Dear Fellow Taxpayer,

Each spring, the elected members of the Florida Legislature return to Tallahassee to perform their roles as the representatives of the people of the Sunshine State. Surrounded by interest groups both large and small, regular citizens and high-powered lobbyists, our senators and representatives propose and debate new laws and attempt to meet the needs of their constituents.

The 2015 Regular Session will be remembered as a unique one, with an unusual ending that has not been seen in Florida in decades. On top of the progress of many bills coming to an abrupt end, the Legislature failed to pass its only required piece of legislation: a budget.

During Session, Florida TaxWatch provides on our website the public a weekly recap of bills related to the issues that we are following, including economic development, health care, criminal and juvenile justice, and education policies and programs.

This publication is a final look at legislation related to telehealth, one of the top issues covered by TaxWatch.

For more information on TaxWatch research on this issue, please visit http://www.floridataxwatch.org/telehealth

Sincerely,

Dominic M. Calabro
President & CEO
Note: Florida TaxWatch has recommended expanding the use of telehealth in Florida by creating a legislative framework in its March 2014 report, “Critical Connections to Care,” and advancing public policy to remain nationally competitive in its November 2014 report, “Time for Telehealth.” In addition, Florida TaxWatch hosted the Telehealth Cornerstone Conference in November 2014 and will be hosting the Second Annual Telehealth Conference in September 2015. This 2015 Florida Legislative Session Wrap-Up Summary was prepared for its members and telehealth partners. If you would like to be included on future telehealth mailings and conference calls, please contact Stephani Meyers at smeyers@floridataxwatch.org.

Telehealth Research Background

The Sunshine State prides itself on being an ideal location to live, work, and play. While Florida, now the nation’s third most populous state, remains competitive across areas such as economic development, business opportunities, cutting-edge research, and arguably leads the nation in tourism, Florida lags behind a majority of states when it comes to addressing the health access needs of its large, rapidly growing, diversely-aged population. In the Sunshine State, where more than 24 percent of the population is estimated to be ages 65 years and older by 2030, geographic and status disparities in health as noted by America’s Health Rankings place Florida in the bottom quintile of all states. Projected health workforce needs further suggest that long-term health planning solutions are needed to ensure a healthy Florida going forward. In the midst of health financing uncertainties, research suggests that telehealth could play a major role in health care delivery. Telehealth can reduce certain health care expenses, with a mere one percent reduction to annual Florida hospital-related charges through less-costly, timely, and appropriate health care via telehealth saving approximately $1 billion or more.

In the time that Florida considered telehealth legislation this session, other states were continuing to advance policy, putting Florida even further behind in comparison. For example, in May 2015, the American Telemedicine Association reported that 35 states and Washington D.C. received higher composite scores than Florida in coverage and reimbursement for telehealth, up from 28 states and Washington D.C. in September 2014.

Telehealth Legislative Background in Florida

After several years of attempted legislation, the business and health industries pushed telehealth as a top priority issue heading into the 2014 Legislative Session, when four telemedicine bills: SB 70, HB 167, HB 751, and SB 1646 were introduced. Although the issue ultimately failed to pass as part of a surviving omnibus health bill package (PCS for CS/HB 7113), it was championed heavily prior to
the start of the 2015 Legislative Session, and did stand a significant chance of being enacted into law, prior to legislative impasse primarily centered on issues that included Medicaid expansion and Low Income Pool (LIP) funding. The bills introduced this session show a movement toward Senate and House consensus for a foundational telehealth law.

Following months of legislator and stakeholder discussions and media push in favor of telehealth legislation, the 2015 Legislative Session saw two telehealth bills actively move through committees of reference: CS/HB 545 and CS/SB 478. Unlike previous session bills, which contemplated a broad spectrum of issues that included reimbursement, mandates, and licensure, the 2015 bills were narrowly crafted to provide a foundational basis for telehealth. CS/HB 545 was not heard in its last committee of reference prior to cessation of House committee meetings, and no additional movement occurred after mid-March. CS/SB 478, while making to the full Senate Appropriations Committee, its last committee of reference, remained unheard and was not revived in the tumultuous last week of the 2015 Legislative Session. Below is a brief summary of where the final bill versions are the same and where they differ, followed by a detailed review of each bill separately, both final and prior versions.

**CS/HB 545 & CS/SB 478 – Highlights of Where Current Bill Versions are the Same**

“Telehealth” – Excludes audio-only, e-mail, and fax, but specifically includes public health and health care administration.

- *Health care provider chapters specifically included as “telehealth providers”:* acupuncture, allopathic and osteopathic medicine, chiropractic medicine, podiatric medicine, optometry, nursing, dentistry, midwifery, speech-language pathology and audiology, occupational therapy, radiology personnel, respiratory therapy, diet and nutrition, athletic trainers, orthotics/prosthetics, electrolysis, massage, clinical laboratory personnel, medical physicists, optical devices/hearing aids, physical therapy, psychology, clinical counseling and psychotherapy, and medical transportation services (emergency medical technicians and paramedics). *Note: PCS to CS/SB 478 was made more expansive by including certified behavior analysts.*

- Standard of care for telehealth is the same as in-person
  - Telehealth patient evaluation sufficient to diagnose and treat without in-person exam or research of patient medical history (Note: who deems sufficient different)
  - Non-physician telehealth provider acting within own scope of practice is not practicing medicine (Note: reference to practice act varies)
• Authorized prescribers can prescribe Schedules II-V; no chronic non-malignant pain except if a physician is treating a hospital inpatient (Note: CS/SB 478 more expansive by including advanced registered nurse practitioners and treatment of hospice patients.)

• Record keeping same as in-person

• Excludes telehealth products from definition of “discount medical plan” under 636.202

CS/HB 545 & PCS to CS/SB 478 – Highlights of Where Final Bill Versions Differ

<table>
<thead>
<tr>
<th>Final Version of CS/HB 545</th>
<th>Final Version (PCS) of CS/SB 478</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creates 456.47</td>
<td>Creates 456.4501</td>
</tr>
<tr>
<td>Provider and patient may be “in any location”</td>
<td>Provider and patient may be “in separate locations”</td>
</tr>
<tr>
<td>Excludes all consultations</td>
<td>Excludes consultations between FL telehealth provider and licensed out-of-state providers when the FL provider maintains responsibility</td>
</tr>
<tr>
<td>Standard of care determines evaluation sufficiency</td>
<td>Provider determines evaluation sufficiency</td>
</tr>
<tr>
<td>Authorized prescribers can prescribe Schedules II-V; no chronic non-malignant pain except if a hospital</td>
<td>Authorized prescribers can prescribe Schedules I-V; no chronic non-malignant pain except if physician or ARNP prescribing for hospital in-patient or hospice</td>
</tr>
<tr>
<td>No eye-specific prohibition.</td>
<td>Eye-specific prohibition: Cannot tele-prescribe optical devices (e.g., contacts, glasses) based only on refractive error shown by computer-controlled device</td>
</tr>
</tbody>
</table>
SB 478

History of CS/SB 478

CS/SB 478, sponsored by the Senate Health Policy Committee and introduced by Chairman Aaron Bean and Senator Arthenia Joyner, covered an array of telehealth policy issues. It underwent a series of language changes, including a Medicaid reference removal, a change of reference from “telemedicine services” to “telehealth,” and additional defining of providers, practice standards, prescribing, eye care, and record-keeping, before being voted favorably with a committee substitute adopted. The final version was similar to the House position in the final CS/HB 545 with exceptions to wording, consultations, breadth of teleprescribing restrictions (ARNPs), and eye care.

CS/SB 478 passed favorably out of Health Policy with committee substitute, underwent a first reading, and then passed favorably Appropriations Subcommittee on Health and Human Services with another committee substitute. At the end of session, it remained unheard in the Senate Appropriations Committee. Senate staff analyses are available.

The following is a history of the bill from originally introduced text to where the bill text currently stands. For a snapshot look at how the final (PCS) version of CS/SB 478 compares with the previous versions of this bill, please see the table on pages 8-9.

Summary of SB 478 as Originally Introduced

SB 478 creates a new section of Chapter 456 (456.4501), defines “telemedicine services,” references certain providers, prescribing, rulemaking, and emergency medical service provisions. The bill defines “telemedicine services” to specifically exclude “audio-only transmissions, e-mail messages,” and “facsimile transmissions.” The definition of “telemedicine services” specifically includes various purposes and technologies, of note both “synchronous and asynchronous telecommunications…consultation…monitoring…and patient and professional health-related education.”

Medical transportation services personnel (emergency medical technicians and paramedics) or a “health care practitioner” may provide telemedicine services to Florida residents. The services “shall be covered by Medicaid under parts III and IV of chapter 409 in the same manner” as in-person services. Also, prescribers cannot use telehealth to prescribe controlled substances for chronic non-malignant pain (as defined in general health professions laws) without exception or reference to Schedules. In addition, the Department of Health and applicable regulatory boards are granted rulemaking authority but any rules cannot prohibit telemedicine use. Furthermore, this new section may not be read as restricting the delivery of emergency medical services.

The effective date is July 1, 2015.
Amendments to SB 478 as Originally Introduced

On February 16, Chairman Bean offered a strike-all amendment to SB 478 as originally introduced, Bar Code 813832. Senator Galvano successfully offered an amendment to the amendment, Bar Code 539316, which prohibited telehealth use for prescribing corrective eyewear and other optical devices or prescribe based “solely on the refractive error of the human eye generated by a computer-controlled device such as an autorefractor.” These changes are collectively reflected in the summary for the intermediate (first) version of CS/SB 478 below.

Summary of The Intermediate (First) Version of CS/SB 478

CS/SB 478 creates a new section of Chapter 456 (456.4501), defines: telehealth, telehealth provider, prescription boundaries, practice standards, and record-keeping. The bill defines “telehealth” to specifically exclude “audio-only transmissions, e-mail messages, facsimile transmissions, or consultations between a telehealth provider in this state and a provider lawfully licensed in another state when the provider licensed in this state maintains responsibility for the care of a patient in this state.” The definition of “telehealth” specifically includes various purposes and technologies, of note both “synchronous and asynchronous telecommunications…consultation…monitoring…patient and professional health-related education, public health services, and health care administration.”

A “telehealth provider” is explicitly defined to include a broad spectrum of statutorily-recognized professionals in health care areas: acupuncture, allopathic and osteopathic medicine, chiropractic medicine, podiatric medicine, optometry, nursing, dentistry, midwifery, speech-language pathology and audiology, occupational therapy, radiology personnel, respiratory therapy, diet and nutrition, athletic trainers, orthotics/prosthetics, electrolysis, massage, clinical laboratory personnel, medical physicists, optical devices/hearing aids, physical therapy, psychology, clinical counseling and psychotherapy, and medical transportation services (emergency medical technicians and paramedics).

The standard of care for a telehealth provider is the same as that “generally accepted” for health care professional providing in-person care. If the provider conducts a patient evaluation, which can be performed via telehealth, “sufficient to diagnose and treat the patient,” there is no requirement of either researching a patient’s medical history or conducting a physical exam before providing services via telehealth. The provider and patient may be “in separate locations” when telehealth services are provided. Also, a non-physician telehealth provider who is acting within his or her relevant, previously noted, scope of practice is not deemed to be practicing medicine without a license.

In addition, prescribers can teleprescribe controlled substances in Schedules I through V, but cannot use telehealth to prescribe controlled substances for chronic non-malignant pain (as statutorily-defined in allopathic medicine laws) with an exception for the treatment of hospital inpatients and
hospice patients. Furthermore, providers may not use telehealth to prescribe optical devices such as glasses or contact lenses based exclusively on the refractive error of the human eye generated by a computer-controlled device.

Finally, record-keeping standards for telehealth services are the same as those used for in-person care.

The effective date is July 1, 2015.

Amendments to The Intermediate (First) Version of CS/SB 478

On April 13, Senator Bean offered an amendment to the intermediate (first) version of CS/SB 478 at line 63, Bar Code 620994. This amendment mirrored House bill language (CS/HB 545) excluding telehealth products from the statutory definition of “discount medical plan.” In addition, the amendment expanded statutory references to the definition of “chronic nonmalignant pain” to include a definition under osteopathic medicine. The newly-referenced definition is identical to that under allopathic medicine, which was already included in prior bill versions. (“Chronic nonmalignant pain” means pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery). Finally, the amendment did not preclude “a physician” from using telehealth to order controlled substance for a hospital inpatient or hospice patient.

On April 14, Senator Bean offered a substitute amendment, Bar Code 596394, to that just described in the previous paragraph above. The substitute amendment was identical with one notable exception: the amendment did not preclude “a practitioner licensed under chapter 458 or chapter 459 or an advanced registered nurse practitioner certified under s. 464.012” from using telehealth to order controlled substance for a hospital inpatient or hospice patient.

Senator Bean offered another amendment at line 39 on April 14th, Bar Code 707614. This amendment expanded the definition of “telehealth provider” to include certified behavior analysts.

Summary of Final Version (PCS) of CS/SB 478

The Final Version/Proposed Committee Substitute (PCS) to CS/SB 478 filed on April 16, creates a new section of Chapter 456 (456.4501), defines telehealth, telehealth provider, prescription boundaries, practice standards, and record-keeping. The bill defines “telehealth” to specifically exclude “audio-only transmissions, e-mail messages, facsimile transmissions,” and “consultations” without exception. The definition of “telehealth” specifically includes various purposes and technologies, of note both “synchronous and asynchronous telecommunications… monitoring… patient and professional health-related education, public health services, and health care administration.”
A “telehealth provider” is explicitly defined to include a broad spectrum of statutorily-recognized professionals in health care areas: acupuncture, allopathic and osteopathic medicine, chiropractic medicine, podiatric medicine, optometry, nursing, dentistry, midwifery, speech-language pathology and audiology, occupational therapy, radiology personnel, respiratory therapy, diet and nutrition, athletic trainers, orthotics/prosthetics, electrolysis, massage, clinical laboratory personnel, medical physicists, optical devices/hearing aids, physical therapy, psychology, clinical counseling and psychotherapy, medical transportation services (emergency medical technicians and paramedics), and certified behavior analysts.

The standard of care for a telehealth provider is the same as that for a health care professional providing in-person care. If the provider conducts a patient evaluation, which can be performed via telehealth, “in a manner consistent with the applicable standard of care sufficient to diagnose and treat the patient,” there is no requirement of either researching a patient’s medical history or conducting a physical exam before providing services via telehealth. The provider and patient may be “in any location” when telehealth services are provided. Also, a non-physician telehealth provider who is acting within his or her applicable scope of practice is not deemed to be practicing medicine without a license.

In addition, prescribers can teleprescribe controlled substances in Schedules I through V, but cannot use telehealth to prescribe controlled substances for chronic non-malignant pain (as statutorily-defined in either allopathic or osteopathic medicine laws) with an exception for the treatment of hospital inpatients and hospice patients by “a practitioner licensed under chapter 458 or chapter 459 or an advanced registered nurse practitioner certified under s. 464.012.” Furthermore, providers may not use telehealth to prescribe optical devices such as glasses or contact lenses based exclusively on the refractive error of the human eye generated by a computer-controlled device.

Furthermore, record-keeping standards for telehealth services are the same as those used for in-person care.

Finally, “any telehealth product regulated under s. 456.47” is explicitly excluded from the term “discount medical plan” as defined in s. 636.202, Florida Statutes.

The effective date is July 1, 2015.
<table>
<thead>
<tr>
<th>Final Version (PCS) of CS/SB 478</th>
<th>Intermediate (First) Version of CS/SB 478</th>
<th>SB 478 As Introduced</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change from prior version</td>
<td>“Telehealth” includes public health &amp; health care administration. Excludes consultations between FL telehealth provider and licensed out-of-state providers when the FL provider maintains responsibility</td>
<td>“Telemedicine services”</td>
</tr>
<tr>
<td>Adds certified behavior analysts to definition of listed telehealth providers</td>
<td>Defines telehealth providers. Includes spectrum of health providers</td>
<td>Does not define telehealth providers other than EMT/paramedic and health care providers generally</td>
</tr>
<tr>
<td>No change from prior version</td>
<td>No Medicaid mandate</td>
<td>Medicaid mandate – covered “in the same manner” as in-person</td>
</tr>
<tr>
<td>No change from prior version</td>
<td>Rulemaking references removed</td>
<td>FL Department of Health rulemaking unless board regulated; cannot prohibit telemedicine services</td>
</tr>
<tr>
<td>Allows Rx Schedules I-V except chronic non-malignant pain unless “a practitioner licensed under chapter 458 or chapter 459 or an advanced registered nurse practitioner certified under s. 464.012” prescribing for hospital in-patient/hospice</td>
<td>Allows Rx Schedules I-V except chronic non-malignant pain unless “physician” prescribing for hospital in-patient/hospice</td>
<td>Prohibits Rx chronic non-malignant pain without schedule or exception</td>
</tr>
<tr>
<td>Defines chronic non-malignant pain by referencing 458.3265 (Allopathic Medicine chapter) and 459.0137 (Osteopathic Medicine chapter).</td>
<td>Defines chronic non-malignant pain by referencing 458.3265 (Allopathic Medicine chapter)</td>
<td>Defines chronic non-malignant pain by referencing 456.44 (General Provisions for Health Professions)</td>
</tr>
<tr>
<td>No change from prior version</td>
<td>Provider and patient may be “in separate locations”</td>
<td>Patient location not mentioned</td>
</tr>
<tr>
<td>No change from prior version</td>
<td>Adds standard of practice and record-keeping requirements</td>
<td>No requirements for standard of practice or record-keeping</td>
</tr>
<tr>
<td>Excludes telehealth products from definition of “discount medical plan” under 636.202</td>
<td>No reference to “discount medical plan”</td>
<td>No reference to “discount medical plan”</td>
</tr>
</tbody>
</table>
HB 545

History of CS/HB 545

CS/HB 545, sponsored by the House Health Quality Subcommittee, and introduced by Representatives Travis Cummings and Mia Jones, covered an array of telehealth policy issues. It underwent a series of subtle but significant language changes in the committee substitute (original strike-all amendment by Representative Cummings), including a change to statute section created, an exclusion of all consultations from the definition of “telehealth,” a change in measuring the sufficiency of patient evaluation for telehealth services, a change in permitted schedules for teleprescribing, and the exclusion of telehealth from discount medical plans.

CS/HB 545 passed favorably with committee substitute out of the House Health Quality Subcommittee and underwent a first reading. The bill remained unheard by its next committee of reference, the Health & Human Services Committee. It was also referenced to Health Care Appropriations early in the process. House staff analyses are available.

The following is a history of the bill from originally introduced text to where the bill text finally stood at the end of the 2015 Legislative Session. For a snapshot look at how the final version of HB 545 compared with the previous (original) version of this bill, please see the table on page 12.

The effective date was July 1, 2015.

Summary of HB 545 as Originally Introduced

HB 545 creates a new section of Chapter 465 (465.47), defines telehealth, telehealth provider, prescription boundaries, practice standards, and record-keeping. The bill defines “telehealth” to specifically exclude “audio-only transmissions, e-mail messages, facsimile transmissions, or consultations between a telehealth provider in this state and a provider lawfully licensed in another state when the provider licensed in this state maintains responsibility for the care of a patient in this state.” The definition of “telehealth” specifically includes various purposes and technologies, of note both “synchronous and asynchronous telecommunications…consultation…monitoring…patient and professional health-related education, public health services, and health care administration.”

A “telehealth provider” is explicitly defined to include a broad spectrum of statutorily-recognized professionals in health care areas: acupuncture, allopathic and osteopathic medicine, chiropractic medicine, podiatric medicine, optometry, nursing, dentistry, midwifery, speech-language pathology and audiology, occupational therapy, radiology personnel, respiratory therapy, diet and nutrition, athletic trainers, orthotics/prosthetics, electrolysis, massage, clinical laboratory personnel, medical physicists, optical devices/hearing aids, physical therapy, psychology, clinical counseling and
psychotherapy, and medical transportation services (emergency medical technicians and paramedics).

The standard of care for a telehealth provider is the same as that “generally accepted” for a health care professional providing in-person care. If the provider conducts a patient evaluation, which can be performed via telehealth, “sufficient to diagnose and treat the patient,” there is no requirement of either researching a patient’s medical history or conducting a physical exam before providing services via telehealth. The provider and patient may be “in separate locations” when telehealth services are provided. Also, a non-physician telehealth provider who is acting within his or her relevant, previously noted, scope of practice is not deemed to be practicing medicine without a license.

In addition, prescribers can teleprescribe controlled substances in Schedules I through IV, but cannot use telehealth to prescribe controlled substances for chronic non-malignant pain with an exception for the treatment of hospital inpatients.

Finally, record-keeping standards for telehealth services are the same as those used for in-person care.

The effective date is July 1, 2015.

Amendments to HB 545 as Originally Introduced
On March 11, Representative Cummings offered a strike-all amendment, Bar Code 929099 that was adopted without objection and is reflected in the summary for final version of CS/HB 545 below. Another amendment to HB 545 as originally introduced, Bar Code 568813, filed by Representative Gaetz on March 11th, was withdrawn prior to consideration. The amendment, mirroring SB 478 language, would have prohibited telehealth use for prescribing corrective eyewear and other optical devices or prescribe based “solely on the refractive error of the human eye generated by a computer-controlled device such as an autorefractor.”

Summary of Final Version of CS/HB 545
CS/HB 545 creates a new section of Chapter 456 (456.47), defines telehealth, telehealth provider, prescription boundaries, practice standards, and record-keeping. The bill defines “telehealth” to specifically exclude “audio-only transmissions, e-mail messages, facsimile transmissions,” and “consultations” without exception. The definition of “telehealth” specifically includes various purposes and technologies, of note both “synchronous and asynchronous telecommunications… monitoring… patient and professional health-related education, public health services, and health care administration.”
A “telehealth provider” is explicitly defined to include a broad spectrum of statutorily-recognized professionals in health care areas: acupuncture, allopathic and osteopathic medicine, chiropractic medicine, podiatric medicine, optometry, nursing, dentistry, midwifery, speech-language pathology and audiology, occupational therapy, radiology personnel, respiratory therapy, diet and nutrition, athletic trainers, orthotics/prosthetics, electrolysis, massage, clinical laboratory personnel, medical physicists, optical devices/hearing aids, physical therapy, psychology, clinical counseling and psychotherapy, and medical transportation services (emergency medical technicians and paramedics).

The standard of care for a telehealth provider is the same as that for a health care professional providing in-person care. If the provider conducts a patient evaluation, which can be performed via telehealth, “in a manner consistent with the applicable standard of care sufficient to diagnose and treat the patient,” there is no requirement of either researching a patient’s medical history or conducting a physical exam before providing services via telehealth. The provider and patient may be “in any location” when telehealth services are provided. Also, a non-physician telehealth provider who is acting within his or her applicable scope of practice is not deemed to be practicing medicine without a license.

In addition, prescribers can teleprescribe controlled substances in Schedules II through V, but cannot use telehealth to prescribe controlled substances for chronic non-malignant pain (more broadly defined than under CS/SB 478) with an exception for the treatment of hospital inpatients. Furthermore, record-keeping standards for telehealth services are the same as those used for in-person care.

Finally, “any telehealth product regulated under s. 456.47” is explicitly excluded from the term “discount medical plan” as defined in s. 636.202, Florida Statutes.
<table>
<thead>
<tr>
<th>Final Version as CS/HB 545</th>
<th>Original Introduction as HB 545</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creates 456.47</td>
<td>Creates 465.47</td>
</tr>
<tr>
<td>Specifically excludes all consultations from telehealth definition</td>
<td>Defines telehealth to include consultation; excludes consultations between FL telehealth provider and licensed out-of-state providers when the FL provider maintains responsibility</td>
</tr>
<tr>
<td>Removes “generally accepted” caveat to standard of care</td>
<td>Contains “generally accepted” caveat to standard of care</td>
</tr>
<tr>
<td>Telehealth evaluation sufficiency for diagnosis and treatment determined by <em>standard of care</em></td>
<td>Telehealth evaluation sufficiency for diagnosis and treatment determined by <em>provider</em></td>
</tr>
<tr>
<td>Provider and PT may each be “in any location”</td>
<td>Provider and PT may each be “in separate locations”</td>
</tr>
<tr>
<td>Non-physician provider using telehealth and acting within “applicable scope” not practicing medicine without reference to practice act</td>
<td>Non-physician provider using telehealth and acting within “relevant scope” not practicing medicine under any referenced practice act</td>
</tr>
<tr>
<td>Allows Rx Schedules II-V except chronic non-malignant pain (defined 458.3265 &amp; 459.0137) unless hospital</td>
<td>Allows Rx Schedules I-IV except chronic non-malignant pain (defined 458.3265 only) unless hospital</td>
</tr>
<tr>
<td>Excludes telehealth products from definition of “discount medical plan” under 636.202</td>
<td>No explicit mention of financial or reimbursement issues</td>
</tr>
</tbody>
</table>
The findings in this Report are based on the data and sources referenced. Florida TaxWatch research is conducted with every reasonable attempt to verify the accuracy and reliability of the data, and the calculations and assumptions made herein. Please feel free to contact us if you feel that this paper is factually inaccurate. The research findings and recommendations of Florida TaxWatch do not necessarily reflect the view of its members, staff, Executive Committee, or Board of Trustees; and are not influenced by the individuals or organizations who may have sponsored the research.