Amendment No. (for drafter's use only)

CHAMBER ACTION

Senate	House
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Representative Homan offered the following:

Amendment (with title amendment)

Remove line(s) 785-1389, and insert:

Section 22. Section 627.3575, Florida Statutes, is created to read:

627.3575 Health Care Professional Liability Insurance Facility.--

(1) FACILITY CREATED; PURPOSE; STATUS.--There is created the Health Care Professional Liability Insurance Facility. The facility is intended to meet ongoing availability and affordability problems relating to liability insurance for health care professionals by providing an affordable, self-supporting source of excess insurance coverage for those professionals who are willing and able to self-insure for smaller losses. The facility shall operate on a not-for-profit basis. The facility is self-funding and is intended to serve a

public purpose but is not a state agency or program, and no activity of the facility shall create any state liability.

(2) GOVERNANCE; POWERS.--

(a) The facility shall operate under a seven-member board of governors consisting of the Secretary of Health, three members appointed by the Governor, and three members appointed by the Chief Financial Officer. The board shall be chaired by the Secretary of Health. The secretary shall serve by virtue of his or her office, and the other members of the board shall serve terms concurrent with the term of office of the official who appointed them. Any vacancy on the board shall be filled in the same manner as the original appointment. Members serve at the pleasure of the official who appointed them. Members are not eligible for compensation for their service on the board, but the facility may reimburse them for per diem and travel expenses at the same levels as are provided in s. 112.061 for state employees.

(b) The facility shall have such powers as are necessary to operate as an insurer, including the power to:

1. Sue and be sued.

2. Hire such employees and retain such consultants, attorneys, actuaries, and other professionals as it deems appropriate.

3. Contract with such service providers as it deems appropriate.

4. Maintain offices appropriate to the conduct of its business.

5. Take such other actions as are necessary or appropriate in fulfillment of its responsibilities under this section.

(3) COVERAGE PROVIDED.--The facility shall provide liability insurance coverage for health care professionals. The facility shall allow policyholders to select from policies with deductibles of $25,000 per claim, $50,000 per claim, and $100,000 per claim and with coverage limits of $100,000 per claim and $300,000 annual aggregate, $250,000 per claim and $750,000 annual aggregate, and $1 million per claim and $3 million annual aggregate. To the greatest extent possible, the terms and conditions of the policies shall be consistent with terms and conditions commonly used by professional liability insurers.

(4) ELIGIBILITY; TERMINATION.--

(a) Any health care professional is eligible for coverage provided by the facility if the professional at all times maintains either:

1. An escrow account consisting of cash or assets eligible for deposit under s. 625.52 in an amount equal to the deductible amount of the policy; or

2. An unexpired, irrevocable letter of credit, established pursuant to chapter 675, in an amount not less than the deductible amount of the policy. The letter of credit shall be payable to the health care professional as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit

shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state.

(b) The eligibility of a health care professional for coverage terminates upon:

1. The failure of the professional to comply with paragraph (a);

2. The failure of the professional to timely pay premiums; or

3. The commission of any act of fraud in connection with the policy, as determined by the board of governors.

(c) The board of governors, in its discretion, may reinstate the eligibility of a health care professional whose eligibility has terminated pursuant to paragraph (b) upon determining that the professional has come back into compliance with paragraph (a) or has paid the overdue premiums. Eligibility may be reinstated in the case of fraud only if the board determines that its initial determination of fraud was in error.

(5) PREMIUMS.--

(a) The facility shall charge the actuarially indicated premium for the coverage provided and shall retain the services of consulting actuaries to prepare its rate filings. The facility shall not provide dividends to policyholders, and, to the extent that premiums are more than the amount required to cover claims and expenses, such excess shall be retained by the facility for payment of future claims. In the event of

dissolution of the facility, any amounts not required as a reserve for outstanding claims shall be transferred to the policyholders of record as of the last day of operation.

(b) To ensure that the facility has the funds to pay claims:

1. From each judgment awarded and settlement agreed to from which a claim will be paid in whole or in part by the facility, the facility shall retain 1 percent of its portion of the award or settlement for deposit into a separate account for guaranteeing payment of claims.

2. From the funds of the Florida Birth-Related Neurological Injury Compensation Association, the facility shall receive the interest on the association's investments for deposit into a separate account for guaranteeing payment of claims.

(6) REGULATION; APPLICABILITY OF OTHER STATUTES.--

(a) The facility shall operate pursuant to a plan of operation approved by order of the Office of Insurance Regulation of the Financial Services Commission. The board of governors may at any time adopt amendments to the plan of operation and submit the amendments to the Office of Insurance Regulation for approval.

(b) The facility is subject to regulation by the Office of Insurance Regulation of the Financial Services Commission in the same manner as other insurers.

(c) The facility is not subject to part II of chapter 631, relating to the Florida Insurance Guaranty Association.

(7) STARTUP PROVISIONS.--

(a) It is the intent of the Legislature that the facility begin providing coverage no later than January 1, 2004.

(b) The Governor and the Chief Financial Officer shall make their appointments to the board of governors of the facility no later than July 1, 2003. Until the board is appointed, the Secretary of Health may perform ministerial acts on behalf of the facility as chair of the board of governors.

(c) Until the facility is able to hire permanent staff and enter into contracts for professional services, the office of the Secretary of Health shall provide support services to the facility.

(d) In order to provide startup funds for the facility, the board of governors may incur debt or enter into agreements for lines of credit, provided that the sole source of funds for repayment of any debt is future premium revenues of the facility. The amount of such debt or lines of credit may not exceed $10 million. In addition to the debt or lines of credit provided for in this paragraph, the facility shall be authorized to borrow up to $10 million from the Florida Birth-Related Neurological Injury Compensation Association and repay the association in equal annual installments over a period of 10 years.

Section 23. Subsection (1) and paragraph (n) of subsection (2) of section 627.912, Florida Statutes, are amended to read:

627.912 Professional liability claims and actions; reports by insurers.--

(1)(a) Each self-insurer authorized under s. 627.357 and each insurer or joint underwriting association providing professional liability insurance to a practitioner of medicine

licensed under chapter 458, to a practitioner of osteopathic medicine licensed under chapter 459, to a podiatric physician licensed under chapter 461, to a dentist licensed under chapter 466, to a hospital licensed under chapter 395, to a crisis stabilization unit licensed under part IV of chapter 394, to a health maintenance organization certificated under part I of chapter 641, to clinics included in chapter 390, to an ambulatory surgical center as defined in s. 395.002, or to a member of The Florida Bar shall report in duplicate 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:

1.~~(a)~~ A final judgment in any amount.

2.~~(b)~~ A settlement in any amount.

Reports shall be filed with the department.

(b) In addition to the requirements of paragraph (a), if the insured party is licensed under chapter 395, chapter 458, chapter 459, chapter 461, or chapter 466, the insurer shall report in duplicate to the Office of Insurance Regulation any other disposition of the claim, including, but not limited to, a dismissal. If the insured is licensed under chapter 458, chapter 459, or chapter 461, any claim that resulted in a final judgment or settlement in the amount of $50,000 or more shall be reported to the Department of Health no later than 30 days following the occurrence of that event. If the insured is licensed under chapter 466, any claim that resulted in a final judgment or

settlement in the amount of $25,000 or more shall be reported to the Department of Health no later than 30 days following the occurrence of that event ~~and, if the insured party is licensed under chapter 458, chapter 459, chapter 461, or chapter 466, with the Department of Health, no later than 30 days following the occurrence of any event listed in paragraph (a) or paragraph (b)~~. The Department of Health shall review each report and determine whether any of the incidents that resulted in the claim potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply. The Department of Health, as part of the annual report required by s. 456.026, shall publish annual statistics, without identifying licensees, on the reports it receives, including final action taken on such reports by the Department of Health or the appropriate regulatory board.

(2) The reports required by subsection (1) shall contain:

(n) Any other information required by the department to analyze and evaluate the nature, causes, location, cost, and damages involved in professional liability cases. The Financial Services Commission shall adopt by rule requirements for additional information to assist the Office of Insurance Regulation in its analysis and evaluation of the nature, causes, location, cost, and damages involved in professional liability cases reported by insurers under this section.

Section 24. Section 627.9121, Florida Statutes, is created to read:

627.9121 Required reporting of claims; penalties.--Each entity that makes payment under a policy of insurance, self-insurance, or otherwise in settlement, partial settlement, or

satisfaction of a judgment in a medical malpractice action or claim that is required to report information to the National Practitioner Data Bank under 42 U.S.C. s. 11131 must also report the same information to the Office of Insurance Regulation. The office shall include such information in the data that it compiles under s. 627.912. 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 such reporting requirements.

Section 25. Subsections (3) and (4) of section 766.106, Florida Statutes, are amended, and subsection (13) is added to said section, to read:

766.106 Notice before filing action for medical malpractice; presuit screening period; offers for admission of liability and for arbitration; informal discovery; review.--

(3)(a) No suit may be filed for a period of 180 ~~90~~ days after notice is mailed to any prospective defendant. During the 180-day ~~90-day~~ period, the prospective defendant's insurer or self-insurer shall conduct a review to determine the liability of the defendant. Each insurer or self-insurer shall have a procedure for the prompt investigation, review, and evaluation of claims during the 180-day ~~90-day~~ period. This procedure shall include one or more of the following:

1. Internal review by a duly qualified claims adjuster;

2. Creation of a panel comprised of an attorney knowledgeable in the prosecution or defense of medical malpractice actions, a health care provider trained in the same or similar medical specialty as the prospective defendant, and a duly qualified claims adjuster;

3. A contractual agreement with a state or local professional society of health care providers, which maintains a medical review committee;

4. Any other similar procedure which fairly and promptly evaluates the pending claim.

Each insurer or self-insurer shall investigate the claim in good faith, and both the claimant and prospective defendant shall cooperate with the insurer in good faith. If the insurer requires, a claimant shall appear before a pretrial screening panel or before a medical review committee and shall submit to a physical examination, if required. Unreasonable failure of any party to comply with this section justifies dismissal of claims or defenses. There shall be no civil liability for participation in a pretrial screening procedure if done without intentional fraud.

(b) At or before the end of the 180 ~~90~~ days, the insurer or self-insurer shall provide the claimant with a response:

1. Rejecting the claim;

2. Making a settlement offer; or

3. Making an offer of admission of liability and for arbitration on the issue of damages. This offer may be made contingent upon a limit of general damages.

(c) The response shall be delivered to the claimant if not represented by counsel or to the claimant's attorney, by certified mail, return receipt requested. Failure of the prospective defendant or insurer or self-insurer to reply to the notice within 180 ~~90~~ days after receipt shall be deemed a final rejection of the claim for purposes of this section.

(d) Within 30 days after ~~of~~ receipt of a response by a prospective defendant, insurer, or self-insurer to a claimant represented by an attorney, the attorney shall advise the claimant in writing of the response, including:

1. The exact nature of the response under paragraph (b).

2. The exact terms of any settlement offer, or admission of liability and offer of arbitration on damages.

3. The legal and financial consequences of acceptance or rejection of any settlement offer, or admission of liability, including the provisions of this section.

4. An evaluation of the time and likelihood of ultimate success at trial on the merits of the claimant's action.

5. An estimation of the costs and attorney's fees of proceeding through trial.

(4) The notice of intent to initiate litigation shall be served within the time limits set forth in s. 95.11. However, during the 180-day ~~90-day~~ period, the statute of limitations is tolled as to all potential defendants. Upon stipulation by the parties, the 180-day ~~90-day~~ period may be extended and the statute of limitations is tolled during any such extension. Upon receiving notice of termination of negotiations in an extended period, the claimant shall have 60 days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

(13) In matters relating to professional liability insurance coverage for medical negligence, an insurer shall not be held in bad faith for failure to timely pay its policy limits if it tenders its policy limits and meets all other conditions

of settlement prior to the conclusion of the presuit screening period provided for in this section.

Section 26. Section 766.1065, Florida Statutes, is created to read:

766.1065 Mandatory staging of presuit investigation and mandatory mediation.--

(1) Within 30 days after service of the presuit notice of intent to initiate medical malpractice litigation, each party shall voluntarily produce to all other parties, without being requested, any and all medical, hospital, health care, and employment records concerning the claimant in the disclosing party's possession, custody, or control, and the disclosing party shall affirmatively certify in writing that the records produced include all records in that party's possession, custody, or control or that the disclosing party has no medical, hospital, health care, or employment records concerning the claimant.

(a) Subpoenas may be issued according to the Florida Rules of Civil Procedure as though suit had been filed for the limited purpose of obtaining copies of medical, hospital, health care, and employment records of the claimant. The party shall indicate on the subpoena that it is being issued in accordance with the presuit procedures of this section and shall not be required to include a case number.

(b) Nothing in this section shall limit the ability of any party to use any other available form of presuit discovery available under this chapter or the Florida Rules of Civil Procedure.

(2) Within 60 days after service of the presuit notice of intent to initiate medical malpractice litigation, all parties must be made available for a sworn deposition. Such deposition may not be used in a civil suit for medical negligence.

(3) Within 120 days after service of the presuit notice of intent to initiate medical malpractice litigation, each party's corroborating expert, who will otherwise be tendered as the expert complying with the affidavit provisions set forth in s. 766.203, must be made available for a sworn deposition.

(a) The expenses associated with the expert's time and travel in preparing for and attending such deposition shall be the responsibility of the party retaining such expert.

(b) An expert shall be deemed available for deposition if suitable accommodations can be made for appearance of said expert via real-time video technology.

(4) Within 180 days after service of the presuit notice of intent to initiate medical malpractice litigation, all parties shall attend in person mandatory mediation in accordance with s. 44.102 if binding arbitration under s. 766.106 or s. 766.207 has not been agreed to by the parties. The Florida Rules of Civil Procedure shall apply to mediation held pursuant to this section.

Section 27. Section 766.1067, Florida Statutes, is created to read:

766.1067 Mandatory mediation after suit is filed.--Within 120 days after suit being filed, unless such period is extended by mutual agreement of all parties, all parties shall attend in-person mandatory mediation in accordance with s. 44.102 if binding arbitration under s. 766.106 or s. 766.207 has not been

agreed to by the parties. The Florida Rules of Civil Procedure shall apply to mediation held pursuant to this section.

Section 28. Section 766.118, Florida Statutes, is created to read:

766.118 Determination of noneconomic damages.--With respect to a cause of action for personal injury or wrongful death resulting from medical negligence, including actions pursuant to s. 766.209, damages recoverable for noneconomic losses to compensate for pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity for enjoyment of life, and all other noneconomic damages shall not exceed $250,000, regardless of the number of claimants or defendants involved in the action.

Section 29. Subsection (5) of section 766.202, Florida Statutes, is amended to read:

766.202 Definitions; ss. 766.201-766.212.--As used in ss. 766.201-766.212, the term:

(5) "Medical expert" means a person familiar with the evaluation, diagnosis, or treatment of the medical condition at issue who:

(a) Is duly and regularly engaged in the practice of his or her profession, ~~who~~ holds a health care professional degree from a university or college, and has had special professional training and experience; or

(b) Has ~~one possessed of~~ special health care knowledge or skill about the subject upon which he or she is called to testify or provide an opinion.

Such expert shall certify that he or she has similar credentials and expertise in the area of the defendant's particular practice or specialty, if the defendant is a specialist.

Section 30. Subsection (2) of section 766.203, Florida Statutes, is amended to read:

766.203 Presuit investigation of medical negligence claims and defenses by prospective parties.--

(2) Prior to issuing notification of intent to initiate medical malpractice litigation pursuant to s. 766.106, the claimant shall conduct an investigation to ascertain that there are reasonable grounds to believe that:

(a) Any named defendant in the litigation was negligent in the care or treatment of the claimant; and

(b) Such negligence resulted in injury to the claimant.

Corroboration of reasonable grounds to initiate medical negligence litigation shall be provided by the claimant's submission of a verified written medical expert opinion from a medical expert as defined in s. 766.202(5), at the time the notice of intent to initiate litigation is mailed, which statement shall corroborate reasonable grounds to support the claim of medical negligence. This opinion and statement are subject to discovery and are admissible in future proceedings, subject to exclusion under s. 90.403.

Section 31. Subsections (2) and (3) of section 766.207, Florida Statutes, are amended to read:

766.207 Voluntary binding arbitration of medical negligence claims.--

(2) Upon the completion of presuit investigation with preliminary reasonable grounds for a medical negligence claim intact, the parties may elect to have damages determined by an arbitration panel. Such election may be initiated by either party by serving a request for voluntary binding arbitration of damages within 180 ~~90~~ days after service of the claimant's notice of intent to initiate litigation upon the defendant. The evidentiary standards for voluntary binding arbitration of medical negligence claims shall be as provided in ss. 120.569(2)(g) and 120.57(1)(c).

(3) Upon receipt of a party's request for such arbitration, the opposing party may accept the offer of voluntary binding arbitration within 30 days. However, in no event shall the defendant be required to respond to the request for arbitration sooner than 180 ~~90~~ days after service of the notice of intent to initiate litigation under s. 766.106. Such acceptance within the time period provided by this subsection shall be a binding commitment to comply with the decision of the arbitration panel. The liability of any insurer shall be subject to any applicable insurance policy limits.

Section 32. (1) The Department of Health shall study and report to the Legislature as to whether medical review panels should be included as part of the presuit process in medical malpractice litigation. Medical review panels review a medical malpractice case during the presuit process and make judgments on the merits of the case based on established standards of care with the intent of reducing the number of frivolous claims. The panel's report could be used as admissible evidence at trial or for other purposes. The department's report should address:

(a) Historical use of medical review panels and similar pretrial programs in this state, including the mediation panels created by chapter 75-9, Laws of Florida.

(b) Constitutional issues relating to the use of medical review panels.

(c) The use of medical review panels or similar programs in other states.

(d) Whether medical review panels or similar panels should be created for use during the presuit process.

(e) Other recommendations and information that the department deems appropriate.

(2) If the department finds that medical review panels or a similar structure should be created in this state, it shall include draft legislation to implement its recommendations in its report.

(3) The department shall submit its report to the Speaker of the House of Representatives and the President of the Senate no later than December 31, 2003.

Section 33. Subsection (5) of section 768.81, Florida Statutes, is amended to read:

768.81 Comparative fault.--

(5) Notwithstanding anything in law to the contrary, in an action for damages for personal injury or wrongful death arising out of medical malpractice, whether in contract or tort, ~~when an apportionment of damages pursuant to this section is attributed to a teaching hospital as defined in s. 408.07,~~ the court shall enter judgment ~~against the teaching hospital~~ on the basis of each ~~such~~ party's percentage of fault and not on the basis of the doctrine of joint and several liability. In the trial of any

action for medical malpractice which follows a settlement between the plaintiff and one or more defendants or potential defendants for the same injury, the plaintiff shall be estopped from denying that the fault on the part of any such settled defendant or prospective defendant contributed to causing the plaintiff's injuries.

Section 34. Section 1004.08, Florida Statutes, is created to read:

1004.08 Patient safety instructional requirements.--Every public school, college, and university that offers degrees in medicine, nursing, and allied health shall include in the curricula applicable to such degrees material on patient safety, including patient safety improvement. Materials shall include, but need not be limited to, effective communication and teamwork; epidemiology of patient injuries and medical errors; vigilance, attention, and fatigue; checklists and inspections; automation and technological and computer support; psychological factors in human error; and reporting systems.

Section 35. Section 1005.07, Florida Statutes, is created to read:

1005.07 Patient safety instructional requirements.--Every nonpublic school, college, and university that offers degrees in medicine, nursing, and allied health shall include in the curricula applicable to such degrees material on patient safety, including patient safety improvement. Materials shall include, but need not be limited to, effective communication and teamwork; epidemiology of patient injuries and medical errors; vigilance, attention, and fatigue; checklists and inspections;

automation and technological and computer support; psychological factors in human error; and reporting systems.

Section 36. The Agency for Health Care Administration is directed to study the types of information the public would find relevant in the selection of hospitals. The agency shall review and recommend appropriate methods of collection, analysis, and dissemination of that information. The agency shall complete its study and report its findings and recommendations to the Legislature by January 15, 2004.

Section 37. Comprehensive study and report on the creation of a Patient Safety Authority.--

(1) The Agency for Health Care Administration, in consultation with the Department of Health, is directed to study the need for, and the implementation requirements of, establishing a Patient Safety Authority. The authority would be responsible for performing activities and functions designed to improve patient safety and the quality of care delivered by health care facilities and health care practitioners.

(2) In undertaking its study, the agency shall examine and evaluate a Patient Safety Authority that would, either directly or by contract:

(a) Analyze information concerning adverse incidents reported to the Agency for Health Care Administration pursuant to s. 395.0197, Florida Statutes, for the purpose of recommending changes in practices and procedures that may be implemented by health care practitioners and health care facilities to prevent future adverse incidents.

(b) Collect, analyze, and evaluate patient safety data submitted voluntarily by a health care practitioner or health

care facility. The authority would communicate to health care practitioners and health care facilities changes in practices and procedures that may be implemented for the purpose of improving patient safety and preventing future patient safety events from resulting in serious injury or death. At a minimum, the authority would:

1. Be designed and operated by an individual or entity with demonstrated expertise in health care quality data and systems analysis, health information management, systems thinking and analysis, human factors analysis, and identification of latent and active errors.

2. Include procedures for ensuring its confidentiality, timeliness, and independence.

(c) Foster the development of a statewide electronic infrastructure, which would be implemented in phases over a multiyear period, that is designed to improve patient care and the delivery and quality of health care services by health care facilities and practitioners. The electronic infrastructure would be a secure platform for communication and the sharing of clinical and other data, such as business data, among providers and between patients and providers. The electronic infrastructure would include a core electronic medical record. Health care providers would have access to individual electronic medical records, subject to the consent of the individual. The right, if any, of other entities, including health insurers and researchers, to access the records would need further examination and evaluation by the agency.

(d) Foster the use of computerized physician medication ordering systems by hospitals that do not have such systems and develop protocols for these systems.

(e) Implement paragraphs (c) and (d) as a demonstration project for Medicaid recipients.

(f) Identify best practices and share this information with health care providers.

(g) Engage in other activities that improve health care quality, improve the diagnosis and treatment of diseases and medical conditions, increase the efficiency of the delivery of health care services, increase administrative efficiency, and increase access to quality health care services.

(3) The agency shall also consider ways in which a Patient Safety Authority would be able to facilitate the development of no-fault demonstration projects as means to reduce and prevent medical errors and promote patient safety.

(4) The agency shall seek information and advice from and consult with hospitals, physicians, other health care providers, attorneys, consumers, and individuals involved with and knowledgeable about patient safety and quality-of-care initiatives.

(5) In evaluating the need for, and the operation of, a Patient Safety Authority, the agency shall determine the costs of implementing and administering an authority and suggest funding sources and mechanisms.

(6) The agency shall complete its study and issue a report to the Legislature by February 1, 2004. In its report, the agency shall include specific findings, recommendations, and proposed legislation.

Section 38. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared severable.

Section 39. This act shall take effect upon becoming a law and shall apply to all actions filed after the effective date of the act.

========== T I T L E A M E N D M E N T ==========

Remove line(s) 52-104, and insert:

Financial Services Commission; creating s. 627.3575, F.S.; creating the Health Care Professional Liability Insurance Facility; providing purpose; providing for governance and powers; providing eligibility requirements; providing for premiums; providing for regulation; providing applicability; specifying duties of the Department of Health; providing for debt and regulation thereof; amending s. 627.912, F.S.; requiring certain claims information to be filed with the Office of Insurance Regulation and the Department of Health; providing for rulemaking by the Financial Services Commission; creating s. 627.9121, F.S.; requiring certain information relating to medical malpractice to be reported to the Office of Insurance Regulation; providing for enforcement; amending s. 766.106, F.S.; extending the time period for the presuit screening period; providing conditions for causes

of action for bad faith against insurers providing coverage for medical negligence; creating s. 766.1065, F.S.; requiring parties to provide certain information to parties without request; authorizing the issuance of subpoenas without case numbers; requiring that parties and certain experts be made available for deposition; providing for mandatory presuit mediation; providing an exception; creating s. 766.1067, F.S.; providing for mandatory mediation in medical negligence causes of action; creating s. 766.118, F.S.; providing a limitation on noneconomic damages which can be awarded in causes of action involving medical negligence; amending s. 766.202, F.S.; providing requirements for medical experts; amending s. 766.203, F.S.; providing for discovery and admissibility of opinions and statements tendered during presuit investigation; amending s. 766.207, F.S.; conforming provisions to the extension in the time period for presuit investigation; requiring the Department of Health to study the efficacy and constitutionality of medical review panels; requiring a report; amending s. 768.81, F.S.; providing that a defendant's liability for damages in medical negligence cases is several only; estoppping plaintiffs from denying fault of settling defendants; creating s. 1004.08, F.S.; requiring patient safety instruction for certain students in public schools, colleges, and universities; creating s. 1005.07, F.S.; requiring patient safety instruction for certain students in nonpublic schools, colleges, and universities; requiring a report by the Agency for Health Care

Administration regarding information to be provided to health care consumers; requiring a report by the Agency for Health Care Administration regarding the establishment of a Patient Safety Authority; specifying elements of the report; providing severability; providing an effective date.