Tab 1	**SB 1568** by **Brodeur;** Identical to H 01297 Electronic Prescribing

Tab 2	**SB 1606** by **Grall;** Identical to H 01083 Patient Access to Records

900268	A	S	HP, Grall	Delete L.463 - 474.	03/24 12:30 PM

Tab 3	**SB 656** by **Rodriguez;** Similar to H 00547 Health Care Billing and Collection Activities

967282	D	S	HP, Rodriguez	Delete everything after	03/21 12:09 PM

Tab 4	**SB 68** by **Martin;** Similar to CS/H 00229 Health Facilities Authorities

534268	A	S	HP, Martin	Delete L.26:	03/24 12:28 PM

Tab 5	**SB 1690** by **McClain;** Similar to CS/H 00791 Surrendered Infants

Tab 6	**SB 1346** by **Polsky;** Similar to H 01195 Fentanyl Testing

609278	A	S	HP, Polsky	Delete L.30:	03/24 01:25 PM

Tab 7	**SB 1224** by **Harrell;** Similar to CS/H 00519 Administration of Controlled Substances

375076	A	S	L	HP, Harrell	Delete L.18 - 20:	03/24 01:58 PM

Tab 8	**SB 524** by **Harrell;** Identical to H 01089 Newborn Screenings

Tab 9	**SB 172** by **Burton (CO-INTRODUCERS) Passidomo;** Similar to H 01341 Health Care Practitioner Specialty Titles and Designations

310092	A	S	HP, Burton	Delete L.55 - 221:	03/24 01:21 PM

Tab 10	**SPB 7028** by **HP;** Cancer

Tab 11	**SB 1842** by **Burton;** Similar to H 01101 Out-of-network Providers

371962	D	S	HP, Burton	Delete everything after	03/24 01:22 PM

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Burton, Chair
Senator Harrell, Vice Chair

MEETING DATE: Tuesday, March 25, 2025
TIME: 1:30—3:30 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

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

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

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

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
8	**SB 524** Harrell (Identical H 1089)	Newborn Screenings; Beginning on a specified date, requiring that the Department of Health's rules require that newborns be screened for Duchenne muscular dystrophy at the appropriate age, etc. HP 03/25/2025 AHS FP	
9	**SB 172** Burton (Similar H 1341)	Health Care Practitioner Specialty Titles and Designations; Prohibiting the use of specified titles and designations by health care practitioners not licensed as physicians or osteopathic physicians, as applicable, with an exception; specifying the manner in which health care practitioners may represent their specialty practice areas; specifying specialist titles and designations that physicians and osteopathic physicians, respectively, are prohibited from using unless they have received formal recognition by the appropriate recognizing agency for such specialty certifications, etc. HP 03/25/2025 RC	
	Consideration of proposed bill:		
10	**SPB 7028** **(Preliminary Draft Available - final draft will be made available at least 24 hours prior to the meeting)**	Cancer Research; (PRELIMINARY DRAFT) providing legislative intent, etc.	
11	**SB 1842** Burton (Similar H 1101)	Out-of-network Providers; Requiring a health care practitioner to notify a patient in writing upon referring the patient to certain providers; requiring certain health insurers to apply payments for services provided by nonpreferred providers toward insureds' deductibles and out-of-pocket maximums if specified conditions are met, etc. HP 03/25/2025 AHS FP	
	Other Related Meeting Documents		

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1568
INTRODUCER:	Senator Brodeur
SUBJECT:	Electronic Prescribing
DATE:	March 24, 2025
REVISED:	

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

I. Summary:

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

The bill lists exceptions for prescribers who:

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

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

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

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

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

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

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

II. Present Situation:

E-prescribing

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

Federal Medicare E-Prescribing Requirements

The federal *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act* (SUPPORT Act), enacted in 2018, mandated that prescriptions for controlled substances covered under Medicare Part D be transmitted electronically beginning January 1, 2021.[4] CMS is responsible for enforcing this mandate and has established the Electronic Prescribing for Controlled Substances (EPCS) Program to oversee compliance.[5]

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

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

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[3] *Agency for Health Care Administration, 2023 Electronic Prescribing Annual Report* (Jan. 2024); available at https://ahca.myflorida.com/content/download/25388/file/2023eRxAnnualReport_Final.pdf (last visited Mar. 23, 2025).
[4] *Substance Use–Disorder Prevention That Promotes Opioid Recovery and Treatment for Patients and Communities Act,* Pub. L. No. 115-271, 132 Stat. 3894 (2018); available at https://www.congress.gov/115/plaws/publ271/PLAW-115publ271.pdf (last visited Mar. 23, 2025).
[5] *Centers for Medicare & Medicaid Services, Electronic Prescribing for Controlled Substances (EPCS) Program,* available at https://www.cms.gov/medicare/e-health/eprescribing/cms-eprescribing-for-controlled-substances-program (last visited Mar. 23, 2025).

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

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

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

Florida E-Prescribing Requirements

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

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

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

[6] *42 U.S.C. § 1395w–104(e)(7)(B);* available at https://www.govinfo.gov/app/details/USCODE-2021-title42/USCODE-2021-title42-chap7-subchapXVIII-partD-subpart1-sec1395w-104 (last visited Mar. 23, 2025).
[7] *See* "Effect of Proposed Changes" to compare Florida's exceptions for all prescription drugs with the EPCS exceptions.
[8] *42 C.F.R. § 423.160(a)(5)(i);* available at https://www.ecfr.gov/current/title-42/section-423.160 (last visited Mar. 23, 2025).

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

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 456.42, F.S., to require health care practitioners who are licensed by law to prescribe a medicinal drug and who are prescribing medicinal drugs in their capacity as an owner, an employee, or a contractor of a licensed health care facility or practice that maintains a system of electronic health records[10] to electronically transmit prescriptions for such drugs. The bill creates two exceptions, retains one in current law, and removes seven, as follows.

The bill creates the following two exceptions:

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

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

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

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

The bill retains the following exception in current law:

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

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

[9] Section 456.43, F.S.
[10] "Electronic health record" means a record of a person's medical treatment which is created by a licensed health care provider and stored in an interoperable and accessible digital format. Section 408.051, F.S.
[11] *Supra* note 5.
[12] *Id.*
[13] *Id.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The exemption for individuals receiving hospice care from the federal electronic prescribing requirements for controlled substances under Medicare Part D was removed with the publication of the 2024 Physician Fee Schedule final rule (CMS-1784-F) by CMS on November 16, 2023.[19]

However, the exemption for residents of long-term care (LTC) facilities (which generally include nursing home facilities in Florida law) from the federal electronic prescribing requirements for controlled substances under Medicare Part D has been extended by three years, from 2025 to 2028.[20] The CMS finalized a policy to delay compliance actions against prescribers who do not meet the EPCS requirement for prescriptions written for beneficiaries in LTC facilities until January 1, 2028.[21] This extension aligns the timeline for EPCS compliance in LTC facilities with the adoption of updated electronic prescribing standards that include improved communication functionalities between pharmacies and LTC facilities.[22]

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[17] *Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Final Rule,* 86 Fed. Reg. 64996 (Nov. 19, 2021); available at https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf. (last visited Mar. 23, 2025).
[18] *Id.*
[19] *Centers for Medicare & Medicaid Services, Medicare Program: CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Final Rule,* 88 Fed. Reg. 81280, 82539 (Nov. 16, 2023) (to be codified at 42 C.F.R. pt. 423).
[20] *American Medical Association, Summary of Final CY 2025 Medicare Physician Fee Schedule (PFS) Rule,* at 8 (2023); available at https://www.ama-assn.org/system/files/ama-2025-mpfs-summary.pdf (last visited Mar. 23, 2025).
[21] *Centers for Medicare & Medicaid Services, Electronic Prescribing for Controlled Substances (EPCS) Program,* available at https://www.cms.gov/medicare/e-health/eprescribing/cms-eprescribing-for-controlled-substances-program (last visited Mar. 23, 2025).
[22] *American Medical Association, Summary of Final CY 2025 Medicare Physician Fee Schedule (PFS) Rule,* at 8 (2023); available at https://www.ama-assn.org/system/files/ama-2025-mpfs-summary.pdf (last visited Mar. 23, 2025).

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

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

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

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

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

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

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[23] Rule 64B-3.009, F.A.C. (2025).

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:[24]

The DOH reports that both the department and the Board of Pharmacy would need to update rules[25] that reference subsections of statute that are renumbered by the bill. Additionally, the DOH would need to communicate the revised requirements to all prescribing practitioners through the customer contact center virtual agent (ELI), board websites, and email notifications. The DOH indicates that current resources and budget authority are sufficient to absorb the associated non-recurring costs and the expected temporary increase in workload.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

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

[24] Department of Health, Senate Bill 1568Legislative Analysis (Mar. 11, 2025) (on file with the Senate Committee on Health Policy).
[25] Rules 64B-3.009 and 64B16-27.831(5), F.A.C. (2025).

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Brodeur

10-01056A-25 20251568__

A bill to be entitled

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

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

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

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

(1)~~(3)~~ A health care practitioner licensed by law to prescribe a medicinal drug who ~~maintains a system of electronic health records as defined in s. 408.051(2)(c), or who~~ prescribes medicinal drugs as an owner, an employee, or a contractor of a licensed health care facility or practice that maintains ~~such~~ a system of electronic health records as defined in s. 408.051(2)(c) and who is prescribing in his or her capacity as such an owner, an employee, or a contractor~~,~~ may only electronically transmit prescriptions for such drugs. This requirement applies to such a health care practitioner upon renewal of the health care practitioner's license or by July 1, 2026 ~~2021~~, whichever is earlier, but does not apply if:

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

(b) The practitioner is located in an area for which a state of emergency is declared pursuant to s. 252.36; or

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

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

(c) The practitioner has been issued a waiver by the department, not to exceed 1 year in duration, from the requirement to use electronic prescribing due to demonstrated economic hardship, technological limitations that are not reasonably within the control of the practitioner, or another exceptional circumstance demonstrated by the practitioner~~;~~

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

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

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

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

~~(h) The practitioner determines that it is in the best interest of the patient, or the patient determines that it is in his or her own best interest, to compare prescription drug prices among area pharmacies. The practitioner must document~~

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

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

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

458.347 Physician assistants.—

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

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

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

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

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

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

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

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

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

459.022 Physician assistants.—

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

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

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

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

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

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

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

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

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

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

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 17, 2025

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

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Jason Brodeur
Florida Senate, District 10

File signed original with committee office

S-020 (03/2004)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1606
INTRODUCER:	Senator Grall
SUBJECT:	Patient Access to Records
DATE:	March 24, 2025
REVISED:	

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

I. Summary:

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

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

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

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

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

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

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

II. Present Situation:

Federal Right of Access to Records Under HIPAA

The federal Health Insurance Portability and Accountability Act (HIPAA) establishes national standards for the protection of individually identifiable health information. The HIPAA Privacy Rule[1], implements these protections and sets forth the individual right of access to medical records.[2] The U.S. Department of Health and Human Services' Office for Civil Rights (OCR) is responsible for implementing and enforcing the HIPAA Privacy Rule.[3]

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

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

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

The Privacy Rule requires covered entities to provide access to PHI contained in what is known as a *designated record set*. A designated record set is defined[6] as a group of records maintained by or for a covered entity that is used, in whole or in part, to make decisions about individuals. These records include:

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

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

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[1] 45 C.F.R. Part 160 and Subparts A and E of Part 164.
[2] 45 C.F.R. § 164.524.
[3] U.S. Department of Health and Human Services, Office for Civil Rights, *Summary of the HIPAA Privacy Rule*, available at: https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html (last visited Mar. 22, 2025).
[4] 45 C.F.R. § 160.103.
[5] 45 C.F.R. §§ 160.103, 164.502(e).
[6] 45 C.F.R. § 164.501.
[7] *Id.*

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

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

Interaction of HIPAA with State Law[12]

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

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

Federal Information Blocking Prohibition

The 21st Century Cures Act[13] prohibits certain actors from engaging in "*information blocking*," which is broadly defined as any practice that is likely to interfere with access, exchange, or use of *electronic health information* (EHI), unless the practice is required by law or covered by a regulatory exception.[14] The Office of the National Coordinator for Health Information

[8] 45 C.F.R. § 164.524(b)(2).
[9] 45 C.F.R. § 164.524(c)(2).
[10] 45 C.F.R. § 164.524(c)(4).
[11] U.S. Department of Health and Human Services, Office for Civil Rights, *Individuals' Right under HIPAA to Access their Health Information 45 CFR § 164.524*, available at: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html (last visited Mar. 22, 2025).
[12] U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, When a state or federal law or regulation (such as the HIPAA Privacy Rule) requires that EHI be released, is it ever information blocking not to release it?, available at: https://www.healthit.gov/faq/when-state-or-federal-law-or-regulation-such-hipaa-privacy-rule-requires-ehi-be-released-no (last visited Mar. 22, 2025).
[13] Pub. L. No. 114-255.
[14] 42 U.S.C. § 300jj-52.

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

The federal Information Blocking Rule[17], adopted by ONC in 2020, applies to three categories of actors:

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

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

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

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

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

Interaction of the Information Blocking Rule with State Law

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

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[15] U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology, *Information Blocking Overview*, available at: https://www.healthit.gov/topic/information-blocking (last visited Mar. 22, 2025).
[16] U.S. Department of Health and Human Services, Office of Inspector General, *Information Blocking Enforcement*, available at: https://oig.hhs.gov/reports/featured/information-blocking/ (last visited Mar. 22, 2025).
[17] 45 C.F.R. Part 171.
[18] 45 C.F.R. § 171.102.
[19] "Health care provider" for purposes of the Information Blocking Rule has the same meaning as "health care provider" in 42 U.S.C. § 300jj.
[20] 45 C.F.R. § 171.103.
[21] *See* 45 C.F.R. § 171.102, referencing 45 C.F.R. § 164.501.
[22] 45 C.F.R. §§ 171.200–171.303.
[23] *Id.*

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

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

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

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

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

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

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 394.4615, F.S., to require a **mental health service provider**[25] to furnish copies of clinical records[26] within 14 working days of receiving a request, if:

- The patient or the patient's guardian[27] or legal custodian authorizes the release;

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

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

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

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

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

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

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

Section 2 also changes the term "agency" (as in the Agency for Health Care Administration) to "Department of Health" and "department" to clarify[28] and correct[29] that the DOH has the authority to issue subpoenas for patient records from entities regulated under ch. 395, F.S., for the purposes of investigating a health care practitioner.

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

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

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

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

[28] Department of Health, Senate Bill 1606 Legislative Analysis (Mar. 20, 2025) (on file with the Senate Committee on Health Policy).
[29] Agency for Health Care Administration, Senate Bill 1606 Legislative Analysis (Mar. 19, 2025) (on file with the Senate Committee on Health Policy).
[30] *See* 42 CFR § 482.24(b)(3) and 42 C.F.R. § 482.13(d)(2).
[31] For purposes of this section, the term "legal representative" has the same meaning as in s. 408.833(1), F.S., as created in section 5 of the bill.

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

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

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

Section 5 of the bill creates s. 408.833, F.S., within the Health Care Licensing Procedures Act[34] to establish uniform standards for record access by clients[35] of **health care providers**,[36] including facilities, that are licensed, registered, or certified by the AHCA and not otherwise addressed in statute. Records maintained by psychiatric hospitals, substance abuse treatment providers, or nursing homes are exempt from this section pursuant to subsection (4).

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

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

[32] Note that access to assisted living facility resident records is also governed by this section in current law. *See* changes made to s. 429.294, F.S., in section 11 of the bill.
[33] 42 C.F.R. § 483.10(g)(2)(ii) requires Medicare- or Medicaid-certified long-term care facilities to provide residents or their legal representatives the opportunity to inspect all records, including clinical records, within 24 hours (excluding weekends and holidays) of an oral or written request.
[34] Chapter 408, Part II, F.S. *See also* s. 408.801(1), F.S.
[35] "Client" means any person receiving services from a provider listed in s. 408.802. Section 408.803(6), F.S.
[36] The Act applies to all of the following facilities: Laboratories authorized to perform testing under the Drug-Free Workplace Act; birth centers; abortion clinics; crisis stabilization units; short-term residential treatment facilities; residential treatment facilities; residential treatment centers for children and adolescents; hospitals; ambulatory surgical centers; nursing homes; assisted living facilities; home health agencies; nurse registries; companion services or homemaker services providers; adult day care centers; hospices; adult family-care homes; homes for special services; transitional living facilities; prescribed pediatric extended care centers; home medical equipment providers; intermediate care facilities for persons with developmental disabilities; health care services pools; health care clinics; and organ, tissue, and eye procurement organizations. Section 408.802, F.S. *See also* s. 408.803(12), F.S.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

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

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

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

VII. Related Issues:

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

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

VIII. Statutes Affected:

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

This bill creates section 408.833 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

900268

LEGISLATIVE ACTION

Senate . House

. . . . . .

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

Senate Amendment (with title amendment)

Delete lines 463 - 474.

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

And the title is amended as follows:

Delete line 42

and insert:

amending ss. 316.1932, 316.1933, 395.4025,

By Senator Grall

29-01058A-25 20251606__

A bill to be entitled

An act relating to patient access to records; amending s. 394.4615, F.S.; requiring a service provider to furnish and provide access to records within a specified timeframe after receiving a request for such records; requiring that certain service providers furnish such records in the manner chosen by the requester; amending s. 395.3025, F.S.; removing provisions requiring a licensed facility to furnish patient records only after discharge to conform to changes made by the act; revising provisions relating to the appropriate disclosure of patient records without consent; amending s. 397.501, F.S.; requiring a service provider to furnish and provide access to records within a specified timeframe after receiving a request from an individual or the individual's legal representative; requiring that certain service providers furnish such records in the manner chosen by the requester; amending s. 400.145, F.S.; revising the timeframe within which a nursing home facility must provide access to and copies of resident records after receiving a request for such records; creating s. 408.833, F.S.; defining the term "legal representative"; requiring a provider to furnish and provide access to records within a specified timeframe after receiving a request from a client or the client's legal representative; requiring that certain providers furnish such records in the manner chosen by the requester; authorizing a provider to impose

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

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

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

394.4615 Clinical records; confidentiality.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Upon receipt of a written request that complies with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and this section, a nursing home facility shall furnish to a competent resident, or to a representative of that resident who is authorized to make requests for the resident's records under HIPAA or subsection (2), copies of the resident's paper and electronic records that are in possession of the facility. Such records must include any medical records and records concerning the care and treatment of the resident performed by the facility, except for progress notes and consultation report sections of a psychiatric nature. The facility shall provide a resident with access to the requested records within 24 hours, excluding weekends and holidays, and provide copies of the requested records within 2 ~~14~~ working days after receipt of a request relating to a current resident or within 30 working days after receipt of a request relating to a former resident.

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

408.833 Client access to medical records.—

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

(2) Within 14 working days after receiving a written

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

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

(4) This section does not apply to:

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

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

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

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

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

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

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

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

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

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

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

(1)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Full information does not include manuals, schematics, or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

456.47 Use of telehealth to provide services.—

(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 as used for in-person services. Medical records, including video, audio, electronic, or other records generated as a result of providing such services, are confidential pursuant to ss. 395.3025(2) and 456.057 ~~ss. 395.3025(4) and 456.057~~.

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

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 6, 2025

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

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Erin K. Grall

Senator Erin Grall
Florida Senate, District 29

File signed original with committee office

S-020 (03/2004)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 656
INTRODUCER:	Senator Rodriguez
SUBJECT:	Health Care Billing and Collection Activities
DATE:	March 24, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Pre-meeting**
2.			CM	
3.			RC	

I. Summary:

SB 656 amends s. 395.3011, F.S., to extend protections from "extraordinary collection actions" by hospitals and ambulatory surgical centers (ASC) to all actions relating to payments a of a bill for care. Current protections, created in 2024, apply only to bills for care covered under the hospital's or ASC's financial assistance policy. The bill also allows a hospital or ASC to sell an individual's debt under certain circumstances and allows such facilities to share medical debt information to consumer reporting agencies and credit scoring services as long as the consumer has paid the debt or has enter into a payment plan to pay the debt and is meeting his or her obligations. The bill requires consumer reporting agencies and credit scoring services to adopt reasonable procedures to make use of such positive consumer credit information.

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

II. Present Situation:

Medical Debt

Medical debt, or personal debt incurred from unpaid medical bills, is a leading cause of bankruptcy in the United States. Two-thirds of medical debts are the result of a one-time or short-term medical expense arising from an acute medical need.[1] Many medical collections on consumer credit reports are low-dollar accounts. Data from the federal Consumer Financial Protection Bureau's Consumer Credit Panel show that in 2020, the median medical collection was $310, the mean medical collection was $773, and 62 percent of medical collections were under $490.[2] In Florida, approximately 6.6 percent of the population has medical debt in

[1] Hamel, Liz et al. "The Burden of Medical Debt: January 2016 Results from the Kaiser Family Foundation/New York Times Medical Bills Survey." Kaiser Family Foundation. January 2016. The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey (kff.org) (last visited Mar. 24, 2025).

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

collection.[3] The median amount of medical debt in collections is $1593.[4] The percentage of persons without health insurance coverage is 11.1 percent.[5]

Medical Debt Collection in Florida

Debt Collection in General

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

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

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

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

Changes Specific to Medical Debt

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

- Prohibits hospitals and ASCs from filing an extraordinary collection action for medical debt;
- Establishes a new three-year statute of limitation period for medical debt collections which begins on the date the hospital or ASC refers the medical debt to a third party;

[3] Debt in America 2024, Urban Data Catalog, *Debt in America State-Level Medical Debt*, Sep. 12, 2024, available at Debt in America 2024 | Urban Data Catalog, (last visited Mar. 24, 2025).
[4] *Id.*
[5] *Id.*
[6] Art. X, s. 4(a), Fla. Const.
[7] For example, the federal ERISA law provides that most retirement plans are exempt from creditor claims.
[8] Section 222.11, F.S.
[9] Section 222.13, F.S.
[10] Section 222.15, F.S.
[11] Section 222.18, F.S.
[12] Section 222.22, F.S.
[13] Section 222.25, F.S.

- Exempts up to $10,000 of a debtor's property from attachment, garnishment, or other legal action by a hospital or ASC to recover a medical debt; and
- Prohibits a hospital or ASC from engaging in extraordinary action to collect a medical debt while a patient 's eligibility for, enrollment in, or grievance about other coverages are pending.

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

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

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

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

III. Effect of Proposed Changes:

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

- Expand the scope of "extraordinary collection action" to include actions taken in relation to obtaining payment for any bill of care, rather than only bills of care that are covered under a hospital's or ASC's financial assistance policy.
- Exclude selling an individual's debt from the definition of "extraordinary collection action" as long as the debt:
  - Is not subject to interest, fees, or actions that require a legal or judicial process; and
  - Is returned to the facility if it is determined that the debt qualifies for charity care under the facility's financial assistance policy.
- Provide definitions for:
  - "Furnisher of medical debt information" to mean an entity that owns the medical debt account and provides to a consumer reporting agency information pertaining to transactions, accounts, balances, repayment terms, repayment history, and other similar information relating to medical debts; and
  - "Medical debt" to mean a debt arising from the receipt of medical services, products, or devices.
- Allow information relating to medical debt that has been paid or settled by a consumer to be furnished to a consumer reporting agency.
- Allow information relating to a consumer's satisfaction of the obligations of a payment plan may be furnished to a consumer reporting agency if:
  - The medical debt owner and the consumer have entered into a payment plan, including a deferred payment agreement or a debt forgiveness program with respect to medical debt; and
  - The consumer is meeting the obligations of the payment plan, as determined by the medical debt owner.
- Require consumer reporting agencies and credit scoring service providers to adopt reasonable standards to use positive consumer credit information so that the information is:
  - Included in a consumer report used, in whole or in part, for the purpose of serving as a factor in establishing a consumer's eligibility for credit, employment purposes, and other purposes authorized by this part;
  - Used in the generation of any credit score; and
  - Provided in a manner that is fair to the consumer, with regard for the confidentiality, accuracy, relevancy, and proper use of such information in accordance with the requirements of this part.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 395.3011 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

967282

LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

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

395.3011 Billing and collection activities.—

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

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

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

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

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

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

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

2. Foreclosing on the individual's real property;

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

4. Commencing a civil action against the individual;

5. Causing the individual's arrest; or

6. Garnishing the individual's wages.

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

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

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

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

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

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

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

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

By Senator Rodriguez

40-01084-25 2025656__

A bill to be entitled

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

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

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

395.3011 Billing and collection activities.—

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

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

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

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

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

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

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

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

b.~~2.~~ Foreclosing on the individual's real property.~~;~~

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

d.~~4.~~ Commencing a civil action against the individual.~~;~~

e.~~5.~~ Causing the individual's arrest.~~; or~~

f.~~6.~~ Garnishing the individual's wages.

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

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

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

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

1. The medical debt owner and the consumer have entered into a payment plan, including a deferred payment agreement or a debt forgiveness program with respect to medical debt; and

2. The consumer is meeting the obligations of the payment plan, as determined by the medical debt owner.

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

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

2. Used in the generation of any credit score; and

3. Provided in a manner that is fair to the consumer, with regard for the confidentiality, accuracy, relevancy, and proper use of such information in accordance with the requirements of this part.

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

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: February 26, 2025

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

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Ana Maria Rodriguez
Florida Senate, District 40

File signed original with committee office

S-020 (03/2004)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 68
INTRODUCER:	Senator Martin
SUBJECT:	Health Facilities Authorities
DATE:	March 24, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Shuler	Fleming	CA	**Favorable**
2.	Smith	Brown	HP	**Pre-meeting**
3.			RC	

I. Summary:

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

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

II. Present Situation:

Health Facilities Authorities

Generally

The Health Facilities Authorities Law[1] (the Law) was enacted in 1974, to provide health facilities in each local agency (defined as a county or municipality[2]) with a measure of assistance and an alternate method to enable the health facilities to provide the facilities and structures that are determined to be needed by the community to improve the development and maintenance of the public health.[3]

[1] Part III of ch. 154, F.S.
[2] Section 154.205(9), F.S.
[3] Section 154.203, F.S.

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

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

The Law authorizes a local agency to create an authority if the governing body[5] of the local agency determines there is a need for an authority by adopting an ordinance or resolution.[6] An authority is a public corporation created by s. 154.207, F.S.; or a board, body, commission, or department of a local agency succeeding to the principal functions of the public corporation or to whom the powers and responsibilities authorized by the Law are given by the local agency.[7] The governing body of the local agency is required to appoint five persons, who must be residents of the local agency, as members of the authority to serve staggered terms of 4 years each.[8] Members of the authority are eligible for reappointment and serve without compensation, but are paid for necessary expenses incurred while engaged in the performance of the authority's duties.[9] Costs of employing professionals, staff, and other costs of operating the authority must be paid from funds obtained under the Law.[10]

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

[4] Section 154.205(8), F.S.
[5] The governing body means the board, commission, or other governing body of any local agency in which the general legislative powers of such local agency are vested. Section 154.205(7), F.S.
[6] Section 154.207(1), F.S.
[7] Section 154.205(2), F.S.
[8] Section 154.207(4), F.S.
[9] Section 154.207(8), F.S.
[10] *See* s. 154.211, F.S.
[11] Section 154.207(9), F.S.
[12] Section 154.207(7), F.S.

Purpose and Powers of the Authority

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

A "project" is defined[15] as any structure, facility, machinery, equipment, or other property suitable for use by a health facility in connection with its operations or proposed operations, including without limitation:

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

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

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

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

[13] Section 154.209, F.S.
[14] Section 154.247, F.S.
[15] Section 154.205(10), F.S.

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

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

The Law provides that if a project is subject to review under the Health Facility and Services Development Act in ss. 408.031 – 408.045, F.S., a certificate of need (CON) is required before revenue bonds are validated for a project.[18] A CON is a written statement issued by the Agency for Health Care Administration (Agency) evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility or hospice.[19] Currently, a CON is required for the addition of beds in community nursing homes or intermediate care facilities for the developmentally disabled, the new construction or establishment of additional health care facilities[20] the conversion from one type of health care facility to another, and the establishment

[16] *See* ss. 154.209, 154.217, and 154.219, F.S.
[17] Section 154.223, F.S.
[18] Section 154.245, F.S. *See also* s. 154.213, F.S.
[19] Section 408.032(3), F.S.
[20] Except for a replacement health care facility when the proposed project site is located on the same site as or within 1 mile of the existing health care facility if the number of beds in each licensed bed category will not increase. Section 408.036(1)(b), F.S.

of a hospice, certain hospice inpatient facilities.[21] A CON issued by the Agency is not required for certain projects upon request.[22]

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

III. Effect of Proposed Changes:

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

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

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

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

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

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[21] Section 408.036(1), F.S.

[22] *See* s.408.036(3), F.S.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

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

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

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

IX. Additional Information:

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

None.

B. Amendments:

None.

534268

LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment

Delete line 26

and insert:

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

By Senator Martin

33-00198-25 202568__

A bill to be entitled

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

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

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

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

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

(a) Hospital services in accordance with chapter 395;

(b) Nursing home care services in accordance with chapter 400;

(c) Life care services in accordance with chapter 651;

(d) Services for the developmentally disabled under chapter 393;

(e) Services for the mentally ill under chapter 394;

(f) Assisted living services in accordance with chapter 429; or

(g) Hospice services in accordance with chapter 400.

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

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

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

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

functions under this part.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

154.219 Revenue bonds.—

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

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

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

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

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

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

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

154.225 Revenues.—

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

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

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

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

154.235 Refunding bonds.—

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

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

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

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

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

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

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

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

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

SENATOR JONATHAN MARTIN
33rd District

March 21, 2025

RE: SB 68: Health Facilities Authorities

Dear Chair Burton,

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

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

Sincerely,

Jonathan Martin
Senate District 33

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

Senate's Website: *www.flsenate.gov*

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1690
INTRODUCER:	Senator McClain
SUBJECT:	Surrendered Infants
DATE:	March 24, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Morgan	Brown	HP	**Pre-meeting**
2.			JU	
3.			RC	

I. Summary:

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

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

II. Present Situation:

Infant Safe Haven Laws

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

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

[1] Child Welfare Information Gateway, *Infant Safe Haven Laws* (Sep. 2021), *available at* https://www.childwelfare.gov/resources/infant-safe-haven-laws/ (last visited Mar. 22, 2025).
[2] *Id*.
[3] Chapter 2024-213, L.O.F.

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

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

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

Surrender of Infants in Florida

The Florida Legislature enacted Florida's initial abandoned newborn infant law in 2000.[11] The law created s. 383.50, F.S., and authorized the abandonment of a newborn infant, up to three days old or younger, at a hospital or a fire station and addressed the presumption of relinquishment of parental rights, implied consent to treatment, anonymity, and physical custody of the infant.[12]

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

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

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[4] *Supra* note 1. Connecticut, Idaho, Illinois, Indiana, Iowa, Louisiana, Minnesota, New Hampshire, Vermont, and Wisconsin.
[5] National Conference of State Legislatures, *Safe Haven Laws Memo* (Mar. 24, 2025) (on file with Senate Committee on Health Policy). Arkansas, Idaho, Indiana, Kentucky, Louisiana, Maine, Mississippi, Montana, New Hampshire, Oklahoma, South Dakota, Tennessee, Virginia, and West Viriginia.
[6] *Supra* note 3.
[7] *Supra* note 1. Arizona, Arkansas, Connecticut, Georgia, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Montana, Nebraska, Nevada, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, and West Virginia.
[8] *Supra* note 1.
[9] National Safe Haven Alliance, *2023 Annual/Impact Report, available at* https://www.nationalsafehavenalliance.org/_files/ugd/1c34fd_d0b326dc49884c0ca87f8e023d354cea.pdf (last visited Mar. 22, 2025).
[10] National Safe Haven Alliance, *Our Cause, available at* https://www.nationalsafehavenalliance.org/our-cause (last visited Mar. 22, 2025).
[11] Chapter 2000-188, L.O.F.
[12] Section 383.50, F.S.
[13] Chapter 2001-53, s. 15, L.O.F.
[14] Chapter 2008-90, s. 4, L.O.F.

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

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

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

A Safe Haven for Newborns[18] reports that over the past 25 years, approximately 476 newborns have been surrendered or abandoned in Florida.[19] Since 2000, 411 newborns have been surrendered in a safe haven hospital, EMS station, or a fire station, and approximately 65 newborns have been abandoned in unsafe places. In 2025, as of this writing, three newborns have been recorded as surrendered to a safe haven.[20]

Safe Haven Baby Boxes

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

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[15] *Supra* note 3.
[16] Sections 383.50(3) and 395.1041, F.S.
[17] Section 383.50(7), F.S.
[18] A Safe Haven for Newborns is a program of The Florida M. Silverio Foundation, a 501(c)(3) organization located in Miami, Florida.
[19] A Safe Haven for Newborns, *A Safe Haven for Newborns Statistics*, *available at* https://asafehavenfornewborns.com/what-we-do/safe-haven-statistics/ (last visited Mar. 22, 2025).
[20] *Id*.
[21] Safe Haven Baby Boxes, *available at* https://www.shbb.org/ (last visited Mar. 23, 2025).

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

Over 150 babies have been surrendered nationwide inside Safe Haven Baby Boxes since the first was installed in 2016.[26] There are 317 active baby boxes, five of which are in Florida.[27] Arizona also has baby drawers, which can be found at six different medical centers in the state.[28] Florida's Safe Haven baby boxes are located at the Martin Luther King, Jr. (MLK), First Responder Campus and the Marion County Fire and Rescue in Ocala; the Citrus County Fire Rescue in Crystal River; the Hernando County Fire Department in Spring Hill; and the Newberry Fire Station #28 in Newberry.[29] In January 2023, an infant was surrendered at the baby box at the MLK First Responder Campus in Ocala.[30]

III. Effect of Proposed Changes:

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

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

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

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[22] *See* Indiana Secretary of State Corporation and Business Entity Search; *search by entity name at:* https://bsd.sos.in.gov/publicbusinesssearch (last visited Mar. 23, 2025).
[23] *See* United States Patent (dated Apr. 28, 2020), *available at* https://img1.wsimg.com/blobby/go/0e1dea24-4aa4-477a-b7dd-0e668b1de6d1/downloads/Patent%20.pdf?ver=1610398180477 (last visited Mar. 23, 2025).
[24] *See* Trademark Certificate (registered Oct. 15, 2019), *available at* https://img1.wsimg.com/blobby/go/0e1dea24-4aa4-477a-b7dd-0e668b1de6d1/downloads/Tradmark%20Certificate.pdf?ver=1610398180478 (last visited Mar. 23, 2025).
[25] *See* Letter from U.S. Food and Drug Administration to Safe Haven Baby Boxes, Inc. (dated Feb. 15, 2019), *available at* https://img1.wsimg.com/blobby/go/0e1dea24-4aa4-477a-b7dd-0e668b1de6d1/downloads/C180100.Letter.pdf?ver=1610398180478 (last visited Mar. 23, 2025).
[26] Safe Haven Baby Boxes, *Mission, available at* https://www.shbb.org/history (last visited Mar. 23, 2025).
[27] Safe Haven Baby Boxes, *SHBB Locations, available at* https://project-safe-haven-babybox.vercel.app/ (last visited Mar. 23, 2025).
[28] Arizona Safe Baby Haven Foundation, *AZ Safe Haven Law, available at* https://azsafebabyhaven.org/information/ (last visited Mar. 23, 2025). Banner Thunderbird Medical Center, Banner Cardon Children's Medical Center, Banner Estrella Medical Center, HonorHealth Scottsdale Osborn Medical Center, Maricopa Medical Center, and Mayo Clinic Phoenix.
[29] *Supra* note 27.
[30] *See* Newborn surrendered at Florida fire station is first baby save by state's only "Baby Box" by Charine Akbara, (published Jan. 10, 2023, Fox 13 News), *available at* https://www.fox13news.com/news/newborn-surrendered-at-florida-fire-station-is-first-baby-saved-by-states-only-baby-box (last visited Mar. 23, 2025).

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

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

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

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

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

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

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

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator McClain

9-01530-25 20251690__

A bill to be entitled

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

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

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

383.50 Treatment of surrendered infant.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Provide emergency medical services to the infant to the extent that he or she is trained to provide those services; and

(b) Arrange for the immediate transportation of the infant to the nearest hospital having emergency services.

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

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

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

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

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

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

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

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

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

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

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

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

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

63.0423 Procedures with respect to surrendered infants.—

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

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

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

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 10, 2025

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

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Stan Mcclain
Florida Senate, District 9

File signed original with committee office

S-020 (03/2004)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1346
INTRODUCER:	Senator Polsky
SUBJECT:	Fentanyl Testing
DATE:	March 24, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Pre-meeting**
2.			JU	
3.			RC	

I. Summary:

SB 1346 creates s. 395.1042, F.S., entitled "Gage's Law"[1] to require a hospital or hospital-based off-campus emergency department (stand-alone ED) to test a patient for fentanyl if the patient is receiving emergency services and care[2] for a possible drug overdose or poisoning and the hospital or stand-alone ED conducts a urine test to assist in diagnosing the individual. The bill specifies that if the urine test comes back positive for fentanyl, the hospital must perform laboratory and toxicology screenings and maintain the results of the urine test and the screenings as part of the patient's clinical record.

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

II. Present Situation:

Fentanyl

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

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

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

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

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

According to the CDC, synthetic opioids (like fentanyl) are the primary driver of overdose deaths in the United States.[3]

Toxicology Screening

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

Drug testing is possible using samples from urine, serum, breath, sweat, or saliva. Breath testing is used nearly entirely on estimating alcohol concentrations, and urine and serum tests remain the most commonly used for medical professionals.[4]

Urine Testing

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

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

Many assays include benzodiazepines as well. In addition to issues with false positives or negatives of the test, the standard urine assay will not screen for some existing illicit drugs. The

[3] Facts About Fentanyl, United States Drug Enforcement Administration, *available at* https://www.dea.gov/resources/facts-about-fentanyl, (last visited Mar. 20, 2025).
[4] Mukherji P, Azhar Y, Sharma S. Toxicology Screening. [Updated 2023 Aug 7]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. *Available* from: https://www.ncbi.nlm.nih.gov/books/NBK499901/, (last visited Mar. 20, 2025).

epidemiology of drug use has shifted over the past 10 years, and there is a higher prevalence of substances such as synthetic cannabinoid, MDMA (ecstasy), and chemical variants of opioids and PCP, which may not be detected by many urine screenings. Other drugs of misuse that are generally unscreened include ketamine, chloral hydrate, gamma-hydroxybutyrate (GHB), psilocybin, and "bath salts" (cathinones).

Most urine drug screenings do not provide quantitative testing, so a simple "positive" or "negative" result is given if the assay detects substrate.[5]

Serum Testing

Serum tests screen for common, over-the-counter drugs which are likely sources for intended overdoses. These tests commonly obtain acetaminophen, aspirin, salicylates, and ethanol. Some extended serum screens include tricyclic antidepressants or barbiturates. Unlike urine screens, these tests are often quantitative and are useful in measuring blood concentrations. Concentrations require interpretation as to the reported times and amounts of ingestion, and often serial concentrations are necessary when the history is lacking or unreliable. While ethanol is detectable in the alcohol screen, other toxic alcohols like methanol, ethylene glycol, and isopropyl alcohol are not detectable.[6]

III. Effect of Proposed Changes:

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

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[5] *Supra*, note 3.
[6] *Id.*

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

SB 1346 requires a hospital to conduct "laboratory and toxicology screenings" if a patient tests positive for fentanyl under certain circumstances. However, many laboratory or toxicology screening types exist for many different conditions. It is unclear which screenings a hospital would be required to conduct under the bill.

Additionally, the bill requires the hospital to conduct the screenings but does not provide a hospital with an exception if the patient refuses the screenings and does not provide a timeframe for the screenings to be conducted. As such, it may be advisable to clarify in the bill which screenings must be conducted and under what time frame, as well as the hospital's responsibility should a patient refuse the screenings.

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

VIII. Statutes Affected:

This bill creates section 395.1042 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

609278

LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment (with title amendment)

Delete line 30

and insert:

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

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

And the title is amended as follows:

Delete lines 8 - 9

609278

and insert:

to perform a confirmation test if the urine test results are positive for

By Senator Polsky

30-00921A-25 20251346__

A bill to be entitled

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

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

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

395.1042 Fentanyl testing.—

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

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

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

hospital must perform laboratory and toxicology screenings.

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

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

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

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

SELECT COMMITTEE:
Joint Select Committee on Collective Bargaining

SENATOR TINA SCOTT POLSKY
30th District

March 7, 2025

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

Chairwoman Burton,

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

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

Kindest Regards,

Senator Tina S. Polsky
Florida Senate, District 30

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

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

Senate's Website: *www.flsenate.gov*

BEN ALBRITTON
President of the Senate

JASON BRODEUR
President Pro Tempore

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1224
INTRODUCER:	Senator Harrell
SUBJECT:	Administration of Controlled Substances
DATE:	March 24, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Pre-meeting**
2.			CA	
3.			RC	

I. Summary:

SB 1224 amends s. 893.05, F.S., to allow a practitioner[1] to delegate to a certified paramedic the administration of a controlled substance if the paramedic is working under the direction and supervision of the practitioner.

The bill takes effect upon becoming law.

II. Present Situation:

Paramedics

A paramedic is an allied health professional whose primary focus is to provide advanced emergency medical care for critical and emergent patients who access the emergency medical system. A paramedic possesses the complex knowledge and skills necessary to provide patient care and transportation. Paramedics function as part of a comprehensive emergency medical system (EMS) response, under medical oversight. Paramedics perform interventions with the basic and advanced equipment typically found on an ambulance and are a link from the scene of an emergent encounter into the health care system.[2]

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

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

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

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

Medication Administration Training for Paramedics

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

- Medication safety;
- Medication legislation;
- Naming;
- Classifications;
- Schedules;
- Pharmacokinetics;
- Storage and security;
- Autonomic pharmacology;
- Metabolism and excretion;
- Mechanism of action;
- Phases of medication activity;
- Medication response relationships;

[3] Section 401.23(18), F.S.
[4] Section 401.23(9), F.S., defines "basic life support" as the assessment or treatment by a person qualified under this part through the use of techniques described in the EMT (Emergency Medical Technician) -Basic National Standard Curriculum or the National EMS (Emergency Medical Services) Education Standards of the United States Department of Transportation and approved by the DOH. The term includes the administration of oxygen and other techniques that have been approved and are performed under conditions specified by rules of the DOH.
[5] Section 401.23(2), F.S., defines "advanced life support" as assessment or treatment by a person qualified under this part through the use of techniques such as endotracheal intubation, the administration of drugs or intravenous fluids, telemetry, cardiac monitoring, cardiac defibrillation, and other techniques described in the EMT-Paramedic National Standard Curriculum or the National EMS Education Standards, pursuant to rules of the DOH.
[6] *Available at* https://www.ems.gov/assets/National-EMS-Education-Standards-FINAL-Jan-2009.pdf (last visited Mar. 21, 2025).
[7] Section 401.27(4)(b), and (c), F.S.
[8] *Supra* n. 2 at p. 15

- Medication interactions;[9]
- Toxicity.

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

Controlled Substances

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

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

Unless specifically allowed under ch. 893 or ch. 499, F.S., a person may not sell, manufacture, deliver, or possess with the intent to sell, manufacture, deliver a controlled substance.[12] Health care practitioners[13] are authorized under s. 893.05, F.S., to prescribe, administer, dispense, mix, or otherwise prepare a controlled substance or may cause the controlled substance to be administered by a licensed nurse or an intern practitioner under the practitioner's direction and supervision. Currently, ch. 893, F.S., does not authorize a practitioner to delegate the administration of a controlled substance to a paramedic.

[9] *Id.*
[10] *Supra* n. 2 at p. 16
[11] Section 893.03, F.S.
[12] Section 893.13, F.S.
[13] As defined in s. 893.02, F.S. *See* n. 1.

III. Effect of Proposed Changes:

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

The bill takes effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 893.05 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

375076

LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment (with title amendment)

Delete lines 18 - 20

and insert:

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

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

375076

And the title is amended as follows:

Delete line 5

and insert:

administered by a certified paramedic in the course of providing emergency services; providing an

By Senator Harrell

31-01276-25 20251224__

A bill to be entitled

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

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

Section 1. Paragraph (a) of subsection (1) of section 893.05, Florida Statutes, is amended to read:

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

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

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

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

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

SENATOR GAYLE HARRELL
31st District

March 12, 2025

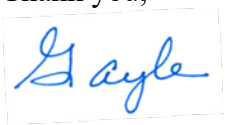
Senator Burton
408 Senate Office Building
Tallahassee, FL 32399

Dear Chair Burton,

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

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

Thank you,



Senator Gayle Harrell
Senate District 31

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

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

Senate's Website: *www.flsenate.gov*

BEN ALBRITTON
President of the Senate

JASON BRODEUR
President Pro Tempore

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 524
INTRODUCER:	Senator Harrell
SUBJECT:	Newborn Screenings
DATE:	March 24, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Morgan	Brown	HP	**Pre-meeting**
2.			AHS	
3.			FP	

I. Summary:

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

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

II. Present Situation:

The Florida Department of Health

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

Newborn Screening

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

[1] Section 381.001, F.S.

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

Federal Recommendations for NBS

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

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

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

The Florida NBS Program

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

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

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[3] Health Resources & Services Administration, *Advisory Committee on Heritable Disorders in Newborns and Children, available at* https://www.hrsa.gov/advisory-committees/heritable-disorders (last visited Mar. 22, 2025).
[4] *Id.*
[5] *See*, Tatiana Wing, R.C. Philips Research and Education Unit, *Newborn Screening Update* (2020), *available at* https://genetics.pediatrics.med.ufl.edu/wordpress/files/2019/11/RCPU-Newborn-screening-update.pdf (last visited Mar. 22, 2025); Watson, S., Lloyd-Puryear, M., & Howell, R. (2022), *The Progress and Future of US Newborn Screening*, International Journal of Neonatal Screening, 8:41, *available at* https://doi.org/10.3390/ijns8030041 (last visited Mar. 22, 2025). Phenylketonuria (PKU) is a rare inherited disorder that causes an amino acid called phenylalanine to build up in the body resulting in dangerous symptoms unless a specific diet is adhered to. PKU was the first inheritable condition for which a relatively simple and repeatable blood test was able to be conducted at a high enough throughput to enable population-level screening.
[6] Section 383.14, F.S.
[7] Florida Department of Health, *Florida Newborn Screening 2022 Protocols* (Mar. 15, 2022), *available at* https://floridanewbornscreening.com/wp-content/uploads/NBS-Protocols-2022-FINAL.pdf (last visited Mar. 22, 2025).
[8] Section 383.14, F.S.; Rule 64C-7.008, F.A.C. The health care provider must attempt to get a written statement of objection to be placed in the medical record.

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

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

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

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

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

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[9] *Supra* note 6.
[10] Florida Department of Health, *2025 Agency Legislative Bill Analysis, HB 1089* (Mar. 12, 2025) (on file with the Senate Committee on Health Policy).
[11] *Supra* note 6.
[12] *Supra* note 10.
[13] *Supra* note 6.
[14] Florida Department of Health, Florida Newborn Screening Program, *What is Newborn Screening?, available at* https://floridanewbornscreening.com/parents/what-isnewborn-screening/ (last visited Mar. 22, 2025). *See also,* Florida Department of Health, Florida Newborn Screening, *Specimen Collection Card, available at* http://floridanewbornscreening.com/wp-content/uploads/Order-Form.png (last visited Mar. 22, 2025).
[15] Florida Department of Health, *2024 Agency Legislative Bill Analysis, HB 499* (Feb. 7, 2024) (on file with the Senate Committee on Health Policy).

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

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

Duchenne Muscular Dystrophy

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

DMD Symptoms

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

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

[16] *Id*.
[17] Section 383.145, F.S.
[18] *Supra* note 6.
[19] Cleveland Clinic, *Duchenne Muscular Dystrophy (DMD), available at* https://my.clevelandclinic.org/health/diseases/23538-duchenne-muscular-dystrophy-dmd#symptoms-and-causes (last visited Mar. 22, 2025).
[20] *Id*.

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

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

What Causes DMD?

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

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

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

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

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

DMD Diagnosis and Testing

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

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

[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] *Id.*

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

DMD Management and Treatment

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

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

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

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[28] *Id*.

[29] The FDA is responsible for protecting the public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, medical devices, our nation's food supply, cosmetics, and products that emit radiation. The FDA also provides accurate, science-based health information to the public. USAGov, *Food and Drug Administration (FDA)*, available at https://www.usa.gov/agencies/food-and-drug-administration#:~:text=The%20Food%20and%20Drug%20Administration,and%20products%20that%20emit%20radiation. (last visited Mar. 22, 2025).

[30] *Supra* note 19.

DMD Prevention and NBS

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

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

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

RUSP Nomination Not Approved

DMD was nominated for inclusion in the RUSP by the Parent Project Muscular Dystrophy[39] and the Muscular Dystrophy Association.[40] The process began in February 2023, but a pause in the review process was requested by the nominators after the Advisory Committee determined there

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[31] *Id*.
[32] Cleveland Clinic, *Genetic Counseling*, *available at* https://my.clevelandclinic.org/health/articles/23086-genetic-counseling (last visited Mar. 22, 2025).
[33] *Supra* note 19.
[34] Birnkrant, D. J., Bushby, K., Bann, C. M., Apkon, S. D., Blackwell, A., Brumbaugh, D., Case, L. E., Clemens, P. R., Hadjiyannakis, S., Pandya, S., Street, N., Tomezsko, J., Wagner, K. R., Ward, L. M., Weber, D. R., & DMD Care Considerations Working Group (2018), *Diagnosis and management of Duchenne muscular dystrophy, part 1: diagnosis, and neuromuscular, rehabilitation, endocrine, and gastrointestinal and nutritional management*, The Lancet, Neurology, 17(3), 251–267, *available at* https://doi.org/10.1016/S1474-4422(18)30024-3 (last visited Mar. 22, 2025).
[35] Parent Project Muscular Dystrophy, *Newborn Screening Action Center*, *available at* https://www.parentprojectmd.org/advocacy/newborn-screening-action-center/ (last visited Mar. 22, 2025).
[36] Thomas, S., Conway, K. M., Fapo, O., Street, N., Mathews, K. D., Mann, J. R., Romitti, P. A., Soim, A., Westfield, C., Fox, D. J., Ciafaloni, E., & Muscular Dystrophy Surveillance, Tracking, and Research Network (MD STARnet) (2022), *Time to diagnosis of Duchenne muscular dystrophy remains unchanged: Findings from the Muscular Dystrophy Surveillance, Tracking, and Research Network*, 2000-2015, Muscle & nerve, 66(2), 193–197, *available at* https://doi.org/10.1002/mus.27532 (last visited Mar. 22, 2025).
[37] *Supra* note 35.
[38] *Supra* note 34.
[39] Parent Project Muscular Dystrophy, *available at* https://www.parentprojectmd.org/ (last visited Mar. 22, 2025).
[40] Muscular Dystrophy Association, *available at* https://www.mda.org/ (last visited Mar. 2, 2025).

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

III. Effect of Proposed Changes:

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

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

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

[42] *Supra* note 34.

B. Private Sector Impact:

None.

C. Government Sector Impact:

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

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 383.14 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

[43] *Supra* note 10.

By Senator Harrell

31-00466-25 2025524__

A bill to be entitled

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

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

Section 1. Paragraph (a) of subsection (2) of section 383.14, Florida Statutes, is amended to read:

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

(2) RULES.—

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

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

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

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

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

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

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 4, 2025

I respectfully request that **Senate Bill #542**, relating to Decreasing Racial and Ethnic Disparities in Mental Health and Substance Abuse Services, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Rosalind Osgood

Senator Rosalind Osgood
Florida Senate, District 32

File signed original with committee office

S-020 (03/2004)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 172
INTRODUCER:	Senators Burton and Passidomo
SUBJECT:	Health Care Practitioner Specialty Titles and Designations
DATE:	March 24, 2025
REVISED:	

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

I. Summary:

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

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

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

To enforce these requirements, the bill authorizes the Department of Health to pursue remedies under s. 456.065, F.S., relating to the unlicensed practice of a health care profession.

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

II. Present Situation:

The Health, Safety, and Welfare of the Public

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

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

Licensure and Regulation of Health Care Practitioners

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

- The Board of Acupuncture, created under ch. 457, F.S.;
- The Board of Medicine, created under ch. 458, F.S.;
- The Board of Osteopathic Medicine, created under ch. 459, F.S.;
- The Board of Chiropractic Medicine, created under ch. 460, F.S.;
- The Board of Podiatric Medicine, created under ch. 461, F.S.;
- Naturopathy, as provided under ch. 462, F.S.;
- The Board of Optometry, created under ch. 463, F.S.;
- The Board of Nursing, created under part I of ch. 464, F.S.;
- Nursing assistants, as provided under part II of ch. 464, F.S.;
- The Board of Pharmacy, created under ch. 465, F.S.;
- The Board of Dentistry, created under ch. 466, F.S.;

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

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

[3] Section 456.001(4), F.S.

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

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

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

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

The boards determine the course of action and any disciplinary action to take against a practitioner under the respective practice act.[6] For professions for which there is no board, the DOH determines the action and discipline to take against a practitioner and issues the final

[4] Department of Health, *Investigative Services*, http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/isu.html (last visited Mar. 24, 2025).
[5] Department of Health, *Prosecution Services*, http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/psu.html (last visited Mar. 24, 2025).
[6] Section 456.072(2), F.S.

orders.[7] The DOH is responsible for ensuring that licensees comply with the terms and penalties imposed by the boards.[8] If a case is appealed, DOH attorneys defend the final actions of the boards before the appropriate appellate court.[9]

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

The Unlicensed Activity Unit

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

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

The Unlicensed Activity Investigation Process

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

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

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[7] Professions which do not have a board include naturopathy, nursing assistants, midwifery, respiratory therapy, dietetics and nutrition, electrolysis, medical physicists, genetic counselors, and school psychologists.
[8] *Supra*, note 5.
[9] *Id.*
[10] The Department of Health, Licensing and Regulation, enforcement, Unlicensed Activity, *Reporting Unlicensed Activity*, available at https://www.floridahealth.gov/licensing-and-regulation/enforcement/report-unlicensed-activity/index.html (last visited Mar. 24, 2025).

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

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

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

Under s. 456.065, F.S., investigations involving the unlicensed practice of a health care profession are criminal investigations that require the development of sufficient evidence (probable cause) to present to law enforcement or file charges with the State Attorney's Office in the county of occurrence. While ULA investigators are non-sworn, many have law enforcement experience gained from prior careers as police officers and detectives. ULA investigators work cooperatively with many law enforcement agencies in joint investigations that are either initiated by the DOH or the agency concerned.[11]

Health Care Specialties and Florida Licensure

The DOH does not license health care practitioners by specialty or subspecialty. A health care practitioner's specialty area of practice is acquired through the practitioner's additional education, training, or experience in a particular area of health care practice. Practitioners who have acquired additional education, training, or experience in a particular area may also elect to become board-certified in that specialty by private, national specialty boards, such as the American Board of Medical Specialties (ABMS), the Accreditation Board for Specialty Nursing Certification, and the American Board of Dental Specialties.[12] Board certification is not required to practice a medical or osteopathic specialty.

Title Prohibitions Under Current Florida Law

Current law limits which health care practitioners may hold themselves out as board-certified specialists. Under s. 458.3312, F.S., an allopathic physician may not hold himself or herself out as a board-certified specialist unless he or she has received formal recognition as a specialist

[11] The Department of Health, Licensing and Regulation, enforcement, Unlicensed Activity, *Investigate Complaints*, available at https://www.floridahealth.gov/licensing-and-regulation/enforcement/report-unlicensed-activity/investigate-complaints.html (last visited Mar. 24, 2025).

[12] Examples of specialties include dermatology, emergency medicine, ophthalmology, pediatric medicine, certified registered nurse anesthetist, clinical nurse specialist, cardiac nurse, nurse practitioner, endodontics, orthodontics, and pediatric dentistry.

from a specialty board of the ABMS or other recognizing agency[13] approved by the BOM.[14] Similarly, under s. 459.0152, F.S., an osteopathic physician may not hold himself or herself out as a board-certified specialist unless he or she has successfully completed the requirements for certification by the American Osteopathic Association (AOA) or the Accreditation Council on Graduate Medical Education (ACGME) and is certified as a specialist by a certifying agency[15] approved by the BOOM.[16] In addition, an allopathic physician may not hold himself or herself out as a board-certified specialist in dermatology unless the recognizing agency, whether authorized in statute or by rule, is triennially reviewed and reauthorized by the BOM.[17] However, a physician licensed under ch. 458 or 459 may indicate the services offered and may state that his or her practice is limited to one or more types of services when this accurately reflects the scope of practice of the physician.[18]

A podiatric physician also may not advertise that he or she is board certified unless the organization is approved by the Board of Podiatric Medicine (BPM) for the purposes of advertising only and the name of the organization is identified in full in the advertisement. In order for an organization to obtain the BPM approval it must be the American Podiatric Medical Association, the National Council of Competency Assurance, or an organization that must:

- Be composed of podiatric physicians interested in a special area of practice demonstrated through successful completion of examinations or case reports;
- Subscribe to a code of ethics;
- Have rules and procedures for maintaining a high level of professional conduct and discipline among its membership;
- Have an active membership of at least seventy-five (75);
- Sponsor annual meeting and courses in Board approved continuing education; and
- Be a national organization in scope and give a certification examination at least once a year before the podiatric physician can advertise possession of the certification.[19]

A dentist may not hold himself or herself out as a specialist, or advertise membership in or specialty recognition by an accrediting organization, unless the dentist has completed a specialty education program approved by the American Dental Association and the Commission on Dental Accreditation and the dentist is:[20]

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[13] The Board of Medicine has approved the specialty boards of the ABMS as recognizing agencies. Fla. Admin. Code. R. 64B8-11.001(1)(f),(2025). The board has also approved the following recognizing agencies: American Board of Facial Plastic & Reconstructive Surgery, Inc., American Board of Pain Medicine, American Association of Physician Specialists, Inc./American Board of Physician Specialties, American Board of Interventional Pain Physicians, American Board of Vascular Medicine, United Council for Neurologic Subspecialties, and American Board of Electrodiagnositic Medicine. Fla.-Admin. Code. R. 64B8-11.001(8),(2025).

[14] Section 458.3312, F.S.

[15] The Board of Osteopathic Medicine has approved the specialty boards of the ABMS and AOA as recognizing agencies. Fla. Admin. Code R. 64B15-14.001(2)(h),(2025). The osteopathic board has also approved the following recognizing agencies: American Association of Physician Specialists, Inc., and American Board of Interventional Pain Physicians. Fla.-Admin. Code R. 64B15-14.001(5),(2025).

[16] Section 459.0152, F.S.

[17] *Id.*

[18] Sections 458.3312 and 459.0152, F.S.

[19] Fla. Admin. Code R. 64B18-14.004 (2025).

[20] Section 466.0282, F.S. A dentist may also hold himself or herself out as a specialist if the dentist has continuously held himself or herself out as a specialist since December 31, 1964, in a specialty recognized by the American Dental Association.

- Eligible for examination by a national specialty board recognized by the American Dental Association; or
- Is a diplomate of a national specialty board recognized by the American Dental Association.

If a dentist announces or advertises a specialty practice for which there is not an approved accrediting organization, the dentist must clearly state that the specialty is not recognized or that the accrediting organization has not been approved by the American Dental Association or the Florida Board of Dentistry.[21]

The Board of Chiropractic Medicine (BCM) permits a chiropractor to advertise that he or she has attained diplomate status in a chiropractic specialty area recognized by the BCM. BCM specialties include those which are recognized by the Councils of the American Chiropractic Association, the International Chiropractic Association, the International Academy of Clinical Neurology, or the International Chiropractic Pediatric Association.[22]

Practitioner Discipline

Section 456.072, F.S., authorizes a regulatory board, or the DOH if there is no board, to discipline a health care practitioner's licensure for a number of offenses, including, but not limited to:

- Making misleading, deceptive, or fraudulent representations in or related to the practice of the licensee's profession; or
- Failing to identify through writing or orally to a patient the type of license under which the practitioner is practicing.

If a board or the DOH finds that a licensee committed a violation of a statute or rule, the board or the DOH may:[23]

- Refuse to certify, or to certify with restrictions, an application for a license;
- Suspend or permanently revoke a license;
- Place a restriction on the licensee's practice or license;
- Impose an administrative fine not to exceed $10,000 for each count or separate offense; if the violation is for fraud or making a false representation, a fine of $10,000 must be imposed for each count or separate offense;
- Issue a reprimand or letter of concern;
- Place the licensee on probation;
- Require a corrective action plan;
- Refund fees billed and collected from the patient or third party on behalf of the patient; or
- Require the licensee to undergo remedial education.

[21] Section 466.0282(3), F.S.
[22] Fla. Admin. Code R. 64B2-15.001(2)(e), (2025). Examples of chiropractic specialties include chiropractic acupuncture, chiropractic internist, chiropractic and clinical nutrition, radiology chiropractic, and pediatric chiropractors.
[23] Section 456.072(2), F.S.

State Versus Federal Practitioner Licensure

The federal government does not license health care practitioners, nor does it regulate practitioner behavior in terms of scope of practice, standards of practice, or practitioner discipline. Instead, the federal government relies on state governments to fulfill those functions.

Conditions of Participation in Federal Health Care Programs

In addition to state licensure requirements, Medicare, Medicaid, and other government reimbursement programs[24] rely on the power of the purse to manage practitioners and facilities in the provision of health care services to persons enrolled in such programs. These programs impose "conditions of participation" and "conditions of payment," which essentially mandate compliance with specified standards. Certification under a federal health care program is a right to participate in government payment systems. It is distinct from licensure by a state government or accreditation by a nationally-recognized board.[25]

Examples of Federal Deference to State Regulatory Authority

For example, under federal labor law found in 29 CFR s. 825.125, the definition of "health care provider" includes, in part, a doctor of medicine or osteopathy who is authorized to practice medicine or surgery *by the state in which the doctor practices*.

That section of federal law goes on to reference other practitioners, including podiatrists, dentists, clinical psychologists, optometrists, chiropractors, nurse practitioners, nurse midwives, clinical social workers, and physician assistants who are *authorized to practice in their state and performing within the scope of their practice as defined under state law*.

Another example is found in federal law creating a workers' compensation program for longshoremen and harbor workers.[26] Under that federal program, for the purpose of establishing who may be paid for providing services to persons enrolled in the program, the term "physician" includes doctors of medicine, surgeons, podiatrists, dentists, clinical psychologists, optometrists, chiropractors, and osteopathic practitioners *within the scope of their practice as defined by state law*.[27]

This federal workers' compensation program that reimburses health care providers as described above will also reimburse for treatment based on prayer or spiritual means alone if provided by an accredited practitioner of a church or religious denomination that is recognized by the federal government in certain ways.[28]

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[24] Such as the federal workers' compensation program for longshoremen and harbor workers found under 20 CFR Subchapter A, available at: https://www.law.cornell.edu/cfr/text/20/chapter-VI/subchapter-A (last visited Mar. 24, 2025).
[25] The Healthcare Law Review: USA, *Spotlight: The Regulation of Healthcare Providers and Professionals in the USA*, Sept. 7, 2020, available at: https://www.lexology.com/library/detail.aspx?g=c3c193d0-753e-4244-914a-fd943e70ec8e (last visited Mar. 24, 2025).
[26] *Supra* note 24.
[27] *See* 20 CFR s. 702.404.
[28] *See* 20 CFR s. 702.401(b).

Federal Distinctions Between Physicians and Other Providers

Other federal programs draw specific distinctions between "physicians" and non-physicians who are included in the "physician" payment provisions above. For example, federal Medicaid law requires that state Medicaid programs "must provide for payment of optometric services as physician services, whether furnished by *an optometrist or a physician*," thereby differentiating between optometrists and physicians instead of classifying them jointly.[29]

These federal laws do not license or regulate such practitioners the way state laws do. They also do not define practitioner credentials, titles, or scopes of practice outside the provisions of state law and regulations that provide for such designations.

Florida Requirements for Billing Medicare Patients

In 1992, the Legislature created s. 456.056, F.S., relating to how Florida-licensed practitioners may bill patients enrolled in Medicare. The sole purpose of this section of statute is to prohibit Florida-based practitioners who participate in Medicare from directly invoicing Medicare patients in excess of the amounts that patients owe, according to Medicare payment methodologies.

Section 456.056, F.S., provides that the term "physician" is defined in a manner consistent with federal law that governs Medicare billing. As the term is used in that section of the Florida Statutes, "physician" means:

- A *physician* licensed under ch. 458, F.S.,
- An osteopathic *physician* licensed under ch. 459, F.S.,
- A chiropractic *physician* licensed under ch. 460, F.S.,
- A podiatric *physician* licensed under ch. 461, F.S., or
- An optometrist licensed under ch. 463, F.S.[30]

This definition of "physician," which was written to apply only to Medicare billing issues, is comparable to Medicare's definition of "physician services" found in 42 CFR Part 414, which is entitled "Payment for Part B Medical and Other Health Services." This portion of Medicare law[31] provides that, for payment purposes, "physician services" includes the following services, to the extent they are covered by Medicare: professional services of doctors of medicine and osteopathy, doctors of optometry, doctors of podiatry, doctors of dental surgery and dental medicine,[32] and chiropractors.

Section 456.056, F.S., goes on to provide that any attempt by a Florida-licensed "physician," as defined above, to collect from a Medicare beneficiary any amount of charges in excess of an

[29] *See* 42 CFR s. 441.30.
[30] *See* s. 456.056(1)(a), F.S.
[31] *See* 42 CFR s. 414.2.
[32] Dentistry is omitted from s. 456.056, F.S., since traditional Medicare does not cover most dental care apart from emergencies or dental services provided in a hospital setting. *See:* https://www.medicare.gov/coverage/dental-services (last visited Mar. 24, 2025).

unmet deductible or the 20 percent of charges that Medicare does not pay, is deemed null, void, and of no merit.[33]

As such, the only purpose of s. 456.056, F.S., is to regulate the dollar amounts that specified practitioners may attempt to collect from their patients as payment for Medicare services, consistent with Medicare's terminology for billing. This Florida statute does not provide authority for any health care practitioner to use certain titles.

"Nurse Anesthesiologist"

On August 8, 2019, at the general Board of Nursing (BON) meeting, the BON considered requests for declaratory statements.[34] The second request for a declaratory statement was made by John P. McDonough, APRN,[35] CRNA,[36] license number 3344982.[37]

For the meeting, McDonough's Petition for Declaratory Statement acknowledged that the type of Florida nursing license he held was as an advanced practice registered nurse (APRN), and that he was a certified registered nurse anesthetist (CRNA), but requested that he be permitted to use the phrase "nurse anesthesiologist" as a descriptor for him or his practice, and that the BON not subject him to discipline under ss. 456.072 and 464.018, F.S.,[38] based on the following grounds:

- A New Hampshire Board of Nursing's Position Statement that the nomenclature, *Nurse Anesthesiologist* and *Certified Registered Nurse Anesthesiologist*, are not title changes or an expansion of scope of practice, but are optional, accurate descriptors;[39] and
- Florida law grants no title protection to the words *anesthesiologist* or *anesthetist*.[40]

The Florida Association of Nurse Anesthetists (FANA) and the Florida Medical Association, Inc. (FMA), Florida Society of Anesthesiologists, Inc. (FSA), and Florida Osteopathic Medical

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[33] *See* s. 456.056(5), F.S.

[34] Section 120.565, F.S. Provides that, "[a]ny substantially affected person may seek a declaratory statement regarding an agency's opinion as to the applicability of a statutory provision as it applies to the petitioner's particular set of circumstances. The agency must give notice of the filing of a petition in the Florida Administrative Register, provide copies of the petition to the board, and issue a declaratory statement or deny the petition within 90 days after the filing. The declaratory statement or denial of the petition is then noticed in the next Florida Administrative Register, and disposition of a petition is a final agency action."

[35] An APRN is an advanced practice registered nurse licensed under ch. 464, F.S.

[36] A CRNA is a certified registered nurse anesthetist, or an APRN who specializes is anesthesia.

[37] The Florida Board of Nursing, Meeting Minutes, Disciplinary Hearings & General Business, *Declaratory Statements*, No. 2, Aug. 8, 2019, *available at* https://floridasnursing.gov/meetings/minutes/2019/08-august/08072019-minutes.pdf p. 28 (last visited Mar. 24, 2025).

[38] *Petition for Declaratory Statement Before the Board of Nursing, In re: John P. McDonough, A.P.R.N., C.R.N.A., Ed.D.*, filed at the Department of Health, July 10, 2019 (on file with the Senate Committee on Health Policy).

[39] New Hampshire Board of Nursing, *Position Statement Regarding the use of Nurse Anesthesiologist as a communication tool and optional descriptor for Certified Registered Nurse Anesthetists (CRNAs)*, Nov. 20, 2018, *available at* https://static1.squarespace.com/static/5bf069ef3e2d09d0f4e0a54f/t/5f6f8a708d2cb23bb10f50a0/1601145457231/NH+BON+NURSE+ANESTHESIOLOGIST.pdf (last visited Mar. 24, 2025).

[40] *Id.*

Association, Inc. (FOMA), filed timely and legally sufficient[41] motions to intervene[42] pursuant to Florida Administrative Code Rule 28-106.205.[43] The FANA's petition[44] was in support of petitioner's Declaratory Statement while the motion filed jointly by the FMA, FSA, and FOMA was in opposition.

The FMA, FSA, and FOMA argued they were entitled to participate in the proceedings, on behalf of their members, as the substantial interests of their members – some 32,300 – could be adversely affected by the proceeding.[45, 46] Specifically, the FMA, FSA, and FOMA argued that the substantial interests of their respective members would be adversely affected by the issuance of a Declaratory Statement that a petitioner could use the term "nurse anesthesiologist," without violating ss. 456.072 and 464.018, F.S., on the grounds that:

- A substantial number of their members use the term "anesthesiologist" with the intent and understanding that patients, and potential patients, would recognize the term to refer to them as physicians licensed under chs. 458 or 459, F.S., not "nurse anesthetists;"
- Sections 458.3475(1)(a) and 459.023(1)(a), F.S., both define the term "anesthesiologist" as a licensed allopathic or osteopathic physician and do not include in those definitions a "nurse anesthetist;"
- The Merriam-Webster Dictionary defines an "anesthesiologist" as a "physician specializing in anesthesiology," not as a nurse specializing in anesthesia; and
- The Legislature clearly intended a distinction between the titles to be used by physicians practicing anesthesiology and nurses delivering anesthesia, to avoid confusion, as s. 464.015(6), F.S., specifically states that:
  - Only persons who hold valid certificates to practice as certified registered nurse anesthetists in this state may use the title "Certified Registered Nurse Anesthetist" and the abbreviations "C.R.N.A." or "nurse anesthetist;" and
  - Petitioner is licensed as a "registered nurse anesthetist" under s. 464.012(1)(a), F.S., and the term "nurse anesthesiologist" is not found in statute.

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[41] Fla. Adm. Code R. 28-105.0027(2) and 28.106.205(2) (2019), both of which state that to be legally sufficient, a motion to intervene in a proceeding on a petition for a declaratory statement must contain the following information: (a) The name, address, the e-mail address, and facsimile number, if any, of the intervenor; if the intervenor is not represented by an attorney or qualified representative;(b) The name, address, e-mail address, telephone number, and any facsimile number of the intervener's attorney or qualified representative, if any; (c) Allegations sufficient to demonstrate that the intervenor is entitled to participate in the proceeding as a matter of constitutional or statutory right or pursuant to agency rule, or *that the substantial interests of the intervenor are subject to determination or will be affected by the declaratory statement;* (d) The signature of the intervener or intervener's attorney or qualified representative; and (e) The date.

[42] The Florida Medical Association, Inc., Florida Society of Anesthesiologists, Inc., and Florida Osteopathic Medical Association, Inc., *Motion to Intervene In Florida Board of Nursing's Consideration of the Petition for Declaratory Statement in Opposition of Petitioner John P. McDonough, A.P.R.N., C.R.N.A., Ed.D.*, filed at the Department of Health, Aug. 1, 2019, (on file with the Senate Health Policy Committee).

[43] Fla. Adm. Code. R. 28-106.205 (2019), in pertinent part, provides, "Persons other than the original parties to a pending proceeding whose substantial interest will be affected by the proceeding and who desire to become parties may move the presiding officer for leave to intervene."

[44] *Florida Association of Nurse Anesthetists Motion to Intervene,* filed at the Department of Health, July 31, 2019, (on file with the Senate Committee on Health Policy).

[45] *Supra* note 43.

[46] *See Florida Home Builders Association, et al., Petitioners, v. Department of Labor And Employment Security, Respondent*, 412 S.2d 351 (Fla. 1982), holding that a trade association does have standing under s. 120.56(1), F.S., to challenge the validity of an agency ruling on behalf of its members when that association fairly represents members who have been substantially affected by the ruling.

At the hearing, the attorney for the BON advised the BON that, "[t]he first thing the Board need[ed] to do [was] determine whether or not the organizations that [had] filed petitions to intervene have standing in order to participate in the discussion of the Declaratory Statement"[47] and that:

> "Basically in order to make a determination of whether an organization has standing, they have to show that the members of their organization would have an actual injury in fact, or suffer an immediate harm of some sort of immediacy were the Board to issue this particular Declaratory Statement, and then the Board also has to make a determination of whether the nature of the injury would be within the zone of interest that the statute is addressing."[48]

However, the above special injury standard,[49] provided by board counsel to the BON to apply to determine the organizations' standing to intervene, based on their members' substantial interests being affected by the declaratory statement, was held inapplicable to trade associations in *Florida Home Builders Ass'n. v. Department of Labor and Employment Security*, 412 So 2d 351 (Fla. 1982). The Florida Supreme Court, in *Florida Home Build*ers, *Ass'n.*, held that a trade or professional association is able to challenge an agency action on behalf of its members, even though each member could individually challenge the agency action, if the organization could demonstrate that:

- A substantial number of the association members, though not necessarily a majority, would be "substantially affected" by the challenged action;
- The subject matter of the challenged action is within the association's scope of interest and activity; and
- The relief requested is appropriate for the association's members.[50]

The FANA's motion to intervene was granted, based on the application of an incorrect standard, without the BON making the findings required by *Florida Home Build*ers, *Ass'n.* The motion to intervene filed by the FMA, FSA, and FOMA was denied, also based on the application of an incorrect standard, on the grounds that:

- Their members are regulated by the Board of Medicine, not the Board of Nursing;
- Nursing disciplinary guidelines were being discussed;
- Their members' licenses and discipline would not be affected by an interpretation of nursing discipline;[51] and
- Their members are not regulated by the Nurse Practice Act.

A motion was made to approve McDonough's Petition for Declaratory Statement, and it passed unanimously. According to the BON's approval, McDonough may now use of the term "nurse anesthesiologist" as a descriptor, and such use is not grounds for discipline against his nursing license. However, while s. 120.565, F.S., provides that any person may seek a declaratory

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[47] Record at p. 3, ll. 13-17. Declaratory Statement, Dr. John P. McDonough, Before the Board of Nurses, State of Florida, Department of Health, Sanibel Harbor Marriott. (on file with the Senate Committee on Health Policy).
[48] *Id.* p. 3-4, ll. 22- 25, 1-6.
[49] *United States Steel Corp. v. Save Sand Key, Inc.*, 303 So.2d 9 (Fla. 1974).
[50] *Florida Home Builders Ass'n. v. Department of Labor and Employment Security*, 412 So.2d 351 (Fla. 1982), pp. 353-354.
[51] Record at p. 7, ll. 1-13. Declaratory Statement, Dr. John P. McDonough, Before the Board of Nurses, State of Florida, Department of Health, Sanibel Harbor Marriott. (on file with the Senate Committee on Health Policy).

statement regarding the potential impact of a statute, rule or agency opinion on a petitioner's particular situation, approval or denial of the petition only applies to the petitioner. It is not a method of obtaining a policy statement from a board of general applicability.[52]

News media have reported that the BON's Declaratory Statement in favor of McDonough has created significant concern for patient safety and the potential for confusion in the use of the moniker "anesthesiologist" among Florida's medical professionals.[53, 54]

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 456.003(2), F.S., regarding Legislative intent for the regulation of health care professions to provide a Legislative finding that the health, safety, and welfare of the public may be harmed or endangered under any of the following conditions:

- By the unlawful practice of a profession;
- By a misleading, deceptive, or fraudulent representation relating to a person's authority to practice a profession lawfully; or
- When patients are uninformed about the profession under which a practitioner is practicing before receiving professional consultation or services from the practitioner.

The bill provides that the Legislature's regulation of health care professions as provided under current law in s. 456.003(2), F.S., is a matter of great public importance.

Section 2 of the bill creates s. 456.65, F.S., to prohibit a health care practitioner not licensed as a physician under ch. 458, F.S., or ch. 459, F.S., from holding himself or herself out to a patient or the general public as a specialist by describing himself or herself or his or her practice through the use of any medical specialist title or designation specifically listed under s. 458.3312(2), F.S., as created in section 3 of the bill, or under s. 459.0152(2), as created in section 4 of the bill, either alone or in combination, or in connection with other words, unless the practitioner is specifically authorized by law to use that medical specialist title or designation.

The bill creates ss. 458.3312(3) and 459.0152(3), F.S., to authorize the BOM and the BOOM to, by rule, create other specialist titles that are subject to the respective prohibitions on physicians licensed under those chapters of statute.

A violation of this prohibition would constitute the unlicensed practice of medicine or osteopathic medicine, as applicable, and DOH may pursue remedies under s. 456.065, F.S., which may include: issuing and delivering a notice to cease and desist (and pursuing an injunction or writ of mandamus if enforcement is needed), issuing an administrative penalty of

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[52] Florida Department of Health, Board of Nursing, *What is a Declaratory Statement?*, *available at* https://floridasnursing.gov/help-center/what-is-a-declaratory-statement/ (last visited Mar. 24, 2025).
[53] Christine Sexton, The News Service of Florida, "*Nursing Board Signs Off On 'Anesthesiologist' Title,"* August 16, 2019, The Gainesville Sun, *available at*: https://www.gainesville.com/news/20190816/nursing-board-signs-off-on-anesthesiologist-title (last visited Mar. 24, 2025).
[54] Christine Sexton, The News Service of Florida, *"Florida Lawmaker Takes Aim At Health Care Titles,*" October 10, 2019, Health News Florida, *available at* https://health.wusf.usf.edu/post/florida-lawmaker-takes-aim-health-care-titles (last visited Mar. 24, 2025).

not less than $500 and not more than $5000 per incident, and seeking the imposition of a civil penalty through the circuit court.

Exceptions

Notwithstanding the prohibition created in this section, the bill provides that a **licensed health care practitioner** may use the name or title of his or her profession that is authorized under his or her practice act, and any corresponding designations or initials so authorized, to describe himself or herself and his or her practice.

Additionally, the bill provides that a **licensed health care practitioner who has a specialty area of practice authorized under his or her practice act** may use the following format to identify himself or herself or describe his or her practice: "...(name or title of the practitioner's profession)..., specializing in ...(name of the practitioner's specialty)...."

A **chiropractic physician** licensed under ch. 460, F.S., is authorized to use the title "chiropractic radiologist" and other titles, abbreviations, or designations authorized under his or her practice act reflecting those chiropractic specialty areas in which the chiropractic physician has attained diplomate status as recognized by the American Chiropractic Association, the International Chiropractors Association, the International Academy of Clinical Neurology, or the International Chiropractic Pediatric Association.

A **podiatric physician** licensed under ch. 461, F.S., may use the following titles and abbreviations as applicable to his or her license, specialty, and certification: "podiatric surgeon," "Fellow in the American College of Foot and Ankle Surgeons," and any other titles or abbreviations authorized under his or her practice act.

A **dentist** licensed under ch. 466, F.S., may use the following titles and abbreviations as applicable to his or her license, specialty, and certification: "doctor of dental surgery," "D.D.S.," "oral surgeon," "maxillofacial surgeon," "oral and maxillofacial surgeon," "O.M.S.," "dental anesthesiologist," "oral pathologist," "oral radiologist," and any other titles or abbreviations authorized under his or her practice act.

An **anesthesiologist assistant** licensed under ch. 458, F.S., or ch. 459, F.S., may use only the titles "anesthesiologist assistant" or "certified anesthesiologist assistant" and the abbreviation "C.A.A."

The bill provides that s. 456.65, F.S., as created by the bill, may not be construed to prohibit or interfere with a licensed practitioner's ability to lawfully bill the Medicare program or other federal health care program using definitions or terminology provided under applicable federal law or regulations for services rendered to a enrolled patients.

Section 3 of the bill amends s. 458.3312, F.S., for allopathic physician specialties and **section 4** of the bill amends s. 459.0152, F.S., for osteopathic physician specialties.

Under current law, an allopathic physician licensed under ch. 458, F.S., may not hold himself or herself out as a board-certified specialist unless the physician has received formal recognition as

a specialist from a specialty board of the American Board of Medical Specialties or other recognizing agency that has been approved by the BOM.

Similarly, an osteopathic physician licensed under ch. 459, F.S., may not hold himself or herself out as a board-certified specialist under current law unless the osteopathic physician has:

- Successfully completed the requirements for certification by the American Osteopathic Association (AOA) or the Accreditation Council on Graduate Medical Education (ACGME); and
- Is certified as a specialist by a certifying agency approved by the BOOM.

In sections 3 and 4, the bill creates a list of medical specialist titles and designations that may be used only by physicians under ch. 458 or ch. 459, F.S., respectively, who have met the above requirements and become board-certified. The BOM and the BOOM are authorized to adopt additional specialist titles and designations by rule that would be reserved for use by board-certified physicians.

The bill reserves the use of the following medical specialist titles and designations for board-certified allopathic and osteopathic physicians:

- Surgeon.
- Neurosurgeon.
- General surgeon.
- Anesthesiologist.
- Cardiologist.
- Dermatologist.
- Endocrinologist.
- Gastroenterologist.
- Gynecologist.
- Hematologist.
- Hospitalist.
- Intensivist.
- Internist.
- Laryngologist.
- Nephrologist.
- Neurologist.
- Obstetrician.
- Oncologist.
- Ophthalmologist.
- Orthopedic surgeon.
- Orthopedist.
- Otologist.
- Otolaryngologist.
- Otorhinolaryngologist.
- Pathologist.
- Pediatrician.
- Proctologist.

- Psychiatrist.
- Radiologist.
- Rheumatologist.
- Rhinologist.
- Urologist.

In conjunction with changes made in section 2 of the bill, a health care practitioner who is not board-certified in those specialties by the BOM or the BOOM may not hold himself or herself out as a board-certified specialist using any of the above titles or designations.

Section 5 of the bill provides an effective date of July 1, 2025.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

To the extent persons violate the bill's provisions, the bill could have a potential workload increase and an increase in costs for the DOH's ULA Unit of an indeterminate amount.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 456.003, 458.3312, and 459.0152.

This bill creates section 456.65 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete lines 55 - 221
and insert:
Section 2. Paragraph (a) of subsection (2) of section 456.065, Florida Statutes, is amended to read:
456.065 Unlicensed practice of a health care profession; intent; cease and desist notice; penalties; enforcement; citations; fees; allocation and disposition of moneys collected.—

(2) The penalties for unlicensed practice of a health care profession shall include the following:

(a)1. When the department has probable cause to believe that any person not licensed by the department, or the appropriate regulatory board within the department, has violated any provision of this chapter or any statute that relates to the practice of a profession regulated by the department, or any rule adopted pursuant thereto, the department may issue and deliver to such person a notice to cease and desist from such violation.

2. When the department has probable cause to believe that any licensed health care practitioner has engaged in the unlicensed practice of a health care profession by violating s. 456.65, the department may issue and deliver to such health care practitioner a notice to cease and desist from such violation and may pursue other remedies authorized under this section which apply to the unlicensed practice of a health care profession.

3. In addition to the remedies under subparagraphs 1. and 2., the department may issue and deliver a notice to cease and desist to any person who aids and abets the unlicensed practice of a profession by employing the ~~such unlicensed~~ person engaging in the unlicensed practice.

4. The issuance of a notice to cease and desist shall not constitute agency action for which a hearing under ss. 120.569 and 120.57 may be sought. For the purpose of enforcing a cease and desist order, the department may file a proceeding in the name of the state seeking issuance of an injunction or a writ of mandamus against any person who violates any provisions of such

order.

Section 3. Section 456.65, Florida Statutes, is created to read:

456.65 Specialties.—

(1)(a) A health care practitioner not licensed as a physician under chapter 458 may not hold himself or herself out to a patient or the public at large as a specialist by describing himself or herself or his or her practice through the use of any specialist title or designation specifically listed under s. 458.3312(2), either alone or in combination, or in connection with other words, unless the practitioner is authorized to use such specialist title or designation under subsection (3).

(b) A health care practitioner not licensed as a physician under chapter 459 may not hold himself or herself out to a patient or the public at large as a specialist by describing himself or herself or his or her practice through the use of any specialist title or designation specifically listed under s. 459.0152(2), either alone or in combination, or in connection with other words, unless the practitioner is authorized to use such specialist title or designation under subsection (3).

(2) A violation of subsection (1) constitutes the unlicensed practice of medicine or osteopathic medicine, as applicable, and the department may pursue remedies under s. 456.065 for such violation.

(3) Notwithstanding subsection (1):

(a) A licensed health care practitioner may use the name or title of his or her profession which is authorized under his or her practice act, and any corresponding designations or initials

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so authorized, to describe himself or herself and his or her practice.

(b) A licensed health care practitioner who has a specialty area of practice authorized under his or her practice act may use the following format to identify himself or herself or describe his or her practice: "...(name or title of the practitioner's profession)..., specializing in ...(name of the practitioner's specialty)...."

(c) A chiropractic physician licensed under chapter 460 may use the title "chiropractic radiologist" and other titles, abbreviations, or designations authorized under his or her practice act reflecting those chiropractic specialty areas in which the chiropractic physician has attained diplomate status as recognized by the American Chiropractic Association, the International Chiropractors Association, the International Academy of Clinical Neurology, or the International Chiropractic Pediatric Association.

(d) A podiatric physician licensed under chapter 461 may use the following titles and abbreviations as applicable to his or her license, specialty, and certification: "podiatric surgeon," "Fellow in the American College of Foot and Ankle Surgeons," and any other titles or abbreviations authorized under his or her practice act.

(e) A dentist licensed under chapter 466 may use the following titles and abbreviations as applicable to his or her license, specialty, and certification: "doctor of dental surgery," "D.D.S.," "oral surgeon," "maxillofacial surgeon," "oral and maxillofacial surgeon," "O.M.S.," "dental anesthesiologist," "oral pathologist," "oral radiologist," and

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any other titles or abbreviations authorized under his or her practice act.

(f) An anesthesiologist assistant licensed under chapter 458 or chapter 459 may use the titles "anesthesiologist assistant" or "certified anesthesiologist assistant" and the abbreviations "A.A." or "C.A.A.," as applicable.

(g) A physician licensed under chapter 458 or chapter 459 may use a specialist title or designation according to s. 458.3312 or s. 459.0152, as applicable.

Section 4. Section 458.3312, Florida Statutes, is amended to read:

458.3312 Specialties.—

(1) A physician licensed under this chapter may not hold himself or herself out as a board-certified specialist unless the physician has received formal recognition as a specialist from a specialty board of the American Board of Medical Specialties or other recognizing agency that has been approved by the board. However, a physician may indicate the services offered and may state that his or her practice is limited to one or more types of services when this accurately reflects the scope of practice of the physician.

(2) Specialist titles and designations to which subsection (1) applies include:

(a) Surgeon.

(b) Neurosurgeon.

(c) General surgeon.

(d) Plastic surgeon.

(e) Thoracic surgeon.

(f) Allergist.

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(g) Anesthesiologist.
(h) Cardiologist.
(i) Dermatologist.
(j) Endocrinologist.
(k) Gastroenterologist.
(l) Geriatrician.
(m) Gynecologist.
(n) Hematologist.
(o) Hospitalist.
(p) Immunologist.
(q) Intensivist.
(r) Internist.
(s) Laryngologist.
(t) Nephrologist.
(u) Neurologist.
(v) Neurotologist.
(w) Obstetrician.
(x) Oncologist.
(y) Ophthalmologist.
(z) Orthopedic surgeon.
(aa) Orthopedist.
(bb) Otologist.
(cc) Otolaryngologist.
(dd) Otorhinolaryngologist.
(ee) Pathologist.
(ff) Pediatrician.
(gg) Proctologist.
(hh) Psychiatrist.
(ii) Pulmonologist.

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(jj) Radiologist.

(kk) Rheumatologist.

(ll) Rhinologist.

(mm) Urologist.

(3) The board may adopt by rule additional specialist titles and designations to which subsection (1) applies.

Section 5. Section 459.0152, Florida Statutes, is amended to read:

459.0152 Specialties.—

(1) An osteopathic physician licensed under this chapter may not hold himself or herself out as a board-certified specialist unless the osteopathic physician has successfully completed the requirements for certification by the American Osteopathic Association or the Accreditation Council on Graduate Medical Education and is certified as a specialist by a certifying agency approved by the board. However, an osteopathic physician may indicate the services offered and may state that his or her practice is limited to one or more types of services when this accurately reflects the scope of practice of the osteopathic physician.

(2) Specialist titles and designations to which subsection (1) applies include:

(a) Surgeon.

(b) Neurosurgeon.

(c) General surgeon.

(d) Plastic surgeon.

(e) Thoracic surgeon.

(f) Allergist.

(g) Anesthesiologist.

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(h) Cardiologist.
(i) Dermatologist.
(j) Endocrinologist.
(k) Gastroenterologist.
(l) Geriatrician.
(m) Gynecologist.
(n) Hematologist.
(o) Hospitalist.
(p) Immunologist.
(q) Intensivist.
(r) Internist.
(s) Laryngologist.
(t) Nephrologist.
(u) Neurologist.
(v) Neurotologist.
(w) Obstetrician.
(x) Oncologist.
(y) Ophthalmologist.
(z) Orthopedic surgeon.
(aa) Orthopedist.
(bb) Otologist.
(cc) Otolaryngologist.
(dd) Otorhinolaryngologist.
(ee) Pathologist.
(ff) Pediatrician.
(gg) Proctologist.
(hh) Psychiatrist.
(ii) Pulmonologist.
(jj) Radiologist.

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(kk) Rheumatologist.

(ll) Rhinologist.

(mm) Urologist.

(3) The board may adopt by rule additional specialist titles and designations to which subsection (1) applies.

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

And the title is amended as follows:

Delete lines 4 - 20

and insert:

revising legislative findings; amending s. 456.065, F.S.; providing circumstances under which the Department of Health may issue a notice to cease and desist and pursue other remedies upon finding probable cause; creating s. 456.65, F.S.; prohibiting the use of specified titles and designations by health care practitioners not licensed as physicians or osteopathic physicians, as applicable, with an exception; providing that the use of such titles and designations constitutes the unlicensed practice of medicine or osteopathic medicine, as applicable; authorizing the department to pursue specified remedies for such violations; authorizing health care practitioners to use names and titles, and their corresponding designations and initials, authorized by their respective practice acts; specifying the manner in which health care practitioners may represent their specialty practice areas; specifying titles and abbreviations certain health care practitioners may

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use; amending ss. 458.3312 and

By Senator Burton

12-00972-25 2025172__

A bill to be entitled

An act relating to health care practitioner specialty titles and designations; amending s. 456.003, F.S.; revising legislative findings; creating s. 456.65, F.S.; prohibiting the use of specified titles and designations by health care practitioners not licensed as physicians or osteopathic physicians, as applicable, with an exception; providing that the use of such titles and designations constitutes the unlicensed practice of medicine or osteopathic medicine, as applicable; authorizing the Department of Health to pursue specified remedies for such violations; authorizing health care practitioners to use names and titles, and their corresponding designations and initials, authorized by their respective practice acts; specifying the manner in which health care practitioners may represent their specialty practice areas; specifying titles and abbreviations certain health care practitioners may use; providing construction; amending ss. 458.3312 and 459.0152, F.S.; specifying specialist titles and designations that physicians and osteopathic physicians, respectively, are prohibited from using unless they have received formal recognition by the appropriate recognizing agency for such specialty certifications; authorizing the Board of Medicine and the Board of Osteopathic Medicine, as applicable, to adopt certain rules; providing an effective date.

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

Section 1. Subsection (2) of section 456.003, Florida Statutes, is amended to read:

456.003 Legislative intent; requirements.—

(2) The Legislature further finds ~~believes~~ that such professions must ~~shall~~ be regulated only for the preservation of the health, safety, and welfare of the public under the police powers of the state, and that the health, safety, and welfare of the public may be harmed or endangered by the unlawful practice of a profession; by a misleading, deceptive, or fraudulent representation relating to a person's authority to practice a profession lawfully; or when patients are uninformed about the profession under which a health care practitioner is practicing before receiving professional consultation or services from the practitioner. As a matter of great public importance, such professions must ~~shall~~ be regulated when:

(a) Their unregulated practice can harm or endanger the health, safety, and welfare of the public, and when the potential for such harm is recognizable and clearly outweighs any anticompetitive impact which may result from regulation.

(b) The public is not effectively protected by other means, including, but not limited to, other state statutes, local ordinances, or federal legislation.

(c) Less restrictive means of regulation are not available.

Section 2. Section 456.65, Florida Statutes, is created to read:

456.65 Specialties.—

(1)(a) A health care practitioner not licensed as a

physician under chapter 458 may not hold himself or herself out to a patient or the public at large as a specialist by describing himself or herself or his or her practice through the use of any specialist title or designation specifically listed under s. 458.3312(2), either alone or in combination, or in connection with other words, unless the practitioner is authorized to use such specialist title or designation under subsection (2).

(b) A health care practitioner not licensed as a physician under chapter 459 may not hold himself or herself out to a patient or the public at large as a specialist by describing himself or herself or his or her practice through the use of any specialist title or designation specifically listed under s. 459.0152(2), either alone or in combination, or in connection with other words, unless the practitioner is authorized to use such specialist title or designation under subsection (2).

(c) A violation of paragraph (a) or paragraph (b) constitutes the unlicensed practice of medicine or osteopathic medicine, as applicable, and the department may pursue remedies under s. 456.065 for such violation.

(2) Notwithstanding subsection (1):

(a) A licensed health care practitioner may use the name or title of his or her profession which is authorized under his or her practice act, and any corresponding designations or initials so authorized, to describe himself or herself and his or her practice.

(b) A licensed health care practitioner who has a specialty area of practice authorized under his or her practice act may use the following format to identify himself or herself or

describe his or her practice: "...(name or title of the practitioner's profession)..., specializing in ...(name of the practitioner's specialty)...."

(c) A chiropractic physician licensed under chapter 460 may use the title "chiropractic radiologist" and other titles, abbreviations, or designations authorized under his or her practice act reflecting those chiropractic specialty areas in which the chiropractic physician has attained diplomate status as recognized by the American Chiropractic Association, the International Chiropractors Association, the International Academy of Clinical Neurology, or the International Chiropractic Pediatric Association.

(d) A podiatric physician licensed under chapter 461 may use the following titles and abbreviations as applicable to his or her license, specialty, and certification: "podiatric surgeon," "Fellow in the American College of Foot and Ankle Surgeons," and any other titles or abbreviations authorized under his or her practice act.

(e) A dentist licensed under chapter 466 may use the following titles and abbreviations as applicable to his or her license, specialty, and certification: "doctor of dental surgery," "D.D.S.," "oral surgeon," "maxillofacial surgeon," "oral and maxillofacial surgeon," "O.M.S.," "dental anesthesiologist," "oral pathologist," "oral radiologist," and any other titles or abbreviations authorized under his or her practice act.

(f) An anesthesiologist assistant licensed under chapter 458 or chapter 459 may use only the titles "anesthesiologist assistant" or "certified anesthesiologist assistant" and the

abbreviation "C.A.A."

(3) This section may not be construed to prohibit or interfere with a licensed practitioner's ability to bill lawfully the Medicare program or other federal health care program using definitions or terminology provided under applicable federal law or regulations for services rendered to a patient enrolled in such program.

Section 3. Section 458.3312, Florida Statutes, is amended to read:

458.3312 Specialties.—

(1) A physician licensed under this chapter may not hold himself or herself out as a board-certified specialist unless the physician has received formal recognition as a specialist from a specialty board of the American Board of Medical Specialties or other recognizing agency that has been approved by the board. However, a physician may indicate the services offered and may state that his or her practice is limited to one or more types of services when this accurately reflects the scope of practice of the physician.

(2) Specialist titles and designations that are subject to subsection (1) include:

(a) Surgeon.

(b) Neurosurgeon.

(c) General surgeon.

(d) Anesthesiologist.

(e) Cardiologist.

(f) Dermatologist.

(g) Endocrinologist.

(h) Gastroenterologist.

(i) Gynecologist.

(j) Hematologist.

(k) Hospitalist.

(l) Intensivist.

(m) Internist.

(n) Laryngologist.

(o) Nephrologist.

(p) Neurologist.

(q) Obstetrician.

(r) Oncologist.

(s) Ophthalmologist.

(t) Orthopedic surgeon.

(u) Orthopedist.

(v) Otologist.

(w) Otolaryngologist.

(x) Otorhinolaryngologist.

(y) Pathologist.

(z) Pediatrician.

(aa) Proctologist.

(bb) Psychiatrist.

(cc) Radiologist.

(dd) Rheumatologist.

(ee) Rhinologist.

(ff) Urologist.

(3) The board may adopt by rule additional specialist titles and designations that are subject to subsection (1).

Section 4. Section 459.0152, Florida Statutes, is amended to read:

459.0152 Specialties.—

(1) An osteopathic physician licensed under this chapter may not hold himself or herself out as a board-certified specialist unless the osteopathic physician has successfully completed the requirements for certification by the American Osteopathic Association or the Accreditation Council on Graduate Medical Education and is certified as a specialist by a certifying agency approved by the board. However, an osteopathic physician may indicate the services offered and may state that his or her practice is limited to one or more types of services when this accurately reflects the scope of practice of the osteopathic physician.

(2) Specialist titles and designations that are subject to subsection (1) include:

(a) Surgeon.

(b) Neurosurgeon.

(c) General surgeon.

(d) Anesthesiologist.

(e) Cardiologist.

(f) Dermatologist.

(g) Endocrinologist.

(h) Gastroenterologist.

(i) Gynecologist.

(j) Hematologist.

(k) Hospitalist.

(l) Intensivist.

(m) Internist.

(n) Laryngologist.

(o) Nephrologist.

(p) Neurologist.

(q) Obstetrician.

(r) Oncologist.

(s) Ophthalmologist.

(t) Orthopedic surgeon.

(u) Orthopedist.

(v) Otologist.

(w) Otolaryngologist.

(x) Otorhinolaryngologist.

(y) Pathologist.

(z) Pediatrician.

(aa) Proctologist.

(bb) Psychiatrist.

(cc) Radiologist.

(dd) Rheumatologist.

(ee) Rhinologist.

(ff) Urologist.

(3) The board may adopt by rule additional specialist titles and designations that are subject to subsection (1).

Section 5. This act shall take effect July 1, 2025.

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:	SPB 7028
INTRODUCER:	For consideration by the Health Policy Committee
SUBJECT:	Cancer
DATE:	March 24, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Brown		**Pre-meeting**

I. Summary:

SPB 7028 revises several aspects of the Casey DeSantis Cancer Research Program. The bill adds members to the Cancer Connect Collaborative, creates parameters for the awarding of grants through the Cancer Innovation Fund, and requires an annual report on the results of projects funded through the Cancer Innovation Fund and the performance of parties that receive the grants.

The bill creates the Cancer Connect Collaborative Research Incubator, to be overseen by the Collaborative, to provide funding for a targeted area of cancer research for a five-year period, subject to appropriation. The bill provides parameters for the awarding of funds through the Incubator and requires annual reports.

The bill creates a new cancer research effort by establishing the Bascom Palmer Eye Institute VisionGen Initiative, subject to appropriation, and provides that the purpose of the initiative is to advance genetic and epigenetic research on inherited eye diseases and ocular oncology.

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

II. Present Situation:

Florida Cancer Research Programs

The Legislature funds cancer research in Florida through four main programs: William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program (Bankhead-Coley program), the Casey DeSantis Cancer Research Program (Casey DeSantis Program), Live Like Bella Initiative – Pediatric Cancer Research Program, and the Cancer Innovation Fund. Currently, $200.5 million is appropriated annually for these research programs as follows:[1]

[1] Chapter 2024-231, Laws of Fla. See specific appropriations 456C, 457A, 457C, and 457B, respectively.

- Bankhead-Coley – $10 million Biomedical Trust Fund
- Casey DeSantis Cancer Research Program – $127.5 million ($111.1 General Revenue; $16.4 Trust Fund)
- Live Like Bella Initiative – $3 million Biomedical Trust Fund
- Florida Cancer Innovation Fund – $60 million Biomedical Research Trust Fund

William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program

In 2006, the Legislature created the William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program to advance progress toward cures for cancer through grants awarded through a peer-reviewed, competitive process.[2]

The program provides grants for cancer research to further the search for cures for cancer, by pursuing the following goals:[3]

- Significantly expand cancer research capacity in Florida.
- Improve both research and treatment through greater pediatric and adult participation in clinical trials networks.
- Reduce the impact of cancer on disproportionately impacted individuals.

Currently, the Bankhead-Coley Program is funded at $10 million annually.[4]

The Casey DeSantis Cancer Research Program

In 2014, the Legislature created the Florida Consortium of National Cancer Institute Centers Program, which was renamed as the Casey DeSantis Cancer Research Program in 2022. The Casey DeSantis Program was established to:[5]

- Enhance the quality and competitiveness of cancer care in Florida;
- Further a statewide biomedical research strategy directly responsive to the health needs of Florida's citizens; and
- Capitalize on potential educational opportunities available to students.

The Florida Department of Health (DOH) is required to make payments to cancer centers recognized by the NCI as NCI-designated comprehensive cancer centers, cancer centers, and cancer centers working toward achieving NCI designation.[6]

The NCI designates institutions as:[7]

- Comprehensive Cancer Centers – focused on substantial transdisciplinary research that bridges all cancer-related research areas;
- Cancer Centers – focused on one research area such as clinical, prevention, cancer control or population science research; or

[2] Section 381.922(1), F.S.
[3] Section 381.922(2), F.S.
[4] Chapter 2024-231, Laws of Fla. See specific appropriation 456C.
[5] Section 381.915(2), F.S.
[6] *Id.*
[7] National Cancer Institute, NCI-Designated Cancer Centers, *available at*: https://www.cancer.gov/research/infrastructure/cancer-centers (last visited Mar. 21, 2025).

- Basic Laboratory Cancer Centers – focused on laboratory research and work collaboratively with other institutions.

A participating cancer center's annual allocation of funds is determined by a statutory tier-weighted formula that factors in a cancer center's reportable cancer cases; peer-review costs; and biomedical education and training.[8] The tier designations are weighted based on the participating cancer center's NCI-designation status. The program's three-tier designations are:[9]

- Tier 1: NCI-designated comprehensive cancer centers;
- Tier 2: NCI-designated cancer centers; and
- Tier 3: Cancer centers seeking NCI designation and meeting additional criteria related to their research and biomedical education.

Currently, there are two NCI-designed comprehensive cancer centers and two NCI-designated cancer centers in Florida:[10]

- H. Lee Moffitt Cancer Center – Comprehensive Cancer Center
- Mayo Clinic Cancer Center – Comprehensive Cancer Center
- The University of Florida (UF) Health Shands Cancer Hospital – Cancer Center
- University of Miami (UM) Sylvester Cancer Center – Cancer Center

See chart below for the NCI-designed cancer center funding history of the Casey DeSantis Program:

	FY 20-21	FY 21-22	FY 22-23	FY 23-24	FY 24-25
H. Lee Moffitt	$ 24,911,553	$ 23,313,325	$ 39,368,392	$ 38,060,795	$ 39,620,622
Mayo Clinic	N/A	N/A	N/A	$ 23,314,286	$ 23,314,286
UF Health Shands Cancer Hospital	$ 20,722,858	$ 22,321,087	$ 30,721,560	$ 37,135,352	$ 35,219,873
UM Sylvester Cancer Center	$ 16,594,331	$ 16,595,331	$ 29,910,047	$ 28,989,567	$ 29,345,219
Total	**$ 62,228,742**	**$ 62,229,743**	**$ 99,999,999**	**$ 127,500,000**	**$ 127,500,000**

Starting July 1, 2025, the DOH, in conjunction with participating cancer centers, must provide an annual report to the Cancer Control and Research Advisory Council (CCRAB) by July 1. The report must include the following:[11]

- An analysis of trending age-adjusted cancer mortality rates in the state by age group, geographic region, and type of cancer.
- Identification of trends in overall federal funding, broken down by institutional source, for cancer-related research in the state.

[8] Section 381.915(3), F.S.
[9] Section 381.915(4), F.S.
[10] National Cancer Institute, NCI-Designated Cancer Centers, "Find a Cancer Centers" directory, *available at*: https://www.cancer.gov/research/infrastructure/cancer-centers/find (last visited Mar. 21, 2025).
[11] Section 381.915(10), F.S. Prior to 2025, the report was required once every three years.

- A list and narrative description of collaborative grants and interinstitutional collaboration among participating cancer centers, a comparison of collaborative grants in proportion to the grant totals for each cancer center, a catalog of retreats and progress seed grants using state funds, and targets for collaboration in the future and reports on progress regarding such targets where appropriate.

Live Like Bella Initiative – Pediatric Cancer Research

The Live Like Bella Pediatric Cancer Research Initiative was established to advance progress toward curing pediatric cancer through grants awarded through a peer-reviewed, competitive process.[12] The Initiative will provide grants for research to further the search for cures for pediatric cancer, by pursuing the following goals to:[13]

- Significantly expand pediatric cancer research capacity in Florida.
- Improve both research and treatment through greater pediatric enrollment in clinical trial networks.
- Reduce the impact of pediatric cancer on disproportionately impacted individuals.

Currently, the Live Like Bella Initiative is funded with $3 million annually.[14]

Florida Cancer Innovation Fund

The Florida Cancer Innovation Fund was established in Fiscal Year 2023-2024 to fund projects focused on innovative research in cancer care and treatment. The funding aims to provide opportunities to break down longstanding silos between researchers, cancer facilities, and medical providers to improve cancer research and treatment through innovative approaches to data infrastructure and best practices.[15] Funding is limited to Florida-based institutions.

The projects funded through Cancer Innovation Fund grant awards are required to focus on at least one of three goal areas below:[16]

- Data – to identify the reasons data is slow to move or hard to access and ways to dismantle those barriers.
- Best Practices – to streamline, encourage, and incentivize the sharing of treatment best practices among public and private entities.
- Innovation – to make advancements in cutting-edge technology and clinical treatments.

Currently, the Cancer Innovation Fund is appropriated $60 million annually.[17]

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[12] Section 381.922(2), F.S.
[13] Department of Health, Biomedical Research Program Funding Announcement, Fiscal Year 2023-2024, *available at*: https://www.floridahealth.gov/provider-and-partner-resources/research/funding-opportunity-announcements/BRACFOAApprovedFINAL.pdf (last visited Mar. 21, 2025).
[14] Chapter 2024-231, Laws of Fla. See specific appropriations 457C.
[15] Department of Health, Funding Opportunity Announcement, The Florida Cancer Innovation Fund, *available at* https://www.floridahealth.gov/provider-and-partner-resources/research/florida-cancer-innovation-fund/index.html (last visited Mar. 21, 2025).
[16] *Id.*
[17] Chapter 2024-231, Laws of Fla. See specific appropriation 457B.

Florida Cancer Control and Research Advisory Council (CCRAB)

The Florida Cancer Control Research Advisory Council was established by the Legislature as an advisory body appointed to function on a continuing basis for the study of cancer and to make recommendations on solutions and policy alternatives to the Board of Governors and the State Surgeon General.[18] The CCRAB closely monitors Florida's cancer burden and recommends changes in policies, systems, and environments that lead to improved prevention, early detection, high-quality treatment, and increased cancer serval rates.[19]

The Council consists of 16 members:[20]

- The State Surgeon General or his or her designee within the DOH;
- A representative of the H. Lee Moffitt Cancer Center and Research Institute, Inc.;
- A representative of the Sylvester Comprehensive Cancer Center of the University of Miami;
- A representative of the University of Florida Shands Cancer Center;
- A representative of the Mayo Clinic in Jacksonville;
- A representative of the American Cancer Society;
- A representative of the Association of Community Cancer Centers;
- A member of the Florida Hospital Association who specializes in the field of oncology;
- A member of the Florida Medical Association who specializes in the field of oncology;
- A representative of the Florida Nurses Association who specializes in the field of oncology;
- A representative of the Florida Osteopathic Medical Association who specializes in the field of oncology;
- A specialist in pediatric oncology research or clinical care appointed by the Governor;
- A specialist in oncology clinical care or research appointed by the President of the Senate;
- A current or former cancer patient or a current or former caregiver to a cancer patient appointed by the Speaker of the House of Representatives;
- A member of the House of Representatives appointed by the Speaker of the House of Representatives; and
- A member of the Senate appointed by the President of the Senate.

CCRAB members serve four-year terms.[21]

Florida Cancer Connect Collaborative

Established in 2023, the Florida Cancer Connect Collaborative[22] (Collaborative) is an initiative begun by First Lady Casey DeSantis in partnership with the DOH and the Agency for Health Care Administration. It was created by executive action of the Governor. The Collaborative originated as a team composed of medical professionals and government officials to analyze

[18] Section 1004.435, F.S.
[19] Florida Cancer Control and Research Advisory Council, CCRAB Annual Report 2024, The State of Cancer in Florida, *available at*: https://www.ccrab.org/_cache/files/c/3/c388cd5a-94e1-4342-b946-d21f872724cc/72B5F6981BBF2571E5C3B73AF0DC1169.2024ccrab-annualreport-final.pdf (last visited Mar. 21, 2025).
[20] Section 1004.435(4), F.S.
[21] Section 1004.435(4), F.S.
[22] The Cancer Connect Collaborative is an expansion of Cancer Connect, an initiative launched by First Lady Casey DeSantis in August 2022 to provide cancer information and survivor stories.

Florida's approach to combatting cancer. The original goal of the Collaborative was to break down long-standing silos between researchers, cancer facilities, and medical providers to improve cancer research and treatment. When first created, according to the Governor and First Lady, the Collaborative had five main objectives:[23]

- Data – The Collaborative will seek to identify the reasons data is slow to move or hard to access and dismantle those barriers.
- Best practices – The Collaborative will seek to streamline, encourage and incentivize the sharing of treatment best practices among public and private entities so that everyone is treated with the most effective treatment possible.
- Innovation – The Collaborative will identify the reasons that technology gets held up — whether it be special interests, over-litigiousness or bureaucratic red tape — and recommend ways to eliminate these barriers.
- Funding – The Collaborative will provide recommendations for the implementation of the Governor's proposed $170 million in funding to improve the pace of cancer research and novel technologies.
- Honesty – The Collaborative will be tasked with identifying the ways to ensure cancer causes, treatment, prevention, and diagnosis information is available and easy to access.

In 2024, the Legislature codified the Collaborative in Florida law through an amendment to s. 381.915, F.S.,[24] which houses statutes relating to the Casey DeSantis Program. The 2024 law revised the mission of the Casey DeSantis Program to include a goal of promoting "the provision of high-quality, innovative health care for persons undergoing cancer treatment in this state" and to "make cancer innovation grant funding available through the Cancer Innovation Fund to health care providers and facilities that demonstrate excellence in patient-centered cancer treatment or research."

The Collaborative is now a council[25] as defined in s. 20.03, F.S., created within the DOH to advise the department and the Legislature on developing a holistic approach to the state's efforts to fund cancer research, cancer facilities, and treatments for cancer patients. The Collaborative is authorized to make recommendations on proposed legislation, proposed rules, best practices, data collection and reporting, issuance of grant funds, and other proposals for state policy relating to cancer research or treatment.

The Collaborative is chaired by the State Surgeon General who serves as an ex officio, non-voting member. The remaining membership of the Collaborative is composed as follows, all of whom are voting members:

- Two members appointed by the Governor, one member appointed by the President of the Senate, and one member appointed by the Speaker of the House of Representatives, prioritizing their appointments on members who have the following experience or expertise:

[23] Florida Governor Ron DeSantis, First Lady Casey DeSantis Announces the Cancer Connect Collaborative to Explore Innovative Strategies for Cancer Treatment and Care, *available at*: https://www.flgov.com/2023/02/23/first-lady-casey-DeSantis-announces-the-cancer-connect-collaborative-to-explore-innovative-strategies-for-cancer-treatment-and-care/ (last visited Mar. 21, 2025).

[24] *See* ch. 2024-247, Laws of Florida.

[25] Section 20.03, F.S., defines a "council" or an "advisory council" as an advisory body created by specific statutory enactment and appointed to function on a continuing basis for the study of the problems arising in a specified functional or program area of state government and to provide recommendations and policy alternatives.

  - The practice of a health care profession specializing in oncology clinical care or research;
  - The development of preventive and therapeutic treatments to control cancer;
  - The development of innovative research into the causes of cancer, the development of effective treatments for persons with cancer, or cures for cancer; or
  - Management-level experience with a cancer center licensed under ch. 395, F.S.
- A Florida resident who can represent the interests of cancer patients in this state, appointed by the Governor.

Members of the Collaborative have staggered terms, and vacancies are to be filled in the same manner as first appointed. Members serve without compensation but are entitled to reimbursement for per diem and travel expenses pursuant to s. 112.061, F.S.

The Collaborative meets as necessary, but at least quarterly, at the call of the chair. A majority of the members of the Collaborative constitute a quorum, and a meeting may not be held with less than a quorum present. To establish a quorum, the Collaborative may conduct its meetings through teleconference or other electronic means. The DOH is required to provide reasonable and necessary support staff and materials to assist the Collaborative in the performance of its duties.

The Collaborative was required in 2024 to develop a long-range comprehensive plan for the Casey DeSantis Program and solicit input from cancer centers, research institutions, biomedical education institutions, hospitals, and medical providers. The long-range plan was required to be submitted to the President of the Senate, the Speaker of the House of Representatives, and the Executive Office of the Governor no later than December 1, 2024,[26] to include, but not be limited to, the following components:

- Expansion of grant funding opportunities to include a broader pool of Florida-based cancer centers, research institutions, biomedical education institutions, hospitals, and medical providers to receive funding through the Cancer Innovation Fund.
- An evaluation to determine metrics that focus on patient outcomes, quality of care, and efficacy of treatment.
- A compilation of best practices relating to cancer research or treatment.

The Collaborative must advise the DOH on the awarding of grants issued through the Cancer Innovation Fund. During any fiscal year for which funds are appropriated, the Collaborative must recommend to the DOH the awarding of grants to support innovative cancer research and treatment models, including emerging research and treatment trends and promising treatments that may serve as catalysts for further research and treatments. The Collaborative is directed to give priority to applications seeking to expand the reach of innovative cancer treatment models into underserved areas of the state. The Collaborative must review all grant applications and make grant funding recommendations to the DOH, and the DOH is directed under the bill to make final grant allocation awards.

[26] The long-range plan was completed and submitted as required by statute. It is *available at*: https://www.floridahealth.gov/provider-and-partner-resources/research/index1.html (last visited Mar. 21, 2025).

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 381.915, F.S., to make several revisions to the Casey DeSantis Program.

Definitions

The bill revises the definition of "Florida-based" to specify that in order for health care providers and facilities to meet the definition, such an entity must be physically located in Florida and provide services in Florida.

The Collaborative

The bill provides that the President of the Senate and the Speaker of the House of Representatives each have three appointments to the membership of the Collaborative, instead of one apiece as under current law. This results in the Governor and the Legislature's presiding officers each having three appointments.

The bill deletes the obsolete requirement for the Collaborative to develop and submit a long-range comprehensive plan for the Casey DeSantis Program by December 1, 2024.

Cancer Innovation Fund

The bill creates parameters for the awarding of grants through the Cancer Innovation Fund, including:

- A new criterion for applications that will get priority during the Collaborative's review of proposals for grant funding. The new priority criterion will be applications having the goal to expand the reach of cancer screening efforts into underserved areas.
- A list of criteria that grant applicants must meet in order to be eligible. Under the bill, an eligible applicant must:
  - Operate as a licensed hospital that has a minimum of 30 percent of current cancer patients that reside in rural or underserved areas;
  - Operate as a licensed health care clinic or facility that employs or contracts with at least one Florida-licensed allopathic or osteopathic physician who is board-certified in oncology and that delivers chemotherapy treatments for cancer;
  - Operate as a licensed facility that employs or contracts with at least one Florida-licensed allopathic or osteopathic physician who is board-certified in oncology and that delivers radiation therapy treatments for cancer;
  - Operate as a licensed health care clinic or facility that provides cancer screening services at no cost or a minimal cost to patients;
  - Operate as a rural hospital as defined in s. 395.602(2)(b), F.S.;
  - Operate as a critical access hospital as defined in s. 408.07(14), F.S.;
  - Operate as a specialty hospital as defined in s. 395.002(28)(a), F.S., that provides cancer treatment for patients from birth to 18 years old;
  - Engage in biomedical research intended to develop therapies, medical pharmaceuticals, treatment protocols, or medical procedures intended to cure cancer or improve the quality of life of cancer patients; or

  - Educate or train students, post-doctoral fellows, or licensed or certified health care practitioners in the screening, diagnosis, or treatment of cancer.
- A requirement that, for ensuring all proposals are appropriate and are evaluated fairly on the basis of scientific merit, the DOH must appoint peer review panels of independent, scientifically qualified individuals to review the scientific merit of each proposal and establish a priority score. The priority scores must be forwarded to the Collaborative and must be considered in determining which proposals the Collaborative recommends for grant funding. The bill requires members of the Collaborative and the panels to establish and follow rigorous guidelines for ethical conduct and adhere to a strict policy regarding conflicts of interest.
- A requirement for the Collaborative to prepare a report for the Governor, President of the Senate, and Speaker of the House of Representatives by December 1 each year, starting in 2025, that identifies and evaluates performance and the effects of grants issued through the Cancer Innovation Fund on cancer treatment, research, screening, diagnosis, prevention, practitioner and workforce education, and survivorship. The report must include the following:
  - Amounts of grant funds awarded to each awardee.
  - Descriptions of each awardee's research or project that includes, but need not be limited to: goals or projected outcomes, population to be served, and research methods or project implementation plan.
  - An assessment of awardees of grant funds that evaluates performance toward achieving objectives specified in their grant funds applications.
  - Recommendations for best practices that may be implemented by health care providers in this state that diagnose, treat, and screen for cancer, based on the outcomes of projects funded through the Cancer Innovation Fund.

Annual Report to the CCRAB

For the report that the DOH, in conjunction with participating NCI-designated cancer centers, must provide to the CCRAB by July 1 each year, the bill requires the report to include a description of the numbers and types of cancer cases seen annually at each participating cancer center.

The Cancer Connect Collaborative Research Incubator

The bill provides Legislative findings and creates the Cancer Connect Collaborative Research Incubator (Incubator) within the DOH, to be overseen by the Collaborative, to provide funding for a targeted area of cancer research for a five-year period. For the five-year period beginning July 1, 2025, the bill provides that the Incubator's targeted area of cancer research will be pediatric cancer.

Contingent on the appropriation of funds, grants issued through the Incubator will be awarded through a peer-reviewed, competitive process. Emphasis will be given to applicants that focus on improving both research and treatment through greater participation in clinical trials that pertain to the targeted area of cancer research, including:

- Identifying ways to increase enrollment in cancer clinical trials;

- Supporting public and private professional education programs designed to increase the awareness and knowledge about cancer clinical trials;
- Providing tools to cancer patients and community-based oncologists to aid in the identification of cancer clinical trials available in the state; and
- Creating opportunities for the state's academic cancer centers to collaborate with community-based oncologists in cancer clinical trials networks.

Preference for Incubator funding may be given to grant proposals that foster collaborations among institutions, researchers, and community practitioners, to support the advancement of cures through basic or applied research, including clinical trials involving cancer patients and related networks.

The bill provides that applications for Incubator funding may be submitted by any Florida-based specialty hospital as defined in s. 395.002(28)(a), F.S., that provides cancer treatment for patients from birth to 18 years old. All qualified applicants are to have equal access and opportunity to compete for the research funding. Incubator grants will be recommended by the Collaborative and awarded by the DOH on the basis of scientific merit, as determined by a competitively open and peer-reviewed process to ensure objectivity, consistency, and high quality.

To ensure that all proposals for research funding through the Incubator are appropriate and are evaluated fairly on the basis of scientific merit, the DOH is directed by the bill to appoint peer review panels of independent, scientifically qualified individuals to review the scientific merit of each proposal and establish its priority score. The priority scores will be forwarded to the Collaborative and must be considered in determining which proposals the Collaborative recommends for funding.

The Collaborative and the panels are directed by the bill to establish and follow rigorous guidelines for ethical conduct and adhere to a strict policy with regard to conflicts of interest regarding the assessment of Incubator grant applications. A member of the Collaborative or a panel may not participate in any discussion or decision of the Collaborative or a panel with respect to a research proposal by any firm, entity, or agency with which the member is associated as a member of the governing body or as an employee or with which the member has entered into a contractual arrangement.

Each recipient of Incubator grant funds must enter into an allocation agreement with the DOH, and each allocation agreement must include all of the following:

- A line-item budget narrative documenting the annual allocation of funds to a recipient.
- A cap on the annual award of 15 percent for administrative expenses.
- A requirement for the recipient to submit quarterly reports of all expenditures made by the recipient with funds received through the Incubator.
- A provision to allow the department and other state auditing bodies to audit all financial records, supporting documents, statistical records, and any other documents pertinent to the allocation agreement.
- A provision requiring the annual reporting of outcome data and protocols used in achieving those outcomes.

The bill requires that, beginning December 1, 2026, and annually through December 1, 2030, the Collaborative must submit a report to the Governor, President of the Senate, and Speaker of the House of Representatives that evaluates research conducted through the Incubator and provides details on outcomes and findings available through the end of the fiscal year immediately preceding each report.

The bill provides that if the Collaborative decides to recommend that the Incubator be extended beyond its five-year lifespan, the Collaborative is directed to make such recommendation in the report due December 1, 2029, and to include a recommendation for the next targeted area of cancer research. The report due on December 1, 2030, must include:

- Details of all results of the research conducted with Incubator funding that has been completed or the status of research in progress; and
- An evaluation of all research conducted with Incubator funding during the five fiscal years preceding the report.

Section 2 of the bill amends s. 381.922, F.S., to create a new cancer research initiative within the Bankhead-Coley program. The bill establishes the Bascom Palmer Eye Institute VisionGen Initiative and provides that the purpose of the initiative is to advance genetic and epigenetic research on inherited eye diseases and ocular oncology by awarding grants through the peer-reviewed, competitive process statutorily-required under the Bankhead-Coley program. The initiative is subject to the annual appropriation of funds by the Legislature.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The DOH may experience an increased workload under the bill to fulfill its requirement under current law to provide reasonable and necessary support staff and materials to assist the Collaborative in the performance of the Collaborative's duties and to manage additional biomedical research grants.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.915 and 381.922.

IX. Additional Information:

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

None.

B. Amendments:

None.

FOR CONSIDERATION By the Committee on Health Policy

588-02667A-25 20257028pb

A bill to be entitled

An act relating to cancer; amending s. 381.915, F.S.; revising the definitions of the terms "cancer center" and "Florida-based"; defining the term "Cancer Connect Collaborative" or "collaborative"; making clarifying changes; deleting an obsolete date; revising the composition of the collaborative; deleting obsolete provisions; requiring the collaborative to review all submitted Cancer Innovation Fund grant applications using certain parameters; requiring the collaborative to give priority to certain applications; requiring licensed or certified health care providers, facilities, or entities to meet certain criteria to be eligible for specified grant funding; specifying such criteria; requiring the Department of Health to appoint peer review panels for a specified purpose; requiring that priority scores be forwarded to the collaborative and be considered in determining which proposals the collaborative recommends for certain grant funding; requiring the collaborative and peer review panels to establish and follow certain guidelines and adhere to a certain policy; prohibiting a member of the collaborative or a panel from participating in certain discussions or decisions under certain circumstances; requiring, beginning on a specified date and annually thereafter, the collaborative to prepare and submit a specified report to the Governor and the Legislature; requiring that the report include certain information; revising the

requirements for a specified report by the department; requiring, beginning on a specified date, that certain allocation agreements include certain information; providing legislative findings; creating the Cancer Connect Collaborative Research Incubator within the department, and overseen by the collaborative, to provide funding for a specified purpose over a specified timeframe; specifying the incubator's targeted area of cancer research for the first specified timeframe; providing that grants issued through the incubator are contingent upon the appropriation of funds and must be awarded through a specified process; requiring that priority be given to certain applicants; authorizing the prioritization of certain grant proposals; providing that applications for incubator funding may be submitted by specified hospitals; requiring that all qualified applicants have equal access and opportunity to compete for research funding; requiring that incubator grants be recommended by the collaborative and awarded by the department in a certain manner; requiring the department to appoint peer review panels for a specified purpose; requiring that priority scores be forwarded to the collaborative and be considered in determining which proposals the collaborative recommends for funding; requiring the collaborative and peer review panels to establish and follow certain guidelines and adhere to a certain policy; prohibiting a member of the collaborative or a panel from

participating in certain discussions or decisions; requiring recipients of incubator grant funds to enter into an allocation agreement with the department; specifying requirements for such allocation agreements; requiring, beginning on a specified date and annually until a specified date, the collaborative to prepare and submit a specified report to the Governor and the Legislature; requiring the collaborative to make a certain recommendation under certain circumstances; requiring that a specified report include certain information; amending s. 381.922, F.S.; establishing the Bascom Palmer Eye Institute VisionGen Initiative within the William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program; providing the purpose of the initiative; providing that funding for the initiative is subject to annual appropriation; providing an effective date.

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

Section 1. Present paragraphs (c), (d), and (e) of subsection (3) and present subsections (12) and (13) of section 381.915, Florida Statutes, are redesignated as paragraphs (d), (e), and (f) of subsection (3) and subsections (13) and (14), respectively, a new paragraph (c) is added to subsection (3), paragraph (d) is added to subsection (10), a new subsection (12) is added to that section, and paragraph (b) and present paragraph (c) of subsection (3), paragraphs (a), (b), (e), (f), and (h) of subsection (8), and subsections (9) and (11) of that

section are amended, to read:

381.915 Casey DeSantis Cancer Research Program.—

(3) On or before September 15 of each year, the department shall calculate an allocation fraction to be used for distributing funds to participating cancer centers. On or before the final business day of each quarter of the state fiscal year, the department shall distribute to each participating cancer center one-fourth of that cancer center's annual allocation calculated under subsection (6). The allocation fraction for each participating cancer center is based on the cancer center's tier-designated weight under subsection (4) multiplied by each of the following allocation factors based on activities in this state: number of reportable cases, peer-review costs, and biomedical education and training. As used in this section, the term:

(b) "Cancer center" means a comprehensive center with at least one geographic site in the state, a freestanding center located in the state, a center situated within an academic institution, or a Florida-based formal research-based consortium under centralized leadership that has achieved NCI designation ~~or is prepared to achieve NCI designation by June 30, 2024~~.

(c) "Cancer Connect Collaborative" or "collaborative" means the council created under subsection (8).

(d)~~(c)~~ "Florida-based" means that a cancer center's actual or sought designated status is or would be recognized by the NCI as primarily located in Florida and not in another state, or that a health care provider or facility is physically located in Florida and provides services in Florida.

(8) The Cancer Connect Collaborative, a council as defined

in s. 20.03, is created within the department to advise the department and the Legislature on developing a holistic approach to the state's efforts to fund cancer research, cancer facilities, and treatments for cancer patients. The collaborative may make recommendations on proposed legislation, proposed rules, best practices, data collection and reporting, issuance of grant funds, and other proposals for state policy relating to cancer research or treatment.

(a) The Surgeon General shall serve as an ex officio, nonvoting member of the collaborative and shall serve as the chair.

(b) The collaborative shall be composed of the following voting members~~, to be appointed by September 1, 2024~~:

1. Two members appointed by the Governor, three members ~~one member~~ appointed by the President of the Senate, and three members ~~one member~~ appointed by the Speaker of the House of Representatives, based on the criteria of this subparagraph. The appointing officers shall make their appointments prioritizing members who have the following experience or expertise:

a. The practice of a health care profession specializing in oncology clinical care or research;

b. The development of preventive and therapeutic treatments to control cancer;

c. The development of innovative research into the causes of cancer, the development of effective treatments for persons with cancer, or cures for cancer; or

d. Management-level experience with a cancer center licensed under chapter 395.

2. One member who is a resident of this state who can

represent the interests of cancer patients in this state, appointed by the Governor.

(e) Members of the collaborative whose terms have expired may continue to serve until replaced or reappointed, but for no more than 6 months after the expiration of their terms.

(f) Members of the collaborative shall serve without compensation but are entitled to reimbursement for per diem and travel expenses pursuant to s. 112.061.

~~(h) The collaborative shall develop a long-range comprehensive plan for the Casey DeSantis Cancer Research Program. In the development of the plan, the collaborative must solicit input from cancer centers, research institutions, biomedical education institutions, hospitals, and medical providers. The collaborative shall submit the plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than December 1, 2024. The plan must include, but need not be limited to, all of the following components:~~

~~1. Expansion of grant fund opportunities to include a broader pool of Florida-based cancer centers, research institutions, biomedical education institutions, hospitals, and medical providers to receive funding through the Cancer Innovation Fund.~~

~~2. An evaluation to determine metrics that focus on patient outcomes, quality of care, and efficacy of treatment.~~

~~3. A compilation of best practices relating to cancer research or treatment~~.

(9)(a) The collaborative shall advise the department on the awarding of grants issued through the Cancer Innovation Fund.

During any fiscal year for which funds are appropriated to the fund, the collaborative shall review all submitted grant applications using the parameters provided in paragraph (c) and make recommendations to the department for awarding grants to support innovative cancer research and treatment models, including emerging research and treatment trends and promising treatments that may serve as catalysts for further research and treatments. The department shall make the final grant allocation awards. The collaborative shall give priority to applications seeking to expand the reach of cancer screening efforts and innovative cancer treatment models into underserved areas of this state.

(b) To be eligible for grant funding under this section, a licensed or certified health care provider, facility, or entity must meet at least one of the following criteria:

1. Operates as a licensed hospital that has a minimum of 30 percent of its current cancer patients residing in rural or underserved areas.

2. Operates as a licensed health care clinic or facility that employs or contracts with at least one physician licensed under chapter 458 or chapter 459 who is board certified in oncology and that administers chemotherapy treatments for cancer.

3. Operates as a licensed facility that employs or contracts with at least one physician licensed under chapter 458 or chapter 459 who is board certified in oncology and that administers radiation therapy treatments for cancer.

4. Operates as a licensed health care clinic or facility that provides cancer screening services at no cost or a minimal

cost to patients.

5. Operates as a rural hospital as defined in s. 395.602(2)(b).

6. Operates as a critical access hospital as defined in s. 408.07(14).

7. Operates as a specialty hospital as defined in s. 395.002(28)(a) which provides cancer treatment for patients from birth to 18 years of age.

8. Engages in biomedical research intended to develop therapies, medical pharmaceuticals, treatment protocols, or medical procedures intended to cure cancer or improve the quality of life of cancer patients.

9. Educates or trains students, postdoctoral fellows, or licensed or certified health care practitioners in the screening, diagnosis, or treatment of cancer.

(c) To ensure that all proposals for grant funding issued through the Cancer Innovation Fund are appropriate and are evaluated fairly on the basis of scientific merit, the department shall appoint peer review panels of independent, scientifically qualified individuals to review the scientific merit of each proposal and establish its priority score. The priority scores must be forwarded to the collaborative and must be considered in determining which proposals the collaborative recommends for grant funding through the Cancer Innovation Fund.

(d) The collaborative and the peer review panels shall establish and follow rigorous guidelines for ethical conduct and adhere to a strict policy with regard to conflicts of interest regarding the assessment of Cancer Innovation Fund grant applications. A member of the collaborative or a panel may not

participate in any discussion or decision of the collaborative or a panel with respect to a research proposal by any firm, entity, or agency with which the member is associated as a member of the governing body or as an employee or with which the member has entered into a contractual arrangement.

(e) Beginning December 1, 2025, and annually thereafter, the collaborative shall prepare and submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which identifies and evaluates the performance and the impact of grants issued through the Cancer Innovation Fund on cancer treatment, research, screening, diagnosis, prevention, practitioner training, workforce education, and cancer patient survivorship. The report must include all of the following:

1. Amounts of grant funds awarded to each recipient.

2. Descriptions of each recipient's research or project which include, but need not be limited to, the following:

a. Goals or projected outcomes.

b. Population to be served.

c. Research methods or project implementation plan.

3. An assessment of grant recipients which evaluates their progress toward achieving objectives specified in each recipient's grant application.

4. Recommendations for best practices that may be implemented by health care providers in this state who diagnose, treat, and screen for cancer, based on the outcomes of projects funded through the Cancer Innovation Fund.

(10) Beginning July 1, 2025, and each year thereafter, the department, in conjunction with participating cancer centers,

shall submit a report to the Cancer Control and Research Advisory Council and the collaborative on specific metrics relating to cancer mortality and external funding for cancer-related research in this state. If a cancer center does not endorse this report or produce an equivalent independent report, the cancer center is ineligible to receive program funding for 1 year. The department must submit this annual report, and any equivalent independent reports, to the Governor, the President of the Senate, and the Speaker of the House of Representatives no later than September 15 of each year the report or reports are submitted by the department. The report must include:

(d) A description of the numbers and types of cancer cases treated annually at each participating cancer center, including reportable and nonreportable cases.

(11) Beginning July 1, 2025 ~~2024~~, each allocation agreement issued by the department relating to cancer center payments under paragraph (2)(a) ~~subsection (2)~~ must include all of the following:

(a) A line-item budget narrative documenting the annual allocation of funds to a cancer center.

(b) A cap on the annual award of 15 percent for administrative expenses.

(c) A requirement for the cancer center to submit quarterly reports of all expenditures made by the cancer center with funds received through the Casey DeSantis Cancer Research Program.

(d) A provision to allow the department and other state auditing bodies to audit all financial records, supporting documents, statistical records, and any other documents pertinent to the allocation agreement.

(e) A provision requiring the annual reporting of outcome data and protocols used in achieving those outcomes.

(12)(a) The Legislature finds that targeted areas of cancer research require increased resources and that Florida should become a leader in promoting research opportunities for these targeted areas. Floridians should not have to leave the state to receive the most advanced cancer care and treatment. To meet this need, the Cancer Connect Collaborative Research Incubator, or "incubator" as used in this subsection, is created within the department, to be overseen by the collaborative, to provide funding for a targeted area of cancer research over a 5-year period. For the 5-year period beginning July 1, 2025, the incubator's targeted area of cancer research is pediatric cancer.

(b) Contingent upon the appropriation of funds by the Legislature, grants issued through the incubator must be awarded through a peer-reviewed, competitive process. Priority must be given to applicants that focus on enhancing both research and treatment by increasing participation in clinical trials related to the targeted area of cancer research, including all of the following:

1. Identifying strategies to increase enrollment in cancer clinical trials.

2. Supporting public and private professional education programs to raise awareness and knowledge about cancer clinical trials.

3. Providing tools for cancer patients and community-based oncologists to help identify available cancer clinical trials in this state.

4. Creating opportunities for the state's academic cancer centers to collaborate with community-based oncologists in cancer clinical trial networks.

(c) Priority may be given to grant proposals that foster collaborations among institutions, researchers, and community practitioners to support the advancement of cures through basic or applied research, including clinical trials involving cancer patients and related networks.

(d) Applications for incubator funding may be submitted by any Florida-based specialty hospital as defined in s. 395.002(28)(a) which provides cancer treatment for patients from birth to 18 years of age. All qualified applicants must have equal access and opportunity to compete for research funding. Incubator grants must be recommended by the collaborative and awarded by the department on the basis of scientific merit, as determined by a competitively open and peer-reviewed process to ensure objectivity, consistency, and high quality.

(e) To ensure that all proposals for research funding are appropriate and are evaluated fairly on the basis of scientific merit, the department shall appoint peer review panels of independent, scientifically qualified individuals to review the scientific merit of each proposal and establish its priority score. The priority scores must be forwarded to the collaborative and must be considered in determining which proposals the collaborative recommends for funding.

(f) The collaborative and the peer review panels shall establish and follow rigorous guidelines for ethical conduct and adhere to a strict policy with regard to conflicts of interest regarding the assessment of incubator grant applications. A

member of the collaborative or a panel may not participate in any discussion or decision of the collaborative or a panel regarding a research proposal from any firm, entity, or agency with which the member is associated as a governing body member, as an employee, or through a contractual arrangement.

(g) Each recipient of incubator grant funds must enter into an allocation agreement with the department. Each such allocation agreement must include all of the following:

1. A line-item budget narrative documenting the annual allocation of funds to a recipient.

2. A cap on the annual award of 15 percent for administrative expenses.

3. A requirement for the recipient to submit quarterly reports of all expenditures made by the recipient with funds received through the incubator.

4. A provision to allow the department and other state auditing bodies to audit all financial records, supporting documents, statistical records, and any other documents pertinent to the allocation agreement.

5. A provision requiring the annual reporting of outcome data and protocols used in achieving those outcomes.

(h) Beginning December 1, 2026, and annually through December 1, 2030, the collaborative shall prepare and submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives which evaluates research conducted through the incubator and provides details on outcomes and findings available through the end of the fiscal year immediately preceding each report. If the collaborative recommends that the incubator be extended beyond its 5-year

lifespan, the collaborative shall make such recommendation in the report due December 1, 2029, and shall include a recommendation for the next targeted area of cancer research. The report due on December 1, 2030, must include all of the following:

1. Details of all results of the research conducted with incubator funding which has been completed or the status of research in progress.

2. An evaluation of all research conducted with incubator funding during the 5 fiscal years preceding the report.

Section 2. Paragraph (d) is added to subsection (2) of section 381.922, Florida Statutes, to read:

381.922 William G. "Bill" Bankhead, Jr., and David Coley Cancer Research Program.—

(2) The program shall provide grants for cancer research to further the search for cures for cancer.

(d) There is established within the program the Bascom Palmer Eye Institute VisionGen Initiative. The purpose of the initiative is to advance genetic and epigenetic research on inherited eye diseases and ocular oncology by awarding grants through the peer-reviewed, competitive process established under subsection (3). Funding for the initiative is subject to the annual appropriation of funds by the Legislature.

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

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1842
INTRODUCER:	Senator Burton
SUBJECT:	Out-of-network Providers
DATE:	March 24, 2025
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Morgan	Brown	HP	**Pre-meeting**
2.			AHS	
3.			FP	

I. Summary:

SB 1842 amends s. 456.0575, F.S., to require a health care practitioner to notify a patient in writing upon referring the patient to a nonparticipating provider for nonemergency services, or to a provider that is not under contract with the patient's health maintenance organization (HMO), or risk disciplinary action.

The bill also amends s. 627.6471, F.S., to require, under certain circumstances, any insurer issuing a policy of health insurance in the state of Florida to apply the payment for a service provided to an insured by a nonpreferred provider toward the insured's deductible and out-of-pocket maximum as if the service had been provided by a preferred provider.

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

II. Present Situation:

Insurer

Under s. 627.6471(1)(a), F.S., an "insurer" means:

- Every person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuity; or
- A multiple-employer welfare arrangement.[1]

[1] The term "multiple-employer welfare arrangement" means an employee welfare benefit plan or any other arrangement which is established or maintained for the purpose of offering or providing health insurance benefits or any other benefits described in s. 624.33, other than life insurance benefits, to the employees of two or more employers, or to their beneficiaries; *see* s. 624.437(1), F.S.

Health Insurance

Under s. 624.603, F.S., "health insurance" is insurance of human beings against bodily injury, disablement, or death by accident or accidental means, or the expense thereof, or against disablement or expense resulting from sickness, and every insurance appertaining thereto. Health insurance does not include workers' compensation coverages, except as provided in s. 624.406(4), F.S.

Health Maintenance Organization

Under s. 641.19(12), F.S., a "health maintenance organization" (HMO) is any organization authorized under part I of ch. 641, F.S., which:

- Provides, through arrangements with other persons, emergency care; inpatient hospital services; physician care including care provided by physicians licensed under chs. 458, 459, 460, and 461, F.S.;[2] ambulatory diagnostic treatment; and preventive health care services.
- Provides, either directly or through arrangements with other persons, health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis.
- Provides, either directly or through arrangements with other persons, comprehensive health care services which subscribers[3] are entitled to receive pursuant to a contract.
- Provides physician services, by physicians licensed under chs. 458, 459, 460, and 461, F.S.,[4] directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians.
- If offering services through a managed care system, has a system in which a primary physician licensed under chs. 458, 459, 460, or 461, F.S.,[5] is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating the health care of the subscriber of the requested service and for referring the subscriber to other providers of the same discipline when necessary. Each female subscriber may select as her primary physician an obstetrician/gynecologist who has agreed to serve as a primary physician and is in the HMO's provider network.

Participating vs. Nonparticipating Providers

Generally, medical health insurance plans and HMOs have a list of physicians, hospitals, and other practitioners or providers[6] that have agreed to participate in the plan's network. Providers participating in the network have a contract with the health plan to care for its members at a certain cost. A member of the plan will typically pay less for medical services when using

[2] Chapter 458, F.S., is the practice act for medical doctors, a.k.a. allopathic physicians. Chapter 459, F.S., is the practice act for osteopathic physicians. Chapter 460, F.S., is the practice act for chiropractic physicians. Chapter 461, F.S., is the practice act for podiatric physicians.

[3] "Subscriber" means an entity or individual who has contracted, or on whose behalf a contract has been entered into, with an HMO for health care coverage or other persons who also receive health care coverage as a result of the contract; *see* s. 641.19(18), F.S.

[4] *Supra* note 2.

[5] *Id.*

[6] "Provider" means any physician, hospital, or other institution, organization, or person that furnishes health care services and is licensed or otherwise authorized to practice in the state; *see* s. 641.47(14), F.S.

participating providers. If a plan member sees a practitioner or uses a hospital or other facility that does not participate with the health plan, the member is going out-of-network and will usually have to pay more for services rendered by a nonparticipating provider. Some plans will not cover any amount of out-of-network care, while others cover a percentage of care.[7]

Participating providers[8] have a contract with an insurer that limits the amount of money the provider may charge individuals who are covered under the contracted insurance company. The agreed-upon contract rate includes both the patient and insurer shares and may be based on certain assumptions regarding the volume of patients that will use that provider's services. The portion of the contracted rate a patient pays is determined by his or her insurance policy or HMO subscriber contract.[9]

Nonparticipating providers[10] are those who have not agreed to accept a contracted rate with a patient's insurance company or HMO. If a patient chooses to seek treatment outside of his or her network, insurance companies and HMOs typically increase cost-sharing.[11]

Health Insurance Cost-Sharing

The term "cost-sharing" refers to how health plan costs are shared between insurers and insureds, sometimes called "out-of-pocket" costs when referring to the insured's share of costs for services that a plan covers that the insured must pay out of their own pocket.[12]

Types of Cost-Sharing

Health insurance policies and HMO subscriber contracts may include the following types of cost-sharing:

- Premium Contribution – A health coverage premium is the total amount that must be paid in advance to obtain coverage for a particular level of services. Usually, premiums are billed and paid on a monthly basis.[13] Employers typically require employees to share the cost of the

[7] Medicare.gov, *Health Maintenance Organizations (HMOs), available at* https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/HMO (last visited Mar. 21, 2025).
[8] "Participating provider" means a preferred provider as defined in s. 627.6471 or an exclusive provider as defined in s. 627.6472; *see* s. 627.64194(1)(f), F.S.
[9] Centers for Medicare & Medicaid Services, *No Surprises: Health insurance terms you should know, available at* https://www.cms.gov/files/document/nosurpriseactfactsheet-health-insurance-terms-you-should-know508c.pdf (last visited Mar. 21, 2025).
[10] "Nonparticipating provider" means a provider who is not a preferred provider as defined in s. 627.6471 or a provider who is not an exclusive provider as defined in s. 627.6472. For purposes of covered emergency services under this section, a facility licensed under chapter 395 or an urgent care center defined in s. 395.002 is a nonparticipating provider if the facility has not contracted with an insurer to provide emergency services to its insureds at a specified rate; *see* s. 627.64194(1)(e), F.S.
[11] *Supra* note 9.
[12] *Id.*
[13] Centers for Medicare & Medicaid Services, *Course 2 Health Coverage Basics, available at* https://www.cms.gov/marketplace/technical-assistance-resources/training-materials/health-coverage-basics-training.pdf (last visited Mar. 21, 2025).

plan premium. Employers are free to require employees to cover some or all of the premium cost for dependents, such as a spouse or children.[14]

- Copayments – A copayment or copay is a flat fee paid by the patient at the time of service.[15]
- Coinsurance – Coinsurance is the insured's share of costs of a covered health service, calculated as a percent of the allowed amount for the service. If the plan pays 70 percent of the cost, then the patient pays 30 percent of the cost. If the plan pays 90 percent, then the patient pays 10 percent, and so forth.[16]
- Deductible – The deductible is the amount the insured pays before the plan pays anything. Deductibles generally apply per person per calendar year.[17] Typically, the higher the deductible, the lower the premium. Some plans with particularly high deductibles are known as "high deductible" plans. While these plans may have significantly lower premiums, the insured is usually exposed to higher out-of-pocket costs.[18]
- Out-of-Pocket Maximum – The most that the insured or subscriber could pay during a coverage period (usually one year) for their share of the costs of covered services. After meeting the limit, the plan will usually pay 100 percent of the allowed amount. This limit helps the insured or subscriber plan for health care costs. This limit never includes the premium, balance-billed charges, or health care the plan does not cover. Some plans do not count all copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.[19]

Regulation of Health Insurance and HMOs in Florida

The Florida Office of Insurance Regulation (OIR) licenses and regulates insurers, HMOs, and other risk-bearing entities.[20] To operate in Florida, an insurer or HMO must obtain a certificate of authority from the OIR.[21] The Florida Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Prior to receiving a certificate of authority[22] from the OIR, an HMO must receive a Health Care Provider Certificate from the AHCA. As part of the certification process used by the AHCA, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[23]

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[14] Kaiser Family Foundation, *Employer-Sponsored Health Insurance 101* (May 28, 2024), *available at* https://www.kff.org/health-policy-101-employer-sponsored-health-insurance/?entry=table-of-contents-introduction (last visited Mar. 21, 2025).
[15] *Supra* note 9.
[16] *Id*.
[17] *Id*.
[18] South Carolina Department of Insurance, *Understanding Your Deductible, available at* https://doi.sc.gov/1019/Understanding-Your-Deductible#:~:text=Policies%20with%20lower%20deductibles%20typically,need%20to%20file%20a%20claim. (last visited Mar. 21, 2025).
[19] *Supra* note 9.
[20] Section 20.121(3)(a)1., F.S.
[21] Section 641.21(1), F.S.
[22] Sections 624.401 and 641.49, F.S.
[23] Section 641.495, F.S.

Balance Billing

A provider, regardless of contracted status with an HMO, may not collect or attempt to collect money from an HMO subscriber.[24] The subscriber is not liable for payment of fees to the provider.[25] Balance billing is also prohibited in cases when emergency services are provided by a nonparticipating provider, and when nonemergency services are provided by a nonparticipating provider and the insured or subscriber does not have the ability and opportunity to choose a participating provider at the facility who is available to treat the covered patient.[26]

Florida Regulation of Health Care Practitioners

Health care practitioners[27] are regulated by the Florida Department of Health (DOH) under ch. 456, F.S., and individual practice acts for each profession. Many practitioners are regulated by profession-specific boards or councils of members of the profession appointed by the Governor and administered by the DOH; however, some health care practitioners are regulated directly by the DOH without a board or council.[28]

Chapter 456, F.S., and individual practice acts delineate standards of licensure and practice, and the boards, or the DOH if there is no board, enforce violations under the Administrative Procedure Act. Boards and the DOH may issue a reprimand or letter of concern, assess fines, suspend or restrict licenses, or revoke licenses, among other penalties, based on the nature of the violation.[29]

Florida Price Transparency: Health Care Facilities

Under s. 395.301, F.S., a health care facility[30] must provide, within seven days of a written request, a good faith estimate (GFE) of reasonably anticipated charges for the facility to treat the patient's condition. Upon request, the facility must also provide revisions to the estimate. The estimate may represent the average charges for that diagnosis related group[31] or the average

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[24] Sections 641.315(1), and 641.3154(1) and (4), F.S.
[25] *Id*.
[26] Section 627.64194, F.S.
[27] "Health care practitioner" means any person licensed under chapter 457 (acupuncture); chapter 458 (medical practice); chapter 459 (osteopathic medicine); chapter 460 (chiropractic medicine); chapter 461 (podiatric medicine); chapter 462 (naturopathy); chapter 463 (optometry); chapter 464 (nursing); chapter 465 (pharmacy); chapter 466 (dentistry, dental hygiene, and dental laboratories); chapter 467 (midwifery); part I, part II, part III, part V, part X, part XIII, or part XIV of chapter 468 (speech-language pathology and audiology, nursing home administration, occupational therapy, respiratory therapy, dietetics and nutrition practice, athletic trainers, or orthotics, prosthetics, and pedorthics); chapter 478 (electrolysis); chapter 480 (massage therapy practice); part I, part II, or part III of chapter 483 (clinical laboratory personnel, medical physicists, or genetic counseling); chapter 484 (dispensing of optical devices and hearing aids); chapter 486 (physical therapy practice); chapter 490 (psychological services); or chapter 491 (clinical, counseling, and psychotherapy services); *see* s. 456.001(4), F.S.
[28] Florida Department of Health, *Licensing and Regulation, available at* https://www.floridahealth.gov/licensing-and-regulation/index.html (last visited Mar. 21, 2025).
[29] Section 456.072, F.S.
[30] The term "health care facilities" refers to hospitals and ambulatory surgical centers, which are licensed under part I of ch. 395, F.S.
[31] Diagnosis related groups (DRGs) are a patient classification scheme which provides a means of relating the type of patients a hospital treats (i.e., its case mix) to the costs incurred by the hospital. DRGs allow facilities to categorize patients based on severity of illness, prognosis, treatment difficulty, need for intervention, and resource intensity.

charges for that procedure. The facility is required to place a notice in the reception area that this information is available. A facility that fails to provide the estimate as required may be fined $500 for each instance of the facility's failure to provide the requested information.

Also, pursuant to s. 395.301, F.S., a licensed facility must notify each patient during admission and at discharge of his or her right to receive an itemized bill upon request. If requested, within seven days of discharge or release, the licensed facility must provide an itemized statement, in language comprehensible to an ordinary layperson, detailing the specific nature of charges or expenses incurred by the patient. This initial bill must contain a statement of specific services received and expenses incurred for the items of service, enumerating in detail the constituent components of the services received within each department of the licensed facility and including unit price data on rates charged by the licensed facility. The patient or patient's representative may elect to receive this level of detail in subsequent billings for services.

Current law directs these health care facilities to publish information on their websites detailing the cost of specific health care services and procedures, as well as information on financial assistance that may be available to prospective patients. The facility must disclose to the consumer that these averages and ranges of payments are estimates and that actual charges will be based on the services actually provided.[32]

Florida Health Finder

Under s. 408.05, F.S., the AHCA contracts with a vendor to collect and publish this facility cost information to consumers on an internet site.[33] Hospitals and other facilities post a link to this site – known as Florida Health Finder[34] – to comply with the price transparency requirements. The cost information is searchable, based on descriptive bundles of commonly performed procedures and services. The information must, at a minimum, provide the estimated average payment received and the estimated range of payment from all non-governmental payers for the bundles available at the facility.[35]

Florida law also establishes the right of a patient to request a personalized estimate on the costs of care from health care practitioners who provide services in a licensed hospital facility or ambulatory surgical center.[36]

Centers for Medicare & Medicaid Services, *Design and development of the Diagnosis Related Group (DRG)* (Oct. 2020), *available at* https://www.cms.gov/icd10m/version38-fullcode-cms/fullcode_cms/Design_and_development_of_the_Diagnosis_Related_Group_(DRGs).pdf (last visited Mar. 21, 2025).

[32] Section 395.301, F.S.

[33] Section 408.05(3)(c), F.S.

[34] Florida Agency for Health Care Administration, Health Care Transparency, *FloridaHealthPriceFinder, available at* https://price.healthfinder.fl.gov/#! (last visited Mar. 21, 2025).

[35] *Supra* note 33.

[36] Section 456.0575(2), F.S.

Federal Transparency Requirements

Federal Oversight and Enforcement Relating to Price Transparency Requirements for Hospitals

On November 15, 2019, the federal Centers for Medicare & Medicaid Services (CMS) finalized regulations[37] changing payment policies and rates for services furnished to Medicare beneficiaries in hospital outpatient departments. In doing so, the federal CMS also established new requirements for hospitals to publish standard charges for a wide range of health care services offered by such facilities. Specifically, the regulations require hospitals to make public both a machine-readable file of standard charges, as well as a consumer-friendly presentation of prices for at least 300 "shoppable" health care services or an online price estimator tool. The regulations became effective on January 1, 2021.[38]

The regulations define a "shoppable" service as one that can be scheduled in advance, effectively giving patients the opportunity to select the venue in which to receive the service. This is a more expansive designation of shoppable services than currently exists in Florida law. For each shoppable service, a hospital must disclose several pricing benchmarks to include:[39]

- The gross charge;
- The payer-specific negotiated charge;
- A de-identified minimum negotiated charge;
- A de-identified maximum negotiated charge; and
- The discounted cash price.

This information should provide a patient with both a reasonable estimate of the charge for a shoppable service, and also a range in which the actual charge can be expected to fall. The penalty for facility noncompliance under the federal regulations is a maximum fine of $300 per day.[40]

A 2021 review of more than 3,500 hospitals found that 55 percent of hospitals were not compliant with the rule and had not posted price information for commercial plans or had not posted any prices at all.[41] Nearly 84 percent of hospitals failed to post machine-readable files containing standard charges, and roughly 78 percent of hospitals did not provide a consumer-friendly shoppable services display.[42] Another review of more than 6,400 hospitals in 2022 indicated widespread non-compliance with the federal transparency rule in that more than 63

[37] Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals to Make Standard Charges Public, 84 F.R. 65524 (November 27, 2019) (codified at 45 C.F.R. § 180).
[38] *Id*.
[39] *Id*.
[40] *Id*.
[41] John Xuefeng Jiang, et al., *Factors associated with compliance to the hospital price transparency final rule: A national landscape study, Journal of General Internal Medicine* (2021), *available at* https://link.springer.com/article/10.1007/s11606-021-07237-y (last visited Mar. 21, 2025).
[42] *Id*.

percent of hospitals were estimated to be non-compliant.[43] According to that review, only 38 percent of Florida hospitals were in compliance.[44]

Federal Transparency in Coverage Requirements – Insurers and HMOs

On October 29, 2020, the federal departments of Health and Human Services (HHS), Labor, and Treasury finalized Transparency in Coverage regulations[45] imposing new transparency requirements on issuers of individual and group health insurance plans.

Central to the new regulations is a requirement for insurers and HMOs to provide an estimate of an insured's cost-sharing liability for covered items or services furnished by a particular provider. Under the final rule, health insurers and HMOs must disclose cost-sharing estimates at the request of an enrollee and publicly release negotiated rates for in-network providers, historical out-of-network allowed amounts and billed charges, and drug pricing information. The rule's goal is to enable insured patients to estimate their out-of-pocket costs before receiving health care services, to encourage shopping and price competition among providers.[46]

Transparency in Coverage Final Rules

The Transparency in Coverage Final Rules (TiC Rules) require non-grandfathered group health insurers and HMOs offering non-grandfathered group and individual health insurance coverage to make cost-sharing information available to insureds and subscribers through an Internet-based self-service tool and in paper form, upon request.[47] This information must be made available for plan years (in the individual market, policy years) beginning on or after January 1, 2023, with respect to the 500 items and services identified by the departments[48] in Table 1 of the preamble to the TiC Rules,[49] and with respect to all covered items and services, for plan or policy years beginning on or after January 1, 2024.[50]

The insurer or HMO must make available to an insured or subscriber upon request cost-sharing information for a discrete covered item or service by billing code or descriptive term, and

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[43] Foundation for Government Accountability, *How America's Hospitals Are Hiding the Cost of Health Care* (Aug. 2022), *available at* https://www.TheFGA.org/paper/americas-hospitals-are-hiding-the-cost-of-health-care. (last visited Mar. 21, 2025).
[44] *Id*.
[45] Transparency in Coverage, 85 F.R. 73158 (Nov. 12, 2020) (codified at 29 C.F.R. § 54, 29 C.F.R. § 2590, 45 C.F.R. § 147, and 45 C.F.R. § 158).
[46] Health Affairs Blog, *Trump Administration Finalizes Transparency Rule for Health Insurers* (Nov. 1, 2020), *available at* https://www.healthaffairs.org/do/10.1377/hblog20201101.662872/full/ (last visited Mar. 21, 2025).
[47] 26 C.F.R. § 54.9815-2715A2(b); 29 C.F.R. § 2590.715-2715A2(b); and 45 C.F.R. § 147.211(b). The Consolidated Appropriations Act, 2021 imposed a largely duplicative requirement, and added a requirement that price comparison guidance also be provided by telephone, upon request. *See* also FAQs about Affordable Care Act and Consolidated Appropriations Act, 2021 Implementation Part 49 (Aug. 20, 2021), Q3, *available at* https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-49.pdf, and FAQs about Affordable Care Act Implementation Part 61 (cms.gov) (Sep. 27, 2024) (last visited Mar. 21, 2025).
[48] Department of Treasury, Department of Labor, and Department of Health and Human Services.
[49] 85 F.R. 72158, 72182-90 (Nov. 12, 2020)
[50] 26 C.F.R. § 54.9815-2715A2(c)(1); 29 C.F.R. § 2590.715-2715A2(c)(1); and 45 C.F.R. § 147.211(c)(1).

generally must furnish it according to the insured's or subscriber's request.[51] Further, the TiC Rules require an insurer or subscriber to provide cost-sharing information for a covered item or service in connection with an in-network provider or providers, or an out-of-network allowed amount for a covered item or service provided by an out-of-network provider, according to the insured's or subscriber's request, permitting the individual to specify the information necessary for the insurer or HMO to provide meaningful cost-sharing liability information.[52]

The Federal "No Surprises" Act

On December 27, 2020, Congress enacted the No Surprises Act (Act) as part of the Consolidated Appropriations Act of 2021.[53] The Act includes a wide range of provisions aimed at protecting patients from surprise billing practices and ensuring that patients have access to accurate information about the costs of health care. Most sections of the Act went into effect on January 1, 2022, and the federal departments of HHS, Treasury, and Labor are tasked with issuing regulations and guidance to implement a number of the provisions.[54]

Federal "No Surprises" Act Requirements Relating to Estimates – Facilities

The Act requires a health insurer or HMO to generate an "advanced explanation of benefits" (AEOB) that combines information on charges provided by a hospital facility with patient-specific cost information provided by a policy or contract. The process is triggered when a patient schedules a service at a hospital facility or requests cost information on a specific set of services. A hospital facility must share a GFE of the total expected charges for scheduled items or services, including any expected ancillary services, with a health insurer (if the patient is insured) or individual (if the patient is uninsured).[55]

Federal "No Surprises" Act Requirements of Health Insurers and HMOs

Under the Act, once the GFE has been shared with a patient's health insurer or HMO, then the insurer or HMO must then develop the AEOB. This personalized cost estimate must include the following:[56]

- An indication of whether the facility participates in the patient's insurer's or HMO's network. If the facility is non-participating, information must be included on how the patient can receive services from a participating provider;
- The GFE prepared by the hospital facility based on billing or diagnostic codes;
- A GFE of the amount to be covered by the health insurer or HMO;
- A GFE of the amount of the patient's out-of-pocket costs;
- A GFE of the accrued amounts already met by the patient towards any deductible or out-of-pocket maximum under the patient's policy or contract;

[51] In responding to an insured's or subscriber's request, the group health plan or health insurer may limit the number of providers with respect to which cost-sharing information for covered items and services is provided to no fewer than 20 providers per request. 26 C.F.R. § 54.9815-2715A2(b)(2)(ii); 29 C.F.R. § 2590.715-2715A2(b)(2)(ii); and 45 C.F.R. § 147.211(b)(2)(ii).
[52] 26 C.F.R. § 54.9815-2715A2(b)(1); 29 C.F.R. § 2590.715-2715A2(b)(1); and 45 C.F.R. § 147.211(b)(1).
[53] Public Law 116-260. The No Surprises Act is found in Division BB of the Act.
[54] *Id*.
[55] *Id*.
[56] *Id*.

- A disclaimer indicating whether the services scheduled are subject to medical management techniques (e.g., medical necessity determinations, prior authorization, step therapy, etc.); and
- A disclaimer that the information provided is only an estimate of costs and may be subject to change.

Deferral of Federal Enforcement Related to the GFEs and the AEOBs for Insured Individuals

In October 2021, the decision to defer enforcement of certain requirements described above was made in response to stakeholder requests that standards first be established for the data transfer from providers and facilities to plans and issuers, and give plans, issuers, providers, and facilities enough time to build the infrastructure necessary to support the transfers.

In September 2022, the federal government issued a Request for Information (RFI) relating to the AEOB and the GFE for covered individuals. In the RFI, as noticed in the Federal Register, it was stated that the HHS is deferring enforcement of the requirement that providers and facilities must provide a GFE to plans and issuers for covered individuals enrolled in a health plan or coverage and seeking to have a claim submitted for scheduled (or requested) items or services to their plan or coverage, as well as deferring enforcement of the requirement that plans and issuers must provide these covered individuals with an AEOB.[57]

On April 23, 2024, the federal government provided an update[58] on progress towards AEOB rulemaking and implementation. The update included a summary of comments received in response to the September 2022 RFI. According to the update, various types of health care providers, payers, and third-party vendors were studied to understand technical needs and capabilities, existing claims processes, communications channels, and potential financial and operational constraints. Additionally, the federal government engaged digital service researchers, who recommended a single data exchange standard for the transmission of data between payers and providers and emphasized that current published technical standards may not be sufficient to meet the AEOB requirements. As a result, new standards may need to be developed to ensure successful implementation.[59]

At this time, no further federal guidance has been issued to indicate how long enforcement will be deferred.[60]

III. Effect of Proposed Changes:

Section 1 amends s. 456.0575, F.S., to require a health care practitioner to notify a patient in writing upon referring the patient to a nonparticipating provider for nonemergency services, as those terms are defined, for health insurance, in s. 627.64194(1), F.S., or to a provider, as

[57] 87 F.R. 56905.
[58] Centers for Medicare & Medicaid Services, *Progress Toward Advanced Explanation of Benefits (AEOB) Rulemaking and Implementation, available at* https://www.cms.gov/files/document/progress-aeob-rulemaking-implementation.pdf (last visited Mar. 22, 2025).
[59] NFP, An Aon Company, *FAQ: When must group health plans comply with the CAA 2021 Advanced Explanation of Benefits (AEOB) requirement, available at* https://www.nfp.com/insights/faq-when-must-group-health-plans-comply-with-the-caa-2021-advanced-explanation-of-benefits-aeob-requirement/ (last visited Mar. 22, 2025).
[60] *Id*.

defined, for HMO coverage, in s. 641.47, F.S., that is not under contract with the patient's HMO. The written notice must be documented in the patient's medical record and state that the services will be provided on an out-of-network basis, which may result in additional cost-sharing responsibilities for the patient. Failure to comply, without good cause, will result in disciplinary action against the health care practitioner.

Section 2 amends s. 627.6471, F.S., to require that any insurer issuing a policy of health insurance in the state must apply an insured's payment for a service provided to a person covered under the policy by a nonpreferred provider toward the insured's deductible and out-of-pocket maximum as if the service had been provided by a preferred provider and if all of the following conditions apply:

- The insured requests that the insurer apply the payment for the service provided to the insured by the nonpreferred provider toward the insured's deductible and out-of-pocket maximum.
- The service provided to the insured by the nonpreferred provider is within the scope of services covered under the insured's policy.
- The amount that the nonpreferred provider charged the insured for the service is the same as or less than:
  - The average amount that the insured's preferred provider network charges for the service; or
  - The statewide average amount for the service based on data reported on the Florida Health Finder website.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill requires health care practitioners to notify patients in writing upon referring the patient for nonemergency services to a provider not participating in the patient's health insurance network or to a provider that is not under contract with the patient's HMO. Provision of these notices, as well as looking-up insurer and HMO provider networks, may result in increased workload for health care practitioners.

The bill also requires, under certain circumstances, any insurer issuing a policy of health insurance in the state to apply the payment for a service provided to an insured by a nonpreferred provider toward the insured's deductible and out-of-pocket maximum as if the service had been provided by a preferred provider. This new requirement could result in additional administrative costs to the insurer due to the inclusion of out-of-network patient expenditures in deductible and out-of-pocket maximums. To the extent the bill results in greater patient utilization of nonpreferred providers, the insurer may experience:

- A negative fiscal impact, which could also result in future increases in cost-sharing for the insured.
- An erosion in the insurer's ability to attract providers into its network due to a loss of confidence by providers that policyholders are adequately incentivized to choose network providers, which could lead to a negative fiscal impact for insurers and insureds.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 1 of the bill excludes referrals for emergency services from the bill's requirement that practitioners must provide notification to patients about nonparticipating providers. However, the bill does not appear to exclude emergency service practitioners, such as physicians who provide care in a hospital emergency department, from having to provide such notification when referring patients in emergency care settings for follow-up care. It could be impractical for such emergency service practitioners to spend time checking whether a provider for a patient's follow-up care is an in-network provider as would be required under the bill.

The bill also requires that disciplinary action be taken against a health care practitioner who fails to comply, without good cause, with the bill's requirement for written patient notifications. However, it is unclear what constitutes "good cause" or a "disciplinary action."

Section 2 of the bill could result in greater patient utilization of nonpreferred providers who have not been credentialed[61] by an insurer.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 456.0575 and 627.6471.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

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

None.

B. Amendments:

None.

[61] Provider credentialing (also known as physician credentialing or medical credentialing) is a regulated process of assessing the qualifications of specific types of providers. This important safety check requires providers, such as doctors, dentists, and other allied health care professionals, to show they have the proper education, training and licenses to care for patients. Hospitals and health plans verify the information supplied by the provider before they are included as an in-network or preferred provider. *See* Council for Affordable Quality Healthcare, *Provider Credentialing: Explained, available at* https://www.caqh.org/blog/provider-credentialing-explained (last visited Mar. 21, 2025).

371962

LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Present subsection (2) of section 456.0575, Florida Statutes, is redesignated as subsection (3), and a new subsection (2) is added to that section, to read:

456.0575 Duty to notify patients.—

(2)(a) When providing nonemergency services, as defined in s. 627.64194, to a patient, or upon referring the patient to a

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provider for nonemergency services, a health care practitioner or his or her employee must, at the point of service, confirm whether the referral provider participates in the provider network of the patient's health insurer or health maintenance organization. The practitioner or his or her employee may confirm the referral provider's participation by contacting the referral provider or the patient's health insurer or health maintenance organization, as necessary.

(b) The requirements of paragraph (a) do not apply if the patient declines the practitioner's offer to make the confirmation or declines to share with the referral provider the name and identification number associated with his or her health insurance policy or health maintenance organization contract.

(c) When making any referral, the practitioner must notify a patient in writing that services provided by an out-of-network provider or that are not covered services under the patient's health coverage may result in additional cost-sharing responsibilities for the patient, and such notice must be documented in the patient's medical record.

(d) Failure to comply with this subsection, without good cause, shall result in disciplinary action against the health care practitioner.

(e) The department may adopt rules to implement this subsection.

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

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

And the title is amended as follows:

Delete everything before the enacting clause

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and insert:

A bill to be entitled

An act relating to out-of-network providers; amending s. 456.0575, F.S.; requiring a health care practitioner or his or her employee to confirm whether a referral provider participates in the provider network of the patient's health insurer or health maintenance organization under certain circumstances; authorizing the practitioner or his or her employee to confirm the referral provider's participation in a specified manner; providing applicability; requiring a health care practitioner to notify a patient in writing that certain services are not covered services under the patient's health coverage; requiring that such notice be documented; providing for health care practitioner disciplinary action under certain conditions; authorizing the Department of Health to adopt rules; providing an effective date.

By Senator Burton

12-01057A-25 20251842__

A bill to be entitled

An act relating to out-of-network providers; amending s. 456.0575, F.S.; requiring a health care practitioner to notify a patient in writing upon referring the patient to certain providers; providing requirements for such notice; providing for health care practitioner disciplinary action under certain conditions; amending s. 627.6471, F.S.; requiring certain health insurers to apply payments for services provided by nonpreferred providers toward insureds' deductibles and out-of-pocket maximums if specified conditions are met; providing an effective date.

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

Section 1. Present subsection (2) of section 456.0575, Florida Statutes, is redesignated as subsection (3), and a new subsection (2) is added to that section, to read:

456.0575 Duty to notify patients.—

(2) A health care practitioner shall notify a patient in writing upon referring the patient to a nonparticipating provider for nonemergency services, as those terms are defined in s. 627.64194(1), or to a provider, as defined in s. 641.47, that is not under contract with the patient's health maintenance organization. Such notice must state that the services will be provided on an out-of-network basis, which may result in additional cost-sharing responsibilities for the patient, and such notice must be documented in the patient's medical record. Failure to comply with this subsection, without good cause,

shall result in disciplinary action against the health care practitioner.

Section 2. Present subsection (7) of section 627.6471, Florida Statutes, is redesignated as subsection (8), and a new subsection (7) is added to that section, to read:

627.6471 Contracts for reduced rates of payment; limitations; coinsurance and deductibles.—

(7) Any insurer issuing a policy of health insurance in this state shall apply the payment for a service provided to an insured by a nonpreferred provider toward the insured's deductible and out-of-pocket maximum as if the service had been provided by a preferred provider if all of the following conditions apply:

(a) The insured requests that the insurer apply the payment for the service provided to the insured by the nonpreferred provider toward the insured's deductible and out-of-pocket maximum.

(b) The service provided to the insured by the nonpreferred provider is within the scope of services covered under the insured's policy.

(c) The amount that the nonpreferred provider charged the insured for the service is the same as or less than:

1. The average amount that the insured's preferred provider network charges for the service; or

2. The statewide average amount for the service based on data reported on the Florida Health Finder website.

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