

**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.)

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Prepared By: The Professional Staff of the Committee on Appropriations

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BILL: SB 7012

INTRODUCER: Children, Families, and Elder Affairs Committee

SUBJECT: Mental Health

DATE: February 19, 2020

REVISED: \_\_\_\_\_

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
	<u>Delia</u>	<u>Hendon</u>		<b>CF Submitted as Committee Bill</b>
1.	<u>Sneed</u>	<u>Kidd</u>	<u>AHS</u>	<b>Recommend: Fav/CS</b>
2.	<u>Sneed</u>	<u>Kynoch</u>	<u>AP</u>	<b>Pre-meeting</b>

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**I. Summary:**

SB 7012 implements several measures related to suicide prevention. Specifically, the bill:

- Broadens the scope and duties of the Statewide Office of Suicide Prevention in the Department of Children and Families (DCF);
- Broadens the scope and duties of the Suicide Prevention Coordinating Council and adds five new members to the Council;
- Adds new training and staffing requirements for instructional personnel at public and charter schools;
- Adds new continuing education requirements related to suicide prevention for various health care practitioners;
- Requires certain health insurance plans to comply with federal regulations relating to mental health and substance use disorder coverage to ensure that Floridians that are privately insured have adequate insurance coverage to help prevent suicides;
- Requires Baker Act receiving facilities to provide suicide prevention information resources to minors being released from a facility;
- Provides civil immunity to persons who help or attempt to help others at imminent risk of suicide; and
- Requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to submit a report that looks at other states' suicide prevention programs.

The bill is expected to have a significant fiscal impact on state government. The Office of Suicide Prevention in the DCF will need additional staff to meet workload and information sharing requirements. The Department of Transportation, which is required to develop a plan to implement evidence-based suicide deterrent design elements in infrastructure projects, may incur additional project costs. Additionally, the bill has an indeterminate fiscal impact on local school districts.

The bill takes effect July 1, 2020.

## II. Present Situation:

Suicide is a major public health issue and a leading cause of death nationally,<sup>1</sup> with complex causes such as mental health and substance use disorders, painful losses, exposure to violence, and social isolation.<sup>2</sup> Suicide rates increased in nearly every state from 1999 through 2016.<sup>3</sup> In 2017, suicide was the second leading cause of death nationwide for persons aged 10–14, 15–19, and 20–24.<sup>4</sup> After stable trends from 2000 to 2007, suicide rates for persons aged 10–24 increased 56 percent from 2007 (6.8 per 100,000 persons) to 2017 (10.6 per 100,000 persons).<sup>5</sup>

While suicide is often characterized as a response to a single event or set of circumstances, suicide is the result of complex interactions among neurobiological, genetic, psychological, social, cultural, and environmental risk and protective factors.<sup>6</sup> The factors that contribute to any particular suicide are diverse; therefore, efforts related to suicide prevention must incorporate multiple approaches.<sup>7</sup>

In Florida, the rate of suicides increased by 10.6 percent from 1996 to 2016.<sup>8</sup> According to the 2017 Florida Morbidity Statistics Report, the total number of deaths due to suicide in Florida was 3,187 in 2017, a slight increase from 3,122 in 2016.<sup>9</sup> Suicide was the eighth leading cause of death in Florida, and the suicide rate per 100,000 population was 15.5.<sup>10</sup> This is a slight increase from 2016 (15.4).<sup>11</sup> Suicide was the second leading cause of death for individuals within the 25–34 age group in 2017, similar to the national ranking of 2016, and the third leading cause of death for individuals within 15–24 age group. Suicide was the fourth leading cause of death for individuals within the 5–14, 35–44, and 45–54 age groups.<sup>12</sup>

### Statewide Office for Suicide Prevention

The Statewide Office of Suicide Prevention (Statewide Office), which is housed within the Department of Children and Families (DCF),<sup>13</sup> must coordinate education and training curricula

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<sup>1</sup> Heron M. *Deaths: Leading Causes for 2017*. National Vital Statistics Reports; Vol. 68 No 6. Hyattsville, MD: National Center for Health Statistics. 2019.

<sup>2</sup> Substance Abuse and Mental Health Service Administration, *Suicide Prevention*, available at: <https://www.samhsa.gov/suicide-prevention> (last visited November 7, 2019) and Centers for Dis

<sup>3</sup> Centers for Disease Control and Prevention, *Suicides Rising Across the U.S.* (June 7, 2018), available at: <https://www.cdc.gov/vitalsigns/suicide/index.html> (last visited November 6, 2019).

<sup>4</sup> *Supra* note 1.

<sup>5</sup> Heron M., Curtin, S., *Death Rates Due to Suicide and Homicide Among Persons Aged 10-24: United States, 2007-2017*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention National Center for Health Statistics, available at: <https://www.cdc.gov/nchs/data/databriefs/db352-h.pdf> (last visited November 6, 2019).

<sup>6</sup> *Supra* at note 1.

<sup>7</sup> *Id.*

<sup>8</sup> *Supra* at note 2.

<sup>9</sup> Florida Department of Health, *2017 Florida Morbidity Statistics Report, 2017*, available at [http://www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/disease-reporting-and-surveillance/data-and-publications/\\_documents/2017-annual-morbidity-statistics-report.pdf](http://www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/disease-reporting-and-surveillance/data-and-publications/_documents/2017-annual-morbidity-statistics-report.pdf) (last visited November 8, 2019).

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> Ch. 2011-51, L.O.F.; Section 14.2019, F.S.

in suicide prevention efforts for law enforcement personnel, first responders to emergency calls, health care providers, school employees, and others who may have contact with persons at risk of suicide.<sup>14</sup>

The Statewide Office is allowed to seek and accept grants or funds from federal, state, or local sources to support the operation and defray the authorized expenses of the Statewide Office and the Suicide Prevention Coordinating Council.<sup>15</sup>

### **Suicide Prevention Coordinating Council**

The Suicide Prevention Coordinating Council (Council) is located within the DCF and develops strategies for preventing suicide and advises the Statewide Office regarding the development of a statewide plan for suicide prevention. A report on the plan is prepared and presented annually to the Governor, the President of the Senate, and the Speaker of the House of Representatives.<sup>16</sup>

The Council is currently comprised of 27 voting members and 1 nonvoting member. Thirteen of the members are appointed by the director of the Statewide Office, four are appointed by the Governor, and ten are state agency directors or their designees.<sup>17</sup>

### **First-Episode Psychosis**

The term “psychosis” is used to describe a condition that affects the mind and generally involves some loss of contact with reality. Psychosis can include hallucinations (seeing, hearing, smelling, tasting, or feeling something that is not real), paranoia, delusions (believing something that is not real even when presented with facts), or disordered thoughts and speech.<sup>18</sup> Psychosis may be caused by medications or alcohol or drug abuse but can also be a symptom of mental illness or a physical condition.<sup>19</sup>

Psychosis affects people from all walks of life. Approximately three out of 100 people will experience psychosis at some time in their lives, often beginning when a person is in their late teens to mid-twenties.<sup>20</sup> Researchers are still learning about how and why psychosis develops, but it is generally thought to be triggered by a combination of genetic predisposition and life stressors during critical stages of brain development.<sup>21</sup> Risk factors that may contribute to the development of psychosis include stressors such as physical illness, substance use, and psychological or physical trauma.<sup>22</sup>

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<sup>14</sup> Section 14.2019, F.S.

<sup>15</sup> *Id.*

<sup>16</sup> Section 14.20195, F.S.

<sup>17</sup> *Id.*

<sup>18</sup> National Institute of Mental Health, *Fact Sheet: First Episode Psychosis*, available at:

<https://www.nimh.nih.gov/health/topics/schizophrenia/raise/fact-sheet-first-episode-psychosis.shtml> (last visited November 7, 2019).

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

<sup>21</sup> National Alliance on Mental Illness, *What is Early and First-Episode Psychosis?* (July 2016), available at:

<https://www.nami.org/NAMI/media/NAMI-Media/Images/FactSheets/What-is-Early-and-First-Episode-Psychosis.pdf> (last visited November 7, 2019).

<sup>22</sup> *Id.*

Early psychosis, known as “first-episode psychosis,” is the most important time to connect an individual with treatment.<sup>23</sup> Studies have shown that it is common for a person to experience psychotic symptoms for more than a year before ever receiving treatment.<sup>24</sup> Reducing the duration of untreated psychosis is critical to improving a person’s chance of recovery. The most effective treatment for early psychosis is coordinated specialty care, which uses a team-based approach with shared decision-making that focuses on working with individuals to reach their recovery goals.<sup>25</sup>

Programs that provide coordinated specialty care are often called first-episode psychosis (FEP) programs. Studies show that young people who engage in FEP programs have greater improvement in their symptoms, stay in treatment longer, are more likely to stay in school or working, and are more connected socially than those who receive standard mental care.<sup>26</sup>

## **Veterans and Mental Health**

### ***Mental Health among Veterans***

According to the National Center for Post-Traumatic Stress Disorder, between 11 and 20 percent of veterans who served in Operations Iraqi Freedom and Enduring Freedom have Post-Traumatic Stress Disorder (PTSD) in a given year.<sup>27</sup> Additionally, 12 percent of Gulf War Veterans and 15 percent of Vietnam Veterans have PTSD, and up to 30 percent of Vietnam Veterans will have PTSD in their lifetime.<sup>28</sup> Statistics on depression in veterans vary, but it is estimated that between 2 and 10 percent of servicemembers return from active military operations with major depression.<sup>29</sup>

The 2019 National Veteran Suicide Prevention Annual Report published by the United States Department of Veterans Affairs (USDVA) details veteran deaths from suicide from 2005 to 2017.<sup>30</sup> During that time span, veteran suicides increased from 5,787 in 2005 to 6,139 in 2017.<sup>31</sup> The annual number of veteran suicide deaths has exceeded 6,000 every year since 2008,<sup>32</sup> and the annual number of veteran suicide deaths increased by 129 from 2016 to 2017.<sup>33</sup>

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<sup>23</sup> *Id.*

<sup>24</sup> *Supra* note 18.

<sup>25</sup> *Supra* note 21.

<sup>26</sup> *First Episode Psychosis Programs: A Guide to State Expansion*, National Alliance on Mental Illness, p. 4, (Feb. 2017), available at: <https://www.nami.org/getattachment/Extranet/Advocacy/FEP-State-Advocacy-Toolkit/FEP-State-Advocacy-Guide.pdf> (last visited November 7, 2019).

<sup>27</sup> National Center for PTSD, *How Common is PTSD? PTSD and the Military*, available at [https://www.ptsd.va.gov/understand/common/common\\_veterans.asp](https://www.ptsd.va.gov/understand/common/common_veterans.asp) (last visited November 6, 2019).

<sup>28</sup> *Id.*

<sup>29</sup> RAND Center for Military Health Policy Research, *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, at 54 (Terri Tanielian and Lisa H. Jaycox, Eds.) (2008), available at [http://www.rand.org/pubs/monographs/2008/RAND\\_MG720.pdf](http://www.rand.org/pubs/monographs/2008/RAND_MG720.pdf) (last visited November 6, 2019).

<sup>30</sup> U.S. Department of Veterans Affairs, *2019 National Veteran Suicide Prevention Annual Report*, 2019, available at [https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019\\_National\\_Veteran\\_Suicide\\_Prevention\\_Annual\\_Report\\_508.pdf](https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf) (last visited November 6, 2019).

<sup>31</sup> *Id.*

<sup>32</sup> *Id.*

<sup>33</sup> *Id.*

## **Federal Mental Health Parity Laws**

### ***Commercial Plans***

Prior to 1996, health insurance coverage for mental illness was generally not as comprehensive as coverage for medical and surgical benefits. In response, the Mental Health Parity Act<sup>34</sup> (MHPA) was enacted in 1996, which requires parity of medical and surgical benefits with mental health benefits for annual and aggregate lifetime limits of large group plans.

In 2008, Congress passed the Mental Health Parity and Addiction Equity Act<sup>35</sup> (MHPAEA), which generally applies to large group health plans.<sup>36</sup> The MHPAEA expanded parity of coverage to include treatment of substance use disorders, financial requirements, treatment limitations, and in- and out-of-network coverage if a plan provided coverage for mental illness.<sup>37</sup> Like the MHPA, the MHPAEA does not require large group plans to provide benefits for mental health or substance use disorders. The MHPAEA contains a cost exemption, which allows a group health plan to receive a waiver, exempting them from some of the key requirements, if the plan demonstrates that costs increased at least 1 percent because of compliance.<sup>38</sup>

In 2010, the Patient Protection and Affordable Care Act<sup>39</sup> (PPACA) amended the MHPAEA to apply the provisions to individual health insurance coverage. The PPACA mandates that qualified health insurance must provide coverage of 10 essential health benefits,<sup>40</sup> including coverage for mental health and substance use disorders for individual and small group qualified health plans. The final rule, implementing these provisions, generally requires health insurers offering health insurance coverage in the individual and small group markets to comply with the requirements of the MHPAEA regulations in order to satisfy the essential health benefit requirement.<sup>41</sup>

### **The Office of Insurance Regulation**

The Florida Office of Insurance Regulation (OIR) licenses and regulates insurers, health maintenance organizations (HMOs), and other risk-bearing entities.<sup>42</sup> The Agency for Health Care Administration (AHCA) regulates the quality of care provided by HMOs under part III of

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<sup>35</sup> Pub. L. No. 110-343.

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<sup>36</sup> See final regulations available at <http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf> (last viewed November 7, 2019).

<sup>37</sup> 45 CFR ss. 146 and 160.

<sup>38</sup> Plans and issuers that make changes to comply with MHPAEA and incur an increased cost of at least 2 percent in the first year that MHPAEA applies to the plan or coverage or at least 1 percent in any subsequent plan year may claim an exemption from MHPAEA based on their increased cost. If such a cost is incurred, the plan or coverage is exempt from MHPAEA requirements for the plan or policy year following the year the cost was incurred. The plan sponsors or issuers must notify the plan beneficiaries that MHPAEA does not apply to their coverage. These exemptions last 1 year. After that, the plan or coverage is required to comply again; however, if the plan or coverage incurs an increased cost of at least 1 percent in that plan or policy year, the plan or coverage could claim the exemption for the following plan or policy year.

<sup>39</sup> Pub. L. No. 111-148, as amended by Pub. L. No. 111-152.

<sup>40</sup> 45 CFR s. 156.115.

<sup>41</sup> See 45 CFR 147.150 and 156.115 (78 FR 12834, Feb. 25, 2013).

<sup>42</sup> Section 20.121(3)(a), F.S.

ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from AHCA.<sup>43</sup> As part of the certification process used by the agency, 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.<sup>44</sup>

The OIR reviews health insurance policies and contracts for compliance with MHPAEA. The OIR communicates any violations of MHPAEA to the insurer or HMO. If the insurer or HMO fails to correct the issue, the OIR would refer the issue to the appropriate federal regulator as a possible violation of federal law.

### ***Coverage for Mental and Nervous Disorders***

Section 627.668, F.S., requires insurers and HMOs offering group coverage to make available optional coverage for mental and nervous disorders for an appropriate additional premium that would include benefits delineated in this section.

### ***Coverage for Substance Abuse***

Section 627.669, F.S., requires insurers and HMOs offering group coverage to make available optional coverage for substance abuse that would include benefits listed in the section.

### **Continuing Education Requirements for Health Care Practitioners**

Compliance with continuing education (CE) requirements is a condition of renewal of licensure for health care practitioners. Boards, or the Department of Health (DOH) when there is no board, require each licensee to demonstrate competency by completing CEs during each licensure cycle. The number of required CE hours varies by profession. The requirements for CEs may be found in ch. 456, F.S., professional practice acts, administrative rules, or a combination of these references. Failure to comply with CE requirements may result in disciplinary action against the licensee, in accordance with the disciplinary guidelines established by the applicable board, or the DOH if there is no board.

The DOH or boards, when applicable, monitor health care practitioner's compliance with the CE requirements in a manner required by statute. The statutes vary as to the required method to use. For example, the DOH or a board, when applicable, may have to randomly select a licensee to request the submission of CE documentation,<sup>45</sup> require a licensee to submit sworn affidavit or statement attesting that he or she has completed the required CE hours,<sup>46</sup> or perform an audit. Licensees are responsible for maintaining documentation of the CE courses completed.

### **The Good Samaritan Act**

The "Good Samaritan Act," codified in s. 768.13, F.S., provides immunity from civil liability for damages to any person who:

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<sup>43</sup> Section 641.21(1), F.S.

<sup>44</sup> Section 641.495, F.S.

<sup>45</sup> See s. 457.107, F.S.

<sup>46</sup> See ss.458.347(4)(e), 466.0135(6), 466.014, and 466.032(5), F.S.

- Gratuitously and in good faith renders emergency care or treatment either in direct response to declared state emergencies or at the scene of an emergency situation, without objection of the injured victim, if that person acts as an ordinary reasonably prudent person would have acted under the same or similar circumstances.<sup>47</sup>
- Participates in emergency response activities of a community emergency response team if that person acts prudently and within the scope of his or her training.<sup>48</sup>
- Gratuitously and in good faith renders emergency care or treatment to an injured animal at the scene of an emergency if that person acts as an ordinary reasonably prudent person would have acted under the same or similar circumstances.<sup>49</sup>

The Good Samaritan Act, however, does not specifically address immunity from liability for individuals who attempt to render aid to others at risk of dying or attempting to die by suicide. Several states have implemented such measures in their Good Samaritan statutes in order to shield those who make a good faith effort to render aid from civil liability.<sup>50</sup>

### **Suicide Prevention Certified Schools**

Section 1012.583, F.S., requires the Department of Education (DOE), in consultation with the Statewide Office for Suicide Prevention and suicide prevention experts, to develop a list of approved youth suicide awareness and prevention training materials and suicide screening instruments that may be used for training in youth suicide awareness, suicide prevention and suicide screening for school instructional personnel. The approved list of materials:<sup>51</sup>

- Must identify available standardized suicide screening instruments appropriate for use with a school-age population and which have validity and reliability and include information about obtaining instruction in the administration and use of such instruments.
- Must include training on how to identify appropriate mental health services and how to refer youth and their families to those services;
- May include materials currently being used by a school district if such materials meet any criteria established by the department; and
- May include programs that instructional personnel can complete through a self-review of approved youth suicide awareness and prevention materials.

A school is considered a “Suicide Prevention Certified School” if it:

- Has at least two school-based staff members certified or otherwise deemed competent in the use of a DOE-approved suicide screening instrument; and
- Chooses to incorporate 2 hours of the DOE-approved training materials and requires all of its instructional personnel to participate in the training.

Currently, neither public school instructional personnel nor charter school instructional personnel are required to participate in suicide prevention training, or be certified or deemed competent in

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<sup>47</sup> Section 768.13(2)(a), F.S.

<sup>48</sup> Section 768.13(2)(d), F.S.

<sup>49</sup> Section 768.13(3), F.S.

<sup>50</sup> Schiff, Damien, *Samaritans: Good, Bad and Ugly: A Comparative Law Analysis*, 11 Roger Williams Univ. L. Rev. 95 (2005).

<sup>51</sup> Section 1012.583(1), F.S.

the use of a suicide risk screening instrument. Additionally, neither public schools nor charter schools are required to use a suicide risk screening instrument to evaluate a student's suicide risk prior to initiating or requesting to initiate the Baker Act.

### III. Effect of Proposed Changes:

**Section 1** amends s. 14.2019, F.S., adding veterans and service members to the list of stakeholders that comprise the network of community-based programs intended to improve suicide prevention initiatives. The bill also requires the Statewide Office to coordinate education and training curricula in suicide prevention efforts for veterans and service members. The bill requires the Statewide Office to act as a clearinghouse for information and resources related to suicide prevention by disseminating evidence-based practices and by collecting and analyzing data on trends in suicide by various population demographics. The bill requires the Statewide Office to advise the Florida Department of Transportation (DOT) on the implementation of evidence-based suicide deterrents when designing new infrastructure projects.

**Section 2** amends s. 14.20195, F.S., directing the Suicide Prevention Coordinating Council (Council) to make findings and recommendations regarding suicide prevention specifically related to the implementation of evidence-based mental health awareness and assistance training programs and gatekeeper training throughout the state. The bill requires the Council to work with the DCF to advise the public on the locations and availability of local behavioral health providers.

The bill also adds five new voting members to the Council and requires that 18, rather than 13, members be appointed by the director of the Statewide Office. The bill amends the list of organizations appointed by the Statewide Office to include:

- The Florida Behavioral Health Association (the bill eliminates the individual memberships of the Florida Alcohol and Drug Abuse Association and the Florida Council for Community Mental Health because these organizations have merged to form the Florida Behavioral Health Association);
- The Florida Medical Association;
- The Florida Osteopathic Medical Association;
- The Florida Psychiatric Society;
- The Florida Psychological Association;
- Veterans Florida; and
- The Florida Association of Managing Entities.

**Section 3** amends s. 334.044, F.S., requiring the DOT to work with the Statewide Office in developing a plan to consider evidence-based suicide deterrents on all newly planned infrastructure projects throughout the state.

**Section 4** amends s. 394.455, F.S., defining first episode psychosis (FEP) programs as evidence-based programs that use intensive case management, individual or group therapy, supported employment, family education and supports, and appropriate psychotropic medication to treat individuals 14 to 30 years of age who are experiencing early indications of serious mental illness, especially first-episode psychosis.



**Section 5** amends s. 394.4573, F.S., establishing FEP programs as an essential element of a coordinated system of care and requires the DCF to conduct an assessment of the availability of and access to FEP programs in the state, including any gaps in availability or access that may exist. This assessment must be included in the DCF's annual report to the Governor and Legislature on the assessment of behavioral health services in the state. The bill also adds FEP programs to the elements of a coordinated system of care.

**Section 6** amends s. 394.463, F.S., requiring facilities who hold and release Baker Act patients who are minors to provide information regarding the availability of mobile response teams, suicide prevention resources, social supports, and local self-help groups to the patient's guardian upon release.

**Section 7** creates s. 456.0342, F.S., adding suicide prevention to the continuing education (CE) requirements for allopathic physicians, osteopath physicians, and nurses, effective January 1, 2022. Such licensees must complete two hours of CE courses on suicide risk assessment, treatment, and management. The bill requires the respective licensing board for each of the three professions to include the hours required for completion in the total hours of continuing education required by law.

**Section 8** amends s. 627.6675, F.S., requiring health insurers to offer benefits specified in the newly created s. 627.4193, F.S., rather than the benefits specified in s. 627.668 (optional coverage for mental and nervous disorders) and s. 627.669 (optional coverage for substance use impaired persons). The effective date of this section is January 1, 2021.

**Section 9** transfers and amends s. 627.668, F.S., and renumbers it as s. 627.4193, F.S., requiring insurers that issue, deliver, or provide comprehensive major medical individual or group coverage to comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) and provide the benefits or level of benefits needed for the medically necessary care and treatment of mental and nervous disorders, including substance use disorders. The bill also requires both individual and group policies to be provided in a manner no more restrictive than medical and surgical benefits, while nonquantitative treatment limitations cannot be applied more stringently than applicable restrictions in federal law.

The bill requires insurers to submit annual affidavits attesting to compliance with the MHPAEA, and requires the OIR to implement and enforce applicable provisions of the MHPAEA and federal guidance/regulations relating to the MHPAEA. The bill provides rulemaking authority to the Financial Services Commission for implementation. The effective date of this section is January 1, 2021.

**Section 10** repeals s. 627.669, F.S., relating to optional insurance coverage requirements for substance abuse impaired persons. The effective date of this section is January 1, 2021.

**Section 11** amends s. 627.6699, F.S., making health benefit plans that provide coverage to employees of a small employer subject to the newly created s. 627.4193, F.S., to ensure compliance with the MHPAEA. The effective date of this section is January 1, 2021.

**Section 12** amends s. 641.26, F.S., requiring HMOs that issue or deliver comprehensive major medical coverage to submit annual affidavits to the OIR attesting to compliance with the newly created s. 627.4193, F.S., to ensure compliance with the MHPAEA, and provides rulemaking authority for OIR to implement the requirement. The effective date of this section is January 1, 2021.

**Section 13** amends s. 641.31, F.S., requiring all health maintenance contracts that provide comprehensive medical coverage to comply with the provisions of the newly created s. 627.4193, F.S., and provides rulemaking authority for the OIR to implement the requirement. The effective date of this section is January 1, 2021.

**Section 14** creates s. 786.1516, F.S., defining ‘emergency care’ to mean assistance or advice offered to avoid or attempt to mitigate a suicide emergency. The bill defines a ‘suicide emergency’ as an occurrence that reasonably indicates one is at risk of dying of or attempting suicide. The bill provides civil immunity for persons who provide emergency care at or near the scene of a suicide emergency.

**Section 15** amends s. 1002.33, F.S., requiring all charter schools to incorporate 2 hours of suicide prevention training for all instructional personnel by October 1, 2020. The bill also requires all charter schools to have at least 2 school-based staff members certified or otherwise competent in the use of an approved suicide screening instrument and have a policy in place to utilize the instrument to gauge a student’s suicide risk before initiating a Baker Act or requesting the initiation of a Baker Act. The bill requires each charter school to report their compliance with these provisions to the DOE.

**Section 16** amends s. 1012.583, F.S., putting in place the same requirements for public schools as those detailed in Section 15 for charter schools. The bill also eliminates the ‘Suicide Prevention Certified School’ designation in statute.

**Section 17** amends s. 394.495, F.S., to correct cross-references related to child and adolescent mental health systems of care.

**Section 18** amends s. 394.496, F.S., to correct cross-references related to service planning.

**Section 19** amends s. 394.9085, F.S., to correct a cross-reference related to behavioral provider liability.

**Section 20** amends s. 409.972, F.S., to correct a cross-reference related to mandatory and voluntary enrollment in Medicaid.

**Section 21** amends s. 464.012, F.S., to correct a cross-reference related to licensure of advanced registered nurse practitioners, fees, and controlled substance prescribing.

**Section 22** amends s. 744.2007, F.S., to correct a cross-reference related to powers and duties of public guardians.

**Section 23** requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to perform a review of suicide prevention programs in other states and make recommendations on their applicability to Florida. The bill also requires the OPPAGA to submit a report containing the findings and recommendations to the President of the Senate and the Speaker of the House of Representatives by January 1, 2021.

**Section 24** provides an effective date for the bill of July 1, 2020.

**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:

SB 7012 would require large employer group health policies and HMO contracts to provide coverage for mental health and substance use disorders as that coverage would no longer be at the option of the employer. Additionally, certain health care practitioners may be impacted by the bill's continuing education requirement.

Charter schools may be impacted by having to train and/or hire new personnel to meet the suicide prevention training and staffing requirements under the bill. These impacts are indeterminate.

**C. Government Sector Impact:**

According to the DCF, two additional full-time equivalent (FTE) staff positions are needed for the Statewide Office of Suicide Prevention for \$155,386 in recurring costs and \$8,896 in nonrecurring costs. In addition, there will be additional recurring contract costs of \$262,650 to maintain the Network of Care website that provides information on locations and availability of local health care providers.

The bill has an indeterminate fiscal impact on the Department of Transportation to develop a plan relating to evidence-based suicide deterrents in certain locations.

The bill has an indeterminate fiscal impact on public schools and charter schools due to the bill's provisions relating to in-service suicide prevention training requirements.

**VI. Technical Deficiencies:**

None.

**VII. Related Issues:**

None.

**VIII. Statutes Affected:**

This bill substantially amends the following sections of the Florida Statutes: 14.2019, 14.20195, 334.044, 394.455, 394.4573, 394.463, 394.495, 394.496, 394.9085, 409.972, 464.012, 627.6675, 627.6699, 641.26, 641.31, 744.2007, 1002.33, and 1012.583.

This bill creates the following sections of the Florida Statutes: 456.0342, 627.4193, and 786.1516.

This bill repeals the following sections of the Florida Statutes: 627.668 and 627.669.

**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.