The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Bean, Chair
Senator Sobel, Vice Chair

MEETING DATE: Wednesday, March 4, 2015
TIME: 1:00 —3:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Bean, Chair; Senator Sobel, Vice Chair; Senators Braynon, Flores, Gaetz, Galvano, Garcia, Grimsley, and Joyner

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 758** Evers (Similar H 751, Compare H 155)	Prescription and Use of Opioid Antagonists for Emergency Treatment of Opioid Overdoses; Citing this act as the "Florida Opioid Overdose Prevention Act"; providing the purposes of the act; providing for the prescribing of opioid antagonists to, and the use of them by, patients and caregivers who have received emergency overdose treatment information; providing for the prescribing of opioid antagonists to, and the use of them by, first responders; providing immunities from liability. etc. HP 03/04/2015 Fav/CS AHS AP	Fav/CS Yeas 9 Nays 0
2	**SB 606** Gaetz (Similar H 657)	Dental Care; Establishing a joint local and state dental care access account initiative, subject to the availability of funding; requiring the Department of Health to implement an electronic benefit transfer system; authorizing the department to transfer state funds remaining in a closed account at a specified time and to return unspent funds from local sources; requiring the Department of Economic Opportunity to rank shortage areas and medically underserved areas, etc. HP 03/04/2015 Fav/CS AHS AP	Fav/CS Yeas 9 Nays 0
3	**Workshop and Panel Discussion on Health Care Coverage Options:** Healthy Indiana Plan 2.0.: Presentation by Joseph Moser, Indiana Medicaid Director, Brian Neale, Governor Pence's Health Policy Advisor, and Seema Verma, Governor Pence's Health Policy Consultant. A Healthy Florida Works Presentation. Florida Chamber of Commerce: Presentation by Mark Wilson, President and CEO. Florida Statewide Medicaid Managed Care Implementation: Presentation by Justin Senior, Deputy Secretary for Medicaid, Florida Agency For Health Care Administration. Florida Health Plans: Presentation by David Pollack, President of Molina Healthcare of Florida, Inc.		Presented

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:	CS/SB 758
INTRODUCER:	Health Policy Committee and Senator Evers
SUBJECT:	Prescription and Use of Opioid Antagonists for Emergency Treatment of Opioid Overdoses
DATE:	March 4, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Fav/CS**
2.			AHS	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 758 establishes the "Florida Opioid Overdose Prevention Act" (Act). The Act encourages the administration of opioid antagonists for the emergency treatment of known or suspected opioid overdoses when a health care practitioner is not available.

The bill authorizes health care practitioners to prescribe and dispense opioid antagonists to patients, caregivers, and first responders. Each patient and caregiver to whom an opioid antagonist is prescribed or dispensed must receive emergency overdose treatment information from the prescribing health care practitioner or his or her agent.

Pharmacists are authorized to dispense an appropriately labeled opioid antagonist based on a prescription that has been issued in the name of a patient or caregiver. The patient or caregiver may store and possess a dispensed opioid antagonist for later administration to a person he or she believes in good faith to be experiencing an opioid overdose, regardless of whether that person has a prescription for an opioid antagonist.

Civil liability protection is extended to any person, including health care practitioners, pharmacists, and first responders who possess, administer, or store an approved opioid antagonist in accordance with the Act. A health care practitioner acting in good faith and exercising reasonable care is not subject to discipline under the applicable professional licensure statute and

is also immune from civil or criminal liability for prescribing or dispensing an opioid antagonist in accordance with the Act.

This Act does not create a duty or standard of care for a person to prescribe or administer an opioid antagonist.

The fiscal impact on local governmental agencies is indeterminate since the purchase and use of opioid antagonists is optional for first responders.

II. Present Situation:

An opioid can be a prescription medication or an illegal drug, such as heroin, and is used to treat pain. Opioids work by binding to certain receptors in the brain, spinal cord, and gastrointestinal tract to minimize the body's perception of pain. A variety of effects can occur after a person takes opioids, ranging from pleasure to nausea, vomiting, severe allergic reactions (anaphylaxis) and overdose, in which breathing and heartbeat slow or even stop.[1] Opioid antagonists have been developed to reverse the effects of opioid overdoses and have been around for decades.

Opioid Deaths Nationwide

From 1999 through 2012, the age-adjusted drug-poisoning (drug overdose) death rate nationwide more than doubled, from 6.1 per 100,000 of the population in 1999 to 13.1 in 2012, while death from opioid analgesics alone more than tripled, from 1.4 per 100,000 to 5.1 during the same time period.[2] The 2012 total deaths due to drug poisoning was over 41,000, with opioid analgesics involved in 16,007 of that number and heroin involved in 5,925.[3] On January 12, 2015, the White House Office of National Drug Control Policy announced that drug deaths related to prescription opioids for 2013 had remained stable since 2012, with a 1 percent increase in deaths, while deaths associated with heroin and cocaine had increased 39 percent and 12 percent, respectively.[4]

Drug poisoning deaths involving opioids for the time period of 2009-2010 nationally shows that the highest death rate occurs in the 35 - 54 age bracket at 9.9 deaths per 100,000 and was more prevalent in males at 8.1 compared to 5.1 for females and for white, non-Hispanic individuals.[5]

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[1] U.S. Department of Health and Human Services, *SAMSHA Opioid Overdose Toolkit*, p. 4, http://store.samhsa.gov/shin/content//SMA14-4742/Overdose_Toolkit.pdf (last visited Feb. 28, 2015).
[2] Centers for Disease Control and Prevention, *Trends in Drug-Poisoning Deaths Involving Opioid Analgesics and Heroin: United States, 1999-2012* http://www.cdc.gov/nchs/data/hestat/drug_poisoning/drug_poisoning_deaths_1999-2012.pdf (last visited Feb. 28, 2015).
[3] *Id.*
[4] Press Release, Centers for Disease Control and Prevention, *2013 Drug Overdose Mortality Data Announced*, (Jan. 20, 2015) http://www.cdc.gov/media/releases/2015/p0114-drug-overdose.html (last visited Feb. 28, 2015).
[5] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States 2013 with Special Feature on Prescription Drugs*, p. 29, (on file with the Senate Committee on Health Policy).

Opioid Deaths in Florida

Drug overdose deaths in Florida rose 61 percent from 1,804 to 2,905 during 2003 - 2009, with especially large increases in deaths related to opioid pain relievers and benzodiazepine.[6] After implementing several laws and enforcement actions relating to prescription drugs and pain management clinics, death rates for prescription drugs decreased 16.7 percent from 3,201 to 2,666, representing a 16.7 percent decrease from 2010 - 2012.[7] However, reports of increasing deaths from heroin overdose, sometimes attributed to the crackdown on "pill mills" and the overprescribing of controlled substances for the treatment of pain, is being termed an epidemic.[8]

For Florida, the 2013 total year data from the Centers for Disease Control and Prevention (CDC), shows over 2,600 individuals died from a drug-induced cause. While the CDC number was not just from opioid deaths, the partial year data from the Florida Medical Examiners Commission indicate that prescription drugs, such as benzodiazepines, carisoprodol/meprobamate, zolpidem and all opioids, continue to be found more often than illicit drugs, both as the cause of death and present at death.[9] These drugs are often prescribed for medical conditions such as muscle relaxation, anxiety, insomnia, and panic attacks. Opioids include:

Opioid Drug Occurrences in Florida - January - June 2013[10]			
Opioid	**Present at Death**	**Cause of Death**	**Total Occurrences**
Buprenorphine	10	7	17
Codeine	38	50	88
Fentanyl	85	52	137
Heroin	68	2	70
Hydrocodone	158	273	431
Hydromorphone	89	131	220
Meperidine	2	6	8
Methadone	221	103	324
Morphine	268	189	457
Oxycodone	279	262	541
Oxymorphone	24	100	124
Tramadol	51	177	228

[6] Centers for Disease Control and Prevention, *Decline in Drug Overdose Deaths After State Policy Changes - Florida 2010-2012* (July 4, 2014) http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a3.htm (last visited Feb. 28, 2015).
[7] *Id*.
[8] *See* for example: National Institute on Drug Abuse, *What Can We Do About the Heroine Overdoes Epidemic?* (June 24, 2014) http://www.drugabuse.gov/about-nida/noras-blog/2014/06/what-can-we-do-about-heroin-overdose-epidemic (last visited Feb 28, 2015); National Institute on Drug Abuse, *Drug Abuse Patterns and Trends in Miami-Dade and Broward Counties, Florida—Update: January 2014* (February 2014) http://www.drugabuse.gov/about-nida/organization/workgroups-interest-groups-consortia/community-epidemiology-work-group-cewg/meeting-reports/highlights-summaries-january-2014/miami (last visited Feb. 28, 2015); Reuters, *Heroin Abuse at 'Epidemic' Level in South Florida – Drug Report*, (January 30, 2014) http://www.reuters.com/article/2014/01/30/us-usa-florida-heroin-idUSBREA0T24D20140130 (last visited Feb. 28, 2015), and 8WFLA.com, *Heroin Deaths on the Rise in Tampa Bay* (February 10, 2015) http://www.wfla.com/story/28073721/heroin-deaths-on-the-rise-in-tampa-bay (last visited Feb. 28, 2015).
[9] Florida Department of Law Enforcement, *Drugs Identified in Deceased Persons by Florida Medical Examiners*, p. ii (Interim Report 2013) (May 2014) http://www.fdle.state.fl.us/Content/getdoc/5de77741-a6bd-4a88-8000-ce9431321a6c/2013-Interim-Report-Final-(1).aspx (last visited Feb. 28, 2015).
[10] *Id* at p. 3.

TOTAL:	**1,293**	**1,352**	**2,645**

Naloxone: An Opioid Antagonist

Naloxone injection is in a class of medications called opiate antagonists. It works by blocking the effects of opiates to relieve dangerous symptoms caused by high levels of opiates in the blood.[11] Naloxone displaces opiates from receptor sites in the brain and reverses respiratory depression that usually is the cause of overdose deaths. During the period of time when an overdose can become fatal, respiratory depression can be reversed by giving the individual naloxone.[12] Naloxone injection and naloxone pre-filled auto-injection device are used along with emergency medical treatment to reverse the life-threatening effects of opiate overdose. Naloxone injection is also used after surgery to reverse the effects of opiates given during surgery and is given to newborns to decrease the effects of opiates received by the pregnant mother prior to delivery.[13]

Naloxone can be used when someone believes an individual is suffering either an opioid or a heroin overdose. Naloxone injection comes as a solution (liquid) to be injected intravenously (into a vein), intramuscularly (into a muscle), or subcutaneously (just under the skin) and as a pre-filled auto-injection device containing a solution (liquid) to be injected intramuscularly (into a muscle) or subcutaneously (under the skin).[14] It is usually given as needed to treat opiate overdoses. However, it does not work on benzodiazepine overdoses.[15,16] Naloxone is also known by its brand names of Narcan or Evzio.

First responders have been regularly carrying the drug for 40 years and the CDC reports that many law enforcement agencies across the nation have also been equipped with naxolone.[17] The federal government has made a tool-kit available through a Department of Justice grantee website on the use of naloxone that is geared toward the law enforcement community.[18] One version of the product comes with a trainer that talks the caregiver through the drug administration.

As of December 31, 2014, 24 states authorize health care practitioners to prescribe opioid antagonists to third parties.[19]

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[11] *Supra* note 1.
[12] *Supra* note, 1 at 5.
[13] Medline Plus, *Naloxone Injection* (May 15, 2014) http://www.nlm.nih.gov/medlineplus/druginfo/meds/a612022.html (last visited Feb. 28, 2015)
[14] *Id*.
[15] *Supra* note 12.
[16] Examples of benzodiazepines include: Valium, Xanax, or Klonopin.
[17] *Supra* note 4 and note 12.
[18] *Infra* note 29.
[19] These states are: California, Colorado, Georgia, Illinois, Kentucky, Massachusetts, Maryland, Maine, Michigan, North Carolina, New Jersey, New Mexico, new York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Utah, Virginia, Vermont, Washington, and Wisconsin. *See* Law Atlas, The Policy Surveillance Portal, Public Health law Research, Robert Wood Johnson Foundation, http://lawatlas.org/query?dataset=laws-regulating-administration-of-naloxone (last visited Feb. 28, 2015).

Regulatory Landscape

Barriers may exist to the access to and the administration of the opioid antagonist where state health care practice laws prevent a non-patient from being issued a prescription as a caregiver or a friend and a dispenser from filling such a prescription, or where prescribers or dispensers have liability concerns.

The Florida Board of Medicine reviewed this issue at its December 5, 2014 meeting. A health care practitioner had raised the issue whether he could prescribe an opioid antagonist to his patient for administration by a third party at a later date and to teach overdose prevention and response education without violating certain provisions of the practice act.[20] The areas of concern covered by those provisions are:[21]

- Aiding or assisting an unlicensed person to practice medicine;
- Failing to perform any statutory or legal obligation placed on a licensed physician;
- Prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including a controlled substance, other than in the course of the physician's practice;
- Committing medical malpractice; and
- Delegating professional responsibilities to a person when the licensee delegating those responsibilities knows or has reason to know that such a person is not qualified to perform them.

The board granted the practitioner's request noting that its approval was specific only to his petition and suggested that a legislative change be sought.[22]

A pharmacist is subject to discipline for dispensing a drug pursuant to a prescription when the pharmacist knows or has reason to believe that the prescription is not based on a valid practitioner-patient relationship.[23]

The Florida Legislature and the federal government have already enacted legislation allowing third parties to receive prescriptions for the benefit of others relating to a variety of other health care services. For example:

- The Emergency Allergy Treatment Act authorizes a variety of persons, such as camp counselors, scout leaders, and tour guides, and entities to possess and store epinephrine auto-

[20] The specific practice acts include ss. 458.331(1)(f), (g), (q), (t) or (w), F.S., or any other rule of the board. *See* Florida Bd. of Medicine, Florida Dep't of Health, *Final Order on Petition for Declaratory Statement (p.144 of the Public Book Addendum)* (February 6, 2015) http://ww10.doh.state.fl.us/pub/medicine/Agenda_Info/Public_Information/Public_Books/2015/February/02062015_FBAddendum_PublicBook.pdf (last visited Feb. 27, 2015).

[21] Florida Bd. of Medicine, Florida Dep't of Health, *Final Order on Petition for Declaratory Statement (p.144 of the Public Book Addendum)* (February 6, 2015) http://ww10.doh.state.fl.us/pub/medicine/Agenda_Info/Public_Information/Public_Books/2015/February/02062015_FBAddendum_PublicBook.pdf (last visited Feb. 27, 2015).

[22] Florida Bd. of Medicine, Florida Dep't of Health, *Minutes for December 5, 2015 Meeting*, p. 20, *http://ww10.doh.state.fl.us/pub/medicine/Agenda_Info/Public_Information/Public_Minutes/2015/February/02062015_FB_Minutes.pdf* (last visited Feb. 27, 2015).

[23] Section 465.016(1)(s), F.S.

injectors for later use on a person who the individual believes in good faith is experiencing a severe allergic reaction.[24]

- Pharmacists may administer, in the event of an allergic reaction, epinephrine using an auto injection delivery system within the framework of an established protocol with a physician when providing immunizations. [25]
- School personnel may purchase and maintain a supply of epinephrine auto-injectors in a secure, locked location on its premises for use if a student has an anaphylactic reaction.[26]
- Federal *School Access to Emergency Epinephrine Act* provides a financial incentive to schools to maintain a supply of the epinephrine medication and to permit trained personnel to administer it. [27]

The Emergency Allergy Treatment Act also authorizes a health care practitioner to prescribe epinephrine auto-injectors in the name of an authorized entity and pharmacists to dispense epinephrine auto-injectors pursuant to a prescription issued in the name of an authorized entity. Under that act, immunity from liability is provided to persons, authorized entities, and health care practitioners when acting in accordance with authorizations in the act.

Good Samaritan Act

Florida's Good Samaritan Act, found in s. 768.13, F.S., provides, in part:

> (2)(a) Any person, including those licensed to practice medicine, who gratuitously and in good faith renders emergency care or treatment either in direct response to emergency situations related to and arising out of a public health emergency …, a state of emergency …, or at the scene of an emergency outside of a hospital, doctor's office, or other place having proper medical equipment, without objection of the injured victim or victims thereof, shall not be held liable for any civil damages as a result of such care or treatment or as a result of any act or failure to act in providing or arranging further medical treatment where the person acts as an ordinary reasonably prudent person would have acted under the same or similar circumstances.

III. Effect of Proposed Changes:

CS/SB 758 creates the "Florida Opioid Overdose Prevention Act" as s. 381.887, F.S., and provides definitions. The following definitions are created specific to the Act:

- Administer or administration means the introduction of an opioid antagonist approved by the United States Food and Drug Administration (FDA) into the body of a person;
- Authorized health care practitioner means a Florida licensed practitioner authorized to prescribe drugs;
- Caregiver means a family member, friend, or any other person who may assist a person at risk of an opioid overdose; and

[24] Chapter 2014-141, Laws of Fla.
[25] Chapter Law 2012-60, s. 1, Laws of Fla.
[26] Chapter Law 2013-63, ss. 1 and 3, Laws of Fla.
[27] Pub. Law 113-48, H.R. 2094, 113th Cong. (Nov. 13, 2013)

- Emergency overdose treatment information means information relating to:
  - Recognition of an opioid overdose and prevention,
  - How to perform rescue breathing,
  - Opioid antagonist dosage and administration,
  - The importance of calling 911, and
  - How to care for an overdose victim after an opioid antagonist administration;
- Opioid antagonist means naloxone hydrochloride or any similar acting drug that blocks the effects of opioids that is administered outside of the body and is approved by the FDA for treatment of opioid overdose; and
- Patient means a person at risk of experiencing an opioid overdose.

The bill authorizes the prescription of an opioid antagonist to a patient or a caregiver and to encourage the administration of that antagonist for the emergency treatment of a known or expected opioid overdose when a physician or other authorized health care practitioner is not available.

CS/SB 758 authorizes health care providers to prescribe and dispense the opioid antagonist and requires the health care practitioner or his or her agent to provide the recipient of the prescription with the emergency overdose information.

A pharmacist is authorized to dispense an opioid antagonist based on a prescription that is issued to patient or caregiver. The bill requires the prescription to be appropriately labeled with instructions for use and to be issued in the name of the patient or the caregiver.

The bill permits the patient or caregiver who has an opioid antagonist prescription to store and possess the drug. The patient or caregiver is also permitted to administer the drug to a person whom he or she believes in good faith may be experiencing an opioid overdose, regardless of whether that person has his or her own prescription for an opioid antagonist.

An authorized health care practitioner may directly or through a standing order, prescribe and dispense an opioid antagonist to first responders. The bill identifies first responders as those defined under s. 112.1815, F.S.:

- Law enforcement officers as defined in s. 943.10, F.S.;
- Firefighters as defined in s. 633.102, F.S.;
- Emergency medical technicians or paramedics as defined in s. 401.23, F.S., employed by state or local government; and
- Volunteer law enforcement officers, firefighters, emergency medical technicians or paramedics engaged by the state or local governments.

First responders are authorized to administer an approved opioid antagonist in accordance with his or her employers' policies.

Civil liability immunity protection is extended under the Good Samaritan Act to any person, an authorized or dispensing health care practitioner, or a first responder who possesses, administers, or stores an approved opioid antagonist under the provisions of this bill.

The bill also provides civil and criminal liability and protection from professional licensure action or other adverse action for any licensed health care practitioner or pharmacist, acting in good faith and exercising reasonable care as a result of prescribing or dispensing an opioid antagonist under the provisions of this bill.

The bill does not limit any immunities that currently exist for first responders and others that are provided under statute or rule. Also, the bill does not create a duty or standard of care for a person to prescribe or to administer an opioid antagonist.

The bill is effective upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Caregivers or other persons in a position to help someone at risk of an opioid overdose who have received emergency overdose treatment information would be eligible under the bill to acquire a prescription for an opioid antagonist. Individuals participating in this process would incur costs to acquire the opioid antagonist after receiving the required information.

C. Government Sector Impact:

The Bureau of Health Care Practitioner Regulation at the Department of Health reports no fiscal impact for CS/SB 758.[28]

[28] Department of Health, Bureau of Health Care Practitioner Regulation, *Senate Bill 758 Analysis,* p. 4 (Feb. 11, 2015) (on file with the Senate Committee on Health Policy).

To the extent that local governments opt to stock a supply of opioid antagonists to address drug over-doses for their emergency medical services, police and fire departments or other first responders, there could be a cost incurred to acquire the drugs.

According to the Bureau of Justice Assistance, the cost of a single rescue kit ranges from $22 to $60.[29]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 381.887, 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 4, 2015:
The committee substitute makes the prescribing health care practitioner or his or her agent responsible for providing the emergency overdose treatment information to the patient or caregiver receiving the opioid antagonist prescription rather a third party organization. The committee substitute also provides a statutory cross reference for the term "first responder."

B. Amendments:

None.

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

[29] This information is provided by the Bureau of Justice Assistance, a contractor of the Office of Justice Programs, U.S. Department of Justice whose mission is to support state, local and tribal justice professionals to achieve safer communities. The Bureau has a Law Enforcement Naloxone Toolkit available at: https://www.bjatraining.org/tools/naloxone/Naloxone%2BBackground (last visited Feb. 26, 2015).

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/04/2015	.	
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The Committee on Health Policy (Galvano) recommended the following:

Senate Amendment

Delete lines 63 - 94
and insert:
prescribing authorized health care practitioner or his or her agent. The patient or caregiver who has an opioid antagonist prescription may store and possess an approved opioid antagonist. In an emergency situation when a physician or other authorized health care practitioner is not immediately

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available, any patient or caregiver who has received emergency overdose treatment information may administer the opioid antagonist to a person believed in good faith to be experiencing an opioid overdose, regardless of whether that person has a prescription for an opioid antagonist.

(4) An authorized health care practitioner may, directly or by standing order, prescribe and dispense opioid antagonists to first responders, as defined in s. 112.1815, and such first responders may possess, store, and administer approved opioid antagonists as prescribed and clinically indicated, and in accordance with the policies of the employer of such first responders.

(5) Any person, including an authorized health care practitioner, a dispensing health care practitioner, a pharmacist, or a first responder, as defined in s. 112.1815, who possesses,

By Senator Evers

2-00542A-15 2015758__

A bill to be entitled

An act relating to the prescription and use of opioid antagonists for emergency treatment of opioid overdoses; providing a short title; creating s. 381.887, F.S.; defining terms; providing the purposes of the act; providing for the prescribing of opioid antagonists to, and the use of them by, patients and caregivers who have received emergency overdose treatment information; providing for the prescribing of opioid antagonists to, and the use of them by, first responders; providing immunities from liability; providing applicability; providing an effective date.

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

Section 1. This act may be cited as the "Florida Opioid Overdose Prevention Act."

Section 2. Section 381.887, Florida Statutes, is created to read:

381.887 Prescription for and dispensing of opioid antagonists.—

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

(a) "Administer" or "administration" means to introduce an opioid antagonist into the body of a person by using a formulation approved by the United States Food and Drug Administration.

(b) "Authorized health care practitioner" means a licensed practitioner authorized by the laws of this state to prescribe drugs.

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2-00542A-15 2015758__

(c) "Caregiver" means a family member, a friend, or any other person in a position to assist a person at risk of experiencing an opioid overdose.

(d) "Emergency overdose treatment information" means information regarding issues that include, but are not limited to, opioid overdose prevention and recognition, how to perform rescue breathing, opioid antagonist dosage and administration, the importance of calling 911 for assistance with an opioid overdose, and care for an overdose victim after administration of an opioid antagonist.

(e) "Opioid antagonist" means naloxone hydrochloride or any similarly acting drug that blocks the effects of opioids that have been administered from outside the body and that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose.

(f) "Patient" means a person at risk of experiencing an opioid overdose.

(2) The purpose of this section is to provide for the prescription of an opioid antagonist to patients and caregivers and to encourage the administration of opioid antagonists for emergency treatment of known or suspected opioid overdoses when a physician or other authorized health care practitioner is not immediately available.

(3) An authorized health care practitioner may prescribe an opioid antagonist for use in accordance with this section to a patient or caregiver who has received emergency overdose treatment information. A dispensing health care practitioner or pharmacist may dispense an opioid antagonist, appropriately labeled with instructions for use, pursuant to a prescription

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

which has been issued in the name of a patient or caregiver. In order to fulfill the requirement that a patient or caregiver receive emergency overdose treatment information, such information may be provided to a patient or caregiver by the prescribing authorized health care practitioner or by an organization that addresses medical or social issues related to drug addiction with which the prescribing authorized health care practitioner maintains a written agreement and which also is exempt from taxation pursuant to 26 U.S.C. s. 501, a federal, state, or local governmental entity, or a substance abuse organization. Such agreement must include procedures for providing emergency overdose treatment information, instructions as to how employees or volunteers providing the information will be trained, and standards for documenting, on behalf of the prescribing authorized health care practitioner, the provision of emergency overdose treatment information to patients and caregivers. The patient or caregiver who has an opioid antagonist prescription may store and possess an approved opioid antagonist. In an emergency situation when a physician or other authorized health care practitioner is not immediately available, any patient or caregiver who has received emergency overdose treatment information may administer the opioid antagonist to a person believed in good faith to be experiencing an opioid overdose, regardless of whether that person has a prescription for an opioid antagonist.

(4) An authorized health care practitioner may, directly or by standing order, prescribe and dispense opioid antagonists to first responders, including law enforcement officers and emergency medical technicians, and such first responders may

possess, store, and administer approved opioid antagonists as prescribed and clinically indicated, and in accordance with the policies of the employer of such first responders.

(5) Any person, including an authorized health care practitioner, a dispensing health care practitioner, a pharmacist, or a first responder, including any law enforcement officer or emergency medical technician, who possesses, administers, or stores an approved opioid antagonist in compliance with this section and with s. 768.13 is afforded the civil liability immunity protection provided under s. 768.13.

(6) Any authorized health care practitioner, acting in good faith and exercising reasonable care, is not subject to discipline or other adverse action under any professional licensure statute or rule and is immune from any civil or criminal liability as a result of prescribing an opioid antagonist in accordance with this section. Any dispensing healthcare practitioner or pharmacist, acting in good faith and exercising reasonable care, is not subject to discipline or other adverse action under any professional licensure statute or rule and is immune from any civil or criminal liability as a result of dispensing an opioid antagonist in accordance with this section.

(7) This section does not limit any existing immunities for first responders and others provided under any other applicable statute or rule. This section does not create a duty or standard of care for a person to prescribe or administer an opioid antagonist.

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

03/04/2015
Meeting Date

758
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Brian Jogerst

Job Title _____

Address 215 S. Monroe St Suit 703
Street

Phone _____

32301
City *State* *Zip*

Email brian@bhandassociates.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Shatterproof

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/15
Meeting Date

SB 758
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Opioid Antagonists

Name Christopher Nuland

Job Title

Address 1000 Riverside Drive
Street

Jacksonville FL
City *State* *Zip*

Phone

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Public Health Association / American College of Physicians

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3.4.15
Meeting Date

SB 758
Bill Number (if applicable)

Topic Opiod Antagonists

Amendment Barcode (if applicable)

Name Barney Bishop

Job Title CEO

Address 204 S. Monroe St., Ste. 201
Street

Phone 577-3032

Tall FL 32301
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Fla. Smart Justice Alliance

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/2015
Meeting Date

758
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Florida Opioid Overdose Prevention Act

Name Julia Negron

Job Title Lead Organizer, Suncoast Harm Reduction Project

Address 661 Alligator Dr.
Street
Venice CA 34293
City *State* *Zip*

Phone 818 679 3156

Email julia@negron.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Suncoast Harm Reduction Project (overdose survivor)

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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S-001 (10/14/14)

1:00 PM
412-K

WAIVE TIME IN SUPPORT

THE FLORIDA SENATE

APPEARANCE RECORD

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

3-4-2015
Meeting Date

Topic PRESCRIPTION AND USE OF OPIOID ANTAGONISTS Bill Number SB 758 *(if applicable)*

Name STEPHEN R. WINN Amendment Barcode _____ *(if applicable)*

Job Title EXECUTIVE DIRECTOR OF THE FOMA

Address 2007 APALACHEE PARKWAY *Street* Phone 878-7364

TALLAHASSEE *City* FL *State* 32301 *Zip* E-mail _____

Speaking: ☒ For ☐ Against ☐ Information

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

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

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

March 4, 2015
Meeting Date

SB758
Bill Number (if applicable)

Topic Naloxone Bill - A Mother's Act

Amendment Barcode (if applicable)

Name Chuck Madden

Job Title Interventionist

Address 4557 Camino Real
Street

Phone 941-545-4360

Sarasota — *City* | Florida — *State* | 34231 — *Zip*

Email chuck@madden-group.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Madden Group

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

March 4, 2015
Meeting Date

SB758
Bill Number (if applicable)

Topic A Mother's Act Naloxone Bill

Amendment Barcode (if applicable)

Name Lisa Brandy

Job Title President - Brandi's Wish Foundation

Address 4557 Camino Real
Street

Phone 941-232-1420

Sarasota FL 34231
City *State* *Zip*

Email lisabrandy@brandiswish.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Brandi's Wish Foundation and Sarasota Harm Reduction Project

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/2015
Meeting Date

SB 758
Bill Number (if applicable)

Topic Prescription and Use of Opioid Antagonists

Amendment Barcode (if applicable)

Name Dr. Scott A. Teitelbaum

Job Title Chief, Division of Addiction Medicine, University of Florida

Address 1600 SW Archer Rd
Street

Phone 352-265-5497

Gainesville FL 32610
City *State* *Zip*

Email teitesa@ufl.edu

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Society of Addiction Medicine

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/2014
Meeting Date

SB 758
Bill Number (if applicable)

Topic Prescription and Use of Opioid Antagonists

Amendment Barcode (if applicable)

Name Kelly Corredor

Job Title President & CEO of The Skeeterhawk Experiment

Address 1405 Fryston Street
Street

Saint Johns FL 32259
City *State* *Zip*

Phone 904-657-6371

Email kelly@skeeterhawk.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing The Skeeterhawk Experiment, a partner in "A Mother's Act" Coalition

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

Mar 4th
Meeting Date

SB 758
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Prescription & Use of Opiod Antagonists

Name Leon Smith

Job Title Retired Dentist / Parent

Address 49 San Carlos Dr
Street

Palm Coast Fl 32137
City *State* *Zip*

Phone 352-552-5551

Email leonsmithdds@gmail.com

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

Representing Andrew Smith memorial fund a partner in A Mother's ACT

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

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3-4-15
Meeting Date

758
Bill Number (if applicable)

Topic Prescription & Use of Opioid Antagonists

Amendment Barcode (if applicable)

Name Jill Gran

Job Title Legislative Affairs Director

Address 2508 Mahan Dr.
Street

Tallahassee FL 32308
City *State* *Zip*

Phone 878 2196

Email jill@fedaa.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Alcohol & Drug Abuse Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/15
Meeting Date

758
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Prescription and Use of Opioid Antagonists for Emergency Treatment of Opioid Overdoses

Name Tabitha McDonald

Job Title Government Affairs Coordinator

Address 2617 Mahan Drive
Street

Tallahassee FL 32308
City *State* *Zip*

Phone 850-877-2165

Email tmcdonald@flsheriffs.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Sheriffs Association

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3-4-15
Meeting Date

SB 758
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Opioid Abatement

Name KAREN BAILEY

Job Title REAL ESTATE BROKER

Address 2335 SW 80th St.
Street

Phone 352-875-3391

OCALA FL 34476
City *State* *Zip*

Email OCALASBESTHOMES@AOL.COM

Speaking: ☐ For ☐ Against ☐ Information

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

Representing

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/14/14)

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 606
INTRODUCER:	Health Policy Committee and Senators Gaetz, Montford, and Sobel
SUBJECT:	Dental Care
DATE:	March 4, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Fav/CS**
2.			AHS	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 606 authorizes the creation of joint state and local dental care access accounts to promote local economic development and to encourage Florida-licensed dentists to practice in dental health professional shortage or medically underserved areas or serve a medically underserved population, subject to the availability of funds.

The Department of Health (department) is directed to create individual benefit accounts through an electronic benefits transfer system for each dentist who satisfies the requirements of participation. A qualifying dentist must be actively employed by a public health program in a targeted area or demonstrate a commitment to opening a dental practice that serves at least 1,200 patients and obtaining local financial support from the community where the dentist will practice in a targeted area.

Funds from the account may be used to repay dental school loans; purchase property, facilities, or equipment for a dental office; or pay for transitional expenses relating to relocating or opening a dental practice. A practitioner may receive funds for up to 5 years, subject to availability. An account will be closed if a practitioner fails to comply with program requirements and any unspent funds will be returned to the donor on a pro-rata basis or re-distributed to available applicants or initiative participants.

CS/SB 606 requires the department to develop a marketing plan with the state's dental schools and the Florida Dental Association for the dental care access account initiative.

The department estimates first year implementation expenditures of $130,341 and on-going maintenance and support costs for the initiative of $152,050.

II. Present Situation:

Health Professional Shortage Areas

Health Professional Shortage Areas (HPSAs) are designated by the U.S. Department of Health and Human Services, Health Resources and Services Administration according to criteria developed in accordance with section 332 of the Public Health Services Act. HPSA designations are used to identify areas and population groups within the United States that are experiencing a shortage of health professionals.

There are three categories of HPSA designation: 1) primary medical; 2) dental; and 3) mental health. For each discipline category, there are three types of HPSA designations based on the area or population group that is experiencing the shortage: 1) geographic area; 2) population group; and 3) facility.

A geographic HPSA indicates that the entire area may experience barriers in accessing care, while a population HPSA indicates that a particular subpopulation of an area (e.g., homeless or low-income) may be underserved. Finally, a facility HPSA is granted to a unique facility that primarily cares for an underserved population. The primary factor used to determine a HPSA designation is the number of health professionals relative to the population with consideration of high need. The threshold for a dental HPSA is a population-to-provider ratio of at least 5,000 to 1 (4,000 to 1 in high need communities).

Medically Underserved Area

Medically Underserved Areas (MUA) are also designated by the U.S. Department of Health and Human Services. These areas are designated using one of three methods and can be a whole county or group of contiguous counties, or census tracts.[1] The first method, the Index of Medical Underservice (IMU), calculates a score based on the ratio of primary medical care physicians per 1,000 population, percentage of the population with incomes below the poverty level, infant mortality rate, and percentage of population age 65.

The second method, Medically Underserved Populations (MUP), builds off data collected under the MUA process, and reviews the ratio of primary care physicians serving the population seeking the designation. A MUP is a group of people who encounter economic or cultural barriers to primary health care services.

Finally, the third process, Exceptional MUP Designations, includes those population groups which do not meet the criteria of an IMU, but may be considered for designation because of

[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Shortage Demonstration: Health Professional Areas & Medically Underserved Areas/Populations* http://www.hrsa.gov/shortage/ (Last visited Mar. 2, 2015).

unusual conditions with a request by the Governor or another senior executive level official and local state health official.[2]

The Dental Workforce

Nationally, the pool of dentists to serve a growing population of Americans is shrinking. The American Dental Association has found that 6,000 dentists retire each year in the U.S., while there are only 4,000 dental school graduates each year to replace them. The projected shortage of dentists is even greater in rural America. Of the approximately 150,000 general dentists in practice in the U.S., only 14 percent practice in rural areas, 7.7 percent in large rural areas, 3.7 percent in small rural areas, and 2.2 percent in isolated rural areas. In 2003, there were 2,235 federally designated dental health professional shortage areas (HPSAs).[3] Today, the number of dental HPSAs has increased to over 4,900.

While the dental workforce is projected to grow from 2012 to 2025 by 6 percent, it is not expected to meet the overall national demand. States expected to have the greatest shortfall are California with the largest number (1,234 fewer FTE dentists than needed) followed by Florida (1,152 fewer dentists than needed).[4]

Similar to the national trend, most dentists in Florida are concentrated in the more populous areas of the state, while rural areas, especially the central Panhandle counties and interior counties of south Florida, have a noticeable dearth of dentists.[5] This is true for both general dentistry as well as for dental specialists. Over 20 percent of Florida licensed dentists that responded to the 2011-2012 *Florida Workforce Survey of Dentists* (survey) currently do not practice in this state.[6]

Most dentists, 77.8 percent, practice in general dentistry.[7] In many rural communities, the county health department may be the primary provider of health care services, including dental care. Florida currently has 220 designated dental HPSAs, which have only enough dentists to serve 17 percent of the population living within them. For 2012, HRSA estimated that 853 additional dentists were required to meet the total need. This puts Florida among the states with the highest proportion of their population that are deemed underserved. By 2025, the need grows to 1,152 dentists.[8]

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[2] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Medically Underserved Areas/Populations* http://www.hrsa.gov/shortage/mua/index.html (last visited Mar. 2, 2015).

[3] National Rural Health Association, *Issue Paper: Recruitment and Retention of a Quality Health Workforce in Rural Areas*, (November 2006) (on file with the Senate Committee on Health Policy).

[4] U.S. Department of Health and Human Services, Health Resources and Services Administration, *National and State Level Projections of Dentists and Dental Hygienists in the U.S., 2012-2015*, pp.-3-4 (February 2015) http://bhpr.hrsa.gov/healthworkforce/supplydemand/dentistry/nationalstatelevelprojectionsdentists.pdf (last visited Feb. 27, 2015).

[5] Florida Dept. of Health, *Report on the 2011-2012 Workforce Survey of Dentists*, p. 6 (April 2014) http://www.floridahealth.gov/programs-and-services/community-health/dental-health/workforce-reports/florida-workforce-survey-of-dentists-2011-2012.pdf (last visited Feb. 27, 2015). In 2009, the department developed this workforce survey for dentists. The survey was administered on a voluntary basis in conjunction with biennial renewal of dental licenses and 87 percent of dentists with an active Florida license responded to the survey; a drop of 2 percent points from the 2009-2010 survey.

[6] Id. at 46.

[7] Id.

[8] *Supra* note 4, at 9.

The American Dental Association has also studied this issue and found that while there may be a sufficient number of dentists overall, there may be an inadequate number among certain populations or in certain geographic areas.[9] Children are acutely affected by the shortage of dentists to serve low income patients. In 2012, 26 percent of Medicaid-enrolled children in Florida received one or more dental care services according data from the Agency for Health Care Administration (AHCA).[10] The survey noted a noticeable participation difference between private practice dentists and those who practice in a safety net setting. Of those in a private office setting only 13.7 percent report seeing Medicaid enrollees while over 60 percent of safety net providers report participation.[11]

In 2011, the Legislature passed HB 7107[12] creating the Statewide Medicaid Managed Care (SMMC) program as part IV of ch. 409, F.S. The program has two primary components: Managed Medical Assistance program (MMA) and Long Term Care program. To implement MMA, the law required the AHCA to create an integrated managed care program for Medicaid enrollees that incorporates all of the minimum benefits, for the delivery of primary and acute care, including dental. Medicaid recipients who are enrolled in the MMAP program receive their dental services through the fully integrated managed care plans. Although most dental services are designated as a minimum benefit only for Medicaid recipients under age 21, many of the managed care plans also provide, as an enhanced benefit, dental services for adults.

The Cost of Dental Education

Among U.S. dental schools, the cost of a 4-year degree has risen dramatically over the last 10 years — by 93 percent for in-state residents (from about $89,000 to $171,000) and by 82 percent for out-of-state residents (from $128,000 to $234,000). Dental school debt has increased proportionately. The average debt for dental school graduates in 2011 was $245,497.[13]

Of concern is whether such high debt loads limit a graduate's ability to choose from starting a private practice, entering the public practice, joining academic dentistry, or serving low-income patients. A second concern is whether rising costs and indebtedness discourage economically disadvantaged and minority students from pursuing dentistry as a career. Some studies suggest that minority dentists are more likely to provide care to minority patients. Thus, increased educational costs and indebtedness could further erode access to care for vulnerable, underserved populations.[14]

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[9] Bradley Munson, B.A., and Marko Vujicic, Ph.D.: Health Policy Institute Research Brief, American Dental Association, *Supply of Dentists in the United States Likely to Grow*, p.2. (October 2014) http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1014_1.ashx (last visited Feb. 27, 2015).
[10] *Supra* note 5, at 8.
[11] *Supra* note 5, at 35.
[12] *See* ch. 2011-134, Laws of Fla.
[13] *Supra* note 4, at 6.
[14] American Dental Education Association, *A Report of the ADEA Presidential Task Force on the Cost of Higher Education and Student Borrowing*, pp. 17-18 (March 2013) http://www.adea.org/uploadedFiles/ADEA/Content_Conversion_Final/publications/Documents/ADEACostandBorrowingReportMarch2013.pdf (last viewed Feb. 27, 2015). *See* also U.S. Dept. of Health and Human Services, Health Resources and Services Administration, *Financing Dental Education: Public Policy Interests, Issues and Strategic Considerations*, p. 39 (2005) http://bhpr.hrsa.gov/healthworkforce1/reports/financedentaledu.pdf (last visited Feb 27. 2015).

At least three studies, including a 2011 Florida Senate Report,[15] have recommended consideration of loan forgiveness programs as one strategy for addressing dental workforce shortage concerns.[16]

Florida Health Services Corps

In 1992, the Legislature created the Florida Health Services Corps (FHSC), administered by the department, to encourage medical professionals to practice in locations that are underserved because of a shortage of qualified professionals.[17] The FHSC was defined[18] as a program that offered scholarships to allopathic, osteopathic, chiropractic, podiatric, dental, physician assistant, and nursing students, and loan repayment assistance and travel and relocation expenses to allopathic and osteopathic residents and physicians, chiropractic physicians, podiatric physicians, nurse practitioners, dentists, and physician assistants, in return for service in a public health care program[19] or in a medically underserved area.[20] Membership in the FHSC could be extended to any health care practitioner who provided uncompensated care to medically indigent patients.[21] All FHSC members were required to enroll in Medicaid and to accept all patients referred by the department pursuant to the program agreement.[22] In exchange for this service, an FHSC member was made an agent of the state and granted sovereign immunity under s. 768.28(9), F.S., when providing uncompensated care to medically indigent patients referred for treatment by the department.[23]

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[15] Comm. on Health Regulation, The Florida Senate, *Review Eligibility of Dentist Licensure in Florida and Other Jurisdictions*, p.15 (Interim Report 2012-127) (Sept. 2011) http://www.flsenate.gov/PublishedContent/Session/2012/InterimReports/2012-127hr.pdf (last visited Mar. 2, 2015). The report concluded, in part: "Florida may become more competitive in its recruitment of dentists in rural areas and may enhance Florida's dental care for underserved populations if it offers a loan forgiveness program. The program could require dentists seeking loan assistance to serve in a rural area (the Panhandle or central, south Florida) and require dentists to serve a certain percentage of Medicaid recipients or participate in the provider network of managed care entities participating in the Medicaid program for a particular period of time. Considering the current lack of state resources, it may be beneficial to limit the number of dentists that may apply to the loan forgiveness program and target resources to areas with the most need for general dentists or specialists." At the time, Florida was one of only eight states that did not have a state loan forgiveness program. According to the American Dental Association, it is one of only 11 states: Alabama, Arkansas, Connecticut, Florida, Georgia, Hawaii, Idaho, Indiana, Montana, Texas, and Utah as of July 2014. http://www.ada.org/~/media/ADA/Education%20and%20Careers/Files/dental-student-loan-repayment-resource.ashx (Last visited Mar. 2, 2015).

[16] American Dental Education Association, *supra* note 14, at 26; *Financing Dental Education*, *supra* note 14, at 40.

[17] Ch. 92-33, s. 111, Laws of Fla. (creating s. 381.0302, F.S., effective July 1, 1992).

[18] Section 381.0302(2)(b)1., F.S. (2011).

[19] "Public health program" was defined to include a county health department, a children's medical services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program designated by the department. Section 381.0302(2)(e), F.S. (2011).

[20] "Medically underserved area" was defined to include: a geographic area, a special population, or a facility that has a shortage of health professionals as defined by federal regulations; a county health department, community health center, or migrant health center; or a geographic area or facility designated by rule of the department that has a shortage of health care practitioners who serve Medicaid and other low-income patients. Section 381.0302(2)(c), F.S. (2011).

[21] "Medically indigent person" was defined as a person who lacks public or private health insurance, is unable to pay for care, and is a member of a family with income at or below 185 percent of the federal poverty level. Section 381.0302(2)(d), F.S. (2011).

[22] Section 381.0302(10), F.S. (2011).

[23] Section 381.0302(11), F.S. (2011).

The statute authorized the department to provide loan repayment assistance and travel and relocation reimbursement to allopathic and osteopathic medical residents with primary care specialties during their last 2 years of residency training or upon completion of residency training, and to physician assistants and nurse practitioners with primary care specialties, in return for an agreement to serve a minimum of 2 years in the FHSC. During the period of service, the maximum amount of annual financial payments was limited to no more than the annual total of loan repayment assistance and tax subsidies authorized by the National Health Services Corps loan repayment program.[24]

During the 20 years the program was in statute, it was funded only three times. A total of $3,684,000 was appropriated in the 1994-1995 fiscal year, 1995-1996 fiscal year, and 1996-1997 fiscal year for loan assistance payments to all categories of eligible health care practitioners. Of that amount, $971,664 was directed to 18 dentists for an average award of $25,570 per year of service in the program.[25] The 2007 Legislature attempted to reinvigorate the program by appropriating $700,000 to fund loan repayment assistance for dentists, only.[26] However, the appropriation and a related substantive bill were vetoed by the Governor.[27] The Legislature repealed the program in 2012.[28]

National Health Service Corps

The National Health Service Corps (NHSC) programs provide scholarships and educational loan repayment to primary care providers[29] who agree to practice in areas that are medically underserved. NHSC loan repayment program (LRP) participants fulfill their service requirement by working at NHSC-approved sites in HPSAs. The NHSC-approved sites are community-based health care facilities that provide comprehensive outpatient, ambulatory, primary health care services. Eligible dental facilities must be located in a dental HPSA and offer comprehensive primary dental health services. NHSC-approved sites (with the exception of correctional facilities and free clinics) are required to provide services for free or on a sliding fee scale (SFS) or discounted fee schedule for low-income individuals. The SFS or discounted fee schedule is based upon the Federal Poverty Guidelines, and patient eligibility is determined by annual income and family size.[30]

The LRP provides funds to participants to repay their outstanding qualifying educational loans. Maximum loan reimbursement under the program is $50,000 for either a 2-year, full-time or 2-year, half-time clinical practice for up to $15,000, although participants may be eligible to

[24] Section 381.0302(6), F.S. (2011).
[25] Email from Karen Lundberg, Florida Dept. of Health, to Joe Anne Hart, Florida Dental Association (Sept. 16, 2005) (on file with the Senate Committee on Health Policy).
[26] Ch. 2007-72, Laws of Fla. The funding was contained in Specific Appropriations 677A of the General Appropriation Act, but later vetoed pursuant to the Governor's line item veto authority.
[27] *Journal of the Florida Senate*, at 3 (June 12, 2007).
[28] Ch. 2012-184, s. 45, Laws of Fla.
[29] Primary care physicians, nurse practitioners, certified nurse midwives, physician assistants, dentists, dental hygienists, and behavioral and mental health providers, including health service psychologists, licensed clinical social workers, marriage and family therapists, psychiatrist nurse specialists, and licensed professional counselors.
[30] U.S. Dept. of Health and Human Services, Health Resources and Services Administration, *National Health Service Corps Site Reference Guide*, (April 14, 2014) http://nhsc.hrsa.gov/downloads/sitereference.pdf (last visited Mar. 2, 2015).

continue loan repayment beyond the initial term.[31,32] Participants who breach their LRP agreement are subject to monetary damages, which are the sum of the amount of assistance received by the participant representing any period of obligated service not completed, a penalty, and interest. Loan repayments are exempt from federal income and employment taxes and are not included as wages when determining benefits under the Social Security Act.[33] In 2013, there were 38.5 full time equivalent NHSC dentists in Florida.[34]

A second NHSC program, the State Loan Repayment Program (SLRP) offers cost-sharing grants to states to operate their own state educational loan repayment programs for primary care providers, including dental professionals, working in HPSAs within the state. The SLRP varies from state-to-state, and may differ in eligible categories of providers, practice sites, length of required service commitment, and the amount of loan repayment assistance offered. However, there are certain statutory requirements SLRP grantees must meet. There is a minimum 2-year service commitment with an additional 1 year commitment for each year of additional support requested. Any SLRP program participant must practice at an eligible site located in a federally-designated HPSA. Like the NHSC loan repayment program awards, assistance provided through a SLRP is not taxable.

In addition, the SLRP requires a $1 state match for every $1 provided under the federal grant. While the SLRP does not limit award amounts, the maximum award amount per provider that the federal government will support through its grant is $50,000 per year, with a minimum service commitment of 2 years.

Currently, Florida does not participate in SLRP.

III. Effect of Proposed Changes:

CS/SB 606 creates the dental care access accounts initiative at the Department of Health. The initiative is conditioned on the availability of funds and is intended to encourage dentists to practice in dental health professional shortage areas or medically underserved areas or serve a medically underserved population. The bill defines several key terms:

- Dental health professional shortage area: A geographic area so designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services;
- Medically underserved area: A designated health professional shortage area that lacks an adequate number of dental health professionals to serve Medicaid and other low income patients; and

[31] The definition of part-time and full-time vary by discipline. The guidelines for both can be found in the *Fiscal Year 2015 Application and Program Guidance* packet beginning on 19 http://www.nhsc.hrsa.gov/loanrepayment/lrpapplicationguidance.pdf (last viewed Feb, 27, 2015).
[32] U.S. Department of Health and Human Services, Loan Repayment Program - *Fiscal Year 2015 Application and Program Guidance*, pp. 4-5 (January 2015) http://www.nhsc.hrsa.gov/loanrepayment/lrpapplicationguidance.pdf (last viewed Feb. 27, 2015).
[33] U.S. Dept. of Health and Human Services, Health Resources and Services Administration, *National Health Service Corps 101* (on file in the Senate Health Policy Committee).
[34] Email from Philip Street, Senior Policy Coordinator, Health Statistics and Performance Management, Florida Dept. of Health (Nov. 19, 2013) (on file with the Senate Committee on Health Policy).

- Public health program: A county health department, the Children's Medical Services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program designated by the department.

The initiative will be developed by the department to benefit dentists licensed to practice in this state who demonstrate, as required by department rule:

- Active employment by a public health program in a dental health professional shortage area or a medically underserved area; or
- A commitment to opening a private practice in a dental health professional shortage area or medically underserved area by residing in the area, maintaining a Medicaid provider agreement, enrolling with one or more Medicaid managed care plans, expending capital to open an office to serve at least 1,200 patients and obtaining community financial support.

The department is required to establish dental access accounts for dentists who meet the requirements in the bill and to implement an electronic benefits transfer system. Funds from the account may be used only for specific purposes, such as payment of student loans; investment in property, facilities, or equipment necessary to establish an office and payment of transitional expenses related to relocating or opening a dental practice.

Subject to available appropriations, the department is to distribute funds to the dental access accounts in amounts not to exceed $100,000 and no less than $10,000. A state award may not exceed three times the amount contributed to an account in the same year from a local source. The department is authorized to accept funds for deposit from local sources.

If a dentist qualifies for an account on the basis of his or her employment with a public health program, the dentist's salary and associated employer expenditures may count as local match for a state award if the salary and employer expenditures are not state funds. State funds may not be used to calculate amounts contributed from local sources.

Accounts may be terminated if the dentist no longer works for a public health program and does not open a dental practice in a designated area within 30 days of terminating employment, the dentist's practice is no longer located in a dental professional shortage area or a medically underserved area, the provider has been terminated from Medicaid or the provider has participated in any fraudulent activity. The department is directed to close an account 5 years after the first deposit or upon a dentist's termination from the program.

Any remaining funds after 5 years or from terminated accounts may be awarded to another account or returned to the donor. A dentist is required to repay any funds withdrawn from the account after the occurrence of an event which requires account closure, if the dentist fails to maintain eligibility for the program through employment in a public health program or establishing a dental practice for a minimum of 2 years, or uses the funds for unauthorized purposes. The department is authorized to recover the withdrawn funds through disciplinary enforcement actions and other methods authorized by law.

The department is authorized to adopt rules for application procedures that:

- Limit the number of applicants;

- Incorporate a documentation process for evidence of sufficient capital expenditures in opening a dental practice, such as contracts or leases or other acquisitions of a practice location of at least 30 percent of the value of equipment or supplies necessary to operate a practice; and
- Give priority to those applicants practicing in the areas receiving higher rankings by the Department of Economic Opportunity.

The department may also establish by rule a process to verify that funds withdrawn from an account have been used for the purposes authorized.

The Department of Economic Opportunity shall rank the dental professional shortage areas and medically underserved areas based on the extent to which limited access to dental care is impeding economic development.

The department must develop a marketing plan for the dental care access account initiative with the University of Florida College of Dentistry, the Nova Southeastern College of Dental Medicine, the Lake Erie College of Osteopathic Medicine School of Dental Medicine, and the Florida Dental Association.

The effective date is July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Floridians living in those areas identified as medically underserved and have little to no access to dental care would benefit from this initiative as it would likely bring additional dental professionals to their community. The initiative also permits the grantees to utilize

the funds to transition or relocate to new areas and to build or renovate office space in rural communities which would generate economic growth for small towns and cities.

The ability to maintain good oral health for adults and children enables workers to also be more productive and for children to participate more actively in school activities.

Additionally, dentists who qualify for loan repayment assistance will benefit from a reduction in their student loan debt.

C. Government Sector Impact:

The department reports a fiscal impact to implement and manage the dental care access account initiative.

The initial cost for the electronic benefit transfer contract/vendor is unknown, but the department reported a nominal cost of approximately $0.50 per participant per month as a maintenance fee. The program also anticipates a withdrawal fee of at least $1 per transaction when a dentist makes a withdrawal from his or her account. The number of dentists qualifying for this initiative is unknown.[35]

The department also reports a workload impact which current staff is unable to meet. Two additional staff members (2 FTEs) would be required to develop the application process and adopt rules, Staff will also be needed to monitor activity, dentist conduct, dentist membership status, and rulings by the Board of Dentistry on recipients.

The following are the estimated expenditures for the department:[36]

Estimated Expenditures	1st Year	2nd Year Annualization/Recurring
SALARIES		
1 FTE **Health Care Program Analyst @ $40,948 - pay grade 24**	$41,460	$55,280
1 FTE **Senior Management Analyst II @ $46,381 - pay grade 26**	$46,961	$62,614
EXPENSES		
2 FTEs Calculated with standard DOH professional package (limited travel) @ $15,616	$31,232	$23,468
HUMAN RESOURCES SERVICES		
2 FTEs Calculated with standard DOH Central Office package @ $344	$688	$688

[35] Florida Department of Health, *Senate Bill 606 Analysis*, pp.4-5, (Feb. 6, 2015) (on file with the Senate Committee on Health Policy).
[36] Id.

Estimated Expenditures	1st Year	2nd Year Annualization/Recurring
Operating Capital Outlay		
Operating Capital Outlay	$0.00	$0.00
Contractual Services		
Estimate for the development, implementation and maintenance of an electronic benefit transfer (EBT) system	$10,000	$10,000
TOTAL ESTIMATED EXPENDITURES	**$130,341**	**$152,050**

The department is also directed to develop a marketing plan with Florida based dental schools. The cost of that marketing plan has not yet been developed by the department.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 381.4019, 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 - March 4, 2015
The committee substitute:

- Adds medically underserved populations to the focus areas of the dental care access account initiative.
- Authorizes the salary and associated employer expenditures of an employee in a public health program to qualify as local match if no state funds contribute to these costs and specifically prohibits state funds from counting toward local match.
- Provides that local funds are to be returned on a pro rata basis.
- Provides standards for rulemaking regarding the demonstration of sufficient capital to show substantial progress in opening a dental practice.
- Requires rule to verify funds are used for allowable purposes.
- Requires the department to develop a marketing plan with the state dental schools.

B. Amendments:

None.

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

504938

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/04/2015	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 44 - 146

and insert:

underserved areas or who treat a medically underserved population. The Legislature recognizes that maintaining good oral health is integral to overall health status and that the good health of residents of this state is an important contributing factor in economic development. Better health, including better oral health, enables workers to be more

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productive, reduces the burden of health care costs, and enables children to improve in cognitive development.

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

(a) "Dental health professional shortage area" means a geographic area so designated by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(b) "Department" means the Department of Health.

(c) "Medically underserved area" means a geographic area so designated by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(d) "Public health program" means a county health department, the Children's Medical Services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program as designated by the department.

(2) The department shall develop and implement a dental care access account initiative to benefit dentists licensed to practice in this state who demonstrate, as required by the department by rule:

(a) Active employment by a public health program located in a dental health professional shortage area or a medically underserved area; or

(b) A commitment to opening a private practice in a dental health professional shortage area or a medically underserved area evidenced by residing in the designated area, maintaining an active Medicaid provider agreement, enrolling in one or more Medicaid managed care plans, expending sufficient capital to make substantial progress in opening a dental practice that is

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capable of serving at least 1,200 patients, and obtaining financial support from the local community in which the dentist is practicing or intending to open a practice.

(3) The department shall establish dental care access accounts as individual benefit accounts for each dentist who satisfies the requirements of subsection (2) and is selected by the department for participation. The department shall implement an electronic benefit transfer system that enables each dentist to spend funds from his or her account for the purposes described in subsection (4).

(4) Funds contributed from state and local sources to a dental care access account may be used for one or more of the following purposes:

(a) Repayment of dental school student loans.

(b) Investment in property, facilities, or equipment necessary to establish and operate a dental office consisting of no fewer than two operatories.

(c) Payment of transitional expenses related to the relocation or opening of a dental practice which are specifically approved by the department.

(5) Subject to legislative appropriation, the department shall distribute state funds as an award to each dental care access account. Such awards must be in an amount not more than $100,000 and not less than $10,000, except that a state award may not exceed 3 times the amount contributed to an account in the same year from local sources. If a dentist qualifies for a dental care access account under paragraph (2)(a), the dentist's salary and associated employer expenditures constitute a local match and qualify the account for a state award if the salary

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and associated expenditures do not come from state funds. State funds may not be included in a determination of the amount contributed to an account from local sources.

(6) The department may accept contributions of funds from local sources for deposit in the account of a dentist designated by the donor.

(7) The department shall close an account no later than 5 years after the first deposit of state or local funds into that account or immediately upon the occurrence of any of the following:

(a) Termination of the dentist's employment with a public health program, unless, within 30 days of such termination, the dentist opens a private practice in a dental health professional shortage area or medically underserved area.

(b) Termination of the dentist's practice in a designated dental health professional shortage area or medically underserved area.

(c) Termination of the dentist's participation in the Florida Medicaid program.

(d) Participation by the dentist in any fraudulent activity.

(8) Any state funds remaining in a closed account may be awarded and transferred to another account concurrent with the distribution of funds under the next legislative appropriation for the initiative. The department shall return to the donor on a pro rata basis unspent funds from local sources which remain in a closed account.

(9) If the department determines that a dentist has withdrawn account funds after the occurrence of an event

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specified in subsection (7), has used funds for purposes not authorized in subsection (4), or has not remained eligible for a dental care access account for a minimum of 2 years, the dentist shall repay the funds to his or her account. The department may recover the withdrawn funds through disciplinary enforcement actions and other methods authorized by law.

(10) The department shall establish by rule:

(a) Application procedures for dentists who wish to apply for a dental care access account. An applicant may demonstrate that he or she has expended sufficient capital to make substantial progress in opening a dental practice that is capable of serving at least 1,200 patients by documenting contracts for the purchase or lease of a practice location and providing executed obligations for the purchase or other acquisition of at least 30 percent of the value of equipment or supplies necessary to operate a dental practice. The department may limit the number of applicants selected and shall give priority to those applicants practicing in the areas receiving higher rankings pursuant to subsection (11). The department may establish additional criteria for selection which recognize an applicant's active engagement with and commitment to the community providing a local match.

(b) A process to verify that funds withdrawn from a dental care access account have been used solely for the purposes described in subsection (4).

(11) The Department of Economic Opportunity shall rank the dental health professional shortage areas and medically underserved areas of the state based on the extent to which limited access to dental care is impeding the area's economic

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development, with a higher ranking indicating a greater impediment to development.

(12) The department shall develop a marketing plan for the dental care access account initiative in cooperation with the University of Florida College of Dentistry, the Nova Southeastern University College of Dental Medicine, the Lake Erie College of Osteopathic Medicine School of Dental Medicine, and the Florida Dental Association.

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

And the title is amended as follows:

Delete lines 25 - 31

and insert:

disciplinary enforcement actions and to use other legal means to recover funds; requiring the department to establish by rule application procedures and a process to verify the use of funds withdrawn from a dental care access account; requiring the department to give priority to applications from dentists practicing in certain areas; requiring the Department of Economic Opportunity to rank shortage areas and medically underserved areas; requiring the Department of Health to develop a marketing plan in cooperation with certain dental colleges and the Florida Dental Association; providing an

By Senator Gaetz

1-00253A-15 2015606__

A bill to be entitled

An act relating to dental care; creating s. 381.4019, F.S.; establishing a joint local and state dental care access account initiative, subject to the availability of funding; authorizing the creation of dental care access accounts; specifying the purpose of the initiative; defining terms; providing criteria for the selection of dentists for participation in the initiative; providing for the establishment of accounts; requiring the Department of Health to implement an electronic benefit transfer system; providing for the use of funds deposited in the accounts; authorizing the department to distribute state funds to accounts subject to legislative appropriations; authorizing the department to accept contributions from local sources for deposit in designated accounts; limiting the number of years that an account may remain open; providing for the immediate closure of accounts under certain circumstances; authorizing the department to transfer state funds remaining in a closed account at a specified time and to return unspent funds from local sources; requiring a dentist to repay funds in certain circumstances; authorizing the department to pursue enforcement actions and to use other legal means to recover funds; authorizing the department to establish application procedures by rule; requiring the department to give priority to applications from dentists practicing in certain areas; requiring the

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

1-00253A-15 2015606__

Department of Economic Opportunity to rank shortage areas and medically underserved areas; providing an effective date.

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

Section 1. Section 381.4019, Florida Statutes, is created to read:

381.4019 Dental care access accounts.—Subject to the availability of funds, the Legislature establishes a joint local and state dental care access account initiative and authorizes the creation of dental care access accounts to promote economic development by supporting qualified dentists who practice in dental health professional shortage areas or medically underserved areas. The Legislature recognizes that maintaining good oral health is integral to overall health status and that the good health of residents of this state is an important contributing factor in economic development. Better health, including better oral health, enables workers to be more productive, reduces the burden of health care costs, and enables children to improve in cognitive development.

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

(a) "Dental health professional shortage area" means a geographic area so designated by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(b) "Department" means the Department of Health.

(c) "Medically underserved area" means a geographic area so designated by the Health Resources and Services Administration

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

of the United States Department of Health and Human Services.

(d) "Public health program" means a county health department, the Children's Medical Services program, a federally funded community health center, a federally funded migrant health center, or other publicly funded or nonprofit health care program as designated by the department.

(2) The department shall develop and implement a dental care access account initiative to benefit dentists licensed to practice in this state who demonstrate, as required by the department by rule:

(a) Active employment by a public health program located in a dental health professional shortage area or a medically underserved area; or

(b) A commitment to opening a private practice in a dental health professional shortage area or a medically underserved area evidenced by residing in the designated area, maintaining an active Medicaid provider agreement, enrolling in one or more Medicaid managed care plans, expending sufficient capital to make substantial progress in opening a dental practice that is capable of serving at least 1,200 patients, and obtaining financial support from the local community in which the dentist is practicing or intending to open a practice.

(3) The department shall establish dental care access accounts as individual benefit accounts for each dentist who satisfies the requirements of subsection (2) and is selected by the department for participation. The department shall implement an electronic benefit transfer system that enables each dentist to spend funds from his or her account for the purposes described in subsection (4).

(4) Funds contributed from state and local sources to a dental care access account may be used for one or more of the following purposes:

(a) Repayment of dental school student loans.

(b) Investment in property, facilities, or equipment necessary to establish and operate a dental office consisting of no fewer than two operatories.

(c) Payment of transitional expenses related to the relocation or opening of a dental practice that are specifically approved by the department.

(5) Subject to legislative appropriation, the department shall distribute state funds as an award to each dental care access account. Such awards must be in an amount not more than $100,000 and not less than $10,000, except that no state award may exceed 3 times the amount contributed to an account in the same year from local sources.

(6) The department is authorized to accept contributions of funds from local sources for deposit in the account of a dentist designated by the donor.

(7) The department shall close an account no later than 5 years after the first deposit of state or local funds into that account or immediately upon the occurrence of any of the following:

(a) Termination of the dentist's employment with a public health program.

(b) Termination of the dentist's practice in a designated dental health professional shortage area or medically underserved area.

(c) Termination of the dentist's participation in the

Florida Medicaid program.

(d) Participation by the dentist in any fraudulent activity.

(8) Any state funds remaining in a closed account may be awarded and transferred to another account concurrent with the distribution of funds under the next legislative appropriation for the initiative. The department shall return to the donor unspent funds from local sources that remain in a closed account.

(9) If the department determines that a dentist has withdrawn account funds after the occurrence of an event specified in paragraphs (7)(a)-(d), the dentist shall repay the funds to his or her account. The department may recover the withdrawn funds through enforcement actions and other methods authorized by law.

(10) The department shall establish by rule application procedures for dentists who wish to apply for a dental care access account. The department may limit the number of applicants selected and shall give priority to those applicants practicing in the areas receiving higher rankings pursuant to subsection (11). The department may establish additional criteria for selection which recognize the applicant's active engagement with and commitment to the community providing a local match.

(11) The Department of Economic Opportunity shall rank the dental health professional shortage areas and medically underserved areas of the state based on the extent to which limited access to dental care is impeding the area's economic development, with a higher ranking indicating a greater

impediment to development.

Section 2. This act shall take effect July 1, 2015.

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/15
Meeting Date

606
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic DENTAL CARE

Name TODD STEIBLY

Job Title GOVERNMENT CONSULTANT

Address 301 S. BRONOUGH ST.
Street

TALLAHASSEE FL 32301
City *State* *Zip*

Phone 850.577.9090

Email tsteibly@gray-robinson.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing FLORIDA SOCIETY OF ORAL AND MAXILLOFACIAL SURGEONS

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/15
Meeting Date

SB 606
Bill Number (if applicable)

Topic Dental Care

584938
Amendment Barcode (if applicable)

Name Joe Anne Hart

Job Title

Address 118 E. Jefferson St
Street
Tallahassee FL 32301
City *State* *Zip*

Phone

Email

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Dental Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/15
Meeting Date

SB 606
Bill Number (if applicable)

Topic Dental Care

Amendment Barcode (if applicable)

Name JoAnne Hart

Job Title Director of Governmental Affairs

Address 118 E Jefferson St
Street

Phone (850) 224-1089

Tallahassee, FL 32301
City *State* *Zip*

Email

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Dental Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/15
Meeting Date

SB 606
Bill Number (if applicable)

Topic Dental Care

Amendment Barcode (if applicable)

Name Andy Behrman

Job Title President

Address _____ Phone _____
Street

_____ Email _____
City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information

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

Representing FL. Association of Community Health Centers

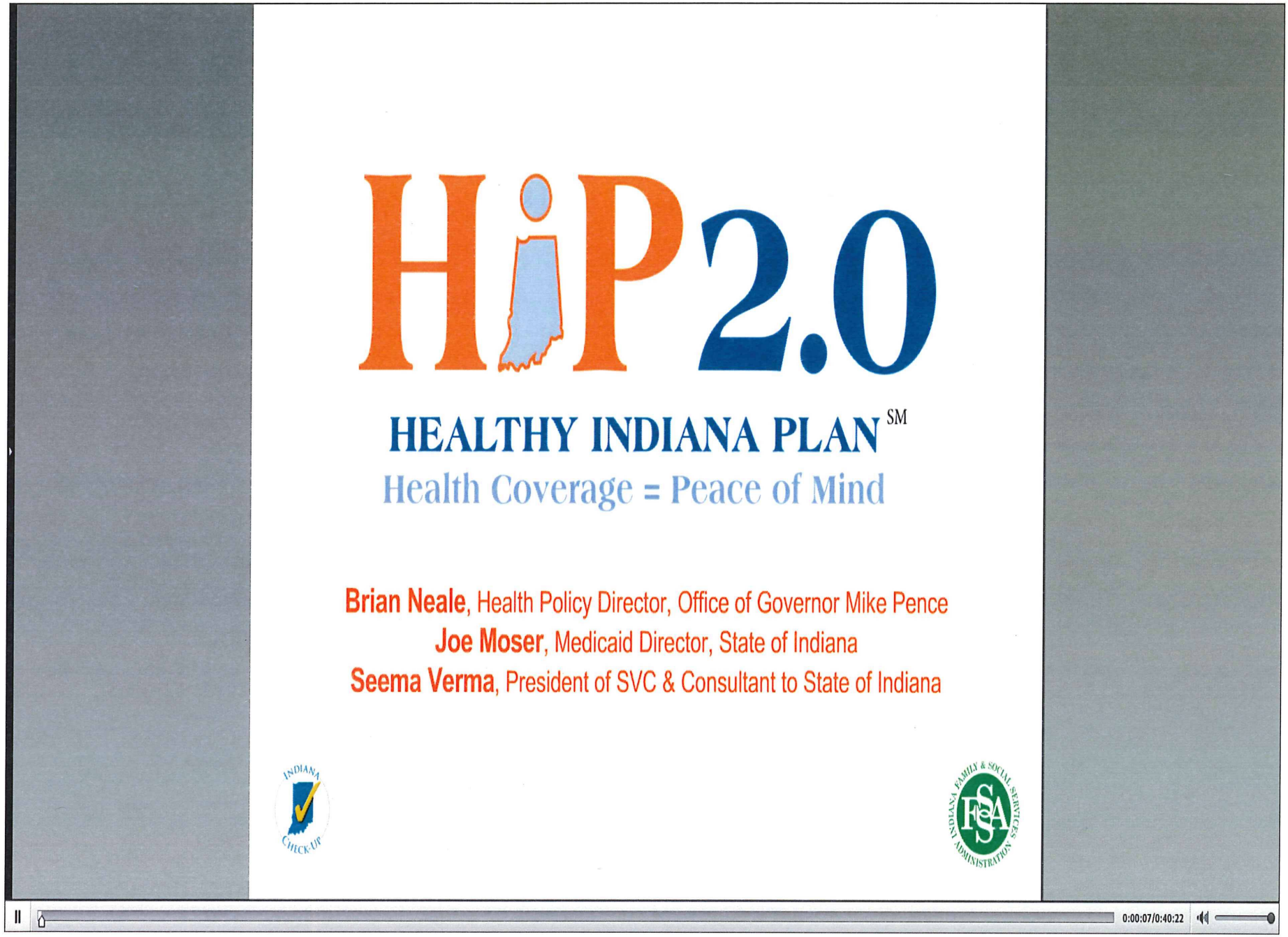
Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/14/14)


HiP 2.0
HEALTHY INDIANA PLAN SM
Health Coverage = Peace of Mind
Brian Neale, Health Policy Director, Office of Governor Mike Pence
Joe Moser, Medicaid Director, State of Indiana
Seema Verma, President of SVC & Consultant to State of Indiana
INDIANA CHECK-UP
INDIANA FAMILY & SOCIAL SERVICES ADMINISTRATION
FSSA
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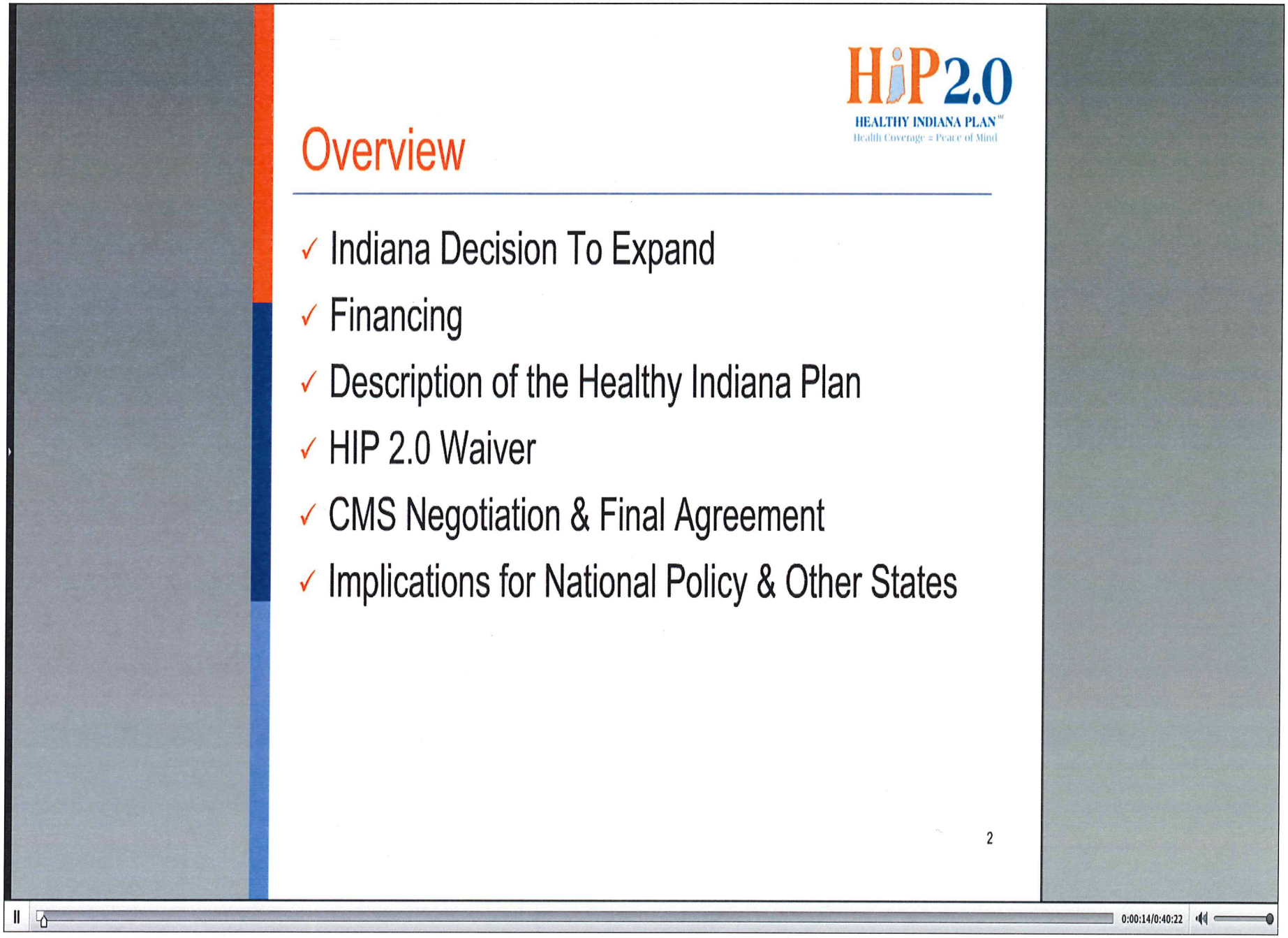
HiP2.0
HEALTHY INDIANA PLAN
Health Coverage = Peace of Mind
Overview
✓ Indiana Decision To Expand
✓ Financing
✓ Description of the Healthy Indiana Plan
✓ HIP 2.0 Waiver
✓ CMS Negotiation & Final Agreement
✓ Implications for National Policy & Other States
2
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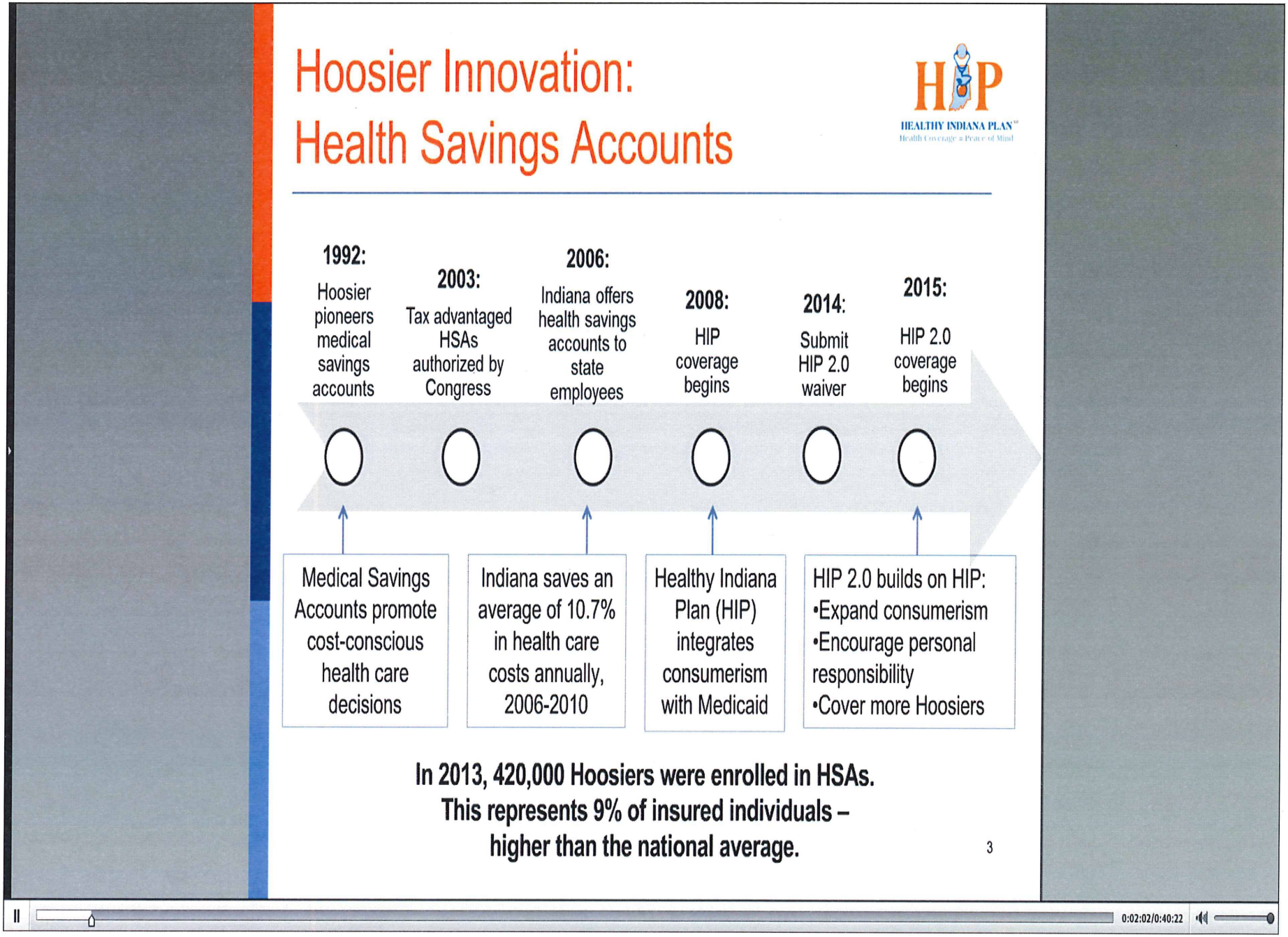
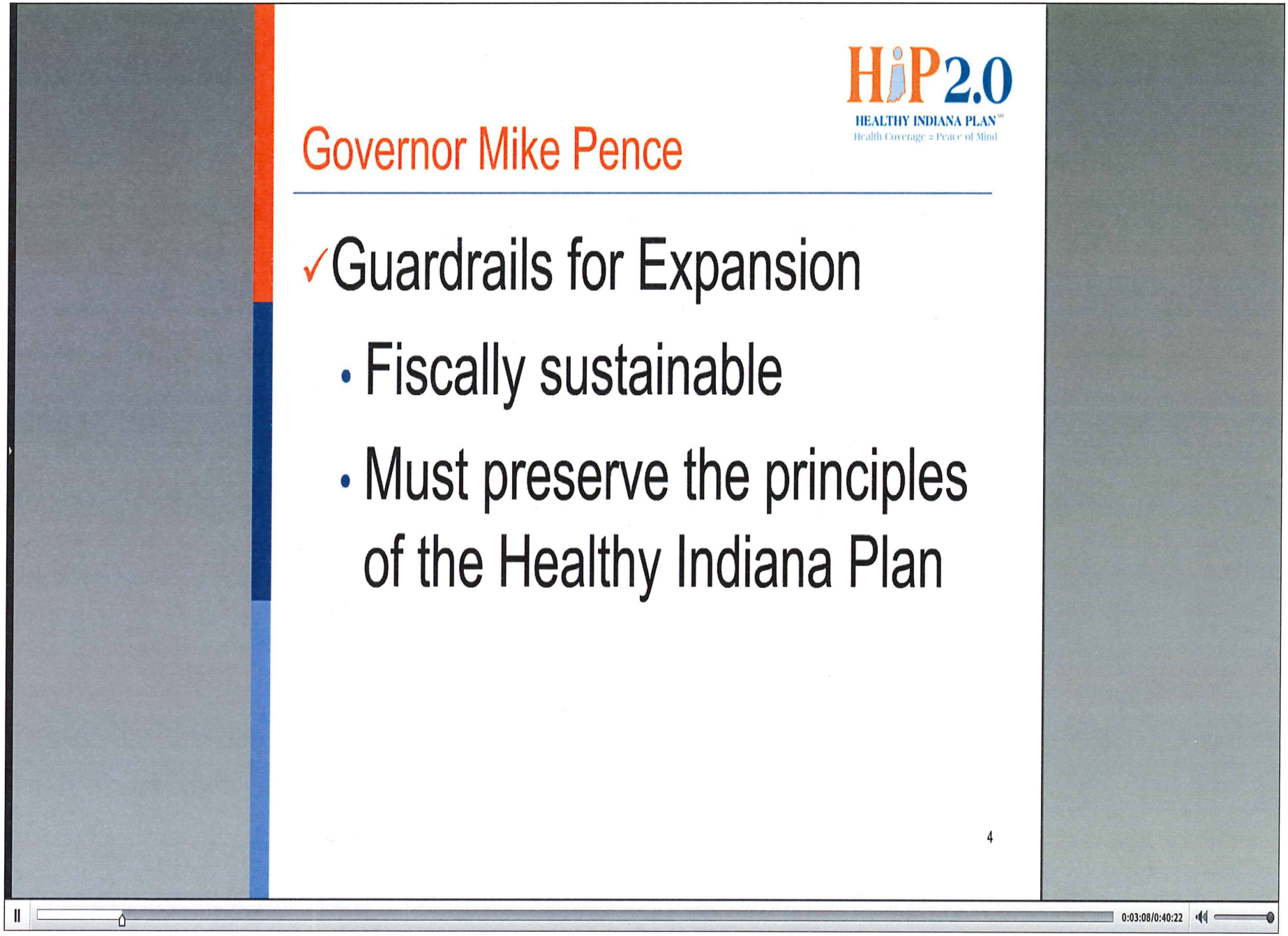
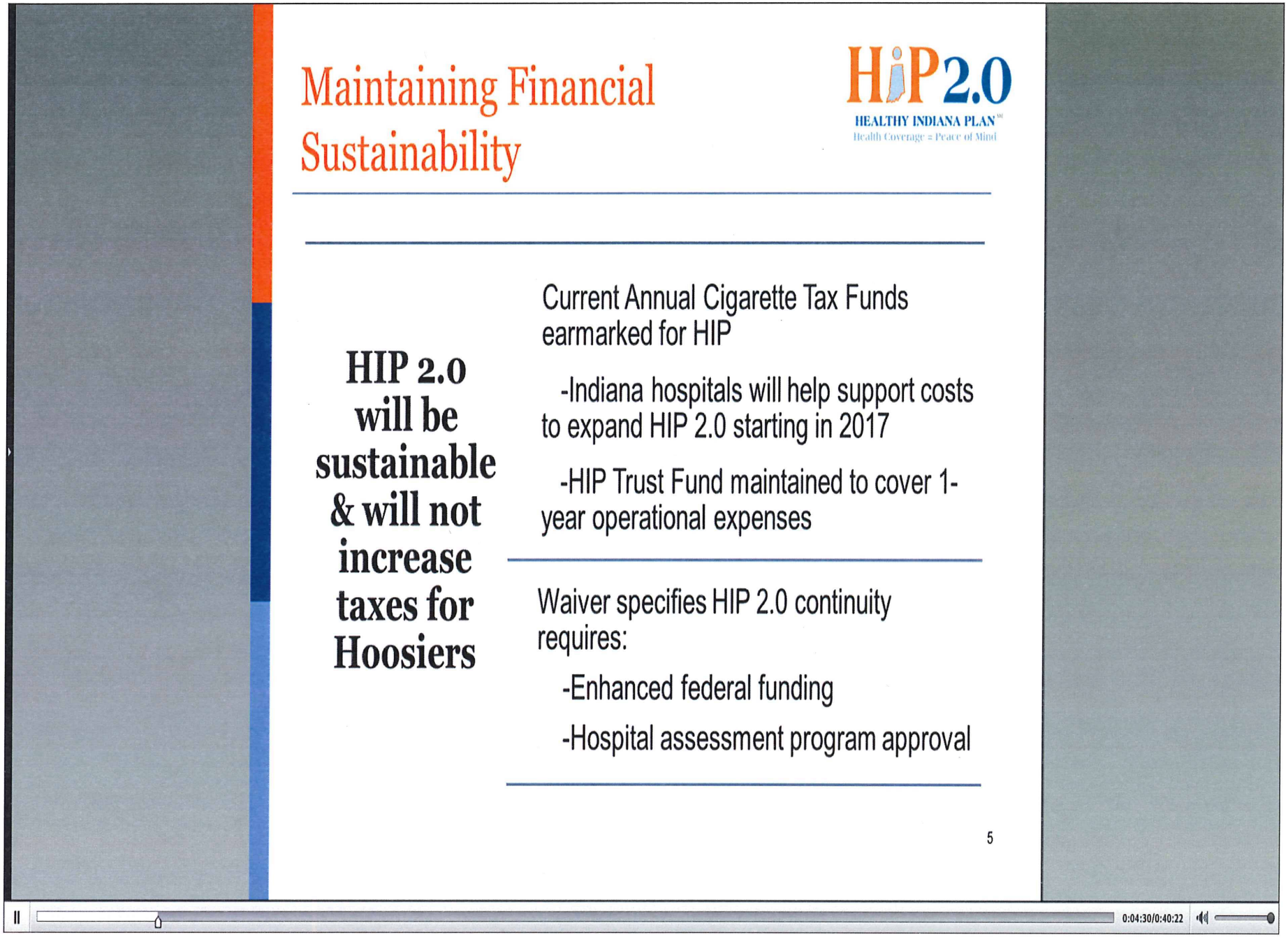
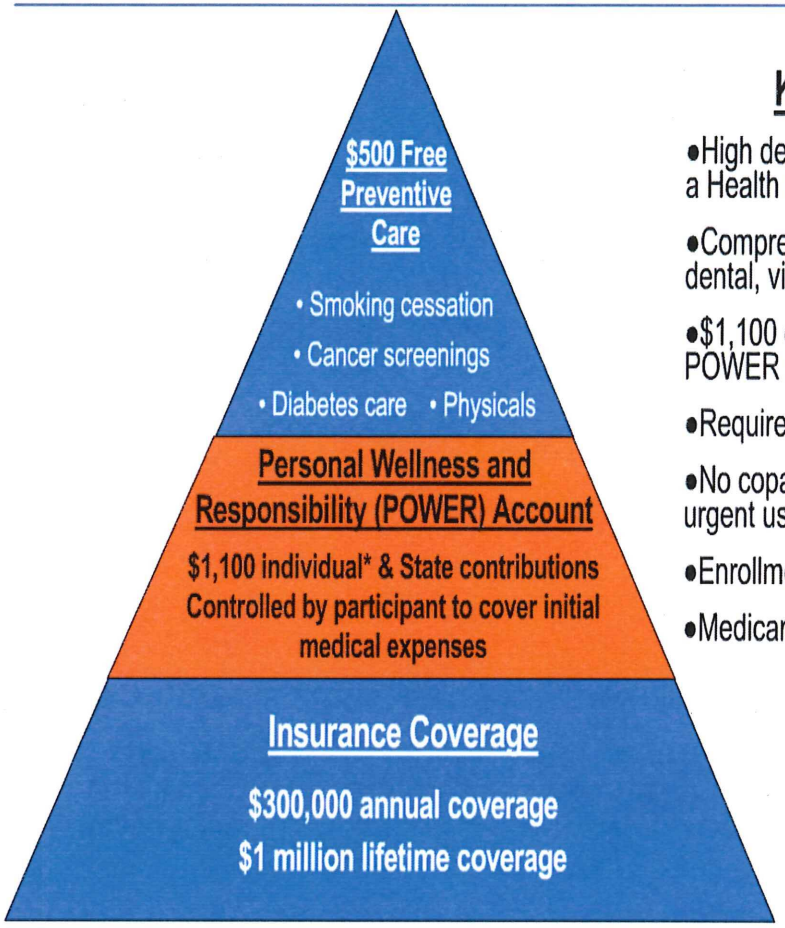

Hoosier Innovation:
Health Savings Accounts
HIP
HEALTHY INDIANA PLAN
1992:
Hoosier pioneers medical savings accounts
2003:
Tax advantaged HSAs authorized by Congress
2006:
Indiana offers health savings accounts to state employees
2008:
HIP coverage begins
2014:
Submit HIP 2.0 waiver
2015:
HIP 2.0 coverage begins
Medical Savings Accounts promote cost-conscious health care decisions
Indiana saves an average of 10.7% in health care costs annually, 2006-2010
Healthy Indiana Plan (HIP) integrates consumerism with Medicaid
HIP 2.0 builds on HIP:
•Expand consumerism
•Encourage personal responsibility
•Cover more Hoosiers
In 2013, 420,000 Hoosiers were enrolled in HSAs.
This represents 9% of insured individuals –
higher than the national average.
3
0:02:02/0:40:22


HiP2.0
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind
Governor Mike Pence
✓Guardrails for Expansion
• Fiscally sustainable
• Must preserve the principles of the Healthy Indiana Plan
4
0:03:08/0:40:22


Maintaining Financial Sustainability
HIP 2.0
HEALTHY INDIANA PLAN
Health Coverage = Peace of Mind
HIP 2.0 will be sustainable & will not increase taxes for Hoosiers
Current Annual Cigarette Tax Funds earmarked for HIP
-Indiana hospitals will help support costs to expand HIP 2.0 starting in 2017
-HIP Trust Fund maintained to cover 1-year operational expenses
Waiver specifies HIP 2.0 continuity requires:
-Enhanced federal funding
-Hospital assessment program approval
5
0:04:30/0:40:22

Original Healthy Indiana Plan (HIP) Structure

HIP
HEALTHY INDIANA PLAN™
Health Coverage & Peace of Mind



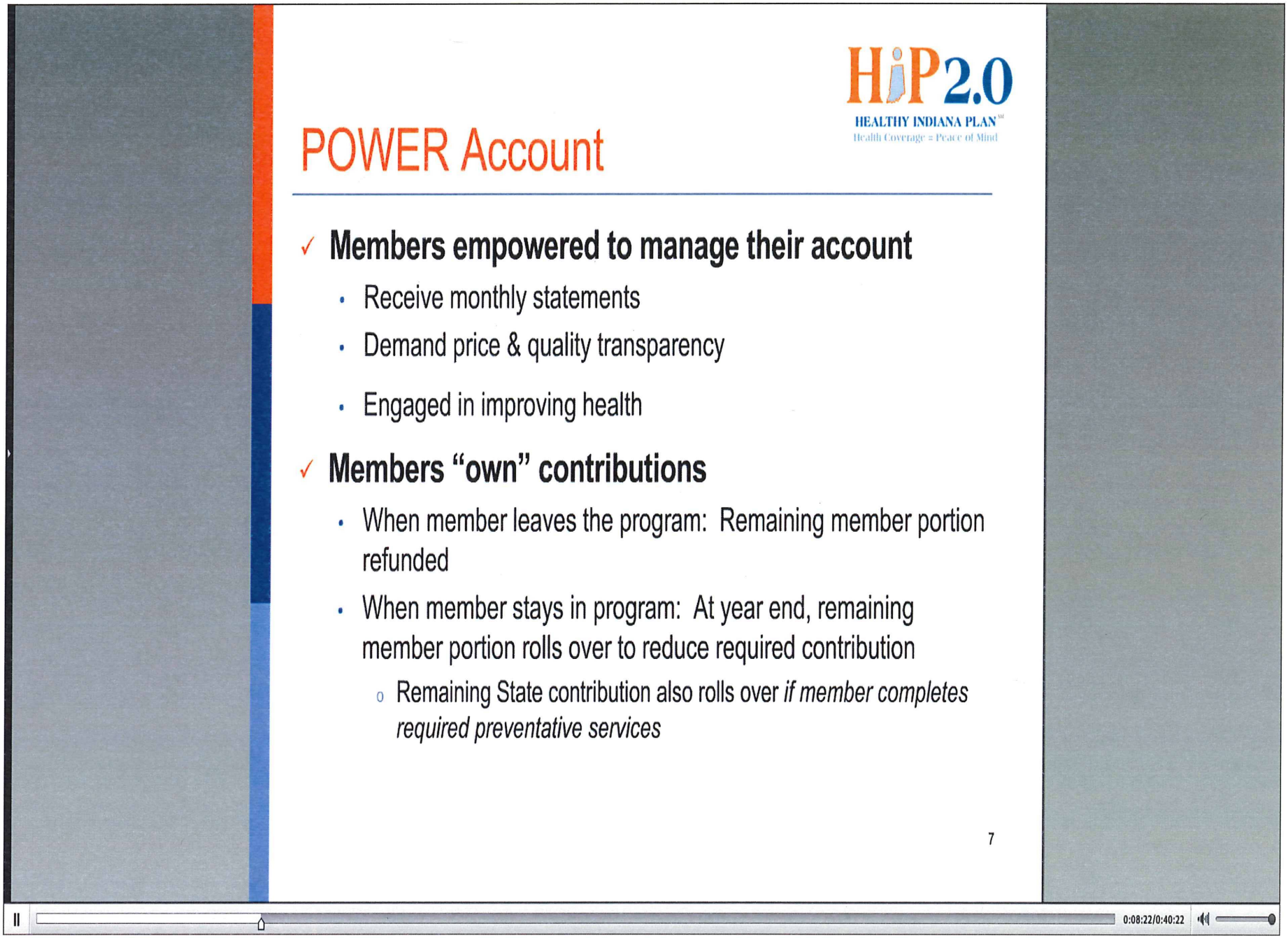
Key Features:

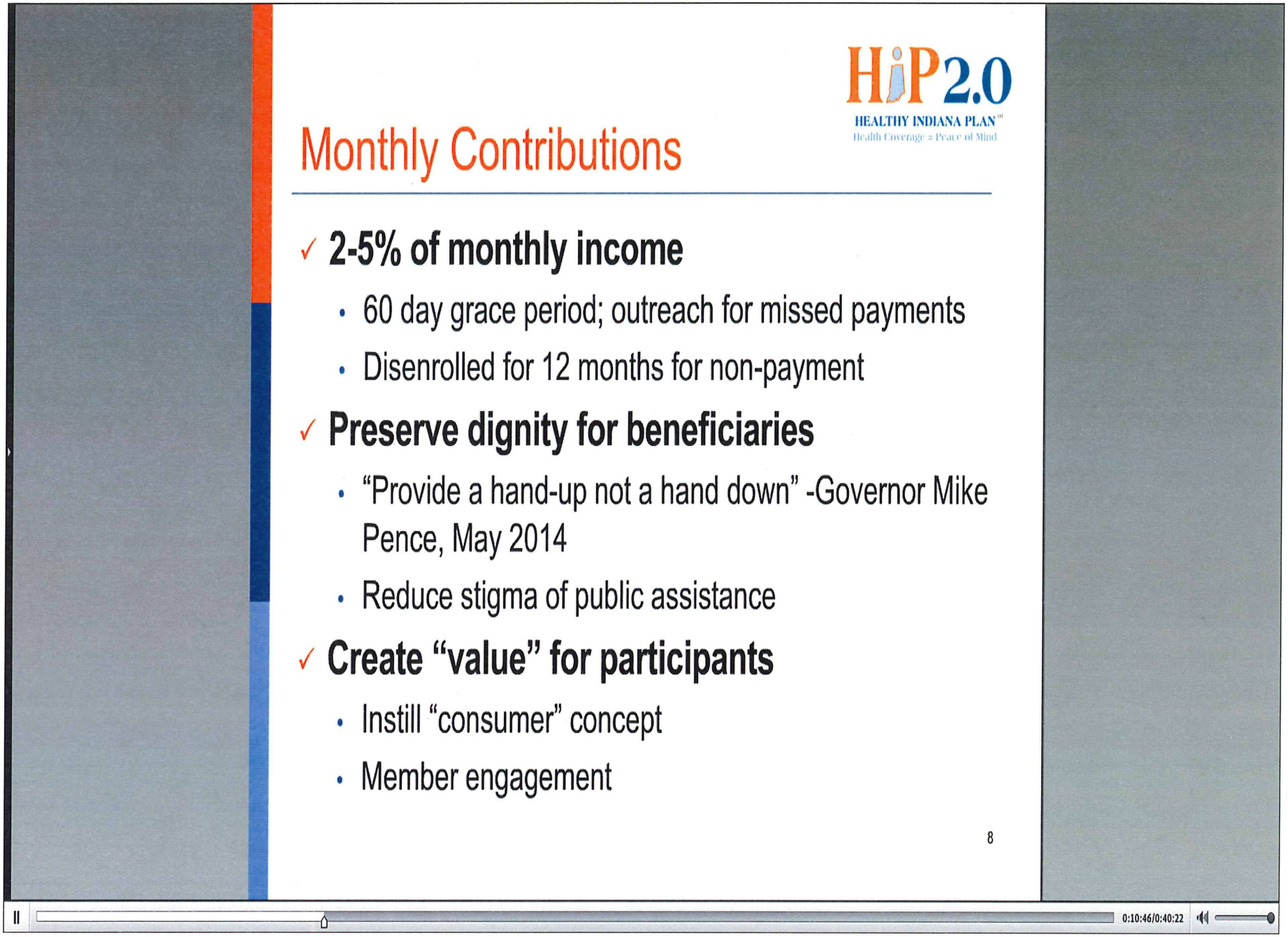
- High deductible plan paired with a Health Savings like account
- Comprehensive benefits, but no dental, vision or maternity
- $1,100 deductible paid by POWER account
- Required monthly contributions
- No copays, except for non-urgent use of ER
- Enrollment cap
- Medicare payment rates

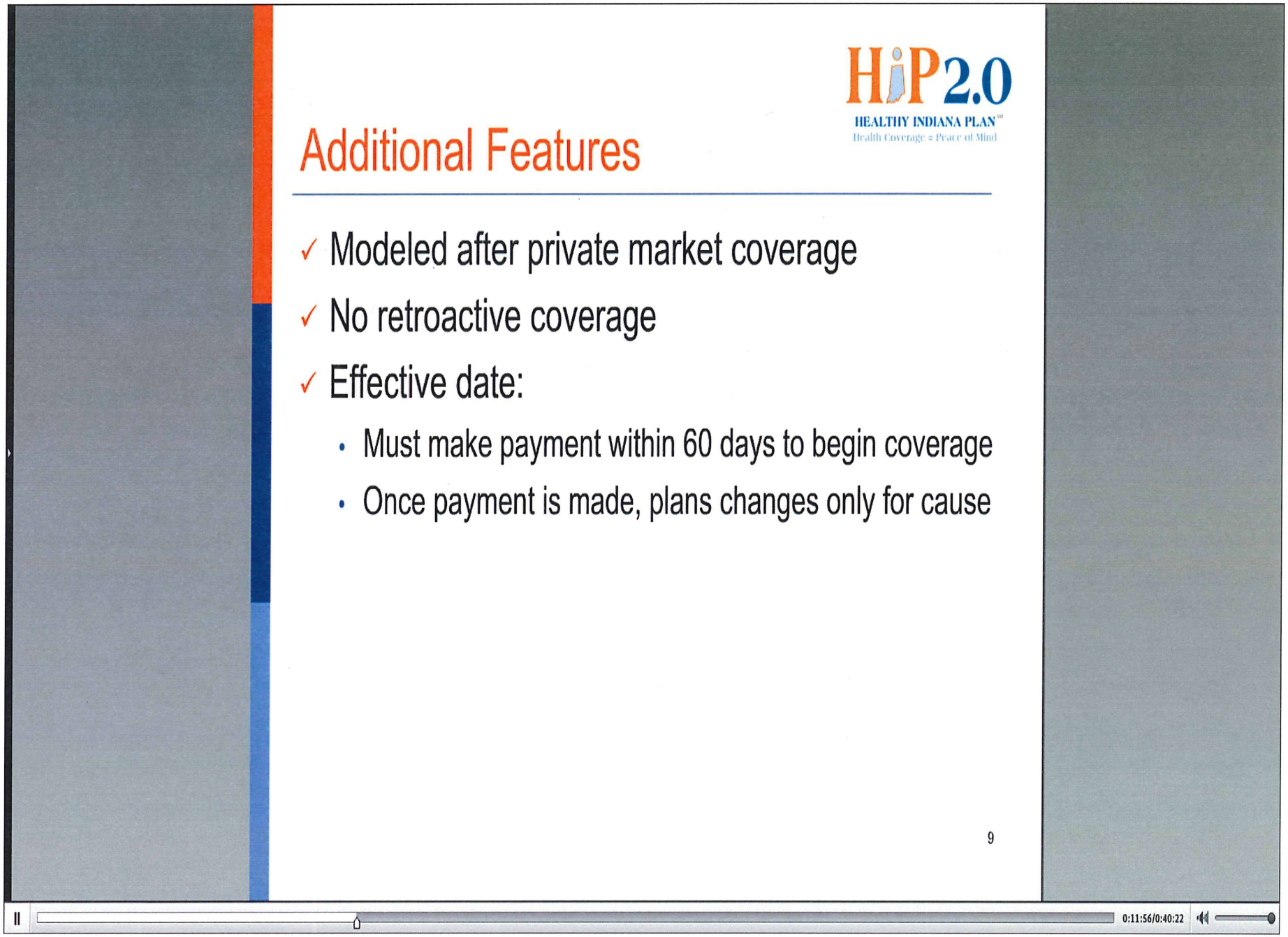
6

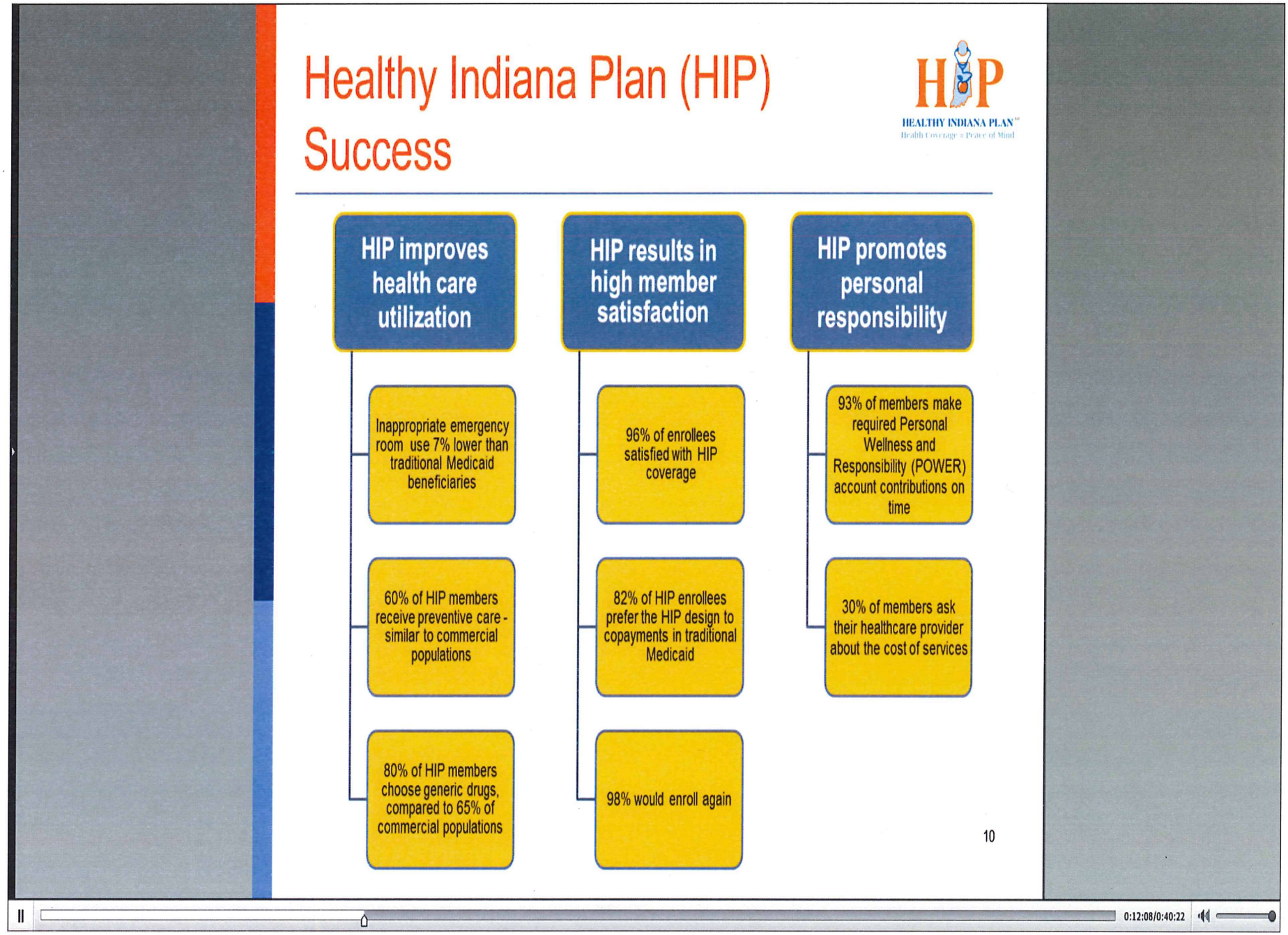
*Individual contribution not to exceed 5% of gross annual household income

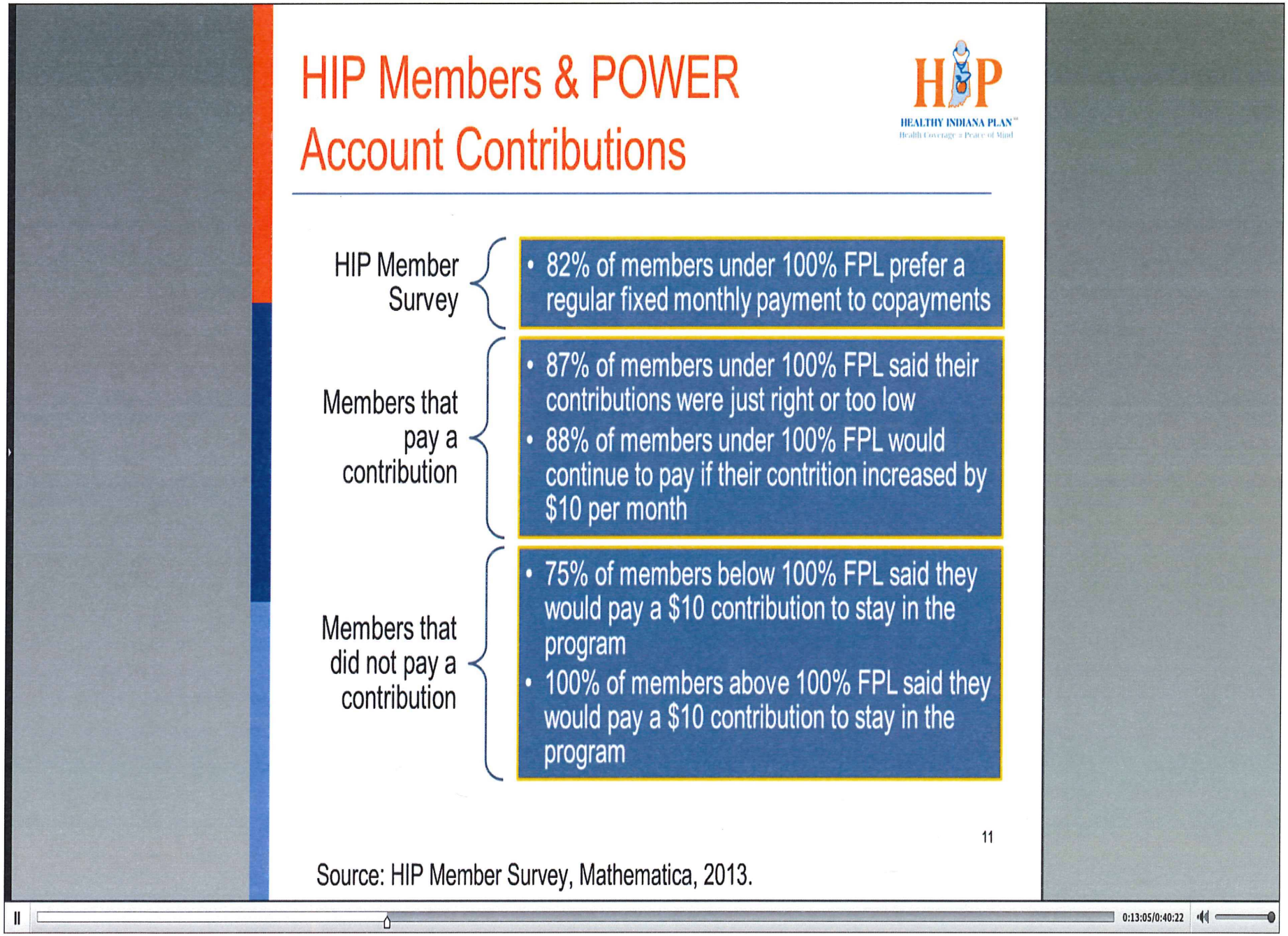
0:05:34/0:40:22

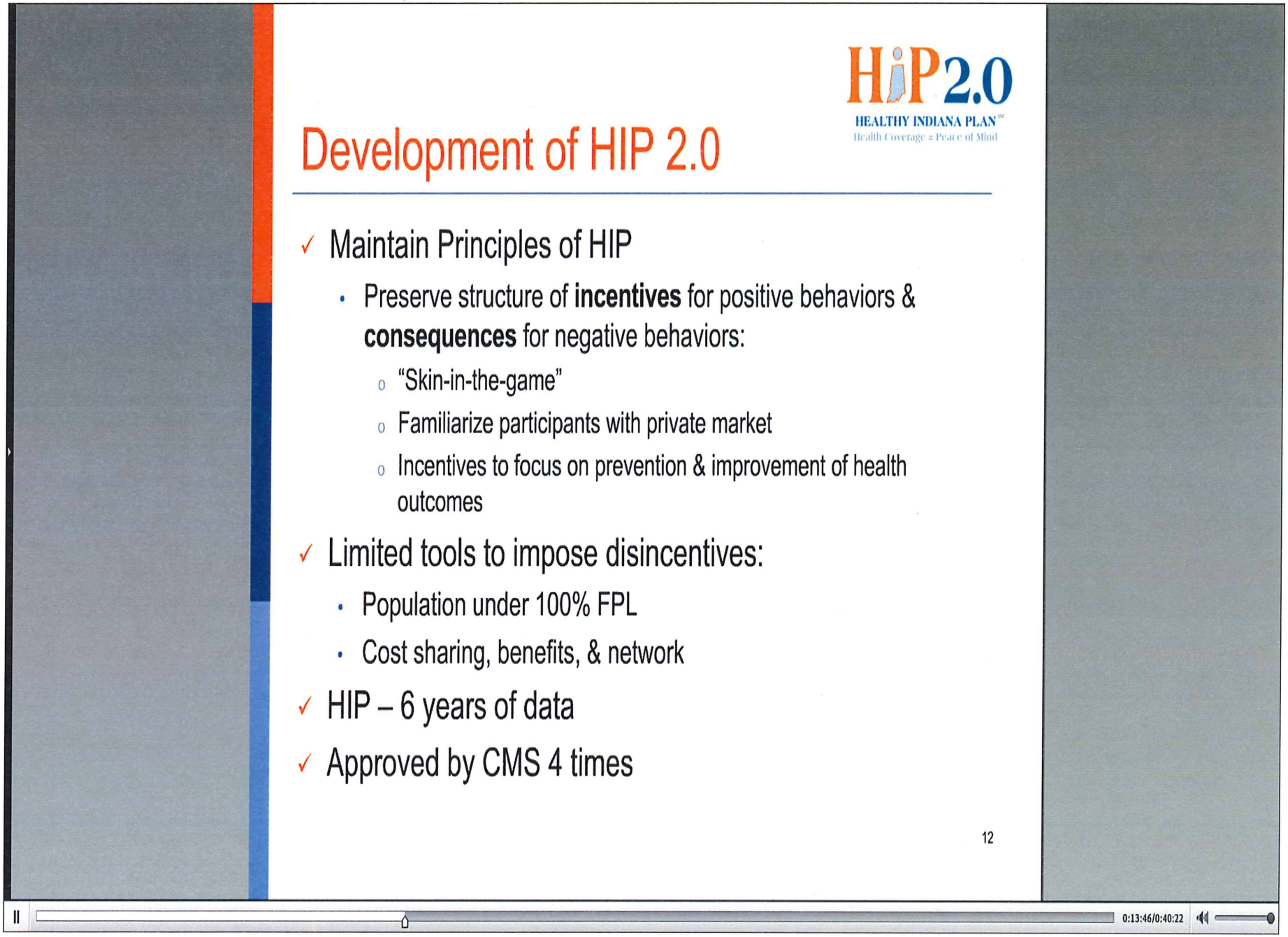

HiP2.0
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind
POWER Account
✓ Members empowered to manage their account
• Receive monthly statements
• Demand price & quality transparency
• Engaged in improving health
✓ Members "own" contributions
• When member leaves the program: Remaining member portion refunded
• When member stays in program: At year end, remaining member portion rolls over to reduce required contribution
o Remaining State contribution also rolls over *if member completes required preventative services*
7
0:08:22/0:40:22

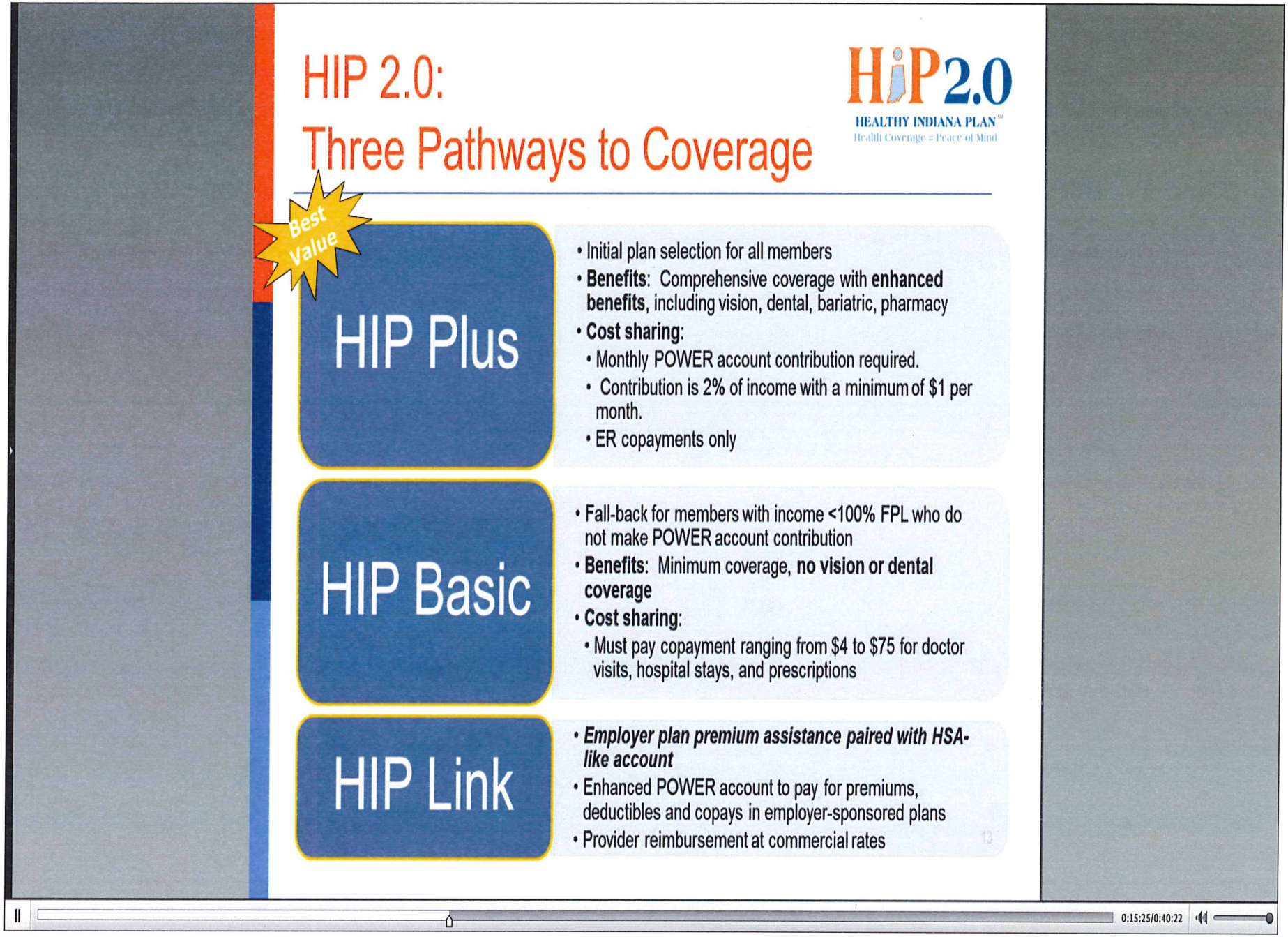

HiP2.0
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind
Monthly Contributions
✓ 2-5% of monthly income
• 60 day grace period; outreach for missed payments
• Disenrolled for 12 months for non-payment
✓ Preserve dignity for beneficiaries
• "Provide a hand-up not a hand down" -Governor Mike Pence, May 2014
• Reduce stigma of public assistance
✓ Create "value" for participants
• Instill "consumer" concept
• Member engagement
8
0:10:46/0:40:22

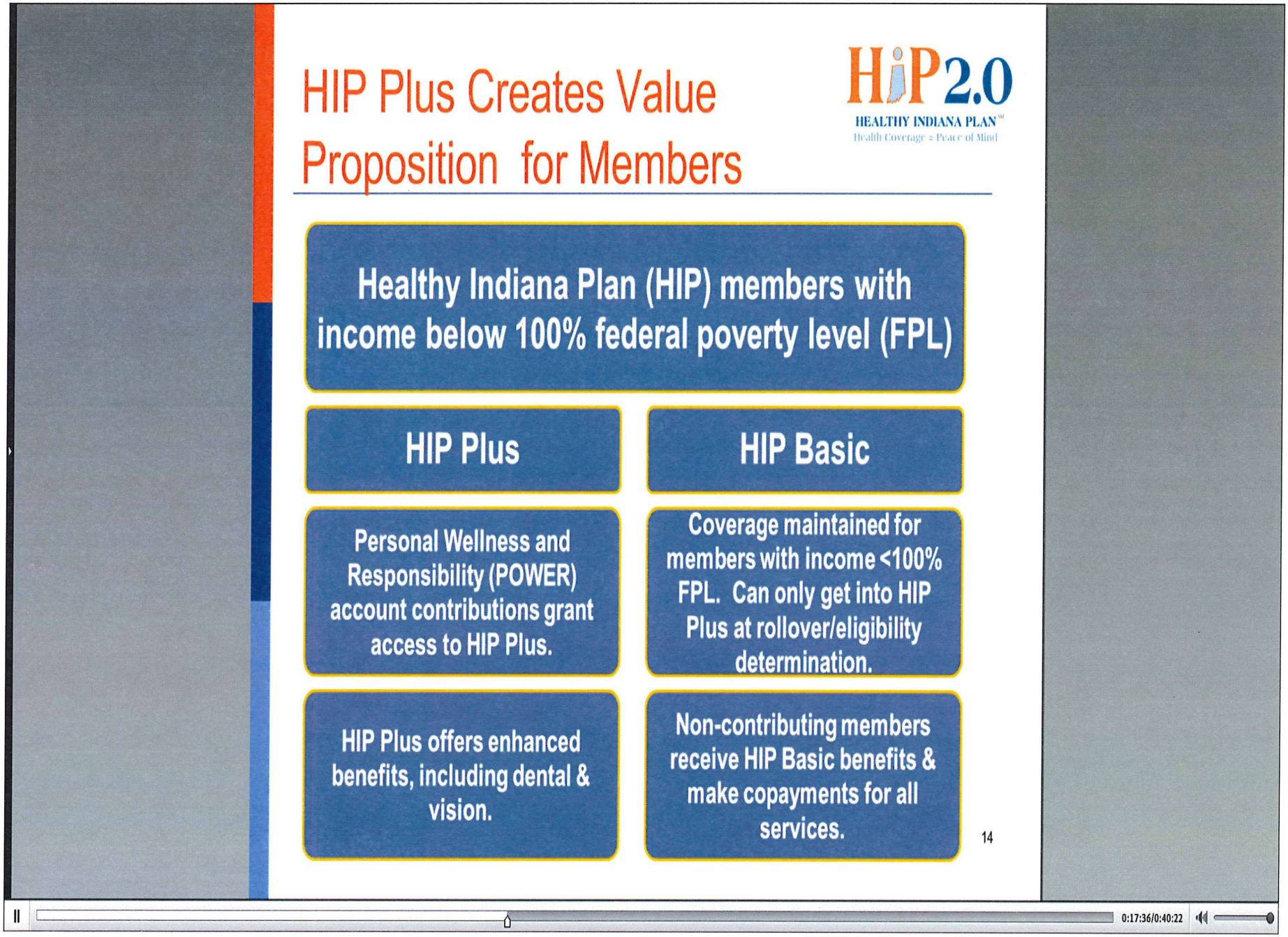

HiP2.0
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind
Additional Features
✓ Modeled after private market coverage
✓ No retroactive coverage
✓ Effective date:
• Must make payment within 60 days to begin coverage
• Once payment is made, plans changes only for cause
9
0:11:56/0:40:22

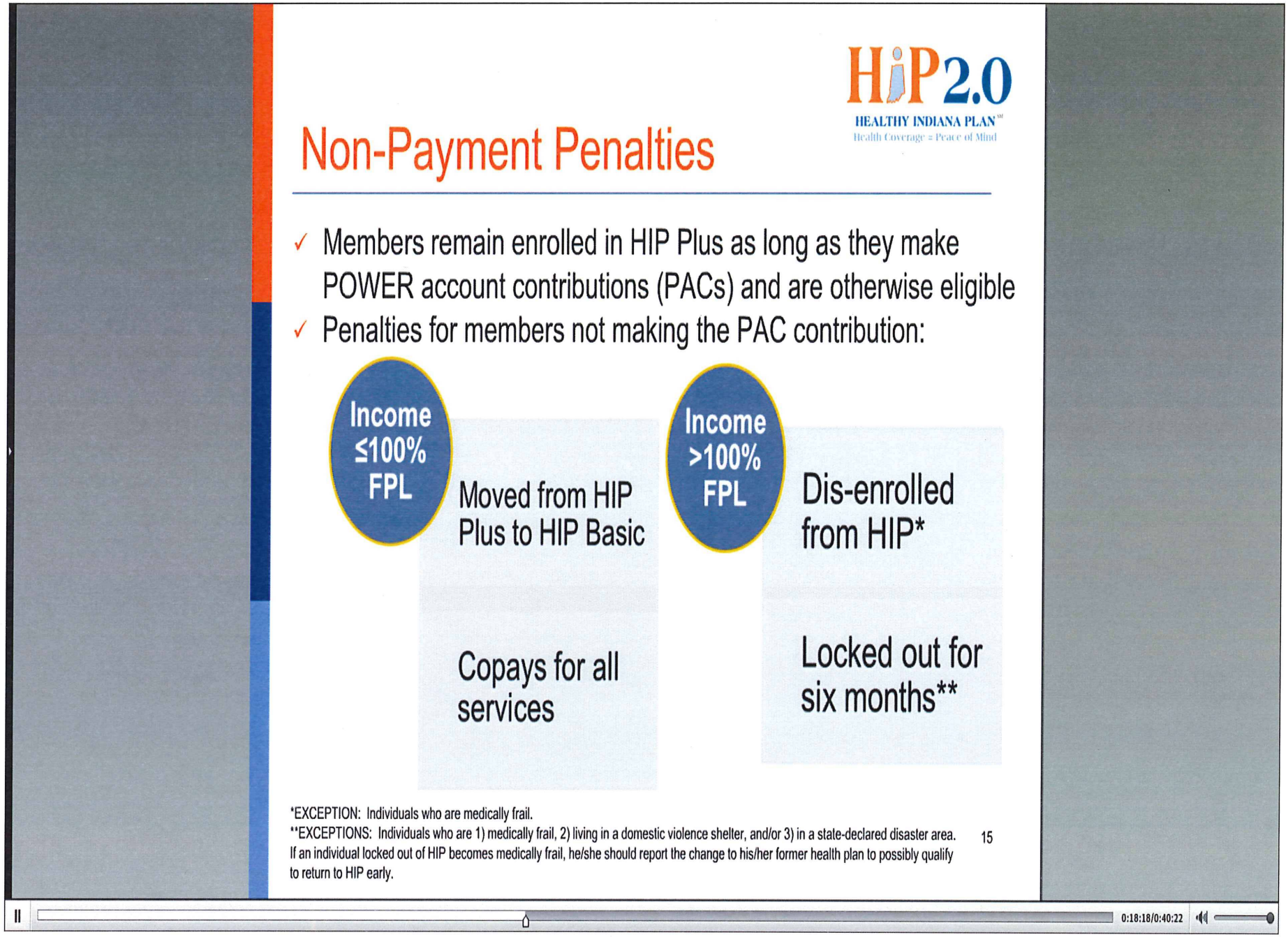

Healthy Indiana Plan (HIP) Success
HIP
HEALTHY INDIANA PLAN
Health Coverage = Peace of Mind
HIP improves health care utilization
Inappropriate emergency room use 7% lower than traditional Medicaid beneficiaries
60% of HIP members receive preventive care - similar to commercial populations
80% of HIP members choose generic drugs, compared to 65% of commercial populations
HIP results in high member satisfaction
96% of enrollees satisfied with HIP coverage
82% of HIP enrollees prefer the HIP design to copayments in traditional Medicaid
98% would enroll again
HIP promotes personal responsibility
93% of members make required Personal Wellness and Responsibility (POWER) account contributions on time
30% of members ask their healthcare provider about the cost of services
10
0:12:08/0:40:22


HIP Members & POWER Account Contributions
HIP
HEALTHY INDIANA PLAN
Health Coverage a Peace of Mind
HIP Member Survey
• 82% of members under 100% FPL prefer a regular fixed monthly payment to copayments
Members that pay a contribution
• 87% of members under 100% FPL said their contributions were just right or too low
• 88% of members under 100% FPL would continue to pay if their contrition increased by $10 per month
Members that did not pay a contribution
• 75% of members below 100% FPL said they would pay a $10 contribution to stay in the program
• 100% of members above 100% FPL said they would pay a $10 contribution to stay in the program
11
Source: HIP Member Survey, Mathematica, 2013.
0:13:05/0:40:22


HIP 2.0
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind
Development of HIP 2.0
✓ Maintain Principles of HIP
• Preserve structure of **incentives** for positive behaviors & **consequences** for negative behaviors:
o "Skin-in-the-game"
o Familiarize participants with private market
o Incentives to focus on prevention & improvement of health outcomes
✓ Limited tools to impose disincentives:
• Population under 100% FPL
• Cost sharing, benefits, & network
✓ HIP – 6 years of data
✓ Approved by CMS 4 times
12
0:13:46/0:40:22


HIP 2.0:
Three Pathways to Coverage
HiP2.0
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind
Best Value
HIP Plus
• Initial plan selection for all members
• Benefits: Comprehensive coverage with enhanced benefits, including vision, dental, bariatric, pharmacy
• Cost sharing:
• Monthly POWER account contribution required.
• Contribution is 2% of income with a minimum of $1 per month.
• ER copayments only
HIP Basic
• Fall-back for members with income <100% FPL who do not make POWER account contribution
• Benefits: Minimum coverage, no vision or dental coverage
• Cost sharing:
• Must pay copayment ranging from $4 to $75 for doctor visits, hospital stays, and prescriptions
HIP Link
• Employer plan premium assistance paired with HSA-like account
• Enhanced POWER account to pay for premiums, deductibles and copays in employer-sponsored plans
• Provider reimbursement at commercial rates
13
0:15:25/0:40:22


HIP Plus Creates Value Proposition for Members
HIP 2.0
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind
Healthy Indiana Plan (HIP) members with income below 100% federal poverty level (FPL)
HIP Plus
HIP Basic
Personal Wellness and Responsibility (POWER) account contributions grant access to HIP Plus.
Coverage maintained for members with income <100% FPL. Can only get into HIP Plus at rollover/eligibility determination.
HIP Plus offers enhanced benefits, including dental & vision.
Non-contributing members receive HIP Basic benefits & make copayments for all services.
14
0:17:36/0:40:22


HiP2.0
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind
Non-Payment Penalties
✓ Members remain enrolled in HIP Plus as long as they make POWER account contributions (PACs) and are otherwise eligible
✓ Penalties for members not making the PAC contribution:
Income ≤100% FPL
Moved from HIP Plus to HIP Basic
Copays for all services
Income >100% FPL
Dis-enrolled from HIP*
Locked out for six months**
*EXCEPTION: Individuals who are medically frail.
**EXCEPTIONS: Individuals who are 1) medically frail, 2) living in a domestic violence shelter, and/or 3) in a state-declared disaster area. If an individual locked out of HIP becomes medically frail, he/she should report the change to his/her former health plan to possibly qualify to return to HIP early.
15
0:18:18/0:40:22

HIP Plus: POWER Account Contributions

HIP 2.0
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind

- ✓ POWER account contributions are approximately 2% of member income
- ✓ Minimum contribution of $1 per month even for individuals with no income & maximum contribution of $100 per month
- ✓ Employers & not-for-profits may assist with contributions

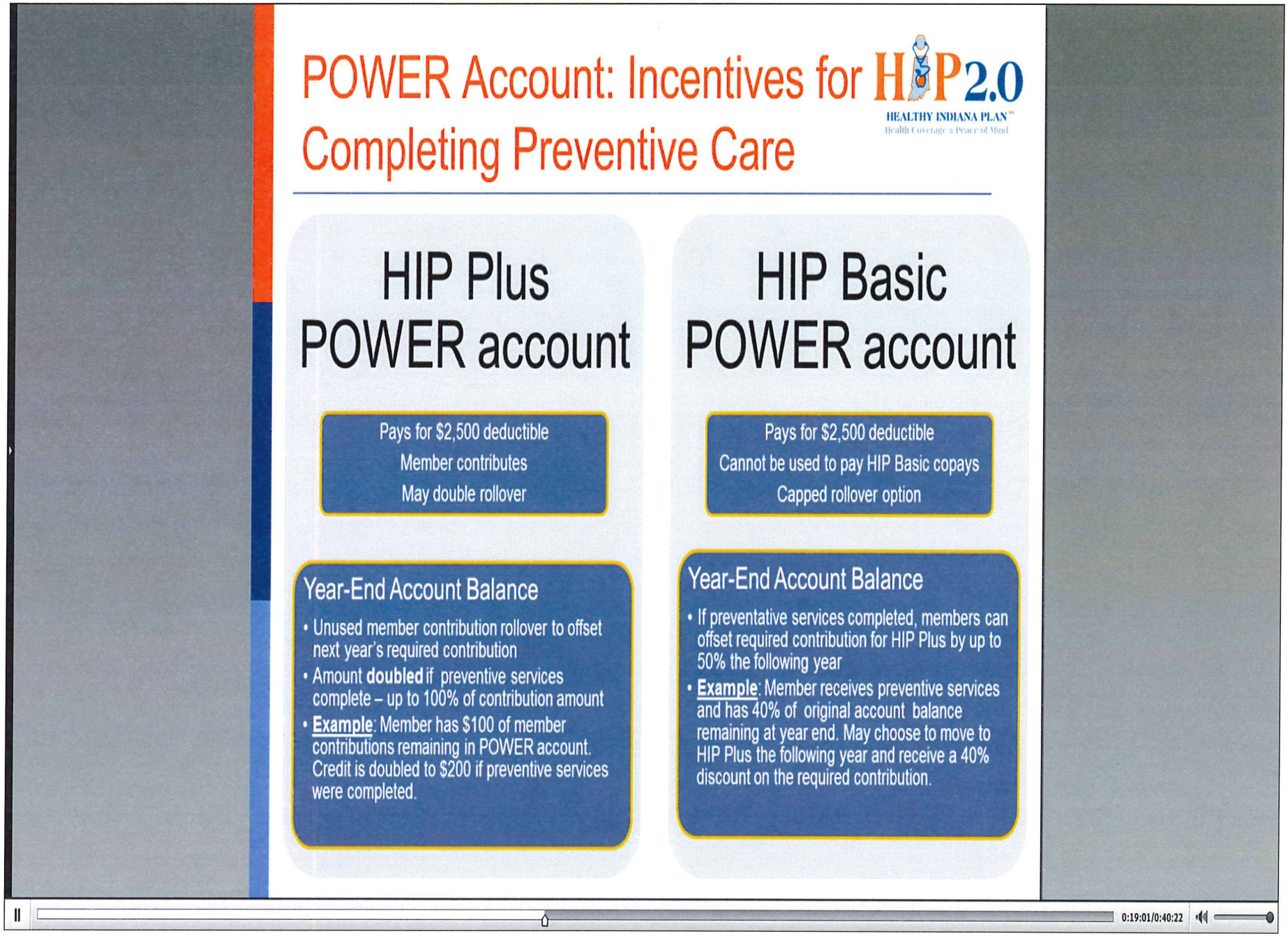
Maximum monthly HIP 2.0 POWER account contributions (PAC)

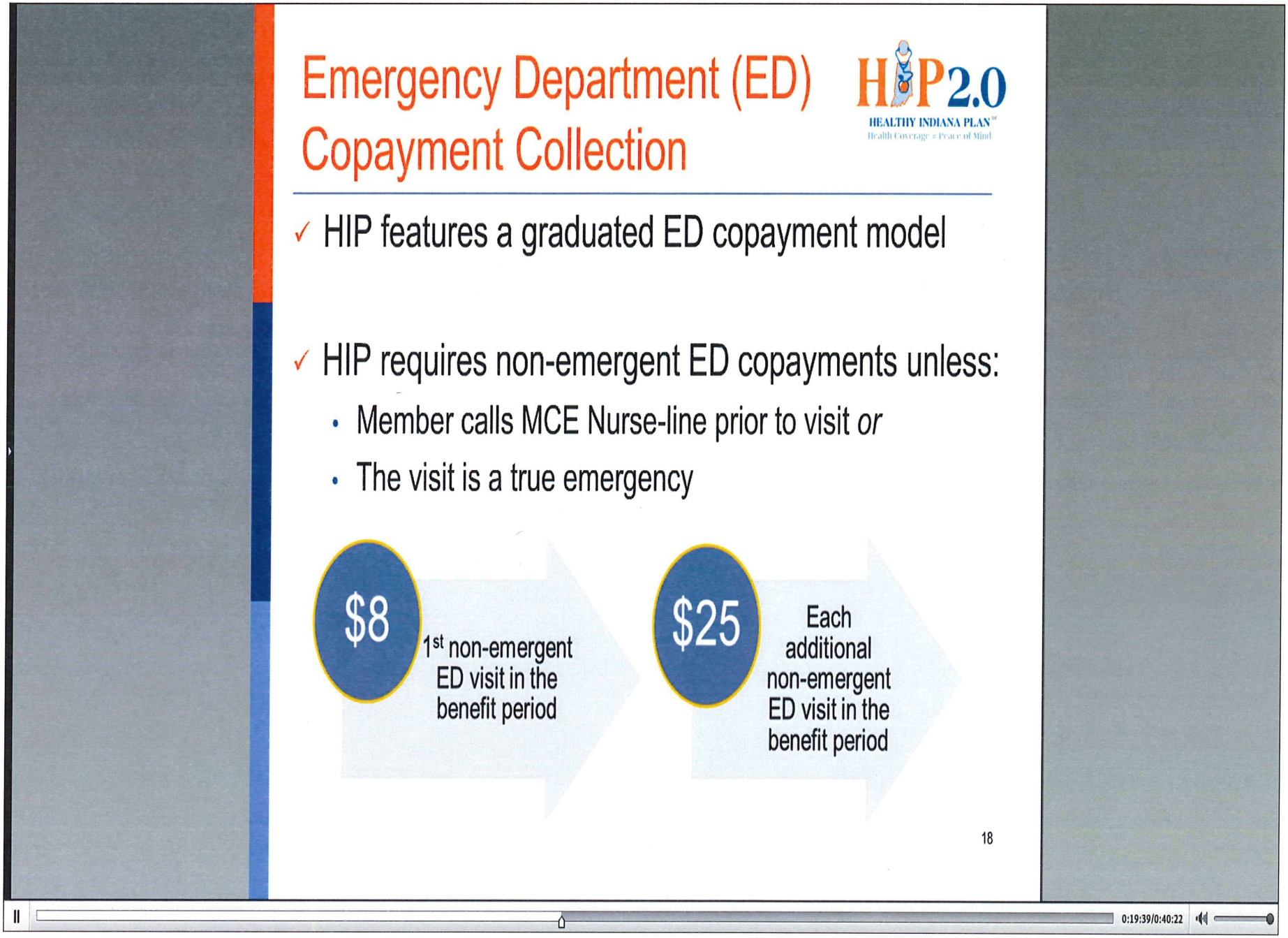
FPL	Monthly Income, Single Individual	Maximum Monthly PAC*, Single Individual	Maximum Monthly Income, Household of 2
<22%	Less than $216	$4.32	Less than $292
23%-50%	$216.01 to $491	$9.82	$292.01 to $664
51%-75%	$491.01 to $736	$14.72	$664.01 to $996
76%-100%	$736.01 to $981	$19.62	$996.01 to $1,328
101%-138%	$981.01 to $1,369.73	$27.39	$1,328.01 to $1,853.85

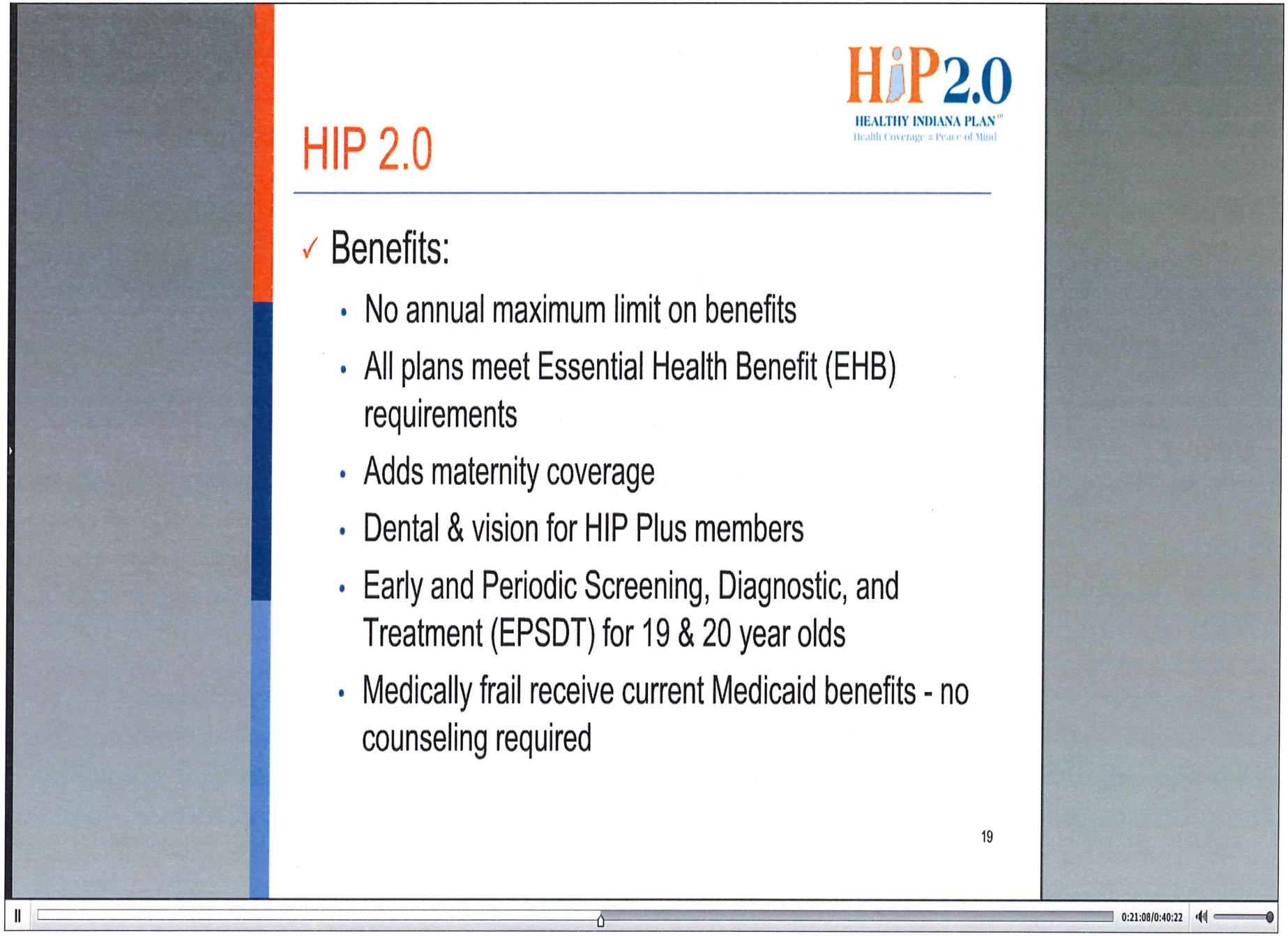
16

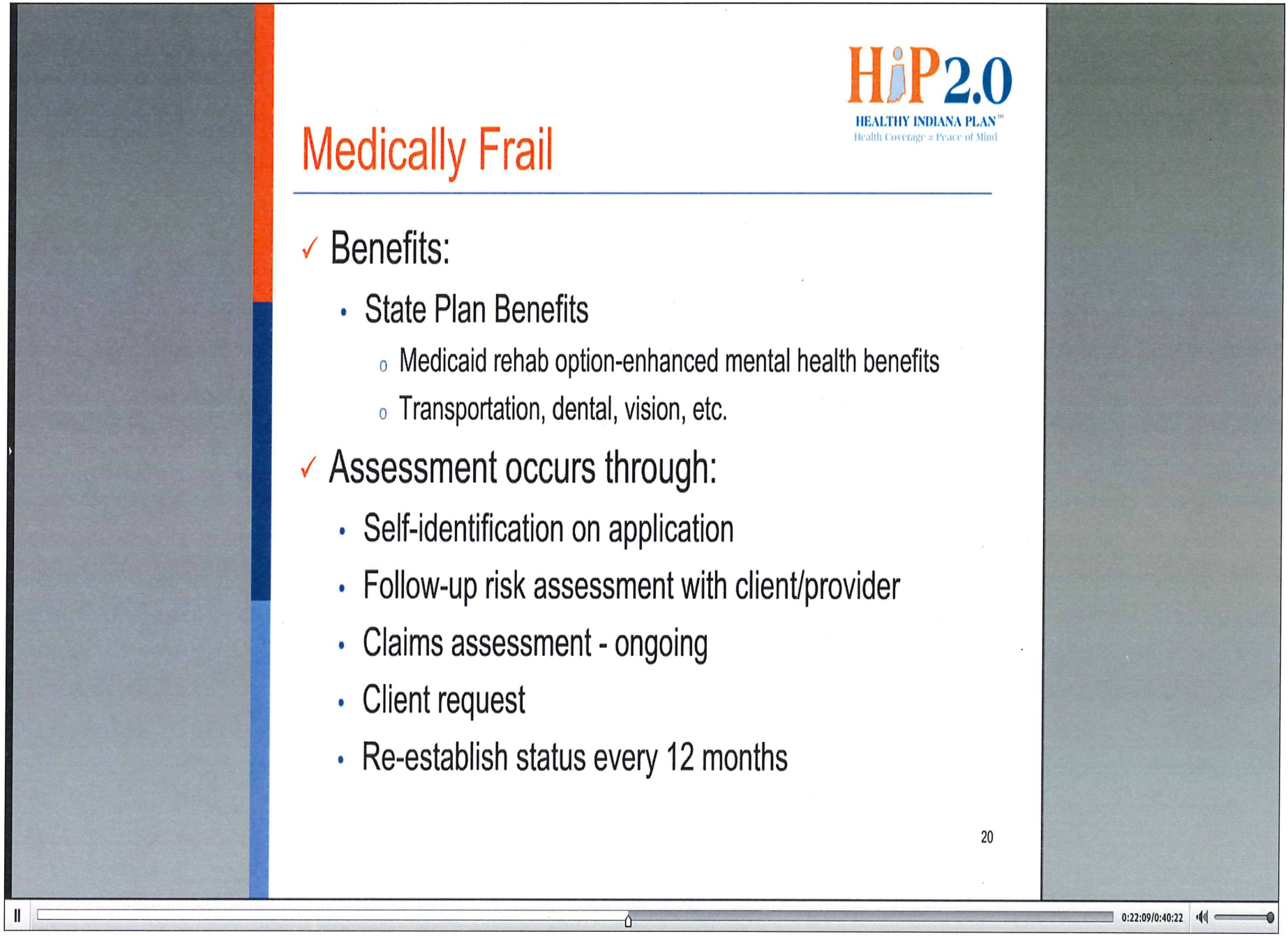
*Amounts can be reduced by other Medicaid or CHIP premium costs
**To receive the split contribution for spouses, both spouses must be enrolled in HIP

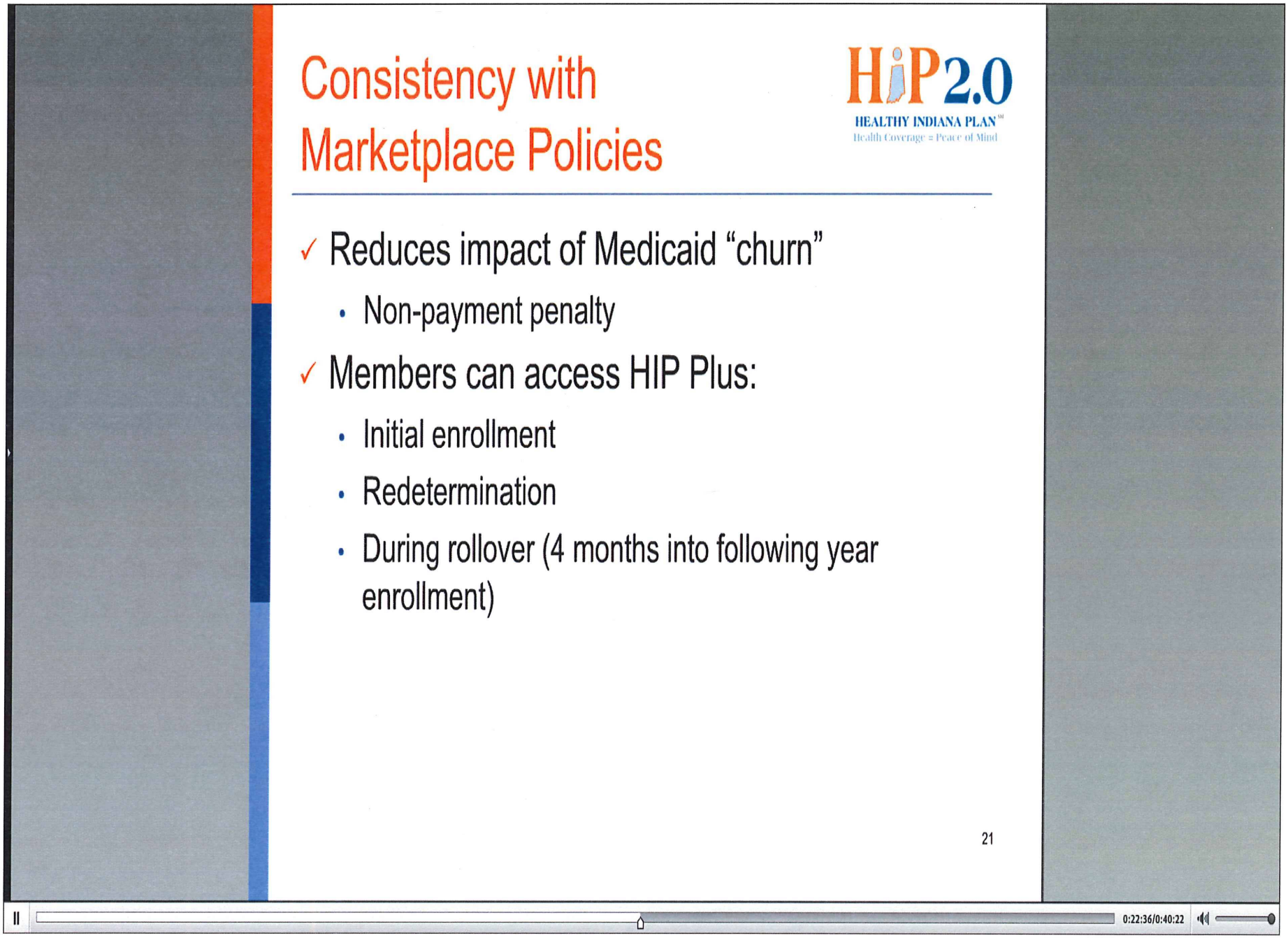
0:18:42/0:40:22

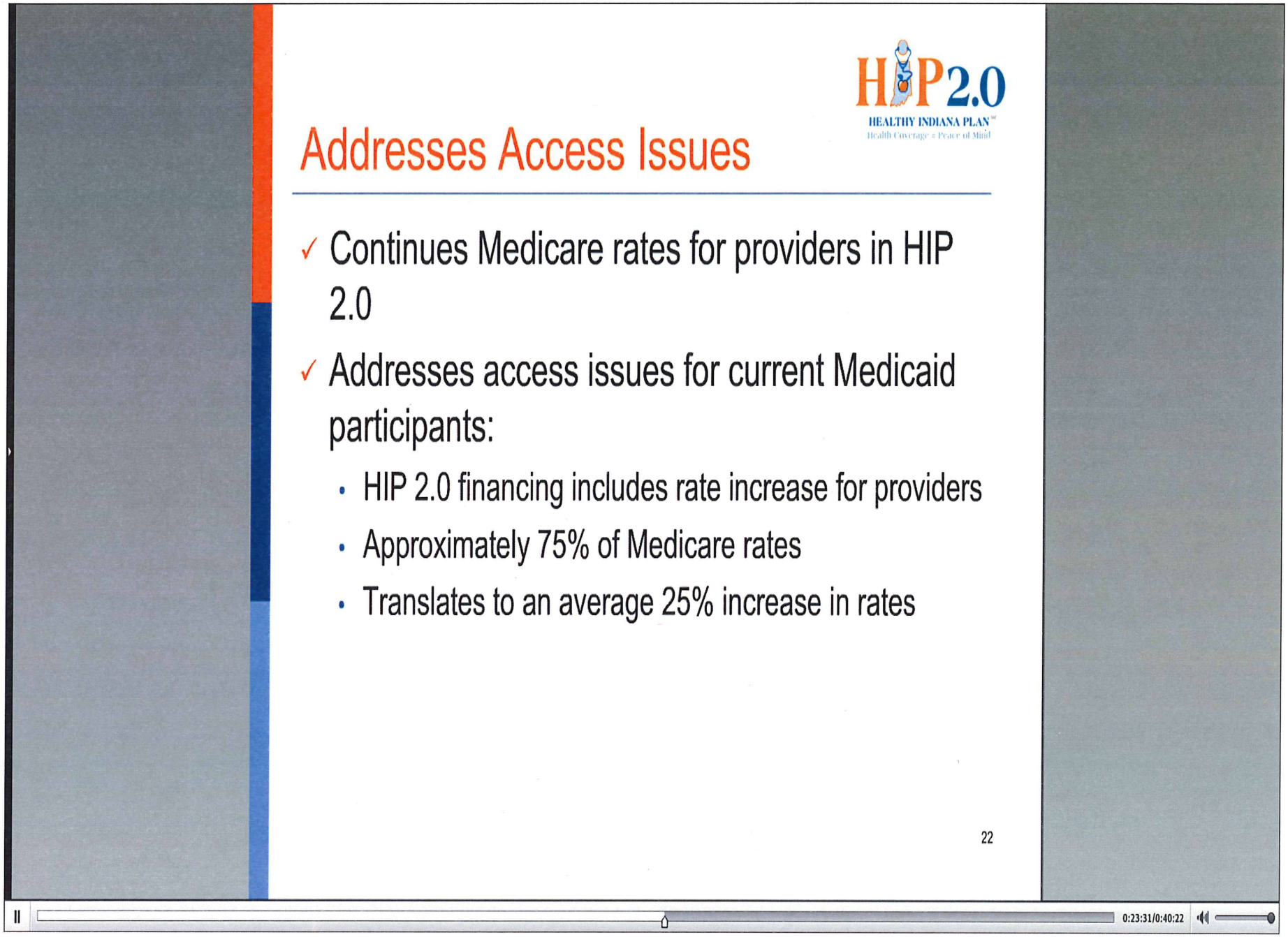

POWER Account: Incentives for HIP 2.0
HEALTHY INDIANA PLAN
Health Coverage = Peace of Mind
Completing Preventive Care
HIP Plus POWER account
Pays for $2,500 deductible
Member contributes
May double rollover
Year-End Account Balance
• Unused member contribution rollover to offset next year's required contribution
• Amount doubled if preventive services complete – up to 100% of contribution amount
• Example: Member has $100 of member contributions remaining in POWER account. Credit is doubled to $200 if preventive services were completed.
HIP Basic POWER account
Pays for $2,500 deductible
Cannot be used to pay HIP Basic copays
Capped rollover option
Year-End Account Balance
• If preventative services completed, members can offset required contribution for HIP Plus by up to 50% the following year
• Example: Member receives preventive services and has 40% of original account balance remaining at year end. May choose to move to HIP Plus the following year and receive a 40% discount on the required contribution.
0:19:01/0:40:22

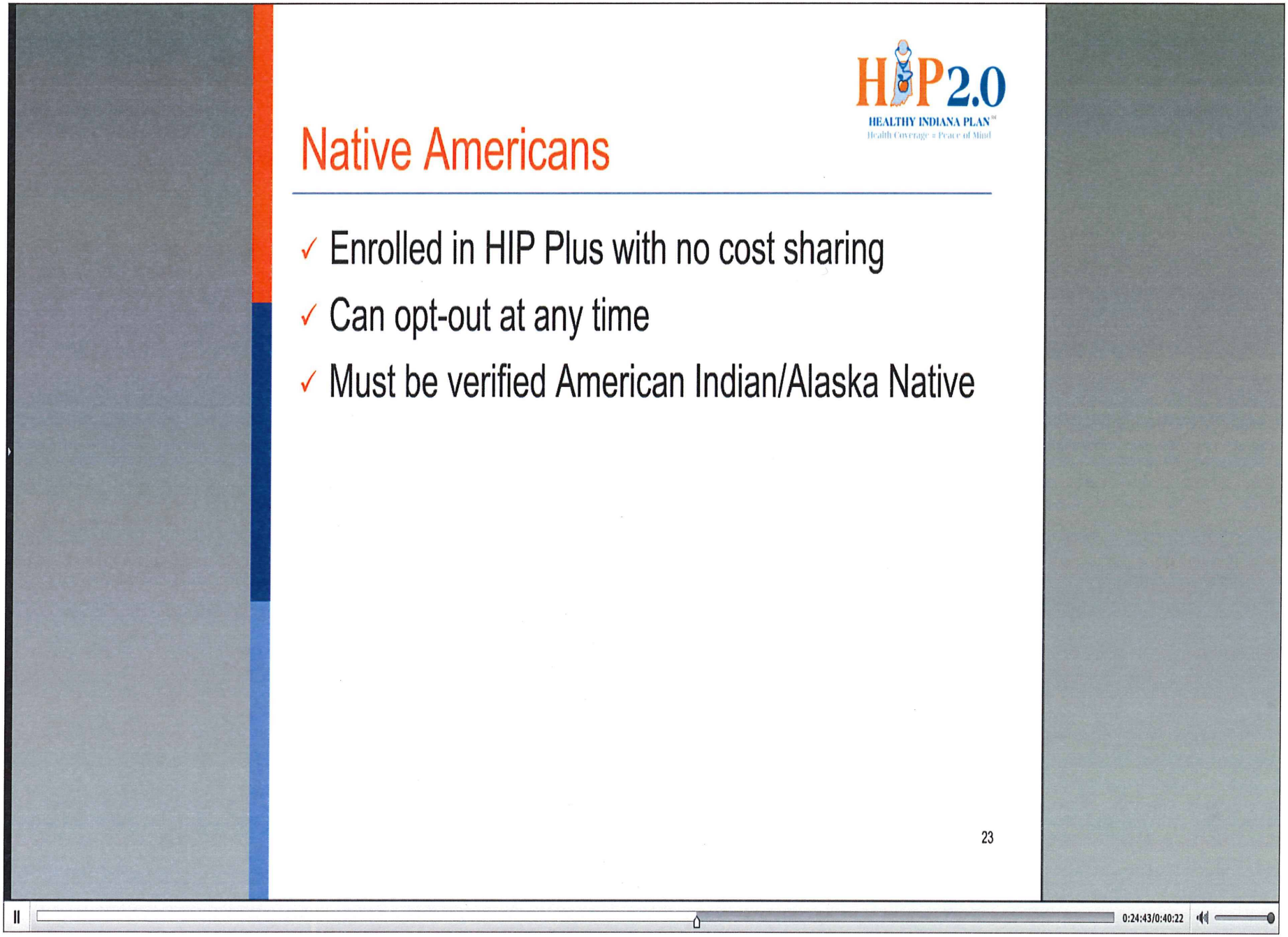

Emergency Department (ED) Copayment Collection
HIP 2.0
HEALTHY INDIANA PLAN
Health Coverage = Peace of Mind
✓ HIP features a graduated ED copayment model
✓ HIP requires non-emergent ED copayments unless:
• Member calls MCE Nurse-line prior to visit or
• The visit is a true emergency
$8
1st non-emergent ED visit in the benefit period
$25
Each additional non-emergent ED visit in the benefit period
18
0:19:39/0:40:22

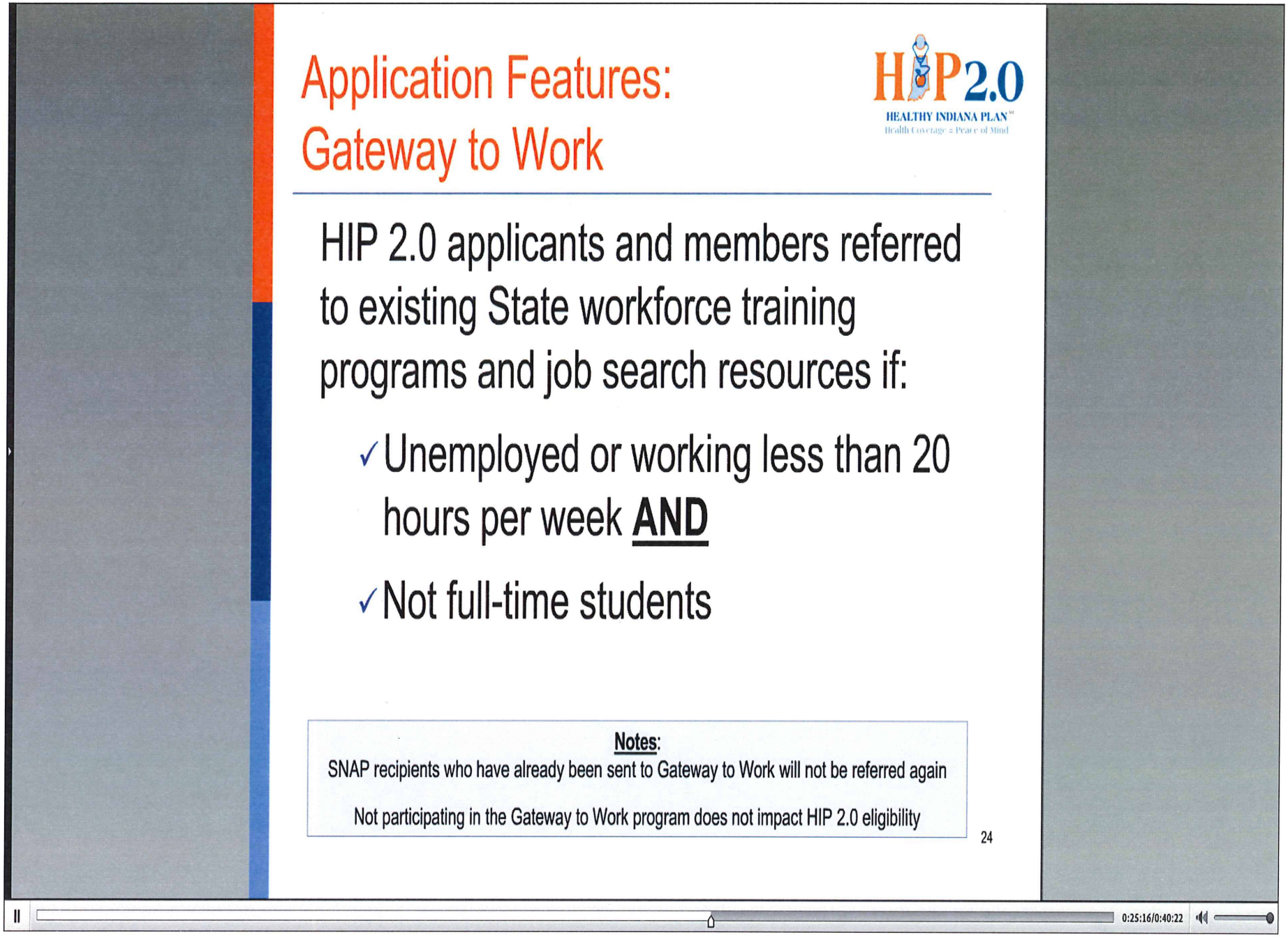

HIP 2.0
HIP2.0
HEALTHY INDIANA PLAN
Health Coverage = Peace of Mind
✓ Benefits:
• No annual maximum limit on benefits
• All plans meet Essential Health Benefit (EHB) requirements
• Adds maternity coverage
• Dental & vision for HIP Plus members
• Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) for 19 & 20 year olds
• Medically frail receive current Medicaid benefits - no counseling required
19
0:21:08/0:40:22

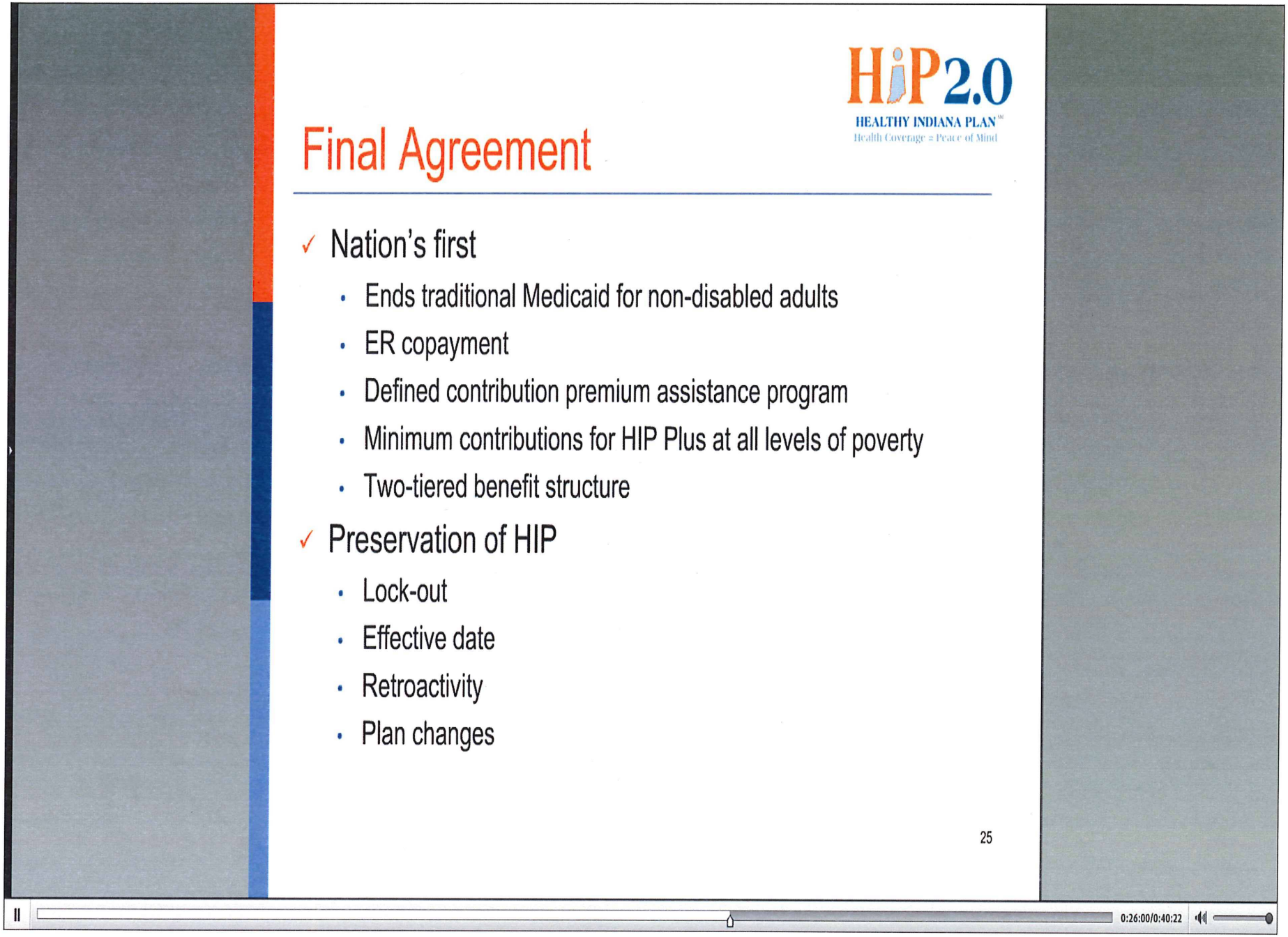

HiP2.0
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind
Medically Frail
✓ Benefits:
• State Plan Benefits
o Medicaid rehab option-enhanced mental health benefits
o Transportation, dental, vision, etc.
✓ Assessment occurs through:
• Self-identification on application
• Follow-up risk assessment with client/provider
• Claims assessment - ongoing
• Client request
• Re-establish status every 12 months
20
0:22:09/0:40:22

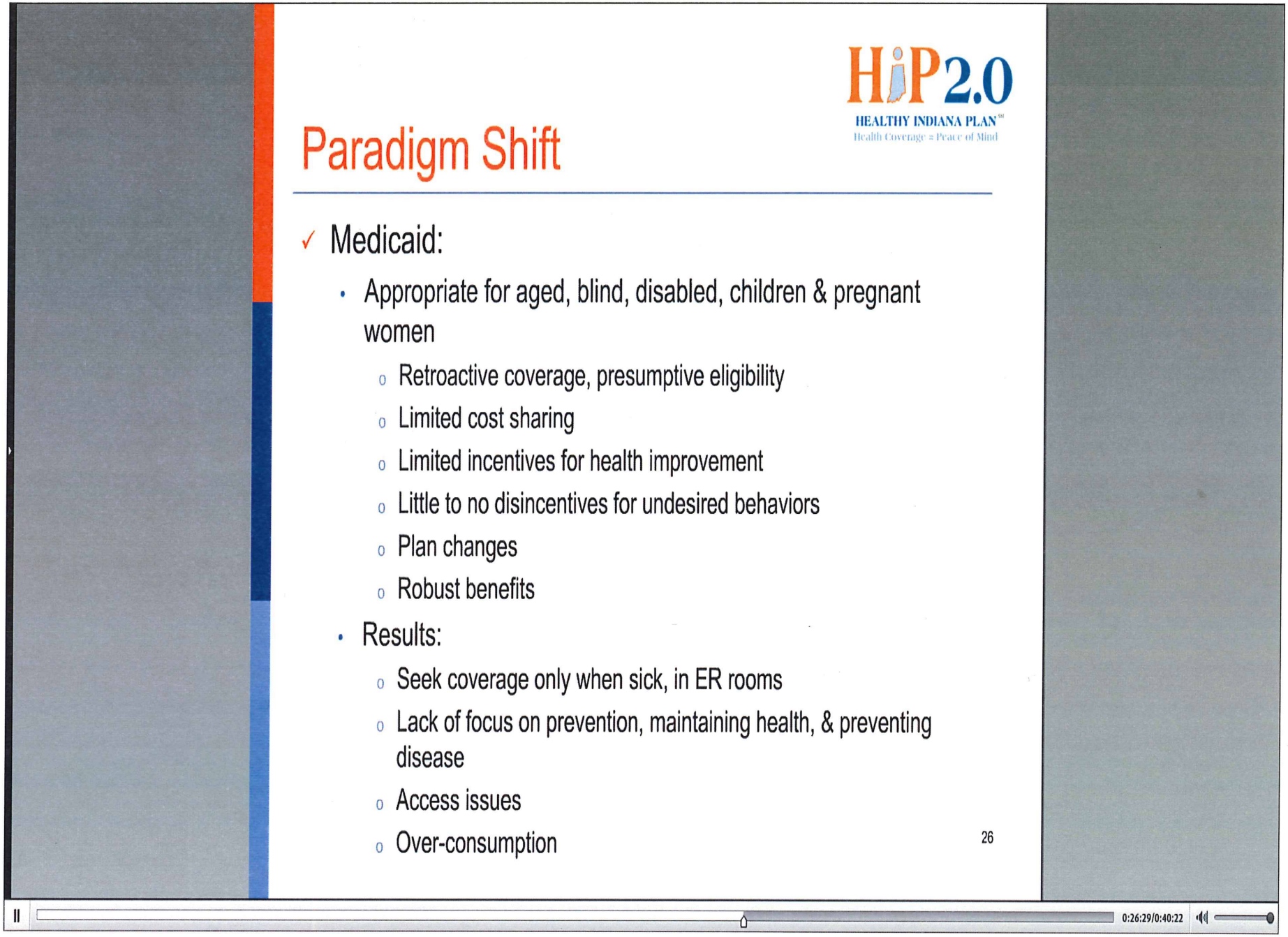

Consistency with Marketplace Policies
HIP 2.0
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind
✓ Reduces impact of Medicaid "churn"
• Non-payment penalty
✓ Members can access HIP Plus:
• Initial enrollment
• Redetermination
• During rollover (4 months into following year enrollment)
21
0:22:36/0:40:22

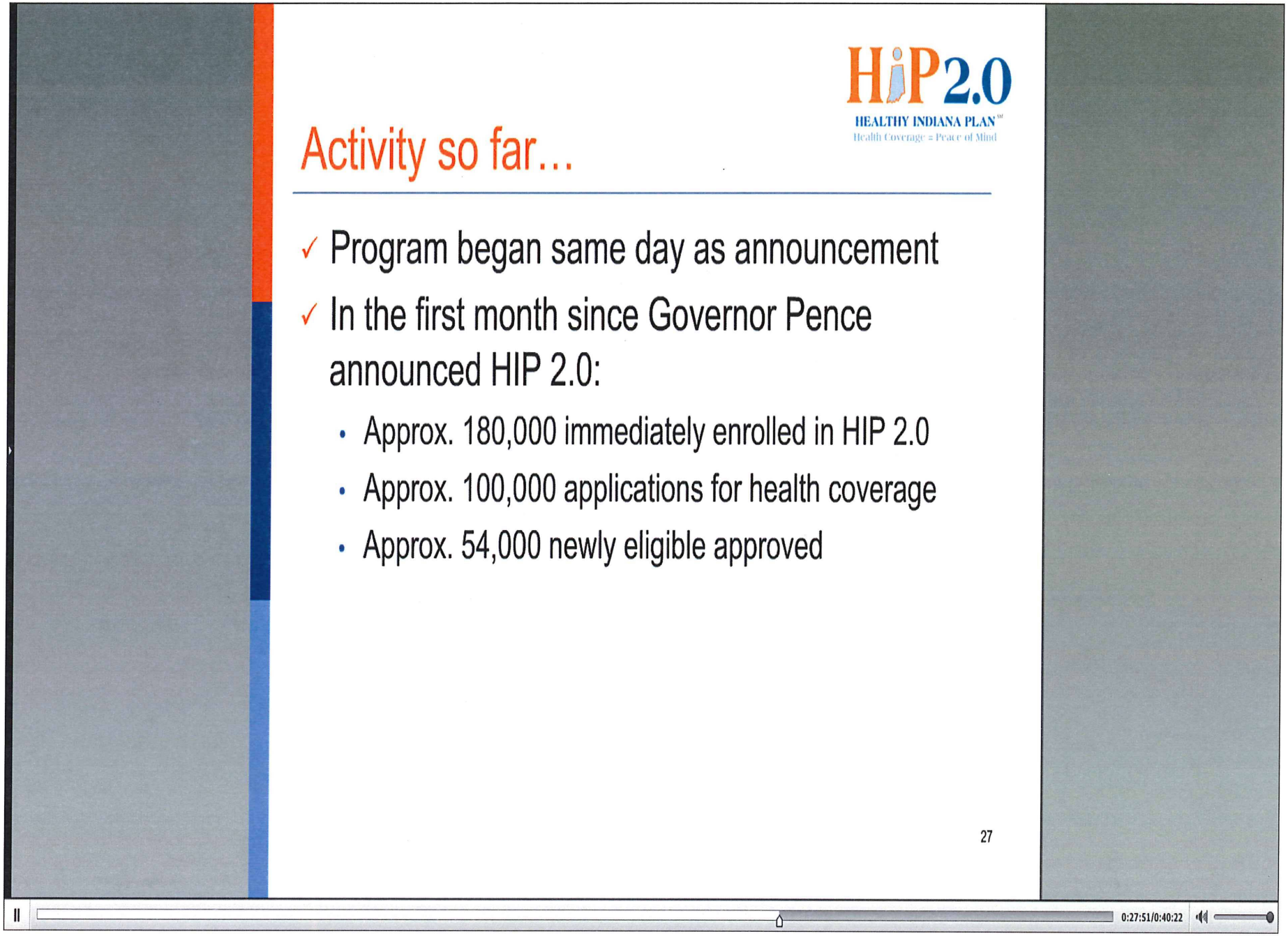

HIP2.0
HEALTHY INDIANA PLAN
Addresses Access Issues
✓ Continues Medicare rates for providers in HIP 2.0
✓ Addresses access issues for current Medicaid participants:
• HIP 2.0 financing includes rate increase for providers
• Approximately 75% of Medicare rates
• Translates to an average 25% increase in rates
22
0:23:31/0:40:22


HIP2.0
HEALTHY INDIANA PLAN
Health Coverage = Peace of Mind
Native Americans
✓ Enrolled in HIP Plus with no cost sharing
✓ Can opt-out at any time
✓ Must be verified American Indian/Alaska Native
23
0:24:43/0:40:22

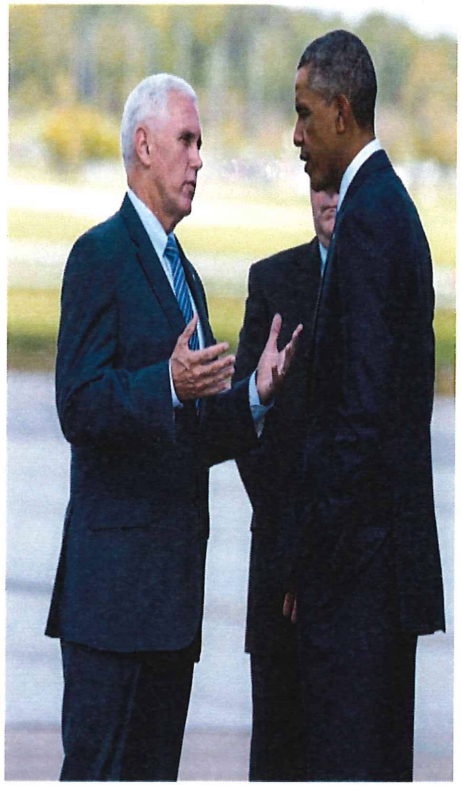

Application Features:
Gateway to Work
HIP 2.0
HEALTHY INDIANA PLAN
Health Coverage = Peace of Mind
HIP 2.0 applicants and members referred to existing State workforce training programs and job search resources if:
✓Unemployed or working less than 20 hours per week AND
✓Not full-time students
Notes:
SNAP recipients who have already been sent to Gateway to Work will not be referred again
Not participating in the Gateway to Work program does not impact HIP 2.0 eligibility
24
0:25:16/0:40:22


HIP2.0
HEALTHY INDIANA PLAN
Health Coverage = Peace of Mind
Final Agreement
✓ Nation's first
• Ends traditional Medicaid for non-disabled adults
• ER copayment
• Defined contribution premium assistance program
• Minimum contributions for HIP Plus at all levels of poverty
• Two-tiered benefit structure
✓ Preservation of HIP
• Lock-out
• Effective date
• Retroactivity
• Plan changes
25
0:26:00/0:40:22


HiP2.0
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind
Paradigm Shift
✓ Medicaid:
• Appropriate for aged, blind, disabled, children & pregnant women
o Retroactive coverage, presumptive eligibility
o Limited cost sharing
o Limited incentives for health improvement
o Little to no disincentives for undesired behaviors
o Plan changes
o Robust benefits
• Results:
o Seek coverage only when sick, in ER rooms
o Lack of focus on prevention, maintaining health, & preventing disease
o Access issues
o Over-consumption
26
0:26:29/0:40:22


HiP2.0
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind
Activity so far…
✓ Program began same day as announcement
✓ In the first month since Governor Pence announced HIP 2.0:
• Approx. 180,000 immediately enrolled in HIP 2.0
• Approx. 100,000 applications for health coverage
• Approx. 54,000 newly eligible approved
27
0:27:51/0:40:22

HIP 2.0
HEALTHY INDIANA PLAN℠
Health Coverage = Peace of Mind



(AP Photo/Evan Vucci)

QUESTIONS?

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28

0:28:24/0:40:22

A HEALTHY FLORIDA WORKS

A Healthy Florida Works Program

Section 1 – Provides Legislative intent

Section 2 – Creates a new section of statute, s. 409.XXX relating to "A Healthy Florida Works Program".

1) PROGRAM CREATION
   - Establishes a health care marketplace premium assistance program for uninsured low income adults with incomes up to 133 percent of the federal poverty level who meet the eligibility and participation requirements.
   - The Agency for Health Care Administration will directly, or through the services of a Third Party Administrator, manage and administer the program.
   - The Agency will apply for and implement state plan amendments or waivers of applicable federal laws and regulations necessary to implement the program by July 1, 2015.
   - The Agency is authorized to adopt rules to administer the program.
2) DEFINITIONS
   - Provides definitions specific to the program.
3) ELIGIBILITY
   - Must be determined eligible in accordance with federal and state regulations.
   - Must participate in job and education training requirements.
4) ENROLLMENT
   - Enrollment of applicants into the program will not begin until October 1, 2015 or until the waiver has been approved by the Centers for Medicare and Medicaid Services.
   - Enrollment may occur directly, through a third party administrator, or as a result of an eligibility determination and subsequent referral by DCF and the federal exchange.
   - The earliest coverage effective date under the program will be January 1, 2016.
   - The third party administrator will provide an enrollee a choice of at least two plans and consider contracts that provide family plans.
   - A lock-in period of 12 months is specifically included and exceptions may be given to that lock-in period that take into consideration good cause reasons and qualifying events.
   - The third party administrator may select a plan before the coverage start date if no selection was made by the enrollee.
   - The effective date of coverage is the first day of the month after the premium is paid and the state is not responsible for retroactive coverage.
   - The Agency must provide an enrollee who disenrolls with information about other insurance programs.

5) DELIVERY OF SERVICES
   - The Agency will contract with authorized insurers licensed under ch. 627, F.S., managed care organizations authorized under ch. 641, F.S., and provider service networks authorized under ss. 409.912(4)(d) and 409.962(13).
   - During the first year, the Agency shall contract with Medicaid MCOs under contract pursuant to Part IV of ch. 409.
   - In Year 2, health plans may submit an application to the Agency for consideration.

- Thereafter, plans will be selected to coincide with the next Managed Medical Assistance (MMA) procurement cycle.
- The Agency must establish network standards and quality standards.
- Health plans are required to report encounter data, meet the 85% MLR, and have a Health Care Provider Certificate.

6) BENEFITS
   - The benchmark benefit plan containing the ten essential benefits will be used that must also meet the alternative benefits package requirements under section 1937 of the Social Security Act.
   - The Agency will establish a process for the payment of wrap-around services.
   - Nonemergency transportation services are not provided, except for pregnant women and medically frail, for the first year of program operation.
   - Plans may establish a prior authorization processes and other utilization controls if approved by the Agency.
   - Authorizes the establishment of health reimbursement accounts or health savings accounts.
   - Authorizes the agency to make premium assistance payments for individuals with Employer Sponsored Insurance (ESI) if the agency determines that the plans meet the benchmark benefit plan and payments are cost-effective.
7) COST SHARING
   - Provides for a sliding scale payment of premiums:
     - <22% FPL; $3 monthly
     - 23%FPL - 50%FPL; 8 monthly
     - 51%FPL - 100%FPL; $15 monthly
     - 101%FPL - 133%FPL; $25 monthly
   - Provides for a 6 month lock-out period for individuals with incomes from 101% - 133% FPL who do not make a premium payment within a 60 day grace period.
   - Provides for co-payment for individuals above the federal poverty level.
   - Requires individuals above 100% to 133% FPL to pay a co-payment of $25 for the first visit and $50 for the second visit in the same year for non-emergency use of the emergency department.
   - Provides that the provider is responsible for collecting the cost-sharing.
8) PROGRAM MANAGEMENT
   - The Agency is responsible for maintaining a process for determining eligibility, calculating premium assistance payments and cost-sharing, arranging for the collection of premiums for comprehensive health insurance coverage and making premium assistance payments to health insurance plans.
   - Requires the Agency to competitively contract with a Third Party Administrator for the administration of the program.
   - Requires the Agency to monitor quality assurance and access, establish reporting requirements, educational programs, grievance process, job and educational requirements and a program integrity process.
9) APPLICABILITY OF LAWS RELATING TO MEDICAID
   - Cross references s. 409.902, F.S. relating to the Agency as the designated single state agency for Medicaid; s. 409.9128, F.S., relating to providing emergency services and care; and, s. 409.920, F.S, relating to Medicaid provider fraud. These provisions would apply to the A Healthy Florida Works program in the same manner in which they apply in Medicaid.

10) PROGRAM EVALUATION

- Requires monthly enrollment reports to be submitted to the Legislature.
- Requires the Agency to contract with an independent third party vendor and submit an interim evaluation of the program to the Legislature no later than July 1, 2017 with annual evaluations due July 1 each year thereafter.

11) PLAN PENALTIES

- Provides for penalties for early withdrawal and enrollment reduction and failure to report encounter data.
- Provides for a transition process for termination of contracts for noncompliance with requirements.

12) PROGRAM EXPIRATION

- Provides that the program will expire at the end of the state fiscal year in which any of several conditions happen, whichever occurs first.
  - The federal match falling below 90 percent;
  - The federal match contribution falls below the increased FMAP; or
  - A blended federal match formula for A Healthy Florida Works program and the Medicaid program causes the overall federal contribution to be reduced compared to separate, non-blended federal contributions.

Section 3 – Amends s.409.904, F.S. related to optional payments

- Eliminates the Medically Needy Program, effective January 1, 2016.

Section 4 – Provides an appropriation

- Provides an appropriation for health care coverage for newly eligibles.
- Provides an appropriation to contract with a Third Party Administrator to administer the program.

Section 5 – Provides that the act shall take effect upon becoming a law.

A HEALTHY FLORIDA WORKS

A Healthy Florida Works Program

Policy Proposal

The smart choice for individuals and businesses in Florida

TABLE OF CONTENTS

Introduction

In 2010, the passage of the *Patient Protection and Affordable Care Act* (PPACA) mandated health insurance for approximately 30 million Americans. Following a lengthy legal challenge, the issue was resolved by the United States Supreme Court. The Court deemed the law constitutional but left it up to the individual states to decide whether it would be fully implemented. Florida has thus far declined to fully implement the law.

As state lawmakers consider whether to extend coverage to approximately one million Floridians, it is important to understand the impact the decision will have on the well-being of Florida's families, businesses and our economy.

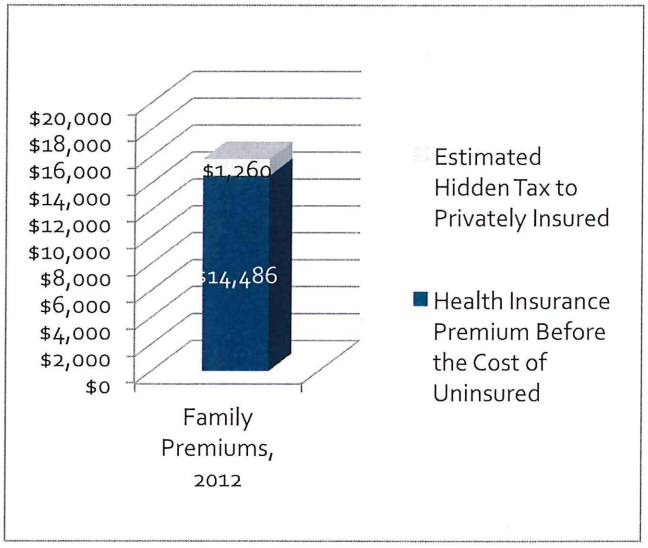
PPACA provides federal tax credits and subsidies for individuals to purchase coverage in health insurance exchanges, but these benefits are only available for those who earn between 100-400 percent of the Federal Poverty Level (FPL). Many individuals below 100 percent of the FPL have no access to health insurance; this equates to an annual income of up to approximately $12,000 for an individual or $24,000 for a family of four. If Florida does not extend coverage, there will continue to be a gap in coverage for the working poor who are uninsured.

It is important to note that PPACA is funded through four mechanisms:

1. Medicaid disproportional share hospital (DSH) reductions;
2. Medicare DSH reductions;
3. Taxes on durable medical equipment; and
4. Taxes on insurance providers.

These four funding sources remain regardless of whether or not our state chooses to extend health care coverage. If policymakers choose not to extend coverage, billions of Florida dollars will continue to be paid to the federal government with no benefit to Floridians. In addition to the reductions mentioned above, employers and individuals will continue paying for care for the uninsured.

On average, families pay eight percent more per year in health care premiums through a "hidden tax" to cover the cost of caring for those who cannot afford to pay for their care.



Health Insurance Premium Cost Shift
The cost of charity care becomes a "hidden tax" for businesses and raises health insurance premiums around eight percent per year.

There are additional costs for employers in states that do not extend coverage. Beginning in 2015, employers must offer insurance benefits that meet the minimum benefits and must offer and help pay for health insurance to all full-time employees. Large employers (more than 100 full-time employees) that fail to provide the mandated coverage are subject to financial penalties.

This is not a partisan decision. More than half of our nation's states are taking action and addressing the issue of coverage through innovative approaches. Twenty-eight states have either extended coverage or are seeking approval of a waiver to extend coverage.

Introduction continued

Of these states, ten are led by a Republican Governor and five have a Republican-led legislature. States that have extended coverage are reporting decreases in the number of uninsured individuals and experiencing the economic benefits of providing health care coverage.

This proposal describes how the state can extend health care coverage to approximately one million Floridians using available federal funds over the next five years. The proposal describes the population covered, eligibility criteria, benefits/services, infrastructure and plan eligibility, personal responsibility and accountability components, funding sources and the authority mechanism. The proposal includes Florida-specific components, as well as innovative ideas that have been successfully implemented in other states.

By implementing A Healthy Florida Works Program, our state can dramatically cut the costs of uncompensated care, take full advantage of the federal funds set aside for coverage and improve the health of approximately one million low-income, working Floridians. This will have a dramatic, positive impact on Florida families, businesses and the economy.

Executive Summary

A Healthy Florida Works Program is designed to increase access to high-quality, affordable health care while promoting personal accountability. The program encourages responsible behavior and provides individual choice in the selection of a private health insurance plan. By using available federal funds, A Healthy Florida Works Program will extend coverage to approximately 800,000 low-income Floridians during the 2015-2016 state fiscal year and approximately one million low-income Floridians over time. Coverage is available to individuals earning less than 138 percent of the FPL who are not currently eligible under section 409.902, Florida Statutes.

This includes:

- Parents and individuals aged 19 and 20 with income between 22 and 138 percent of the FPL; this equates to an annual income of approximately $2,500- $16,000 for an individual, or $5,200 - $32,900 for a family of four
- Supplemental Security Income (SSI), Aged and Disabled individuals with income between 74 and 138 percent of the FPL; this equates to an annual income of approximately $8,600 - $16,000
- Childless adults up to 138 percent of the FPL; this equates to an annual income of approximately $16,000

State Fiscal Year	Estimated Enrollment[1]
2015 – 2016	816, 113
2016 – 2017	946,676
2017 – 2018	957,737
2018 – 2019	968,647
2019 - 2020	979,396

Estimated Enrollment
March 7, 2013
Social Services Estimating Conference

Individuals and families will choose a health plan from a self-sustaining, private insurance marketplace. Health plan benefits include the benchmark package for basic coverage. The benchmark package services include outpatient care, emergency room visits, inpatient stays, obstetrical care, mental health/substance abuse services, prescription drugs, rehabilitation services, lab tests, preventive care and pediatric care. In the first year, managed care plans currently under contract with the Agency for Health Care Administration (AHCA) will be paid a per member, per month premium. In year two and beyond, health plans that want to participate will submit a rate proposal for inclusion in the program.

Personal responsibility and accountability are encouraged through premium payments and work/education participation requirements. Funds collected through premium payments are invested in *A Healthy Benefits Accounts* for use by enrollees once specific criteria are met. The program will be funded through state and federal funds. The state share can be funded through General Revenue savings generated from the elimination of the Medically Needy Program. The program will be authorized through an 1115 Demonstration Waiver for five years, or if the federal government reduces its financial participation, whichever comes first.

Program Description

A Healthy Florida Works Program extends health care coverage to low-income Floridians. The program will be authorized through an independent 1115 Demonstration Waiver specific to the eligible population and will be operated through a self-sustaining, private insurance marketplace.

The program will improve access to affordable, quality care by:

- Increasing access to health care coverage for specific populations with incomes up to 138 percent of the FPL
- Promoting healthy behaviors and personal responsibility through a cost sharing design
- The program uses managed care plans to offer benefits on a private insurance marketplace. Access to basic health care coverage will be provided for:
    - Parents and individuals aged 19 and 20 with income between 22 and 138 percent FPL
    - SSI, Aged and Disabled individuals with income between 74 and 138 percent FPL
    - Childless adults up to 138 percent FPL

The program will leverage efficiencies of the private market to improve continuity, access and quality for participants resulting in improved health outcomes and lower health care costs for all Floridians.

A Healthy Florida Works Program encourages personal responsibility, while protecting our most vulnerable citizens. Personal responsibility and accountability will be achieved through:

- Premium Requirements: Premiums will be paid through a prepaid, per member per month basis, and participants will contribute towards the cost of their health benefit coverage. Individual premium amounts will be collected.

- Healthy Behaviors Incentives: Plans are encouraged to incentivize healthy behaviors, while individuals who meet specific healthy behavior requirements may access additional services and educational incentives.

- Encouraging Employment: According to the Centers for Disease Control and Prevention, good living conditions (e.g. employment) are fundamental to well-being. Its research shows that well-being is associated with numerous health-, job-, family-, and economically-related benefits, which are associated with decreased risk of disease, illness, and injury; better immune function; speedier recovery; and increased longevity. The goal of encouraging employment is to better enable low-income individuals to move out of poverty while improving overall well-being.

Implementation and operation of A Healthy Florida Works Program is contingent on the Federal Medical Assistance Percentage (FMAP), as provided in section 1905(y) of the Social Security Act (42 U.S.C. § 1396(y)).

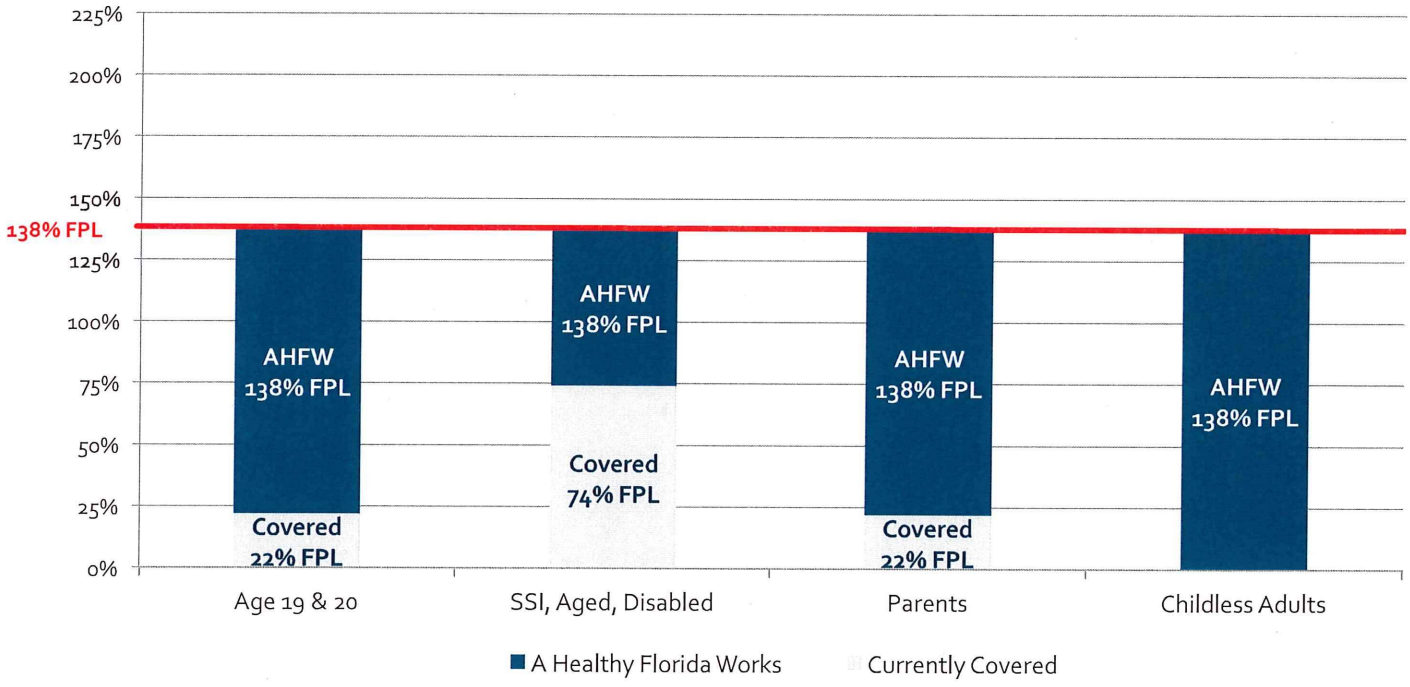
Coverage Population and Eligibility

A Healthy Florida Works Program will provide access to basic health care coverage for eligible uninsured Floridians. It creates incentives and opportunities for low-income individuals to engage in more healthy behaviors, and connect with employers and educators. Eligibility for A Healthy Florida Works Program will be determined using the same process as required under section 409.902, Florida Statutes.

Coverage populations include:

- Parents and individuals aged 19 and 20 with income between 22 and 138 percent of the FPL
- SSI, Aged and Disabled individuals with income between 74 and 138 percent of the FPL
- Childless adults up to 138 percent of the FPL

Coverage by Eligibility Group and Income



Family of one in Florida:

- Parents and individuals aged 19 and 20 who are eligible, earn between $2,567 and $16,105 annually.
- SSI, Aged and disabled individuals who are eligible, earn between $8,636 and $16,105 annually.
- Eligible childless adults who earn $16,105 or less annually.

2014 Federal Poverty Level Guidelines

Household Size	22% of FPL	74% of FPL	100% of FPL	138% of FPL	200% of FPL	400% of FPL
1	$2,567	$8,636	$11,670	$16,105	$23,340	$46,680
2	$3,461	$11,640	$15,730	$21,707	$31,460	$62,920
3	$4,354	$14,645	$19,790	$27,310	$39,580	$79,160
4	$5,247	$17,649	$23,850	$32,913	$47,700	$95,400

Eligibility is contingent on premium payment and enrollee participation in Job and Education Training (JET) activities. Premiums will be invested in *A Healthy Benefits Account*. When participants meet the criteria to use the account, funds may be used to purchase additional health care services offered by their health plan; additional health care services offered by other health plans or providers offered on the insurance marketplace; over-the-counter medications from participating pharmacies; and/or job and education training (JET) activities.

Benefits and Services

A Healthy Florida Works Program will include the benchmark package of covered services specified under 45 CFR §156.100(c) and 45 CFR §156.110. Benchmark services include:

- Preventive and wellness services and chronic disease management
- Maternity and newborn care
- Pediatric services, including oral and vision care
- Hospitalization
- Rehabilitative and habilitative services and devices
- Ambulatory patient services
- Laboratory services
- Emergency services
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs

Infrastructure and Managed Care

Infrastructure

A Healthy Florida Works Program will be administered by a self-sustaining, private insurance marketplace. Florida will establish this marketplace through a competitive bid process. The private marketplace will be a flexible option that can be customized to address the needs of its customers.

Managed Care

Eligible individuals will have an opportunity to choose a health plan for coverage through a private insurance marketplace.

Plan Eligibility Requirements

Health plans with a current contract pursuant to Part IV of Chapter 409, Florida Statutes, will be eligible to offer plans through a private insurance marketplace in year one (July 2015 – June 2016). In order to participate in A Healthy Florida Works Program, health plans must:

- Have a Health Care Provider Certificate
- Be accredited by an organization approved by AHCA
- Demonstrate adequate networks
- Provide a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan
- Educate all enrollees on appropriate provider delivery (i.e. primary care options outside of the emergency department)
- Submit encounter data pursuant to section 409.91211, Florida Statutes

Plan Payments

A rate will be set by region and population based on the essential benefits provided. During the first year, health plans that do not currently have a contract pursuant to Part IV of Chapter 409, Florida Statutes, which are interested in serving this population, may submit an application compliant with 42 CFR, Chapter IV, Subchapter C, Part 438.

Infrastructure and Managed Care continued

Plan Penalties

Penalties will be enforced for plans reducing enrollment or withdrawing. Plans that reduce enrollment levels, or leave a region before the end of the contract term, must reimburse the cost of enrollment changes and other transition activities. If more than one plan leaves a region at the same time, costs must be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing plans must pay a per-enrollee penalty of up to three months' payment and continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another plan, whichever occurs first.

In addition to payment of costs, all other departing plans must pay a penalty of 25 percent of that portion of the minimum surplus maintained pursuant to s. 641.225(1), which is attributable to the provision of coverage to A Healthy Florida Works Program enrollees. Plans shall provide at least 180 days' notice before withdrawing from a region.

If a plan fails to comply with the encounter data reporting requirements for 30 days, AHCA must assess a fine of $5,000 per day for each day of noncompliance beginning on the 31st day. On the 31st day, the agency must notify the plan that the agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance before that date.

Additional Plans

In year two (July 2016 – June 2017), additional health plans will have an opportunity to participate in the program. Health plans not participating in year one must meet all health plan requirements, with the exception of a current contract with AHCA, pursuant to Part IV of Chapter 409, Florida Statutes, and submit an acceptable rate by January 1, 2016. Plans will be notified by March 15, 2016, if the bid is accepted.

Personal Responsibility and Accountability

Premiums

Under the program, a private insurance marketplace will be authorized to collect premiums from enrollees in accordance with federal law. Payment of mandatory monthly premiums may be required before coverage starts for an enrollee. Premiums collected will be invested in *A Healthy Benefits Account*.

Plan recipients will have access to accounts after 12 months of continuous premium contributions, a documented annual wellness check-up with a primary care provider and participation in JET activities.

Personal Responsibility and Accountability continued

A Healthy Florida Works Program Premiums

FPL	PROPOSED MONTHY CONTRIBUTION	PROPOSED ANNUAL CONTRIBUTION	PARTICIPATION
<22%	$3	$36	Mandatory
23% - 50%	$8	$96	Mandatory
51% - 100%	$15	$180	Mandatory
101% - 138%	$25	$300	Mandatory

Job and Education Training Requirements

Participants (excluding those with disabilities) are required to participate in JET activities. JET activities include employment search, on-the-job training, job placement and education opportunities for a specific trade. The private insurance marketplace will coordinate with appropriate entities.

STATUS	JET ACTIVITES
Parents	20 hours weekly
Childless adults	35 hours weekly

Funding

A Healthy Florida Works Program will be funded with general revenue savings generated by the elimination of the Medically Needy Program. The Medically Needy population currently covered would qualify for A Healthy Florida Works Program.

In addition, the program's elimination will result in an estimated savings of $410 million annually in state general revenue. These savings would cover the state share as the federal financial participation ranges from 100 percent to 90 percent over the five-year demonstration period.

Federal Financial Participation (FFP)

Calendar Year	2015	2016	2017	2018	2019	2020
FFP	100%	100%	95%	94%	93%	90%

On March 7, 2013, the Medicaid Impact Conference met to discuss various programs and services. Issues included were the impact of a program such as A Healthy Florida Works Program on the Medically Needy Program, Mental Health and Substance Abuse services and AIDS Drug Assistance Services.

Funding continued

Estimated State Savings

Year	State Cost [1]	State GR Savings from Elimination of Medically Needy Program [2]	State GR Savings from Reductions in Substance and Mental Health Program [2]	State GR Savings from Reductions in the HIV/AIDS Program [2]	Total State GR Savings	Net State Savings
2015-16		$410,473,475	$216,200,000	$10,500,000	$637,173,475	$637,173,475
2016-17	$144,644,699	$410,473,475	$216,200,000	$10,500,000	$637,173,475	$492,528,776
2017-18	$329,673,427	$410,473,475	$216,200,000	$10,500,000	$637,173,475	$307,500,048
2018-19	$403,521,013	$410,473,475	$216,200,000	$10,500,000	$637,173,475	$233,652,462
2019-20	$546,892,070	$410,473,475	$216,200,000	$10,500,000	$637,173,475	$90,281,405
	$1,424,731,209	$2,052,367,375	$1,081,000,000	$52,500,000	$3,185,867,375	$1,761,136,166

[1] *March 7, 2013 Social Services Estimating Conference*

[2] *March 7, 2013 Medicaid Impact Conference, Revised Agency for Health Care Administration Estimates*

Authority

The program will be authorized through an 1115 Demonstration Waiver. It expires on July 1, 2020, or if the federal government reduces the Federal Financial Participation, whichever occurs first.

Conclusion

A Healthy Florida Works Program improves access to quality, affordable health care, promotes personal accountability, is good for Florida businesses and improves the state's economy. Florida policymakers have an opportunity to provide basic health care services for those most in need while also ensuring the state's financial security. Florida dollars have already paid for this. We should accept the available federal funds so we can get back what we sent to Washington D.C., rather than allowing those dollars to fund programs in other states. More and more states, despite their governors' and state lawmakers' party affiliations, are choosing to accept the available federal funds and create a health care coverage program that is right for them. It is time Florida did as well.




SMARTER HEALTHCARE COVERAGE IN FLORIDA

The Florida Chamber's Plan for Making Florida More Competitive by Bending the Cost Curve for Florida's Families and Job Creators

FLORIDA CHAMBER of Commerce

www.FloridaChamber.com/HealthCareSolutions

MAKING FLORIDA MORE COMPETITVE BY BENDING THE

Making Florida more competitive means making tough choices – putting the long-term security of Florida's future ahead of short-term fixes. When it comes to fixing federal healthcare, we believe this situation is the proverbial making lemonade out of lemons. Like many of our partners, the Florida Chamber of Commerce remains significantly concerned about the growth of federal entitlements and the resulting erosion of our freedoms.

To be clear, the Florida Chamber opposes the traditional expansion of Medicaid. Only if an alternative plan, one that embraces private solutions with flexible steps to eliminate the $1.4 billion cost shift on Florida families and caps Florida's Medicaid budget at 32 percent, would we support the use of additional federal funds. Without these provisions, the Florida Chamber does not support the expansion of Medicaid.

The Florida Chamber's Healthcare Task Force took a careful look at Florida's situation and has recommended a seven point comprehensive plan for making Florida more competitive and to mitigate our concern over the growth of entitlements. The members of the task force deserve our thanks as they spent weeks hearing from experts, reviewing what competitor states are doing and deliberating over the right set of recommendations that makes Florida more competitive.

As Florida prepares to welcome six million new residents by 2030, Florida has an important opportunity to get healthcare coverage right. As lawmakers consider extending healthcare coverage to as many as one million uninsured Floridians, the Florida Chamber is continuing to play an integral role in helping reform our state's healthcare system.

The Florida Chamber's Plan for Smarter Healthcare Coverage is very simple:

- Eliminating the expensive cost shift on Florida's families and businesses,
- Producing better health and economic outcomes for Florida, and
- Improving access to healthcare for uninsured Floridians.

Some believe expanding healthcare coverage is a simple 'yes' or 'no' solution. Some want Florida to accept more than $50 billion in federal tax dollars without any promise of better outcomes and without eliminating the cost shift forced upon Floridians.

The federal government had an opportunity to make America more competitive by getting the Affordable Care Act right, instead they created a bureaucratic malaise that is taxing Americans and making our country less competitive.

The Florida Chamber believes Florida can and should do better.

CONSIDER FLORIDA'S SITUATION

The Affordable Care Act (ACA) has made health care coverage anything but affordable, and rates have risen substantially. The Florida Office of Insurance Regulation has projected that insurance plans under the ACA will increase 13.2 percent in 2015. In addition to rate increases, the ACA has created new regulatory burdens on businesses and raised taxes on nearly all wage earners to pay for subsidized health care coverage for the nation's uninsured.

From 2003-2010, total premiums for family coverage across all states rose by 50 percent, and out-of-pocket and deductibles skyrocketed 63 percent, according to the Commonwealth Fund. In 2013, Floridians paid $31 billion on health insurance premiums alone. The ACA was to have addressed these ever-increasing rates, but so far, it has actually increased costs.

The federal ACA provides tax credits and subsidies for individuals to purchase health insurance coverage through exchanges. However, for individuals below 100 percent of the Federal Poverty Level, there remains a gap in coverage.

To date, Florida leaders have chosen not to expand healthcare coverage. The federal governments perceived "all or nothing" policy on expanding coverage has been a major reason Florida has not accepted federal tax dollars to extend healthcare coverage.

COST CURVE FOR FLORIDA'S FAMILIES AND JOB CREATORS

With the approval of the U.S. Department of Health and Human Services, 28 states have initiated some version of flexible healthcare solutions to meet their state's needs. Recently, the Florida Chamber urged U.S. Department of Health and Human Services Secretary Sylvia Mathews Burwell to reopen conversations with Florida's elected leaders, and work toward a Florida solution. Maximum flexibility to cover Florida's uninsured would help prevent a hidden tax of eight percent, or $1.4 billion, forced onto families and small businesses.

Without a plan for smarter coverage, the gap of uninsured will grow and the cost will continue to shift. In fact, the federal government's decision to end funding for the $2.9 billion Low Income Pool (LIP) will likely force an even more costly shift onto Florida's families and businesses.

Part of the concern with the approach to the ACA is that it uses other people's money – one pot representative of all taxpayer dollars. Unless the cost shift is eliminated, and better outcomes are produced, Florida's ability to be competitive greatly diminishes. The Florida Chamber's Plan for Smarter Healthcare Coverage will help ensure taxpayers benefit from expanding coverage instead of being punished by shifting even more costs of extended healthcare coverage to families and businesses.

DID YOU KNOW:

- **Floridians pay an additional $1.4 billion in hidden healthcare taxes to cover healthcare received by the uninsured.**
- **Insured Floridians pay about $2,000 for every hospital stay to cover the cost of the uninsured.**
- **Florida ranks second with the highest number of uninsured – 3 million.**

"The Florida Chamber is focused on making Florida more competitive and bending the cost curve for Florida's families and job creators."

– MARK WILSON
PRESIDENT AND CEO
FLORIDA CHAMBER OF COMMERCE

THE FLORIDA CHAMBER'S PLAN FOR SMARTER HEALTHCARE COVERAGE

The Florida Chamber's Plan for Smarter Healthcare Coverage is a cost efficient, sustainable healthcare model that provides coverage to the uninsured and eliminates the cost shift on Floridians. Our priority areas of focus include:

1 SMARTER COVERAGE

Reduce and eliminate the cost shift on Florida's families and small businesses by addressing the cost equation. By putting solutions in place that will reduce health care costs, and not simply alter the funding mechanisms, we can build on Florida's quality of life and business friendly atmosphere by covering more of Florida's uninsured. Additionally, personal accountability guidelines will reduce entitlements and increase a stronger commitment by all toward better health. To achieve these goals, Florida should:

- *As a requirement of expanded coverage, the Florida Chamber Healthcare Task Force believes Florida should limit the overall financial impact on the Medicaid budget to no more than 32 percent, and provide healthcare coverage for a maximum number of uninsured Floridians in a manner that facilitates an expeditious end to the cost shift and immediately allows for "flow through" savings to employers. Job creators should see an immediate benefit in lower premiums to pass along to their employees.*
- *Allow private insurance solutions and continue to ensure a managed care model is implemented for those eligible.*
- *Address the medical costs of the state's most needy and the prison population.*
- *Conduct an annual performance review to measure quality of care, cost containment and efficiency.*

2 HEALTHCARE DELIVERY SYSTEM AND MEDICAL PROFESSIONAL CAPACITY

Ensure Florida's healthcare delivery system has the capacity to respond at a high level of quality and meet the needs of Floridians.

- *Allow telemedicine to serve as an alternative healthcare delivery system to increase capacity, deliver high quality of care and control costs.*
- *Increase the capacity and number of medical professionals by allowing nurse practitioners and physician assistants to practice to their fullest potential.*
- *Help decrease Florida's growing need for physicians by expanding medical residency positions and providing targeted training in key health education programs to ensure an adequate supply of allied health professionals.*

3 LAWSUIT ABUSE REFORM — A MAJOR COST DRIVER

When it comes to lawsuit abuse, billboard trial lawyers are exploiting Florida's broken legal system and forcing families to pay approximately $3,400 in lawsuit abuse "taxes" each year. The Florida Chamber believes that to attract and retain the best medical professionals, we must improve on Florida's bottom 10 legal climate and prevent meritless lawsuits and penalties that deter doctors from entering the medical field.

- *Oppose attempts to increase medical liability lawsuits, including those based on the false premises related to the patient compensation system.*
- *Encourage a statutory fix to a medical malpractice law recently overturned by the activist Florida Supreme Court.*
- *Close the phantom damages loophole which unfairly allows juries to pay a plaintiffs' inflated healthcare costs.*

4 WORKERS' COMPENSATION — A MAJOR COST DRIVER

Ensuring Florida's workers' comp system is fair and not inflated by trial lawyer tactics and other unnecessary costs will help lower the cost of doing business in Florida. The Florida Chamber's workers' comp reforms have resulted in a 57 percent savings over the last 10 years. To keep rates low, the Florida Chamber supports:

- *Implementing a new phased-in fee schedule for inpatient, outpatient and ambulatory center services.*
- *Mitigating court decisions that put Florida's workers' comp system at risk.*

5 HEALTHCARE FRAUD — A MAJOR COST DRIVER

Eliminating healthcare fraud and abuse will lower total healthcare costs. The Florida Chamber supports innovative practices and technologies to combat the billions of dollars wasted each year in healthcare fraud and abuse.

6 STEP THERAPY AND PRIOR AUTHORIZATION

The Florida Chamber opposes current legislation that would undermine the use of prior authorization and step therapy protocols in Florida. These policies were enacted to enable patients to receive safe and high-quality prescription drugs as well as control the usage and costs. Unless a smarter solution or a compromise position can be reached, the financial impact of such a policy would likely dramatically increase drug costs which, inturn would be borne by employers and families in higher premiums.

7 MEDICAID MANAGED CARE

The Florida Chamber does not support efforts to undermine the tenets of the managed care model – including the so-called 'any willing provider' provision.

"Healthcare accounts for an estimated one-seventh of Florida's economy – a figure that equals more than $100 billion."

– DR. JERRY PARRISH
CHIEF ECONOMIST
FLORIDA CHAMBER FOUNDATION

JOIN THE FLORIDA CHAMBER'S HEALTHCARE ALLIANCE

Contact David Christian, Vice President of Governmental Affairs, at (850) 521-1211 or dchristian@flchamber.com.

FLORIDA CHAMBER of Commerce

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March 4, 2015

The Honorable Aaron Bean
Florida Senate
404 South Monroe Street
202 Senate Office Building
Tallahassee, FL 32399

RE: For a more competitive Florida, *Smarter Healthcare Coverage in Florida*

Dear Chairman Bean:

Thank you for inviting the Florida Chamber of Commerce to present our Healthcare Task Force's proposal for Smarter Healthcare Coverage in Florida. On behalf of the Florida Chamber, we applaud your pursuit of ideas on how Florida can end the $1.4 billion cost shift and make Florida more competitive.

For your convenience and information, please find attached the following documents:

1. My letter, dated December 23, 2014, to HHS Secretary Sylvia Mathews Burwell requesting maximum flexibility with regards to Florida's potential coverage expansion,
2. The *Smarter Healthcare Coverage in Florida Act* – Draft legislation from the Florida Chamber,
3. The Florida Chamber's section-by-section bill analysis, and
4. Did You Know? Floridians Pay a "Hidden Tax" of $1.4 Billion Due to Uncompensated Care.

Additionally, the Florida Chamber's website, www.flchamber.com/issue/health-care/, hosts a number of healthcare-related resources. There you will find our *Smarter Healthcare Coverage in Florida* plan, as well as video and audio interviews with healthcare professionals from throughout Florida on topics such as telemedicine, scope of practice and other innovations in healthcare.

Senators, thank you for your leadership and, in advance, for the work you will do to negotiate a sound solution with the House of Representatives and Governor Scott. I remain convinced that if we put consumers and small businesses first, Florida wins. If my team or I can be of additional assistance, please call my office at 850-521-1200.

My best,

Mark Wilson

Mark Wilson
President and CEO

cc: David Hart, Executive Vice President

FLORIDA CHAMBER of Commerce

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December 23, 2014

The Honorable Sylvia Mathews Burwell
Secretary
The U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

Re: Florida Chamber of Commerce Requests Maximum Flexibility to Cover Florida's Uninsured

Dear Secretary Burwell:

The Florida Chamber of Commerce believes the business community plays an important role in reforming Florida's healthcare system, and ensuring a healthy quality of life for Floridians. Increasing access to healthcare, while also controlling costs, we believe, will lead to better outcomes for Floridians and help Florida be even more competitive.

As you know, Florida has not adopted a plan to expand Medicaid. The perceived 'all or nothing' policy on expanding coverage is chief among our state's reasons for not accepting federal taxpayer dollars.

At the Florida Chamber, we believe the time is right to reopen conversations with elected leaders, and work toward providing coverage to approximately 800,000 more Floridians by incorporating flexible solutions. Chief among the concepts to consider are:

- Incorporating private market and managed care program options,
- Including personal accountability by sharing in co-pays and some out-of-pocket expenses,
- Limiting the expansion to working Floridians or those enrolled in an educational program, and
- Incorporating innovative funding paths to ensure taxpayers are not further burdened with higher taxes and penalties.

Of most concern to the Florida Chamber, its members and the more than three million Floridians they employ, is a hidden tax forced onto both employers and employees. This cost shift occurs when Florida's uninsured receive healthcare at a hospital emergency room. This costly, inefficient care is paid for by families and small businesses through higher health insurance premiums.

As you know, Florida ranks second with the highest number of uninsured - resulting in a reported eight percent hidden tax on health insurance premiums being shifted to families and small businesses. Floridians pay a hidden tax of $1.4 billion to cover those who seek care without insurance. When the cost trickles down from hospitals and insurance companies to insured Floridians, it equates to $1,700 to $2,200 for every insured admission. Eliminating this cost shift is a top priority, and can be achieved by allowing

savings to flow through to employers and employees in the form of lower insurance premiums from an estimated $50 billion in federal funding over the next seven years through 2021.

Without a plan for smarter coverage, the gap of uninsured will grow – as will the cost shift. Currently, Florida receives federal funding through a unique program, known as the Low Income Pool, which provides almost $3 billion to hospitals offering health care to those without an ability to pay. This program is no longer authorized by the federal government, and will cease to receive and distribute funding on July 1, 2015. Therefore, the federal government's decision to end funding for the Low Income Pool will force a cost shift to Florida's families and businesses that is even more costly.

In your capacity as Secretary of Health and Human Services, the Florida Chamber encourage you to send the proper signals to the Florida Legislatures that you are willing to entertain flexible solutions to expanding coverage as well as efforts to eliminate the cost shift on Florida's families and small businesses.

Thank you, in advance, for your consideration. Please contact me at mwilson@flchamber.com or 850.521.1209 should you have any questions.

My best,

Mark Wilson

Thank you, in advance, for helping make Florida more competitive.
Mark

Mark Wilson
President and CEO

A bill to be entitled

An act relating to health care;

WHEREAS The Legislature finds that Floridians pay an additional $1.4 billion in hidden health care fees to cover health care received by the uninsured, and

WHEREAS insured Floridians pay about $2,000 for every hospital stay to cover the cost of the uninsured, and

WHEREAS Florida ranks second with the highest number of uninsured, and

WHEREAS the Legislature further finds that eliminating the expensive cost shift on Florida's families and businesses, producing better health and economic outcomes, and improving access to health care for uninsured Floridians will bend the health care cost curve down in the State of Florida, and

WHEREAS, it is the intent of the Legislature to create the Smarter Healthcare Coverage in Florida Plan to reduce and eliminate the health care cost shift on Florida's families and businesses, and

WHEREAS it is incumbent upon us to require greater personal accountability guidelines that will reduce entitlement spending and increase commitments by all toward better health, and

WHEREAS it is to the benefit of the State of Florida to enable telehealth to serve as an alternative health care delivery system to increase capacity, deliver high quality of care and control costs, and

WHEREAS we should increase the capacity and number of medical professionals by allowing nurse practitioners and

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physician assistants to practice to their fullest potential, and

WHEREAS we need to meet Florida's growing need for physicians by expanding medical residency positions and providing targeted training in key health education programs to ensure an adequate supply of allied health professionals and

WHEREAS we must prevent lawsuit abuse by closing the phantom damages loophole so that personal injury awards are related to the actual costs of treatment, and

WHEREAS we must implement a new phased-in fee schedule for inpatient, outpatient and ambulatory center services in Florida's worker's compensation system; and expand the number of individuals entering the private health insurance market, NOW, THEREFORE,

Section 1. Section 456.4501, Florida Statutes, is created to read:

456.4501 Use of telehealth to provide services.—

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

(a) "Telehealth" means the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to, patient assessment, diagnosis, consultation, treatment, and monitoring; the transfer of medical data; patient and professional health-related education; public health services; and health care administration. The term does not include audio-only transmissions, e-mail messages, facsimile transmissions, or consultations between a telehealth provider in this state and a provider lawfully licensed in another state

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when the provider licensed in this state maintains responsibility for the care of a patient in this state.

(b) "Telehealth provider" means a person who provides health care and related services using telehealth and who is licensed under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part III, part IV, part V, part X, part XIII, or part XIV of chapter 468; chapter 478; chapter 480; parts III and IV of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491, or who is certified under part III of chapter 401.

(2) PRACTICE STANDARDS.—

(a) The standard of care for a telehealth provider providing medical care to a patient is the same as the standard of care generally accepted for a health care professional providing in-person health care services to a patient. If a telehealth provider conducts a patient evaluation sufficient to diagnose and treat the patient, the telehealth provider is not required to research the patient's medical history or conduct a physical examination of the patient before using telehealth to provide services to the patient. A telehealth provider may use telehealth to perform a patient evaluation.

(b) A telehealth provider and a patient may be in separate locations when telehealth is used to provide health care services to the patient.

(c) A nonphysician telehealth provider using telehealth and acting within the relevant scope of practice is not deemed to be

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practicing medicine without a license under any provision of law listed in paragraph (1)(b).

(d) A telehealth provider who is otherwise authorized to prescribe a controlled substance named or described in Schedules I through V of s. 893.03 may use telehealth to prescribe the controlled substance, except that telehealth may not be used to prescribe a controlled substance to treat chronic nonmalignant pain as defined in s. 458.3265. This paragraph does not preclude a physician from using telehealth to order a controlled substance for an inpatient admitted to a facility licensed under chapter 395 or a hospice patient under chapter 400.

(3) RECORDS.—A telehealth provider shall document in the patient's medical record the health care services rendered using telehealth according to the same standard used for in-person health care services pursuant to ss. 395.3025(4) and 456.057.

Section 2. Subsection (7) of section 110.12315, Florida Statutes, is amended to read:

110.12315 Prescription drug program. The state employees' prescription drug program is established. This program shall be administered by the Department of Management Services, according to the terms and conditions of the plan as established by the relevant provisions of the annual General Appropriations Act and implementing legislation, subject to the following conditions:

(7) The department shall establish the reimbursement schedule for prescription pharmaceuticals dispensed under the program. Reimbursement rates for a prescription pharmaceutical

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must be based on the cost of the generic equivalent drug if a generic equivalent exists, unless the physician, advanced registered nurse practitioner, or physician assistant prescribing the pharmaceutical clearly states on the prescription that the brand name drug is medically necessary or that the drug product is included on the formulary of drug products that may not be interchanged as provided in chapter 465, in which case reimbursement must be based on the cost of the brand name drug as specified in the reimbursement schedule adopted by the department.

Section 3. Paragraph (c) of subsection (1) of section 310.071, Florida Statutes, is amended to read:

310.071 Deputy pilot certification.

(1) In addition to meeting other requirements specified in this chapter, each applicant for certification as a deputy pilot must:

(c) Be in good physical and mental health, as evidenced by documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician within the preceding 6 months. The board shall adopt rules to establish requirements for passing the physical examination, which rules shall establish minimum standards for the physical or mental capabilities necessary to carry out the professional duties of a certificated deputy pilot. Such standards shall include zero tolerance for any controlled substance regulated under chapter 893 unless that individual is under the care of a physician, advanced registered nurse practitioner, or physician assistant

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and that controlled substance was prescribed by that physician, advanced registered nurse practitioner, or physician assistant. To maintain eligibility as a certificated deputy pilot, each certificated deputy pilot must annually provide documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician. The physician must know the minimum standards and certify that the certificateholder satisfactorily meets the standards. The standards for certificateholders shall include a drug test.

Section 4. Subsection (3) of section 310.073, Florida Statutes, is amended to read:

310.073 State pilot licensing. In addition to meeting other requirements specified in this chapter, each applicant for license as a state pilot must:

(3) Be in good physical and mental health, as evidenced by documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician within the preceding 6 months. The board shall adopt rules to establish requirements for passing the physical examination, which rules shall establish minimum standards for the physical or mental capabilities necessary to carry out the professional duties of a licensed state pilot. Such standards shall include zero tolerance for any controlled substance regulated under chapter 893 unless that individual is under the care of a physician, advanced registered nurse practitioner, or physician assistant and that controlled substance was prescribed by that physician, advanced registered nurse practitioner, or physician assistant.

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To maintain eligibility as a licensed state pilot, each licensed state pilot must annually provide documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician. The physician must know the minimum standards and certify that the licensee satisfactorily meets the standards. The standards for licensees shall include a drug test.

Section 5. Paragraph (b) of subsection (3) of section 310.081, Florida Statutes, is amended to read:

310.081 Department to examine and license state pilots and certificate deputy pilots; vacancies.

(3) Pilots shall hold their licenses or certificates pursuant to the requirements of this chapter so long as they:

(b) Are in good physical and mental health as evidenced by documentary proof of having satisfactorily passed a physical examination administered by a licensed physician or physician assistant within each calendar year. The board shall adopt rules to establish requirements for passing the physical examination, which rules shall establish minimum standards for the physical or mental capabilities necessary to carry out the professional duties of a licensed state pilot or a certificated deputy pilot. Such standards shall include zero tolerance for any controlled substance regulated under chapter 893 unless that individual is under the care of a physician, advanced registered nurse practitioner, or physician assistant and that controlled substance was prescribed by that physician, advanced registered nurse practitioner, or physician assistant. To maintain

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eligibility as a certificated deputy pilot or licensed state pilot, each certificated deputy pilot or licensed state pilot must annually provide documentary proof of having satisfactorily passed a complete physical examination administered by a licensed physician. The physician must know the minimum standards and certify that the certificateholder or licensee satisfactorily meets the standards. The standards for certificateholders and for licensees shall include a drug test. Upon resignation or in the case of disability permanently affecting a pilot s ability to serve, the state license or certificate issued under this chapter shall be revoked by the department.

Section 6. Subsection (7) of section 456.072, Florida Statutes, is amended to read:

456.072 Grounds for discipline; penalties; enforcement.

(7) Notwithstanding subsection (2), upon a finding that a physician has prescribed or dispensed a controlled substance, or caused a controlled substance to be prescribed or dispensed, in a manner that violates the standard of practice set forth in s. 458.331(1)(q) or (t), s. 459.015(1)(t) or (x), s. 461.013(1)(o) or (s), or s. 466.028(1)(p) or (x), or that an advanced registered nurse practitioner has prescribed or dispensed a controlled substance, or caused a controlled substance to be prescribed or dispensed, in a manner that violates the standard of practice set forth in s. 464.018(1)(n) or (p)6., the physician or advanced registered nurse practitioner shall be suspended for a period of not less than 6 months and pay a fine

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of not less than $10,000 per count. Repeated violations shall result in increased penalties.

Section 7. Subsections (2) and (3) of section 456.44, Florida Statutes, are amended to read:

456.44 Controlled substance prescribing.

(2) REGISTRATION. ~~Effective January 1, 2012~~, A physician licensed under chapter 458, chapter 459, chapter 461, or chapter 466, a physician assistant licensed under chapter 458 or chapter 459, or an advanced registered nurse practitioner certified under part I of chapter 464 who prescribes any controlled substance, listed in Schedule II, Schedule III, or Schedule IV as defined in s. 893.03, for the treatment of chronic nonmalignant pain, must:

(a) Designate himself or herself as a controlled substance prescribing practitioner on his or her ~~the physician s~~ practitioner profile.

(b) Comply with the requirements of this section and applicable board rules.

(3) STANDARDS OF PRACTICE. The standards of practice in this section do not supersede the level of care, skill, and treatment recognized in general law related to health care licensure.

(a) A complete medical history and a physical examination must be conducted before beginning any treatment and must be documented in the medical record. The exact components of the physical examination shall be left to the judgment of the registrant ~~clinician~~ who is expected to perform a physical

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examination proportionate to the diagnosis that justifies a treatment. The medical record must, at a minimum, document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, a review of previous medical records, previous diagnostic studies, and history of alcohol and substance abuse. The medical record shall also document the presence of one or more recognized medical indications for the use of a controlled substance. Each registrant must develop a written plan for assessing each patient s risk of aberrant drug-related behavior, which may include patient drug testing. Registrants must assess each patient s risk for aberrant drug-related behavior and monitor that risk on an ongoing basis in accordance with the plan.

(b) Each registrant must develop a written individualized treatment plan for each patient. The treatment plan shall state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and shall indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the registrant ~~physician~~ shall adjust drug therapy to the individual medical needs of each patient. Other treatment modalities, including a rehabilitation program, shall be considered depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment. The interdisciplinary nature of the treatment plan shall be documented.

(c) The registrant ~~physician~~ shall discuss the risks and

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benefits of the use of controlled substances, including the risks of abuse and addiction, as well as physical dependence and its consequences, with the patient, persons designated by the patient, or the patient s surrogate or guardian if the patient is incompetent. The registrant ~~physician~~ shall use a written controlled substance agreement between the registrant ~~physician~~ and the patient outlining the patient s responsibilities, including, but not limited to:

1. Number and frequency of controlled substance prescriptions and refills.

2. Patient compliance and reasons for which drug therapy may be discontinued, such as a violation of the agreement.

3. An agreement that controlled substances for the treatment of chronic nonmalignant pain shall be prescribed by a single treating registrant ~~physician~~ unless otherwise authorized by the treating registrant ~~physician~~ and documented in the medical record.

(d) The patient shall be seen by the registrant ~~physician~~ at regular intervals, not to exceed 3 months, to assess the efficacy of treatment, ensure that controlled substance therapy remains indicated, evaluate the patient s progress toward treatment objectives, consider adverse drug effects, and review the etiology of the pain. Continuation or modification of therapy shall depend on the registrant's ~~physician s~~ evaluation of the patient s progress. If treatment goals are not being achieved, despite medication adjustments, the registrant ~~physician~~ shall reevaluate the appropriateness of continued treatment. The registrant ~~physician~~ shall monitor patient

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compliance in medication usage, related treatment plans, controlled substance agreements, and indications of substance abuse or diversion at a minimum of 3-month intervals.

(e) The registrant ~~physician~~ shall refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention shall be given to those patients who are at risk for misusing their medications and those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder requires extra care, monitoring, and documentation and requires consultation with or referral to an addiction medicine specialist or psychiatrist.

(f) A registrant ~~physician~~ registered under this section must maintain accurate, current, and complete records that are accessible and readily available for review and comply with the requirements of this section, the applicable practice act, and applicable board rules. The medical records must include, but are not limited to:

1. The complete medical history and a physical examination, including history of drug abuse or dependence.

2. Diagnostic, therapeutic, and laboratory results.

3. Evaluations and consultations.

4. Treatment objectives.

5. Discussion of risks and benefits.

6. Treatments.

7. Medications, including date, type, dosage, and quantity prescribed.

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8. Instructions and agreements.

9. Periodic reviews.

10. Results of any drug testing.

11. A photocopy of the patient s government-issued photo identification.

12. If a written prescription for a controlled substance is given to the patient, a duplicate of the prescription.

13. The registrant's ~~physician's~~ full name presented in a legible manner.

(g) Patients with signs or symptoms of substance abuse shall be immediately referred to a board-certified pain management physician, an addiction medicine specialist, or a mental health addiction facility as it pertains to drug abuse or addiction unless the registrant is a physician who is board certified or board-eligible in pain management. Throughout the period of time before receiving the consultant s report, a prescribing registrant ~~physician~~ shall clearly and completely document medical justification for continued treatment with controlled substances and those steps taken to ensure medically appropriate use of controlled substances by the patient. Upon receipt of the consultant s written report, the prescribing registrant ~~physician~~ shall incorporate the consultants recommendations for continuing, modifying, or discontinuing controlled substance therapy. The resulting changes in treatment shall be specifically documented in the patient's medical record. Evidence or behavioral indications of diversion shall be followed by discontinuation of controlled substance therapy, and the patient shall be discharged, and all results of testing and

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actions taken by the registrant ~~physician~~ shall be documented in the patient s medical record.

This subsection does not apply to a board-eligible or board certified anesthesiologist, physiatrist, rheumatologist, or neurologist, or to a board-certified physician who has surgical privileges at a hospital or ambulatory surgery center and primarily provides surgical services. This subsection does not apply to a board-eligible or board-certified medical specialist who has also completed a fellowship in pain medicine approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, or who is board eligible or board certified in pain medicine by the American Board of Pain Medicine, the American Board of Interventional Pain Physicians, the American Association of Physician Specialists, or a board approved by the American Board of Medical Specialties or the American Osteopathic Association and performs interventional pain procedures of the type routinely billed using surgical codes. This subsection does not apply to a registrant, advanced registered nurse practitioner, or physician assistant who prescribes medically necessary controlled substances for a patient during an inpatient stay in a hospital licensed under chapter 395.

Section 8. Paragraph (f) of subsection (4) of section 458.347, Florida Statutes, is amended to read:

458.347 Physician assistants.

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.

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(f)1. The council shall establish a formulary of medicinal drugs that a fully licensed physician assistant having prescribing authority under this section or s. 459.022 may not prescribe. The formulary must include ~~controlled substances as defined in chapter 893,~~ general anesthetics, and radiographic contrast materials.

2. In establishing the formulary, the council shall consult with a pharmacist licensed under chapter 465, but not licensed under this chapter or chapter 459, who shall be elected by the State Surgeon General.

3. Only the council shall add to, delete from, or modify the formulary. Any person who requests an addition, deletion, or modification of a medicinal drug listed on such formulary has the burden of proof to show cause why such addition, deletion, or modification should be made.

4. The boards shall adopt the formulary required by this paragraph, and each addition, deletion, or modification to the formulary, by rule. Notwithstanding any provision of chapter 120 to the contrary, the formulary rule shall be effective 60 days after the date it is filed with the Secretary of State. Upon adoption of the formulary, the department shall mail a copy of such formulary to each fully licensed physician assistant having prescribing authority under this section or s. 459.022, and to each pharmacy licensed by the state. The boards shall establish, by rule, a fee not to exceed $200 to fund the provisions of this paragraph and paragraph (e).

Section 9. Section 464.012, Florida Statutes, is amended to

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read:

464.012 Certification of advanced registered nurse practitioners; fees; controlled substance prescribing.

(1) Any nurse desiring to be certified as an advanced registered nurse practitioner shall apply to the department and submit proof that he or she holds a current license to practice professional nursing and that he or she meets one or more of the following requirements as determined by the board:

(a) Satisfactory completion of a formal postbasic educational program of at least one academic year, the primary purpose of which is to prepare nurses for advanced or specialized practice.

(b) Certification by an appropriate specialty board. Such certification shall be required for initial state certification and any recertification as a registered nurse anesthetist or nurse midwife. The board may by rule provide for provisional state certification of graduate nurse anesthetists and nurse midwives for a period of time determined to be appropriate for preparing for and passing the national certification examination.

(c) Graduation from a program leading to a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills. For applicants graduating on or after October 1, 1998, graduation from a master s degree program shall be required for initial certification as a nurse practitioner under paragraph (4)(c). For applicants graduating on or after October 1, 2001, graduation from a master s degree program shall be required for initial certification as a

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registered nurse anesthetist under paragraph (4)(a).

(2) The board shall provide by rule the appropriate requirements for advanced registered nurse practitioners in the categories of certified registered nurse anesthetist, certified nurse midwife, and certified nurse practitioner.

(3) An advanced registered nurse practitioner shall perform those functions authorized in this section within the framework of an established protocol that is filed with the board upon biennial license renewal and within 30 days after entering into a supervisory relationship with a physician or changes to the protocol. The board shall review the protocol to ensure compliance with applicable regulatory standards for protocols. The board shall refer to the department licensees submitting protocols that are not compliant with the regulatory standards for protocols. A practitioner currently licensed under chapter 458, chapter 459, or chapter 466 shall maintain supervision for directing the specific course of medical treatment. Within the established framework, an advanced registered nurse practitioner may:

(a) Prescribe, dispense, administer, or order any ~~Monitor and alter~~ drug ~~therapies~~.

(b) Initiate appropriate therapies for certain conditions.

(c) Perform additional functions as may be determined by rule in accordance with s. 464.003(2).

(d) Order diagnostic tests and physical and occupational therapy.

(4) In addition to the general functions specified in subsection (3), an advanced registered nurse practitioner

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may perform the following acts within his or her specialty:

(a) The certified registered nurse anesthetist may, to the extent authorized by established protocol approved by the medical staff of the facility in which the anesthetic service is performed, perform any or all of the following:

1. Determine the health status of the patient as it relates to the risk factors and to the anesthetic management of the patient through the performance of the general functions

2. Based on history, physical assessment, and supplemental laboratory results, determine, with the consent of the responsible physician, the appropriate type of anesthesia within the framework of the protocol.

3. Order under the protocol preanesthetic medication.

4. Perform under the protocol procedures commonly used to render the patient insensible to pain during the performance of surgical, obstetrical, therapeutic, or diagnostic clinical procedures. These procedures include ordering and administering regional, spinal, and general anesthesia; inhalation agents and techniques; intravenous agents and techniques; and techniques of hypnosis.

5. Order or perform monitoring procedures indicated as pertinent to the anesthetic health care management of the patient.

6. Support life functions during anesthesia health care, including induction and intubation procedures, the use of appropriate mechanical supportive devices, and the management of fluid, electrolyte, and blood component balances.

7. Recognize and take appropriate corrective action for

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abnormal patient responses to anesthesia, adjunctive medication, or other forms of therapy.

8. Recognize and treat a cardiac arrhythmia while the patient is under anesthetic care.

9. Participate in management of the patient while in the postanesthesia recovery area, including ordering the administration of fluids and drugs.

10. Place special peripheral and central venous and arterial lines for blood sampling and monitoring as appropriate.

(b) The certified nurse midwife may, to the extent authorized by an established protocol which has been approved by the medical staff of the health care facility in which the midwifery services are performed, or approved by the nurse midwife s physician backup when the delivery is performed in a patient s home, perform any or all of the following:

1. Perform superficial minor surgical procedures.

2. Manage the patient during labor and delivery to include amniotomy, episiotomy, and repair.

3. Order, initiate, and perform appropriate anesthetic procedures.

4. Perform postpartum examination.

5. Order appropriate medications.

6. Provide family-planning services and well-woman care.

7. Manage the medical care of the normal obstetrical patient and the initial care of a newborn patient.

(c) The nurse practitioner may perform any or all of the following acts within the framework of established protocol:

1. Manage selected medical problems.

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2. Order physical and occupational therapy.

3. Initiate, monitor, or alter therapies for certain uncomplicated acute illnesses.

4. Monitor and manage patients with stable chronic diseases.

5. Establish behavioral problems and diagnosis and make treatment recommendations.

(5) The board shall certify, and the department shall issue a certificate to, any nurse meeting the qualifications in this section. The board shall establish an application fee not to exceed $100 and a biennial renewal fee not to exceed $50. The board is authorized to adopt such other rules as are necessary to implement the provisions of this section.

Section 10. Paragraph (p) is added to subsection (1) of section 464.018, Florida Statutes, to read:

464.018 Disciplinary actions.

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(p) For an advanced registered nurse practitioner:

1. Presigning blank prescription forms.

2. Prescribing for office use any medicinal drug appearing on Schedule II in chapter 893.

3. Prescribing, ordering, dispensing, administering, supplying, selling, or giving a drug that is an amphetamine or a sympathomimetic amine drug, or a compound designated pursuant to chapter 893 as a Schedule II controlled substance, to or for any person except for:

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a. The treatment of narcolepsy; hyperkinesis; behavioral syndrome in children characterized by the developmentally inappropriate symptoms of moderate to severe distractibility, short attention span, hyperactivity, emotional lability, and impulsivity; or drug-induced brain dysfunction.

b. The differential diagnostic psychiatric evaluation of depression or the treatment of depression shown to be refractory to other therapeutic modalities.

c. The clinical investigation of the effects of such drugs or compounds when an investigative protocol is submitted to, reviewed by, and approved by the department before such investigation is begun.

4. Prescribing, ordering, dispensing, administering supplying, selling, or giving growth hormones, testosterone or its analogs, human chorionic gonadotropin (HCG), or other hormones for the purpose of muscle building or to enhance athletic performance. As used in this subparagraph, the term muscle building does not include the treatment of injured muscle. A prescription written for the drug products listed in this paragraph may be dispensed by a pharmacist with the presumption that the prescription is for legitimate medical use.

5. Promoting or advertising on any prescription form a community pharmacy unless the form also states: This prescription may be filled at any pharmacy of your choice.

6. Prescribing, dispensing, administering, mixing, or otherwise preparing a legend drug, including a controlled substance, other than in the course of his or her professional practice. For the purposes of this subparagraph, it is legally

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presumed that prescribing, dispensing, administering, mixing, or otherwise preparing legend drugs, including all controlled substances, inappropriately or in excessive or inappropriate quantities is not in the best interest of the patient and is not in the course of the advanced registered nurse practitioner's professional practice, without regard to his or her intent.

7. Prescribing, dispensing, or administering a medicinal drug appearing on any schedule set forth in chapter 893 to himself or herself, except a drug prescribed, dispensed, or administered to the advanced registered nurse practitioner by another practitioner authorized to prescribe, dispense, or administer medicinal drugs.

8. Prescribing, ordering, dispensing, administering, supplying, selling, or giving amygdalin (laetrile) to any person.

9. Dispensing a controlled substance listed on Schedule II or Schedule III in chapter 893 in violation of s. 465.0276.

10. Promoting or advertising through any communication medium the use, sale, or dispensing of a controlled substance appearing on any schedule in chapter 893.

Section 11. Subsection (21) of section 893.02, Florida Statutes, is amended to read:

893.02 Definitions. The following words and phrases as used in this chapter shall have the following meanings, unless the context otherwise requires:

(21) "Practitioner" means a physician licensed under ~~pursuant to~~ chapter 458, a dentist licensed under ~~pursuant to~~

chapter 466, a veterinarian licensed under pursuant to chapter 474, an osteopathic physician licensed under pursuant to chapter 459, an advanced registered nurse practitioner certified under chapter 464, a naturopath licensed under ~~pursuant to~~ chapter 462, a certified optometrist licensed under ~~pursuant to~~ chapter 463, ~~or~~ a podiatric physician licensed under ~~pursuant to~~ chapter 461, or a physician assistant licensed under chapter 458 or chapter 459, provided such practitioner holds a valid federal controlled substance registry number.

Section 12. Paragraph (n) of subsection (1) of section 948.03, Florida Statutes, is amended to read:

948.03 Terms and conditions of probation.

(1) The court shall determine the terms and conditions of probation. Conditions specified in this section do not require oral pronouncement at the time of sentencing and may be considered standard conditions of probation. These conditions may include among them the following, that the probationer or offender in community control shall:

(n) Be prohibited from using intoxicants to excess or possessing any drugs or narcotics unless prescribed by a physician, advanced registered nurse practitioner, or physician assistant. The probationer or community controllee may ~~shall~~ not knowingly visit places where intoxicants, drugs, or other dangerous substances are unlawfully sold, dispensed, or used.

Section 13. Subsection (3) of s. 310.071, Florida Statutes, is reenacted for the purpose of incorporating the amendment made

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by this act to s. 310.071, Florida Statutes, in a reference thereto.

Section 14. Paragraph (mm) of subsection (1) of s. 456.072 and s. 466.02751, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to s.456.44, Florida Statutes, in references thereto.

Section 15. Section 458.303, paragraph (e) of subsection (4) and paragraph (c) of subsection (9) of s. 458.347, paragraph (b) of subsection (7) of s. 458.3475, paragraph (e) of subsection (4) and paragraph (c) of subsection (9) of s.459.022, and paragraph (b) of subsection (7) of s. 459.023, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to s. 458.347, Florida Statutes, in references thereto.

Section 16. Paragraph (a) of subsection (1) of s. 456.041, subsections (1) and (2) of s. 458.348, and subsection (1) of s. 459.025, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to s. 464.012, Florida Statutes, in references thereto.

Section 17. Subsection (11) of s. 320.0848, subsection (2)of s. 464.008, subsection (5) of s. 464.009, subsection (2) of s. 464.018, and paragraph (b) of subsection (1), subsection (3), and paragraph (b) of subsection (4) of s. 464.0205, Florida Statutes, are reenacted for the purpose of incorporating the amendment made by this act to s. 464.018, Florida Statutes, in

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672 references thereto.
673
674 Section 18. Section 775.051, Florida Statutes, is reenacted
675 for the purpose of incorporating the amendment made by this act
676 to s. 893.02, Florida Statutes, in a reference thereto.
677
678 Section 19. Paragraph (a) of subsection (3) of s. 944.17,
679 subsection (8) of s. 948.001, and paragraph (e) of subsection
680 (1) of s. 948.101, Florida Statutes, are reenacted for the
681 purpose of incorporating the amendment made by this act to s.
682 948.03, Florida Statutes, in references thereto.
683
684 Section 20. This act shall take effect July 1, 2015.
685
686 Section 21. Subsection 6 of section 409.909, Florida Statutes,
687 is amended to read:
688 409.909 Statewide Medicaid Residency Program.-
689 (6) For the 2015-2016 fiscal year, an additional sum of
690 $20,000,000 in recurring general revenue is appropriated to the
691 Agency for Health Care Administration to create a graduate
692 medical education bonus pool that will allocate one-time bonus
693 funds in the amount of $100,000 to any hospital that creates a
694 medical residency slot in a medical specialty currently
695 underserved in the state and accredited by the Accreditation
696 Council for Graduate Medical Education or the American
697 Osteopathic Association. All unused bonus funds will be
698 allocated through the existing allocation fraction formula.
699 (7) ~~(6)~~ The agency may adopt rules to administer this

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section

Section 22. Section 408.912, Florida Statutes, is created to read:

408.912 Private health insurance coverage improvement.—Notwithstanding any general or specific laws to the contrary, the Florida Legislature directs the Agency for Health Care Administration to draft and submit a Federal 1115 Demonstration Waiver to the U.S. Department of Health and Human Services by September 15, 2015 seeking authority to secure enhanced Federal matching funds to embrace a private sector solution to increase the number of individuals participating in the health insurance market in a cost-effective manner.

(1) The Agency is authorized to do all that is necessary and appropriate to successfully and promptly negotiate with the federal Department of Health and Human Services and other appropriate federal authorities for the approval of an 1115 waiver consistent with the requirements of this section. The waiver shall extend the option for health care coverage to low-income citizens of Florida and to provide health insurance cost relief to individuals and the business community by reducing the cost shift currently related to uncompensated care beginning in 2016.

(2) Upon approval of the 1115 waiver, the Agency shall promptly establish by rule procedures to implement the provisions of the waiver to enroll eligible low-income citizens of Florida in contracted health plans within 90 days of the waiver approval.

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(3) Upon approval of the 1115 waiver, the Agency shall promptly establish by rule procedures to establish a Health Coverage Trust Fund where all estimated general revenue savings from health care coverage expansion agreed upon by the Social Services Estimating Conference shall be deposited. The Social Services Estimating Conference shall consider but are not limited to estimating savings from the state Medically Needy Program, the state Substance Abuse and Mental Health program, state funding for HIV/AIDS, and state funding for health care in correctional facilities, for deposit in the Health Coverage Trust Fund.

(4) The guiding principles of the waiver are as follows:

(a) Promote personal accountability and responsibility and incentivize appropriate use of the health care system through a demonstration waiver that expands privately administered health insurance coverage for eligible citizens between age 19 and 64, inclusive, with family incomes under 138 percent of the Federal Poverty Level, not currently eligible for Medicaid, in the State of Florida.

(b) Individuals participating in the demonstration waiver must meet one of the following workforce criteria:

1. Be employed more than 30 hours/week; or

2. Be enrolled and fully participating in a Department of Economic Opportunity approved workforce program, or

3. Be a full-time who is enrolled for the number of hours or courses the school considers to be full-time attendance.

(c) All individuals participating in the demonstration waiver must pay a monthly health insurance premium or forfeit their

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health insurance coverage for a period greater than six months. Coverage will be effective on the date of the first premium payment.

(d) Create a program that mandates and rewards healthy behaviors and self-sufficiency of individuals participating in the demonstration waiver.

(e) Create a program that provides access to private health insurance that offers an alternative benefit package not greater than the 10 essential health benefits required by the Affordable Care Act and one that does not offer the traditional mandatory enhanced Medicaid benefits.

(f) Create a program that will be fully funded from funds deposited in the Health Coverage Trust Fund.

(g) Create a program that will not cause the state Medicaid program to exceed 32 percent of the state's budget in a fiscal year.

(h) Create a program that will bend the health care cost curve down and will lower costs for business and individuals participating in the health care marketplace.

(i) Create a program that shall establish performance metrics in quality, cost containment and efficiency, that shall be evaluated annually by an independent consultant.

(j) The program authorized under this subchapter shall terminate within one hundred twenty (120) days after a reduction in any of the following federal medical assistance percentages:

1. One hundred percent (100%) in 2016;

2. Ninety-five percent (95%) in 2017;

3. Ninety-four percent (94%) in 2018;

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4. Ninety-three percent (93%) in 2019;

5. Ninety percent (90%) in 2020 or any year after 2020.

Section 23.

(1) Within 90 days after the effective date of this act, the Office of Insurance Regulation shall enter into a contract with an independent consultant to calculate the health care savings expected for individuals and business as a result of this act. The contract shall require the use of generally accepted actuarial techniques and standards provided in s. 627.0651, Florida Statutes, in determining the expected impact on losses and expenses. Within 12 months after the effective date of the waiver contemplated in this act, the office shall submit to the Governor, the President of Senate, the Speaker of the House of Representatives, and the Florida Chamber of Commerce a report concerning the results of the independent consultant's calculations. The consultant shall make an initial baseline report to the legislature regarding rates for insurers writing individual and group health insurance in this state, individually and overall. Beginning 24 months after the effective date of the waiver contemplated in this act, the office shall annually make a report regarding the evidence of the change in health insurance rates compared to the initial baseline report and factors affecting health insurance rates, including but not limited to expanded health insurance coverage.

(2) Within 90 days after the effective date of this act, the Agency for Health Care Administration shall enter into a contract with and independent consultant to calculate the

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reduction in uncompensated health care and the reduction in provider costs as a result of this act. The contract shall require the use of generally accepted actuarial techniques and standards provided in s. 627.0651, Florida Statutes, in determining the expected impact on losses and expenses. Within 12 months after the effective date of the waiver contemplated in this act, the agency shall submit to the Governor, the President of Senate, the Speaker of the House of Representatives, and the Florida Chamber of Commerce a report concerning the results of the independent consultant's calculations. The consultant shall make an initial baseline report to the legislature regarding costs for health care providers in this state. Beginning 24 months after the effective date of the waiver contemplated in this act, the agency shall annually report health care costs compared to the initial baseline report and factors affecting costs, including but not limited to expanded health insurance coverage.

(3) After the first full year of enrollment in the coverage expansion, in conjunction with the office and the agency, the independent consultant shall examine the financial reports of health insurers and evaluate the initial impact that expanding health care coverage to more Florida citizens has had on the costs of uncompensated health care as it relates to health insurance rates and health insurance rate change filings, as well as its resulting net effect on health care rates overall.

(4) By December 31, 2016, an insurer writing individual and small group health insurance in this state shall make a rate filing with the office. Due to the fact that this legislation

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will reduce uncompensated care delivered by health care providers and reduce the need to shift the costs of that uncompensated health care to privately insured individuals, overall health insurance rates should be lowered. If an insurer requests a rate less than an eight percent (8%) reduction as applied to the current rate in its overall base rate for health insurance, the insurer must include in its rate filling a detailed explanation of the reasons for failure to achieve an eight percent (8%) reduction in health insurance rates.

(5) The office shall consider the evaluations described in this section in the annual review and approval of health insurance rates.

Section 24. Upon this act becoming law, section 768.755, Florida Statutes, is created to read:

768.755 Damages recoverable for cost of medical or health care services; evidence of amount of damages; applicability.—

(1)(a) In any personal injury or wrongful death action to which this part applies, damages for the cost of medical or health care services provided to a claimant may be recovered only for medical or health care services that are determined, by a preponderance of the evidence, to be medically necessary, which may be established, subject to rebuttal by way of expert testimony, as set forth in this paragraph, based on the introduction into evidence of the claimant's medical records. A defendant is not liable for damages arising from or related to the rendering of medical or health care services determined to be medically unnecessary, but is required to establish that a

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medical or health care service is unnecessary through expert witness testimony from a health care provider licensed and practicing in the same specialty as the health care provider who provided the service.

(b) The award of damages shall be calculated as follows:

1. For such medical or health care services provided by a particular health care provider to the claimant that are paid for by the claimant and for which an outstanding balance is not due the provider, the actual amount remitted to the provider is the maximum amount recoverable. Any difference between the amount originally billed by the provider and the actual amount remitted to the provider is not recoverable or admissible into evidence. In an action in which there is more than one health care provider who has provided health care services to the claimant, the evidence admissible under this subsection as to a provider with no outstanding balance due may not be used as evidence regarding the reasonableness of the amounts billed by any of the other health care providers who have an outstanding balance due.

2. For such medical or health care services provided by a particular health care provider to the claimant that are paid for by a governmental or commercial insurance payor and for which an outstanding balance is not due the provider, other than a copay or deductible owed by the claimant, the actual amount remitted to the provider by the governmental or commercial insurance payor and any copay or deductible owed by the claimant is the maximum amount recoverable. Any difference between the amount originally billed by the provider and the actual amount

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remitted to the provider or due from the claimant for a copay or deductible is not recoverable or admissible into evidence. In an action in which there is more than one health care provider who has provided health care services to the claimant, the evidence admissible under this subsection as to a provider with no outstanding balance due may not be used as evidence regarding the reasonableness of the amounts billed by any of the other health care providers who have an outstanding balance due.

3. For such medical or health care services provided to the claimant for which an outstanding balance is claimed to be due the provider, the parties may introduce into evidence:

a. Amounts the provider routinely accepts as payment from governmental or commercial insurance payors for identical or substantially similar medical or health care services.

b. Amounts billed by the provider for the services provided to the claimant, including those amounts billed under an agreement between the provider and the claimant or the claimant's representative.

c. Amounts the provider received in compensation, if any, for the sale of the agreement between the provider and the claimant or the claimant's representative under which the medical or health care services were provided to the claimant.

4. Notwithstanding any provision of this section, if the claimant has commercial health insurance, the maximum amounts recoverable and admissible into evidence are those amounts the claimant's commercial health insurance paid or would have paid for medical or health care services provided pursuant to an agreement with the claimant's commercial health insurer. This

limitation also applies to any lien or claim of subrogation asserted for medical or health care services in the action, except for a lien or claim of subrogation described in subsection (3).

(2) Individual contracts between providers and licensed commercial insurers or licensed health maintenance organizations are not subject to discovery or disclosure in an action arising from medical negligence, and such information is not admissible into evidence in an action to which this section applies.

(3) Notwithstanding any provision of this section, if Medicaid, Medicare, or a payor regulated under the Florida Insurance Code has covered or is covering the cost of a claimant's medical or health care services and has given notice of assertion of a lien or subrogation claim for past medical expenses in the action, the amount of the lien or subrogation claim, in addition to the amount of any copayments or deductibles paid or payable by the claimant, is the maximum amount recoverable and admissible into evidence with respect to the covered services.

(4)(a) This section applies only to those actions for personal injury or wrongful death to which this part applies arising on or after the effective date of this act. This section has no other application or effect regarding compensation paid to providers of medical or health care services. A determination as to medical necessity under this section may not be used by any person in an effort or action to recoup or recover payment made by a payor to a provider for medical or health care

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services or in any malpractice, disciplinary, or regulatory action or other proceeding against the provider.

(b) The provisions of this section relating to a determination of medical necessity do not apply to:

1. "Emergency care and services" provided to relieve an "emergency medical condition" as defined in s. 395.002, including emergency services and care rendered by a first responder as defined in s. 112.1815(1).

2. Medical or health care services rendered as a result of the commission of a crime as defined in s. 775.08, or intentional misconduct as defined in s. 768.72, by the defendant.

Section 25. Section 766.118, Florida Statutes, is amended to read:

766.118 Determination of noneconomic damages.-

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

(a) "Catastrophic injury" means a permanent impairment constituted by:

1. Spinal cord injury involving severe paralysis of an arm, a leg, or the trunk;

2. Amputation of an arm, a hand, a foot, or a leg involving the effective loss of use of that appendage;

3. Severe brain or closed-head injury as evidenced by:

a. Severe sensory or motor disturbances;

b. Severe communication disturbances;

c. Severe complex integrated disturbances of cerebral function;

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d. Severe episodic neurological disorders; or

e. Other severe brain and closed-head injury conditions at least as severe in nature as any condition provided in sub-subparagraphs a.-d.;

4. Second-degree or third-degree burns of 25 percent or more of the total body surface or third-degree burns of 5 percent or more to the face and hands;

5. Blindness, defined as a complete and total loss of vision; or

6. Loss of reproductive organs which results in an inability to procreate.

(b) "Noneconomic damages" means noneconomic damages as defined in s. 766.202(8).

(c) "Practitioner" means any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 466, chapter 467, or chapter 486 or certified under s. 464.012. "Practitioner" also means any association, corporation, firm, partnership, or other business entity under which such practitioner practices or any employee of such practitioner or entity acting in the scope of his or her employment. For the purpose of determining the limitations on noneconomic damages set forth in this section, the term "practitioner" includes any person or entity for whom a practitioner is vicariously liable and any person or entity whose liability is based solely on such person or entity being vicariously liable for the actions of a practitioner.

(2) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF PRACTITIONERS.—

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(a) With respect to a cause of action for personal injury or wrongful death arising from medical negligence of practitioners, regardless of the number of such practitioner defendants, noneconomic damages shall not exceed $250,000 ~~$500,000~~ per claimant. ~~No practitioner shall be liable for more than $500,000 in noneconomic damages, regardless of the number of claimants.~~

(b) Notwithstanding paragraph (a), if the negligence resulted in a permanent vegetative state or death, the total noneconomic damages recoverable from a single ~~all~~ practitioners, ~~regardless of the number of claimants,~~ under this paragraph shall not exceed $500,000 ~~1 million~~. In cases that do not involve death or permanent vegetative state, the patient injured by medical negligence may recover noneconomic damages not to exceed $500,000 ~~1 million~~ if:

1. The trial court determines that a manifest injustice would occur unless increased noneconomic damages are awarded, based on a finding that because of the special circumstances of the case, the noneconomic harm sustained by the injured patient was particularly severe; and

2. The trier of fact determines that the defendant's negligence caused a catastrophic injury to the patient.

~~(c) The total noneconomic damages recoverable by all claimants from all practitioner defendants under this subsection shall not exceed $1 million in the aggregate.~~

(3) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF NONPRACTITIONER DEFENDANTS.—

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(a) With respect to a cause of action for personal injury or wrongful death arising from medical negligence of nonpractitioners, regardless of the number of such nonpractitioner defendants, noneconomic damages shall not exceed $500,000 ~~750,000~~ per claimant.

(b) Notwithstanding paragraph (a), if the negligence resulted in a permanent vegetative state or death, the total noneconomic damages recoverable by such claimant ~~from all nonpractitioner defendants~~ under this paragraph shall not exceed $1.0 ~~1.5~~ million. The patient injured by medical negligence of a nonpractitioner defendant may recover noneconomic damages not to exceed $1.0 ~~1.5~~ million if:

1. The trial court determines that a manifest injustice would occur unless increased noneconomic damages are awarded, based on a finding that because of the special circumstances of the case, the noneconomic harm sustained by the injured patient was particularly severe; and

2. The trier of fact determines that the defendant's negligence caused a catastrophic injury to the patient.

(c) Nonpractitioner defendants are subject to the cap on noneconomic damages provided in this subsection regardless of the theory of liability, including vicarious liability.

~~(d) The total noneconomic damages recoverable by all claimants from all nonpractitioner defendants under this subsection shall not exceed $1.5 million in the aggregate.~~

(4) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF PRACTITIONERS PROVIDING EMERGENCY SERVICES AND CARE.—Notwithstanding subsections (2) and (3), with respect to a cause

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of action for personal injury or wrongful death arising from medical negligence of practitioners providing emergency services and care, as defined in s. 395.002(9), or providing services as provided in s. 401.265, or providing services pursuant to obligations imposed by 42 U.S.C. s. 1395dd to persons with whom the practitioner does not have a then-existing health care patient-practitioner relationship for that medical condition:

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

~~(b) Notwithstanding paragraph (a), the total noneconomic damages recoverable by all claimants from all such practitioners shall not exceed $300,000.~~ The limitation provided by this subsection applies only to noneconomic damages awarded as a result of any act or omission of providing medical care or treatment, including diagnosis that occurs prior to the time the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the limitation provided by this subsection applies to any act or omission of providing medical care or treatment which occurs prior to the stabilization of the patient following the surgery.

(5) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF NONPRACTITIONER DEFENDANTS PROVIDING EMERGENCY SERVICES AND CARE.—Notwithstanding subsections (2) and (3), with respect to a cause of action for personal injury or wrongful death arising from medical negligence of defendants other than practitioners

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providing emergency services and care pursuant to obligations imposed by s. 395.1041 or s. 401.45, or obligations imposed by 42 U.S.C. s. 1395dd to persons with whom the practitioner does not have a then-existing health care patient-practitioner relationship for that medical condition:

(a) ~~Regardless of the number of such nonpractitioner defendants, noneconomic~~ Noneconomic damages shall not exceed $750,000 per claimant.

(b) ~~Notwithstanding paragraph (a), the total noneconomic damages recoverable by all claimants from all such nonpractitioner defendants shall not exceed $1.5 million.~~

~~(c)~~ Nonpractitioner defendants may receive a full setoff for payments made by practitioner defendants.

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

(6) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF A PRACTITIONER PROVIDING SERVICES AND CARE TO A MEDICAID RECIPIENT.—Notwithstanding subsections (2), (3), and (5), with respect to a cause of action for personal injury or wrongful

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death arising from medical negligence of a practitioner committed in the course of providing medical services and medical care to a Medicaid recipient, ~~regardless of the number of such practitioner defendants providing the services and care~~, noneconomic damages may not exceed $200,000 ~~300,000~~ per claimant, unless the claimant pleads and proves, by clear and convincing evidence, that the practitioner acted in a wrongful manner. ~~A practitioner providing medical services and medical care to a Medicaid recipient is not liable for more than $200,000 in noneconomic damages, regardless of the number of claimants, unless the claimant pleads and proves, by clear and convincing evidence, that the practitioner acted in a wrongful manner.~~ The fact that a claimant proves that a practitioner acted in a wrongful manner does not preclude the application of the limitation on noneconomic damages prescribed elsewhere in this section. For purposes of this subsection:

(a) The terms "medical services," "medical care," and "Medicaid recipient" have the same meaning as provided in s. 409.901.

(b) The term "practitioner," in addition to the meaning prescribed in subsection (1), includes any hospital, ambulatory surgical center, or mobile surgical facility as defined and licensed under chapter 395.

(c) The term "wrongful manner" means in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property, and shall be construed in conformity with the standard set forth in s. 768.28(9)(a).

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(7) SETOFF.—In any case in which the jury verdict for noneconomic damages exceeds the limits established by this section, the trial court shall reduce the award for noneconomic damages within the same category of defendants in accordance with this section after making any reduction for comparative fault as required by s. 768.81 but before application of a setoff in accordance with ss. 46.015 and 768.041. In the event of a prior settlement or settlements involving one or more defendants subject to the limitations of the same subsection applicable to a defendant remaining at trial, the court shall make such reductions within the same category of defendants as are necessary to ensure that the total amount of noneconomic damages recovered by the claimant does not exceed the aggregate limit established by the applicable subsection. This subsection is not intended to change current law relating to the setoff of economic damages.

(8) ACTIONS GOVERNED BY SOVEREIGN IMMUNITY LAW.—This section shall not apply to actions governed by s. 768.28.

Section 26. Paragraphs (a) and (b) of subsection (12) of section 440.13 Florida Statutes, are amended to read:

440.13 Medical services and supplies; penalty for violations; limitations.-

(12) CREATION OF THREE-MEMBER PANEL; GUIDES OF MAXIMUM REIMBURSEMENT ALLOWANCES.—

(a) A three-member panel is created, consisting of the Chief Financial Officer, or the Chief Financial Officer's designee, and two members to be appointed by the Governor,

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subject to confirmation by the Senate, one member who, on account of present or previous vocation, employment, or affiliation, shall be classified as a representative of employers, the other member who, on account of previous vocation, employment, or affiliation, shall be classified as a representative of employees. The panel shall determine statewide schedules of maximum reimbursement allowances for medically necessary treatment, care, and attendance provided by physicians, hospitals, ambulatory surgical centers, work hardening programs, pain programs, and durable medical equipment. The maximum reimbursement allowances for inpatient hospital care shall be based on a rate of up to 140 percent of the Medicare inpatient prospective payment system rates ~~a schedule of per diem rates~~, to be approved by the three-member panel no later than October 1st of each year for the following calendar year ~~March 1, 1994~~, to be used in conjunction with a precertification manual as determined by the department, including maximum hours in which an outpatient may remain in observation status, which shall not exceed 23 hours. No later than October 1st of each year for the following calendar year, the three-member panel must approve all compensable charges for hospital outpatient care, which shall be reimbursed at up to 140 percent of the Medicare outpatient prospective payment system rates ~~75 percent of usual and customary charges,~~ except as otherwise provided by this subsection. Annually, the three-member panel shall adopt schedules of maximum reimbursement allowances for physicians, hospital inpatient care, hospital outpatient care, ambulatory surgical centers, work-hardening

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programs, and pain programs. An individual physician, hospital, ambulatory surgical center, pain program, or work-hardening program shall be reimbursed either the agreed-upon contract price or the maximum reimbursement allowance in the appropriate schedule.

(b) It is the intent of the Legislature to increase the schedule of maximum reimbursement allowances for selected physicians effective January 1, 2004, and to pay for the increases through reductions in payments to hospitals. Revisions developed pursuant to this subsection are limited to the following:

1. Payments for outpatient physical, occupational, and speech therapy provided by hospitals shall be reduced to the schedule of maximum reimbursement allowances for these services which applies to nonhospital providers.

2. Payments for scheduled outpatient nonemergency radiological and clinical laboratory services that are not provided in conjunction with a surgical procedure shall be reduced to the schedule of maximum reimbursement allowances for these services which applies to nonhospital providers.

3. ~~Outpatient reimbursement for scheduled surgeries shall be reduced from 75 percent of charges to 60 percent of charges.~~

~~4.~~ Maximum reimbursement for a physician licensed under chapter 458 or chapter 459 shall be increased to 110 percent of the reimbursement allowed by Medicare, using appropriate codes and modifiers or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater.

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4.~~5~~. Maximum reimbursement for surgical procedures shall be increased to 140 percent of the reimbursement allowed by Medicare or the medical reimbursement level adopted by the three-member panel as of January 1, 2003, whichever is greater.

Section 27. Paragraph (a) of subsection (2) of section 440.15, Florida Statutes, is amended to read:

440.15 Compensation for disability.- Compensation for disability shall be paid to the employee, subject to the limits provided in s. 440.12(2), as follows:

(2) TEMPORARY TOTAL DISABILITY.—

(a) Subject to subsection (7), in case of disability total in character but temporary in quality, 66 2/3 or 66.67 percent of the average weekly wages shall be paid to the employee during the continuance thereof, not to exceed 104 weeks except as provided in this subsection, s. 440.12(1), and s. 440.14(3). Once the employee reaches the maximum number of weeks allowed, or the employee reaches the date of maximum medical improvement, whichever occurs earlier, temporary disability benefits shall cease and the injured worker's permanent impairment shall be determined. If an employee reaches the maximum number of weeks allowed for temporary disability benefits, but has not reached maximum medical improvement, then the temporary disability benefits shall continue until the employee reaches maximum medical improvement, whereupon a permanent impairment rating shall be assigned immediately.

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Section 28. Section 440.34, Florida Statutes, is amended to read:

440.34 Attorney's fees; costs.-

(1) A fee, gratuity, or other consideration may not be paid for a claimant in connection with any proceedings arising under this chapter, unless approved by the judge of compensation claims or court having jurisdiction over such proceedings. Any attorney's fee approved by a judge of compensation claims for benefits secured on behalf of a claimant shall be limited to ~~must equal to~~ 20 percent of the first $5,000 of the amount of the benefits secured, 15 percent of the next $5,000 of the amount of the benefits secured, 10 percent of the remaining amount of the benefits secured to be provided during the first 10 years after the date the claim is filed, and 5 percent of the benefits secured after 10 years; however, if the total amount of the benefits secured is less than $10,000, then a judge of compensation claims may award an amount up to, but not to exceed, $2,500 as an attorney's fee. The judge of compensation claims shall not approve a compensation order, a joint stipulation for lump-sum settlement, a stipulation or agreement between a claimant and his or her attorney, or any other agreement related to benefits under this chapter which provides for an attorney's fee in excess of the amount permitted by this section. The judge of compensation claims is not required to approve any retainer agreement between the claimant and his or her attorney. The retainer agreement as to fees and costs may not be for compensation in excess of the amount allowed under this subsection or subsection (7).

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(2) In awarding a claimant's attorney's fee, the judge of compensation claims shall consider only those benefits secured by the attorney. An attorney is not entitled to attorney's fees for representation in any issue that was ripe, due, and owing and that reasonably could have been addressed, but was not addressed, during the pendency of other issues for the same injury. The amount, statutory basis, and type of benefits obtained through legal representation shall be listed on all attorney's fees awarded by the judge of compensation claims. For purposes of this section, the term "benefits secured" does not include future medical benefits to be provided on any date more than 5 years after the date the claim is filed. In the event an offer to settle an issue pending before a judge of compensation claims, including attorney's fees as provided for in this section, is communicated in writing to the claimant or the claimant's attorney at least 30 days prior to the trial date on such issue, for purposes of calculating the amount of attorney's fees to be taxed against the employer or carrier, the term "benefits secured" shall be deemed to include only that amount awarded to the claimant above the amount specified in the offer to settle. If multiple issues are pending before the judge of compensation claims, said offer of settlement shall address each issue pending and shall state explicitly whether or not the offer on each issue is severable. The written offer shall also unequivocally state whether or not it includes medical witness fees and expenses and all other costs associated with the claim.

(3) If any party should prevail in any proceedings before a judge of compensation claims or court, there shall be taxed

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against the nonprevailing party the reasonable costs of such proceedings, not to include attorney's fees. A claimant is responsible for the payment of her or his own attorney's fees, except that a claimant is entitled to recover an attorney's fee in an amount equal to the amount provided for in subsection (1) or subsection (7) from a carrier or employer:

(a) Against whom she or he successfully asserts a petition for medical benefits only, if the claimant has not filed or is not entitled to file at such time a claim for disability, permanent impairment, wage-loss, or death benefits, arising out of the same accident;

(b) In any case in which the employer or carrier files a response to petition denying benefits with the Office of the Judges of Compensation Claims and the injured person has employed an attorney in the successful prosecution of the petition;

(c) In a proceeding in which a carrier or employer denies that an accident occurred for which compensation benefits are payable, and the claimant prevails on the issue of compensability; or

(d) In cases where the claimant successfully prevails in proceedings filed under s. 440.24 or s. 440.28. Regardless of the date benefits were initially requested, attorney's fees shall not attach under this subsection until 30 days after the date the carrier or employer, if self-insured, receives the petition.

(4) In such cases in which the claimant is responsible for the payment of her or his own attorney's fees, such fees are a

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lien upon compensation payable to the claimant, notwithstanding s. 440.22.

(5) If any proceedings are had for review of any claim, award, or compensation order before any court, the court may award the injured employee or dependent an attorney's fee to be paid by the employer or carrier, in its discretion, which shall be paid as the court may direct.

(6) A judge of compensation claims may not enter an order approving the contents of a retainer agreement that permits placing any portion of the employee's compensation into an escrow account until benefits have been secured.

(7) If an attorney's fee is owed under paragraph (3)(a), the judge of compensation claims may approve an alternative attorney's fee not to exceed $3,500 ~~$1,500~~ only once per accident, based on a maximum hourly rate of $150 per hour, if the judge of compensation claims expressly finds that the attorney's fee amount provided for in subsection (1), based on benefits secured, fails to fairly compensate the attorney for disputed medical-only claims as provided in paragraph (3)(a) and the circumstances of the particular case warrant such action.

Section 29. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2015.

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

Smarter Healthcare Coverage for Florida

Section 1 Telehealth

This language is identical to SB 478 filed by Senator Bean and defines telehealth services and telehealth provider and establishes that the standard of care for a telehealth service is the same as the standard of care for a health professional providing in-person services. The bill specifies that a non-physician telehealth provider who is using telehealth and acting within the relevant scope of practice is not practicing medicine without a license.

Section 2-20 Advanced Registered Nurse Practitioner and Physician Assistants

This language is identical to SB 614 filed by Senator Grimsley and allows for drug prescription by Advanced Registered Nurse Practitioners and Physician Assistants while requiring advanced registered nurse practitioners and physician assistants who prescribe controlled substances for certain pain to comply with registration requirements and follow specified standards of practice.

Section 21 Statewide Medicaid Residency Program

An additional sum of $20,000,000 in recurring general revenue is appropriated to the Agency for Health Care Administration to create a graduate medical education bonus pool that will allocate one-time bonus funds in the amount of $100,000 to any hospital that creates a medical residency slot in a medical specialty currently underserved in the state and accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association. All unused bonus funds will be allocated through the existing allocation fraction formula.

Section 22 Health Care Coverage Improvement

Directs the Agency for Health Care Administration to draft and submit a Federal 1115 Demonstration Waiver to the U.S. Department of Health and Human Services seeking authority to secure enhanced federal matching funds to embrace a private sector solution to increase the number of individuals participating in the health insurance market. The waiver shall extend the option for health care coverage to low-income citizens of Florida and to provide health insurance cost relief to individuals and the business community by reducing the cost shift currently related to uncompensated care.

The guiding principles of the waiver are as follows:

- All individuals must be employed, enrolled and fully participating in a Department of Economic Opportunity approved workforce program, or be a full-time student.

- All individuals must pay a monthly health insurance premium or forfeit their health insurance coverage for a period greater than six months.

- Rewards healthy behaviors and self-sufficiency of individuals participating in the demonstration waiver.

- Offers an alternative benefit package not greater than the 10 essential health benefits required by the Affordable Care Act.

- Will not cause the state Medicaid program to exceed 32 percent of the state's budget in a fiscal year.

- Will bend the health care cost curve down and will lower costs for business and individuals participating in the health care marketplace.

- Will establish performance metrics in quality, cost containment and efficiency, that shall be evaluated annually by an independent consultant.

- The program will be funded by state savings from the Medically Needy Program, Substance Abuse Mental Health program, and health care costs in correctional facilities.

- The program authorized under this subchapter shall terminate within one hundred twenty (120) days after a reduction in any of the following federal medical assistance percentages:

    1. One hundred percent (100%) in 2016;

    2. Ninety-five percent (95%) in 2017;

    3. Ninety-four percent (94%) in 2018;

    4. Ninety-three percent (93%) in 2019;

    5. Ninety percent (90%) in 2020 or any year after 2020.

Section 23 AHCA and OIR Savings Analysis

This section requires OIR to retain an independent consultant to calculate the savings to health insurance premiums resulting from expanded coverage. The report is due 12 months from the act's effective date. The office is required to report any changes to health insurance rates every year beginning 24 months after the act's passage. The section requires AHCA to retain an independent consultant to calculate expected reduction in provider costs resulting from expanded coverage. The report is due 12 months from the act's effective date. Beginning 24 months after the act's effective date and each year thereafter, AHCA is required to report costs comparison between the baseline prior to expanded coverage to current provider costs. The consultant shall also review the financial reports of health insurers to evaluate the impact of expanded coverage on costs. By December 31, 2016, all health insurers shall make a rate filing, with the expectation

that rates will be reduced by 8%. Absent such reduction, the insurer shall include an explanation in the rate filing of why the rates were not reduced by the targeted amount.

Section 24 Accuracy in Damages

This section attempts to ensure that a person injured as a result of wrong doing is compensated for medically necessary services at amounts actually needed to deliver the care. First, under the section, the defendant is able to challenge the medical necessity of non-emergency care delivered to the claimant. Second, for medical care already delivered to the claimant and for which a balance is not due to a provider, the jury would only be presented information about the actual amount paid and accepted by the provider as payment in full. As to amounts due for medical care delivered, but for which a balance is due, the jury would be able to consider the following information when determining the amount due from the defendant: (a) amounts routinely accepted by the provider for similar services; (b) amounts billed by the provider for the services at issue; and (c) amount the account receivable was sold for, if it was in fact sold. Also, if the claimant has health insurance available to pay for the medical care, the claimant's recovery from the defendant would be capped at the amount of the insurance.

Section 25 Non-Economic Caps on Damages

In an effort to address the recent Florida Supreme Court case on caps on noneconomic damages in medical malpractice cases resulting in wrongful death, the section proposes a series of changes to strengthen the constitutionality of the caps. First, the caps are applied per claimant, with no aggregate cap per claimant or per defendant. Second, the cap for practitioners is changed from $500,000 to $250,000, but applies per claimant and per defendant. In the event of a death or "permanent vegetative state," the cap is $500,000 per claimant, per practitioner defendant. As to non-practitioners (think hospitals), the cap is moved from $750,000 to $500,000, but applies per claimant per institutional provider. In the case of death or permanent vegetative state, the cap for facilities was moved from $1.5 million to $1 million, but applies per claimant per institutional defendant. In the case of emergency services from provided by practitioners, the cap is moved from an aggregate of $300,000 to a per claimant per defendant cap of $150,000. For facilities providing emergency services, the aggregate cap was removed and the cap remains at $750,000 per claimant per defendant for all injuries occurring in the emergency services arena. Finally, in the context of Medicaid services, the noneconomic damage cap was moved from $300,000 per claimant with an aggregate cap of $200,000 on each practitioner to a system where there is a per claimant per defendant practitioner cap of $200,000, unless the claimant proves by clear and convincing evidence that the standard of care was violated. In such is proved, the general caps (non Medicaid services) would apply.

Section 26 Compensable Charges

Provides that all compensable charges for hospital outpatient care be reimbursed at up to 140 percent of the Medicare outpatient prospective payment system, except as otherwise provided. For inpatient hospital care, the maximum reimbursement allowances are to be based on up to 140

percent of the Medicare inpatient prospective payment system. Both inpatient and outpatient reimbursement rates must be approved by the Three-Member panel no later than October 1st of each year for the following calendar year

Section 27 Temporary Total Disability

This section increases the amount of time an employee may remain on temporary total disability beyond the current limit of 104 weeks in those instances when a physician has made a determination that care is medically necessary in order for the employee to reach maximum medical improvement.

Section 28 Workers' Compensation

Provides for an increase in the statutory amount of attorney's fees that can be awarded up to $2,500 in workers' compensation claims if the amount of the benefits is secured is less than $10,000. This section also increases the amount of attorney's fees that can be awarded by a judge of compensation claims from $1,500 to $3,500, once per accident, in those instances where the judge expressly finds that the attorney's fee amount awarded based on the benefits secured fails to fairly compensate the attorney for disputed medical-only claims and the circumstances of the particular case warrant such action.

Section 29

Provides for an effective date of July 1, 2015, unless otherwise provided for in the bill.

Did you know? Floridians pay a "hidden tax" of $1.4 billion due to uncompensated care. When this cost trickles down from hospitals and insurance companies to insured Floridians, it equates to between $1,700 to $2,200 for every insured admission.

As Florida's business community is well aware, healthcare costs continue to have a significant impact on the bottom line. As costs continue to increase, Florida businesses struggle to prosper and the overall competitiveness of the business community diminishes. This week's Scorecard Did You Know highlights the real cost of rising healthcare expenses to Florida businesses, more commonly known as the healthcare cost shift.

"Hospitals need to manage care delivery differently, moving toward focusing more exclusively on outcomes and efficiency of treatment," said Rich Morrison with Florida Hospital. "This is an issue and challenge for those of us in the care industry as well as the business community as a whole. Taking into account uncompensated care to the uninsured, unpaid deductibles and copayments, and unreimbursed costs from Medicare/Medicaid, Florida Hospital alone spent more than $400 million last year on treatment and care that was never paid for. When this number is added up across the industry, the results are a massive cost shift and represent a hidden tax that ends up being paid for by consumers, the insured, and the businesses that pay the majority of insurance coverage. In a state with such a sizable number of retirees, this is a pressing challenge for Florida over the next 20-plus years."

Florida's demand for healthcare services is typically much higher than other states due to a significantly higher population of retirees. Between now and 2030, the Florida Chamber Foundation estimates Florida's population is expected to increase by six million residents. Of these, the Florida Office of Economic and Demographic Research estimates as many as 55.4 percent will be aged 60 and older.

Calculating this cost shift is complex, but a range can be estimated. The first step is comparing total costs of service to the total charges, which then is allocated among the 2.4 million yearly hospital admissions in the state. The analysis leads to a range of cost-shift of about $2,000 for each uninsured to insured admission and this estimate does not include the additional cost shifts present in the Medicare and Medicaid programs.

The cost shift occurs when the costs for medical care for the uninsured are "passed" onto insured patients. When a doctor or hospital provides care to an uninsured party, the costs of those services have to come from somewhere. Insurance companies are ultimately forced to incorporate them into higher premiums, which are paid (the majority of the time) by companies providing benefits for their employees. To make Florida more attractive for business startups and relocations, healthcare costs must be slowed and show real decline, especially with respect to the cost shift.

Learn More
Read the Florida Chamber's *Smarter Healthcare Coverage in Florida* plan here.

Statewide Medicaid Managed Care

Justin M. Senior
Deputy Secretary for Medicaid
Agency for Health Care Administration

Senate Health Policy Committee
March 4, 2015

- As requested by the Committee, this presentation will address:
  1. Update on the Statewide Medicaid Managed Care (SMMC) Program
  2. Medicaid Expansion utilizing SMMC Managed Medical Assistance Plans
  3. Medicaid Expansion Utilizing phased transition, Phase One, initially enroll new adult group in MMA plans then move them in Phase Two to a new delivery mechanism, including Florida Healthy Kids and Florida Health Choices

Statewide Medicaid Managed Care Program

The Statewide Medicaid Managed Care Program

- In 2011, the Florida Legislature required the Agency to expand managed care statewide for most Medicaid recipients.
- The Agency successfully implemented the Statewide Medicaid Managed Care (SMMC) program August 1, 2013, through August 1, 2014.
- The program has two components: the Long-Term Care (LTC) program and the Managed Medical Assistance (MMA) program.
  - MMA covers most recipients of any age who are eligible to receive full Medicaid benefits.
  - LTC covers most recipients 18 years of age or older who need nursing facility level of care.

SMMC Program Goals

The goals of the Statewide Medicaid Managed Care Program are:

- To improve coordination of care
- Improve the health of recipients, not just paying claims when people are sick
- Enhance accountability
- Allow recipients a choice of plans and benefit packages
- Allow plans the flexibility to offer services not otherwise covered
- Enhance prevention of fraud and abuse through contract requirements.

MMA Program Elements

- Plan Choice
- HMOs and PSNs (provider service networks)
- Specialty Plans in MMA
- Choice of Benefit Package
- Choice Counseling
- Risk Adjusted Rates
- Low Income Pool

MMA Program Enhancements: Expanded Benefits

- The Agency negotiated with health plans to provide extra benefits at no cost to the state. These benefits include expanded:
  - Adult dental
  - Adult hearing and vision coverage
  - Outpatient hospital coverage
  - Physician coverage, among many others.

MMA Program Enhancements: Plan Accreditation

- Each managed care plan must be accredited by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body, or have initiated the accreditation process, within 1 year after the contract is executed.
- For any plan not accredited within 18 months after executing the contract, the agency shall suspend automatic assignment.

MMA Program Enhancements: Network Adequacy Standards

- Time and distance standards
- Ratios of patients to providers
- Increasing the number of primary care and specialist providers accepting new Medicaid enrollees
- Increasing the number of primary care providers that offer appointments after normal business hours
- Extremely low level of complaints/issues.

MMA Program Enhancements: Competitive Rates

- Competitive procurement required .
- "Best value" to the state included negotiated capitation rates for the period of May 1, 2014 – Aug 31, 2015 for MMA.
- Rate-related negotiation goals:
  - Actuarially sound.
  - Take advantage of competitive process; listen to industry.
  - Achieve savings target established in statute.
  - Establish common base rates for all selected standard plans in each region.

MMA Program Enhancements: Risk Adjusted Rates

- Under the MMA program rate cells are developed for various eligibility groups.
- For TANF and SSI groups, rates are risk adjusted based on historical claims/ encounter data.
- Separate rates developed for special populations:
  - HIV/AIDS
  - Child Welfare
  - MMA enrollees also enrolled in the LTC program

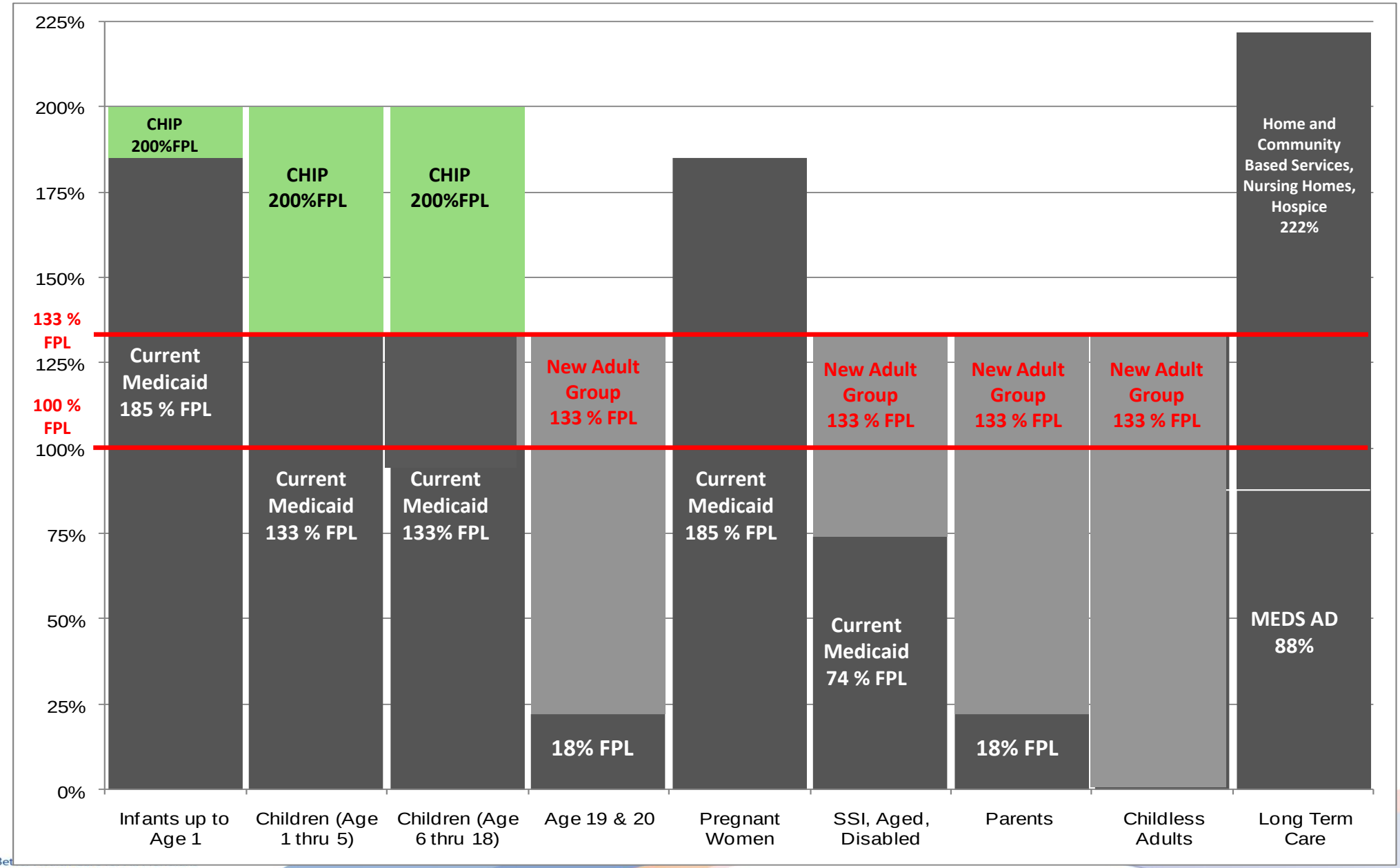
MMA Program Enhancements: Enhanced Accountability

- Centralized Complaint/Issues Hub
  - Monitor all complaints/issues from recipients, providers, and other stakeholders.
  - Identify trends and provides additional tool to take action to correct those issues.
- Performance Measures
  - Plans are required to report annually on 37 performance measures
- Report Cards
  - Publishing consumer-focused Medicaid health plan report card based on performance measures
  - Current information is for Reform and non-Reform plans, however, SMMC plans will be added once enough time has lapsed to collect this data.

Coverage of New Adult Group:

- Who would be covered:
  - Non-pregnant individuals age 19 through 64, not otherwise eligible for Medicaid, with income at or below 133% Federal Poverty level.
  - No resource (asset) test.
- Federal Authority Needed:
  - State plan amendment to add new group
  - 1115 Waiver amendment to enroll in SMMC plans
  - Need additional federal if we want to use an alternative benefit package.

Current Eligibility and New Adult Group



Utilizing MMA Plans

- MMA Plans have the infrastructure in place to provide comprehensive services to both adults and children
- Network standards based on Medicare ratios
  - Required to maintain networks for higher enrollment level than they will have
- Additional rate cells can be added to payment methodology for new adult group
- Choice Counseling and enrollment mechanisms already in place

Utilizing MMA Plans

- In order to add the new adult group under the MMA program:
- State Required Activities:
  - Amend federal authorities
  - Amend MMA Contracts to include new population
  - Develop transition plan
  - System changes to include new eligibility group
  - Choice Counseling ramp up
  - Build new capitation rates for the new eligibility group
  - Update provider network requirements for adults
  - Determine benefit package for new eligibility group

Utilizing MMA Plans

- In order to add the new adult group under the MMA program:
- MMA Plan Required Activities:
  - Expand provider networks if needed
  - Develop new member materials
  - Update systems

Utilizing MMA Plans

- No additional funding needed for state activities
  - Developing federal authority
  - Updating contracts and provider network requirements
  - Systems changes
- Minimize costs for state activities due to economies of scale with current vendor for
  - Choice counseling
  - Rate development

Utilizing Phased Transition

- Utilizing phased transition, Phase One, initially enroll new adult group in MMA plans then move them in Phase Two to a new delivery mechanism
  - Phase one close out activities would be required.
  - Phase two new delivery system start up activities would be required.

Utilizing Phased Transition

- Phase One Close Out: State Required Activities
  - Develop Transition Plan
  - Amend federal authorities
  - Amend MMA contracts
  - Amend Choice Counseling Contract
  - Revise Provider Network Requirements
  - Systems Changes
- Phase One Close Out: MMA Plan Required Activities
  - Amend Member Materials
  - Systems Changes

Utilizing Phased Transition

- Phase Two New Delivery System Required Activities
  - Program Infrastructure Development
    - Renegotiation of federal authorities
    - New health plan contracts or arrangements
    - Development/adoption of minimum plan standards
  - Systems development/changes
  - Rate development
  - Choice counseling/enrollment of recipients (contract with new vendor)
  - Outreach

Utilizing Phased Transition

- Other states have implemented premium assistance programs where states use Medicaid funds to purchase private coverage for the newly eligible adult group using 1115 waiver authority.
- Federal CMS has indicated that all alternative Medicaid expansion waivers (i.e., 1115 waivers) will end by December 31, 2016
- States looking to expand programs using a premium assistance model into 2017 and beyond must apply for State Innovation Waivers

Florida Healthy Kids Corporation

- Currently responsible for contracts with health plans to provide services to children (under the age of 19) through the Healthy Kids component of the Florida Children's Health Insurance Program (CHIP)
- Child focused:
  - Payment rates
  - Networks
- CHIP Program funding ends September 2015.

Florida Health Choices

- Operates two exchanges where people can purchase individual health plans, discount plans, limited benefit plans and identify theft protection
- 59 families and individuals have purchased discount plans
- During an abbreviated open enrollment period for comprehensive coverage, 56 lives enrolled.
- A third exchange will launch this month to serve membership of Florida's largest professional associations.

Florida Health Plans

No materials available

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/2015
Meeting Date

Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Healthcare Coverage Options

Name Kim Williams

Job Title President/CEO Marpan

Address _____ Phone _____
Street

_____ Email _____
City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information

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

Representing A Healthy FL Works

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/2015
Meeting Date

Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Health Care Coverage Options

Name Karen Zeiler

Job Title Sr. V.P. at FL Hospital Assoc.

Address _____ Phone _____
Street

_____ Email _____
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

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

Representing A Healthy FL Works

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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3/4/15
Meeting Date

Bill Number (if applicable)

Topic Smarter Healthcare Coverage

Amendment Barcode (if applicable)

Name Mark Wilson

Job Title President & CEO

Address 136 S. Bronough St.
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Tallahassee FL 32301
City *State* *Zip*

Phone 850/521-1200

Email mwilson@flchamber.com

Speaking: ☐ For ☐ Against ☑ Information

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

Representing Florida Chamber of Commerce

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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3/4/15
Meeting Date

Bill Number (if applicable)

Topic Health Care Coverage Options

Amendment Barcode (if applicable)

Name Justin Senior

Job Title Deputy Secretary for Medicaid

Address 2727 Mahan Drive
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Phone 850-412-3612

Email justin.senior@ahca.myflorida.com

Speaking: ☐ For ☐ Against ☒ Information

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

Representing Agency for Health Care Administration

Appearing at request of Chair: ☒ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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3/4/15
Meeting Date

Bill Number (if applicable)

Topic Panel Discussion

Amendment Barcode (if applicable)

Name David Pollack

Job Title President

Address 8300 NW 33rd St
Street
Doral FL 33122
City *State* *Zip*

Phone 305-908-3508

Email david.pollack@molinahealthcare.com

Speaking: ☐ For ☐ Against ☑ Information

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

Representing Molina Healthcare

Appearing at request of Chair: ☑ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3-4-15
Meeting Date

workshop
Bill Number (if applicable)

Topic Health Care

Amendment Barcode (if applicable)

Name Rose M Naff

Job Title CEO

Address 200 W College Ave #203
Street

Tall FL 32312
City *State* *Zip*

Phone 2220933

Email rnaff@myfloridachoices.org

Speaking: ☐ For ☐ Against ☒ Information

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

Representing Florida Health Choices, Inc

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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3/4/2015
Meeting Date

Workshop Health Care Coverage CP 7185
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Medicaid Expansion

Name Leah Barber-Hing-Heinz

Job Title CEO, FL CHAIN

Address _____
Street

_____
City *State* *Zip*

Phone 570-760-1528

Email leah@floridachain.org

Speaking: ☐ For ☐ Against ☒ Information

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

Representing FL CHAIN & Health Care for Florida Now

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

Meeting Date

Bill Number (if applicable)

Topic HEALTH CARE

Amendment Barcode (if applicable)

Name SAL NUZZO

Job Title VP POLICY

Address 100 DUVAL ST. Phone 850-322-9941

Street

TALL. FL 32301 Email SNUZZO@JAMESMADISON.ORG

City State Zip

Speaking: ☐ For ☐ Against ☒ Information

Waive Speaking: ☐ In Support ☐ Against

(The Chair will read this information into the record.)

Representing JAMES MADISON INSTITUTE

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/14/14)

CourtSmart Tag Report

Room: KN 412 **Case:** **Type:**
Caption: Senate Health Policy Committee **Judge:**

Started: 3/4/2015 1:02:32 PM
Ends: 3/4/2015 3:02:14 PM Length: 01:59:43

1:02:40 PM Chair, Sen. Bean
1:04:34 PM Roll Call
1:04:47 PM Quorum Present
1:04:58 PM TAB 1: SB 758 by Evers-Prescription and Use of Opioid Antagonists for Emergency Treatment of Opioid Overdoses
1:06:46 PM Late File Amendment
1:07:02 PM Sen. Galvano
1:07:11 PM AM 209192
1:07:28 PM AM 209192 is Adopted
1:07:33 PM Public Testimony
1:07:44 PM Brian Jogerst, Shatterproof, Waives in Support
1:07:49 PM Christopher Nuland, FL Public Health Association, Waives in Support
1:07:55 PM Barney Bishop, CEO, FL Smart Justice Alliance, Waives in Support
1:08:01 PM Julia Negron, Suncoast Harm Reduction Project, Waives in Support
1:08:08 PM Stephen R. Winn, Executive Director of the FOMA, Waives in Support
1:08:14 PM Chuck Madden, Interventionist, Madden Group, Waives in Support
1:08:19 PM Lisa Brandy, President-Brandi's Wish Foundation, Waives in Support
1:08:28 PM Dr. Scott A. Teitelbaum, Chief, Division of Addiction Medicine, University of Florida, representing Florida Society of Addicition Medicine, Waives in Support
1:08:36 PM Kelly Corredor, President and CEO of The Skeeterhawk Experiment, Waives in Support
1:08:43 PM Leon Smith, Retired Dentist, Representing Andrew Smith Memorial Fund, Waives in Support
1:08:56 PM Jill Gran, Legislative Affairs Director, FL Alcohol and Drug Abuse Association, Waives in Support
1:09:02 PM Tabitha McDonald, Government Affairs Coordinator, FL Sheriff's Association, Waives in Support
1:09:06 PM Karen Bailey, Real Estate Broker, Waives in Support
1:09:28 PM Debate on Bill
1:09:37 PM Consideration for SB 758 as a Committee Substitute
1:10:05 PM Roll Call
1:10:22 PM Committee Substitute for SB 758 is Adopted
1:10:38 PM TAB 2: SB 606, Dental Care by Gaetz
1:10:40 PM Sen. Gaetz
1:11:16 PM Chair
1:11:25 PM Late File AM 504938
1:11:37 PM AM 504938 is Adopted
1:11:44 PM Sen. Gaetz
1:12:31 PM Chair
1:12:36 PM Public Testimony
1:12:52 PM Todd Steibly, Government Consultant, FL Society of Oral and Maxillofacial Surgeons, Waives in Support
1:12:59 PM JoeAnne Hart, Director of Governmental Affairs, FL Dental Association, Waives in Support
1:13:03 PM Andy Behrman, President, FL Association of Community Health Centers, Waives in Support
1:13:22 PM SB 606 Considered as a Committee Substitute
1:13:44 PM Roll Call
1:13:50 PM Committee Substitute for SB 606 Reported Favorably
1:14:10 PM TAB 3: Workshop and Panel Discussion on Health Care Coverage Options
1:15:58 PM Healthy Indiana Plan 2.0: Presentation by Joseph Moser, Brian Neale, and Seema Verma
1:49:24 PM Chair
1:50:26 PM Panel Responds
1:51:06 PM Chair Opens for Questions
1:51:14 PM Sen. Flores
1:51:29 PM Panel Responds
1:52:40 PM Chair
1:52:46 PM Sen. Galvano Recognized
1:53:26 PM Panel Responds

1:55:33 PM Chair
1:55:37 PM Sen. Sobel, Vice Chair, Recognized
1:56:03 PM Panel Responds
1:56:53 PM Vice Chair
1:56:59 PM Panel Responds
1:57:40 PM Vice Chair
1:57:44 PM Panel Responds
1:58:46 PM Vice Chair
1:59:08 PM Panel Responds
1:59:17 PM Chair
2:01:26 PM A Healthy Florida Works Presentation: By Karen Zeiler and Kim Williams
2:02:45 PM Kim Williams Speaking: President/CEO Marpan, A Healthy FL Works
2:09:03 PM Chair
2:09:15 PM Mark Wilson, President and CEO, Florida Chamber of Commerce, Speaking
2:17:32 PM Chair
2:17:49 PM Justin Senior, Deputy Secretary for Medicaid, FL Agency for Health Care Administration, Speaking
2:19:21 PM SMMC Program Goals
2:20:15 PM MMA Program Elements
2:20:42 PM MMA Program Enhancements: Expanded Benefits
2:21:18 PM MMA Program Enhancements: Plan Accreditation
2:21:38 PM MMA Program Enhancements: Network Adequacy Standards
2:22:14 PM MMA Program Enhancements: Competitive Rates
2:22:40 PM MMA Program Enhancements: Risk Adjusted Rates
2:23:05 PM MMA Program Enhancements: Enhanced Accountability
2:24:05 PM Coverage of New Adult Group
2:24:29 PM Current Eligibility and New Adult Group
2:25:11 PM Utilizing MMA Plans
2:27:22 PM Utilizing Phased Transition
2:28:27 PM Chair
2:29:04 PM David Pollock, President, Molina Healthcare of Florida, Inc., Discussing Florida Health Plans
2:31:39 PM Chair
2:32:53 PM Rose M. Naff, CEO, FL Health Choices, Inc.
2:35:21 PM Chair
2:35:49 PM Chair Opens for Questions
2:36:14 PM Sen. Braynon
2:36:21 PM Justin Senior Responds
2:36:51 PM Mark Wilson Responds
2:38:13 PM Justin Senior Recognized
2:39:44 PM Sen. Braynon
2:39:53 PM Justin Senior
2:40:56 PM Sen. Gaetz Recognized
2:41:51 PM Justin Senior Responds
2:44:13 PM Sen. Gaetz
2:45:08 PM Justin Senior Responds
2:45:19 PM Sen. Gaetz
2:45:28 PM Justin Senior Responds
2:45:46 PM Sen. Gaetz
2:45:53 PM Justin Senior Responds
2:47:52 PM Vice Chair
2:48:21 PM Justin Senior Responds
2:48:28 PM Vice Chair
2:48:42 PM Justin Senior Responds
2:49:04 PM Vice Chair
2:49:18 PM Justin Senior Responds
2:49:44 PM Vice Chair
2:50:33 PM Justin Senior Responds
2:51:35 PM David Pollock Recognized
2:52:06 PM Justin Senior
2:52:35 PM Chair
2:52:36 PM Sen. Garcia
2:53:11 PM Justin Senior Responds
2:53:26 PM David Pollock

2:53:59 PM Sen. Garcia
2:54:21 PM Justin Senior Responds
2:54:57 PM Chair
2:55:18 PM Leah Barber-Heinz, CEO, FL CHAIN, Speaking
2:56:58 PM Chair
2:57:05 PM Sal Nuzzo, VP of Policy, James Madison Institute, Speaking
2:59:35 PM Chair
2:59:39 PM Sen. Gaetz Recognized
2:59:55 PM Sal Nuzzo responds
3:00:34 PM Sen. Gaetz
3:00:42 PM Chair
3:00:50 PM Sen. Joyner
3:00:55 PM Sal Nuzzo responds
3:01:45 PM Chair
3:01:53 PM Rose M. Naff Responds
3:01:58 PM Chair
3:02:01 PM Vice Chair Moves to Rise
3:02:05 PM Meeting Adjourned