The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1016
INTRODUCER:	Senator Hays
SUBJECT:	Sovereign Immunity for Dentists and Dental Hygienist
DATE:	March 11, 2013 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	McElheney	Stovall	HP	**Pre-meeting**
2.			JU	
3.			AHS	
4.			AP	
5.				
6.				

I. Summary:

SB 1016 provides a definition for the term "uncompensated services" as it relates to the extension of sovereign immunity to a dentist who is a government contracted health care provider under the Access to Health Care Act. Specifically, a voluntary contribution from the patient for dental laboratory expenses is not considered compensation for services.

This bill substantially amends section 766.1115 of the Florida Statutes.

II. Present Situation:

Access to Health Care Act

Section 766.1115, F.S., is entitled "The Access to Health Care Act" (the Act). The Act was enacted in 1992 to encourage health care providers to provide care to low-income persons.[1] This section extends sovereign immunity to health care providers who execute a contract with a governmental contractor and who provide volunteer, uncompensated health care services to low-income individuals as an agent of the state. These health care providers are considered agents of the state under s. 768.28(9), F.S., for purposes of extending sovereign immunity while acting within the scope of duties required under the Act.

[1] Low-income persons are defined in the Act as a person who is Medicaid-eligible, a person who is without health insurance and whose family income does not exceed 200 percent of the federal poverty level, or any eligible client of the Department of Health who voluntarily chooses to participate in a program offered or approved by the department.

Health care providers under the Act include:[2]

- A birth center licensed under chapter 383.
- An ambulatory surgical center licensed under chapter 395.
- A hospital licensed under chapter 395.
- A physician or physician assistant licensed under chapter 458.
- An osteopathic physician or osteopathic physician assistant licensed under chapter 459.
- A chiropractic physician licensed under chapter 460.
- A podiatric physician licensed under chapter 461.
- A registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under part I of chapter 464 or any facility which employs nurses licensed or registered under part I of chapter 464 to supply all or part of the care delivered under this section.
- A dentist or dental hygienist licensed under chapter 466.
- A midwife licensed under chapter 467.
- A health maintenance organization certificated under part I of chapter 641.
- A health care professional association and its employees or a corporate medical group and its employees.
- Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.
- A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.
- Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as any one of the professionals listed in subparagraphs 4.-9.
- Any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c) of the Internal Revenue Code, which delivers health care services provided by the listed licensed professionals, any federally funded community health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

A governmental contractor is defined in the Act as the Department of Health (DOH or department), a county health department, a special taxing district with health care responsibilities, or a hospital owned and operated by a governmental entity.[3]

The definition of contract under the Act provides that the contract must be for volunteer, uncompensated services. For services to qualify as volunteer, uncompensated services the health care provider must receive no compensation from the governmental contractor for any services provided under the contract and must not bill or accept compensation from the recipient, or any public or private third-party payor, for the specific services provided to the low-income recipients covered by the contract.[4]

[2] s. 766.1115(3)(d), F.S.
[3] s. 766.1115(3)(c), F.S.
[4] s. 766.1115(3)(a), F.S.

The Act further specifies contract requirements. The contract must provide that:

- The governmental contractor retains the right of dismissal or termination of any health care provider delivering services under the contract.
- The governmental contractor has access to the patient records of any health care provider delivering services under the contract.
- The health care provider must report adverse incidents and information on treatment outcomes.
- The governmental contractor must make patient selection and initial referrals.
- The health care provider must accept all referred patients, however the contract may specify limits on the number of patients to be referred.
- Patient care, including any follow-up or hospital care, is subject to approval by the governmental contractor.
- The health care provider is subject to supervision and regular inspection by the governmental contractor.

The governmental contractor must provide written notice to each patient, or the patient's legal representative, receipt of which must be acknowledged in writing, that the provider is covered under s. 768.28, F.S., for purposes of actions related to medical negligence.

The individual accepting services through this contracted provider must not have medical or dental care coverage for the illness, injury, or condition in which medical or dental care is sought.[5] The services not covered under this program include experimental procedures and clinically unproven procedures. The governmental contractor shall determine whether or not a procedure is covered.

The health care provider may not subcontract for the provision of services under this chapter.[6]

Currently, s. 766.1115, F.S., is interpreted differently across the state. In certain parts of the state one Medical Director interprets this law to mean that as long as there is transparency and clear proof that the volunteer provider is providing services, without receiving personal compensation, then the patient can pay a nominal amount per visit to assist in covering laboratory fees. In other parts of the state, a Medical Director suggests that if any monetary amount is accepted then sovereign immunity is pierced. Patients sometimes offer to pay a nominal contribution to cover some of the cost of laboratory fees that the provider incurs to pay outside providers for items such as dentures for the patient. In many areas the dentist is paying the cost of these fees from his or her own resources.[7]

Sovereign Immunity

The term "sovereign immunity" originally referred to the English common law concept that the government may not be sued because "the King can do no wrong". Sovereign immunity bars

[5] Rule 64I-2.001, F.A.C.
[6] Supra, fn 5
[7] Discussion notes from meeting with representatives from the Florida Dental Association on March 8, 2013.

lawsuits against the state or its political subdivisions for the torts of officers, employees, or agents of such governments unless the immunity is expressly waived.

Article X, s. 13, of the Florida Constitution recognizes the concept of sovereign immunity and gives the Legislature the right to waive such immunity in part or in full by general law. Section 768.28, F.S., contains the limited waiver of sovereign immunity applicable to the state.

Under this statue, officers, employees, and agents of the state will not be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event or omission of action in the scope of her or his employment or function, unless such officer, employee, or agent acted in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.

Instead, the state steps in as the party litigant and defends against the claim. Subsection (5) limits the recovery of any one person to $200,000 for one incidence and limits all recovery related to one incidence to a total of $300,000. The sovereign immunity recovery caps do not prevent a plaintiff from obtaining a judgment in excess of the caps but the plaintiff cannot recover the excess damages without action by the Legislature.[8]

Whether sovereign immunity applies turns on the degree of control of the agent of the state retained by the state.[9] In *Stoll v. Noel*, the Florida Supreme Court explained that independent contractor physicians may be agents of the state for purposes of sovereign immunity:

> One who contracts on behalf of another and subject to the other's control except with respect to his physical conduct is an agent and also independent contractor.[10]

The court examined the employment contract between the physicians and the state to determine whether the state's right to control was sufficient to create an agency relationship and held that it did.[11] The court explained:

> Whether the CMS physician consultants are agents of the state turns on the degree of control retained or exercised by CMS. This Court has held that the right to control depends upon the terms of the employment contract. *National Sur. Corp. v. Windham*, 74 So. 2d 549, 550 (Fla. 1954) ("The [principal's] right to control depends upon the terms of the contract of employment…") The CMS requires each consultant, as a condition of participating in the CMS program, to agree to abide by the terms published in its HRS[12] Manual and CMS Consultants Guide which contain CMS policies and rules governing its relationship with the consultants. The Consultant's Guide states that all services provided to CMS patients must be authorized in advance by the clinic medical director. The language of the HRS Manual ascribes to CMS responsibility to supervise and direct the medical care of all CMS patients and supervisory authority over all personnel. The manual also grants to the CMS medical director absolute authority over payment for

[8] Section 768.28(5), F.S.
[9] Stoll v. Noel, 694 So. 2d 701, 703(Fla. 1997)
[10] Stoll v. Noel, 694 So. 2d 701, 703(Fla. 1997) (quoting The Restatement of Agency)
[11] Stoll v. Noel, 694 So. 2d 701, 703(Fla. 1997)
[12] Florida Department of Health and Rehabilitative Services

treatments proposed by consultants. The HRS Manual and the Consultant's Guide demonstrate that CMS has final authority over all care and treatment provided to CMS patients, and it can refuse to allow a physician consultant's recommended course of treatment of any CMS patient for either medical or budgetary reasons.

Our conclusion is buttressed by HRS's acknowledgement that the manual creates an agency relationship between CMS and its physician consultants, and despite its potential liability in this case, HRS has acknowledged full financial responsibility for the physicians' actions. HRS's interpretation of its manual is entitled to judicial deference and great weight.[13]

III. Effect of Proposed Changes:

The bill amends s. 766.1115(3), F.S., to provide a definition for the term "uncompensated services." If a patient, or a parent or guardian of the patient, voluntarily contributes to the costs of dental laboratory expenses related to the care of the patient, the contribution is not considered compensation for the services.

The bill also amends s. 766.1115(4), F.S., to require another provision be included in the contract between the governmental contractor and the health care provider. The new provision authorizes a health care provider licensed under ch. 466, F.S., to allow a patient or a parent or guardian of the patient to voluntarily contribute a fee to cover costs of dental laboratory work related to the services provided to the patient. The contribution may not exceed the actual cost of the dental laboratory charges.

The effective date of the bill is July 1, 2013.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[13] Stoll v. Noel, 694 So. 2d 701, 703(Fla. 1997)

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The fiscal impact is expected to be minimal since many areas in the state already allow voluntary contributions.[14]

C. Government Sector Impact:

Additional documentation and billing may be required to avoid possible compensation to the practitioner. It could be unclear whether the services of the dentist's staff in coordinating lab services were compensated or not. This can be problematic if the dentist is volunteering through a professional association. Mistakes could result in litigation on the issue of compensation to the health care provider.[15]

VI. Technical Deficiencies:

The term "uncompensated services" is used in the definition of "contract" which governs the extension of sovereign immunity for a variety of health care providers under the Act. The definition of contract provides that it must be for volunteer, uncompensated services. The new definition of "uncompensated services" is tied to a health care provider licensed under ch 466, F.S. As a result, the entire Act may be limited to only apply to services voluntarily provided by dentists.

VII. Related Issues:

None

VIII. Additional Information:

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

None.

B. Amendments:

None.

[14] *See* Department of Health Bill Analysis for SB 1016(dated March 11, 2013) on file with the Senate Health Policy Committee and notes from telephone call with staff on March 12, 2013.
[15] *See* Department of Health Bill Analysis for S B 1016(dated March 11, 2013) on file with the Senate Health Policy Committee.