HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1293 CS Medical Malpractice Insurance
SPONSOR(S): Grant
TIED BILLS: **IDEN./SIM. BILLS:** SB 2160

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee	9 Y, 2 N, w/CS	Bell	Mitchell
2) Health & Families Council		Bell	Moore
3)			
4)			
5)			

SUMMARY ANALYSIS

HB 1293 with CS creates ss. 766.401-766.406, F.S., to provide incentives for statutory teaching hospitals to implement hospital-wide patient safety programs and to address the issue of medical malpractice.

The bill specifies the six statutory teaching hospitals in the state as eligible to participate in the Patient Safety and Provider Liability Act. The hospitals targeted in the bill are: Jackson Memorial Hospital, Tampa General Hospital, Shands at the University of Florida, Shands Jacksonville, Orlando Regional Medical Center, and Mount Sinai Medical Center.

The bill encourages and provides incentives for the eligible hospitals to create a patient safety plan that includes an array of patient safety protection measures that are described in s. 766.403, F.S, created in the bill. Some of the incentives include participation in the Florida Patient Safety Corporation's "near miss" reporting system and implementation of a simulation-based program for skills assessment, training, and retraining of facility staff. Patient safety plans would be reviewed and certified by the Agency for Health Care Administration.

A hospital that obtains certification from AHCA would qualify for a $500,000 limit on noneconomic damages in medical malpractice actions, and periodic payments of economic damages.

The bill also clarifies that *any* hospital may extend insurance or self-insurance coverage to members of its medical staff.

It is unclear how many eligible hospitals would submit a patient safety plan to be certified by the Agency for Health Care Administration (AHCA). AHCA may incur a cost to certify patient safety plans created in the bill. AHCA did not provide the Health Care Regulation Committee with an estimated fiscal impact.

The effective date of the bill is upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government – The bill creates parameters for patient safety plans. Eligible hospitals would be required to get their plans certified by the Agency for Health Care Administration (AHCA). Eligible hospitals with certified patient safety plans would qualify for a $500,000 cap on noneconomic damages arising from medical malpractice and periodic payments of economic damages.

Empower Families – The patient safety plan requirements are likely to improve the quality of care for patients in certified patient safety facilities.

B. EFFECT OF PROPOSED CHANGES:

Overview

The bill creates ss. 766.401-766.406, F.S., to provide incentives for statutory teaching hospitals to implement hospital-wide patient safety programs and to address the issue of medical malpractice.

The bill creates an unnumbered section to designate a short title and provide legislative findings. The short title is, "Patient Safety and Provider Liability Act."

The bill specifies the six statutory teaching hospitals in the state as eligible to participate in the Patient Safety and Provider Liability Act. The hospitals are: Jackson Memorial Hospital, Tampa General Hospital, Shands at the University of Florida, Shands Jacksonville, Orlando Regional Medical Center, and Mount Sinai Medical Center.

The bill encourages and provides incentives for the eligible hospitals to create a patient safety plan that includes an array of patient safety protection measures that are described in s. 766.403, F.S, created in the bill.

Patient safety plans are reviewed and certified by the Agency for Health Care Administration (AHCA). Plans must satisfy all the requirements created in ss. 766.401-766.405, F.S. The patient safety provisions include: participation in the Florida Patient Safety Corporation's "near miss" reporting system, implementation of an early intervention program that provides additional skill training, and a simulation program for skills assessment, training, and staff retraining.

An eligible hospital that obtains certification from AHCA that its patient safety plan meets the requirements qualifies for a $500,000 limit on noneconomic damages in medical malpractice actions and may make periodic payments of economic damages.

The bill amends s. 766.110, F.S. to clarify that any hospital may extend insurance or self-insurance coverage to members of its medical staff.

The effective date of the bill is upon becoming law.

Patient Safety Certification

The bill provides incentives for statutory teaching hospitals to seek designation as a certified patient safety facility by submitting a petition to the Agency for Health Care Administration (AHCA). The petition would seek an AHCA order approving the facility's patient safety plan. The order would remain in effect until revoked by AHCA. The bill requires hospitals with certified patient safety plans to submit an annual report to AHCA.

Patient Safety Requirements

A patient safety plan must include several comprehensive patient safety measures and procedures. In order for a statutory teaching hospital to qualify for the $500,000 cap on noneconomic damages and periodic payments of economic damages, an eligible hospital's patient safety plans must:

- Have in place a process for coordinating the quality control, risk management, and patient-relations functions of the facility and for reporting to the facility's governing board at least quarterly regarding such efforts;
- Establish within the facility a system for reporting near misses and agree to submit any information collected to the Florida Patient Safety Corporation (FPSC);
- Design and make available to facility staff a patient-safety curriculum that provides lectures and web-based training on recognized patient-safety principles. It may include training in communication skills, team-performance assessment and training, risk-prevention strategies, and best practice and evidenced based medicine. The licensed facility shall report annually to AHCA;
- Implement a program to identify health care providers on the facility's staff who may be eligible for an early intervention program that provides additional skills for assessment and training and offer such training to the staff on a voluntary and confidential basis with established mechanisms to assess program performance and results;
- Implement a simulation-based program for skills assessment, training, and retraining of a facility's staff in those tasks and activities that AHCA identifies by rule;
- Designate a patient advocate who coordinates with members of the medical staff and the facility's chief medical officer regarding the disclosure of adverse medical incidents to patients. In addition, the patient advocate shall establish an advisory panel, consisting of providers, patients and their families, and other health care consumers or consumer groups to review general patient-safety concerns and other issues related to relations among and between patients and providers and to identify areas where additional education and program development may be appropriate;
- Establish procedures to biennially review the facility's patient-safety program and its compliance with s. 766.402, F.S. Such review shall be conducted by an independent patient-safety organization as defined by s. 766.1016(1), F.S., or other professional organization approved by AHCA. The organization performing the review shall prepare a written report that contains detailed findings and recommendations. The report shall be forwarded to the facility's risk manager or patient-safety officer, who may make written comments in response. The report and any written comments shall be presented to the governing board of the licensed facility. A copy of the report and any of the facility's responses to the findings and recommendations shall be provided to AHCA within 60 days after the date that the governing board reviewed the report.; and
- Establish a system for trending and tracking of quality patient-safety indicators that AHCA may identify by rule, and a method for review of the data at least semiannually by the facility's patient-safety committee.

Limits on Nonecomonic Damages

In exchange for the patient safety provisions included in the statutory teaching hospital's patient safety plans, eligible hospitals will have a $500,000 limit on noneconomic damages in medical malpractice actions, regardless of number of claimants, number of claims, or theory of liability, including vicarious liability, arising from the same nucleus of operative fact.

Periodic Payments of Economic Damages

Another benefit of compliance with the patient safety plan requirements, is that teaching hospitals will be permitted to make periodic payment of future economic damages. This will provide for the payment of damages over time, rather than lump-sum payments.

The bill requires periodic payments to be paid through an annuity or a reversionary trust. The annuity underwriting company must have a rating of “A” or higher by A.M. Best Company.

Legislative Findings

The bill provides legislative findings and intent related to medical education in Florida, patient safety, medical malpractice, and statutory teaching hospitals. The bill makes the following legislative findings:

- This state is in the midst of a prolonged medical malpractice insurance crisis that has serious adverse effects on patients, practitioners, licensed health care facilities, and all residents of this state.
- Hospitals are central components of the modern health care delivery system.
- The medical malpractice insurance crisis in this state can be alleviated through the adoption of innovative approaches for patient safety in teaching hospitals, which can lead to a reduction in medical errors coupled with a limitation on noneconomic damages that can be awarded against a teaching hospital that implements such innovative approaches.
- Statutory incentives are necessary to facilitate innovative approaches for patient safety in hospitals and that such incentives and patient-safety measures will benefit all persons seeking health care services in this state.
- Coupling patient safety measures with a limitation on provider liability in teaching hospitals will lead to a reduction in the frequency and severity of incidents of medical malpractice in hospitals.
- A reduction in the frequency and severity of incidents of medical malpractice in hospitals will reduce attorney’s fees and other expenses inherent in the medical liability system.
- There is no alternative method that addresses the overwhelming public necessity to implement patient-safety measures and limit provider liability.
- Making high-quality health care available to the residents of this state is an overwhelming public necessity.
- Medical education in this state is an overwhelming public necessity.
- Statutory teaching hospitals are essential for high-quality medical care and medical education in this state.
- The critical mission of statutory teaching hospitals is severely undermined by the ongoing medical malpractice crisis.
- Teaching hospitals are appropriate health care facilities for the implementation of innovative approaches to enhancing patient safety and limiting provider liability.
- There is an overwhelming public necessity to impose reasonable limitations on actions for medical malpractice against teaching hospitals in furtherance of the critical public interest in promoting access to high-quality medical care, medical education, and innovative approaches to patient safety and provider liability.
- There is an overwhelming public necessity for teaching hospitals to implement innovative measures for patient safety and limit provider liability in order to generate empirical data for state policymakers concerning the effectiveness of these measures. Such data may lead to broader application of these measures in a wider array of hospitals after a reasonable period of evaluation and review.
- There is an overwhelming public necessity to promote the academic mission of teaching hospitals. Furthermore, the Legislature finds that the academic mission of these medical facilities is materially enhanced by statutory authority for the implementation of innovative approaches to promoting patient safety and limiting provider liability. Such approaches can be carefully studied and learned by medical students, medical school faculty, and affiliated physicians in appropriate clinical settings, thereby enlarging the body of knowledge concerning patient safety and provider liability which is essential for advancement of patient safety and reduction of expenses inherent in the medical malpractice insurance crisis in this state.

CURRENT SITUATION

Patient Safety Requirements

Currently hospitals are required to have a number of patient safety provisions. Section 395.1012, F.S. requires all hospitals to adopt a patient safety plan, a patient safety officer, and a patient safety committee. The various structures hospitals have developed to meet this requirement vary in composition and quality.

As part of the health care practitioner general licensing provisions in s. 456.013, F.S., health care practitioners are required to take a 2-hour course relating to prevention of medical errors as part of the licensure and biennial renewal process.

As part of licensure, hospitals are required in s. 395.0197, F.S., to have an internal risk management program. The internal risk management program requires hospitals and physicians to disclose adverse incidents to patients. The Agency for Health Care Administration (AHCA) collects data on certain adverse incidents. These reports are known as "code 15" reports. Hospitals must report to AHCA within 15 days:

- The death of a patient;
- Brain or spinal damage to a patient;
- The performance of a surgical procedure on the wrong patient;
- The performance of a wrong surgical procedure;
- The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition;
- The surgical repair of damage resulting to a patient from a planned surgical procedure; and
- The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure.

There are currently no requirements for any hospital to participate in the Florida Patient Safety Corporation (FPSC) "near miss" reporting system. Near miss reporting is important to patient safety because if researchers can understand how near errors were averted they can prevent future errors.

Medical Malpractice Caps on Noneconomic Damages

In 2003, the Legislature adopted several medical malpractice reforms, including caps on noneconomic damages in an action for personal injury or wrongful death arising from medical negligence by a practitioner or nonpractitioner:

- For an injury other than a permanent vegetative state or death, noneconomic damages are capped at $500,000 from each practitioner defendant and $750,000 from a nonpractitioner defendant. However, no more than $1 million and $1.5 million can be recovered from all practitioner defendants and all nonpractitioner defendants, respectively, regardless of the number of claimants. Alternatively, the $500,000 cap and $750,000 cap can be "pierced" to allow an injured patient to recover up to $1 million and $1.5 million aggregated from all practitioner defendants and all nonpractitioner defendants, respectively, if the injury qualifies as a catastrophic injury and manifest injustice would occur if the cap was not pierced.
- For an injury that is a permanent vegetative state or death, noneconomic damages are capped at $1 million and $1.5 million from practitioner defendants and nonpractitioner defendants, respectively, regardless of the number of claimants.
- For any type of injury resulting when a practitioner provides emergency services in a hospital or life support services including transportation, provided there is no pre-existing health care patient-practitioner relationship, noneconomic damages are capped at $150,000 per claimant but cannot exceed $300,000, regardless of the number of claimants or practitioner defendants. This cap only applies to injuries prior to the patient being stabilized.

- For any type of injury resulting when a nonpractitioner provides emergency services in a hospital or prehospital emergency treatment pursuant to statutory obligations, provided there is no pre-existing health care patient-practitioner relationship, noneconomic damages are capped at $750,000 per claimant from all nonpractitioner defendants but cannot exceed $1.5 million, regardless of the number of claimants or nonpractitioner defendants.

Periodic Payment of Economic Damages

Periodic payments for the purposes of medical malpractice claims are allowed in section 766.202, F.S. The section authorizes the payment of an award of future economic damages through structured payments over a period of time.

"Periodic payment" is defined to mean provision for the spreading of future economic damage payments, in whole or in part, over a period of time, as follows:

- A specific finding of the dollar amount of periodic payment which will compensate for future damages after offset by collateral sources must be made;
- The defendant must post a bond or security to assure full payment of these damages awarded. The bond must be written by a company that is rated A+ by A. M. Best Company. If the defendant is unable to adequately assure full payment of the damages, all damages reduced to present value shall be paid to the claimant; and
- The provision for payment of future damages must specify the recipient or recipients of payments.

The Governor's Self Task Force on Healthcare Professional Liability Insurance recommended that the Legislature should amend the Florida Statutes to allow the periodic payment of future noneconomic damages and the Legislature should amend the Florida Statutes to terminate the payment of future economic and noneconomic damages upon the death of the plaintiff.

The courts have upheld the use of annuities to cover future payments in medical malpractice judgments in *St. Mary's Hospitals, Inc. v. Phillipe*[1] and *Tallahassee Memorial Regional Medical Center, Inc. v Kinsey*[2].

Hospitals Insuring Medical Staff

Section 766.110, F.S., currently authorizes hospitals to extend insurance coverage to their medical staff. Hospitals must charge their staff a fair market rate for the insurance provided. The bill clarifies that if a hospital self-insures, it may extend its self-insurance to its medical staff.

BACKGROUND

The Florida Patient Safety Corporation

The Florida Patient Safety Corporation (FPSC) was created as part of the medical malpractice legislation passed after many special sessions in 2002 and was established by the Legislature in 2004. HB 1629 created the Corporation, under s. 381.0271, F.S.

The FPSC does not regulate health care providers in the state. The FPSC is intended to serve as a learning organization, assist health care providers to improve the quality and safety of health care, reduce harm to patients, and work with a consortium of patient safety centers and other patient safety programs within the state.

[1] 699 So.2d 1017 (Fla. 1st DCA 1997), reh'g denied (Oct. 22, 1997)
[2] 655 So.2d 1191 (Fla. 1st DCA 1995), reh'g denied (June 21, 1995), review denied, 622 So. 2d 344

Only a handful of states have taken the initiative to establish patient safety organizations. Florida has the most comprehensive patient safety mandate. The Legislature mandated a long list of important tasks for the FPSC. House Health Care Regulation Committee staff has monitored the development of the FPSC by attending Board meetings, participating in conference calls, and attending select advisory meetings.

As demonstrated in their yearly Progress Report published December 1, 2005, the FPSC is moving ahead on nearly all of its mandates. One of the key duties the FPSC is charged with is creating a medical error, near miss reporting system. Near miss reporting is essential to patient safety because if researchers can understand how near errors were averted they can prevent future errors. Part of medical error prevention involves looking into medical errors and "near misses" to find the root cause of the errors. The near miss data reporting system is being developed in coordination with the University of Miami/JMH Center for Patient Safety, Marsh/STARS, and CRG Medical. The near miss reporting system will have the following characteristics:

- Reporting will be voluntary, anonymous and independent of mandatory reporting systems used for regulatory purposes;
- Reports of near miss data will be published regularly;
- Special alerts will be published regarding newly identified significant risks;
- Aggregated data will be made publicly available; and
- The FPSC will report the performance and result of the near miss project in its annual report.

The FPSC expects to go live with the near miss reporting system in March 2006 and is currently recruiting hospitals to participate.

Spotlight Patient Safety: The Institute of Medicine, *To Err is Human* Report

Since the National Institute of Medicine (IOM) released *To Err is Human: Building a Safety Health System*[3] in 1999, the nation has been trying to make the institution of medicine safer. The IOM report concluded that as many as 44,000 to 98,000 people die in hospitals each year as the result of medical errors. Medical errors result in more deaths than breast cancer, AIDS, or car accidents. Further, the report concluded that 1 in 25 hospital patients are injured by medical errors. These errors come at a large cost to society. IOM estimates that medical errors cost approximately $37.6 billion each year and that about $17 to $29 billion of the costs are associated with preventable errors.[4]

The IOM report in 1999 brought patient safety into the political spotlight. The federal government, provider organizations, purchasers, and consumers are all focused on the issue. The states, with their responsibility to protect public health and safety, addressed patient safety in a number of ways. The National Academy for State Health Policy (NASHP) reports that initially States concentrated on the idea of mandatory adverse incident reporting. More recently, states have been moving towards a systems approach to patient safety. States recognize that in order to improve the safety of the health care system, they must collaborate with providers, consumers, and purchasers; provide leadership to establish clear goals; develop useful benchmarks to measure progress; and coordinate across all agencies of state government to achieve desired outcomes.[5]

A Systems Problem: Most Medical Errors Preventable

The IOM emphasized that most of the medical errors are systems related and not attributable to individual negligence or misconduct. The key to reducing medical errors is to focus on improving the systems of delivery of care and not to blame individuals. Health care professionals are human and, consequently, they

[3]Institute of Medicine, To Err is Human: Building a Safer Health System, Institute of Medicine, (Washington, D.C.: National Academy Press 1999).
[4] Berntsen, K.J., "How Far Has Healthcare Come since, To Err is Human?" Journal of Nurse Care Quality 19 (2004): 5-7.
[5] Rosenthal, J. & Booth, M., "The Flood Tide Forum – State Patient Safety Centers: A new approach to promote patient safety," National Institute on State Health Policy (2004).

make mistakes. But research has shown that system improvements can substantially reduce the error rates and improve the quality of health care.

The Case for Patient Safety Incentives

There is widespread agreement that the health care system is broken. Costs are rising and there are deficiencies in quality of care and reliability of care. Incentives are one of the techniques recommended by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Centers for Medicare and Medicaid Services (CMS) to create systems change. Financial incentives are one of the most powerful tools for bringing about behavioral change.[6] Re-aligning the financial incentives at the heart of our current health care system to focus on quality of care, safety, and outcomes is long over due.

Currently, provider reimbursement depends less on the quality of care and resulting health outcomes, and more on the intensity and frequency of services delivered. Florida Statutes provide for incentives as, "a mechanism for recognizing the achievement of performance standards or for motivating performance that exceeds performance standards (s. 216.011, F.S.).

Ideally, realignment of incentives can benefit all stakeholders. Payers, including employers and health plans, can benefit from reduced direct costs due to improved care and outcomes. Employers also can benefit from indirect cost reductions due to increased on-the-job productivity and reduced absenteeism through workers receiving better care. Physicians and hospitals can gain financial rewards and the benefits of increased visibility and recognition for performance excellence and potentially reduce malpractice claims. Finally, consumers can gain from greater choice and access to higher quality of care.[7]

The most popular incentive programs offer financial rewards to increase quality, manage costs, increase patient satisfaction, or invest in and implement technology. Although most incentives are monetary, programs may utilize a combination of financial and non-financial rewards.

Florida Statutory Teaching Hospitals

The incentives created by the bill are only eligible to statutory teaching hospitals. There are currently six major teaching hospitals. They include:

- University Medical Center (UMC) in Jacksonville, affiliated with the University of Florida;
- Mount Sinai Hospital (MSH) in Dade County, affiliated with the University of Miami;
- Jackson Memorial (JM)[8] in Dade County, affiliated with the University of Miami;
- Shands Teaching Hospital in Gainesville, affiliated with University of Florida;
- Tampa General (TG), affiliated with University of South Florida; and
- Orlando Regional Medical Center (ORMC), affiliated with the University of Florida.

One of the primary missions of the six Florida teaching hospitals is to train interning physicians and a second is to provide primary sites of care for Florida's indigent population. Each teaching facility receives public subsidies (taxes, grants, and other public revenue) to assist with financing these missions. The range of indigent care and therefore public subsidy support (and operational losses) varies widely.

The six major teaching hospitals account for 80 percent of all graduate medical education (i.e., medical residents), 50 percent of all indigent care, and 30 percent of all Medicaid treatment in Florida. Everyday, Florida's statutory teaching hospitals deliver high quality tertiary health care services to thousands of needy

[6] "Principles for the Construct of Pay-For-Performance Programs," Joint Commission on Accreditation of Healthcare Organizations (2005) Online at: [www.jcaho.org].
[7] Conklin, J., & Weiss, A., "Pay-for-performance: Assembling the building blocks of a sustainable program," Thomson Medstat, Online at: [www.medstat.com].
[8] Jackson Memorial currently has sovereign immunity.

patients. These patients often present themselves with advanced disease and are therefore at higher risk for poor health outcomes.[9]

Kluger Test for Limitations on Access to Courts

Kluger v. White, 281 So.2d 1 (Fla. 1973) established the general proposition that the Legislature may abridge a common law right to recover damages in a civil action (without offending Florida's constitutional right of access to courts) upon a showing of "commensurate benefit" to potential claimants or "an overwhelming public necessity" and proof of "no alternative" for the legislative enactment.

The first prong of the *Kluger* test has been used to sustain the constitutionality of statutory limitations on damages for personal injury in certain automobile accidents, industrial accidents, and birth related neurological injuries.

The second prong of *Kluger* has been used to uphold the constitutionality of legislation providing for a contingent cap on noneconomic damages tied to an early resolution scheme in medical malpractice cases.[10]

Recent Nationwide limits on Medical Malpractice

Medical malpractice tort law has always been maintained at the state level. All states have at least some laws governing medical liability lawsuits. The vast majority of states have statutes of limitation of two years for standard medical malpractice claims. Over half of the states have limits on damages awards. Almost all states have eliminated joint and several liability in malpractice lawsuits, and many states have established limits on attorney fees.

In 2005 alone, 48 state legislatures responded to calls for medical liability reform through the introduction of some 400 bills to address the situation. Solutions ranged from enacting limits on noneconomic damages, to malpractice insurance reform, to gathering lawsuit claim data from malpractice insurance companies and the courts for the purpose of assessing the connection between malpractice settlements and premium rates. During the 2005 legislative session, 32 states enacted over 60 bills, and 2 more states had Supreme Court rulings relating to medical liability lawsuit statutes. Some states chose to enact a number of reforms within one bill; other states enacted a number of bills, each addressing one or two points of medical liability reform. The solutions proposed and variety of aspects addressed in the state legislation demonstrate the diversity of the problem of medical liability insurance costs from state to state. 2003 and 2004 also saw discussion and debate in the state legislatures as they progressed through concerns on medical liability costs.[11]

C. SECTION DIRECTORY:

Section 1. – Creates the short title, "Patient Safety and Provider Liability Act."

Section 2. – Provides legislative findings relating to medical malpractice insurance, role of hospitals, statutory teaching hospitals, and patient safety.

Section 3. – Amends s. 766.110, F.S., to allow hospitals to extend insurance or self-insurance to their medical staff.

Section 4. – Amends s. 766.118, F.S., to provide a $500,000 cap on medical malpractice noneconomic damages for qualifying statutory teaching hospitals.

Section 5. – Creates s. 766.401, F.S., to provide definitions.

[9] Information supplied by the University of Miami, 2005.
[10] *University of Miami v. Echarte,* 618 So.2d 189
[11] National Conference of State Legislatures, Medical Malpractice Tort Reform, 2006.

Section 6. – Creates s. 766.402, F.S., to provide for the Agency for Health Care Administration to approve statutory teaching hospital patient-safety plans.

Section 7. – Creates s. 766.403, F.S., to provide standards for patient-safety plans.

Section 8. – Creates s. 766.404, F.S., to direct each certificated patient-safety facility to submit an annual report to the Agency for Health Care Administration.

Section 9. – Creates s. 766.405, F.S., to allow for economic damages awarded in a medical malpractice case to be paid through periodic payments in the form of an annuity or a reversionary trust.

Section 10. – Creates s. 766.406, F.S., to give AHCA rulemaking authority to administer ss. 766.401-766.405, F.S.

Section 11. – Provides that the provisions of this act are severable.

Section 12. – Provides that this act shall govern in the instance of conflicts with professional licensing statutes.

Section 13. – States that the Legislature intends that the provisions of this act are self-executing.

Section 14. – Provides that this act shall take effect upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Indeterminate.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

It is unclear how many eligible hospitals would submit a patient safety plan to be certified by the Agency for Health Care Administration (AHCA). AHCA may incur a cost to certify patient safety plans created in the bill. AHCA did not provide the Health Care Regulation Committee with an estimated fiscal impact.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

Article I, section 21, of the Florida Constitution, guarantees access to courts, providing as follows:

> The courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay.

The Florida Supreme Court has consistently[12] held that the Legislature may not impose a monetary cap on noneconomic damages unless it provides a commensurate benefit, or it shows:

- An overpowering public necessity for the abolishment of the right to such damages exists; and
- There is no alternative method of meeting the public necessity.

B. RULE-MAKING AUTHORITY:

The bill provides the necessary rule making authority to carry out the provisions in the act.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

On March 22, 2006 the Health Care Regulation Committee adopted 5 amendments and reported the bill favorably.

- **Amendment 1:** Removes section three of the bill because insurance companies may already offer medical malpractice policies that exclude hospital coverage under current law.
- **Amendment 2:** Technical amendment that specifies that a hospital does not need a verified trauma center on the premises to extend insurance or self-insurance to its medical staff.
- **Amendment 3:** Clarifies that insurance coverage offered by hospitals to their medical staff must be limited to the hospital premises.
- **Amendment 4:** Allows “approved” insurers the option to offer insurance packages that allow hospital to insure their medical staff.
- **Amendment 5:** Clarifies that the benefits of caps on noneconomic damages and periodic payments apply only when eligible hospitals are employing physicians “full-time.”

The analysis is drafted to the committee substitute.

[12] *Smith v. Department of Insurance*, 507 So. D2 1080 (Fla. 1987), *Kuger v. White*, 281 So.2d 1 (Fla. 1973)