

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 5 Reducing Fetal and Infant Mortality

SPONSOR(S): Grall and others

TIED BILLS: **IDEN./SIM. BILLS:** SB 146

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee	12 Y, 6 N	McElroy	McElroy
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Infant mortality is the death of an infant before the first birthday. The infant mortality rate in the United States is 5.6 deaths per 1,000 live births and Florida ranks 18th in the nation in infant mortality with a rate of six deaths per 1,000 live births. Abortion is the termination of a human pregnancy with an intention other than to produce a live birth or to remove a dead fetus. The bill addresses fetal and infant mortality reduction related to fetal and infant mortality reviews (FIMR), hospital quality initiatives, comprehensive statewide tobacco education and use prevention, and abortion policy.

Fetal and infant mortality review (FIMR) is a community-based fetal and infant mortality review process to identify and address factors that affect infant mortality and morbidity. The Department of Health (DOH) contracts with Healthy Start Coalitions around the state for FIMR programs; however, FIMR programs are not available statewide. The bill requires DOH to contract for additional FIMR committees in all regions of the state. Each Coalition must report FIMR committee findings and recommendations to DOH annually and DOH must submit such in a report to the Governor, President of the Senate, and Speaker of the House of Representatives.

The Florida Perinatal Quality Collaborative (FPQC) partners with stakeholders and partners across the state to develop and implement quality initiatives to reduce maternal and infant mortality. FPQC's initiatives provide quality improvement data reports, toolkits, online toolboxes, and technical assistance to hospitals to assist with implementing process changes to carry out quality improvement initiatives. While many hospitals participate in FPQC initiatives, participation is voluntary and many do not. The bill requires hospitals that provide birthing services (labor and delivery) to participate in at least two quality improvement initiatives developed in collaboration with the FPQC.

The Comprehensive Statewide Tobacco Education and Use Prevention Program (Program) is a program based on best practices from the U.S. Centers for Disease Control and Prevention. The Program educates Floridians, particularly youth and their parents, about the hazards of tobacco and preventing use. The bill requires the Program to include a focus on pregnant women and women who may become pregnant.

Florida law prohibits abortions during the third trimester with certain medical exceptions. Current law also requires the physician performing the abortion to determine, by ultrasound, the gestational age of the fetus at the time the abortion is to be performed.

HB 5 prohibits abortions if the physician performing abortion determines the gestational age of the fetus is more than 15 weeks, based on the first day of the woman's last menstrual period. This replaces the current prohibition against abortions during the third trimester. The bill retains the current medical exception to prohibited abortions and, adds an exception for fatal fetal abnormalities.

Current law requires abortion providers to submit a monthly report to AHCA. Abortion providers are not currently required to report whether the abortion was due to human trafficking or the number of medication abortion regimens prescribed or dispensed by abortion providers.

HB 5 enhances and clarifies current abortion reporting requirements. The bill requires abortion providers to report whether abortions were due to human trafficking. The bill addresses potential data reporting gaps by clarifying that both surgical and medication-induced abortions must be reported and to report the number of medication abortion regimens prescribed and dispensed. The bill also requires AHCA, the Board of Medicine and the Board of Osteopathic Medicine to adopt an electronic reporting form.

This document does not reflect the intent or official position of the bill sponsor or House of Representatives .

STORAGE NAME: h0005a.PPH

DATE: 1/19/2022

The bill has a significant, negative fiscal impact to the Department of Health and no fiscal impact to local governments. The bill appropriates \$260,000 in recurring General Revenue to DOH for these costs.

The bill provides an effective date of July 1, 2022.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

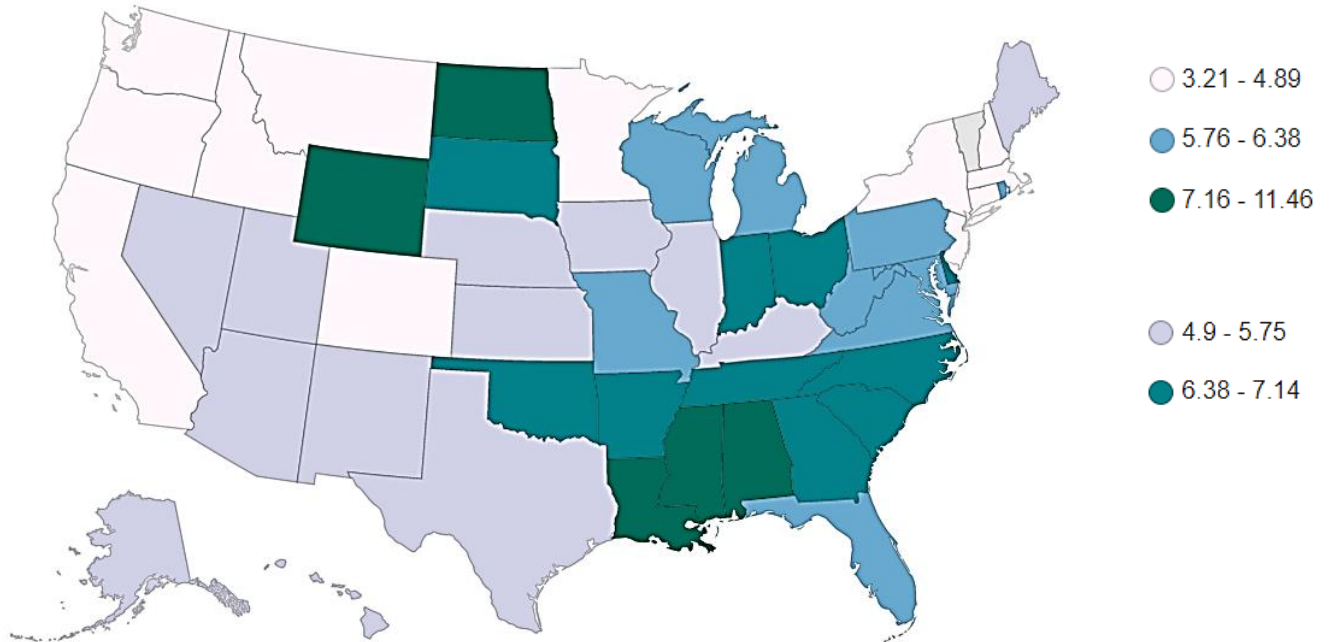
A. EFFECT OF PROPOSED CHANGES:

Background

Infant Mortality

Infant mortality is the death of an infant before the first birthday. The infant mortality rate is the number of infant deaths for every 1,000 live births. In addition to giving key information about maternal and infant health, the infant mortality rate is a marker of the overall health of a society. In 2019, the infant mortality rate in the United States was 5.6 deaths per 1,000 live births.¹

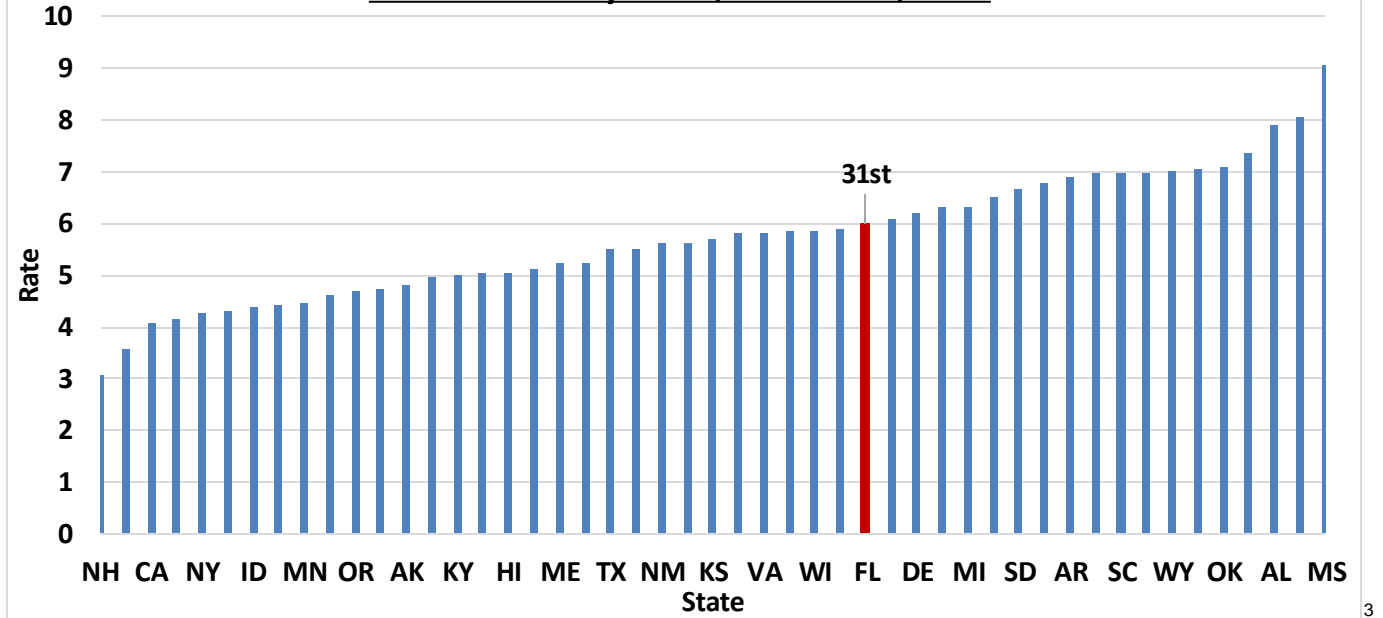
Infant Mortality Rates by State – 2019²



¹ Centers for Disease Control and Prevention, *Infant Mortality*, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm> (last visited Jan. 12, 2022).

² Centers for Disease Control and Prevention, *Infant Mortality Rates by State*, https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm (last visited Jan. 12, 2022).

Infant Mortality Rates, U.S. States, 2019



Infant Mortality in Florida

The Department of Health (DOH) reports annually on fetal and infant deaths through the Florida Vital Statistics Annual Report.⁴ This report provides the number of fetal deaths per 1,000 live births, the number of deaths by race, and compares that data to national figures. Florida ranks 18th in the nation in infant mortality with a rate of six deaths per 1,000 live births (1,213 in 2020).⁵

In Florida, the leading causes of infant mortality, per 1,000 live births, are:⁶

- Birth defects (1.1);
- Preterm and low birth weight (0.9);
- Unintentional injuries (0.5);
- Maternal complications of pregnancy (0.4);
- Complications of placenta, cord, and membranes (0.3); and
- Sudden Infant Death Syndrome (0.3).

³ Centers for Disease Control and Prevention, Reproductive Health – Infant Mortality Rates by State, 2019, <https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm#infant> (last visited Jan. 12, 2022). Note that Vermont’s rate was determined unreliable for 2019 by the CDC and is not included in this chart.

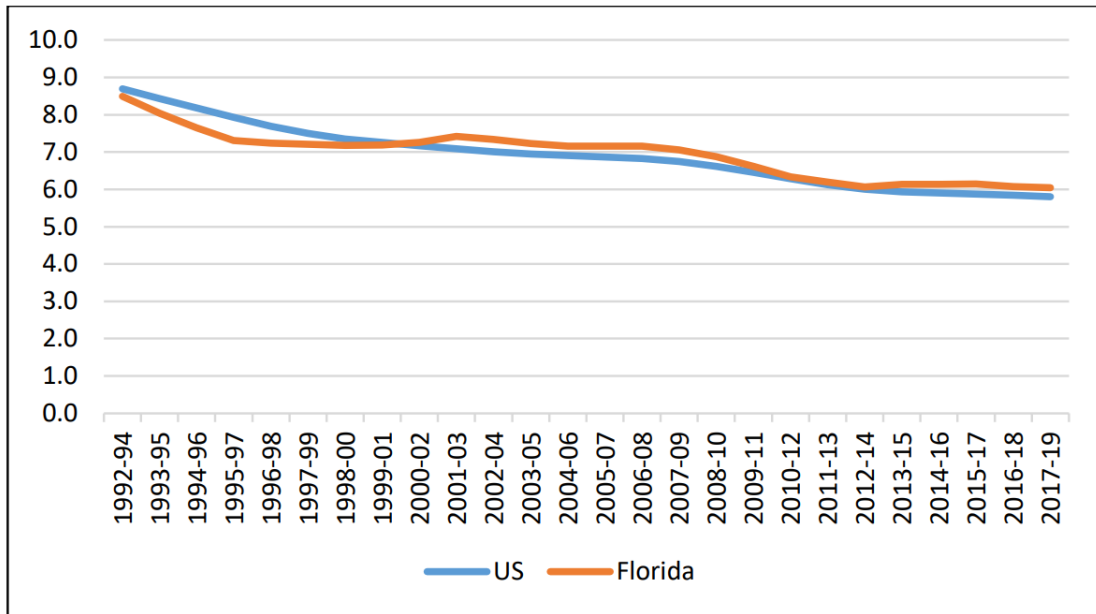
⁴ Florida Vital Statistics Annual Report 2020, <http://www.flpublichealth.com/Vsbook/PDF/2020/Fetal.pdf> (last visited Jan. 12, 2022).

⁵ Id. See also Centers for Disease Control and Prevention, Infant Mortality Rates by State (2019), https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm (last visited Jan. 12, 2022).

⁶ Presentation by Shay Chapman, BSN, MBA, Deputy Division Director, Community Health Promotion, Sept. 21, 2021 meeting of the Professions and Public Health Subcommittee, available at

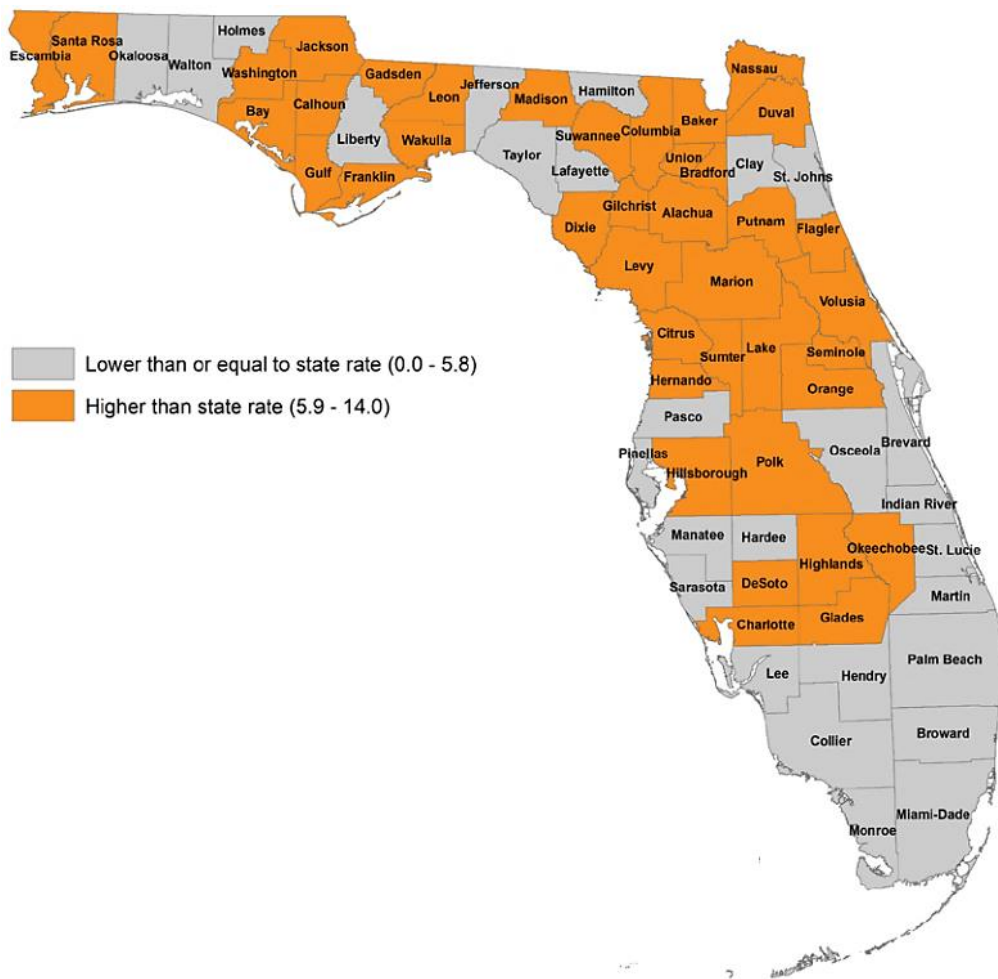
<https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3093&Session=2022&DocumentType=Meeting+Packets&FileName=pph+9-21-21.pdf> (last visited Jan. 12, 2022).

Infant Mortality Rates, 1992-2019, Florida vs. the United States



Source: Florida CHARTS, www.flhealthcharts.com.

Florida Infant Mortality Rates by County⁷



Fetal and Infant Mortality Review

Fetal and infant mortality review (FIMR) is a process of community-based fetal and infant mortality reviews aimed at addressing factors and issues that affect infant mortality and morbidity. FIMR committees aim to gain knowledge through the reviews to empower communities to enhance services, influence policy, and direct planning efforts that will ultimately lower infant mortality rates. The process is based on the National FIMR model which supports case review and interventions at the local level.⁸

FIMR Process

In Florida, FIMR committees operate in a two-tier structure consisting of Healthy Start Coalitions (Coalition) and Case Review Teams (CRT). The FIMR process begins when infant death cases are selected for review by a committee within the Healthy Start Coalition (Coalition) based on specific criteria, including type of death, residence and race. Information is abstracted from birth, death, medical, hospital and autopsy records. Efforts are also made to interview the family. No information which identifies the family or medical providers is included on the abstraction form.⁹

Case summaries are developed by the Coalition committee and presented to the CRT, a multidisciplinary group of community medical and social service professionals. This group usually includes a district and local health officer, obstetrician, pediatrician, social worker, nurse-midwife, a hospital and community nurse, coroner or medical examiner, interviewer, abstractor, community outreach worker, mental health counselor, and other people important to the individual reviews. The CRT examines each case to determine medical, social, financial and other issues that may have impacted the poor birth outcome. Recommendations for community action are crafted by the CRT based on review findings. These recommendations are shared with the Community Action Group, a group of volunteers working with at-risk families and other partner agencies¹⁰ in the region to implement and develop street-level outreach activities.¹¹

FIMR work has several benefits, such as including the perspective of the family, identifying issues unique to a community, allowing for targeted initiatives, and engaging community leaders to identify and implement solutions.¹²

FIMR in Florida

DOH contracts with Healthy Start Coalitions around the state for FIMR programs.¹³ Rather, FIMR is not a statewide program and there is no statutory directive for the FIMR process; programs are authorized in the General Appropriations Act. Approximately half of the counties in the state participate in a FIMR program.¹⁴ Currently, Florida has:¹⁵

- 11 state-funded FIMR programs through contracts with Healthy Start;
- 3 FIMRs funded through the County Health Departments (Orange, Osceola, and Palm Beach counties); and

⁸ Florida Department of Health. *FIMR*, available at http://www.doh.state.fl.us/family/mch/FIMR/fimr_facts.html (last visited Jan. 12, 2022).

⁹ *Id.*

¹⁰ Partner agencies may include health departments, hospitals, medical societies, schools, community and business leaders, and consumers

¹¹ *Supra*, note 8.

¹² National Fetal and Infant Mortality Review Program, *A Guide for Communities: Fetal and Infant Mortality Review Manual, 2nd Edition (2008)*, <https://ncfrp.org/wp-content/uploads/NCRPCD-Docs/FIMRManual.pdf> (last visited Jan 12, 2022).

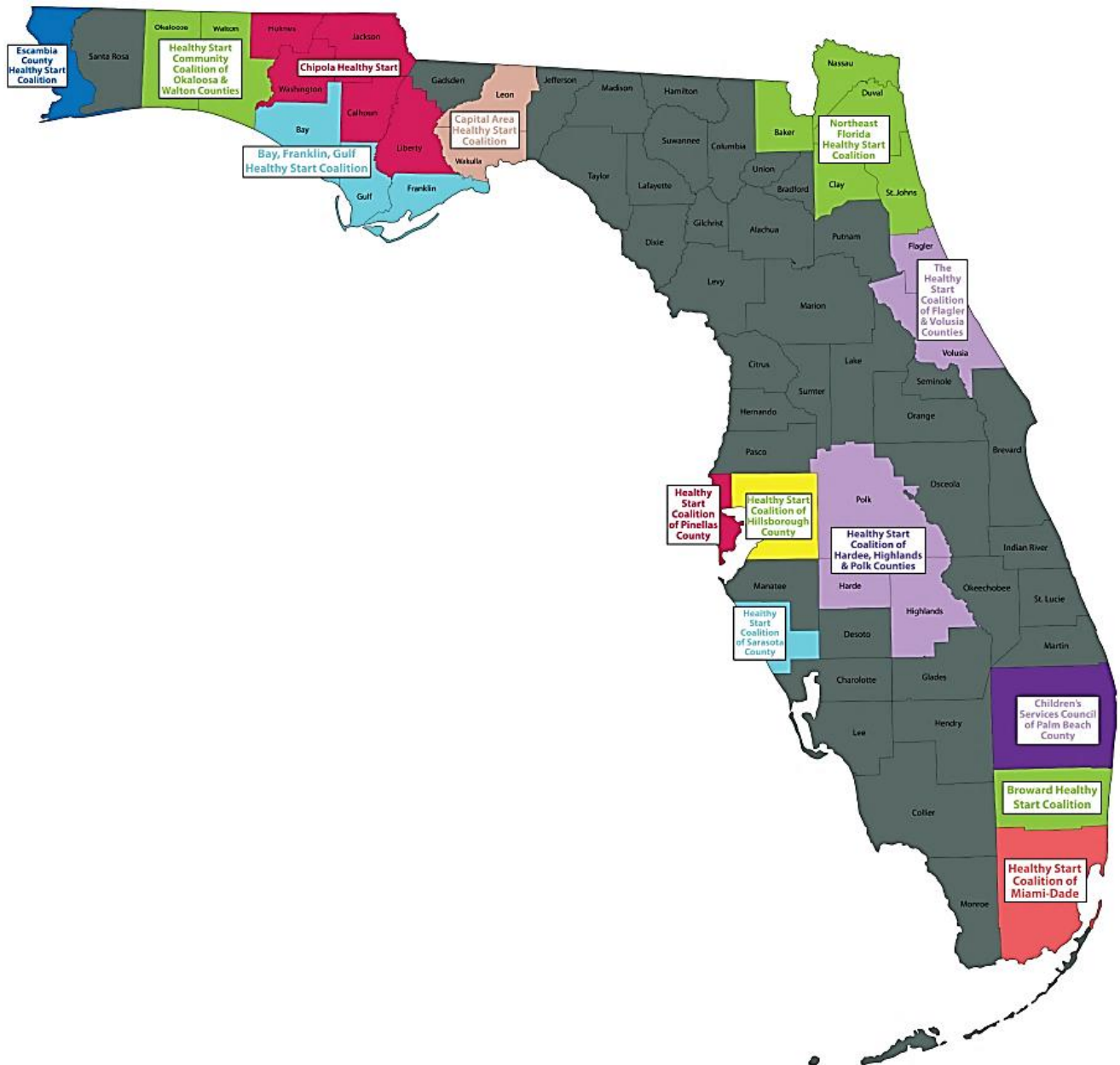
¹³ Email from Andrew Love, Director of Legislative Planning, Department of Health, Infant Mortality Policy Recommendations (Sept. 2, 2021) and

¹⁴ Email from Andrew Love, Director of Legislative Planning, Department of Health, Follow Up Documents (July 26, 2021). See also Presentation by Cathy Timuta, CEO, Florida Association of Healthy Start Coalitions, Inc., and Faye Johnson, CEO, Northeast Florida Healthy Start Coalition, Inc., Oct. 13, 2021 meeting of the Professions and Public Health Subcommittee, available at <https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3093&Session=2022&DocumentType=Meeting+Packets&FileName=pph+10-13-21.pdf> (last visited Jan., 12, 2022).

¹⁵ *Id.*

- 2 FIMRs independently funded (Hillsborough and Indian River counties); and
- 1 inactive FIMR (St. Lucie County).

Healthy Start Coalition FIMR Programs¹⁶



Comprehensive Statewide Tobacco Education and Use Prevention

On November 7, 2006, the voters in the State of Florida adopted Amendment 4, creating the

¹⁶ Presentation by Cathy Timuta, CEO, Florida Association of Healthy Start Coalitions, Inc., and Faye Johnson, CEO, Northeast Florida Healthy Start Coalition, Inc., Oct. 13, 2021 meeting of the Professions and Public Health Subcommittee, available at

<https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3093&Session=2022&DocumentType=Meeting+Packets&FileName=pph+10-13-21.pdf> (last visited Jan., 12, 2022).

Comprehensive Statewide Tobacco Education and Prevention Program.¹⁷ Pursuant to the amendment, the state is required to create a comprehensive, statewide program consistent with the United States Department of Health and Human Services, Centers for Disease Control and Prevention 1999 best practices, as periodically amended. The program must consist, at a minimum, of the following components:¹⁸

- An advertising campaign, funded by at least one-third of the required annual appropriation;
- Evidence-based curricula and programs to educate youth about tobacco and discourage their use of it;
- Programs of local community-based partnerships;
- Enforcement of laws, regulations, and policies against the sale or other provision of tobacco to minors, and the possession of tobacco by minors; and
- Publicly-reported annual evaluations to ensure that moneys appropriated for the program are spent properly.

The Constitution specifies that the Legislature must appropriate 15 percent of the total gross funds that tobacco companies paid to the State of Florida in 2005 under the Tobacco Settlement. This amount must be adjusted annually for inflation using the Consumer Price Index. For Fiscal Year 2021-2022, the mandated appropriation is \$73.9 million.¹⁹

In 2007, the Legislature created section 381.84, Florida Statutes, the Comprehensive Statewide Tobacco Education and Use Prevention Program (Program), to implement the constitutional amendment. The Program consists of nine components:²⁰

- Counter-marketing and advertising;
- Cessation programs, counseling and treatment;
- Surveillance and education;
- Youth and school programs;
- Community programs and chronic disease prevention;
- Training of health care practitioners, tobacco-use cessation counselors and teachers;
- Administration and management;
- Enforcement and awareness of related laws; and
- The area health education centers (AHEC) tobacco-use cessation initiative.

The Program requires each component to focus on educating people, particularly youth and their parents, about the hazards of tobacco and discouraging the use of tobacco. The Program does not specifically address pregnant women and women who may become pregnant.

Hospitals and Infant Mortality

Hospitals are regulated by the Agency for Health Care Administration (AHCA) under chapter 395, F.S., and the general licensure provisions of part II, of chapter 408, F.S. Hospitals offer a range of health care services with beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care.²¹ Hospitals must make regularly available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment.²² Currently, hospitals that provide birthing services must incorporate information on safe sleep practices and the possible causes of Sudden Unexpected Infant Death into postpartum instruction on the care of newborns. Hospitals must also provide parents with an informational pamphlet on infant and childhood eye and vision disorders.²³

¹⁷ Art. X, s. 27, Fla. Const.

¹⁸ *Id.*

¹⁹ Fla. General Appropriation Act Fiscal Year 2021-2022, SB 2500 item 458.

²⁰ S. 381.84(3), F.S.

²¹ S. 395.002(12), F.S.

²² *Id.*

²³ S. 395.1053, F.S.

Florida Perinatal Quality Collaborative

The Florida Perinatal Quality Collaborative (FPQC) was established in 2010 and housed in the Chiles Center at the University of South Florida College of Public Health. FPQC aims to improve Florida's maternal and infant health outcomes through evidence-based perinatal care. FPQC partners with stakeholders, such as perinatal-related organizations, individuals, families, health professionals, hospitals, and payers to develop and implement quality improvement initiatives at partner hospitals that provide birthing services (labor and delivery) to address maternal and infant mortality.²⁴ FPQC's initiatives provide quality improvement data reports, toolkits, online toolboxes, and technical assistance to hospitals to assist with implementing process changes to carry out quality improvement initiatives.

Hospital participation in FPQC initiatives is voluntary.

Currently, FPQC has four active initiatives:²⁵

- **Promoting Primary Vaginal Deliveries (PROVIDE):**²⁶ The goal of the PROVIDE Initiative is to improve maternal and newborn outcomes by applying evidence-based interventions to promote primary vaginal deliveries at Florida delivery hospitals and ultimately reduce Nulliparous, Term, Singleton, Vertex cesareans.²⁷ Seventy-five hospitals currently participate in PROVIDE.
- **Family-Centered Care in the NICU (PAIRED):**²⁸ PAIRED helps hospital neonatal intensive care units (NICU) develop and implement unit-specific strategies to improve how a family engages with the NICU staff to assist in the care of their infant in a way that provides value to the family and to the NICU team. As its centerpiece project, this initiative facilitates adoption or expansion of safe skin-to-skin care, which has a growing evidence base for achieving better infant and family outcomes. Sixteen hospitals currently participate in PAIRED.
- **Perinatal Quality Indicators System (PQI):**²⁹ The PQI initiative supports hospital quality improvement efforts by providing hospital-specific semi-annual or quarterly reports of perinatal indicators and related reports. PQI is offered to all Florida delivery hospitals at no charge and hospitals can enroll at any time. Fifty-six hospitals currently participate in PQI.
- **Maternal Opioid Recovery Effort (MORE):**³⁰ MORE works with providers, hospitals, and other stakeholders to improve identification, clinical care, and coordinated treatment and support for pregnant women with opioid use disorder (OUD) and their infants. MORE focuses on standardization related to OUD screening, prevention, treatment, and comprehensive discharge planning. Thirty-one hospitals are currently participating in MORE.

Since the MORE initiative began in November 2019, participating hospitals have substantially increased screening for substance use disorder, mental health, intimate partner violence, and infectious diseases, as indicated by the graph below.³¹

²⁴ USF Health College of Public Health, *Florida Perinatal Quality Collaborative – About the FPQC*, <https://health.usf.edu/publichealth/chiles/fpgc/about> (last visited Jan. 12, 2022).

²⁵ USF Health College of Public Health, *Florida Perinatal Quality Collaborative*, <https://health.usf.edu/publichealth/chiles/fpgc> (last visited Jan. 12, 2022).

²⁶ USF Health College of Public Health, *Florida Perinatal Quality Collaborative – Promoting Vaginal Deliveries*, <https://health.usf.edu/publichealth/chiles/fpgc/provide> (last visited Jan. 12, 2022).

²⁷ Nulliparous, Term, Singleton, Vertex (NTSV) Cesareans are cesarean births where babies are at or beyond 37.0 weeks gestation to women in their first pregnancy, that are singleton (no twins or beyond) and in the vertex presentation (no breech or transverse positions).

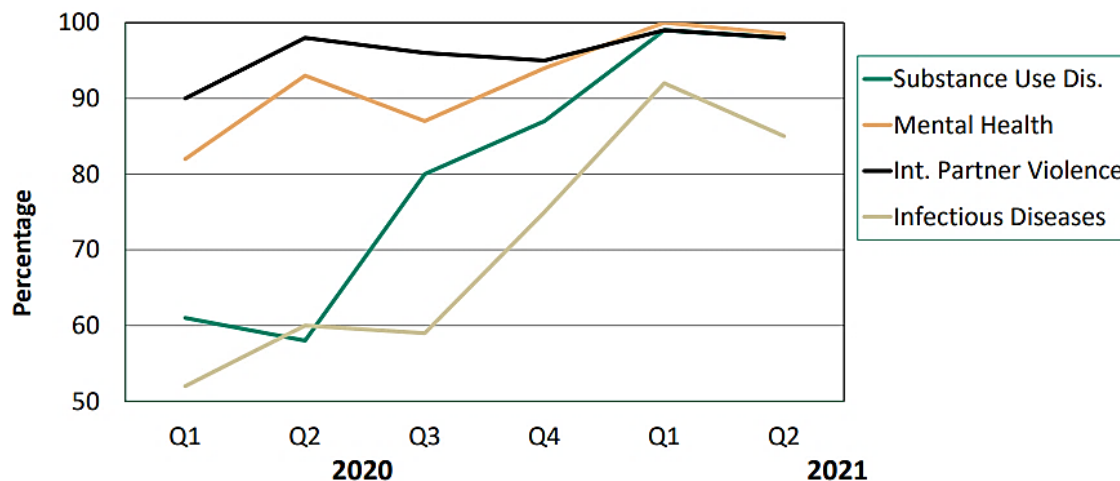
²⁸ USF Health College of Public Health, *Florida Perinatal Quality Collaborative – PAIRED Initiative*, <https://health.usf.edu/publichealth/chiles/fpgc/paired> (last visited Jan. 12, 2022).

²⁹ USF Health College of Public Health, *Florida Perinatal Quality Collaborative – Perinatal Quality Indicators System*, <https://health.usf.edu/publichealth/chiles/fpgc/indicators> (last visited Jan. 12, 2022).

³⁰ USF Health College of Public Health, *Florida Perinatal Quality Collaborative – Maternal Opioid Recovery Effort (MORE)*, <https://health.usf.edu/publichealth/chiles/fpgc/MORE> (last visited Jan. 12, 2022).

³¹ Presentation by William Sappenfield, MD, MPH, CPH, Professor, Director of Chiles Center, University of South Florida, Oct. 13, 2021 meeting of the Professions and Public Health Subcommittee, available at: <https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3093&Session=2022&DocumentType=Meeting+Packets&FileName=pph+10-13-21.pdf> (last visited Jan. 12, 2022).

Maternal Screening in MORE Participating Hospitals³²



Federal Law on Abortion

In 1973, the foundation of modern abortion jurisprudence, *Roe v. Wade*³³, was decided by the U.S. Supreme Court (Supreme Court). The Supreme Court determined that a woman's right to an abortion is part of a fundamental right to privacy guaranteed under the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution. Further, the Court reasoned that state regulation limiting the exercise of this right is subject to strict scrutiny: it must be justified by a compelling state interest, and must be narrowly drawn.³⁴ In 1992, the fundamental holding of *Roe* was upheld by the U.S. Supreme Court in *Planned Parenthood v. Casey*.³⁵

The Viability Standard

In *Roe v. Wade*, the Supreme Court established a rigid trimester framework dictating when, if ever, states can regulate abortion.³⁶ The Court held that states could not regulate abortions during the first trimester of pregnancy.³⁷ With respect to the second trimester, the Court held that states could only enact regulations aimed at protecting the mother's health, not the fetus's life. Therefore, no ban on abortions is permitted during the second trimester. The state's interest in the life of the fetus becomes sufficiently compelling only at the beginning of the third trimester, allowing it to prohibit abortions. Even then, the Court requires states to permit an abortion in circumstances necessary to preserve the health or life of the mother.³⁸

The current viability standard is set forth in *Planned Parenthood v. Casey*.³⁹ Recognizing that medical advancements in neonatal care can advance viability to a point somewhat earlier than the third trimester, the Supreme Court rejected the trimester framework and, instead, limited the states' ability to regulate abortion pre-viability. Thus, while upholding the underlying holding in *Roe*, which authorizes states to "regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother[.]"⁴⁰ the Court determined that the line for this authority should be drawn at "viability," because "there may be some medical developments that affect the precise point of viability . . . but this is an imprecision within tolerable limits given that the medical community and all those who must apply its discoveries will continue to explore the matter."⁴¹

³² *Id.*

³³ *Roe v. Wade*, 410 U.S. 113 (1973).

³⁴ *Id.*

³⁵ *Casey*, 505 U.S. 833 (1992).

³⁶ *Roe*, 410 U.S. 113 (1973).

³⁷ *Id.* at 163-64.

³⁸ *Id.* at 164-165.

³⁹ *Planned Parenthood of SE Pa. v. Casey*, 505 U.S. 833 (1992).

⁴⁰ *See Roe*, 410 U.S. at 164-65.

⁴¹ *See Casey*, 505 U.S. at 870.

Furthermore, the Court recognized that “[i]n some broad sense it might be said that a woman who fails to act before viability has consented to the State’s intervention on behalf of the developing child.”⁴²

The Undue Burden Standard

In *Planned Parenthood v. Casey*, the Supreme Court established the undue burden standard for determining whether a law places an impermissible obstacle to a woman’s right to an abortion. The Court held that health regulations which impose undue burdens on the right to abortion are invalid.⁴³ State regulation imposes an “undue burden” on a woman’s decision to have an abortion if it has the purpose or effect of placing a substantial obstacle in the path of the woman who seeks the abortion of a nonviable fetus.⁴⁴ However, the court opined, not every law which makes the right to an abortion more difficult to exercise is an infringement of that right.⁴⁵

The Medical Emergency Exception

In *Doe v. Bolton*, the U.S. Supreme Court was faced with determining, among other things, whether a Georgia statute criminalizing abortions (pre- and post-viability), except when determined to be necessary based upon a physician’s “best clinical judgment,” was unconstitutionally void for vagueness for inadequately warning a physician under what circumstances an abortion could be performed.⁴⁶ In its reasoning, the Court agreed with the district court decision that the exception was not unconstitutionally vague, by recognizing that:

[T]he medical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman’s age-relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment.⁴⁷

This broad interpretation of what constitutes a medical emergency was later tested in *Casey*⁴⁸, albeit in a different context. One question before the Supreme Court in *Casey* was whether the medical emergency exception to a 24-hour waiting period for an abortion was too narrow in that there were some potentially significant health risks that would not be considered “immediate.”⁴⁹ The exception in question provided that a medical emergency is:

[T]hat condition which, on the basis of the physician’s good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.⁵⁰

In evaluating the more objective standard under which a physician is to determine the existence of a medical emergency, the Court in *Casey* determined that the exception would not significantly threaten the life and health of a woman and imposed no undue burden on the woman’s right to have an abortion.⁵¹

Jackson Women’s Health Organization v. Dobbs

⁴² *Id.*

⁴³ *Id.* at 878.

⁴⁴ *Id.* at 877.

⁴⁵ *Id.* at 873.

⁴⁶ *Doe*, 410 U.S. at 179 (1973). Other exceptions, such as in cases of rape and when, “[t]he fetus would very likely be born with a grave, permanent, and irremediable mental or physical defect.” *Id.* at 183. See also, *U.S. v. Vuitich*, 402 U.S. 62, 71-72 (1971) (determining that a medical emergency exception to a criminal statute banning abortions would include consideration of the mental health of the pregnant woman).

⁴⁷ *Doe*, 410 U.S. at 192.

⁴⁸ *Casey*, 505 U.S. 833 (1992).

⁴⁹ *Id.* at 880.

⁵⁰ *Id.* at 879 (quoting 18 Pa. Cons. Stat. § 3203 (1990)).

⁵¹ *Id.* at 880.

In 2018, Mississippi enacted the Gestational Age Act (Act) which prohibited a person from performing an abortion if the probable gestational age of the fetus is greater than 15 weeks. Jackson Women's Health Organization filed a lawsuit challenging the Act alleging that it was an unconstitutional pre-viability ban on abortion. The state argued the Act was a constitutional restriction on abortion. The federal trial court ruled in favor of Jackson Women's Health Organization, which was upheld by the Fifth Circuit of Appeals.⁵²

The lawsuit matter is currently pending before the U.S. Supreme Court, which held oral arguments on December 1, 2021.⁵³

Florida Abortion Law

Right to Abortion

The Florida Constitution, as interpreted by Florida courts, affords greater privacy rights than those provided by the U.S. Constitution. While the federal Constitution traditionally shields enumerated and implied individual liberties from state or federal intrusion, the U.S. Supreme Court has noted that state constitutions may provide greater protections.⁵⁴ Unlike the U.S. Constitution, Article I, s. 23 of the Florida Constitution contains an express right to privacy:

Every natural person has the right to be let alone and free from governmental intrusion into the person's private life except as otherwise provided herein. This section shall not be construed to limit the public's right of access to public records and meetings as provided by law.

The Florida Supreme Court opined in *In re T.W.* that this section provides greater privacy rights than those implied by the U.S. Constitution.⁵⁵

The Florida Supreme Court has recognized Florida's constitutional right to privacy "is clearly implicated in a woman's decision whether or not to continue her pregnancy."⁵⁶ In *In re T.W.*, the Florida Supreme Court ruled that:⁵⁷

[P]rior to the end of the first trimester, the abortion decision must be left to the woman and may not be significantly restricted by the state. Following this point, the state may impose significant restrictions only in the least intrusive manner designed to safeguard the health of the mother. Insignificant burdens during either period must substantially further important state interests....Under our Florida Constitution, the state's interest becomes compelling upon viability....Viability under Florida law occurs at that point in time when the fetus becomes capable of meaningful life outside the womb through standard medical procedures.

The court recognized that after viability, the state can regulate abortion in the interest of the unborn child if the mother's health is not in jeopardy.⁵⁸

The state may regulate abortion pre-viability based upon its interest in maternal health beginning in the second trimester. In *Fla. Women's Medical Clinic, Inc. v. Smith*, the court held

⁵² See *Jackson Women's Health Organization v. Dobbs*, 945 F.3d 265 (5th Cir. 2019).

⁵³ See *Dobbs v. Jackson Women's Health Organization*, Case No. 19-1392, available at <https://www.supremecourt.gov/search.aspx?filename=/docket/docketfiles/html/public/19-1392.html> (last visited January 16, 2022).

⁵⁴ *Pruneyard Shopping Center v. Robins*, 100 S.Ct. 2035, 2040 (1980), cited in *In re T.W.*, 551 So.2d 1186, 1191 (Fla. 1989).

⁵⁵ *Id.* at 1191-1192.

⁵⁶ *Id.* at 1192.

⁵⁷ *Id.* at 1193.

⁵⁸ *Id.* at 1194.

that the state has an interest in maternal health only after the first trimester, not before, and may not impose substantive clinical standards in the first trimester.⁵⁹

Abortion Regulation

Abortion clinics are regulated by the Agency for Health Care Administration (AHCA) under ch. 390, F.S. Physicians performing abortions (which may take place in abortion clinics, hospitals, physician offices or other physician settings) are regulated by the Department of Health (DOH) under chs. 458 and 459 F.S.

In Florida, abortion is defined as the termination of a human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.⁶⁰ An abortion must be performed by a physician⁶¹ licensed under ch. 458, F.S., or ch. 459, F.S., or a physician practicing medicine or osteopathic medicine in the employment of the United States.⁶²

Florida law prohibits abortions after viability, as well as during the third trimester, unless a medical exception exists. Section 390.01112(1), F.S., prohibits an abortion from being performed if a physician determines that, in reasonable medical judgment, the fetus has achieved viability.⁶³ Section 390.0111, F.S., prohibits an abortion from being performed during the third trimester.⁶⁴ Exceptions to both of these prohibitions exist if:

- Two physicians certify in writing that, in reasonable medical judgment, the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition; or
- One physician certifies in writing that, in reasonable medical judgment, there is a medical necessity for legitimate emergency medical procedures for termination of the pregnancy to save the pregnant woman's life or avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition, and another physician is not available for consultation.⁶⁵

Current law requires the physician performing the abortion to verify the probable gestational age of the fetus, by ultrasound, at the time the abortion is performed.⁶⁶ The physician performing the abortion, or person qualified to operate an ultrasound who is working with in conjunction with the physician, must perform the ultrasound.⁶⁷

Any person who willfully performs, or actively participates in, an abortion in violation of these statutory requirements commits a third degree felony and commits a second-degree felony if the woman dies.⁶⁸

Abortion Data Reporting

Section 390.0112, F.S., requires the medical director of medical facilities where abortions are performed to submit a monthly report to AHCA that must contain information consistent with the United States Standard Report of Induced Termination of Pregnancy adopted by the Centers for Disease

⁵⁹ Fla. Women's Medical Clinic, Inc. v. Smith, 478 F.Supp. 233 (S.D. Fla. 1979); Fla. Women's Medical Clinic, Inc. v. Smith, 536 F.Supp. 1048 (S.D. Fla. 1982).

⁶⁰ Section 390.011(1), F.S.

⁶¹ Section 390.0111(2), F.S.

⁶² Section 390.011(8), F.S.

⁶³ Viability is defined as the stage of fetal development when the life of a fetus is sustainable outside the womb through standard medical measures. Section 390.011(13), F.S.

⁶⁴ Section 390.011(11), F.S., defines the third trimester to mean the weeks of pregnancy after the 24th week of pregnancy.

⁶⁵ Sections 390.0111(1)(a) and (b) and 390.01112(1)(a) and (b), F.S.

⁶⁶ Section 390.0111(3)(a)1.b.II, F.S.

⁶⁷ Section 390.0111(3), F.S.

⁶⁸ Section 390.0111(10), F.S. Such regulations include basic clinical standards for abortion clinics performing abortions after the first trimester and informed consent.

Control and Prevention (CDC).⁶⁹ If the abortion is performed in a location other than a medical facility, the physician who performed the abortion is responsible for reporting the information to AHCA.⁷⁰

In 2020, there were 209,645 live births in Florida.⁷¹ In the same year, there were 74,868 abortion procedures performed in the state. Of those:⁷²

- 70,594 were performed in the first trimester (12 weeks and under);
- 4,274 were performed in the second trimester (13 to 24 weeks); and
- None were performed in the third trimester (25 weeks and over).

The majority of the procedures (65,210) were elective.⁷³ The remainder of the abortions were performed due to:⁷⁴

- Emotional or psychological health of the mother (1,409);
- Physical health of the mother that was not life endangering (1,111);
- Life endangering physical condition (146);
- Rape (112);
- Incest (9)
- Serious fetal genetic defect, deformity, or abnormality (734); and
- Social or economic reasons (15,271).

AHCA must keep this information in a central location from which statistical data can be drawn and must provide this information to the CDC upon request.⁷⁵ The reports are confidential and exempt from public records requirements.⁷⁶ AHCA may impose fines for violations of the reporting requirements.⁷⁷

Abortion providers report abortions due to rape or incest, but are not currently required to report whether the abortion was due to human trafficking.

Additionally, potential gaps in abortion date may exist. If an abortion is performed outside of a medical facility, the physician performing the abortion must submit a monthly report to AHCA. Because AHCA has no regulatory oversight of physicians (this authority rests with the Boards), it is unclear whether all physicians performing abortions outside of medical facilities are reporting. It is equally unclear if all medication abortions are being reported as abortion providers are not currently required to report the number of medication abortion regimens⁷⁸ prescribed or dispensed.

Effect of the Bill

⁶⁹ The CDC requests the following information from states for the U.S. Standard Report of Induced Termination of Pregnancy: facility name (clinic or hospital); city, town or location; county; hospital or clinic's patient identification number (used for querying for missing information without identifying the patient); age; marital status; date of termination; residence of patient; ethnicity; race; education attainment; date of last menses; clinical estimate of gestation; previous pregnancy history; previous abortion history; type of abortion procedure; and name of attending physician and name of person completing report. Centers for Disease Control, Handbook on the Reporting of Induced Termination of Pregnancy, www.cdc.gov/nchs/data/misc/hb_itop.pdf (last visited on January 6, 2022).

⁷⁰ Section 390.0112(2), F.S.

⁷¹ Total Resident Live Births, Department of Health, available at <https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=Birth.DataViewer&cid=25> (last viewed January 8, 2022).

⁷² Reported Induced Terminations of Pregnancy by Reason, by Trimester, Agency for Health Care Administration, available at https://ahca.myflorida.com/mchq/central_services/training_support/docs/TrimesterByReason_2020.pdf (last viewed January 8, 2022).

⁷³ Id.

⁷⁴ Id.

⁷⁵ Id. The CDC compiles statistics voluntarily reported by the 50 states, the District of Columbia and New York City, related to termination of pregnancies to produce a national data report. *Abortion Surveillance- United States, 2019*, Surveillance Summaries, Centers for Disease Control and Prevention, November 26, 2021 / 70(9);1–29 <https://www.cdc.gov/mmwr/volumes/70/ss/ss7009a1.htm> (last visited on January 6, 2022).

⁷⁶ Section 390.0112(3), F.S.

⁷⁷ Section 390.0112(4), F.S.

⁷⁸ The FDA approved medication abortion regimen consists of mifepristone and misoprostol which may be taken through 70 days gestation (70 days or less since the first day of a woman's last menstrual period) to end a pregnancy. *Mifeprex (mifepristone) Information*, U.S. Food and Drug Administration, available at <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information> (last visited on January 15, 2022).

The bill addresses fetal and infant mortality reduction related to FIMR, hospital quality initiatives, comprehensive statewide tobacco education and use prevention, and abortion policy.

Fetal and Infant Mortality Review

The bill requires DOH to contract with local Healthy Start Coalitions to establish fetal and infant mortality review committees in all regions of the state, to improve fetal and infant mortality in each region. Each committee must:

- Review and analyze the geographic area's fetal and infant mortality rates, trends, causes, and other data;
- Develop findings and recommendations for interventions and policy changes to reduce rates; and
- Engage with local communities and stakeholders to implement recommended policies and procedures.

Each Coalition must report FIMR committee findings and recommendations to DOH annually. Beginning on October 1, 2023, DOH must compile FIMR committee findings and submit a report to the Governor, President of the Senate, and Speaker of the House of Representatives.

Comprehensive Statewide Tobacco Education and Use Prevention

The bill requires the Comprehensive Statewide Tobacco Education and Use Prevention Program to include a focus on pregnant women and women who may become pregnant in the program's components.

Hospitals and Infant Mortality

The bill requires hospitals that provide birthing services (labor and delivery) to participate in at least two quality improvement initiatives developed in collaboration with the FPQC at all times.

Abortion Regulation

HB 5 prohibits abortions if the physician performing abortion determines the gestational age of the fetus is more than 15 weeks, as calculated from the first day of the woman's last menstrual period. This replaces the current prohibition against abortions during the third trimester.

The bill retains the same medical exception to prohibited abortions in existing law:

- Two physicians certify in writing that, in reasonable medical judgment, the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition; or
- One physician certifies in writing that, in reasonable medical judgment, there is a medical necessity for legitimate emergency medical procedures for termination of the pregnancy to save the pregnant woman's life or avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition, and another physician is not available for consultation.

The bill adds an exception for fatal fetal abnormalities if two physicians certify in writing that, in reasonable medical judgment, the fetus has a fatal fetal abnormality. Because current law prohibits abortions past the gestational stage of viability, with no exceptions for fatal fetal abnormalities, this exception applies until the fetus reaches the gestational stage of viability. A fetal anomaly is a terminal condition that, in reasonable medical judgment, regardless of the provision of life-saving medical

treatment, is incompatible with life outside the womb and will result in death upon birth or imminently thereafter.

Abortion Reporting

HB 5 enhances and clarifies current abortion reporting requirements. The bill requires abortion providers to report whether abortions were due to human trafficking. The bill addresses potential data reporting gaps by requiring abortion providers to report both surgical and medication-induced abortions and to report the number of medication abortion regimens prescribed and dispensed. The bill also requires AHCA and the Boards to adopt an electronic reporting form. This provides greater regulatory oversight over the reporting requirement for physicians performing abortions outside of a medical facility.

B. SECTION DIRECTORY:

- Section 1:** Amends s. 381.84, F.S., relating to Comprehensive Statewide Tobacco Education and Use Prevention Program.
- Section 2:** Creates s. 383.21625, F.S., relating to fetal and infant mortality review committees.
- Section 3:** Amends s. 390.011, F.S., relating to definitions.
- Section 4:** Amends s. 390.0111, F.S., relating to termination of pregnancies.
- Section 5:** Amends s. 390.0112, F.S., relating to termination of pregnancies; reporting.
- Section 6:** Creates s. 395.0154, F.S., relating to birthing quality improvement initiatives.
- Section 7:** Appropriates funds to DOH to establish fetal and infant mortality review committees.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill appropriates \$260,000 in recurring General Revenue funds to DOH for the purpose of establishing FIMR committees in areas of the state where no state-funded FIMR committees exist. According to DOH, each FIMR committee contract is approximately \$22,000 annually, allowing DOH to contract with local Healthy Start Coalitions to establish 10 new FIMR committees and fund the 11 existing state-funded FIMR programs with Healthy Start, the three FIMR committees funded through local county health departments, and the two independently funded FIMR committees.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

Some local governments may experience an increase in revenues associated with state-funded FIMR programs as such counties may no longer need to fund local FIMR programs.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

See main analysis.

B. RULE-MAKING AUTHORITY:

Current law and the bill provide sufficient rule-making authority to implement the bill's provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES