortgaging of any project or any part thereof as security
207 for repayment of the bonds. Such trust agreement or resolution
208 providing for the issuance of such bonds shall contain such
209 provisions for protecting and enforcing the rights and remedies
210 of the bondholders as may be reasonable and proper and not in
211 violation of law, including covenants setting forth the duties
212 of the authority in relation to the acquisition of property and
213 the construction, improvement, maintenance, repair, operation,
214 and insurance of the project or projects in connection with
215 which such bonds shall have been authorized; the fees, rents,
216 loan payments, and other charges to be fixed and collected; the
217 sale of any project, or part thereof, or other property; the
218 terms and conditions for the issuance of additional bonds; and
219 the custody, safeguarding, and application of all moneys. It
220 shall be lawful for any bank or trust company incorporated under
221 the laws of the state which may act as depositary of the
222 proceeds of bonds, revenues, or other money hereunder to furnish
223 such indemnifying bonds or to pledge such securities as may be
224 required by the authority. Any such trust agreement or
225 resolution shall set forth the rights and remedies of the
226 bondholders and of the trustee and may restrict the individual
227 right of action by bondholders. In addition to the foregoing,
228 any such trust agreement or resolution may contain such other
229 provisions as the authority may deem reasonable and proper for
230 the security of the bondholders. All expenses incurred in
231 carrying out the provisions of such trust agreement or
232 resolution may be treated as a part of the cost of the project

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233 or projects in connection with which bonds are issued or as an
234 expense of administration of such projects, as the case may be.

235 Section 6. Section 154.225, Florida Statutes, is amended to
236 read:

237 154.225 Revenues.—

238 (1) The authority is hereby authorized to fix and to
239 collect fees, rents, loan payments, and charges for the use of
240 any project or projects and any part or section thereof. The
241 authority may require that the health facility operating any
242 project or any part thereof financed or refinanced under this
243 chapter or the lessee of any project or part thereof shall
244 operate, repair, and maintain the project and bear the cost
245 thereof and other costs of the authority in connection with the
246 project or projects financed or refinanced leased as may be
247 provided in the agreement of lease, loan agreement, or other
248 contract with the authority, in addition to other obligations
249 imposed under such agreement or contract.

250 (2) The fees, rents, loan payments, and charges shall be so
251 fixed as to provide a fund sufficient to pay the principal of,
252 and the interest on, such bonds as the same shall become due and
253 payable and to create reserves, if any, deemed by the authority
254 to be necessary for such purposes. The fees, rents, loan
255 payments, charges, and all other revenues and proceeds derived
256 from the project or projects in connection with which the bonds
257 of any issue shall have been issued, except such part thereof as
258 may be necessary for such reserves or any expenditures as may be
259 provided in the resolution authorizing the issuance of such
260 bonds or in the trust agreement securing the same, shall be set
261 aside at such regular intervals as may be specified in such

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262 resolution or such trust agreement in a sinking fund which is
263 hereby pledged to, and charged with, the payment of the
264 principal of and the interest on such bonds as the same shall
265 become due and the redemption price or the purchase price of
266 bonds retired by call or purchase as therein provided. Such
267 pledge shall be valid and binding from the time when the pledge
268 is made. The fees, rents, loan payments, charges, and other
269 revenues and moneys so pledged and thereafter received by the
270 authority shall immediately be subject to the lien of such
271 pledge without any physical delivery thereof or further act, and
272 the lien of any such pledge shall be valid and binding as
273 against all parties having claims of any kind in tort, contract,
274 or otherwise against the authority, irrespective of whether such
275 parties have notice thereof. The use and disposition of money to
276 the credit of such sinking fund shall be subject to the
277 provisions of the resolution authorizing the issuance of such
278 bonds or of such trust agreement. Except as may otherwise be
279 provided in the resolution or the trust agreement, the sinking
280 fund shall be a fund for all such bonds without distinction or
281 priority of one over another.

282 Section 7. Subsection (1) of section 154.235, Florida
283 Statutes, is amended to read:

284 154.235 Refunding bonds.—

285 (1) The authority is hereby authorized to provide for the
286 issuance of revenue bonds for the purpose of refunding:

287 (a) Any of its revenue bonds then outstanding; and

288 (b) Revenue bonds of other issuers, the proceeds of which
289 were used to finance or refinance projects of one or more health
290 facilities.

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291

292 Such refunds may include, including the payment of any
293 redemption premium thereon and any interest accrued or to accrue
294 to the earliest or subsequent date of redemption, purchase, or
295 maturity of such revenue bonds.

296 Section 8. Section 154.247, Florida Statutes, is amended to
297 read:

298 154.247 Financing of projects located outside of local
299 agency.—Notwithstanding any provision of this part to the
300 contrary, an authority may, if it finds that there will be a
301 benefit or a cost savings to a health facility located within
302 its jurisdiction, issue bonds for such health facility to
303 finance projects for such health facility, or for another
304 private corporation or other entity or association organized
305 not-for-profit corporation under common control with such health
306 facility, located outside the geographical limits of the local
307 agency or outside this state.

308 Section 9. This act shall take effect July 1, 2025.



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:

Criminal Justice, *Chair*
Appropriations Committee on Criminal and Civil
Justice, *Vice Chair*
Appropriations
Appropriations Committee on Transportation,
Tourism, and Economic Development
Banking and Insurance
Rules
Transportation

SENATOR JONATHAN MARTIN

33rd District

March 21, 2025

RE: SB 68: Health Facilities Authorities

Dear Chair Burton,

Please allow this letter to serve as my respectful request to place SB 68: Health Facilities Authorities, on the next committee agenda.

Your kind consideration of this request is greatly appreciated. Please feel free to contact my office for any additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "J. Martin".

Jonathan Martin
Senate District 33

REPLY TO:

- 2000 Main Street, Suite 401, Fort Myers, Florida 33901 (239) 338-2570
- 315 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5033

Senate's Website: www.flsenate.gov

BEN ALBRITTON
President of the Senate

JASON BRODEUR
President Pro Tempore

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL: SB 1690

INTRODUCER: Senator McClain

SUBJECT: Surrendered Infants

DATE: March 24, 2025

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Morgan	Brown	HP	<u>Favorable</u>
2. _____	_____	JU	_____
3. _____	_____	RC	_____

I. Summary:

SB 1690 modifies statutory provisions relating to surrendered infants. The bill authorizes a hospital, an emergency medical services (EMS) station, or a fire station that is staffed 24 hours per day to use an infant safety device to accept surrendered infants in accordance with safety procedures specified in the bill.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

Infant Safe Haven Laws

Every state legislature has enacted laws to address infant abandonment and endangerment in response to a reported increase in the abandonment of infants in unsafe locations, such as public restrooms or trash receptacles. Beginning with Texas in 1999, states have enacted these safe haven laws as an incentive for mothers in crisis to safely relinquish their babies at designated locations where the babies are protected and provided with care until a permanent home is found.¹

While there is great variability in the laws across states, safe haven laws generally allow the parent, or an agent of the parent, to remain anonymous and to be shielded from criminal liability and prosecution for child endangerment, abandonment, or neglect in exchange for surrendering the baby to a safe haven.² Most states designate hospitals, EMS providers, health care facilities, and fire stations as a safe haven. In eleven states, including Florida as of July 1, 2024,³

¹ Child Welfare Information Gateway, *Infant Safe Haven Laws* (Sep. 2021), available at <https://www.childwelfare.gov/resources/infant-safe-haven-laws/> (last visited Mar. 22, 2025).

² *Id.*

³ Chapter 2024-213, L.O.F.

emergency medical personnel responding to 911 calls may accept an infant who is being lawfully surrendered.⁴ Laws in 22 states allow a parent to voluntarily deliver an infant to an infant safety device that meets certain safety standards.⁵

The age in which a baby may be lawfully surrendered also varies significantly from state to state. Approximately 24 states, including Florida,⁶ accept infants up to 30 days old.⁷ Ages in other states range from up to 72 hours to one year.⁸

According to the nonprofit organization known as the National Safe Haven Alliance (NSHA), 4,835 safe haven relinquishments occurred during 1999-2023 nationwide,⁹ and 4,996 nationally as of this writing.¹⁰ Illegal abandonments have also occurred during that time span, with some infants found alive and others deceased. These statistics are unofficial estimates, as there is no federally mandated safe haven report requirement.

Surrender of Infants in Florida

The Florida Legislature enacted Florida's initial abandoned newborn infant law in 2000.¹¹ The law created s. 383.50, F.S., and authorized the abandonment of a newborn infant, up to three days old or younger, at a hospital or a fire station and addressed the presumption of relinquishment of parental rights, implied consent to treatment, anonymity, and physical custody of the infant.¹²

In 2001, s. 383.50, F.S., was amended to authorize EMS stations, in addition to hospitals and fire stations, as optional locations for the lawful relinquishment of a newborn infant.¹³

In 2008, multiple provisions of s. 383.50, F.S., were modified to refer to "surrendered newborn infant" rather than "abandoned newborn infant."¹⁴ The three-day age limit for surrender of a newborn infant was increased to a seven-day age limit. Additionally, a provision was added to indicate that when an infant is born in a hospital and the mother expresses intent to leave the infant and not return, the hospital or registrar is directed, upon her request, to complete the infant's birth certificate without naming the mother.

⁴ *Supra* note 1. Connecticut, Idaho, Illinois, Indiana, Iowa, Louisiana, Minnesota, New Hampshire, Vermont, and Wisconsin.

⁵ National Conference of State Legislatures, *Safe Haven Laws Memo* (Mar. 24, 2025) (on file with Senate Committee on Health Policy). Arkansas, Idaho, Indiana, Kentucky, Louisiana, Maine, Mississippi, Montana, New Hampshire, Oklahoma, South Dakota, Tennessee, Virginia, and West Virginia.

⁶ *Supra* note 3.

⁷ *Supra* note 1. Arizona, Arkansas, Connecticut, Georgia, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Montana, Nebraska, Nevada, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, and West Virginia.

⁸ *Supra* note 1.

⁹ National Safe Haven Alliance, *2023 Annual/Impact Report*, available at https://www.nationalsafehavenalliance.org/_files/ugd/1c34fd_d0b326dc49884c0ca87f8e023d354cea.pdf (last visited Mar. 22, 2025).

¹⁰ National Safe Haven Alliance, *Our Cause*, available at <https://www.nationalsafehavenalliance.org/our-cause> (last visited Mar. 22, 2025).

¹¹ Chapter 2000-188, L.O.F.

¹² Section 383.50, F.S.

¹³ Chapter 2001-53, s. 15, L.O.F.

¹⁴ Chapter 2008-90, s. 4, L.O.F.

In 2024, multiple statutory provisions were modified to enact the following:¹⁵

- Changed the term “newborn infant” to “infant.”
- Increased the age in which an infant may be lawfully surrendered from approximately seven days old to approximately 30 days old.
- Provided an additional method of lawful surrender, allowing the parent of an infant to dial 911 to request that an EMS provider meet the parent at a specified location for the surrender of the infant directly to the EMS provider.
- Clarified the manner in which a parent may relinquish an infant at a hospital following delivery.
- Extended immunity from criminal investigation solely because an infant is left with eligible EMS station personnel or at an EMS station or a fire station.
- Extended immunity from criminal or civil liability to medical staff of a hospital for acting in good faith when accepting a surrendered infant at a hospital in accordance with statutory provisions.

Under current law, a firefighter, emergency medical technician, or paramedic at a fire station or EMS station that accepts a surrendered infant must arrange for the immediate transportation of the newborn infant to the nearest hospital having emergency services.¹⁶ Upon admitting a surrendered infant, each hospital in this state with emergency services must provide all necessary emergency services and care for the surrendered infant and immediately contact a local licensed child-placing agency (CPA) or the Department of Children and Families’ (DCF) statewide abuse hotline for the name of a CPA and transfer custody of the surrendered infant.¹⁷

A Safe Haven for Newborns¹⁸ reports that over the past 25 years, approximately 476 newborns have been surrendered or abandoned in Florida.¹⁹ Since 2000, 411 newborns have been surrendered in a safe haven hospital, EMS station, or a fire station, and approximately 65 newborns have been abandoned in unsafe places. In 2025, as of this writing, three newborns have been recorded as surrendered to a safe haven.²⁰

Safe Haven Baby Boxes

A baby box is a safety device provided for under a state’s Safe Haven Law to legally and safely facilitate a mother in crisis to safely, securely, and anonymously surrender an infant if she is unable to care for her infant. A baby box is installed in an exterior wall of a designated fire station or hospital. It has an exterior door that automatically locks upon placement of an infant inside, an alarm system to alert facility staff that a baby is inside, and an interior door which allows a staff member to secure the surrendered infant from inside the designated building.²¹

¹⁵ *Supra* note 3.

¹⁶ Sections 383.50(3) and 395.1041, F.S.

¹⁷ Section 383.50(7), F.S.

¹⁸ A Safe Haven for Newborns is a program of The Florida M. Silverio Foundation, a 501(c)(3) organization located in Miami, Florida.

¹⁹ A Safe Haven for Newborns, *A Safe Haven for Newborns Statistics*, available at <https://asafehavenfornewborns.com/what-we-do/safe-haven-statistics/> (last visited Mar. 22, 2025).

²⁰ *Id.*

²¹ Safe Haven Baby Boxes, available at <https://www.shbb.org/> (last visited Mar. 23, 2025).

Safe Haven Baby Boxes, Inc., is a nonprofit incorporated in Indiana,²² which has patented a device for receiving a surrendered baby,²³ trademarked as a “Safe Haven Baby Box.”²⁴ The federal Food and Drug Administration has determined that a Safe Haven Baby Box is not a medical “device” pursuant to s. 201 of the federal Food, Drug, and Cosmetic Act, and therefore is not required to comply with the requirements of the act.²⁵

Over 150 babies have been surrendered nationwide inside Safe Haven Baby Boxes since the first was installed in 2016.²⁶ There are 317 active baby boxes, five of which are in Florida.²⁷ Arizona also has baby drawers, which can be found at six different medical centers in the state.²⁸ Florida’s Safe Haven baby boxes are located at the Martin Luther King, Jr. (MLK), First Responder Campus and the Marion County Fire and Rescue in Ocala; the Citrus County Fire Rescue in Crystal River; the Hernando County Fire Department in Spring Hill; and the Newberry Fire Station #28 in Newberry.²⁹ In January 2023, an infant was surrendered at the baby box at the MLK First Responder Campus in Ocala.³⁰

III. Effect of Proposed Changes:

Section 1 amends s. 383.50, F.S., to revise the definition of “infant,” and to add a definition of “infant safety device” to mean a device that is installed in a supporting wall of a hospital, an emergency medical services station, or a fire station and that has an exterior point of access allowing an individual to place an infant inside and an interior point of access allowing individuals inside the building to retrieve the infant safely.

The bill authorizes a hospital, an EMS station, or a fire station that is staffed 24 hours per day to use an infant safety device to accept surrendered infants if the device is:

- Physically part of the hospital, EMS station, or fire station and installed in a supporting wall;
- Temperature-controlled and ventilated for the safety of infants;
- Equipped with a dual alarm system connected to the physical location of the device which automatically triggers an alarm inside the building when an infant is placed in the device;

²² See Indiana Secretary of State Corporation and Business Entity Search; *search by entity name available at: <https://bsd.sos.in.gov/publicbusinesssearch>* (last visited Mar. 23, 2025).

²³ See United States Patent (dated Apr. 28, 2020), *available at <https://img1.wsimg.com/blobby/go/0e1dea24-4aa4-477a-b7dd-0e668b1de6d1/downloads/Patent%20.pdf?ver=1610398180477>* (last visited Mar. 23, 2025).

²⁴ See Trademark Certificate (registered Oct. 15, 2019), *available at <https://img1.wsimg.com/blobby/go/0e1dea24-4aa4-477a-b7dd-0e668b1de6d1/downloads/Trademark%20Certificate.pdf?ver=1610398180478>* (last visited Mar. 23, 2025).

²⁵ See Letter from U.S. Food and Drug Administration to Safe Haven Baby Boxes, Inc. (dated Feb. 15, 2019), *available at <https://img1.wsimg.com/blobby/go/0e1dea24-4aa4-477a-b7dd-0e668b1de6d1/downloads/C180100.Letter.pdf?ver=1610398180478>* (last visited Mar. 23, 2025).

²⁶ Safe Haven Baby Boxes, *Mission*, *available at <https://www.shbb.org/history>* (last visited Mar. 23, 2025).

²⁷ Safe Haven Baby Boxes, *SHBB Locations*, *available at <https://project-safe-haven-babybox.vercel.app/>* (last visited Mar. 23, 2025).

²⁸ Arizona Safe Baby Haven Foundation, *AZ Safe Haven Law*, *available at <https://azsafebabylaw.org/information/>* (last visited Mar. 23, 2025). Banner Thunderbird Medical Center, Banner Cardon Children’s Medical Center, Banner Estrella Medical Center, HonorHealth Scottsdale Osborn Medical Center, Maricopa Medical Center, and Mayo Clinic Phoenix.

²⁹ *Supra* note 27.

³⁰ See Newborn surrendered at Florida fire station is first baby save by state’s only “Baby Box” by Charine Akbara, (published Jan. 10, 2023, Fox 13 News), *available at <https://www.fox13news.com/news/newborn-surrendered-at-florida-fire-station-is-first-baby-saved-by-states-only-baby-box>* (last visited Mar. 23, 2025).

- Equipped with a surveillance system that allows employees of the hospital, EMS station, or fire station to monitor the inside of the device 24 hours per day; and
- Located such that the interior point of access is in an area that is conspicuous and visible to the employees of the hospital, EMS station, or fire station.

Under the bill, a hospital, EMS station, or fire station that uses an infant safety device to accept surrendered infants must use the device's surveillance system to monitor the inside of the infant safety device 24 hours per day and must physically check the device at least twice daily and test the device at least weekly to ensure the alarm system is in working order. A fire station that is staffed 24 hours per day except when all firefighter first responders are dispatched from the fire station for an emergency must use the dual alarm system of the infant safety device to dispatch immediately the nearest first responder to retrieve any infant left in the infant safety device.

Existing provisions related to the presumption that the parent intended to leave the infant, consented to appropriate medical treatment and care, and to termination of parental rights; the care and custodial processing off an infant upon lawful surrender; and the parent's anonymity upon surrender, are extended by the bill to occasions when infants are surrendered in an infant safety device.

The bill further provides conforming changes to utilize the term "surrendered" instead of "left."

Section 2 amends s. 63.0423, F.S., to make a conforming and technical change.

Section 3 provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 383.50 and 63.0423.

IX. Additional Information:**A. Committee Substitute – Statement of Changes:**

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

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

By Senator McClain

9-01530-25

20251690

A bill to be entitled
An act relating to surrendered infants; amending s. 383.50, F.S.; revising the definition of the term "infant"; defining the term "infant safety device"; authorizing certain hospitals, emergency medical services stations, and fire stations to use infant safety devices to accept surrendered infants if the device meets specified criteria; requiring such hospitals, emergency medical services stations, and fire stations to monitor the inside of the device 24 hours per day and physically check and test the devices at specified intervals; providing additional requirements for certain fire stations using such devices; conforming provisions to changes made by the act; amending s. 63.0423, F.S.; conforming a cross-reference; providing an effective date.

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

Section 1. Section 383.50, Florida Statutes, is amended to read:

383.50 Treatment of surrendered infant.—

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

(a) "Infant" means a child who a licensed physician reasonably believes is approximately 30 days old or younger at the time the child is surrendered under this section left at a hospital, an emergency medical services station, or a fire station.

(b) "Infant safety device" means a device that is installed

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30 in a supporting wall of a hospital, an emergency medical
31 services station, or a fire station and that has an exterior
32 point of access allowing an individual to place an infant inside
33 and an interior point of access allowing individuals inside the
34 building to retrieve the infant safely.

35 (2) There is a presumption that the parent who leaves the infant in accordance with this section intended to leave the infant and consented to termination of parental rights.

38 (3) (a) A hospital, an emergency medical services station, or a fire station that is staffed 24 hours per day may use an infant safety device to accept surrendered infants under this section if the device is:

42 1. Physically part of the hospital, emergency medical services station, or fire station and installed in a supporting wall.

45 2. Temperature-controlled and ventilated for the safety of infants.

47 3. Equipped with a dual alarm system connected to the physical location of the device which automatically triggers an alarm inside the building when an infant is placed in the device.

51 4. Equipped with a surveillance system that allows employees of the hospital, emergency medical services station, or fire station to monitor the inside of the device 24 hours per day.

55 5. Located such that the interior point of access is in an area that is conspicuous and visible to the employees of the hospital, emergency medical services station, or fire station.

58 (b) A hospital, an emergency medical services station, or a

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59 fire station that uses an infant safety device to accept
60 surrendered infants shall use the device's surveillance system
61 to monitor the inside of the infant safety device 24 hours per
62 day and shall physically check the device at least twice daily
63 and test the device at least weekly to ensure that the alarm
64 system is in working order. A fire station that is staffed 24
65 hours per day except when all firefighter first responders are
66 dispatched from the fire station for an emergency must use the
67 dual alarm system of the infant safety device to dispatch
68 immediately the nearest first responder to retrieve any infant
69 left in the infant safety device.

70 (4) Each emergency medical services station or fire station
71 that is staffed with full-time firefighters, emergency medical
72 technicians, or paramedics shall accept any infant left with a
73 firefighter, an emergency medical technician, or a paramedic or
74 in an infant safety device. The firefighter, emergency medical
75 technician, or paramedic shall consider these actions as implied
76 consent to and shall:

77 (a) Provide emergency medical services to the infant to the
78 extent that he or she is trained to provide those services; and
79 (b) Arrange for the immediate transportation of the infant
80 to the nearest hospital having emergency services.

81
82 A licensee as defined in s. 401.23, a fire department, or an
83 employee or agent of a licensee or fire department may treat and
84 transport an infant pursuant to this section. If an infant is
85 placed in the physical custody of an employee or agent of a
86 licensee or fire department or is placed in an infant safety
87 device, such placement is considered implied consent for

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88 treatment and transport. A licensee, a fire department, or an
89 employee or agent of a licensee or fire department is immune
90 from criminal or civil liability for acting in good faith
91 pursuant to this section. This subsection does not limit
92 liability for negligence.

93 (5) (a) ~~(4)~~ After the delivery of an infant in a hospital,
94 a parent of the infant may leave the infant with medical staff
95 or a licensed health care professional at the hospital if the
96 parent notifies such medical staff or licensed health care
97 professional that the parent is voluntarily surrendering the
98 infant and does not intend to return.

99 (b) Each hospital of this state subject to s. 395.1041
100 shall, and any other hospital may, admit and provide all
101 necessary emergency services and care, as defined in s.
102 395.002(9), to any infant left with the hospital in accordance
103 with this section. The hospital or any of its medical staff or
104 licensed health care professionals shall consider these actions
105 as implied consent for treatment, and a hospital accepting
106 physical custody of an infant has implied consent to perform all
107 necessary emergency services and care. The hospital or any of
108 its medical staff or licensed health care professionals are
109 immune from criminal or civil liability for acting in good faith
110 in accordance with this section. This subsection does not limit
111 liability for negligence.

112 (6) ~~(5)~~ Except when there is actual or suspected child abuse
113 or neglect, any parent who surrenders ~~leaves~~ an infant in
114 accordance with this section ~~a firefighter, an emergency medical~~
115 ~~technician, or a paramedic at a fire station or an emergency~~
116 ~~medical services station, or brings an infant to an emergency~~

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117 room of a hospital and expresses an intent to leave the infant
118 and not return, has the absolute right to remain anonymous and
119 to leave at any time and may not be pursued or followed unless
120 the parent seeks to reclaim the infant. When an infant is born
121 in a hospital and the mother expresses intent to leave the
122 infant and not return, upon the mother's request, the hospital
123 or registrar must ~~shall~~ complete the infant's birth certificate
124 without naming the mother thereon.

125 (7)~~(6)~~ A parent of an infant surrendered left at a
126 ~~hospital, an emergency medical services station, or a fire~~
127 ~~station~~ under this section may claim his or her infant up until
128 the court enters a judgment terminating his or her parental
129 rights. A claim to the infant must be made to the entity having
130 physical or legal custody of the infant or to the circuit court
131 before whom proceedings involving the infant are pending.

132 (8)~~(7)~~ Upon admitting an infant under this section, the
133 hospital shall immediately contact a local licensed child-
134 placing agency or alternatively contact the statewide central
135 abuse hotline for the name of a licensed child-placing agency
136 for purposes of transferring physical custody of the infant. The
137 hospital shall notify the licensed child-placing agency that an
138 infant has been left with the hospital and approximately when
139 the licensed child-placing agency can take physical custody of
140 the infant. In cases where there is actual or suspected child
141 abuse or neglect, the hospital or any of its medical staff or
142 licensed health care professionals shall report the actual or
143 suspected child abuse or neglect in accordance with ss. 39.201
144 and 395.1023 in lieu of contacting a licensed child-placing
145 agency.

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146 (9)~~(8)~~ An infant admitted to a hospital in accordance with
147 this section is presumed eligible for coverage under Medicaid,
148 subject to federal rules.

149 (10)~~(9)~~ An infant surrendered left at a hospital, an
150 emergency medical services station, or a fire station in
151 accordance with this section may not be deemed abandoned and is
152 not subject to the reporting and investigation requirements
153 under s. 39.201 unless there is actual or suspected child abuse
154 or until the Department of Children and Families takes physical
155 custody of the infant.

156 (11)~~(10)~~ If the parent of an infant is unable to surrender
157 the infant in accordance with this section, the parent may call
158 911 to request that an emergency medical services provider meet
159 the surrendering parent at a specified location. The
160 surrendering parent must stay with the infant until the
161 emergency medical services provider arrives to take custody of
162 the infant.

163 (12)~~(11)~~ A criminal investigation may not be initiated
164 solely because an infant is surrendered in accordance with this
165 section unless there is actual or suspected child abuse or
166 neglect.

167 Section 2. Subsection (4) of section 63.0423, Florida
168 Statutes, is amended to read:

169 63.0423 Procedures with respect to surrendered infants.—

170 (4) The parent who surrenders the infant in accordance with
171 s. 383.50 is presumed to have consented to termination of
172 parental rights, and express consent is not required. Except
173 when there is actual or suspected child abuse or neglect, the
174 licensed child-placing agency may not attempt to pursue, search

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175 for, or notify that parent as provided in s. 63.088 and chapter
176 49. For purposes of s. 383.50 and this section, an infant who
177 tests positive for illegal drugs, narcotic prescription drugs,
178 alcohol, or other substances, but shows no other signs of child
179 abuse or neglect, shall be placed in the custody of a licensed
180 child-placing agency. Such a placement does not eliminate the
181 reporting requirement under s. 383.50(8) ~~s. 383.50(7)~~. When the
182 department is contacted regarding an infant properly surrendered
183 under this section and s. 383.50, the department shall provide
184 instruction to contact a licensed child-placing agency and may
185 not take custody of the infant unless reasonable efforts to
186 contact a licensed child-placing agency to accept the infant
187 have not been successful.

188 Section 3. This act shall take effect July 1, 2025.



The Florida Senate
Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 10, 2025

I respectfully request that **Senate Bill #1690**, relating to Surrendered Infants, be placed on the:

- committee agenda at your earliest possible convenience.
- next committee agenda.

A handwritten signature in black ink, appearing to read "Stan McQ." followed by a horizontal line.

Senator Stan Mcclain
Florida Senate, District 9

3/05/25

Meeting Date

Senate Health Policy

Committee

PG Schaefer

Name

2015 SW 43rd Place

Street

Ocala FL

City

State

Zip

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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Tab 5

SB 1690

Bill Number or Topic

Amendment Barcode (if applicable)

352-362-3023

Phone

Email

peegee.rec@gmail.com

Speaking: For Against Information

OR Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without
compensation or sponsorship.

I am a registered lobbyist,
representing:

I am not a lobbyist, but received
something of value for my appearance
(travel, meals, lodging, etc.),
sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf \(flsenate.gov\)](https://flsenate.gov/2020-2022JointRules.pdf)

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S-001 (08/10/2021)

3/25/25

The Florida Senate

APPEARANCE RECORD

SB 1695

Bill Number or Topic

Meeting Date

Health Policy

Committee

Name John Labriola

Amendment Barcode (if applicable)
954-515-2084

Address PO Box 650216

Street

Miami

FL

33265

Zip

Email JohnLabriola@cfeflorida.net

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without compensation or sponsorship.

I am a registered lobbyist, representing:

Christian Family Coalition Florida

I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf](https://flsenate.gov/2020-2022JointRules.pdf) (flsenate.gov)

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

3/25/25

Meeting Date

Health Policy

Committee

Name

Aaron DiPietro

Phone 904-608-4471

Address

P.O. Box 530103

Email aaron@f/family.org

Street

Orlando

FL

32853

Zip

City

Speaking: For Against Information

OR

Waive Speaking:

In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without compensation or sponsorship.

I am a registered lobbyist, representing:

Florida Family Voice

I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf \(flsenate.gov\)](https://www.flsenate.gov/2020-2022JointRules.pdf)

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S-001 (08/10/2021)

3-25-2025

Meeting Date

Health Policy

Committee

Name Andrew Shirrell

Address P. O. Box 12152

Street

Tallahassee FL 32317

City

State

Zip

The Florida Senate APPEARANCE RECORD

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SB 1690

Bill Number or Topic

Amendment Barcode (if applicable)

(386) 569-0563

Phone

Email andrew@Floridavoice
Fortheunborn.com

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without
compensation or sponsorship.

I am a registered lobbyist,
representing:

I am not a lobbyist, but received
something of value for my appearance
(travel, meals, lodging, etc.),
sponsored by:

Florida Voice For the
Unborn

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf \(flsenate.gov\)](https://flsenate.gov/2020-2022JointRules.pdf)

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S-001 (08/10/2021)

The Florida Senate

25 May

Meeting Date

APPEARANCE RECORD

1690

Bill Number or Topic

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Committee

Amendment Barcode (if applicable)

Name

Len Racioppi

Phone

Address

Morgan County
5288 SW 85th

Email

Street

lmrwvu@outlook.com

City

State

Zip

Ocnha FL 32876

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without
compensation or sponsorship.

I am a registered lobbyist,
representing:

I am not a lobbyist, but received
something of value for my appearance
(travel, meals, lodging, etc.),
sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf](https://flsenate.gov/2020-2022JointRules.pdf) (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL: CS/SB 1346

INTRODUCER: Health Policy Committee and Senator Polksky

SUBJECT: Fentanyl Testing

DATE: March 26, 2025

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Looke	Brown	HP	Fav/CS
2.		JU	
3.		RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1346 creates s. 395.1042, F.S., entitled “Gage’s Law”¹ to require a hospital or hospital-based off-campus emergency department (stand-alone ED) to test a patient for fentanyl if the patient is receiving emergency services and care² for a possible drug overdose or poisoning and the hospital or stand-alone ED conducts a urine test to assist in diagnosing the individual. The bill specifies that if the urine test comes back positive for fentanyl, the hospital must perform a confirmation test as defined in s. 440.102(1), F.S.,³ and maintain the results of the urine test and the screenings as part of the patient’s clinical record.

The bill provides an effective date of July 1, 2025.

¹ Gage’s Law is named after Gage Austin Taylor, an Orlando resident who died at 29 from an accidental fentanyl overdose on September 26, 2022. See [Tina Scott Polksky, Rita Harris file ‘Gage’s Law’ to mandate fentanyl tests in suspected overdose cases](#), (last visited Mar. 20, 2025).

² Section 395.002(9), F.S., defines “emergency services and care” to mean medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.

³ Section 440.102, F.S., defines a “confirmation test” to mean a second analytical procedure used to identify the presence of a specific drug or metabolite in a specimen, which test must be different in scientific principle from that of the initial test procedure and must be capable of providing requisite specificity, sensitivity, and quantitative accuracy.

II. Present Situation:

Fentanyl

Fentanyl is a synthetic opioid typically used to treat patients with chronic severe pain or severe pain following surgery. Fentanyl is a Schedule II controlled substance that is similar to morphine but about 100 times more potent. Under the supervision of a licensed medical professional, fentanyl has a legitimate medical use. Patients prescribed fentanyl should be monitored for potential misuse or abuse.

Illicit fentanyl, primarily manufactured in foreign, clandestine labs and smuggled into the United States through Mexico, is being distributed across the country and sold on the illegal drug market. Fentanyl is being mixed with other illicit drugs to increase the potency of the drug, sold as powders and nasal sprays, and increasingly pressed into pills made to look like legitimate prescription opioids. Because there is no official oversight or quality control, these counterfeit pills often contain lethal doses of fentanyl, with none of the promised drug.

There is significant risk that illegal drugs have been intentionally contaminated with fentanyl. Because of its potency and low cost, drug dealers have been mixing fentanyl with other drugs including heroin, methamphetamine, and cocaine, increasing the likelihood of a fatal interaction.

According to the CDC, synthetic opioids (like fentanyl) are the primary driver of overdose deaths in the United States.⁴

Toxicology Screening

Toxicology screenings have changed markedly over the years. Screening methods such as gas chromatography and radioimmunoassays have given way in everyday use to enzyme-linked sorbent immunoassay and cloned enzyme donor immunoassay. This migration is largely due to speed and ease of use. However, these new generation immunoassays carry with them limitations in the form of reduced sensitivity and specificity. The calibration of these screenings can detect specific substances rather than an entire class of drugs and also suffer from cross-reactivity to structurally similar compounds. Comprehensive drug screenings utilizing other methods tend to be prohibitive in terms of expense and typically can take weeks to result, making them impractical for clinical use.

Drug testing is possible using samples from urine, serum, breath, sweat, or saliva. Breath testing is used nearly entirely on estimating alcohol concentrations, and urine and serum tests remain the most commonly used for medical professionals.⁵

⁴ Facts About Fentanyl, United States Drug Enforcement Administration, available at <https://www.dea.gov/resources/facts-about-fentanyl>, (last visited Mar. 20, 2025).

⁵ Mukherji P, Azhar Y, Sharma S. Toxicology Screening. [Updated 2023 Aug 7]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. available from: <https://www.ncbi.nlm.nih.gov/books/NBK499901/>, (last visited Mar. 20, 2025).

Urine Testing

Illicit drugs of abuse are a common area of interest in screening and utilize urine testing. Five drugs commonly tested in the United States in a urine screening are:

- Cocaine.
- Amphetamines.
- Marijuana.
- Phencyclidine (PCP).
- Opioids.

Many assays include benzodiazepines as well. In addition to issues with false positives or negatives of the test, the standard urine assay will not screen for some existing illicit drugs. The epidemiology of drug use has shifted over the past 10 years, and there is a higher prevalence of substances such as synthetic cannabinoid, MDMA (ecstasy), and chemical variants of opioids and PCP, which may not be detected by many urine screenings. Other drugs of misuse that are generally unscreened include ketamine, chloral hydrate, gamma-hydroxybutyrate (GHB), psilocybin, and “bath salts” (cathinones).

Most urine drug screenings do not provide quantitative testing, so a simple “positive” or “negative” result is given if the assay detects substrate.⁶

Serum Testing

Serum tests screen for common, over-the-counter drugs which are likely sources for intended overdoses. These tests commonly obtain acetaminophen, aspirin, salicylates, and ethanol. Some extended serum screens include tricyclic antidepressants or barbiturates. Unlike urine screens, these tests are often quantitative and are useful in measuring blood concentrations.

Concentrations require interpretation as to the reported times and amounts of ingestion, and often serial concentrations are necessary when the history is lacking or unreliable. While ethanol is detectable in the alcohol screen, other toxic alcohols like methanol, ethylene glycol, and isopropyl alcohol are not detectable.⁷

III. Effect of Proposed Changes:

CS/SB 1346 creates s. 395.1042, F.S., entitled “Gage’s Law.” The bill requires that any hospital or stand-alone ED must include fentanyl when testing a patient’s urine to assist in diagnosing a suspected overdose or poisoning and while providing emergency service and care. If the results are positive for fentanyl, the hospital is required to perform a confirmation test as defined in s. 440.102(1), F.S. The bill specifies that the results of the urine test as well as the screenings must be preserved in the patient’s clinical record for the timeframe required by the hospital’s or stand-alone ED’s clinical recordkeeping practices.

The bill provides an effective date of July 1, 2025.

⁶ *Supra*, note 4.

⁷ *Id.*

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

CS/SB 1346 requires hospital to conduct a confirmation test for fentanyl under certain circumstances but does not provide a hospital with an exception if the patient refuses the confirmation test and does not provide a timeframe for the test to be conducted. As such, it may be advisable to clarify in the bill under what time frame the confirmation test must be performed as well as the hospital's responsibility should a patient refuse the test.

It may also be advisable to provide the Agency for Health Care Administration (AHCA) with specific rulemaking authority to implement the new section of law in order to provide the AHCA with flexibility to address issues with implementation of the new requirement as necessary.

VIII. Statutes Affected:

This bill creates section 395.1042 of the Florida Statutes.

IX. Additional Information:

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

CS by Health Policy on March 25, 2025:

The committee substitute removes the requirement for a hospital to perform “laboratory and toxicology screenings” should a patient’s urine test positive for fentanyl and replaces it with the requirement to conduct a “confirmation test” as defined in s. 440.102(1), F.S.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill’s introducer or the Florida Senate.



LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/26/2025	.	
	.	
	.	
	.	

The Committee on Health Policy (Polsky) recommended the following:

1 **Senate Amendment (with title amendment)**

2

3 Delete line 30

4 and insert:

5 hospital must perform a confirmation test as defined in s.
6 440.102(1).

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

8 And the title is amended as follows:

9

10 Delete lines 8 - 9



11 and insert:
12 to perform a confirmation test if the urine test
13 results are positive for

By Senator Polsky

30-00921A-25

20251346

A bill to be entitled
An act relating to fentanyl testing; creating s. 395.1042, F.S.; providing a short title; requiring hospitals and hospital-based off-campus emergency departments to test for fentanyl as part of any urine testing they conduct to treat individuals for possible drug overdose or poisoning; requiring such facilities to perform further laboratory and toxicology screenings if the urine test results are positive for fentanyl; requiring that the results of such tests and screenings be preserved as part of the patient's clinical record in accordance with the facility's current recordkeeping practices; providing an effective date.

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

Section 1. Section 395.1042, Florida Statutes, is created to read:

395.1042 Fentanyl testing.—

(1) This section may be cited as "Gage's Law."

(2) (a) If an individual is treated at a hospital or hospital-based off-campus emergency department for emergency services and care for a possible drug overdose or poisoning and the hospital or hospital-based off-campus emergency department conducts a urine test to assist in diagnosing the individual's condition, the hospital must include testing for fentanyl in the urine test.

(b) If the test results are positive for fentanyl, the

30-00921A-25

20251346

30 hospital must perform laboratory and toxicology screenings.

31 (c) The results of the urine test and the laboratory and
32 toxicology screenings must be preserved as part of the patient's
33 clinical record for the timeframe required by the hospital's or
34 hospital-based off-campus emergency department's current
35 clinical recordkeeping practices.

36 Section 2. This act shall take effect July 1, 2025.



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:

Appropriations on Transportation, Tourism, and Economic Development, *Vice Chair*
Appropriations
Appropriations on Criminal and Civil Justice
Environment and Natural Resources
Ethics and Elections
Governmental Oversight and Accountability
Judiciary
Joint Administrative Procedures

SELECT COMMITTEE:

Joint Select Committee on Collective Bargaining

SENATOR TINA SCOTT POLSKY

30th District

March 7, 2025

Chairwoman Colleen Burton
Committee on Health Policy
530 Knott Building
404 S. Monroe Street
Tallahassee, FL 32399-1100

Chairwoman Burton,

I respectfully request that you place SB 1346, relating to Fentanyl Testing on the agenda of the Committee on Health Policy, at your earliest convenience.

Should you have any questions or concerns, please feel free to contact me or my office. Thank you in advance for your consideration.

Kindest Regards,

Senator Tina S. Polsky
Florida Senate, District 30

cc: Allen Brown, Staff Director
Anhar Al-Asadi, Administrative Assistant

REPLY TO:
 5301 North Federal Highway, Suite 135, Boca Raton, Florida 33487 (561) 443-8170
 220 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5030

Senate's Website: www.flsenate.gov

BEN ALBRITTON
President of the Senate

JASON BRODEUR
President Pro Tempore

3/25/2025

Meeting Date

HEALTH POLICY

Committee

Name ZACH HOOVERAddress 1414 KUHL AVE
StreetCity ORLANDOState FLZip 34787Speaking: For Against Information**OR**Waive Speaking: In Support Against**PLEASE CHECK ONE OF THE FOLLOWING:** I am appearing without compensation or sponsorship. I am a registered lobbyist, representing:ORLANDO HEALTH I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf \(flsenate.gov\)](https://flsenate.gov/2020-2022JointRules.pdf)

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

S-001 (08/10/2021)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL: CS/SB 1224

INTRODUCER: Health Policy Committee and Senator Harrell

SUBJECT: Administration of Controlled Substances

DATE: March 26, 2025

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Looke	Brown	HP	Fav/CS
2.		CA	
3.		RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1224 amends s. 893.05, F.S., to allow a practitioner¹ to delegate to a certified paramedic the administration of a controlled substance if the paramedic is working under the direction and supervision of the practitioner and is in the course of providing emergency services.

The bill takes effect upon becoming law.

II. Present Situation:

Paramedics

A paramedic is an allied health professional whose primary focus is to provide advanced emergency medical care for critical and emergent patients who access the emergency medical system. A paramedic possesses the complex knowledge and skills necessary to provide patient care and transportation. Paramedics function as part of a comprehensive emergency medical system (EMS) response, under medical oversight. Paramedics perform interventions with the

¹ Section 893.02(23), F.S., defines "practitioner" to include a physician licensed under chapter 458, F.S., a dentist licensed under chapter 466, F.S., a veterinarian licensed under chapter 474, F.S., an osteopathic physician licensed under chapter 459, F.S., an advanced practice registered nurse licensed under chapter 464, F.S., a naturopath licensed under chapter 462, F.S., a certified optometrist licensed under chapter 463, F.S., a psychiatric nurse as defined in s. 394.455, F.S., a podiatric physician licensed under chapter 461, F.S., or a physician assistant licensed under chapter 458 or chapter 459, F.S., provided such practitioner holds a valid federal controlled substance registry number.

basic and advanced equipment typically found on an ambulance and are a link from the scene of an emergent encounter into the health care system.²

A paramedic in Florida is a person who is certified by the Department of Health (DOH) to perform both basic and advanced life support.^{3,4,5} DOH Rule 64J-1.009, F.A.C., establishes requirements for qualifications to become a paramedic, including:

- Completing an initial Florida paramedic training course using the 2009 U.S. Department of Transportation (DOT) National EMS Education Standards;⁶
- Submitting an application;
- Attest that he or she is not addicted to alcohol or any controlled substance and that he or she is free from any physical or mental defect that might impair his or her ability to perform his or her duties;⁷
- Passing a paramedic certification exam within two years of completing the initial training program; and
- Specific to certification renewals, either retake the certification exam within the two-year licensure period or have completed 30 hours of continuing education and (for either option) maintain a current Advanced Cardiac Life Support card.

Medication Administration Training for Paramedics

The 2009 U.S. DOT National EMS Education Standards requires training on pharmacology. A paramedic is required to integrate comprehensive knowledge of pharmacology to formulate a treatment plan intended to mitigate emergencies and improve the overall health of the patient.⁸ Paramedics are required to be trained in:

- Medication safety;
- Medication legislation;
- Naming;
- Classifications;
- Schedules;
- Pharmacokinetics;
- Storage and security;
- Autonomic pharmacology;

² 2009 U.S. DOT National EMS Education Standards, p. 10, available at <https://www.ems.gov/assets/National-EMS-Education-Standards-FINAL-Jan-2009.pdf> (last visited Mar. 21, 2025).

³ Section 401.23(18), F.S.

⁴ Section 401.23(9), F.S., defines “basic life support” as the assessment or treatment by a person qualified under this part through the use of techniques described in the EMT (Emergency Medical Technician) -Basic National Standard Curriculum or the National EMS (Emergency Medical Services) Education Standards of the United States Department of Transportation and approved by the DOH. The term includes the administration of oxygen and other techniques that have been approved and are performed under conditions specified by rules of the DOH.

⁵ Section 401.23(2), F.S., defines “advanced life support” as assessment or treatment by a person qualified under this part through the use of techniques such as endotracheal intubation, the administration of drugs or intravenous fluids, telemetry, cardiac monitoring, cardiac defibrillation, and other techniques described in the EMT-Paramedic National Standard Curriculum or the National EMS Education Standards, pursuant to rules of the DOH.

⁶ Available at <https://www.ems.gov/assets/National-EMS-Education-Standards-FINAL-Jan-2009.pdf> (last visited Mar. 21, 2025).

⁷ Section 401.27(4)(b), and (c), F.S.

⁸ *Supra* n. 2 at p. 15

- Metabolism and excretion;
- Mechanism of action;
- Phases of medication activity;
- Medication response relationships;
- Medication interactions;⁹
- Toxicity.

Paramedics are required to be trained to a complex depth and comprehensive breadth in medication administration including routes of administration and how to administer medications within the scope of his or her authorization.¹⁰

Controlled Substances

Chapter 893, F.S., establishes the Florida Comprehensive Drug Abuse Prevention and Control Act (act). The act categorizes certain drugs and substances into schedules I-V which pertain to their potential for abuse.

- Schedule I substances have a high potential for abuse and has no currently accepted medical use in treatment in the United States and in their use under medical supervision does not meet accepted safety standards.
- Schedule II substances have a high potential for abuse and have a currently accepted but severely restricted medical use in treatment in the United States, and abuse of the substance may lead to severe psychological or physical dependence.
- Schedule III substances have a potential for abuse less than the substances contained in Schedules I and II and have a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to moderate or low physical dependence or high psychological dependence or, in the case of anabolic steroids, may lead to physical damage.
- Schedule IV substances have a low potential for abuse relative to the substances in Schedule III and have a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III.
- Schedule V substances have a low potential for abuse relative to the substances in Schedule IV and have a currently accepted medical use in treatment in the United States, and abuse of such compound, mixture, or preparation may lead to limited physical or psychological dependence relative to the substances in Schedule IV.¹¹

Unless specifically allowed under ch. 893 or ch. 499, F.S., a person may not sell, manufacture, deliver, or possess with the intent to sell, manufacture, deliver a controlled substance.¹² Health care practitioners¹³ are authorized under s. 893.05, F.S., to prescribe, administer, dispense, mix, or otherwise prepare a controlled substance or may cause the controlled substance to be administered by a licensed nurse or an intern practitioner under the practitioner's direction and

⁹ *Id.*

¹⁰ *Supra* n. 2 at p. 16

¹¹ Section 893.03, F.S.

¹² Section 893.13, F.S.

¹³ As defined in s. 893.02, F.S. *See* n. 1.

supervision. Currently, ch. 893, F.S., does not authorize a practitioner to delegate the administration of a controlled substance to a paramedic.

III. Effect of Proposed Changes:

CS/SB 1224 amends s. 893.05, F.S., to allow a practitioner to delegate the administration of a controlled substance to a certified paramedic who is working under the direction and supervision of the practitioner in the course of providing emergency services.

The bill takes effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 893.05 of the Florida Statutes.

IX. Additional Information:**A. Committee Substitute – Statement of Substantial Changes:**

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

CS by Health Policy on March 25, 2025:

The committee substitute specifies that a paramedic may only administer controlled substances when delegated the duty in the course of providing emergency services.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.



LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/26/2025	.	
	.	
	.	
	.	

The Committee on Health Policy (Harrell) recommended the following:

1 **Senate Amendment (with title amendment)**

2

3 Delete lines 18 - 20

4 and insert:

5 substance to be administered, under his or her direction and
6 supervision only, by a certified paramedic in the course of
7 providing emergency services, by a licensed nurse, or an intern
8 practitioner under his or her direction and supervision only.

9

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



11 And the title is amended as follows:
12 Delete line 5
13 and insert:
14 administered by a certified paramedic in the course of
15 providing emergency services; providing an

By Senator Harrell

31-01276-25

20251224

A bill to be entitled

An act relating to the administration of controlled substances; amending s. 893.05, F.S.; authorizing a practitioner to cause a controlled substance to be administered by a certified paramedic; providing an effective date.

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

Section 1. Paragraph (a) of subsection (1) of section 05, Florida Statutes, is amended to read:

893.05 Practitioners and persons administering controlled substances in their absence.—

(1) (a) A practitioner, in good faith and in the course of his or her professional practice only, may prescribe, administer, dispense, mix, or otherwise prepare a controlled substance, or the practitioner may cause the controlled substance to be administered by a licensed nurse, a certified paramedic, or an intern practitioner under his or her direction and supervision only.

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



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Committee on Higher
Education, *Chair*
Health Policy, *Vice Chair*
Appropriations
Appropriations Committee on Health
and
Human Services
Children, Families, and Elder Affairs
Education Postsecondary
Environment and Natural Resources
Rules

SENATOR GAYLE HARRELL

31st District

March 12, 2025

Senator Burton
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Burton,

I respectfully request that SB 1224 – Administration of Controlled Substances be placed on the next available agenda for the Health Policy Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

A handwritten signature in blue ink that reads "Gayle".

Senator Gayle Harrell
Senate District 31

Cc: Allen Brown, Staff Director
Anhar Al-Asadi, Committee Administrative Assistant

REPLY TO:

- 312 SE Denver Avenue, Stuart, Florida 34994 (772) 221-4019 FAX: (888) 263-7895
- 404 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5031

Senate's Website: www.flsenate.gov

BEN ALBRITTON
President of the Senate

JASON BRODEUR
President Pro Tempore

03/25/25

Meeting Date

Health Policy
Committee

Name Michael Cheate

Phone

863-245-1845

Address 4400 Owens Way
Street

Email Michael@imagine.com

Ave Maria, FL 34142
City State Zip

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

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Florida Five Chief's Association

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S-001 (08/10/2021)

The Florida Senate

3-25-25

Meeting Date

APPEARANCE RECORD

1224

Bill Number or Topic

Health Policy
CommitteeDeliver both copies of this form to
Senate professional staff conducting the meeting

Amendment Barcode (if applicable)

Name WAYNE BERNOSKA

Phone 321-231-9116

Address 343 W. MADISON St.
Street

Email BERNIE@FPFP.ORG

TALLAHASSEE FL

34711

City

State

Zip

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

 I am appearing without compensation or sponsorship. I am a registered lobbyist, representing: I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

FLORIDA

PROFESSIONAL FIREFIGHTERS

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S-001 (08/10/2021)

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL: **SB 524**

INTRODUCER: Senator Harrell

SUBJECT: Newborn Screenings

DATE: **March 24, 2025**

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. <u>Morgan</u>	<u>Brown</u>	<u>HP</u>	<u>Favorable</u>
2. _____	_____	<u>AHS</u>	_____
3. _____	_____	<u>FP</u>	_____

I. Summary:

SB 524 amends s. 383.14, F.S., to require the Florida Department of Health (DOH) to revise its newborn screening (NBS) rules to require the screening of newborns for Duchenne muscular dystrophy (DMD) at the appropriate age beginning January 1, 2027.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

The Florida Department of Health

The Florida Department of Health (DOH) is responsible for the state's public health system, which must be designed to promote, protect, and improve the health of all people in the state.¹

Newborn Screening

Newborn screening (NBS) is a preventive public health program provided in every state to identify, diagnose, and manage newborns at risk for selected disorders that, without detection and treatment, can lead to permanent developmental and physical damage or death. The federal government produces a standardized list of conditions that it recommends every newborn be screened for, but each state determines which conditions and screenings to include in its own NBS program.²

¹ Section 381.001, F.S.

² Health Resources & Services Administration, Advisory Committee on Heritable Disorders in Newborns and Children, *History of the ACHDNC*, available at <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/heritable-disorders/hrsa-timeline-interactive.pdf> (last visited Mar. 22, 2025).

Federal Recommendations for NBS

The U.S. Department of Health and Human Services (HHS) Advisory Committee on Heritable Disorders in Newborns and Children (Advisory Committee) was established to reduce morbidity and mortality in newborns and children who have, or are at risk for, heritable disorders. The Advisory Committee advises the Secretary of HHS on the most appropriate application of universal NBS tests, technologies, policies, guidelines, and standards.³

The federal Recommended Uniform Screening Panel (RUSP) is a list of disorders recommended by the Secretary of HHS, based on advice from the Advisory Committee, for states to screen as part of their NBS program. The inclusion of a disorder in the RUSP is determined based on evidence supporting the potential net benefit of screening, the ability of states to screen for the disorder, and the availability of effective treatments. Adding a condition to the RUSP usually takes three to four years; it is a multistep process beginning with the submission of a nomination package for review by the Advisory Committee, which might or might not result in a recommendation to include the condition in the RUSP. Anyone can nominate a condition for inclusion by completing a nomination package. The RUSP currently includes screening for 36 core conditions and 26 secondary conditions.

Duchenne muscular dystrophy has been nominated for inclusion in the RUSP but has not been recommended by Advisory Committee.⁴

The Florida NBS Program

The Florida NBS Program was initially established in 1965 to screen newborns for a single condition, phenylketonuria.⁵ The NBS Program has since evolved to screen for a wide range of congenital conditions. The NBS program is housed within the DOH and serves to promote the screening of all newborns for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect.⁶

The NBS Program attempts to screen all newborns to identify, diagnose, and manage newborns at risk for select disorders that, without detection and treatment, can lead to permanent developmental and physical damage or death.⁷ Parents and guardians may decline the screenings.⁸

³ Health Resources & Services Administration, *Advisory Committee on Heritable Disorders in Newborns and Children*, available at <https://www.hrsa.gov/advisory-committees/heritable-disorders> (last visited Mar. 22, 2025).

⁴ *Id.*

⁵ See, Tatiana Wing, R.C. Philips Research and Education Unit, *Newborn Screening Update* (2020), available at <https://genetics.pediatrics.med.ufl.edu.wordpress/files/2019/11/RCPU-Newborn-screening-update.pdf> (last visited Mar. 22, 2025); Watson, S., Lloyd-Puryear, M., & Howell, R. (2022), *The Progress and Future of US Newborn Screening*, *International Journal of Neonatal Screening*, 8:41, available at <https://doi.org/10.3390/ijns8030041> (last visited Mar. 22, 2025). Phenylketonuria (PKU) is a rare inherited disorder that causes an amino acid called phenylalanine to build up in the body resulting in dangerous symptoms unless a specific diet is adhered to. PKU was the first inheritable condition for which a relatively simple and repeatable blood test was able to be conducted at a high enough throughput to enable population-level screening.

⁶ Section 383.14, F.S.

⁷ Florida Department of Health, *Florida Newborn Screening 2022 Protocols* (Mar. 15, 2022), available at <https://floridanewbornscreening.com/wp-content/uploads/NBS-Protocols-2022-FINAL.pdf> (last visited Mar. 22, 2025).

⁸ Section 383.14, F.S.; Rule 64C-7.008, F.A.C. The health care provider must attempt to get a written statement of objection to be placed in the medical record.

The Florida Genetics and Newborn Screening Advisory Council (GNSAC) advises the DOH on disorders to be included in Florida's panel of screened disorders and the procedures for collecting and transmitting specimens.⁹ The Florida NBS Program currently screens for 37 core conditions and 23 secondary conditions, nearly all of which are screened through the collection and testing of blood spots. Hearing screening, critical congenital heart disease, and targeted testing for congenital cytomegalovirus are completed at the birthing facility through point of care (POC) testing.¹⁰

Under current law, when a new condition is added to the federal RUSP, the GNSAC is required to consider the condition and make a recommendation to the DOH as to whether the condition should be included in the state NBS panel within one year.¹¹ GNSAC reviews the recommendations to ensure:¹²

- The state's readiness to screen, diagnose, and treat the condition;
- The condition is known to result in significant impairment in health, intellect, or functional ability if not treated before clinical signs appear;
- The condition can be detected using screening methods accepted by current medical practice;
- The condition can be detected prior to the infant becoming two weeks of age, or at the appropriate age as indicated by accepted medical practice;
- After screening for the disorder, reasonable cost benefits can be anticipated through a comparison of tangible program costs with those medical, institutional, and special educational costs likely to be incurred by an undetected population; and
- When screening for a condition, sufficient pediatric medical infrastructure is available.

The Florida NBS Program involves coordination across several entities, including the Bureau of Public Health Laboratories NBS Laboratory (state laboratory), the DOH's Children's Medical Services (CMS) NBS Follow-up Program, referral centers, birthing centers, and physicians throughout the state. Health care providers in hospitals, birthing centers, perinatal centers, county health departments, and school health programs provide screening as part of the multilevel NBS Program screening process.¹³

Health care providers in hospitals and birthing centers collect drops of blood from the newborn's heel on a standardized specimen collection card, which is then sent to the state laboratory for testing.¹⁴ POC testing is used at the birthing facility to screen for the conditions which cannot be screened for with blood spot testing: pulse oximetry tests for critical congenital heart defect and hearing screening to detect hearing loss.¹⁵

⁹ *Supra* note 6.

¹⁰ Florida Department of Health, *2025 Agency Legislative Bill Analysis, HB 1089* (Mar. 12, 2025) (on file with the Senate Committee on Health Policy).

¹¹ *Supra* note 6.

¹² *Supra* note 10.

¹³ *Supra* note 6.

¹⁴ Florida Department of Health, Florida Newborn Screening Program, *What is Newborn Screening?*, available at <https://florianewbornscreening.com/parents/what-isnewborn-screening/> (last visited Mar. 22, 2025). See also, Florida Department of Health, Florida Newborn Screening, *Specimen Collection Card*, available at <http://florianewbornscreening.com/wp-content/uploads/Order-Form.png> (last visited Mar. 22, 2025).

¹⁵ Florida Department of Health, *2024 Agency Legislative Bill Analysis, HB 499* (Feb. 7, 2024) (on file with the Senate Committee on Health Policy).

Screening results are released to the newborn's health care provider and in the event of an abnormal result, the baby's health care provider, or a nurse or specialist from the CMS NBS Follow-up Program, provides follow-up services and referrals for the child and his or her family.¹⁶

The DOH is authorized to charge and collect a fee not to exceed \$15 per live birth occurring in a hospital or birth center to administer the NBS Program. The DOH must calculate the annual assessment for each hospital and birth center and then quarterly generate and mail each hospital and birth center a statement of the amount due. The DOH bills hospitals and birth centers quarterly using vital statistics data to determine the amount to be billed. The DOH is authorized to bill third-party payers for the screening tests and bills insurers directly for the cost of the screening.¹⁷ The DOH does not bill families that do not have insurance coverage.¹⁸

Duchenne Muscular Dystrophy

Duchenne muscular dystrophy (DMD), the most common form of muscular dystrophy, is a condition that causes skeletal and heart muscle weakness that quickly gets worse with time. Symptoms usually begin by the age of six years, and the condition mainly affects boys. Currently, no cure exists, so treatment involves managing symptoms and improving quality of life.¹⁹

DMD Symptoms

Symptoms of DMD most often appear between the ages of two and four years, though symptoms can present as early as infancy or be noticed later in childhood. DMD causes muscle weakness that progressively worsens, so common symptoms include:²⁰

- Progressive muscle weakness and atrophy (loss of muscle bulk) beginning in the child's legs and pelvis.
- Calf muscle hypertrophy (increase in muscle size).
- Difficulty climbing up stairs.
- Difficulty walking that becomes progressively worse.
- Frequent falls.
- Waddling gait.
- Toe walking.
- Fatigue.
- Cardiomyopathy (disease of the heart muscle).
- Breathing difficulties and shortness of breath.
- Cognitive impairment.
- Delayed speech and language development.

¹⁶ *Id.*

¹⁷ Section 383.145, F.S.

¹⁸ *Supra* note 6.

¹⁹ Cleveland Clinic, *Duchenne Muscular Dystrophy (DMD)*, available at <https://my.clevelandclinic.org/health/diseases/23538-duchenne-muscular-dystrophy-dmd#symptoms-and-causes> (last visited Mar. 22, 2025).

²⁰ *Id.*

- Developmental delay.
- Scoliosis (spine curvature).
- Short stature (height).

DMD affects approximately one in 3,600 male live-born infants. About 2.5 to 20 percent of girls who are DMD carriers may have symptoms that are milder than the typical case.²¹

What Causes DMD?

DMD is caused by a change or mutation in the gene that gives instructions for a protein called dystrophin. Dystrophin is a critical part of the dystrophin-glycoprotein complex (DGC), which plays an important role as a structural unit of muscle.²²

In DMD, both dystrophin and DGC proteins are missing, which ultimately leads to the death (necrosis) of muscle cells. People with DMD have less than five percent of the normal quantity of dystrophin needed for healthy muscles.²³

As an individual with DMD becomes older, the individual's muscles cannot replace the dead cells with new ones, and connective and adipose (fat) tissue gradually replaces muscle fibers.²⁴

DMD has X-linked recessive inheritance, but about 30 percent of cases happen spontaneously without a family history of the condition. X-linked means the gene responsible for DMD is located on the X chromosome, one of two sex chromosomes. Males have an X and Y chromosome, and females have two X chromosomes.²⁵

Genes, like chromosomes, usually come in pairs. When two copies of the responsible gene exist, the nature of a recessive inheritance means both copies must have a disease-causing change (pathogenic variant or mutation) for a person to have the condition. Since males only have one X chromosome, a male will have DMD if that chromosome has the genetic variant that causes DMD.²⁶

DMD Diagnosis and Testing

A health care provider will likely perform a physical, neurological, and muscle exam on a child experiencing symptoms of DMD, asking detailed questions related to symptoms and medical history, and order the following tests:²⁷

- Creatine Kinase (CK) Blood Test – The muscles release CK when damaged, so elevated levels may indicate DMD. Levels typically peak by age two and can be more than 10 to 20 times above the normal range.
- Genetic Blood Test – A genetic blood test looking for a complete or near-complete absence of the dystrophin gene can confirm the diagnosis of DMD.

²¹ *Id.*

²² *Id.*

²³ *Id.*

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

- Muscle Biopsy – A child’s provider may take a small sample of muscle tissue from a muscle in the child’s thigh or calf. A specialist will review the sample under a microscope to look for signs of DMD.
- Electrocardiogram (EKG) – As DMD almost always affects the heart, a child’s provider will likely perform an EKG to look for characteristic signs of DMD and to check the health of the child’s heart.

DMD Management and Treatment

Currently, there is no cure for DMD, so the main goal of treatment is to manage symptoms and improve quality of life. Supportive therapies for DMD include:²⁸

- Corticosteroids – Corticosteroids, such as prednisolone and deflazacort, are beneficial for delaying muscle strength loss, improving lung function, delaying scoliosis, slowing the progression of cardiomyopathy and prolonging survival.
- Medication to Treat Cardiomyopathy – Early treatment with angiotensin-converting enzyme (ACE) inhibitors and/or beta-blockers may slow the progression of cardiomyopathy and prevent the onset of heart failure.
- Physical Therapy – The main goal of physical therapy for DMD is to prevent contractures, permanent tightening of the muscles, tendons and skin. This usually involves certain stretching exercises.
- Surgery to Help Treat Scoliosis and Contractures – Surgery to release contractures may be necessary for severe cases. Surgery to correct scoliosis may improve lung and breathing function.
- Exercise – A child’s health care provider will likely recommend gentle exercise to avoid muscle atrophy due to lack of use. This is usually a combination of swimming and recreation-based exercises.
- Mobility Aids – Braces, canes, wheelchairs, etc.
- Tracheostomy and Assisted Ventilation for Respiratory Failure.

With improvement in supportive care, the life expectancy of DMD has significantly improved over the past few decades. There are also many new drugs currently undergoing clinical testing that show promise in treating DMD. Some newer treatments employing “exon skipping” (patching over a missing or mutated part of the dystrophin gene) have recently received federal Food and Drug Administration (FDA)²⁹ approval. These treatments are applicable only to a minority of cases with specific mutations. Although these treatments increase dystrophin protein amount in muscle, meaningful gain in strength and physical function has not yet been shown.³⁰

²⁸ *Id.*

²⁹ The FDA is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. The FDA also provides accurate, science-based health information to the public. USAGov, *Food and Drug Administration (FDA)*, available at <https://www.usa.gov/agencies/food-and-drug-administration#:~:text=The%20Food%20and%20Drug%20Administration,products%20that%20emit%20radiation>.

(last visited Mar. 22, 2025).

³⁰ *Supra* note 19.

DMD Prevention and NBS

As DMD is an inherited condition, there is no prevention and about a third of cases occur randomly without a family history of the condition.³¹ Genetic counseling is an option that exists to provide information to concerned families about how genetic conditions affect the family, determining the risk for developing or passing on certain conditions.³² In some situations, prenatal testing may be able to diagnose DMD in early pregnancy.³³

NBS has been proposed as a method for ensuring early diagnosis of DMD. Advocates for NBS for DMD point to evidence suggesting that emerging DMD therapies might prove to be most effective if initiated before the onset of symptoms.^{34,35} Furthermore, delayed diagnosis of DMD leads to lost opportunities for genetic counseling, implementation of appropriate standards of care, access to newly approved disease-modifying medications, and participation in clinical trials. However, there are ethical, legal, and social concerns related to the development and implementation of NBS for DMD. These concerns include the limited treatment options available, whether both males and females should be screened, and the high rate of false-positives resulting from the first-tier diagnostic test.³⁶

NBS for DMD has been adopted in several states; it has been implemented in Minnesota and Ohio, and New York and Massachusetts are in the planning phases.³⁷ The method of screening is similar to the conventional diagnostic method for suspected cases of DMD. A blood spot test is conducted to measure CK levels, followed by a confirmatory genetic test. One of the primary concerns with this screening method is the relatively high frequency of elevated CK levels in newborns that are unrelated to DMD, leading to false positives and unnecessary genetic testing.³⁸

RUSP Nomination Not Approved

DMD was nominated for inclusion in the RUSP by the Parent Project Muscular Dystrophy³⁹ and the Muscular Dystrophy Association.⁴⁰ The process began in February 2023, but a pause in the review process was requested by the nominators after the Advisory Committee determined there

³¹ *Id.*

³² Cleveland Clinic, *Genetic Counseling*, available at <https://my.clevelandclinic.org/health/articles/23086-genetic-counseling> (last visited Mar. 22, 2025).

³³ *Supra* note 19.

³⁴ Birnkrant, D. J., Bushby, K., Bann, C. M., Apkon, S. D., Blackwell, A., Brumbaugh, D., Case, L. E., Clemens, P. R., Hadjiyannakis, S., Pandya, S., Street, N., Tomezsko, J., Wagner, K. R., Ward, L. M., Weber, D. R., & DMD Care Considerations Working Group (2018), *Diagnosis and management of Duchenne muscular dystrophy, part 1: diagnosis, and neuromuscular, rehabilitation, endocrine, and gastrointestinal and nutritional management*, *The Lancet, Neurology*, 17(3), 251–267, available at [https://doi.org/10.1016/S1474-4422\(18\)30024-3](https://doi.org/10.1016/S1474-4422(18)30024-3) (last visited Mar. 22, 2025).

³⁵ Parent Project Muscular Dystrophy, *Newborn Screening Action Center*, available at <https://www.parentprojectmd.org/advocacy/newborn-screening-action-center/> (last visited Mar. 22, 2025).

³⁶ Thomas, S., Conway, K. M., Fapo, O., Street, N., Mathews, K. D., Mann, J. R., Romitti, P. A., Soim, A., Westfield, C., Fox, D. J., Ciafaloni, E., & Muscular Dystrophy Surveillance, Tracking, and Research Network (MD STARnet) (2022), *Time to diagnosis of Duchenne muscular dystrophy remains unchanged: Findings from the Muscular Dystrophy Surveillance, Tracking, and Research Network, 2000-2015*, *Muscle & nerve*, 66(2), 193–197, available at <https://doi.org/10.1002/mus.27532> (last visited Mar. 22, 2025).

³⁷ *Supra* note 35.

³⁸ *Supra* note 34.

³⁹ Parent Project Muscular Dystrophy, available at <https://www.parentprojectmd.org/> (last visited Mar. 22, 2025).

⁴⁰ Muscular Dystrophy Association, available at <https://www.mda.org/> (last visited Mar. 2, 2025).

was insufficient evidence to move forward and requested additional information regarding the diagnostic process and clinical utility.⁴¹ The RUSP is largely restricted to neonatal-onset disorders for which early treatment shows improved outcome. DMD differs from the majority of conditions included on the RUSP because onset does not occur until later in childhood.⁴²

III. Effect of Proposed Changes:

Section 1 amends s. 383.14, F.S., to require the DOH to adopt and enforce rules requiring every newborn in the state to be screened for DMD at the appropriate age beginning January 1, 2027.

Section 2 provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

⁴¹ U.S. Department of Health and Human Services, *Advisory Committee on Heritable Disorders in Newborns and Children, Chair Letter to DMD Nominators* (2023), available at <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/heritabledisorders/resources/chair-letter-dmd-nominators.pdf> (last visited Mar. 22, 2025); Health Resources & Services Administration, *Summary of Nominated Conditions to the Recommended Uniform Screening Panel* (2024), available at <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/heritable-disorders/rusp/summary-nominated-conditions.pdf> (last visited Mar. 22, 2025).

⁴² *Supra* note 34.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The DOH estimates a total cost of approximately \$2.7 million (\$2.6 million recurring and \$100,000 nonrecurring) to implement the provisions of the bill.⁴³

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 383.14 of the Florida Statutes.

IX. Additional Information:**A. Committee Substitute – Statement of Changes:**

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

None.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.

⁴³ *Supra* note 10.

By Senator Harrell

31-00466-25

2025524

A bill to be entitled

An act relating to newborn screenings; amending s. 383.14, F.S.; beginning on a specified date, requiring that the Department of Health's rules require that newborns be screened for Duchenne muscular dystrophy at the appropriate age; providing an effective date.

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

Section 1. Paragraph (a) of subsection (2) of section 14, Florida Statutes, is amended to read:

383.14 Screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.—

(2) RULES.—

(a) After consultation with the Genetics and Newborn Screening Advisory Council, the department shall adopt and enforce rules requiring that every newborn in this state shall:

1. Before becoming 1 week of age, have a blood specimen collected for newborn screenings;

2. Be tested for any condition included on the federal Recommended Uniform Screening Panel which the council advises the department should be included under the state's screening program. After the council recommends that a condition be included, the department shall submit a legislative budget request to seek an appropriation to add testing of the condition to the newborn screening program. The department shall expand statewide screening of newborns to include screening for such conditions within 18 months after the council renders such advice, if a test approved by the United States Food and Drug

31-00466-25

2025524

30 Administration or a test offered by an alternative vendor is
31 available. If such a test is not available within 18 months
32 after the council makes its recommendation, the department shall
33 implement such screening as soon as a test offered by the United
34 States Food and Drug Administration or by an alternative vendor
35 is available; and

36 3. At the appropriate age, be tested for such other
37 metabolic diseases and hereditary or congenital disorders as the
38 department may deem necessary. Beginning January 1, 2027, the
39 rules must require that newborns be screened for Duchenne
40 muscular dystrophy at the appropriate age.

41 Section 2. This act shall take effect July 1, 2025.



THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Committee on Higher
Education, *Chair*
Health Policy, *Vice Chair*
Appropriations
Appropriations Committee on Health
and
Human Services
Children, Families, and Elder Affairs
Education Postsecondary
Environment and Natural Resources
Rules

SENATOR GAYLE HARRELL
31st District

March 12, 2025

Senator Burton
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Burton,

I respectfully request that SB 524 –Newborn Screenings be placed on the next available agenda for the Health Policy Committee.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

A handwritten signature in blue ink that reads "Gayle".

Senator Gayle Harrell
Senate District 31

Cc: Allen Brown, Staff Director
Anhar Al-Asadi, Committee Administrative Assistant

REPLY TO:

- 312 SE Denver Avenue, Stuart, Florida 34994 (772) 221-4019 FAX: (888) 263-7895
- 404 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5031

Senate's Website: www.flsenate.gov

BEN ALBRITTON
President of the Senate

JASON BRODEUR
President Pro Tempore

3/25/25

Meeting Date

S. Health Policy
Committee

Name Jennifer Ungru

Address

Street

City

State

Zip

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

Tab 8

524

Bill Number or Topic

Amendment Barcode (if applicable)

Phone 202-680-8841

Email jungru@joneswalker.com

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without
compensation or sponsorship.

I am a registered lobbyist,
representing:

I am not a lobbyist, but received
something of value for my appearance
(travel, meals, lodging, etc.),
sponsored by:

Nemours Children's Hospital

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf](https://flsenate.gov/2020-2022JointRules.pdf) (flsenate.gov)

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

S-001 (08/10/2021)

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL: CS/SB 172

INTRODUCER: Health Policy Committee and Senators Burton and Passidomo

SUBJECT: Health Care Practitioner Specialty Titles and Designations

DATE: March 26, 2025 REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Smith	Brown	HP RC	Fav/CS
2. _____	_____	_____	_____

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 172 amends existing legislative intent under s. 456.003, F.S., relating to the regulation of health care professions and finds that the health, safety, and welfare of the public may be harmed or endangered by unlicensed practice or misleading representations by health care practitioners.

The bill amends ss. 458.3312 and 459.0152, F.S., to specify that only physicians who are board-certified may use a defined list of medical specialist titles and designations—such as “cardiologist,” “dermatologist,” or “orthopedic surgeon”—and authorizes the Board of Medicine (BOM) and the Board of Osteopathic Medicine (BOOM), respectively, to add other titles by rule.

The bill creates s. 456.65, F.S., to prohibit health care practitioners who are not allopathic or osteopathic physicians from using medical specialist titles within the lists of titles created by the bill for physician specialties in ss. 458.3312 and 459.0152, F.S., unless specifically authorized by law or in accordance with other specific exceptions. This section prohibits the use of misleading terms, titles, or designations that may misrepresent a practitioner’s qualifications or imply physician-level training where none exists. Practitioners specifically addressed with exceptions in this section include chiropractic physicians, podiatric physicians, dentists, and anesthesiologist assistants (AAs).

To enforce these requirements, the bill amends s. 456.065, F.S., to authorize the Department of Health (DOH) to issue a notice to cease and desist and pursue other existing remedies if the department has probable cause to believe a health care practitioner has engaged in the unlicensed practice of medicine or osteopathic medicine in violation of s. 456.65, F.S.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

The Health, Safety, and Welfare of the Public

Chapter 456, F.S., is entitled “Health Professions and Occupations: General Provisions.” Section 456.003, F.S., in part, provides Legislative intent about the state’s regulation of health care professions, as follows:

- It is the intent of the Legislature that persons desiring to engage in any lawful profession regulated by the DOH are entitled to do so as a matter of right if otherwise qualified.
- Such professions will be regulated only for the preservation of the health, safety, and welfare of the public under the police powers of the state. Such professions will be regulated when:
 - Their unregulated practice can harm or endanger the health, safety, and welfare of the public, and when the potential for such harm is recognizable and clearly outweighs any anticompetitive impact which may result from regulation.
 - The public is not effectively protected by other means, including, but not limited to, other state statutes, local ordinances, or federal legislation.
 - Less restrictive means of regulation are not available.

Licensure and Regulation of Health Care Practitioners

The Division of Medical Quality Assurance (MQA), within the DOH, has general regulatory authority over health care practitioners.¹ The MQA works in conjunction with 22 regulatory boards and four councils to license and regulate over 1.5 million health care practitioners.² Professions are generally regulated by individual practice acts and by ch. 456, F.S., which provides regulatory and licensure authority for the MQA. The MQA is statutorily responsible for the following boards and professions established within the division:³

- The Board of Acupuncture, created under ch. 457, F.S.;
- The Board of Medicine, created under ch. 458, F.S.;
- The Board of Osteopathic Medicine, created under ch. 459, F.S.;
- The Board of Chiropractic Medicine, created under ch. 460, F.S.;
- The Board of Podiatric Medicine, created under ch. 461, F.S.;
- Naturopathy, as provided under ch. 462, F.S.;
- The Board of Optometry, created under ch. 463, F.S.;
- The Board of Nursing, created under part I of ch. 464, F.S.;

¹ Pursuant to s. 456.001(4), F.S., health care practitioners are defined to include acupuncturists, physicians, physician assistants, chiropractors, podiatrists, naturopaths, dentists, dental hygienists, optometrists, nurses, nursing assistants, pharmacists, midwives, speech language pathologists, nursing home administrators, occupational therapists, respiratory therapists, dieticians, athletic trainers, orthotists, prosthetists, electrologists, massage therapists, clinical laboratory personnel, medical physicists, genetic counselors, dispensers of optical devices or hearing aids, physical therapists, psychologists, social workers, counselors, and psychotherapists, among others.

² Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2023-2024*, p. 7-8, <https://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/2024.10.28.FY23-24AR-FINAL.pdf> (last visited Mar. 24, 2025).

³ Section 456.001(4), F.S.

- Nursing assistants, as provided under part II of ch. 464, F.S.;
- The Board of Pharmacy, created under ch. 465, F.S.;
- The Board of Dentistry, created under ch. 466, F.S.;
- Midwifery, as provided under ch. 467, F.S.;
- The Board of Speech-Language Pathology and Audiology, created under part I of ch. 468, F.S.;
- The Board of Nursing Home Administrators, created under part II of ch. 468, F.S.;
- The Board of Occupational Therapy, created under part III of ch. 468, F.S.;
- Respiratory therapy, as provided under part V of ch. 468, F.S.;
- Dietetics and nutrition practice, as provided under part X of ch. 468, F.S.;
- The Board of Athletic Training, created under part XIII of ch. 468, F.S.;
- The Board of Orthotists and Prosthetists, created under part XIV of ch. 468, F.S.;
- Electrolysis, as provided under ch. 478, F.S.;
- The Board of Massage Therapy, created under ch. 480, F.S.;
- The Board of Clinical Laboratory Personnel, created under part I of ch. 483, F.S.;
- Medical physicists, as provided under part II of ch. 483, F.S.;
- Genetic Counselors as provided under part III of ch. 483, F.S.;
- The Board of Opticianry, created under part I of ch. 484, F.S.;
- The Board of Hearing Aid Specialists, created under part II of ch. 484, F.S.;
- The Board of Physical Therapy Practice, created under ch. 486, F.S.;
- The Board of Psychology, created under ch. 490, F.S.;
- School psychologists, as provided under ch. 490, F.S.;
- The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under ch. 491, F.S.; and
- Emergency medical technicians and paramedics, as provided under part III of ch. 401, F.S.

The DOH and the practitioner boards have different roles in the regulatory system. Boards establish practice standards by rule, pursuant to statutory authority and directives. The DOH receives and investigates complaints about practitioners and prosecutes cases for disciplinary action against practitioners.

The DOH, on behalf of the professional boards, investigates complaints against practitioners.⁴ Once an investigation is complete, the DOH presents the investigatory findings to the boards. The DOH recommends a course of action to the appropriate board's probable cause panel, which may include:⁵

- Issuing an Emergency Order;
- Having the file reviewed by an expert;
- Issuing a closing order; or
- Filing an administrative complaint.

⁴ Department of Health, *Investigative Services*, <http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/isu.html> (last visited Mar. 24, 2025).

⁵ Department of Health, *Prosecution Services*, <http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/psu.html> (last visited Mar. 24, 2025).

The boards determine the course of action and any disciplinary action to take against a practitioner under the respective practice act.⁶ For professions for which there is no board, the DOH determines the action and discipline to take against a practitioner and issues the final orders.⁷ The DOH is responsible for ensuring that licensees comply with the terms and penalties imposed by the boards.⁸ If a case is appealed, DOH attorneys defend the final actions of the boards before the appropriate appellate court.⁹

The DOH and board rules apply to all statutory grounds for discipline against a practitioner. Under current law, the DOH takes on the disciplinary functions of a board relating to violations of a practice act only for practitioner types that do not have a board. The DOH itself takes no final disciplinary action against practitioners for which there is a board.

The Unlicensed Activity Unit

The Unlicensed Activity (ULA) Unit protects Florida residents and visitors from the potentially serious and dangerous consequences of receiving medical and health care services from an unlicensed person. The ULA unit investigates and refers for prosecution all unlicensed health care activity complaints and allegations.

The ULA unit works in conjunction with law enforcement and the state attorney's offices to prosecute individuals practicing without a license. In many instances, unlicensed activity is a felony level criminal offense. More importantly, receiving health care from unlicensed persons is dangerous and could result in further injury, disease or even death.¹⁰

The Unlicensed Activity Investigation Process

The DOH assigns all ULA complaints a computer-generated complaint number for tracking purposes. If the allegations are determined to be legally sufficient, the matter will be forwarded to a ULA investigator whose office is geographically closest to the location where the alleged unlicensed activity is occurring. In cases where the person making the allegation has provided their identifying information, a ULA investigator will contact him or her to verify the allegations. The investigator may also ask for more detailed information concerning certain aspects of the complaint. He or she may also ask to meet with the complainant in person for a formal interview. All ULA investigators are empowered to take sworn statements.

After discussing the allegations with the complainant, the ULA investigator will pursue all appropriate investigative steps (gather documents, conduct surveillance, question witnesses, etc.) in order to make a determination concerning the likelihood that the offense(s) took place in the manner described by the complainant. In the event that a licensed health care provider is alleged to be somehow involved with the unlicensed activity, the ULA investigator will also coordinate

⁶ Section 456.072(2), F.S.

⁷ Professions which do not have a board include naturopathy, nursing assistants, midwifery, respiratory therapy, dietetics and nutrition, electrolysis, medical physicists, genetic counselors, and school psychologists.

⁸ *Supra*, note 5.

⁹ *Id.*

¹⁰ The Department of Health, Licensing and Regulation, enforcement, Unlicensed Activity, *Reporting Unlicensed Activity*, available at <https://www.floridahealth.gov/licensing-and-regulation/enforcement/report-unlicensed-activity/index.html> (last visited Mar. 24, 2025).

his or her investigation with the Investigative Services Unit (ISU) regulatory investigator assigned to investigate the licensee.

If the complainant's allegations can be substantiated, the ULA investigation will conclude with one or more of the following outcomes:

- The subject(s) will be issued a Cease and Desist Agreement.
- The subject(s) will be issued a Uniform Unlicensed Activity Citation (fine).
- The subject(s) will be arrested by law enforcement.

If the investigation determines that the alleged acts either did not take place or if they did occur but all actions were lawful and proper, the investigation will be closed as unfounded. In the event that the allegation(s) cannot be clearly proved or disproved, the matter will be closed as unsubstantiated. In any case, a detailed investigative report will be prepared by the ULA investigator supporting the conclusions reached by the investigation.

Under s. 456.065, F.S., investigations involving the unlicensed practice of a health care profession are criminal investigations that require the development of sufficient evidence (probable cause) to present to law enforcement or file charges with the State Attorney's Office in the county of occurrence. While ULA investigators are non-sworn, many have law enforcement experience gained from prior careers as police officers and detectives. ULA investigators work cooperatively with many law enforcement agencies in joint investigations that are either initiated by the DOH or the agency concerned.¹¹

Health Care Specialties and Florida Licensure

The DOH does not license health care practitioners by specialty or subspecialty. A health care practitioner's specialty area of practice is acquired through the practitioner's additional education, training, or experience in a particular area of health care practice. Practitioners who have acquired additional education, training, or experience in a particular area may also elect to become board-certified in that specialty by private, national specialty boards, such as the American Board of Medical Specialties (ABMS), the Accreditation Board for Specialty Nursing Certification, and the American Board of Dental Specialties.¹² Board certification is not required to practice a medical or osteopathic specialty.

Title Prohibitions Under Current Florida Law

Current law limits which health care practitioners may hold themselves out as board-certified specialists. Under s. 458.3312, F.S., an allopathic physician may not hold himself or herself out as a board-certified specialist unless he or she has received formal recognition as a specialist

¹¹ The Department of Health, Licensing and Regulation, enforcement, Unlicensed Activity, *Investigate Complaints*, available at <https://www.floridahealth.gov/licensing-and-regulation/enforcement/report-unlicensed-activity/investigate-complaints.html> (last visited Mar. 24, 2025).

¹² Examples of specialties include dermatology, emergency medicine, ophthalmology, pediatric medicine, certified registered nurse anesthetist, clinical nurse specialist, cardiac nurse, nurse practitioner, endodontics, orthodontics, and pediatric dentistry.

from a specialty board of the ABMS or other recognizing agency¹³ approved by the BOM.¹⁴ Similarly, under s. 459.0152, F.S., an osteopathic physician may not hold himself or herself out as a board-certified specialist unless he or she has successfully completed the requirements for certification by the American Osteopathic Association (AOA) or the Accreditation Council on Graduate Medical Education (ACGME) and is certified as a specialist by a certifying agency¹⁵ approved by the BOOM.¹⁶ In addition, an allopathic physician may not hold himself or herself out as a board-certified specialist in dermatology unless the recognizing agency, whether authorized in statute or by rule, is triennially reviewed and reauthorized by the BOM.¹⁷ However, a physician licensed under ch. 458 or 459, F.S., may indicate the services offered and may state that his or her practice is limited to one or more types of services when this accurately reflects the scope of practice of the physician.¹⁸

A podiatric physician also may not advertise that he or she is board certified unless the organization is approved by the Board of Podiatric Medicine (BPM) for the purposes of advertising only and the name of the organization is identified in full in the advertisement. In order for an organization to obtain the BPM approval it must be the American Podiatric Medical Association, the National Council of Competency Assurance, or an organization that must:

- Be composed of podiatric physicians interested in a special area of practice demonstrated through successful completion of examinations or case reports;
- Subscribe to a code of ethics;
- Have rules and procedures for maintaining a high level of professional conduct and discipline among its membership;
- Have an active membership of at least seventy-five (75);
- Sponsor annual meeting and courses in Board approved continuing education; and
- Be a national organization in scope and give a certification examination at least once a year before the podiatric physician can advertise possession of the certification.¹⁹

A dentist may not hold himself or herself out as a specialist, or advertise membership in or specialty recognition by an accrediting organization, unless the dentist has completed a specialty education program approved by the American Dental Association and the Commission on Dental Accreditation and the dentist is:²⁰

¹³ The Board of Medicine has approved the specialty boards of the ABMS as recognizing agencies. Fla. Admin. Code. R. 64B8-11.001(1)(f),(2025). The board has also approved the following recognizing agencies: American Board of Facial Plastic & Reconstructive Surgery, Inc., American Board of Pain Medicine, American Association of Physician Specialists, Inc./American Board of Physician Specialties, American Board of Interventional Pain Physicians, American Board of Vascular Medicine, United Council for Neurologic Subspecialties, and American Board of Electrodiagnostic Medicine. Fla.-Admin. Code. R. 64B8-11.001(8),(2025).

¹⁴ Section 458.3312, F.S.

¹⁵ The Board of Osteopathic Medicine has approved the specialty boards of the ABMS and AOA as recognizing agencies. Fla. Admin. Code R. 64B15-14.001(2)(h),(2025). The osteopathic board has also approved the following recognizing agencies: American Association of Physician Specialists, Inc., and American Board of Interventional Pain Physicians. Fla.-Admin. Code R. 64B15-14.001(5),(2025).

¹⁶ Section 459.0152, F.S.

¹⁷ *Id.*

¹⁸ Sections 458.3312 and 459.0152, F.S.

¹⁹ Fla. Admin. Code R. 64B18-14.004 (2025).

²⁰ Section 466.0282, F.S. A dentist may also hold himself or herself out as a specialist if the dentist has continuously held himself or herself out as a specialist since December 31, 1964, in a specialty recognized by the American Dental Association.

- Eligible for examination by a national specialty board recognized by the American Dental Association; or
- Is a diplomate of a national specialty board recognized by the American Dental Association.

If a dentist announces or advertises a specialty practice for which there is not an approved accrediting organization, the dentist must clearly state that the specialty is not recognized or that the accrediting organization has not been approved by the American Dental Association or the Florida Board of Dentistry.²¹

The Board of Chiropractic Medicine (BCM) permits a chiropractor to advertise that he or she has attained diplomate status in a chiropractic specialty area recognized by the BCM. BCM specialties include those which are recognized by the Councils of the American Chiropractic Association, the International Chiropractic Association, the International Academy of Clinical Neurology, or the International Chiropractic Pediatric Association.²²

Practitioner Discipline

Section 456.072, F.S., authorizes a regulatory board, or the DOH if there is no board, to discipline a health care practitioner's licensure for a number of offenses, including, but not limited to:

- Making misleading, deceptive, or fraudulent representations in or related to the practice of the licensee's profession; or
- Failing to identify through writing or orally to a patient the type of license under which the practitioner is practicing.

If a board or the DOH finds that a licensee committed a violation of a statute or rule, the board or the DOH may:²³

- Refuse to certify, or to certify with restrictions, an application for a license;
- Suspend or permanently revoke a license;
- Place a restriction on the licensee's practice or license;
- Impose an administrative fine not to exceed \$10,000 for each count or separate offense; if the violation is for fraud or making a false representation, a fine of \$10,000 must be imposed for each count or separate offense;
- Issue a reprimand or letter of concern;
- Place the licensee on probation;
- Require a corrective action plan;
- Refund fees billed and collected from the patient or third party on behalf of the patient; or
- Require the licensee to undergo remedial education.

²¹ Section 466.0282(3), F.S.

²² Fla. Admin. Code R. 64B2-15.001(2)(e), (2025). Examples of chiropractic specialties include chiropractic acupuncture, chiropractic internist, chiropractic and clinical nutrition, radiology chiropractic, and pediatric chiropractors.

²³ Section 456.072(2), F.S.

“Nurse Anesthesiologist”

On August 8, 2019, at the general Board of Nursing (BON) meeting, the BON considered requests for declaratory statements.²⁴ The second request for a declaratory statement was made by John P. McDonough, APRN,²⁵ CRNA,²⁶ license number 3344982.²⁷

For the meeting, McDonough’s Petition for Declaratory Statement acknowledged that the type of Florida nursing license he held was as an advanced practice registered nurse (APRN), and that he was a certified registered nurse anesthetist (CRNA), but requested that he be permitted to use the phrase “nurse anesthesiologist” as a descriptor for him or his practice, and that the BON not subject him to discipline under ss. 456.072 and 464.018, F.S.,²⁸ based on the following grounds:

- A New Hampshire Board of Nursing’s Position Statement that the nomenclature, *Nurse Anesthesiologist* and *Certified Registered Nurse Anesthesiologist*, are not title changes or an expansion of scope of practice, but are optional, accurate descriptors,²⁹ and
- Florida law grants no title protection to the words *anesthesiologist* or *anesthetist*.³⁰

The Florida Association of Nurse Anesthetists (FANA) and the Florida Medical Association, Inc. (FMA), Florida Society of Anesthesiologists, Inc. (FSA), and Florida Osteopathic Medical Association, Inc. (FOMA), filed timely and legally sufficient³¹ motions to intervene³² pursuant to

²⁴ Section 120.565, F.S. Provides that, “[a]ny substantially affected person may seek a declaratory statement regarding an agency’s opinion as to the applicability of a statutory provision as it applies to the petitioner’s particular set of circumstances. The agency must give notice of the filing of a petition in the Florida Administrative Register, provide copies of the petition to the board, and issue a declaratory statement or deny the petition within 90 days after the filing. The declaratory statement or denial of the petition is then noticed in the next Florida Administrative Register, and disposition of a petition is a final agency action.”

²⁵ An APRN is an advanced practice registered nurse licensed under ch. 464, F.S.

²⁶ A CRNA is a certified registered nurse anesthetist, or an APRN who specializes in anesthesia.

²⁷ The Florida Board of Nursing, Meeting Minutes, Disciplinary Hearings & General Business, *Declaratory Statements*, No. 2, Aug. 8, 2019, available at <https://floridasnursing.gov/meetings/minutes/2019/08-august/08072019-minutes.pdf> p. 28 (last visited Mar. 24, 2025).

²⁸ *Petition for Declaratory Statement Before the Board of Nursing, In re: John P. McDonough, A.P.R.N., C.R.N.A., Ed.D.*, filed at the Department of Health, July 10, 2019 (on file with the Senate Committee on Health Policy).

²⁹ New Hampshire Board of Nursing, *Position Statement Regarding the use of Nurse Anesthesiologist as a communication tool and optional descriptor for Certified Registered Nurse Anesthetists (CRNAs)*, Nov. 20, 2018, available at <https://static1.squarespace.com/static/5bf069ef3e2d09d0f4e0a54f/t/5f6f8a708d2cb23bb10f50a0/1601145457231/NH+BON+NURSE+ANESTHESIOLOGIST.pdf> (last visited Mar. 24, 2025).

³⁰ *Id.*

³¹ Fla. Adm. Code R. 28-105.0027(2) and 28.106.205(2) (2019), both of which state that to be legally sufficient, a motion to intervene in a proceeding on a petition for a declaratory statement must contain the following information: (a) The name, address, the e-mail address, and facsimile number, if any, of the intervenor; if the intervenor is not represented by an attorney or qualified representative; (b) The name, address, e-mail address, telephone number, and any facsimile number of the intervenor’s attorney or qualified representative, if any; (c) Allegations sufficient to demonstrate that the intervenor is entitled to participate in the proceeding as a matter of constitutional or statutory right or pursuant to agency rule, or *that the substantial interests of the intervenor are subject to determination or will be affected by the declaratory statement*; (d) The signature of the intervenor or intervenor’s attorney or qualified representative; and (e) The date.

³² The Florida Medical Association, Inc., Florida Society of Anesthesiologists, Inc., and Florida Osteopathic Medical Association, Inc., *Motion to Intervene In Florida Board of Nursing’s Consideration of the Petition for Declaratory Statement in Opposition of Petitioner John P. McDonough, A.P.R.N., C.R.N.A., Ed.D.*, filed at the Department of Health, Aug. 1, 2019, (on file with the Senate Health Policy Committee).

Florida Administrative Code Rule 28-106.205.³³ The FANA's petition³⁴ was in support of petitioner's Declaratory Statement while the motion filed jointly by the FMA, FSA, and FOMA was in opposition.

The FMA, FSA, and FOMA argued they were entitled to participate in the proceedings, on behalf of their members, as the substantial interests of their members – some 32,300 – could be adversely affected by the proceeding.^{35, 36} Specifically, the FMA, FSA, and FOMA argued that the substantial interests of their respective members would be adversely affected by the issuance of a Declaratory Statement that a petitioner could use the term "nurse anesthesiologist," without violating ss. 456.072 and 464.018, F.S., on the grounds that:

- A substantial number of their members use the term "anesthesiologist" with the intent and understanding that patients, and potential patients, would recognize the term to refer to them as physicians licensed under chs. 458 or 459, F.S., not "nurse anesthetists;"
- Sections 458.3475(1)(a) and 459.023(1)(a), F.S., both define the term "anesthesiologist" as a licensed allopathic or osteopathic physician and do not include in those definitions a "nurse anesthetist;"
- The Merriam-Webster Dictionary defines an "anesthesiologist" as a "physician specializing in anesthesiology," not as a nurse specializing in anesthesia; and
- The Legislature clearly intended a distinction between the titles to be used by physicians practicing anesthesiology and nurses delivering anesthesia, to avoid confusion, as s. 464.015(6), F.S., specifically states that:
 - Only persons who hold valid certificates to practice as certified registered nurse anesthetists in this state may use the title "Certified Registered Nurse Anesthetist" and the abbreviations "C.R.N.A." or "nurse anesthetist;" and
 - Petitioner is licensed as a "registered nurse anesthetist" under s. 464.012(1)(a), F.S., and the term "nurse anesthesiologist" is not found in statute.

At the hearing, the attorney for the BON advised the BON that, "[t]he first thing the Board need[ed] to do [was] determine whether or not the organizations that [had] filed petitions to intervene have standing in order to participate in the discussion of the Declaratory Statement"³⁷ and that:

"Basically in order to make a determination of whether an organization has standing, they have to show that the members of their organization would have an actual injury in fact, or suffer an immediate harm of some sort of immediacy were the Board to issue this particular Declaratory Statement, and then the Board also has to make a determination of

³³ Fla. Adm. Code. R. 28-106.205 (2019), in pertinent part, provides, "Persons other than the original parties to a pending proceeding whose substantial interest will be affected by the proceeding and who desire to become parties may move the presiding officer for leave to intervene."

³⁴ *Florida Association of Nurse Anesthetists Motion to Intervene*, filed at the Department of Health, July 31, 2019, (on file with the Senate Committee on Health Policy).

³⁵ *Supra* note 43.

³⁶ See *Florida Home Builders Association, et al., Petitioners, v. Department of Labor And Employment Security, Respondent*, 412 S.2d 351 (Fla. 1982), holding that a trade association does have standing under s. 120.56(1), F.S., to challenge the validity of an agency ruling on behalf of its members when that association fairly represents members who have been substantially affected by the ruling.

³⁷ Record at p. 3, ll. 13-17. Declaratory Statement, Dr. John P. McDonough, Before the Board of Nurses, State of Florida, Department of Health, Sanibel Harbor Marriott. (on file with the Senate Committee on Health Policy).

whether the nature of the injury would be within the zone of interest that the statute is addressing.”³⁸

However, the above special injury standard,³⁹ provided by board counsel to the BON to apply to determine the organizations’ standing to intervene, based on their members’ substantial interests being affected by the declaratory statement, was held inapplicable to trade associations in *Florida Home Builders Ass’n. v. Department of Labor and Employment Security*, 412 So.2d 351 (Fla. 1982). The Florida Supreme Court, in *Florida Home Builders, Ass’n.*, held that a trade or professional association is able to challenge an agency action on behalf of its members, even though each member could individually challenge the agency action, if the organization could demonstrate that:

- A substantial number of the association members, though not necessarily a majority, would be “substantially affected” by the challenged action;
- The subject matter of the challenged action is within the association’s scope of interest and activity; and
- The relief requested is appropriate for the association’s members.⁴⁰

The FANA’s motion to intervene was granted, based on the application of an incorrect standard, without the BON making the findings required by *Florida Home Builders, Ass’n.* The motion to intervene filed by the FMA, FSA, and FOMA was denied, also based on the application of an incorrect standard, on the grounds that:

- Their members are regulated by the Board of Medicine, not the Board of Nursing;
- Nursing disciplinary guidelines were being discussed;
- Their members’ licenses and discipline would not be affected by an interpretation of nursing discipline;⁴¹ and
- Their members are not regulated by the Nurse Practice Act.

A motion was made to approve McDonough’s Petition for Declaratory Statement, and it passed unanimously. According to the BON’s approval, McDonough may now use of the term “nurse anesthesiologist” as a descriptor, and such use is not grounds for discipline against his nursing license. However, while s. 120.565, F.S., provides that any person may seek a declaratory statement regarding the potential impact of a statute, rule or agency opinion on a petitioner’s particular situation, approval or denial of the petition only applies to the petitioner. It is not a method of obtaining a policy statement from a board of general applicability.⁴²

³⁸ *Id.* p. 3-4, ll. 22- 25, 1-6.

³⁹ *United States Steel Corp. v. Save Sand Key, Inc.*, 303 So.2d 9 (Fla. 1974).

⁴⁰ *Florida Home Builders Ass’n. v. Department of Labor and Employment Security*, 412 So.2d 351 (Fla. 1982), pp. 353-354.

⁴¹ Record at p. 7, ll. 1-13. Declaratory Statement, Dr. John P. McDonough, Before the Board of Nurses, State of Florida, Department of Health, Sanibel Harbor Marriott. (on file with the Senate Committee on Health Policy).

⁴² Florida Department of Health, Board of Nursing, *What is a Declaratory Statement?*, available at <https://floridasnursing.gov/help-center/what-is-a-declaratory-statement/> (last visited Mar. 24, 2025).

News media have reported that the BON's Declaratory Statement in favor of McDonough has created significant concern for patient safety and the potential for confusion in the use of the moniker "anesthesiologist" among Florida's medical professionals.^{43,44}

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 456.003(2), F.S., regarding Legislative intent for the regulation of health care professions to provide a Legislative finding that the health, safety, and welfare of the public may be harmed or endangered under any of the following conditions:

- By the unlawful practice of a profession;
- By a misleading, deceptive, or fraudulent representation relating to a person's authority to practice a profession lawfully; or
- When patients are uninformed about the profession under which a practitioner is practicing before receiving professional consultation or services from the practitioner.

The bill provides that the Legislature's regulation of health care professions as provided under current law in s. 456.003(2), F.S., is a matter of great public importance.

Section 2 of the bill amends s. 456.065, F.S., to establish that the DOH may issue a notice to cease and desist if a health care practitioner has engaged in the unlicensed practice of a health care profession by violating s. 456.65, F.S., regarding the unlicensed practice of medicine or osteopathic medicine, as created in section 3 of the bill and may pursue other remedies authorized under s. 456.065, F.S., which apply to the unlicensed practice of a health care profession. In practice, the DOH would be authorized to treat a health care practitioner's unlawful practice of medicine or osteopathic medicine under the bill as the department would for an unlicensed person, starting with a notice to cease and desist and potentially exercising other authorities in current law if the unlawful practice continues.

Section 3 of the bill creates s. 456.65, F.S., to prohibit a health care practitioner not licensed as a physician under ch. 458, F.S., or ch. 459, F.S., from holding himself or herself out to a patient or the general public as a specialist by describing himself or herself or his or her practice through the use of any medical specialist title or designation specifically listed under s. 458.3312(2), F.S., as created in section 3 of the bill, or under s. 459.0152(2), as created in section 4 of the bill, either alone or in combination, or in connection with other words, unless the practitioner is specifically authorized by law to use that medical specialist title or designation.

The bill creates ss. 458.3312(3) and 459.0152(3), F.S., to authorize the BOM and the BOOM to, by rule, create other specialist titles that are subject to the respective prohibitions on physicians licensed under those chapters of statute.

⁴³ Christine Sexton, The News Service of Florida, "Nursing Board Signs Off On 'Anesthesiologist' Title," August 16, 2019, The Gainesville Sun, available at: <https://www.gainesville.com/news/20190816/nursing-board-signs-off-on-anesthesiologist-title> (last visited Mar. 24, 2025).

⁴⁴ Christine Sexton, The News Service of Florida, "Florida Lawmaker Takes Aim At Health Care Titles," October 10, 2019, Health News Florida, available at <https://health.wusf.usf.edu/post/florida-lawmaker-takes-aim-health-care-titles> (last visited Mar. 24, 2025).

A violation of this prohibition would constitute the unlicensed practice of medicine or osteopathic medicine, as applicable, and DOH may pursue enforcement remedies under s. 456.065, F.S., as amended in section 2 of the bill.

Exceptions

Notwithstanding the prohibition created in this section, the bill provides that a **licensed health care practitioner** may use the name or title of his or her profession that is authorized under his or her practice act, and any corresponding designations or initials so authorized, to describe himself or herself and his or her practice.

Additionally, the bill provides that a **licensed health care practitioner who has a specialty area of practice authorized under his or her practice act** may use the following format to identify himself or herself or describe his or her practice: "...(name or title of the practitioner's profession)...., specializing in ... (name of the practitioner's specialty)...."

A **chiropractic physician** licensed under ch. 460, F.S., is authorized to use the title "chiropractic radiologist" and other titles, abbreviations, or designations authorized under his or her practice act reflecting those chiropractic specialty areas in which the chiropractic physician has attained diplomate status as recognized by the American Chiropractic Association, the International Chiropractors Association, the International Academy of Clinical Neurology, or the International Chiropractic Pediatric Association.

A **podiatric physician** licensed under ch. 461, F.S., may use the following titles and abbreviations as applicable to his or her license, specialty, and certification: "podiatric surgeon," "Fellow in the American College of Foot and Ankle Surgeons," and any other titles or abbreviations authorized under his or her practice act.

A **dentist** licensed under ch. 466, F.S., may use the following titles and abbreviations as applicable to his or her license, specialty, and certification: "doctor of dental surgery," "D.D.S.," "oral surgeon," "maxillofacial surgeon," "oral and maxillofacial surgeon," "O.M.S.," "dental anesthesiologist," "oral pathologist," "oral radiologist," and any other titles or abbreviations authorized under his or her practice act.

An **anesthesiologist assistant** licensed under ch. 458, F.S., or ch. 459, F.S., may use the titles "anesthesiologist assistant" or "certified anesthesiologist assistant" and the abbreviations "A.A." or "C.A.A.," as applicable.

A **physician** licensed under ch. 458, F.S., or ch. 459, F.S., may use a specialist title or designation according to s. 458.3312, F.S., or s. 459.0152, F.S., as applicable.

Section 4 of the bill amends s. 458.3312, F.S., for allopathic physician specialties and **section 5** of the bill amends s. 459.0152, F.S., for osteopathic physician specialties.

Under current law, an allopathic physician licensed under ch. 458, F.S., may not hold himself or herself out as a board-certified specialist unless the physician has received formal recognition as

a specialist from a specialty board of the American Board of Medical Specialties or other recognizing agency that has been approved by the BOM.

Similarly, an osteopathic physician licensed under ch. 459, F.S., may not hold himself or herself out as a board-certified specialist under current law unless the osteopathic physician has:

- Successfully completed the requirements for certification by the American Osteopathic Association (AOA) or the Accreditation Council on Graduate Medical Education (ACGME); and
- Is certified as a specialist by a certifying agency approved by the BOOM.

In sections 4 and 5, the bill creates identical lists of medical specialist titles and designations that may be used only by physicians licensed under ch. 458 or ch. 459, F.S., respectively, who have met the above requirements and become board-certified. The BOM and the BOOM are authorized to adopt additional specialist titles and designations by rule that would be reserved for use by board-certified physicians. Such rules would apply only to licensed allopathic or osteopathic physicians, respectively.

The bill reserves the use of the following medical specialist titles and designations for board-certified allopathic and osteopathic physicians:

- Surgeon.
- Neurosurgeon.
- General surgeon.
- Plastic Surgeon.
- Thoracic Surgeon.
- Allergist.
- Anesthesiologist.
- Cardiologist.
- Dermatologist.
- Endocrinologist.
- Gastroenterologist.
- Geriatrician
- Gynecologist.
- Hematologist.
- Hospitalist.
- Immunologist.
- Intensivist.
- Internist.
- Laryngologist.
- Nephrologist.
- Neurologist.
- Neurotologist.
- Obstetrician.
- Oncologist.
- Ophthalmologist.
- Orthopedic surgeon.

- Orthopedist.
- Otologist.
- Otolaryngologist.
- Otorhinolaryngologist.
- Pathologist.
- Pediatrician.
- Proctologist.
- Psychiatrist.
- Pulminologist.
- Radiologist.
- Rheumatologist.
- Rhinologist.
- Urologist.

In conjunction with the statute created in section 3 of the bill, a health care practitioner who is not a licensed allopathic or osteopathic physician may not hold himself or herself out to a patient or the public at large as a specialist by describing himself or herself or his or her practice using any of the titles or designations that appear in the statutory lists above.

Section 6 of the bill provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

To the extent persons violate the bill's provisions, the bill could have a potential workload increase and an increase in costs for the DOH's ULA Unit of an indeterminate amount.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 456.003, 456.065, 458.3312, and 459.0152.

This bill creates section 456.65 of the Florida Statutes.

IX. Additional Information:**A. Committee Substitute – Statement of Substantial Changes:**

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

CS by Health Policy on March 25, 2025:

The committee substitute establishes that the DOH may issue a notice to cease and desist and may pursue other existing remedies, if a health care practitioner has engaged in the unlicensed practice of a health care profession by violating s. 456.65, F.S., regarding the unlicensed practice of medicine or osteopathic medicine, as created in section 3 of the bill. The CS deletes a provision providing construction for s. 456.65, F.S., and reaffirms under that section that a physician licensed under ch. 458, F.S., or ch. 459, F.S., may use a specialist title or designation according to s. 458.3312, F.S., or s. 459.0152, F.S., as applicable.

To the lists of specialist titles that may be used only by physicians licensed under ch. 458, F.S., or ch. 459, F.S., and who have met statutory requirements and become board-

certified specialists, the CS adds the following titles: plastic surgeon, thoracic surgeon, allergist, geriatrician, immunologist, neurologist, and pulmonologist.

B. Amendments:

None.

This Senate Bill Analysis does not reflect the intent or official position of the bill's introducer or the Florida Senate.



LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/26/2025	.	
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	.	
	.	

The Committee on Health Policy (Burton) recommended the following:

1 **Senate Amendment (with title amendment)**

2

3 Delete lines 55 - 221

4 and insert:

5 Section 2. Paragraph (a) of subsection (2) of section
6 456.065, Florida Statutes, is amended to read:

7 456.065 Unlicensed practice of a health care profession;
8 intent; cease and desist notice; penalties; enforcement;
9 citations; fees; allocation and disposition of moneys
10 collected.—



11 (2) The penalties for unlicensed practice of a health care
12 profession shall include the following:

13 (a) 1. When the department has probable cause to believe
14 that any person not licensed by the department, or the
15 appropriate regulatory board within the department, has violated
16 any provision of this chapter or any statute that relates to the
17 practice of a profession regulated by the department, or any
18 rule adopted pursuant thereto, the department may issue and
19 deliver to such person a notice to cease and desist from such
20 violation.

21 2. When the department has probable cause to believe that
22 any licensed health care practitioner has engaged in the
23 unlicensed practice of a health care profession by violating s.
24 456.65, the department may issue and deliver to such health care
25 practitioner a notice to cease and desist from such violation
26 and may pursue other remedies authorized under this section
27 which apply to the unlicensed practice of a health care
28 profession.

29 3. In addition to the remedies under subparagraphs 1. and
30 2., the department may issue and deliver a notice to cease and
31 desist to any person who aids and abets the unlicensed practice
32 of a profession by employing the such unlicensed person engaging
33 in the unlicensed practice.

34 4. The issuance of a notice to cease and desist shall not
35 constitute agency action for which a hearing under ss. 120.569
36 and 120.57 may be sought. For the purpose of enforcing a cease
37 and desist order, the department may file a proceeding in the
38 name of the state seeking issuance of an injunction or a writ of
39 mandamus against any person who violates any provisions of such



40 order.

41 Section 3. Section 456.65, Florida Statutes, is created to
42 read:

43 456.65 Specialties.—

44 (1) (a) A health care practitioner not licensed as a
45 physician under chapter 458 may not hold himself or herself out
46 to a patient or the public at large as a specialist by
47 describing himself or herself or his or her practice through the
48 use of any specialist title or designation specifically listed
49 under s. 458.3312(2), either alone or in combination, or in
50 connection with other words, unless the practitioner is
51 authorized to use such specialist title or designation under
52 subsection (3).

53 (b) A health care practitioner not licensed as a physician
54 under chapter 459 may not hold himself or herself out to a
55 patient or the public at large as a specialist by describing
56 himself or herself or his or her practice through the use of any
57 specialist title or designation specifically listed under s.
58 459.0152(2), either alone or in combination, or in connection
59 with other words, unless the practitioner is authorized to use
60 such specialist title or designation under subsection (3).

61 (2) A violation of subsection (1) constitutes the
62 unlicensed practice of medicine or osteopathic medicine, as
63 applicable, and the department may pursue remedies under s.
64 456.065 for such violation.

65 (3) Notwithstanding subsection (1):

66 (a) A licensed health care practitioner may use the name or
67 title of his or her profession which is authorized under his or
68 her practice act, and any corresponding designations or initials



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69 so authorized, to describe himself or herself and his or her
70 practice.

71 (b) A licensed health care practitioner who has a specialty
72 area of practice authorized under his or her practice act may
73 use the following format to identify himself or herself or
74 describe his or her practice: "...(name or title of the
75 practitioner's profession)..., specializing in ... (name of the
76 practitioner's specialty)...."

77 (c) A chiropractic physician licensed under chapter 460 may
78 use the title "chiropractic radiologist" and other titles,
79 abbreviations, or designations authorized under his or her
80 practice act reflecting those chiropractic specialty areas in
81 which the chiropractic physician has attained diplomate status
82 as recognized by the American Chiropractic Association, the
83 International Chiropractors Association, the International
84 Academy of Clinical Neurology, or the International Chiropractic
85 Pediatric Association.

86 (d) A podiatric physician licensed under chapter 461 may
87 use the following titles and abbreviations as applicable to his
88 or her license, specialty, and certification: "podiatric
89 surgeon," "Fellow in the American College of Foot and Ankle
90 Surgeons," and any other titles or abbreviations authorized
91 under his or her practice act.

92 (e) A dentist licensed under chapter 466 may use the
93 following titles and abbreviations as applicable to his or her
94 license, specialty, and certification: "doctor of dental
95 surgery," "D.D.S.," "oral surgeon," "maxillofacial surgeon,"
96 "oral and maxillofacial surgeon," "O.M.S.," "dental
97 anesthesiologist," "oral pathologist," "oral radiologist," and



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98 any other titles or abbreviations authorized under his or her
99 practice act.

100 (f) An anesthesiologist assistant licensed under chapter
101 458 or chapter 459 may use the titles "anesthesiologist
102 assistant" or "certified anesthesiologist assistant" and the
103 abbreviations "A.A." or "C.A.A.," as applicable.

104 (g) A physician licensed under chapter 458 or chapter 459
105 may use a specialist title or designation according to s.
106 458.3312 or s. 459.0152, as applicable.

107 Section 4. Section 458.3312, Florida Statutes, is amended
108 to read:

109 458.3312 Specialties.—

110 (1) A physician licensed under this chapter may not hold
111 himself or herself out as a board-certified specialist unless
112 the physician has received formal recognition as a specialist
113 from a specialty board of the American Board of Medical
114 Specialties or other recognizing agency that has been approved
115 by the board. However, a physician may indicate the services
116 offered and may state that his or her practice is limited to one
117 or more types of services when this accurately reflects the
118 scope of practice of the physician.

119 (2) Specialist titles and designations to which subsection
120 (1) applies include:

121 (a) Surgeon.

122 (b) Neurosurgeon.

123 (c) General surgeon.

124 (d) Plastic surgeon.

125 (e) Thoracic surgeon.

126 (f) Allergist.



127 (g) Anesthesiologist.
128 (h) Cardiologist.
129 (i) Dermatologist.
130 (j) Endocrinologist.
131 (k) Gastroenterologist.
132 (l) Geriatrician.
133 (m) Gynecologist.
134 (n) Hematologist.
135 (o) Hospitalist.
136 (p) Immunologist.
137 (q) Intensivist.
138 (r) Internist.
139 (s) Laryngologist.
140 (t) Nephrologist.
141 (u) Neurologist.
142 (v) Neurologist.
143 (w) Obstetrician.
144 (x) Oncologist.
145 (y) Ophthalmologist.
146 (z) Orthopedic surgeon.
147 (aa) Orthopedist.
148 (bb) Otolologist.
149 (cc) Otolaryngologist.
150 (dd) Otorhinolaryngologist.
151 (ee) Pathologist.
152 (ff) Pediatrician.
153 (gg) Proctologist.
154 (hh) Psychiatrist.
155 (ii) Pulmonologist.



310092

156 (jj) Radiologist.

157 (kk) Rheumatologist.

158 (ll) Rhinologist.

159 (mm) Urologist.

160 (3) The board may adopt by rule additional specialist
161 titles and designations to which subsection (1) applies.

162 Section 5. Section 459.0152, Florida Statutes, is amended
163 to read:

164 459.0152 Specialties.—

165 (1) An osteopathic physician licensed under this chapter
166 may not hold himself or herself out as a board-certified
167 specialist unless the osteopathic physician has successfully
168 completed the requirements for certification by the American
169 Osteopathic Association or the Accreditation Council on Graduate
170 Medical Education and is certified as a specialist by a
171 certifying agency approved by the board. However, an osteopathic
172 physician may indicate the services offered and may state that
173 his or her practice is limited to one or more types of services
174 when this accurately reflects the scope of practice of the
175 osteopathic physician.

176 (2) Specialist titles and designations to which subsection
177 (1) applies include:

178 (a) Surgeon.

179 (b) Neurosurgeon.

180 (c) General surgeon.

181 (d) Plastic surgeon.

182 (e) Thoracic surgeon.

183 (f) Allergist.

184 (g) Anesthesiologist.



310092

- 185 (h) Cardiologist.
- 186 (i) Dermatologist.
- 187 (j) Endocrinologist.
- 188 (k) Gastroenterologist.
- 189 (l) Geriatrician.
- 190 (m) Gynecologist.
- 191 (n) Hematologist.
- 192 (o) Hospitalist.
- 193 (p) Immunologist.
- 194 (q) Intensivist.
- 195 (r) Internist.
- 196 (s) Laryngologist.
- 197 (t) Nephrologist.
- 198 (u) Neurologist.
- 199 (v) Neurologist.
- 200 (w) Obstetrician.
- 201 (x) Oncologist.
- 202 (y) Ophthalmologist.
- 203 (z) Orthopedic surgeon.
- 204 (aa) Orthopedist.
- 205 (bb) Otolologist.
- 206 (cc) Otolaryngologist.
- 207 (dd) Otorhinolaryngologist.
- 208 (ee) Pathologist.
- 209 (ff) Pediatrician.
- 210 (gg) Proctologist.
- 211 (hh) Psychiatrist.
- 212 (ii) Pulmonologist.
- 213 (jj) Radiologist.



310092

214 (kk) Rheumatologist.
215 (ll) Rhinologist.
216 (mm) Urologist.
217 (3) The board may adopt by rule additional specialist
218 titles and designations to which subsection (1) applies.
219
220 ===== T I T L E A M E N D M E N T =====

221 And the title is amended as follows:

222 Delete lines 4 - 20

223 and insert:

224 revising legislative findings; amending s. 456.065,
225 F.S.; providing circumstances under which the
226 Department of Health may issue a notice to cease and
227 desist and pursue other remedies upon finding probable
228 cause; creating s. 456.65, F.S.; prohibiting the use
229 of specified titles and designations by health care
230 practitioners not licensed as physicians or
231 osteopathic physicians, as applicable, with an
232 exception; providing that the use of such titles and
233 designations constitutes the unlicensed practice of
234 medicine or osteopathic medicine, as applicable;
235 authorizing the department to pursue specified
236 remedies for such violations; authorizing health care
237 practitioners to use names and titles, and their
238 corresponding designations and initials, authorized by
239 their respective practice acts; specifying the manner
240 in which health care practitioners may represent their
241 specialty practice areas; specifying titles and
242 abbreviations certain health care practitioners may



243

use; amending ss. 458.3312 and

By Senator Burton

12-00972-25

2025172

12-00972-25

2025172

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

31
32 Section 1. Subsection (2) of section 456.003, Florida
33 Statutes, is amended to read:

34 456.003 Legislative intent; requirements.—

35 (2) The Legislature further finds believes that such
36 professions must shall be regulated only for the preservation of
37 the health, safety, and welfare of the public under the police
38 powers of the state, and that the health, safety, and welfare of
39 the public may be harmed or endangered by the unlawful practice
40 of a profession; by a misleading, deceptive, or fraudulent
41 representation relating to a person's authority to practice a
42 profession lawfully; or when patients are uninformed about the
43 profession under which a health care practitioner is practicing
44 before receiving professional consultation or services from the
45 practitioner. As a matter of great public importance, such
46 professions must shall be regulated when:

47 (a) Their unregulated practice can harm or endanger the
48 health, safety, and welfare of the public, and when the
49 potential for such harm is recognizable and clearly outweighs
50 any anticompetitive impact which may result from regulation.

51 (b) The public is not effectively protected by other means,
52 including, but not limited to, other state statutes, local
53 ordinances, or federal legislation.

54 (c) Less restrictive means of regulation are not available.

55 Section 2. Section 456.65, Florida Statutes, is created to
56 read:

57 456.65 Specialties.—

58 (1) (a) A health care practitioner not licensed as a

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59 physician under chapter 458 may not hold himself or herself out
60 to a patient or the public at large as a specialist by
61 describing himself or herself or his or her practice through the
62 use of any specialist title or designation specifically listed
63 under s. 458.3312(2), either alone or in combination, or in
64 connection with other words, unless the practitioner is
65 authorized to use such specialist title or designation under
66 subsection (2).

67 (b) A health care practitioner not licensed as a physician
68 under chapter 459 may not hold himself or herself out to a
69 patient or the public at large as a specialist by describing
70 himself or herself or his or her practice through the use of any
71 specialist title or designation specifically listed under s.
72 459.0152(2), either alone or in combination, or in connection
73 with other words, unless the practitioner is authorized to use
74 such specialist title or designation under subsection (2).

75 (c) A violation of paragraph (a) or paragraph (b)
76 constitutes the unlicensed practice of medicine or osteopathic
77 medicine, as applicable, and the department may pursue remedies
78 under s. 456.065 for such violation.

79 (2) Notwithstanding subsection (1):

80 (a) A licensed health care practitioner may use the name or
81 title of his or her profession which is authorized under his or
82 her practice act, and any corresponding designations or initials
83 so authorized, to describe himself or herself and his or her
84 practice.

85 (b) A licensed health care practitioner who has a specialty
86 area of practice authorized under his or her practice act may
87 use the following format to identify himself or herself or

12-00972-25

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88 describe his or her practice: "...(name or title of the
89 practitioner's profession)..., specializing in ... (name of the
90 practitioner's specialty)...."

91 (c) A chiropractic physician licensed under chapter 460 may
92 use the title "chiropractic radiologist" and other titles,
93 abbreviations, or designations authorized under his or her
94 practice act reflecting those chiropractic specialty areas in
95 which the chiropractic physician has attained diplomate status
96 as recognized by the American Chiropractic Association, the
97 International Chiropractors Association, the International
98 Academy of Clinical Neurology, or the International Chiropractic
99 Pediatric Association.

100 (d) A podiatric physician licensed under chapter 461 may
101 use the following titles and abbreviations as applicable to his
102 or her license, specialty, and certification: "podiatric
103 surgeon," "Fellow in the American College of Foot and Ankle
104 Surgeons," and any other titles or abbreviations authorized
105 under his or her practice act.

106 (e) A dentist licensed under chapter 466 may use the
107 following titles and abbreviations as applicable to his or her
108 license, specialty, and certification: "doctor of dental
109 surgery," "D.D.S.," "oral surgeon," "maxillofacial surgeon,"
110 "oral and maxillofacial surgeon," "O.M.S.," "dental
111 anesthesiologist," "oral pathologist," "oral radiologist," and
112 any other titles or abbreviations authorized under his or her
113 practice act.

114 (f) An anesthesiologist assistant licensed under chapter
115 458 or chapter 459 may use only the titles "anesthesiologist
116 assistant" or "certified anesthesiologist assistant" and the

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117 abbreviation "C.A.A."

118 (3) This section may not be construed to prohibit or
119 interfere with a licensed practitioner's ability to bill
120 lawfully the Medicare program or other federal health care
121 program using definitions or terminology provided under
122 applicable federal law or regulations for services rendered to a
123 patient enrolled in such program.

124 Section 3. Section 458.3312, Florida Statutes, is amended
125 to read:

126 458.3312 Specialties.—

127 (1) A physician licensed under this chapter may not hold
128 himself or herself out as a board-certified specialist unless
129 the physician has received formal recognition as a specialist
130 from a specialty board of the American Board of Medical
131 Specialties or other recognizing agency that has been approved
132 by the board. However, a physician may indicate the services
133 offered and may state that his or her practice is limited to one
134 or more types of services when this accurately reflects the
135 scope of practice of the physician.

136 (2) Specialist titles and designations that are subject to
137 subsection (1) include:

138 (a) Surgeon.

139 (b) Neurosurgeon.

140 (c) General surgeon.

141 (d) Anesthesiologist.

142 (e) Cardiologist.

143 (f) Dermatologist.

144 (g) Endocrinologist.

145 (h) Gastroenterologist.

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- (i) Gynecologist.
- (j) Hematologist.
- (k) Hospitalist.
- (l) Intensivist.
- (m) Internist.
- (n) Laryngologist.
- (o) Nephrologist.
- (p) Neurologist.
- (q) Obstetrician.
- (r) Oncologist.
- (s) Ophthalmologist.
- (t) Orthopedic surgeon.
- (u) Orthopedist.
- (v) Otologist.
- (w) Otolaryngologist.
- (x) Otorhinolaryngologist.
- (y) Pathologist.
- (z) Pediatrician.
- (aa) Proctologist.
- (bb) Psychiatrist.
- (cc) Radiologist.
- (dd) Rheumatologist.
- (ee) Rhinologist.
- (ff) Urologist.

(3) The board may adopt by rule additional specialist titles and designations that are subject to subsection (1).

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175 (1) An osteopathic physician licensed under this chapter
176 may not hold himself or herself out as a board-certified
177 specialist unless the osteopathic physician has successfully
178 completed the requirements for certification by the American
179 Osteopathic Association or the Accreditation Council on Graduate
180 Medical Education and is certified as a specialist by a
181 certifying agency approved by the board. However, an osteopathic
182 physician may indicate the services offered and may state that
183 his or her practice is limited to one or more types of services
184 when this accurately reflects the scope of practice of the
185 osteopathic physician.

186 (2) Specialist titles and designations that are subject to
187 subsection (1) include:

- 188 (a) Surgeon.
- 189 (b) Neurosurgeon.
- 190 (c) General surgeon.
- 191 (d) Anesthesiologist.
- 192 (e) Cardiologist.
- 193 (f) Dermatologist.
- 194 (g) Endocrinologist.
- 195 (h) Gastroenterologist.
- 196 (i) Gynecologist.
- 197 (j) Hematologist.
- 198 (k) Hospitalist.
- 199 (l) Intensivist.
- 200 (m) Internist.
- 201 (n) Laryngologist.
- 202 (o) Nephrologist.
- 203 (p) Neurologist.

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- (q) Obstetrician.
- (r) Oncologist.
- (s) Ophthalmologist.
- (t) Orthopedic surgeon.
- (u) Orthopedist.
- (v) Otologist.
- (w) Otolaryngologist.
- (x) Otorhinolaryngologist.
- (y) Pathologist.
- (z) Pediatrician.
- (aa) Proctologist.
- (bb) Psychiatrist.
- (cc) Radiologist.
- (dd) Rheumatologist.
- (ee) Rhinologist.
- (ff) Urologist.

(3) The board may adopt by rule additional specialist

Section 5. This act shall take effect July 1, 2025.

25 MAR 2025

Meeting Date

Health Policy

Committee

Name

Jeff Otley FLORIDA DENTAL ASSN

Address

545 John Knox Rd

Street

Tallahassee

FL

City

32303

Zip

The Florida Senate
APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

Tab 9

SB 172

Bill Number or Topic

Amendment Barcode (if applicable)

850 224-1089

Phone

Email

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without
compensation or sponsorship.

I am a registered lobbyist,
representing:

I am not a lobbyist, but received
something of value for my appearance
(travel, meals, lodging, etc.),
sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf \(flsenate.gov\)](https://flsenate.gov/2020-2022JointRules.pdf)

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The Florida Senate

3.25.25

Meeting Date

Health Policy

Committee

Name DAVID Rambor

Phone 850-443-4444

Address 120 S. Monroe
Street

Email DavidP.Rambor@consulting.com

Tallahassee

FL

32301

City

State

Zip

Speaking: For Against Information

OR

Waive Speaking:

In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without compensation or sponsorship.

I am a registered lobbyist, representing:

Florida Optometric Association

I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf \(flsenate.gov\)](https://flsenate.gov/2020-2022JointRules.pdf)

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S-001 (08/10/2021)

3/25/20

Meeting Date

Health

Committee

Name Chris Mand

Address _____
Street _____

City _____ State _____ Zip _____

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without compensation or sponsorship.

I am a registered lobbyist, representing:

I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

Plastic Surgery Surgeons

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf \(flsenate.gov\)](https://flsenate.gov/2020-2022JointRules.pdf)

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S-001 (08/10/2021)

3.25.25

The Florida Senate

APPEARANCE RECORD

172

Bill Number or Topic

Meeting Date

Health Policy

Committee

Name

Allison Carvajal

Phone 850.321.7090

Address

120. S. Monroe

Email allison@rambaconsulting.com

Street

TLH

State

32301

Zip

City

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without compensation or sponsorship.

I am a registered lobbyist, representing:

Florida Nurse Practitioner Network

I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf](https://flsenate.gov/2020-2022JointRules.pdf) (flsenate.gov)

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S-001 (08/10/2021)

3/25/25

Meeting Date

S. Health Policy

Committee

Name David Rambau

The Florida Senate

APPEARANCE RECORD

172

Bill Number or Topic

Deliver both copies of this form to
Senate professional staff conducting the meeting

Amendment Barcode (if applicable)

850-321-7096

Address _____

Street

City

State

Zip

Phone

Email

David@rambauconsulting.com

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without
compensation or sponsorship.

I am a registered lobbyist,
representing:

I am not a lobbyist, but received
something of value for my appearance
(travel, meals, lodging, etc.),
sponsored by:

FL Optometric Association

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf \(flsenate.gov\)](https://flsenate.gov/2020-2022JointRules.pdf)

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S-001 (08/10/2021)

The Florida Senate

3/25/25

172

APPEARANCE RECORD

Meeting Date

Health

Committee

Name

ANKUSH BANSAL, MD

Phone

402-213-9376

Address

15926 Ordnado Dr.

Street

Westlake FL 33470

City

State

Zip

Email

dr.ankush2@gmail.com

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without compensation or sponsorship.

I am a registered lobbyist, representing:

I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

Florida Chapter, ACP

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf](https://www.flsenate.gov/2020-2022JointRules.pdf) (flsenate.gov)

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S-001 (08/10/2021)

3.25.25

Meeting Date

HEALTH Policy

Committee

Name Allison CARVAJALPhone 850 · 321 · 7090Address 120. S. MONRUE ST.

Street

TLH

FL.

32312

City

State

Zip

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

 I am appearing without compensation or sponsorship. I am a registered lobbyist, representing:Florida Nurse Practitioner Network I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf](https://www.flsenate.gov/2020-2022JointRules.pdf) (flsenate.gov)

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S-001 (08/10/2021)

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL: SB 7028

INTRODUCER: Health Policy Committee

SUBJECT: Cancer

DATE: March 24, 2025

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. Brown	Brown	_____	HP Submitted as Comm. Bill/Fav
_____	_____	_____	_____

I. Summary:

SB 7028 revises several aspects of the Casey DeSantis Cancer Research Program. The bill adds members to the Cancer Connect Collaborative, creates parameters for the awarding of grants through the Cancer Innovation Fund, and requires an annual report on the results of projects funded through the Cancer Innovation Fund and the performance of parties that receive the grants.

The bill creates the Cancer Connect Collaborative Research Incubator, to be overseen by the Collaborative, to provide funding for a targeted area of cancer research for a five-year period, subject to appropriation. The bill provides parameters for the awarding of funds through the Incubator and requires annual reports.

The bill creates a new cancer research effort by establishing the Bascom Palmer Eye Institute VisionGen Initiative, subject to appropriation, and provides that the purpose of the initiative is to advance genetic and epigenetic research on inherited eye diseases and ocular oncology.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

Florida Cancer Research Programs

The Legislature funds cancer research in Florida through four main programs: William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program (Bankhead-Coley program), the Casey DeSantis Cancer Research Program (Casey DeSantis Program), Live Like Bella Initiative – Pediatric Cancer Research Program, and the Cancer Innovation Fund. Currently, \$200.5 million is appropriated annually for these research programs as follows:¹

¹ Chapter 2024-231, Laws of Fla. See specific appropriations 456C, 457A, 457C, and 457B, respectively.

- Bankhead-Coley – \$10 million Biomedical Trust Fund
- Casey DeSantis Cancer Research Program – \$127.5 million (\$111.1 General Revenue; \$16.4 Trust Fund)
- Live Like Bella Initiative – \$3 million Biomedical Trust Fund
- Florida Cancer Innovation Fund – \$60 million Biomedical Research Trust Fund

William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program

In 2006, the Legislature created the William G. “Bill” Bankhead, Jr., and David Coley Cancer Research Program to advance progress toward cures for cancer through grants awarded through a peer-reviewed, competitive process.²

The program provides grants for cancer research to further the search for cures for cancer, by pursuing the following goals:³

- Significantly expand cancer research capacity in Florida.
- Improve both research and treatment through greater pediatric and adult participation in clinical trials networks.
- Reduce the impact of cancer on disproportionately impacted individuals.

Currently, the Bankhead-Coley Program is funded at \$10 million annually.⁴

The Casey DeSantis Cancer Research Program

In 2014, the Legislature created the Florida Consortium of National Cancer Institute Centers Program, which was renamed as the Casey DeSantis Cancer Research Program in 2022. The Casey DeSantis Program was established to:⁵

- Enhance the quality and competitiveness of cancer care in Florida;
- Further a statewide biomedical research strategy directly responsive to the health needs of Florida’s citizens; and
- Capitalize on potential educational opportunities available to students.

The Florida Department of Health (DOH) is required to make payments to cancer centers recognized by the NCI as NCI-designated comprehensive cancer centers, cancer centers, and cancer centers working toward achieving NCI designation.⁶

The NCI designates institutions as:⁷

- Comprehensive Cancer Centers – focused on substantial transdisciplinary research that bridges all cancer-related research areas;
- Cancer Centers – focused on one research area such as clinical, prevention, cancer control or population science research; or

² Section 381.922(1), F.S.

³ Section 381.922(2), F.S.

⁴ Chapter 2024-231, Laws of Fla. See specific appropriation 456C.

⁵ Section 381.915(2), F.S.

⁶ *Id.*

⁷ National Cancer Institute, NCI-Designated Cancer Centers, *available at:*

<https://www.cancer.gov/research/infrastructure/cancer-centers> (last visited Mar. 21, 2025).

- Basic Laboratory Cancer Centers – focused on laboratory research and work collaboratively with other institutions.

A participating cancer center's annual allocation of funds is determined by a statutory tier-weighted formula that factors in a cancer center's reportable cancer cases; peer-review costs; and biomedical education and training.⁸ The tier designations are weighted based on the participating cancer center's NCI-designation status. The program's three-tier designations are:⁹

- Tier 1: NCI-designated comprehensive cancer centers;
- Tier 2: NCI-designated cancer centers; and
- Tier 3: Cancer centers seeking NCI designation and meeting additional criteria related to their research and biomedical education.

Currently, there are two NCI-designed comprehensive cancer centers and two NCI-designated cancer centers in Florida:¹⁰

- H. Lee Moffitt Cancer Center – Comprehensive Cancer Center
- Mayo Clinic Cancer Center – Comprehensive Cancer Center
- The University of Florida (UF) Health Shands Cancer Hospital – Cancer Center
- University of Miami (UM) Sylvester Cancer Center – Cancer Center

See chart below for the NCI-designed cancer center funding history of the Casey DeSantis Program:

	FY 20-21	FY 21-22	FY 22-23	FY 23-24	FY 24-25
H. Lee Moffitt	\$ 24,911,553	\$ 23,313,325	\$ 39,368,392	\$ 38,060,795	\$ 39,620,622
Mayo Clinic	N/A	N/A	N/A	\$ 23,314,286	\$ 23,314,286
UF Health Shands Cancer Hospital	\$ 20,722,858	\$ 22,321,087	\$ 30,721,560	\$ 37,135,352	\$ 35,219,873
UM Sylvester Cancer Center	\$ 16,594,331	\$ 16,595,331	\$ 29,910,047	\$ 28,989,567	\$ 29,345,219
Total	\$ 62,228,742	\$ 62,229,743	\$ 99,999,999	\$ 127,500,000	\$ 127,500,000

Starting July 1, 2025, the DOH, in conjunction with participating cancer centers, must provide an annual report to the Cancer Control and Research Advisory Council (CCRAB) by July 1. The report must include the following:¹¹

- An analysis of trending age-adjusted cancer mortality rates in the state by age group, geographic region, and type of cancer.
- Identification of trends in overall federal funding, broken down by institutional source, for cancer-related research in the state.

⁸ Section 381.915(3), F.S.

⁹ Section 381.915(4), F.S.

¹⁰ National Cancer Institute, NCI-Designated Cancer Centers, “Find a Cancer Centers” directory, *available at: <https://www.cancer.gov/research/infrastructure/cancer-centers/find>* (last visited Mar. 21, 2025).

¹¹ Section 381.915(10), F.S. Prior to 2025, the report was required once every three years.

- A list and narrative description of collaborative grants and interinstitutional collaboration among participating cancer centers, a comparison of collaborative grants in proportion to the grant totals for each cancer center, a catalog of retreats and progress seed grants using state funds, and targets for collaboration in the future and reports on progress regarding such targets where appropriate.

Live Like Bella Initiative – Pediatric Cancer Research

The Live Like Bella Pediatric Cancer Research Initiative was established to advance progress toward curing pediatric cancer through grants awarded through a peer-reviewed, competitive process.¹² The Initiative will provide grants for research to further the search for cures for pediatric cancer, by pursuing the following goals to:¹³

- Significantly expand pediatric cancer research capacity in Florida.
- Improve both research and treatment through greater pediatric enrollment in clinical trial networks.
- Reduce the impact of pediatric cancer on disproportionately impacted individuals.

Currently, the Live Like Bella Initiative is funded with \$3 million annually.¹⁴

Florida Cancer Innovation Fund

The Florida Cancer Innovation Fund was established in Fiscal Year 2023-2024 to fund projects focused on innovative research in cancer care and treatment. The funding aims to provide opportunities to break down longstanding silos between researchers, cancer facilities, and medical providers to improve cancer research and treatment through innovative approaches to data infrastructure and best practices.¹⁵ Funding is limited to Florida-based institutions.

The projects funded through Cancer Innovation Fund grant awards are required to focus on at least one of three goal areas below:¹⁶

- Data – to identify the reasons data is slow to move or hard to access and ways to dismantle those barriers.
- Best Practices – to streamline, encourage, and incentivize the sharing of treatment best practices among public and private entities.
- Innovation – to make advancements in cutting-edge technology and clinical treatments.

Currently, the Cancer Innovation Fund is appropriated \$60 million annually.¹⁷

¹² Section 381.922(2), F.S.

¹³ Department of Health, Biomedical Research Program Funding Announcement, Fiscal Year 2023-2024, *available at: <https://www.floridahealth.gov/provider-and-partner-resources/research/funding-opportunity-announcements/BRACFOAApprovedFINAL.pdf>* (last visited Mar. 21, 2025).

¹⁴ Chapter 2024-231, Laws of Fla. See specific appropriations 457C.

¹⁵ Department of Health, Funding Opportunity Announcement, The Florida Cancer Innovation Fund, *available at <https://www.floridahealth.gov/provider-and-partner-resources/research/florida-cancer-innovation-fund/index.html>* (last visited Mar. 21, 2025).

¹⁶ *Id.*

¹⁷ Chapter 2024-231, Laws of Fla. See specific appropriation 457B.

Florida Cancer Control and Research Advisory Council (CCRAB)

The Florida Cancer Control Research Advisory Council was established by the Legislature as an advisory body appointed to function on a continuing basis for the study of cancer and to make recommendations on solutions and policy alternatives to the Board of Governors and the State Surgeon General.¹⁸ The CCRAB closely monitors Florida's cancer burden and recommends changes in policies, systems, and environments that lead to improved prevention, early detection, high-quality treatment, and increased cancer survival rates.¹⁹

The Council consists of 16 members:²⁰

- The State Surgeon General or his or her designee within the DOH;
- A representative of the H. Lee Moffitt Cancer Center and Research Institute, Inc.;
- A representative of the Sylvester Comprehensive Cancer Center of the University of Miami;
- A representative of the University of Florida Shands Cancer Center;
- A representative of the Mayo Clinic in Jacksonville;
- A representative of the American Cancer Society;
- A representative of the Association of Community Cancer Centers;
- A member of the Florida Hospital Association who specializes in the field of oncology;
- A member of the Florida Medical Association who specializes in the field of oncology;
- A representative of the Florida Nurses Association who specializes in the field of oncology;
- A representative of the Florida Osteopathic Medical Association who specializes in the field of oncology;
- A specialist in pediatric oncology research or clinical care appointed by the Governor;
- A specialist in oncology clinical care or research appointed by the President of the Senate;
- A current or former cancer patient or a current or former caregiver to a cancer patient appointed by the Speaker of the House of Representatives;
- A member of the House of Representatives appointed by the Speaker of the House of Representatives; and
- A member of the Senate appointed by the President of the Senate.

CCRAB members serve four-year terms.²¹

Florida Cancer Connect Collaborative

Established in 2023, the Florida Cancer Connect Collaborative²² (Collaborative) is an initiative begun by First Lady Casey DeSantis in partnership with the DOH and the Agency for Health Care Administration. It was created by executive action of the Governor. The Collaborative originated as a team composed of medical professionals and government officials to analyze

¹⁸ Section 1004.435, F.S.

¹⁹ Florida Cancer Control and Research Advisory Council, CCRAB Annual Report 2024, The State of Cancer in Florida, available at: https://www.ccrab.org/_cache/files/c/3/c388cd5a-94e1-4342-b946-d21f872724cc/72B5F6981BBF2571E5C3B73AF0DC1169.2024ccrab-annualreport-final.pdf (last visited Mar. 21, 2025).

²⁰ Section 1004.435(4), F.S.

²¹ Section 1004.435(4), F.S.

²² The Cancer Connect Collaborative is an expansion of Cancer Connect, an initiative launched by First Lady Casey DeSantis in August 2022 to provide cancer information and survivor stories.

Florida's approach to combatting cancer. The original goal of the Collaborative was to break down long-standing silos between researchers, cancer facilities, and medical providers to improve cancer research and treatment. When first created, according to the Governor and First Lady, the Collaborative had five main objectives:²³

- Data – The Collaborative will seek to identify the reasons data is slow to move or hard to access and dismantle those barriers.
- Best practices – The Collaborative will seek to streamline, encourage and incentivize the sharing of treatment best practices among public and private entities so that everyone is treated with the most effective treatment possible.
- Innovation – The Collaborative will identify the reasons that technology gets held up — whether it be special interests, over-litigiousness or bureaucratic red tape — and recommend ways to eliminate these barriers.
- Funding – The Collaborative will provide recommendations for the implementation of the Governor's proposed \$170 million in funding to improve the pace of cancer research and novel technologies.
- Honesty – The Collaborative will be tasked with identifying the ways to ensure cancer causes, treatment, prevention, and diagnosis information is available and easy to access.

In 2024, the Legislature codified the Collaborative in Florida law through an amendment to s. 381.915, F.S.,²⁴ which houses statutes relating to the Casey DeSantis Program. The 2024 law revised the mission of the Casey DeSantis Program to include a goal of promoting “the provision of high-quality, innovative health care for persons undergoing cancer treatment in this state” and to “make cancer innovation grant funding available through the Cancer Innovation Fund to health care providers and facilities that demonstrate excellence in patient-centered cancer treatment or research.”

The Collaborative is now a council²⁵ as defined in s. 20.03, F.S., created within the DOH to advise the department and the Legislature on developing a holistic approach to the state's efforts to fund cancer research, cancer facilities, and treatments for cancer patients. The Collaborative is authorized to make recommendations on proposed legislation, proposed rules, best practices, data collection and reporting, issuance of grant funds, and other proposals for state policy relating to cancer research or treatment.

The Collaborative is chaired by the State Surgeon General who serves as an ex officio, non-voting member. The remaining membership of the Collaborative is composed as follows, all of whom are voting members:

- Two members appointed by the Governor, one member appointed by the President of the Senate, and one member appointed by the Speaker of the House of Representatives, prioritizing their appointments on members who have the following experience or expertise:

²³ Florida Governor Ron DeSantis, First Lady Casey DeSantis Announces the Cancer Connect Collaborative to Explore Innovative Strategies for Cancer Treatment and Care, available at: <https://www.flgov.com/2023/02/23/first-lady-casey-DeSantis-announces-the-cancer-connect-collaborative-to-explore-innovative-strategies-for-cancer-treatment-and-care/> (last visited Mar. 21, 2025).

²⁴ See ch. 2024-247, Laws of Florida.

²⁵ Section 20.03, F.S., defines a “council” or an “advisory council” as an advisory body created by specific statutory enactment and appointed to function on a continuing basis for the study of the problems arising in a specified functional or program area of state government and to provide recommendations and policy alternatives.

- The practice of a health care profession specializing in oncology clinical care or research;
- The development of preventive and therapeutic treatments to control cancer;
- The development of innovative research into the causes of cancer, the development of effective treatments for persons with cancer, or cures for cancer; or
- Management-level experience with a cancer center licensed under ch. 395, F.S.
- A Florida resident who can represent the interests of cancer patients in this state, appointed by the Governor.

Members of the Collaborative have staggered terms, and vacancies are to be filled in the same manner as first appointed. Members serve without compensation but are entitled to reimbursement for per diem and travel expenses pursuant to s. 112.061, F.S.

The Collaborative meets as necessary, but at least quarterly, at the call of the chair. A majority of the members of the Collaborative constitute a quorum, and a meeting may not be held with less than a quorum present. To establish a quorum, the Collaborative may conduct its meetings through teleconference or other electronic means. The DOH is required to provide reasonable and necessary support staff and materials to assist the Collaborative in the performance of its duties.

The Collaborative was required in 2024 to develop a long-range comprehensive plan for the Casey DeSantis Program and solicit input from cancer centers, research institutions, biomedical education institutions, hospitals, and medical providers. The long-range plan was required to be submitted to the President of the Senate, the Speaker of the House of Representatives, and the Executive Office of the Governor no later than December 1, 2024,²⁶ to include, but not be limited to, the following components:

- Expansion of grant funding opportunities to include a broader pool of Florida-based cancer centers, research institutions, biomedical education institutions, hospitals, and medical providers to receive funding through the Cancer Innovation Fund.
- An evaluation to determine metrics that focus on patient outcomes, quality of care, and efficacy of treatment.
- A compilation of best practices relating to cancer research or treatment.

The Collaborative must advise the DOH on the awarding of grants issued through the Cancer Innovation Fund. During any fiscal year for which funds are appropriated, the Collaborative must recommend to the DOH the awarding of grants to support innovative cancer research and treatment models, including emerging research and treatment trends and promising treatments that may serve as catalysts for further research and treatments. The Collaborative is directed to give priority to applications seeking to expand the reach of innovative cancer treatment models into underserved areas of the state. The Collaborative must review all grant applications and make grant funding recommendations to the DOH, and the DOH is directed under the bill to make final grant allocation awards.

²⁶ The long-range plan was completed and submitted as required by statute. It is *available at*: <https://www.floridahealth.gov/provider-and-partner-resources/research/index1.html> (last visited Mar. 21, 2025).

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 381.915, F.S., to make several revisions to the Casey DeSantis Program.

Definitions

The bill revises the definition of “Florida-based” to specify that in order for health care providers and facilities to meet the definition, such an entity must be physically located in Florida and provide services in Florida.

The Collaborative

The bill provides that the President of the Senate and the Speaker of the House of Representatives each have three appointments to the membership of the Collaborative, instead of one apiece as under current law. This results in the Governor and the Legislature’s presiding officers each having three appointments.

The bill deletes the obsolete requirement for the Collaborative to develop and submit a long-range comprehensive plan for the Casey DeSantis Program by December 1, 2024.

Cancer Innovation Fund

The bill creates parameters for the awarding of grants through the Cancer Innovation Fund, including:

- A new criterion for applications that will get priority during the Collaborative’s review of proposals for grant funding. The new priority criterion will be applications having the goal to expand the reach of cancer screening efforts into underserved areas.
- A list of criteria that grant applicants must meet in order to be eligible. Under the bill, an eligible applicant must:
 - Operate as a licensed hospital that has a minimum of 30 percent of current cancer patients that reside in rural or underserved areas;
 - Operate as a licensed health care clinic or facility that employs or contracts with at least one Florida-licensed allopathic or osteopathic physician who is board-certified in oncology and that delivers chemotherapy treatments for cancer;
 - Operate as a licensed facility that employs or contracts with at least one Florida-licensed allopathic or osteopathic physician who is board-certified in oncology and that delivers radiation therapy treatments for cancer;
 - Operate as a licensed health care clinic or facility that provides cancer screening services at no cost or a minimal cost to patients;
 - Operate as a rural hospital as defined in s. 395.602(2)(b), F.S.;
 - Operate as a critical access hospital as defined in s. 408.07(14), F.S.;
 - Operate as a specialty hospital as defined in s. 395.002(28)(a), F.S., that provides cancer treatment for patients from birth to 18 years old;
 - Engage in biomedical research intended to develop therapies, medical pharmaceuticals, treatment protocols, or medical procedures intended to cure cancer or improve the quality of life of cancer patients; or

- Educate or train students, post-doctoral fellows, or licensed or certified health care practitioners in the screening, diagnosis, or treatment of cancer.
- A requirement that, for ensuring all proposals are appropriate and are evaluated fairly on the basis of scientific merit, the DOH must appoint peer review panels of independent, scientifically qualified individuals to review the scientific merit of each proposal and establish a priority score. The priority scores must be forwarded to the Collaborative and must be considered in determining which proposals the Collaborative recommends for grant funding. The bill requires members of the Collaborative and the panels to establish and follow rigorous guidelines for ethical conduct and adhere to a strict policy regarding conflicts of interest.
- A requirement for the Collaborative to prepare a report for the Governor, President of the Senate, and Speaker of the House of Representatives by December 1 each year, starting in 2025, that identifies and evaluates performance and the effects of grants issued through the Cancer Innovation Fund on cancer treatment, research, screening, diagnosis, prevention, practitioner and workforce education, and survivorship. The report must include the following:
 - Amounts of grant funds awarded to each awardee.
 - Descriptions of each awardee's research or project that includes, but need not be limited to: goals or projected outcomes, population to be served, and research methods or project implementation plan.
 - An assessment of awardees of grant funds that evaluates performance toward achieving objectives specified in their grant funds applications.
 - Recommendations for best practices that may be implemented by health care providers in this state that diagnose, treat, and screen for cancer, based on the outcomes of projects funded through the Cancer Innovation Fund.

Annual Report to the CCRAB

For the report that the DOH, in conjunction with participating NCI-designated cancer centers, must provide to the CCRAB by July 1 each year, the bill requires the report to include a description of the numbers and types of cancer cases seen annually at each participating cancer center.

The Cancer Connect Collaborative Research Incubator

The bill provides Legislative findings and creates the Cancer Connect Collaborative Research Incubator (Incubator) within the DOH, to be overseen by the Collaborative, to provide funding for a targeted area of cancer research for a five-year period. For the five-year period beginning July 1, 2025, the bill provides that the Incubator's targeted area of cancer research will be pediatric cancer.

Contingent on the appropriation of funds, grants issued through the Incubator will be awarded through a peer-reviewed, competitive process. Emphasis will be given to applicants that focus on improving both research and treatment through greater participation in clinical trials that pertain to the targeted area of cancer research, including:

- Identifying ways to increase enrollment in cancer clinical trials;

- Supporting public and private professional education programs designed to increase the awareness and knowledge about cancer clinical trials;
- Providing tools to cancer patients and community-based oncologists to aid in the identification of cancer clinical trials available in the state; and
- Creating opportunities for the state's academic cancer centers to collaborate with community-based oncologists in cancer clinical trials networks.

Preference for Incubator funding may be given to grant proposals that foster collaborations among institutions, researchers, and community practitioners, to support the advancement of cures through basic or applied research, including clinical trials involving cancer patients and related networks.

The bill provides that applications for Incubator funding may be submitted by any Florida-based specialty hospital as defined in s. 395.002(28)(a), F.S., that provides cancer treatment for patients from birth to 18 years old. All qualified applicants are to have equal access and opportunity to compete for the research funding. Incubator grants will be recommended by the Collaborative and awarded by the DOH on the basis of scientific merit, as determined by a competitively open and peer-reviewed process to ensure objectivity, consistency, and high quality.

To ensure that all proposals for research funding through the Incubator are appropriate and are evaluated fairly on the basis of scientific merit, the DOH is directed by the bill to appoint peer review panels of independent, scientifically qualified individuals to review the scientific merit of each proposal and establish its priority score. The priority scores will be forwarded to the Collaborative and must be considered in determining which proposals the Collaborative recommends for funding.

The Collaborative and the panels are directed by the bill to establish and follow rigorous guidelines for ethical conduct and adhere to a strict policy with regard to conflicts of interest regarding the assessment of Incubator grant applications. A member of the Collaborative or a panel may not participate in any discussion or decision of the Collaborative or a panel with respect to a research proposal by any firm, entity, or agency with which the member is associated as a member of the governing body or as an employee or with which the member has entered into a contractual arrangement.

Each recipient of Incubator grant funds must enter into an allocation agreement with the DOH, and each allocation agreement must include all of the following:

- A line-item budget narrative documenting the annual allocation of funds to a recipient.
- A cap on the annual award of 15 percent for administrative expenses.
- A requirement for the recipient to submit quarterly reports of all expenditures made by the recipient with funds received through the Incubator.
- A provision to allow the department and other state auditing bodies to audit all financial records, supporting documents, statistical records, and any other documents pertinent to the allocation agreement.
- A provision requiring the annual reporting of outcome data and protocols used in achieving those outcomes.

The bill requires that, beginning December 1, 2026, and annually through December 1, 2030, the Collaborative must submit a report to the Governor, President of the Senate, and Speaker of the House of Representatives that evaluates research conducted through the Incubator and provides details on outcomes and findings available through the end of the fiscal year immediately preceding each report.

The bill provides that if the Collaborative decides to recommend that the Incubator be extended beyond its five-year lifespan, the Collaborative is directed to make such recommendation in the report due December 1, 2029, and to include a recommendation for the next targeted area of cancer research. The report due on December 1, 2030, must include:

- Details of all results of the research conducted with Incubator funding that has been completed or the status of research in progress; and
- An evaluation of all research conducted with Incubator funding during the five fiscal years preceding the report.

Section 2 of the bill amends s. 381.922, F.S., to create a new cancer research initiative within the Bankhead-Coley program. The bill establishes the Bascom Palmer Eye Institute VisionGen Initiative and provides that the purpose of the initiative is to advance genetic and epigenetic research on inherited eye diseases and ocular oncology by awarding grants through the peer-reviewed, competitive process statutorily-required under the Bankhead-Coley program. The initiative is subject to the annual appropriation of funds by the Legislature.

Section 3 of the bill provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:**A. Tax/Fee Issues:**

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The DOH may experience an increased workload under the bill to fulfill its requirement under current law to provide reasonable and necessary support staff and materials to assist the Collaborative in the performance of the Collaborative's duties and to manage additional biomedical research grants.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.915 and 381.922.

IX. Additional Information:**A. Committee Substitute – Statement of Changes:**

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

None.

B. Amendments:

None.

FOR CONSIDERATION By the Committee on Health Policy

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30 requirements for a specified report by the department;
31 requiring, beginning on a specified date, that certain
32 allocation agreements include certain information;
33 providing legislative findings; creating the Cancer
34 Connect Collaborative Research Incubator within the
35 department, and overseen by the collaborative, to
36 provide funding for a specified purpose over a
37 specified timeframe; specifying the incubator's
38 targeted area of cancer research for the first
39 specified timeframe; providing that grants issued
40 through the incubator are contingent upon the
41 appropriation of funds and must be awarded through a
42 specified process; requiring that priority be given to
43 certain applicants; authorizing the prioritization of
44 certain grant proposals; providing that applications
45 for incubator funding may be submitted by specified
46 hospitals; requiring that all qualified applicants
47 have equal access and opportunity to compete for
48 research funding; requiring that incubator grants be
49 recommended by the collaborative and awarded by the
50 department in a certain manner; requiring the
51 department to appoint peer review panels for a
52 specified purpose; requiring that priority scores be
53 forwarded to the collaborative and be considered in
54 determining which proposals the collaborative
55 recommends for funding; requiring the collaborative
56 and peer review panels to establish and follow certain
57 guidelines and adhere to a certain policy; prohibiting
58 a member of the collaborative or a panel from

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59 participating in certain discussions or decisions;
60 requiring recipients of incubator grant funds to enter
61 into an allocation agreement with the department;
62 specifying requirements for such allocation
63 agreements; requiring, beginning on a specified date
64 and annually until a specified date, the collaborative
65 to prepare and submit a specified report to the
66 Governor and the Legislature; requiring the
67 collaborative to make a certain recommendation under
68 certain circumstances; requiring that a specified
69 report include certain information; amending s.
70 381.922, F.S.; establishing the Bascom Palmer Eye
71 Institute VisionGen Initiative within the William G.
72 "Bill" Bankhead, Jr., and David Coley Cancer Research
73 Program; providing the purpose of the initiative;
74 providing that funding for the initiative is subject
75 to annual appropriation; providing an effective date.
76

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

78

79 Section 1. Present paragraphs (c), (d), and (e) of
80 subsection (3) and present subsections (12) and (13) of section
81 381.915, Florida Statutes, are redesignated as paragraphs (d),
82 (e), and (f) of subsection (3) and subsections (13) and (14),
83 respectively, a new paragraph (c) is added to subsection (3),
84 paragraph (d) is added to subsection (10), a new subsection (12)
85 is added to that section, and paragraph (b) and present
86 paragraph (c) of subsection (3), paragraphs (a), (b), (e), (f),
87 and (h) of subsection (8), and subsections (9) and (11) of that

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88 section are amended, to read:

89 381.915 Casey DeSantis Cancer Research Program.—

90 (3) On or before September 15 of each year, the department
91 shall calculate an allocation fraction to be used for
92 distributing funds to participating cancer centers. On or before
93 the final business day of each quarter of the state fiscal year,
94 the department shall distribute to each participating cancer
95 center one-fourth of that cancer center's annual allocation
96 calculated under subsection (6). The allocation fraction for
97 each participating cancer center is based on the cancer center's
98 tier-designated weight under subsection (4) multiplied by each
99 of the following allocation factors based on activities in this
100 state: number of reportable cases, peer-review costs, and
101 biomedical education and training. As used in this section, the
102 term:

103 (b) "Cancer center" means a comprehensive center with at
104 least one geographic site in the state, a freestanding center
105 located in the state, a center situated within an academic
106 institution, or a Florida-based formal research-based consortium
107 under centralized leadership that has achieved NCI designation
108 ~~or is prepared to achieve NCI designation by June 30, 2024.~~

109 (c) "Cancer Connect Collaborative" or "collaborative" means
110 the council created under subsection (8).

111 (d) ~~(e)~~ "Florida-based" means that a cancer center's actual
112 or sought designated status is or would be recognized by the NCI
113 as primarily located in Florida and not in another state, or
114 that a health care provider or facility is physically located in
115 Florida and provides services in Florida.

116 (8) The Cancer Connect Collaborative, a council as defined

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117 in s. 20.03, is created within the department to advise the
118 department and the Legislature on developing a holistic approach
119 to the state's efforts to fund cancer research, cancer
120 facilities, and treatments for cancer patients. The
121 collaborative may make recommendations on proposed legislation,
122 proposed rules, best practices, data collection and reporting,
123 issuance of grant funds, and other proposals for state policy
124 relating to cancer research or treatment.

125 (a) The Surgeon General shall serve as an ex officio,
126 nonvoting member of the collaborative and shall serve as the
127 chair.

128 (b) The collaborative shall be composed of the following
129 voting members, ~~to be appointed by September 1, 2024~~:

130 1. Two members appointed by the Governor, three members ~~one~~
131 ~~member~~ appointed by the President of the Senate, and three
132 members ~~one member~~ appointed by the Speaker of the House of
133 Representatives, based on the criteria of this subparagraph. The
134 appointing officers shall make their appointments prioritizing
135 members who have the following experience or expertise:

136 a. The practice of a health care profession specializing in
137 oncology clinical care or research;

138 b. The development of preventive and therapeutic treatments
139 to control cancer;

140 c. The development of innovative research into the causes
141 of cancer, the development of effective treatments for persons
142 with cancer, or cures for cancer; or

143 d. Management-level experience with a cancer center
144 licensed under chapter 395.

145 2. One member who is a resident of this state who can

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146 represent the interests of cancer patients in this state,
147 appointed by the Governor.

148 (e) Members of the collaborative whose terms have expired
149 may continue to serve until replaced or reappointed, but for no
150 more than 6 months after the expiration of their terms.

151 (f) Members of the collaborative shall serve without
152 compensation but are entitled to reimbursement for per diem and
153 travel expenses pursuant to s. 112.061.

154 (h) ~~The collaborative shall develop a long-range
155 comprehensive plan for the Casey DeSantis Cancer Research
156 Program. In the development of the plan, the collaborative must
157 solicit input from cancer centers, research institutions,
158 biomedical education institutions, hospitals, and medical
159 providers. The collaborative shall submit the plan to the
160 Governor, the President of the Senate, and the Speaker of the
161 House of Representatives no later than December 1, 2024. The
162 plan must include, but need not be limited to, all of the
163 following components:~~

164 1. ~~Expansion of grant fund opportunities to include a
165 broader pool of Florida-based cancer centers, research
166 institutions, biomedical education institutions, hospitals, and
167 medical providers to receive funding through the Cancer
168 Innovation Fund.~~

169 2. ~~An evaluation to determine metrics that focus on patient
170 outcomes, quality of care, and efficacy of treatment.~~

171 3. ~~A compilation of best practices relating to cancer
172 research or treatment.~~

173 (9) (a) The collaborative shall advise the department on the
174 awarding of grants issued through the Cancer Innovation Fund.

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175 During any fiscal year for which funds are appropriated to the
176 fund, the collaborative shall review all submitted grant
177 applications using the parameters provided in paragraph (c) and
178 make recommendations to the department for awarding grants to
179 support innovative cancer research and treatment models,
180 including emerging research and treatment trends and promising
181 treatments that may serve as catalysts for further research and
182 treatments. The department shall make the final grant allocation
183 awards. The collaborative shall give priority to applications
184 seeking to expand the reach of cancer screening efforts and
185 innovative cancer treatment models into underserved areas of
186 this state.

187 (b) To be eligible for grant funding under this section, a
188 licensed or certified health care provider, facility, or entity
189 must meet at least one of the following criteria:

190 1. Operates as a licensed hospital that has a minimum of 30
191 percent of its current cancer patients residing in rural or
192 underserved areas.

193 2. Operates as a licensed health care clinic or facility
194 that employs or contracts with at least one physician licensed
195 under chapter 458 or chapter 459 who is board certified in
196 oncology and that administers chemotherapy treatments for
197 cancer.

198 3. Operates as a licensed facility that employs or
199 contracts with at least one physician licensed under chapter 458
200 or chapter 459 who is board certified in oncology and that
201 administers radiation therapy treatments for cancer.

202 4. Operates as a licensed health care clinic or facility
203 that provides cancer screening services at no cost or a minimal

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204 cost to patients.205 5. Operates as a rural hospital as defined in s.206 395.602(2)(b).207 6. Operates as a critical access hospital as defined in s.208 408.07(14).209 7. Operates as a specialty hospital as defined in s.210 395.002(28)(a) which provides cancer treatment for patients from
211 birth to 18 years of age.212 8. Engages in biomedical research intended to develop
therapies, medical pharmaceuticals, treatment protocols, or
214 medical procedures intended to cure cancer or improve the
215 quality of life of cancer patients.216 9. Educates or trains students, postdoctoral fellows, or
217 licensed or certified health care practitioners in the
218 screening, diagnosis, or treatment of cancer.219 (c) To ensure that all proposals for grant funding issued
220 through the Cancer Innovation Fund are appropriate and are
221 evaluated fairly on the basis of scientific merit, the
222 department shall appoint peer review panels of independent,
223 scientifically qualified individuals to review the scientific
224 merit of each proposal and establish its priority score. The
225 priority scores must be forwarded to the collaborative and must
226 be considered in determining which proposals the collaborative
227 recommends for grant funding through the Cancer Innovation Fund.228 (d) The collaborative and the peer review panels shall
229 establish and follow rigorous guidelines for ethical conduct and
230 adhere to a strict policy with regard to conflicts of interest
231 regarding the assessment of Cancer Innovation Fund grant
232 applications. A member of the collaborative or a panel may not

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233 participate in any discussion or decision of the collaborative
234 or a panel with respect to a research proposal by any firm,
235 entity, or agency with which the member is associated as a
236 member of the governing body or as an employee or with which the
237 member has entered into a contractual arrangement.

238 (e) Beginning December 1, 2025, and annually thereafter,
239 the collaborative shall prepare and submit a report to the
240 Governor, the President of the Senate, and the Speaker of the
241 House of Representatives which identifies and evaluates the
242 performance and the impact of grants issued through the Cancer
243 Innovation Fund on cancer treatment, research, screening,
244 diagnosis, prevention, practitioner training, workforce
245 education, and cancer patient survivorship. The report must
246 include all of the following:

247 1. Amounts of grant funds awarded to each recipient.
248 2. Descriptions of each recipient's research or project
249 which include, but need not be limited to, the following:
250 a. Goals or projected outcomes.
251 b. Population to be served.
252 c. Research methods or project implementation plan.
253 3. An assessment of grant recipients which evaluates their
254 progress toward achieving objectives specified in each
255 recipient's grant application.

256 4. Recommendations for best practices that may be
257 implemented by health care providers in this state who diagnose,
258 treat, and screen for cancer, based on the outcomes of projects
259 funded through the Cancer Innovation Fund.

260 (10) Beginning July 1, 2025, and each year thereafter, the
261 department, in conjunction with participating cancer centers,

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262 shall submit a report to the Cancer Control and Research
263 Advisory Council and the collaborative on specific metrics
264 relating to cancer mortality and external funding for cancer-
265 related research in this state. If a cancer center does not
266 endorse this report or produce an equivalent independent report,
267 the cancer center is ineligible to receive program funding for 1
268 year. The department must submit this annual report, and any
269 equivalent independent reports, to the Governor, the President
270 of the Senate, and the Speaker of the House of Representatives
271 no later than September 15 of each year the report or reports
272 are submitted by the department. The report must include:

273 (d) A description of the numbers and types of cancer cases
274 treated annually at each participating cancer center, including
275 reportable and nonreportable cases.

276 (11) Beginning July 1, 2025 ~~2024~~, each allocation agreement
277 issued by the department relating to cancer center payments
278 under paragraph (2) (a) ~~subsection (2)~~ must include all of the
279 following:

280 (a) A line-item budget narrative documenting the annual
281 allocation of funds to a cancer center.

282 (b) A cap on the annual award of 15 percent for
283 administrative expenses.

284 (c) A requirement for the cancer center to submit quarterly
285 reports of all expenditures made by the cancer center with funds
286 received through the Casey DeSantis Cancer Research Program.

287 (d) A provision to allow the department and other state
288 auditing bodies to audit all financial records, supporting
289 documents, statistical records, and any other documents
290 pertinent to the allocation agreement.

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(e) A provision requiring the annual reporting of outcome data and protocols used in achieving those outcomes.

(12) (a) The Legislature finds that targeted areas of cancer research require increased resources and that Florida should become a leader in promoting research opportunities for these targeted areas. Floridians should not have to leave the state to receive the most advanced cancer care and treatment. To meet this need, the Cancer Connect Collaborative Research Incubator, or "incubator" as used in this subsection, is created within the department, to be overseen by the collaborative, to provide funding for a targeted area of cancer research over a 5-year period. For the 5-year period beginning July 1, 2025, the incubator's targeted area of cancer research is pediatric cancer.

(b) Contingent upon the appropriation of funds by the Legislature, grants issued through the incubator must be awarded through a peer-reviewed, competitive process. Priority must be given to applicants that focus on enhancing both research and treatment by increasing participation in clinical trials related to the targeted area of cancer research, including all of the following:

1. Identifying strategies to increase enrollment in cancer clinical trials.

2. Supporting public and private professional education programs to raise awareness and knowledge about cancer clinical trials.

3. Providing tools for cancer patients and community-based oncologists to help identify available cancer clinical trials in this state.

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320 4. Creating opportunities for the state's academic cancer
321 centers to collaborate with community-based oncologists in
322 cancer clinical trial networks.

323 (c) Priority may be given to grant proposals that foster
324 collaborations among institutions, researchers, and community
325 practitioners to support the advancement of cures through basic
326 or applied research, including clinical trials involving cancer
327 patients and related networks.

328 (d) Applications for incubator funding may be submitted by
329 any Florida-based specialty hospital as defined in s.
330 395.002(28)(a) which provides cancer treatment for patients from
331 birth to 18 years of age. All qualified applicants must have
332 equal access and opportunity to compete for research funding.
333 Incubator grants must be recommended by the collaborative and
334 awarded by the department on the basis of scientific merit, as
335 determined by a competitively open and peer-reviewed process to
336 ensure objectivity, consistency, and high quality.

337 (e) To ensure that all proposals for research funding are
338 appropriate and are evaluated fairly on the basis of scientific
339 merit, the department shall appoint peer review panels of
340 independent, scientifically qualified individuals to review the
341 scientific merit of each proposal and establish its priority
342 score. The priority scores must be forwarded to the
343 collaborative and must be considered in determining which
344 proposals the collaborative recommends for funding.

345 (f) The collaborative and the peer review panels shall
346 establish and follow rigorous guidelines for ethical conduct and
347 adhere to a strict policy with regard to conflicts of interest
348 regarding the assessment of incubator grant applications. A

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349 member of the collaborative or a panel may not participate in
350 any discussion or decision of the collaborative or a panel
351 regarding a research proposal from any firm, entity, or agency
352 with which the member is associated as a governing body member,
353 as an employee, or through a contractual arrangement.

354 (g) Each recipient of incubator grant funds must enter into
355 an allocation agreement with the department. Each such
356 allocation agreement must include all of the following:

357 1. A line-item budget narrative documenting the annual
358 allocation of funds to a recipient.

359 2. A cap on the annual award of 15 percent for
360 administrative expenses.

361 3. A requirement for the recipient to submit quarterly
362 reports of all expenditures made by the recipient with funds
363 received through the incubator.

364 4. A provision to allow the department and other state
365 auditing bodies to audit all financial records, supporting
366 documents, statistical records, and any other documents
367 pertinent to the allocation agreement.

368 5. A provision requiring the annual reporting of outcome
369 data and protocols used in achieving those outcomes.

370 (h) Beginning December 1, 2026, and annually through
371 December 1, 2030, the collaborative shall prepare and submit a
372 report to the Governor, the President of the Senate, and the
373 Speaker of the House of Representatives which evaluates research
374 conducted through the incubator and provides details on outcomes
375 and findings available through the end of the fiscal year
376 immediately preceding each report. If the collaborative
377 recommends that the incubator be extended beyond its 5-year

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378 lifespan, the collaborative shall make such recommendation in
379 the report due December 1, 2029, and shall include a
380 recommendation for the next targeted area of cancer research.
381 The report due on December 1, 2030, must include all of the
382 following:

383 1. Details of all results of the research conducted with
384 incubator funding which has been completed or the status of
385 research in progress.

386 2. An evaluation of all research conducted with incubator
387 funding during the 5 fiscal years preceding the report.

388 Section 2. Paragraph (d) is added to subsection (2) of
389 section 381.922, Florida Statutes, to read:

390 381.922 William G. "Bill" Bankhead, Jr., and David Coley
391 Cancer Research Program.—

392 (2) The program shall provide grants for cancer research to
393 further the search for cures for cancer.

394 (d) There is established within the program the Bascom
395 Palmer Eye Institute VisionGen Initiative. The purpose of the
396 initiative is to advance genetic and epigenetic research on
397 inherited eye diseases and ocular oncology by awarding grants
398 through the peer-reviewed, competitive process established under
399 subsection (3). Funding for the initiative is subject to the
400 annual appropriation of funds by the Legislature.

401 Section 3. This act shall take effect July 1, 2025.

3/25/2025

Meeting Date

Health Policy

Committee

Name John Cleveland Ph.D

Address 12902 USF Magnolia Drive

Street

Tampa

FL

33612

City

State

Zip

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without compensation or sponsorship.

I am a registered lobbyist, representing:

I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

Moffitt Cancer Center

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf \(flsenate.gov\)](https://flsenate.gov/2020-2022JointRules.pdf)

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to Senate professional staff conducting the meeting

SB 7028

Bill Number or Topic

Amendment Barcode (if applicable)

561-339-8317

Phone

John.Cleveland@moffitt.org

Email

Tab 10

3/25/25

The Florida Senate

APPEARANCE RECORD

SB 7028

Meeting Date

Sen. App. HHS

Committee

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Bill Number or Topic

Name ADRIAN NUÑEZ

Phone (786) 863-0258

Address 1252 MEMORIAL DR

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CORAL GABLES FL

City

State

33146

Zip

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without
compensation or sponsorship.

I am a registered lobbyist,
representing:

I am not a lobbyist, but received
something of value for my appearance
(travel, meals, lodging, etc.),
sponsored by:

UNIVERSITY OF MIAMI

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf](https://flsenate.gov/2020-2022JointRules.pdf) (flsenate.gov)

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

S-001 (08/10/2021)

3/25/2025

Meeting Date

Health Policy

Committee

Name H. Lee Moffitt

Address 12902 USF Magnolia Drive

Street

Tampa

FL

33612

City

State

Zip

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without compensation or sponsorship.

I am a registered lobbyist, representing:

Moffitt Cancer Center

I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf \(flsenate.gov\)](https://flsenate.gov/2020-2022JointRules.pdf)

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

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

SB 7028

Bill Number or Topic

Deliver both copies of this form to
Senate professional staff conducting the meeting

Amendment Barcode (if applicable)

Phone 813-760-5712

Email mrspeaker@aol.com

3/25/25

The Florida Senate

APPEARANCE RECORD

SPB 7028 (by Health Policy)

Meeting Date

Bill Number or Topic

Health Policy

Deliver both copies of this form to
Senate professional staff conducting the meeting

Amendment Barcode (if applicable)

Committee

Name **Monica Rodriguez**

Phone **(850)577-0444**

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Street

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32301

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State

Zip

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without
compensation or sponsorship.

I am a registered lobbyist,
representing:

University of Florida Health Corporation

I am not a lobbyist, but received
something of value for my appearance
(travel, meals, lodging, etc.),
sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf](https://flsenate.gov/2020-2022JointRules.pdf) (flsenate.gov)

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

3/25/2025

Meeting Date

Health Policy

Committee

Name

Mark Delega

Phone

Address

201 East Park Avenue

Email

Street

TLH

FL

32301

Zip

City

Speaking: For Against Information

OR

Waive Speaking:

In Support

Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without compensation or sponsorship.

I am a registered lobbyist, representing:

I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

Florida Academic Cancer Center Alliance

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf \(flsenate.gov\)](http://flsenate.gov/2020-2022JointRules.pdf)

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

SB 7028

Bill Number or Topic

Amendment Barcode (if applicable)

850583-2400

The Florida Senate
BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL: CS/SB 1842

INTRODUCER: Health Policy Committee and Senator Burton

SUBJECT: Out-of-network Providers

DATE: March 26, 2025

REVISED: _____

ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1. <u>Morgan</u>	<u>Brown</u>	<u>HP</u>	<u>Fav/CS</u>
2. _____	_____	<u>AHS</u>	_____
3. _____	_____	<u>FP</u>	_____

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1842 amends s. 456.0575, F.S., to require a health care practitioner providing nonemergency services to a patient and referring the patient to another provider to confirm whether the referral provider participates in the provider network of the patient's health insurer or health maintenance organization (HMO), unless the patient declines the practitioner's offer to make the network confirmation or declines to share identifying information with the referral provider. The bill allows the referring practitioner to delegate this duty to his or her employee.

The bill requires the practitioner, when making a referral, to notify a patient in writing that additional cost-sharing responsibilities are possible when services are rendered by an out-of-network provider or when the services are not covered under the patient's health coverage.

The bill provides that a practitioner who fails to comply without good cause will face disciplinary action and authorizes the Florida Department of Health (DOH) to adopt rules.

The bill provides an effective date of July 1, 2025.

II. Present Situation:

Insurer

Under s. 627.6471(1)(a), F.S., an “insurer” means:

- Every person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuity; or
- A multiple-employer welfare arrangement.¹

Health Insurance

Under s. 624.603, F.S., “health insurance” is insurance of human beings against bodily injury, disablement, or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining thereto. Health insurance does not include workers’ compensation coverages, except as provided in s. 624.406(4), F.S.

Health Maintenance Organization

Under s. 641.19(12), F.S., a “health maintenance organization” (HMO) is any organization authorized under part I of ch. 641, F.S., which:

- Provides, through arrangements with other persons, emergency care; inpatient hospital services; physician care including care provided by physicians licensed under chs. 458, 459, 460, and 461, F.S.;² ambulatory diagnostic treatment; and preventive health care services.
- Provides, either directly or through arrangements with other persons, health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis.
- Provides, either directly or through arrangements with other persons, comprehensive health care services which subscribers³ are entitled to receive pursuant to a contract.
- Provides physician services, by physicians licensed under chs. 458, 459, 460, and 461, F.S.,⁴ directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians.
- If offering services through a managed care system, has a system in which a primary physician licensed under chs. 458, 459, 460, or 461, F.S.,⁵ is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating the health care of the subscriber of the requested

¹ The term “multiple-employer welfare arrangement” means an employee welfare benefit plan or any other arrangement which is established or maintained for the purpose of offering or providing health insurance benefits or any other benefits described in s. 624.33, other than life insurance benefits, to the employees of two or more employers, or to their beneficiaries; *see* s. 624.437(1), F.S.

² Chapter 458, F.S., is the practice act for medical doctors, a.k.a. allopathic physicians. Chapter 459, F.S., is the practice act for osteopathic physicians. Chapter 460, F.S., is the practice act for chiropractic physicians. Chapter 461, F.S., is the practice act for podiatric physicians.

³ “Subscriber” means an entity or individual who has contracted, or on whose behalf a contract has been entered into, with an HMO for health care coverage or other persons who also receive health care coverage as a result of the contract; *see* s. 641.19(18), F.S.

⁴ *Supra* note 2.

⁵ *Id.*

service and for referring the subscriber to other providers of the same discipline when necessary. Each female subscriber may select as her primary physician an obstetrician/gynecologist who has agreed to serve as a primary physician and is in the HMO's provider network.

Participating vs. Nonparticipating Providers

Generally, medical health insurance plans and HMOs have a list of physicians, hospitals, and other practitioners or providers⁶ that have agreed to participate in the plan's network. Providers participating in the network have a contract with the health plan to care for its members at a certain cost. A member of the plan will typically pay less for medical services when using participating providers. If a plan member sees a practitioner or uses a hospital or other facility that does not participate with the health plan, the member is going out-of-network and will usually have to pay more for services rendered by a nonparticipating provider. Some plans will not cover any amount of out-of-network care, while others cover a percentage of care.⁷

Participating providers⁸ have a contract with an insurer that limits the amount of money the provider may charge individuals who are covered under the contracted insurance company. The agreed-upon contract rate includes both the patient and insurer shares and may be based on certain assumptions regarding the volume of patients that will use that provider's services. The portion of the contracted rate a patient pays is determined by his or her insurance policy or HMO subscriber contract.⁹

Nonparticipating providers¹⁰ are those who have not agreed to accept a contracted rate with a patient's insurance company or HMO. If a patient chooses to seek treatment outside of his or her network, insurance companies and HMOs typically increase cost-sharing.¹¹

Health Insurance Cost-Sharing

The term "cost-sharing" refers to how health plan costs are shared between insurers and insureds, sometimes called "out-of-pocket" costs when referring to the insured's share of costs for services that a plan covers that the insured must pay out of their own pocket.¹²

⁶ "Provider" means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state; *see s. 641.47(14), F.S.*

⁷ Medicare.gov, *Health Maintenance Organizations (HMOs)*, available at <https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/HMO> (last visited Mar. 21, 2025).

⁸ "Participating provider" means a preferred provider as defined in s. 627.6471 or an exclusive provider as defined in s. 627.6472; *see s. 627.64194(1)(f), F.S.*

⁹ Centers for Medicare & Medicaid Services, *No Surprises: Health insurance terms you should know*, available at <https://www.cms.gov/files/document/nosurpriseactfactsheet-health-insurance-terms-you-should-know508c.pdf> (last visited Mar. 21, 2025).

¹⁰ "Nonparticipating provider" means a provider who is not a preferred provider as defined in s. 627.6471 or a provider who is not an exclusive provider as defined in s. 627.6472. For purposes of covered emergency services under this section, a facility licensed under chapter 395 or an urgent care center defined in s. 395.002 is a nonparticipating provider if the facility has not contracted with an insurer to provide emergency services to its insureds at a specified rate; *see s. 627.64194(1)(e), F.S.*

¹¹ *Supra* note 9.

¹² *Id.*

Types of Cost-Sharing

Health insurance policies and HMO subscriber contracts may include the following types of cost-sharing:

- Premium Contribution – A health coverage premium is the total amount that must be paid in advance to obtain coverage for a particular level of services. Usually, premiums are billed and paid on a monthly basis.¹³ Employers typically require employees to share the cost of the plan premium. Employers are free to require employees to cover some or all of the premium cost for dependents, such as a spouse or children.¹⁴
- Copayments – A copayment or copay is a flat fee paid by the patient at the time of service.¹⁵
- Coinsurance – Coinsurance is the insured's share of costs of a covered health service, calculated as a percent of the allowed amount for the service. If the plan pays 70 percent of the cost, then the patient pays 30 percent of the cost. If the plan pays 90 percent, then the patient pays 10 percent, and so forth.¹⁶
- Deductible – The deductible is the amount the insured pays before the plan pays anything. Deductibles generally apply per person per calendar year.¹⁷ Typically, the higher the deductible, the lower the premium. Some plans with particularly high deductibles are known as “high deductible” plans. While these plans may have significantly lower premiums, the insured is usually exposed to higher out-of-pocket costs.¹⁸
- Out-of-Pocket Maximum – The most that the insured or subscriber could pay during a coverage period (usually one year) for their share of the costs of covered services. After meeting the limit, the plan will usually pay 100 percent of the allowed amount. This limit helps the insured or subscriber plan for health care costs. This limit never includes the premium, balance-billed charges, or health care the plan does not cover. Some plans do not count all copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.¹⁹

Regulation of Health Insurance and HMOs in Florida

The Florida Office of Insurance Regulation (OIR) licenses and regulates insurers, HMOs, and other risk-bearing entities.²⁰ To operate in Florida, an insurer or HMO must obtain a certificate of authority from the OIR.²¹ The Florida Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving

¹³ Centers for Medicare & Medicaid Services, *Course 2 Health Coverage Basics*, available at <https://www.cms.gov/marketplace/technical-assistance-resources/training-materials/health-coverage-basics-training.pdf> (last visited Mar. 21, 2025).

¹⁴ Kaiser Family Foundation, *Employer-Sponsored Health Insurance 101* (May 28, 2024), available at <https://www.kff.org/health-policy-101-employer-sponsored-health-insurance/?entry=table-of-contents-introduction> (last visited Mar. 21, 2025).

¹⁵ *Supra* note 9.

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ South Carolina Department of Insurance, *Understanding Your Deductible*, available at <https://doi.sc.gov/1019/Understanding-Your-Deductible#:~:text=Policies%20with%20lower%20deductibles%20typically,need%20to%20file%20a%20claim>. (last visited Mar. 21, 2025).

¹⁹ *Supra* note 9.

²⁰ Section 20.121(3)(a)1., F.S.

²¹ Section 641.21(1), F.S.

a certificate of authority²² from the OIR, an HMO must receive a Health Care Provider Certificate from the AHCA. As part of the certification process used by the AHCA, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.²³

Balance Billing

A provider, regardless of contracted status with an HMO, may not collect or attempt to collect money from an HMO subscriber.²⁴ The subscriber is not liable for payment of fees to the provider.²⁵ Balance billing is also prohibited in cases when emergency services are provided by a nonparticipating provider, and when nonemergency services are provided by a nonparticipating provider and the insured or subscriber does not have the ability and opportunity to choose a participating provider at the facility who is available to treat the covered patient.²⁶

Florida Regulation of Health Care Practitioners

Health care practitioners²⁷ are regulated by the Florida Department of Health (DOH) under ch. 456, F.S., and individual practice acts for each profession. Many practitioners are regulated by profession-specific boards or councils of members of the profession appointed by the Governor and administered by the DOH; however, some health care practitioners are regulated directly by the DOH without a board or council.²⁸

Chapter 456, F.S., and individual practice acts delineate standards of licensure and practice, and the boards, or the DOH if there is no board, enforce violations under the Administrative Procedure Act. Boards and the DOH may issue a reprimand or letter of concern, assess fines, suspend or restrict licenses, or revoke licenses, among other penalties, based on the nature of the violation.²⁹

²² Sections 624.401 and 641.49, F.S.

²³ Section 641.495, F.S.

²⁴ Sections 641.315(1), and 641.3154(1) and (4), F.S.

²⁵ *Id.*

²⁶ Section 627.64194, F.S.

²⁷ “Health care practitioner” means any person licensed under chapter 457 (acupuncture); chapter 458 (medical practice); chapter 459 (osteopathic medicine); chapter 460 (chiropractic medicine); chapter 461 (podiatric medicine); chapter 462 (naturopathy); chapter 463 (optometry); chapter 464 (nursing); chapter 465 (pharmacy); chapter 466 (dentistry, dental hygiene, and dental laboratories); chapter 467 (midwifery); part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468 (speech-language pathology and audiology, nursing home administration, occupational therapy, respiratory therapy, dietetics and nutrition practice, athletic trainers, or orthotics, prosthetics, and pedorthics); chapter 478 (electrolysis); chapter 480 (massage therapy practice); part I, part II, or part III of chapter 483 (clinical laboratory personnel, medical physicists, or genetic counseling); chapter 484 (dispensing of optical devices and hearing aids); chapter 486 (physical therapy practice); chapter 490 (psychological services); or chapter 491 (clinical, counseling, and psychotherapy services); *see* s. 456.001(4), F.S.

²⁸ Florida Department of Health, *Licensing and Regulation*, available at <https://www.floridahealth.gov/licensing-and-regulation/index.html> (last visited Mar. 21, 2025).

²⁹ Section 456.072, F.S.

Florida Price Transparency: Health Care Facilities

Under s. 395.301, F.S., a health care facility³⁰ must provide, within seven days of a written request, a good faith estimate (GFE) of reasonably anticipated charges for the facility to treat the patient's condition. Upon request, the facility must also provide revisions to the estimate. The estimate may represent the average charges for that diagnosis related group³¹ or the average charges for that procedure. The facility is required to place a notice in the reception area that this information is available. A facility that fails to provide the estimate as required may be fined \$500 for each instance of the facility's failure to provide the requested information.

Also, pursuant to s. 395.301, F.S., a licensed facility must notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. If requested, within seven days of discharge or release, the licensed facility must provide an itemized statement, in language comprehensible to an ordinary layperson, detailing the specific nature of charges or expenses incurred by the patient. This initial bill must contain a statement of specific services received and expenses incurred for the items of service, enumerating in detail the constituent components of the services received within each department of the licensed facility and including unit price data on rates charged by the licensed facility. The patient or patient's representative may elect to receive this level of detail in subsequent billings for services.

Current law directs these health care facilities to publish information on their websites detailing the cost of specific health care services and procedures, as well as information on financial assistance that may be available to prospective patients. The facility must disclose to the consumer that these averages and ranges of payments are estimates and that actual charges will be based on the services actually provided.³²

Federal Transparency Requirements

Federal Transparency in Coverage Requirements – Insurers and HMOs

On October 29, 2020, the federal departments of Health and Human Services (HHS), Labor, and Treasury finalized Transparency in Coverage regulations³³ imposing new transparency requirements on issuers of individual and group health insurance plans.

Central to the new regulations is a requirement for insurers and HMOs to provide an estimate of an insured's or subscriber's cost-sharing liability for covered items or services furnished by a particular provider. Under the final rule, health insurers and HMOs must disclose cost-sharing estimates at the request of an enrollee and publicly release negotiated rates for in-network

³⁰ The term "health care facilities" refers to hospitals and ambulatory surgical centers, which are licensed under part I of ch. 395, F.S.

³¹ Diagnosis related groups (DRGs) are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. DRGs allow facilities to categorize patients based on severity of illness, prognosis, treatment difficulty, need for intervention, and resource intensity.

Centers for Medicare & Medicaid Services, *Design and development of the Diagnosis Related Group (DRG)* (Oct. 2020), available at [https://www.cms.gov/icd10m/version38-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_\(DRGs\).pdf](https://www.cms.gov/icd10m/version38-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf) (last visited Mar. 21, 2025).

³² Section 395.301, F.S.

³³ Transparency in Coverage, 85 F.R. 73158 (Nov. 12, 2020) (codified at 29 C.F.R. § 54, 29 C.F.R. § 2590, 45 C.F.R. § 147, and 45 C.F.R. § 158).

providers, historical out-of-network allowed amounts and billed charges, and drug pricing information. The rule's goal is to enable insured patients to estimate their out-of-pocket costs before receiving health care services, to encourage shopping and price competition among providers.³⁴

Transparency in Coverage Final Rules

The Transparency in Coverage Final Rules (TiC Rules) require non-grandfathered group health insurers and HMOs offering non-grandfathered group and individual health insurance coverage to make cost-sharing information available to insureds and subscribers through an Internet-based self-service tool and in paper form, upon request.³⁵ This information must be made available for plan years (in the individual market, policy years) beginning on or after January 1, 2023, with respect to the 500 items and services identified by the departments³⁶ in Table 1 of the preamble to the TiC Rules,³⁷ and with respect to all covered items and services, for plan or policy years beginning on or after January 1, 2024.³⁸

The insurer or HMO must make available to an insured or subscriber upon request cost-sharing information for a discrete covered item or service by billing code or descriptive term, and generally must furnish it according to the insured's or subscriber's request.³⁹ Further, the TiC Rules require an insurer or subscriber to provide cost-sharing information for a covered item or service in connection with an in-network provider or providers, or an out-of-network allowed amount for a covered item or service provided by an out-of-network provider, according to the insured's or subscriber's request, permitting the individual to specify the information necessary for the insurer or HMO to provide meaningful cost-sharing liability information.⁴⁰

The Federal “No Surprises” Act

On December 27, 2020, Congress enacted the No Surprises Act (Act) as part of the Consolidated Appropriations Act of 2021.⁴¹ The Act includes a wide range of provisions aimed at protecting patients from surprise billing practices and ensuring that patients have access to accurate information about the costs of health care. Most sections of the Act went into effect on

³⁴ Health Affairs Blog, *Trump Administration Finalizes Transparency Rule for Health Insurers* (Nov. 1, 2020), available at <https://www.healthaffairs.org/do/10.1377/hblog20201101.662872/full/> (last visited Mar. 21, 2025).

³⁵ 26 C.F.R. § 54.9815-2715A2(b); 29 C.F.R. § 2590.715-2715A2(b); and 45 C.F.R. § 147.211(b). The Consolidated Appropriations Act, 2021 imposed a largely duplicative requirement, and added a requirement that price comparison guidance also be provided by telephone, upon request. See also FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (Aug. 20, 2021), Q3, available at <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf> and <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf>, and [FAQs about Affordable Care Act Implementation Part 61 \(cms.gov\)](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-61.pdf) (Sep. 27, 2024) (last visited Mar. 21, 2025).

³⁶ Department of Treasury, Department of Labor, and Department of Health and Human Services.

³⁷ 85 F.R. 72158, 72182-90 (Nov. 12, 2020)

³⁸ 26 C.F.R. § 54.9815-2715A2(c)(1); 29 C.F.R. § 2590.715-2715A2(c)(1); and 45 C.F.R. § 147.211(c)(1).

³⁹ In responding to an insured's or subscriber's request, the group health plan or health insurer may limit the number of providers with respect to which cost-sharing information for covered items and services is provided to no fewer than 20 providers per request. 26 C.F.R. § 54.9815-2715A2(b)(2)(ii); 29 C.F.R. § 2590.715-2715A2(b)(2)(ii); and 45 C.F.R. § 147.211(b)(2)(ii).

⁴⁰ 26 C.F.R. § 54.9815-2715A2(b)(1); 29 C.F.R. § 2590.715-2715A2(b)(1); and 45 C.F.R. § 147.211(b)(1).

⁴¹ Public Law 116-260. The No Surprises Act is found in Division BB of the Act.

January 1, 2022, and the federal departments of HHS, Treasury, and Labor are tasked with issuing regulations and guidance to implement a number of the provisions.⁴²

Federal “No Surprises” Act Requirements Relating to Estimates – Facilities

The Act requires a health insurer or HMO to generate an “advanced explanation of benefits” (AEOB) that combines information on charges provided by a hospital facility with patient-specific cost information provided by a policy or contract. The process is triggered when a patient schedules a service at a hospital facility or requests cost information on a specific set of services. A hospital facility must share a GFE of the total expected charges for scheduled items or services, including any expected ancillary services, with a health insurer (if the patient is insured) or individual (if the patient is uninsured).⁴³

Federal “No Surprises” Act Requirements of Health Insurers and HMOs

Under the Act, once the GFE has been shared with a patient’s health insurer or HMO, then the insurer or HMO must then develop the AEOB. This personalized cost estimate must include the following:⁴⁴

- An indication of whether the facility participates in the patient’s insurer’s or HMO’s network. If the facility is non-participating, information must be included on how the patient can receive services from a participating provider;
- The GFE prepared by the hospital facility based on billing or diagnostic codes;
- A GFE of the amount to be covered by the health insurer or HMO;
- A GFE of the amount of the patient’s out-of-pocket costs;
- A GFE of the accrued amounts already met by the patient towards any deductible or out-of-pocket maximum under the patient’s policy or contract;
- A disclaimer indicating whether the services scheduled are subject to medical management techniques (e.g., medical necessity determinations, prior authorization, step therapy, etc.); and
- A disclaimer that the information provided is only an estimate of costs and may be subject to change.

Deferral of Federal Enforcement Related to the GFEs and the AEOBs for Insured Individuals

In October 2021, the decision to defer enforcement of certain requirements described above was made in response to stakeholder requests that standards first be established for the data transfer from providers and facilities to plans and issuers, and give plans, issuers, providers, and facilities enough time to build the infrastructure necessary to support the transfers.

In September 2022, the federal government issued a Request for Information (RFI) relating to the AEOB and the GFE for covered individuals. In the RFI, as noticed in the Federal Register, it was stated that the HHS is deferring enforcement of the requirement that providers and facilities must provide a GFE to plans and issuers for covered individuals enrolled in a health plan or coverage and seeking to have a claim submitted for scheduled (or requested) items or services to

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Id.*

their plan or coverage, as well as deferring enforcement of the requirement that plans and issuers must provide these covered individuals with an AEOB.⁴⁵

On April 23, 2024, the federal government provided an update⁴⁶ on progress towards AEOB rulemaking and implementation. The update included a summary of comments received in response to the September 2022 RFI. According to the update, various types of health care providers, payers, and third-party vendors were studied to understand technical needs and capabilities, existing claims processes, communications channels, and potential financial and operational constraints. Additionally, the federal government engaged digital service researchers, who recommended a single data exchange standard for the transmission of data between payers and providers and emphasized that current published technical standards may not be sufficient to meet the AEOB requirements. As a result, new standards may need to be developed to ensure successful implementation.⁴⁷

At this time, no further federal guidance has been issued to indicate how long enforcement will be deferred.⁴⁸

III. Effect of Proposed Changes:

Section 1 amends s. 456.0575, F.S., to require a health care practitioner providing nonemergency services, as defined in s. 627.64194, F.S., to a patient and is referring the patient to a provider for nonemergency services, to confirm whether the referral provider participates in the provider network of the patient's health insurer or HMO at the point of service. The practitioner, or his or her employee, may confirm the referral provider's participation by contacting the referral provider or the patient's health insurer or HMO, as necessary.

The bill provides that such requirement does not apply if the patient declines the practitioner's offer to make the confirmation or declines to share with the referral provider the name and identification number associated with his or her health insurance policy or HMO contract.

The bill requires that when making a referral, a practitioner must notify a patient in writing that services provided by an out-of-network provider or that are not covered services under the patient's health coverage may result in additional cost-sharing responsibilities for the patient, and such notice must be documented in the patient's medical record. Failure to comply, without good cause, will result in disciplinary action against the health care practitioner.

The bill authorizes the DOH to adopt rules to implement its provisions.

Section 2 provides an effective date of July 1, 2025.

⁴⁵ 87 F.R. 56905.

⁴⁶ Centers for Medicare & Medicaid Services, *Progress Toward Advanced Explanation of Benefits (AEOB) Rulemaking and Implementation*, available at <https://www.cms.gov/files/document/progress-aeob-rulemaking-implementation.pdf> (last visited Mar. 22, 2025).

⁴⁷ NFP, An Aon Company, *FAQ: When must group health plans comply with the CAA 2021 Advanced Explanation of Benefits (AEOB) requirement*, available at <https://www.nfp.com/insights/faq-when-must-group-health-plans-comply-with-the-caa-2021-advanced-explanation-of-benefits-aeob-requirement/> (last visited Mar. 22, 2025).

⁴⁸ *Id.*

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill requires health care practitioners providing nonemergency services to notify patients in writing upon referring the patient for nonemergency services to a provider not participating in the patient's health insurance network or to a provider that is not under contract with the patient's HMO. Provision of these notices, as well as looking-up insurer and HMO provider networks, may result in increased workload for health care practitioners.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 1 of the bill requires that disciplinary action be taken against a health care practitioner who fails to comply, without good cause, with the bill's requirement for written patient notifications. However, it is unclear what constitutes "good cause" or a "disciplinary action."

VIII. Statutes Affected:

This bill substantially amends section 456.0575 of the Florida Statutes.

IX. Additional Information:**A. Committee Substitute – Statement of Substantial Changes:**
(Summarizing differences between the Committee Substitute and the prior version of the bill.)**CS by Health Policy on March 25, 2025:**

The committee substitute:

- Removes the underlying bill's amendments to the Insurance Code relating to health insurance deductibles.
- Clarifies that a health care practitioner providing nonemergency services to a patient and making a referral to another provider for nonemergency services, must confirm the referral provider's participation in the provider network of the patient's health insurer or HMO at the point of service unless the patient declines the practitioner's offer to make the network confirmation or declines to share identifying information with the referral provider. The CS allows the referring practitioner to delegate this duty to an employee.
- Requires a practitioner to notify a patient in writing when additional cost-sharing responsibilities are possible when making a referral for services provided by an out-of-network provider or that are not covered services under the patient's health coverage.
- Authorizes the DOH to adopt rules.

B. Amendments:

None.



LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/26/2025	.	
	.	
	.	
	.	

The Committee on Health Policy (Burton) recommended the following:

1 **Senate Amendment (with title amendment)**

2
3 Delete everything after the enacting clause
4 and insert:

5 Section 1. Present subsection (2) of section 456.0575,
6 Florida Statutes, is redesignated as subsection (3), and a new
7 subsection (2) is added to that section, to read:

8 456.0575 Duty to notify patients.—

9 (2) (a) When providing nonemergency services, as defined in
10 s. 627.64194, to a patient, or upon referring the patient to a



371962

11 provider for nonemergency services, a health care practitioner
12 or his or her employee must, at the point of service, confirm
13 whether the referral provider participates in the provider
14 network of the patient's health insurer or health maintenance
15 organization. The practitioner or his or her employee may
16 confirm the referral provider's participation by contacting the
17 referral provider or the patient's health insurer or health
18 maintenance organization, as necessary.

19 (b) The requirements of paragraph (a) do not apply if the
20 patient declines the practitioner's offer to make the
21 confirmation or declines to share with the referral provider the
22 name and identification number associated with his or her health
23 insurance policy or health maintenance organization contract.

24 (c) When making any referral, the practitioner must notify
25 a patient in writing that services provided by an out-of-network
26 provider or that are not covered services under the patient's
27 health coverage may result in additional cost-sharing
28 responsibilities for the patient, and such notice must be
29 documented in the patient's medical record.

30 (d) Failure to comply with this subsection, without good
31 cause, shall result in disciplinary action against the health
32 care practitioner.

33 (e) The department may adopt rules to implement this
34 subsection.

35 Section 2. This act shall take effect July 1, 2025.

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

37 And the title is amended as follows:

38 Delete everything before the enacting clause



and insert:

A bill to be entitled

An act relating to out-of-network providers; amending s. 456.0575, F.S.; requiring a health care practitioner or his or her employee to confirm whether a referral provider participates in the provider network of the patient's health insurer or health maintenance organization under certain circumstances; authorizing the practitioner or his or her employee to confirm the referral provider's participation in a specified manner; providing applicability; requiring a health care practitioner to notify a patient in writing that certain services are not covered services under the patient's health coverage; requiring that such notice be documented; providing for health care practitioner disciplinary action under certain conditions; authorizing the Department of Health to adopt rules; providing an effective date.



LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/26/2025	.	
	.	
	.	
	.	

The Committee on Health Policy (Burton) recommended the following:

1 **Senate Amendment to Amendment (371962)**

2

3 Delete line 10

4 and insert:

5 s. 627.64194, to a patient, and referring the patient to a

By Senator Burton

12-01057A-25

20251842

A bill to be entitled

An act relating to out-of-network providers; amending s. 456.0575, F.S.; requiring a health care practitioner to notify a patient in writing upon referring the patient to certain providers; providing requirements for such notice; providing for health care practitioner disciplinary action under certain conditions; amending s. 627.6471, F.S.; requiring certain health insurers to apply payments for services provided by nonpreferred providers toward insureds' deductibles and out-of-pocket maximums if specified conditions are met; providing an effective date.

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

Section 1. Present subsection (2) of section 456.0575, Florida Statutes, is redesignated as subsection (3), and a new subsection (2) is added to that section, to read:

456.0575 Duty to notify patients.—

(2) A health care practitioner shall notify a patient in writing upon referring the patient to a nonparticipating provider for nonemergency services, as those terms are defined in s. 627.64194(1), or to a provider, as defined in s. 641.47, that is not under contract with the patient's health maintenance organization. Such notice must state that the services will be provided on an out-of-network basis, which may result in additional cost-sharing responsibilities for the patient, and such notice must be documented in the patient's medical record. Failure to comply with this subsection, without good cause,

12-01057A-25

20251842

30 shall result in disciplinary action against the health care
31 practitioner.

32 Section 2. Present subsection (7) of section 627.6471,
33 Florida Statutes, is redesignated as subsection (8), and a new
34 subsection (7) is added to that section, to read:

35 627.6471 Contracts for reduced rates of payment;
36 limitations; coinsurance and deductibles.—

37 (7) Any insurer issuing a policy of health insurance in
38 this state shall apply the payment for a service provided to an
39 insured by a nonpreferred provider toward the insured's
40 deductible and out-of-pocket maximum as if the service had been
41 provided by a preferred provider if all of the following
42 conditions apply:

43 (a) The insured requests that the insurer apply the payment
44 for the service provided to the insured by the nonpreferred
45 provider toward the insured's deductible and out-of-pocket
46 maximum.

47 (b) The service provided to the insured by the nonpreferred
48 provider is within the scope of services covered under the
49 insured's policy.

50 (c) The amount that the nonpreferred provider charged the
51 insured for the service is the same as or less than:

52 1. The average amount that the insured's preferred provider
53 network charges for the service; or
54 2. The statewide average amount for the service based on
55 data reported on the Florida Health Finder website.

56 Section 3. This act shall take effect July 1, 2025.

The Florida Senate

3/25/25

Meeting Date

Health Policy
Committee**APPEARANCE RECORD**

Deliver both copies of this form to

Senate professional staff conducting the meeting

1842

Bill Number or Topic

Amendment Barcode (if applicable)

Name Christopher Mikulas, DO

Phone (321) 427-3382

Address 86606 Illusive Lake Court

Email Christopher.mikulas@jax.ufl.edu

Street

Yulee

FL

32097

City

State

Zip

Speaking: For Against Information**OR**Waive Speaking: In Support Against**PLEASE CHECK ONE OF THE FOLLOWING:** I am appearing without compensation or sponsorship. I am a registered lobbyist, representing: I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

Florida Chapter, American College of Physicians

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. [2020-2022JointRules.pdf \(flsenate.gov\)](https://flsenate.gov/2020-2022JointRules.pdf)

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

S-001 (08/10/2021)

The Florida Senate

March 25, 2025

Meeting Date

APPEARANCE RECORD

SB 1842

Bill Number or Topic

Health Policy

Committee

Name Chante Jones

Deliver both copies of this form to
Senate professional staff conducting the meeting

Amendment Barcode (if applicable)

850-272-0557

Address 215 N Monroe St Ste 603

Street

Tallahassee Fl 32301

City

State

Zip

Phone

Email

cejones@aarp.org

Speaking: For Against Information

OR

Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without
compensation or sponsorship.

I am a registered lobbyist,
representing:

AARP Florida

I am not a lobbyist, but received
something of value for my appearance
(travel, meals, lodging, etc.),
sponsored by:

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

S-001 (08/10/2021)

3/25/25

Meeting Date

The Florida Senate

APPEARANCE RECORD

1842

Bill Number or Topic

Committee

Amendment Barcode (if applicable)

Name Chris Nland

Phone 904-233-3051

Address 4427 Herschel St

Email nlandlaw@aol.com

Street

Jacksonville, FL 32210

City

State

Zip

Speaking: For Against Information

OR Waive Speaking: In Support Against

PLEASE CHECK ONE OF THE FOLLOWING:

I am appearing without compensation or sponsorship.

I am a registered lobbyist, representing:

I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

Florida Chapter, American College of Surgeons

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

S-001 (08/10/2021)

CourtSmart Tag Report

Room: KB 412

Case No.: -

Type:

Caption: Senate Committee on Health Policy

Judge:

Started: 3/25/2025 1:33:45 PM

Ends: 3/25/2025 3:12:57 PM

Length: 01:39:12

1:33:46 PM Call to Order-Chair Burton
1:33:53 PM Roll Call
1:34:03 PM Quorum
1:34:54 PM Tab 1 SB 1568 by Senator Brodeur
1:34:57 PM Senator Brodeur
1:35:31 PM Senator Harrell
1:35:58 PM Senator Brodeur
1:36:41 PM Senator Harrell
1:36:48 PM Senator Brodeur
1:37:11 PM Senator Berman
1:37:25 PM Senator Brodeur
1:37:29 PM Senator Berman
1:37:42 PM Senator Brodeur
1:38:14 PM Public Testimony
1:38:18 PM Blake Buchanan, Florida College of Emergency Physicians
1:39:33 PM Waives read into record
1:39:59 PM Senator Harrell
1:40:04 PM Senator Brodeur
1:41:09 PM Roll Call for SB 1568
1:41:55 PM Reported Favorably
1:42:11 PM Tab 2 SB 1606 by Senator Grall
1:42:12 PM Senator Grall
1:44:21 PM Amendment #900268
1:44:23 PM Senator Grall
1:44:38 PM Adopted
1:44:47 PM Senator Harrell
1:46:07 PM Senator Grall
1:46:44 PM Senator Harrell
1:47:07 PM Senator Grall
1:47:50 PM Senator Berman
1:48:04 PM Senator Grall
1:48:21 PM Senator Berman
1:48:31 PM Senator Grall
1:48:44 PM Senator Berman
1:48:52 PM Senator Grall
1:49:14 PM Public Testimony
1:49:21 PM Waives Read into Record
1:49:35 PM Kyle Prost, Datavant
1:53:00 PM Senator Harrell
1:53:33 PM Senator Grall
1:53:41 PM Roll Call for SB 1606
1:53:57 PM Reported Unfavorably
1:54:44 PM Tab 6 SB 1346 - Senator Berman presented SB 1346 on behalf of Senator Polsky
1:55:01 PM Senator Berman
1:55:42 PM Amendment #609278
1:55:57 PM Senator Berman
1:56:32 PM Public Testimony
1:56:39 PM Waives Read into Record
1:56:45 PM Adopted
1:56:53 PM Roll Call for SB 1346
1:57:36 PM Reported Favorably as a CS
1:57:56 PM Tab 7 SB 1224 by Senator Harrell

1:57:58 PM Senator Harrell
1:58:38 PM Late Filed Amendment #375076
1:58:48 PM Senator Harrell
1:58:57 PM Waives Read into Record
1:59:38 PM Adopted
1:59:42 PM Roll Call for SB 1224
2:00:07 PM Reported Favorably as a CS
2:00:14 PM Tab 3 SB 656
2:00:25 PM Senator Rodriguez
2:00:45 PM Amendment #967282
2:00:59 PM Senator Rodriguez
2:01:40 PM Times Waived Read into Record
2:01:53 PM Adopted
2:02:10 PM Roll Call for SB 656
2:02:37 PM Reported Favorably as a CS
2:02:49 PM Tab 4 SB 68 - Senator Trumbull presented SB 68 on behalf of Senator Martin
2:03:11 PM Senator Trumbull
2:04:06 PM Amendment #534268
2:04:15 PM Senator Trumbull
2:04:32 PM Adopted
2:04:36 PM Senator Berman
2:04:57 PM Senator Trumbull
2:05:28 PM Roll Call for SB 68
2:05:42 PM Reported Favorably as a CS
2:06:08 PM Tab 8 SB 524
2:06:14 PM Senator Harrell
2:06:59 PM Times Waived Read into Record
2:07:38 PM Senator Harrell
2:08:05 PM Roll Call for SB 524
2:08:39 PM Reported Favorably
2:08:46 PM Gavel Given to Senator Harrell
2:09:11 PM Tab 11 SB 1842 by Senator Burton
2:09:21 PM Senator Burton
2:09:27 PM Amendment #371962
2:10:10 PM Senator Burton
2:12:00 PM Senator Berman
2:12:27 PM Senator Burton
2:13:30 PM Senator Berman
2:13:32 PM Senator Burton
2:13:51 PM Amendment to Amendment #505022
2:14:12 PM Amendment to Amendment Adopted
2:14:26 PM Senator Gaetz
2:14:54 PM Senator Burton
2:15:58 PM Senator Gaetz
2:16:20 PM Senator Burton
2:16:58 PM Senator Davis
2:17:35 PM Senator Burton
2:18:34 PM Senator Davis
2:19:05 PM Senator Burton
2:20:15 PM Senator Davis
2:20:39 PM Senator Burton
2:21:07 PM Amendment #371962 Adopted
2:21:57 PM Public Testimony
2:22:01 PM Christopher Mikulas, Florida Chapter American College of Physicians
2:23:06 PM Times Waived Read into Record
2:23:14 PM Senator Burton
2:23:43 PM Senator Gaetz
2:24:14 PM Senator Osgood
2:26:09 PM Senator Harrell
2:26:48 PM Senator Burton
2:27:31 PM Roll Call for SB 1842
2:28:10 PM Reported Favorably as a CS

2:28:25 PM Tab 10
2:28:29 PM SPB 7028 by Committee on Health Policy - presented by Senator Burton
2:28:40 PM Senator Burton
2:33:30 PM Senator Berman
2:33:53 PM Senator Burton
2:34:19 PM Senator Harrell
2:34:35 PM Senator Burton
2:34:39 PM Senator Davis
2:35:14 PM Senator Burton
2:36:07 PM Senator Davis
2:36:29 PM Senator Burton
2:37:07 PM Public Testimony
2:37:15 PM John Cleveland, Moffit Cancer Center
2:38:30 PM Times Waived Read into Record
2:38:54 PM Senator Harrell
2:39:00 PM Motion to Submit as a Committee Bill by Senator Burton
2:39:30 PM Motion adopted
2:40:48 PM Roll Call for SPB 7028
2:40:51 PM Reported Favorably as a Committee Bill
2:41:36 PM Tab 9 SB 172 by Senator Passidomo
2:42:05 PM Senator Passidomo
2:45:31 PM Amendment #310092
2:45:52 PM Senator Passidomo
2:46:49 PM Senator Gaetz
2:47:03 PM Senator Passidomo
2:47:44 PM Adopted
2:48:01 PM Senator Berman
2:48:31 PM Senator Passidomo
2:48:55 PM Times Waived Read into Record
2:49:16 PM Chris Nuland, Florida Association of Plastic Surgeons
2:50:45 PM Ankush Bansal M.D.
2:51:46 PM Senator Harrell
2:51:55 PM Senator Passidomo
2:52:24 PM Roll Call SB 172
2:52:55 PM Reported Favorably as a CS
2:53:06 PM Gavel Passed to Burton
2:53:18 PM Senator Passidomo-Recording Votes
2:53:48 PM Senator Osgood-Recording Votes
2:54:04 PM Senator Leek-Recording Votes
2:54:15 PM Senator Gaetz-Recording Votes
2:54:26 PM Senator Berman-Motion to Reconsider Vote on SB 1606
2:54:28 PM Motion to Reconsider vote on SB 1606 adopted
2:54:58 PM Informal Recess
2:55:06 PM Recording Paused
3:03:24 PM Recording Resumed
3:03:30 PM Call Back to Order-Chair Burton
3:03:43 PM Tab 5 SB 1690 by Senator McClain
3:03:49 PM Senator McClain
3:04:35 PM Senator Berman
3:04:43 PM Senator McClain
3:05:09 PM Senator Berman
3:05:19 PM Senator McClain
3:06:08 PM Public Testimony
3:06:14 PM PG Schafer
3:07:41 PM Waives Read into Record
3:08:08 PM Andrew Shirvell, Florida Voice For the Unborn
3:09:50 PM Senator Berman
3:10:40 PM Senator Harrell
3:11:25 PM Senator McClain
3:11:46 PM Roll Call for SB 1690
3:12:00 PM Reported Favorably
3:12:32 PM Chair Burton

3:12:44 PM Closing Remarks

3:12:57 PM Adjourned