SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/SB 560

SPONSOR: Health, Aging, and Long-Term Care Committee and Senator Saunders

SUBJECT: Medical Malpractice

DATE: March 20, 2003 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Munroe	Wilson	HC	Favorable/CS
2.			JU	
3.			AP	
4.			RC	
5.				
6.				

I. Summary:

This bill contains provisions relating to medical malpractice insurance. The bill requires the Department of Health to forward to the Office of Insurance Regulation information that it collects from Florida-licensed physicians and dentists regarding professional liability claims that are not otherwise reported to the Office of Insurance Regulation.

Under the bill, the rating standards for certain property, casualty, and surety insurances are revised to prohibit the inclusion of payments made by insurers for bad faith or punitive damages in the insurer's rate base. Such payments shall not be used to justify a rate or rate change.

The bill eliminates an existing prohibition against creating new medical malpractice self-insurance funds. The Office of Insurance Regulation is authorized to adopt rules relating to medical malpractice self-insurance funds.

The Office of Insurance Regulation is required to adopt rules regarding information about professional liability closed claims that will assist the office in analyzing the nature, causes, location, cost and damages involved in such claims and is required to impose a fine against insurers for violations of the closed claims reporting requirements. The bill requires additional entities to report medical malpractice actions or claims to the Office of Insurance Regulation.

The bill requires the Office of Program Policy Analysis and Government Accountability to study the eligibility requirements for a birth to be covered under the Florida Birth-Related Neurological Injury Compensation Association and report to the Legislature by January 1, 2004.

Hospitals, ambulatory surgical centers, and mobile surgical facilities are authorized to apply to the Department of Financial Services for certification of any program that is recommended by

the Florida Center for Excellence in Health Care to reduce adverse incidents. Insurers must file with the department a discount in the rate or rates applicable for insurance coverage to reflect the effect of a certified program and these facilities must receive a discount in the rate or rates applicable for mandated basic insurance coverage required by law.

This bill amends amending ss. 456.049, 627.062, 627.357, and 627.912, Florida Statutes.

This bill creates s. 627.9121, F.S., and two undesignated sections of law.

II. Present Situation:

Availability and Affordability of Medical Malpractice Insurance

Medical malpractice insurance covers doctors and other professionals in the medical field for liability claims arising from their treatment of patients. Rapidly rising medical malpractice insurance premiums and the departure of many insurance companies from the medical malpractice market have created a crisis of affordability and availability in many areas of the country, including Florida.

After almost a decade of essentially flat prices, medical malpractice insurance premiums began rising in 2000. According to the Department of Insurance, rate increases for physicians and surgeons from the top 15 professional liability insurers (ranked by direct written premium in Florida as reported 12/31/01) ranged from a minimum of 33.5 percent to a maximum of 149.9 percent from 1/1/01 through 1/1/03. There was a 73 percent average rate increase, weighted for market share. Rate increases for the top three insurers ranged from 74.3 percent to 81.3 percent for the two-year period.

In October, 2002, the Department of Insurance surveyed 18 insurers (top 15 malpractice writers in Florida and three other insurers known to be writing coverage) to determine the status of insurers departing the state and the status of insurers writing new business. Of the 18 insurers, five medical malpractice insurers had decided to no longer write any new or renewal business in Florida. Four additional insurers were not accepting any new business from physicians. Nine remaining insurers were still accepting new business in October, 2002. As of February 28, 2003, the largest medical malpractice insurer in the state, which had not been writing new business in October, 2002, decided to resume writing new business.

While there is general agreement that medical malpractice insurance premiums have risen sharply and that physicians are having a more difficult time obtaining medical malpractice insurance coverage, there appears to be little agreement on the causes of these problems. Insurers and doctors blame “predatory” trial attorneys, “frivolous” law suits, and “out of control” juries for the spike in insurance premiums. Consumer groups accuse insurance companies of “price gouging” and cite “exorbitant” rates of medical errors. Plaintiffs’ attorneys also point to medical errors, and to “predatory” pricing practices and bad business decisions of insurers during the 1990s.

There is also disagreement about possible solutions to these problems. Insurers and physicians demand tort reform, changes in the legal system that will limit the frequency of litigation and the

amount of damage awards. Attorneys argue that past legal reform has unfairly blocked victims' access to the courts while doing nothing to bring down the costs of malpractice insurance. They see the solution in regulation of the insurance industry. Patient advocates focus on safety and suggest mandatory reporting of medical errors and a no-fault approach to victim compensation.

Whatever the causes and solutions, the effects of the rising cost of medical malpractice insurance and the reduction in the availability of such coverage are being felt in Florida's health care system. There have been numerous reports of doctors discontinuing doing risky procedures, retiring prematurely, practicing without insurance, and leaving litigious areas of the state in an effort to deal with the price of liability coverage. In some cases, the decision of high risk specialists to reduce or eliminate their services has led to further reductions in services by hospitals. Some hospitals are discontinuing services such as maternity services and trauma services because of the high cost of malpractice coverage for the specialists needed to provide these services.

Governor's Select Task Force on Healthcare Professional Liability Insurance

In recognition of the problems with the affordability and availability of medical malpractice insurance, Governor Bush appointed the Governor's Select Task Force on Healthcare Professional Liability Insurance on August 28, 2002, to address the impact of skyrocketing liability insurance premiums on health care in Florida. The Task Force was charged with making recommendations to prevent a future rapid decline in accessibility and affordability of health care in Florida and was further charged to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 31, 2003.

The Task Force had ten meetings at which it received testimony and discussed five major areas: (1) health care quality; (2) physician discipline; (3) the need for tort reform; (4) alternative dispute resolution; and (5) insurance premiums and markets. The final report of the Task Force includes findings and 60 recommendations to address the medical malpractice crisis in Florida. The reports and information received by the Task Force, as well as transcripts of the meetings, were compiled into thirteen volumes that accompany the main report.

The following recommendations relating to medical malpractice insurance are included in the final report of the Task Force.

> *Recommendation 4.* The Legislature should be encouraged to authorize the two "no fault" medical malpractice demonstration projects recommended in the November 2002 report, Fostering Rapid Advances in Healthcare, by the Institute of Medicine (IOM) at a university healthcare system or statutory teaching hospital. This project would be governed by criteria compatible with that proposed by the IOM.
>
> *Recommendation 5.* If Recommendation 4 is implemented, contingency fees for attorneys should be eliminated from the claims bill process in the no-fault demonstration project.
>
> *Recommendation 9.* The Legislature should examine the feasibility of developing a process in the Insurance Code for hospitals and other healthcare facilities to receive malpractice insurance discounts if they implement certified patient safety programs.

Recommendation 47. The Legislature should maintain the NICA program because of its success and should further consider and study the issues for broadening the NICA program, as discussed in this report.

Recommendation 48. The Legislature should restore the insured as the owner of the bad faith cause of action. The common law cause of action, as outlined by the Supreme Court in 1980 should be legislatively cured so that the Florida Legislature preempts that rule and only insured, not third party plaintiffs, can bring a bad faith cause of action against its insurer. In addition, section 624.155, Florida Statutes, should be amended to also limit the proper party in a bad faith cause of action to the insured only.

Recommendation 49. The Legislature should articulate standards of what constitutes bad faith on the part of an insurer.

Recommendation 50. The Legislature should require that the maximum liability for bad faith be calculated as the amount of damages that were actually caused by the acts of bad faith, limited by the amount of the reachable assets of the insured.

Recommendation 51. The Legislature should require that, if an insurer is found to be in bad faith or settles a case for bad faith, the Department of Insurance be notified of such finding.

Recommendation 52. The Department of Insurance should conduct an investigation into the specific allegations of the insurer and into the insurer's general practices and should take necessary action against the insurer to punish and prevent future bad faith practices.

Recommendation 53. The Legislature should repeal the prohibition against creating Medical Malpractice Risk Management Trust Funds in section 627.357, Florida Statutes.

Recommendation 54. The Legislature should encourage the creation of self-insured options for healthcare providers.

Recommendation 55. The Legislature should expand the rulemaking authority of the Department of Insurance for self-insurance programs to ensure they remain solvent and provide the insurance coverage purchased by participants.

Recommendation 56. The Legislature should authorize the Department of Insurance to require insurers to provide additional information on closed claims and to penalize the insurers for failure to provide the required data.

Recommendation 57. The Department of Health should forward the information collected pursuant to section 456.049, Florida Statutes, to the Department of Insurance.

Recommendation 58. The Legislature should require every entity reporting to the National Practitioner Data Bank to report the same information to the Department of Insurance for inclusion in the closed claim data files.

Recommendation 59. The Legislature should require the Department of Insurance to compile and review the collected data and fine those entities failing to fully comply with the requirements of law.

Recommendation 60. The Legislature should include in section 627.062, Florida Statutes, related to the setting of rates for most insurers, the provisions of section 627.0651(12), Florida Statutes, prohibiting the inclusion of payments made by insurers for bad faith or punitive damages claims.

Reporting of Professional Liability Closed Claims

Certain insurers providing professional liability insurance to health care practitioners, and certain physicians and dentists licensed in Florida, are required to report liability claims, once they are closed, to various governmental agencies under state and federal law.

Section 627.912, F.S., requires each medical malpractice self-insurer and each insurer or joint underwriting association providing professional liability insurance to specified health care practitioners and facilities, health maintenance organizations, and members of the Florida Bar to report to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of such insured's professional services or based on a claimed performance of professional services without consent, if the claim resulted in:

- A final judgment in any amount; or
- A settlement in any amount.

The Department of Insurance has applied the closed claim reporting requirements to those insurers over which they have regulatory control, i.e. authorized insurers that have a Certificate of Authority from the Department of Insurance to write insurance in Florida. To the extent that health care providers are obtaining medical malpractice insurance through risk retention groups, surplus lines insurers, or offshore insurers, their closed claims are not being reported under s. 627.912, F.S. Also, claims attributable to health care practitioners who are not insured are not reported to the Department of Insurance.

Under s. 456.049, F.S., Florida-licensed physicians and dentists must report to the Department of Health any claim or action for damages for personal injury alleged to have been caused by error, omission, or negligence in the performance of such licensee's professional services or based on a claimed performance of professional services without consent if the claim was not covered by an insurer required to report under s. 627.912, F.S., and the claim resulted in:

- A final judgment in any amount;
- A settlement in any amount; or
- A final disposition not resulting in payment on behalf of the licensee.

The Health Care Quality Improvement Act of 1986 requires reporting of medical malpractice payments, sanctions taken by Boards of Medical Examiners, and professional review actions taken by health care entities to the National Practitioner Data Bank. Under 42 U.S.C. section

11131, each entity (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report information respecting the payment and circumstances thereof. The information to be reported includes:

- The name of any physician or licensed health care practitioner for whose benefit the payment is made;
- The amount of the payment;
- The name (if known) of any hospital with which the physician or practitioner is affiliated or associated;
- A description of the acts or omissions and injuries or illnesses upon which the action or claim was based; and
- Such other information as the Secretary of the U.S. Department of Health and Human Services determines is required for appropriate interpretation of the information reported.

Good Faith Dealings Between an Insurer and Its Insured

Insurance policies which impose an obligation on the insurer to defend and indemnify its insured against liability obligate the insurer to a duty of good faith in the handling of the defense of or settlement of claims against the insured.[1] If the insurer breaches its good faith duty, it may be liable for the amount of the judgment rendered against the insured which exceeds the limits of coverage under the insurance policy or contract with the insured. Florida law provides civil remedies by statute and at common law[2] for aggrieved litigants damaged by an insurer's failure to handle the defense of or settle a claim of the insured. At common law as early as 1938, Florida courts have allowed third party bad faith actions. Even though the tort of bad faith occurred between the insurer and its insured, Florida courts have permitted the injured third party to bring a bad faith action directly against the first party insurer because the injured third-party, as the beneficiary to the bad faith claim, is the real party in interest.[3]

In 1962, the Legislature enacted section 624.155, F.S., which provides civil remedies to any person who has been damaged by an insurer who has not attempted to settle and pay a claim for policy benefits in good faith. Section 624.155(7), F.S., provides that the civil remedy in this section does not preempt any other remedy or cause of action provided for pursuant to any other statute or pursuant to the common law of this state. Any person may obtain a judgment under either the common-law remedy of bad faith or the statutory remedy, but shall not be entitled to a judgment under both remedies. In addition, the section has been interpreted to allow a litigant to choose between his common law and statutory remedies for bad faith. Under s. 624.155(4), F.S., punitive damages are recoverable for the acts of the insurer which give rise to violation in such frequency as to indicate a general business practice and the acts: are willful, wanton, and

[1] See *Boston Old Colony Insurance Company v. Guitierrez*, 386 So.2d 459 (Fla. 1985).
[2] See *Thompson v. Commercial Union Insurance Co. of New York*, 250 So.2d 259 (Fla. 1971) the Florida Supreme Court declared that an insured or injured plaintiffs have the right to sue and recover damages against the insurer for an excess of the policy limits, based on the alleged fraud or bad faith of the insurer in the conduct or handling of the defense of the insured's suit.
[3] See *Auto Mutual Indemnity Co. v. Shaw*, 134 Fla. 815, 184 So. 852 (1938) and *State Farm Mutual Automobile Ins. Co. v. Laforet*, 658 So.2d 55, 58 (Fla. 1995).

malicious; in reckless disregard for the rights of any insured; or in reckless disregard for the rights of the beneficiary under a life insurance contract.

Insurance Rate Standards

All property and casualty insurers authorized to do business in the state are required to file rates for approval with the Department of Insurance either 90 days before the proposed effective date ("file and use") or 30 days after the rate filing is implemented ("use and file").[4] Under the file and use option, the department may finalize its review by issuing a notice of intent to approve or disapprove within 90 days after receipt of the filing. These notices are "agency action" for purposes of the Administrative Procedure Act, and give the insurer the right to choose an administrative hearing or binding arbitration. Prior to approving or disapproving a rate filing, the department may request additional supporting information for the filing from the insurer, but such a request does not toll the 90-day review period. If the department fails to issue a notice of intent to approve or disapprove within the 90-day review period, the filing is deemed approved. Under the "use and file" option, an insurance company may be ordered by the department to refund a portion of the rate to the policyholder in the form of a credit or refund if it is found to be excessive.

The department may disapprove a rate filing if it determines such rates to be "excessive, inadequate, or unfairly discriminatory." These terms are defined in the Florida Statutes in the following manner:[5]

(a) Rates are "excessive" if they are likely to produce a profit from Florida business that is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.[6]

(b) Rates are "inadequate" if they are clearly insufficient, together with investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply. Also, rates are deemed "inadequate" as to premium charged to a risk if discounts or credits are allowed which exceeded a reasonable reflection of expense savings and expected loss experience from the risk.

(c) Rates are "unfairly discriminatory" as to a risk if the application of premium discounts, credits, or surcharges among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.[7]

In making its rating decision, the department must consider, in accordance with generally accepted and reasonable actuarial techniques, thirteen factors which affect the insurer's rate filing which include: past and prospective loss experience, expenses, market competition for the risk insured, investment income, the reasonableness of the judgment reflected in the rate filing,

[4] See s. 627.062, F.S.
[5] S. 627.062, F.S.
[6] Rates are also *excessive* if, among other things, the rate structure established by a stock company provides for replenishment of surpluses from premiums, when the replenishment is attributable to investment losses.
[7] A rating plan, including discounts, credits, or surcharges, shall be deemed *unfairly discriminatory* if it fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program.

dividends, the adequacy of loss reserves, cost of reinsurance, trend factors, catastrophe hazards, profits, medical services (if applicable), and other relevant factors which impact upon the frequency or severity of claims or upon expenses.

Medical Malpractice Self-Insurance Funds

Section 627.357, F.S., once authorized the establishment of medical malpractice self-insurance funds. In 1992, the statute was amended to provide that no such funds could be formed after October 1, 1992. Currently there are only two funds in existence: the South Pinellas Medical Malpractice Risk Management Trust Fund, and the Central Dade Medical Malpractice Risk Management Trust Fund.

A Medical Malpractice Risk Management Trust Fund is authorized to purchase insurance, specific excess insurance, and aggregate excess insurance. The fund is authorized to hire consultants for loss prevention and claims management coordination, and pay claims; the "prudent" investment of trust funds is also authorized. The Department of Insurance is directed to adopt rules to implement the section including ensuring the funds meet a requirement that a trust fund maintain sufficient reserve to cover contingent liabilities in the event of dissolution.

The funding of a Medical Malpractice Risk Management Trust Fund is provided by premiums paid by members. Additionally, each member has a contingent assessment liability to pay actual losses when there is a deficiency due to claims or liquidation. The Department of Insurance must review and approve all expense factors related to rates before a new rate can be implemented. For the Department to approve rates and the associated expense factors, the rates must be justified and reasonable for the benefits and services provided.

The Governor's Select Task Force on Healthcare Professional Liability Insurance found that removing the limitation on the creation of Medical Malpractice Risk Management Trust Funds would provide an additional opportunity for medical facilities and providers to have insurance rather than go without insurance, quit practicing medicine, or reduce services provided. Additionally, the creation of these funds would increase the opportunities to ensure that injured parties are compensated.

Florida Birth-Related Neurological Injury Compensation Association

The Tort and Insurance Reform Act of 1986 created the Academic Task Force for Review of the Insurance and Tort Systems. A major concern of the Task Force was the increasing unavailability of obstetric services to the women of Florida. The significant increase in malpractice insurance premiums caused many physicians to cease the practice of obstetrics, creating a shortage of professionals to provide care for expectant mothers. To combat this health care delivery crisis, the Task Force recommended that the Legislature implement a no-fault plan of compensation for catastrophic birth-related neurological injuries.

In response to the recommendations, the Legislature enacted the Florida Birth-Related Neurological Injury Compensation (NICA) Act in 1988 (ss. 766.301-766.316, F.S.). NICA provides compensation, regardless of fault, for specific birth-related neurological injuries.

Participating hospitals and physicians are immune from liability under medical malpractice for claims covered by NICA. A birth-related neurological injury is defined to mean:

> [I]njury to the brain or spinal cord of a live infant weighing at least 2,500 grams for a single gestation or, in the case of a multiple gestation, a live infant weighing at least 2,000 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post delivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.

The Florida Supreme Court has ruled that in order for an infant to qualify under the above definition, the infant must be both mentally and physically impaired, not just one or the other.[8] If the administrative law judge finds that the statutory criteria are satisfied, then the infant, as well as the infant's parents or legal guardians, are entitled to the award of specifically defined, but limited, financial benefits without regard to fault (s. 766.31, F.S.).

In the fourteen years NICA has been in place, 161 cases have been accepted and there are presently 87 current open cases. Reports reflect an average of $3 million dollars per case is set aside based on actuarial data evaluating the lifetime care of the child, the medical fragility of the child, and the premise that as the child ages, care becomes more expensive.

The Governor's Select Task Force on Healthcare Professional Liability Insurance heard testimony about the high premium costs for medical malpractice coverage for obstetricians and the effects that high premium costs are having on these physicians and hospitals. The Task Force suggested that modifications to the eligibility requirements for NICA, such as changing the birth weights and changing the requirement that the infant be "mentally *and* physically" impaired to "mentally *or* physically" impaired might encourage greater participation. The broadening of the definition of eligible claimants may provide a reasonable alternative and likewise create a stopgap to the insurance crisis facing physicians providing obstetrical services. However, any changes that open the program up to more claims would have to be evaluated for the level of financial assessments that would be required on hospitals and physicians.

III. Effect of Proposed Changes:

Section 1. Amends s. 456.049, F.S., to require the Department of Health to forward to the Office of Insurance Regulation information that it collects from Florida-licensed medical physicians, osteopathic physicians, podiatric physicians, and dentists regarding professional liability claims on behalf of the licensed health care practitioners that result in a final judgment in any amount, a settlement in any amount, or a final disposition not resulting in payment, and that are not covered by an insurer that is required to report under s. 627.912, F.S.

Section 2. Amends s. 627.062, F.S., relating to rating standards for certain property, casualty, and surety insurances, to include in the factors that must be considered by the Office of

[8] Florida Birth-Related Neurological Injury Compensation Association v. Florida Division of Administrative Hearings, 686 So.2d 1349, (1997).

Insurance Regulation in its review of a rate filing, a prohibition on the inclusion of payments made by insurers for bad faith or punitive damages in the insurer's rate base. Such payments shall not be used to justify a rate or rate change.

Section 3. Amends s. 627.357, F.S., to eliminate a prohibition against creating medical malpractice self-insurance funds after October 1, 1992. An application to form a medical malpractice self-insurance fund must be filed with the Office of Insurance Regulation. The Office of Insurance Regulation must ensure that medical malpractice self-insurance funds remain solvent and provide insurance coverage purchased by participants. The Office of Insurance Regulation is granted rulemaking authority to implement its responsibilities over medical malpractice self-insurance trust funds.

Section 4. Amends s. 627.912, F.S., relating to professional liability closed claims reported by insurers, to require the Office of Insurance Regulation to adopt by rule requirements for additional information to assist the office in its analysis and evaluation of the nature, causes, location, cost and damages involved in professional liability cases reported by insurers under this section. The Office of Insurance Regulation is required to impose a fine against insurers for violations of the reporting requirements.

Section 5. Creates s. 627.9121, F.S., to require each entity that makes payment under a policy of insurance, self-insurance, or otherwise in settlement or partial settlement of, or in satisfaction of a judgment in, a medical malpractice action or claim and that is required to report information to the National Practitioner Data Bank under 42 U.S.C. section 11131 to also report the same information to the Office of Insurance Regulation. The Office of Insurance Regulation must include such information in the data that it compiles under s. 627.912, F.S. The office must compile and review the data collected pursuant to this section and must assess an administrative fine on any entity that fails to fully comply with the requirements imposed by law.

Section 6. Creates an undesignated section of law, to require the Office of Program Policy Analysis and Government Accountability to complete a study of the eligibility requirements for a birth to be covered under the Florida Birth-Related Neurological Injury Compensation Association and to submit a report to the Legislature by January 1, 2004, recommending whether or not the statutory criteria for a claim to qualify for referral to the Florida Birth-Related Neurological Injury Compensation Association under s. 766.302, F.S., should be modified.

Section 7. Creates an undesignated section of law, to authorize a licensed hospital, ambulatory surgical center, or mobile surgical facility to apply to the Department of Financial Services for certification of any program that is recommended by the Florida Center for Excellence in Health Care to reduce adverse incidents, which result in the reduction of serious events at the facility. The Department of Financial Services must develop criteria for certification. Insurers must file with the department a discount in the rate or rates applicable for insurance coverage to reflect the effect of a certified program. A health care facility must receive a discount in the rate or rates applicable for mandated basic insurance coverage required by law. The department must consider, in reviewing filings, whether, and the extent to which a certified program is otherwise covered by an insurance company or exchange or self-insurance plan providing medical professional liability coverage.

Section 8. Provides a contingent effective date upon becoming a law if SB 562, SB 564, and SB 566 or similar legislation is adopted in the same legislative session or an extension thereof and becomes law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, Section 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

D. Other Constitutional Issues:

Section 10 of the bill, requires the Department of Health to develop criteria for certification of health care facilities to obtain a discount in rates for insurance coverage. To the extent that the bill requires the department to establish requirements for certification, by rule, or agency action, it raises the question whether this provides adequate limitations and safeguards so that the Legislature's delegation to the department is not violative of Article II, Section 3 of the Florida Constitution. The bill does not appear to expressly provide a sufficient limitation on the department's authority to establish requirements on what entity should be granted certification. The Florida Supreme Court struck down a former section of law respecting the power of the Board of Psychological Examiners to grant certificates with the title "psychologist" and to determine the qualifications of applicants as unconstitutional in that it failed sufficiently to fix the standards to be applied and in effect delegated the application of the statute without sufficient limitations on the board's discretion.[9]

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

[9] See *Husband v. Cassel*, 130 So.2d 69 (1961) and *Askew v. Cross Key Waterways*, 372 So.2d 913 at 921, "Where the Legislature makes the fundamental policy decision and delegates to some other body the task of implementing that policy under adequate safeguards, there is no violation of the [Delegations of Powers] doctrine."

B. Private Sector Impact:

Each entity that is required under federal law to report information to the National Practitioner Data Bank must, pursuant to section 6 of the bill, also report the same information to the Florida Office of Insurance Regulation, and will incur costs to do so.

C. Government Sector Impact:

The Department of Health may incur costs to report closed claims data to the Office of Insurance Regulation under section 1 of the bill.

The Office of Insurance Regulation will incur costs to: modify its review of rates to exclude judgments for bad-faith and punitive damages from an insurer's rate base under section 3 of the bill; review applications to form a medical malpractice self-insurance fund under section 4 of the bill; modify information that it collects regarding closed claims under section 5 of the bill; and handle increased numbers of closed claims being reported under section 6 of the bill.

The Department of Financial Services will incur costs to certify health care facilities' programs to reduce adverse incidents and to review rate filings to ensure that facilities receive a discount for the effects of certified programs.

The Office of Program Policy Analysis and Government Accountability will incur costs to complete the study of eligibility requirements for a birth to be covered by the Florida Birth-Related Neurological Injury Compensation Association.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 6 of the bill requires each entity that is required under federal law to report information to the National Practitioner Data Bank to also report the same information to the Florida Office of Insurance Regulation. Florida may not have any regulatory jurisdiction over such entities have the means to compel compliance of such entities.

VIII. Amendments:

None.