A bill to be entitled

An act relating to medical incidents; providing legislative findings; amending s. 395.0191, F.S.; deleting requirement that persons act in good faith to avoid liability or discipline for their actions regarding the awarding of staff membership or clinical privileges; amending s. 395.1012, F.S.; requiring hospitals, ambulatory surgical centers, and mobile surgical facilities to establish patient safety plans and committees; creating s. 395.1051, F.S.; providing for notification of injuries in a hospital, ambulatory surgical center, or mobile surgical facility; amending s. 456.041, F.S.; requiring additional information to be included in health care practitioner profiles; providing for fines; revising requirements for the reporting of paid liability claims; amending s. 456.042, F.S.; requiring health care practitioner profiles to be updated within a specific time period; amending s. 456.049, F.S.; revising requirements for the reporting of paid liability claims; amending s. 456.057, F.S.; authorizing the Department of Health to utilize subpoenas to obtain patient records without patients' consent under certain circumstances; amending s. 456.072, F.S.; authorizing the Department of Health to determine administrative costs in disciplinary actions; amending s. 456.073, F.S.; extending the time for the Department of Health to refer

a request for an administrative hearing; amending s. 456.077, F.S.; revising provisions relating to designation of certain citation violations; amending s. 456.078, F.S.; revising provisions relating to designation of certain mediation offenses; creating s. 456.085, F.S.; providing for notification of an injury by a physician; amending s. 458.331, F.S.; increasing the amount of paid liability claims requiring investigation by the Department of Health; revising the definition of "repeated malpractice" to conform; creating s. 458.3311, F.S.; establishing emergency procedures for disciplinary actions; amending s. 459.015, F.S.; increasing the amount of paid liability claims requiring investigation by the Department of Health; revising the definition of "repeated malpractice" to conform; creating s. 459.0151, F.S.; establishing emergency procedures for disciplinary actions; amending s. 461.013, F.S.; increasing the amount of paid liability claims requiring investigation by the Department of Health; revising the definition of "repeated malpractice" to conform; amending s. 627.062, F.S.; prohibiting the inclusion of payments made by insurers for bad faith claims in an insurer's rate base; requiring certain rate filings; creating s. 627.0662, F.S.; providing definitions; requiring each medical liability insurer to report certain information to the Office of Insurance Regulation;

providing for determination of whether excessive profit has been realized; requiring return of excessive amounts; amending s. 627.357, F.S.; deleting the prohibition against formation of medical malpractice self-insurance funds; providing requirements to form a self-insurance fund; providing rulemaking authority to the 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 and assessments; 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; revising provisions relating to a claimant's

period to file suit after rejection of a prospective defendant's offer to admit liability and for arbitration on the issue of damages; specifying consequences of failure to cooperate on the part of any party during the presuit investigation; providing factors to be considered with respect to certain claims against bad faith against an insurer; 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; 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 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; 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.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Findings.--

(1) The Legislature finds that Florida is in the midst of a medical malpractice insurance crisis of unprecedented magnitude.

(2) The Legislature finds that this crisis threatens the quality and availability of health care for all Florida citizens.

(3) The Legislature finds that the rapidly growing population and the changing demographics of Florida make it imperative that students continue to choose Florida as the place they will receive their medical educations and practice medicine.

(4) The Legislature finds that Florida is among the states with the highest medical malpractice insurance premiums in the nation.

(5) The Legislature finds that the cost of medical malpractice insurance has increased dramatically during the past decade and both the increase and the current cost are substantially higher than the national average.

(6) The Legislature finds that the increase in medical malpractice liability insurance rates is forcing physicians to practice medicine without professional liability insurance, to leave Florida, to not perform high-risk procedures, or to retire early from the practice of medicine.

(7) The Legislature finds that there are certain elements of damage presently recoverable that have no monetary value, except on a purely arbitrary basis, while other elements of damage are either easily measured on a monetary basis or reflect ultimate monetary loss.

(8) The Governor created the Governor's Select Task Force on Healthcare Professional Liability Insurance to study and make recommendations to address these problems.

(9) The Legislature has reviewed the findings and recommendations of the Governor's Select Task Force on Healthcare Professional Liability Insurance.

(10) The Legislature finds that the Governor's Select Task Force on Healthcare Professional Liability Insurance has established that a medical malpractice crisis exists in the State of Florida which can be alleviated by the adoption of comprehensive legislatively enacted reforms.

(11) The Legislature finds that making high-quality health care available to the citizens of this state is an overwhelming public necessity.

(12) The Legislature finds that ensuring that physicians continue to practice in Florida is an overwhelming public necessity.

(13) The Legislature finds that ensuring the availability of affordable professional liability insurance for physicians is an overwhelming public necessity.

(14) The Legislature finds, based upon the findings and recommendations of the Governor's Select Task Force on Healthcare Professional Liability Insurance, the findings and recommendations of various study groups throughout the nation, and the experience of other states, that the overwhelming public necessities of making quality health care available to the citizens of this state, of ensuring that physicians continue to practice in Florida, and of ensuring that those physicians have the opportunity to purchase affordable professional liability insurance cannot be met unless a cap on noneconomic damages in an amount no higher than $250,000 is imposed.

(15) The Legislature finds that the high cost of medical malpractice claims can be substantially alleviated by imposing a limitation on noneconomic damages in medical malpractice actions.

(16) The Legislature further finds that there is no alternative measure of accomplishing such result without imposing even greater limits upon the ability of persons to recover damages for medical malpractice.

(17) The Legislature finds that the provisions of this act are naturally and logically connected to each other and to the purpose of making quality health care available to the citizens of Florida.

(18) The Legislature finds that each of the provisions of this act is necessary to alleviate the crisis relating to medical malpractice insurance.

Section 2. Subsection (7) of section 395.0191, Florida Statutes, is amended to read:

395.0191 Staff membership and clinical privileges.--

(7) There shall be no monetary liability on the part of, and no cause of action for injunctive relief or damages shall arise against, any licensed facility, its governing board or governing board members, medical staff, or disciplinary board or against its agents, investigators, witnesses, or employees, or against any other person, for any action arising out of or related to carrying out the provisions of this section, absent ~~taken in good faith and without~~ intentional fraud ~~in carrying out the provisions of this section~~.

Section 3. Section 395.1012, Florida Statutes, is created to read:

395.1012 Patient safety.--

(1) Each licensed facility shall adopt a patient safety plan. A plan adopted to implement the requirements of 42 C.F.R. s. 482.21 shall be deemed to comply with this requirement.

(2) Each licensed facility shall appoint a patient safety officer and a patient safety committee, which shall include at least one person who is neither employed by nor practicing in the facility, for the purpose of promoting the health and safety of patients, reviewing and evaluating the quality of patient safety measures used by the facility, and assisting in the implementation of the facility patient safety plan.

Section 4. Section 395.1051, Florida Statutes, is created to read:

395.1051 Duty to notify patients.--Every licensed facility shall inform each patient, or an individual identified pursuant to s. 765.401(1), in person about unanticipated outcomes of care that result in serious harm to the patient. Notification of outcomes of care that result in harm to the patient under this section shall not constitute an acknowledgement or admission of liability, nor can it be introduced as evidence in any civil lawsuit.

Section 5. Section 456.041, Florida Statutes, is amended to read:

456.041 Practitioner profile; creation.--

(1)(a) Beginning July 1, 1999, the Department of Health shall compile the information submitted pursuant to s. 456.039 into a practitioner profile of the applicant submitting the information, except that the Department of Health may develop a format to compile uniformly any information submitted under s. 456.039(4)(b). Beginning July 1, 2001, the Department of Health may, and beginning July 1, 2004, shall, compile the information submitted pursuant to s. 456.0391 into a practitioner profile of the applicant submitting the information.

(b) Each practitioner licensed under chapter 458 or chapter 459 must report to the Department of Health and the Board of Medicine or the Board of Osteopathic Medicine, respectively, all final disciplinary actions, sanctions by a governmental agency or a facility or entity licensed under state law, and claims or actions, as provided under s. 456.051, to which he or she is subjected no later than 15 calendar days after such action or sanction is imposed.

Failure to submit the requisite information within 15 calendar days in accordance with this paragraph shall subject the practitioner to discipline by the Board of Medicine or the Board of Osteopathic Medicine and a fine of $100 for each day that the information is not submitted after the expiration of the 15-day reporting period.

(c) Within 15 days after receiving a report under paragraph (b), the department shall update the practitioner's profile in accordance with the requirements of subsection (7).

(2) On the profile published under subsection (1), the department shall indicate whether ~~if~~ the information provided under s. 456.039(1)(a)7. or s. 456.0391(1)(a)7. is or is not corroborated by a criminal history check conducted according to this subsection. ~~If the information provided under s. 456.039(1)(a)7. or s. 456.0391(1)(a)7. is corroborated by the criminal history check, the fact that the criminal history check was performed need not be indicated on the profile.~~The department, or the board having regulatory authority over the practitioner acting on behalf of the department, shall investigate any information received by the department or the board when it has reasonable grounds to believe that the practitioner has violated any law that relates to the practitioner's practice.

(3) The Department of Health shall ~~may~~ include in each practitioner's practitioner profile that criminal information that directly relates to the practitioner's ability to competently practice his or her profession. The department must include in each practitioner's practitioner profile the following statement: "The criminal history information, if any exists, may be incomplete; federal criminal history information is not available to the public." The department

shall provide in each practitioner profile, for every final disciplinary action taken against the practitioner, a narrative description, written in plain English, that explains the administrative complaint filed against the practitioner and the final disciplinary action imposed on the practitioner. The department shall include a hyperlink to each final order listed on its Internet website report of dispositions of recent disciplinary actions taken against practitioners.

(4) The Department of Health shall include, with respect to a practitioner licensed under chapter 458 or chapter 459, a statement of how the practitioner has elected to comply with the financial responsibility requirements of s. 458.320 or s. 459.0085. The department shall include, with respect to practitioners subject to s. 456.048, a statement of how the practitioner has elected to comply with the financial responsibility requirements of that section. The department shall include, with respect to practitioners licensed under chapter 458, chapter 459, or chapter 461, information relating to liability actions which has been reported under s. 456.049 or s. 627.912 within the previous 10 years for any paid claim of $50,000 or more ~~that exceeds $5,000~~. Such claims information shall be reported in the context of comparing an individual practitioner's claims to the experience of other practitioners within the same specialty, or profession if the practitioner is not a specialist~~, to the extent such information is available to the Department of Health~~. The department shall include a hyperlink to all such comparison reports in such practitioner's profile on its Internet website.If information relating to a liability action is included in a practitioner's practitioner profile, the profile must also include the following statement: "Settlement of a

claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the practitioner. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred."

(5) The Department of Health shall ~~may not~~ include the date of a disciplinary action taken by a licensed hospital or an ambulatory surgical center, in accordance with the requirements of s. 395.0193, in the practitioner profile. Any practitioner disciplined under paragraph (1)(b) must report to the department the date the disciplinary action was imposed. The department shall state whether the action is related to professional competence and whether it is related to the delivery of services to a patient.

(6) The Department of Health may include in the practitioner's practitioner profile any other information that is a public record of any governmental entity and that relates to a practitioner's ability to competently practice his or her profession. However, the department must consult with the board having regulatory authority over the practitioner before such information is included in his or her profile.

(7) Upon the completion of a practitioner profile under this section, the Department of Health shall furnish the practitioner who is the subject of the profile a copy of it. The practitioner has a period of 30 days in which to review the profile and to correct any factual inaccuracies in it. The Department of Health shall make the profile available to the public at the end of the 30-day period. The department shall make the profiles available to the public through the World Wide Web and other commonly used means of distribution.

(8) The Department of Health shall provide in each profile an easy-to-read explanation of any disciplinary action taken and the reason the sanction or sanctions were imposed.

(9)~~(8)~~ Making a practitioner profile available to the public under this section does not constitute agency action for which a hearing under s. 120.57 may be sought.

Section 6. Section 456.042, Florida Statutes, is amended to read:

456.042 Practitioner profiles; update.--A practitioner must submit updates of required information within 15 days after the final activity that renders such information a fact. The Department of Health shall update each practitioner's practitioner profile periodically. An updated profile is subject to the same requirements as an original profile with respect to the period within which the practitioner may review the profile for the purpose of correcting factual inaccuracies.

Section 7. Subsection (1) of section 456.049, Florida Statutes, is amended, and subsection (3) is added to said section, to read:

456.049 Health care practitioners; reports on professional liability claims and actions.--

(1) Any practitioner of medicine licensed pursuant to the provisions of chapter 458, practitioner of osteopathic medicine licensed pursuant to the provisions of chapter 459, podiatric physician licensed pursuant to the provisions of chapter 461, or dentist licensed pursuant to the provisions of chapter 466 shall report to the department 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 and~~ the claim resulted in:

(a) A final judgment of $50,000 or more or, with respect to a dentist licensed pursuant to chapter 466, a final judgment of $25,000 or more ~~in any amount~~.

(b) A settlement of $50,000 or more or, with respect to a dentist licensed pursuant to chapter 466, a settlement of $25,000 or more ~~in any amount~~ .

(c) A final disposition not resulting in payment on behalf of the licensee.

Reports shall be filed with the department no later than 60 days following the occurrence of any event listed in paragraph (a), paragraph (b), or paragraph (c).

(3) The department shall forward the information collected under this section to the Office of Insurance Regulation.

Section 8. Paragraph (a) of subsection (7) of section 456.057, Florida Statutes, is amended to read:

456.057 Ownership and control of patient records; report or copies of records to be furnished.--

(7)(a)1. The department may obtain patient records pursuant to a subpoena without written authorization from the patient if the department and the probable cause panel of the appropriate board, if any, find reasonable cause to believe that a health care practitioner has excessively or inappropriately prescribed any controlled substance specified in chapter 893 in violation of this chapter or any professional practice act or that a health care practitioner has practiced his or her profession below that level of care,

skill, and treatment required as defined by this chapter or any professional practice act and also find that appropriate, reasonable attempts were made to obtain a patient release.

2. The department may obtain patient records and insurance information pursuant to a subpoena without written authorization from the patient if the department and the probable cause panel of the appropriate board, if any, find reasonable cause to believe that a health care practitioner has provided inadequate medical care based on termination of insurance and also find that appropriate, reasonable attempts were made to obtain a patient release.

3. The department may obtain patient records, billing records, insurance information, provider contracts, and all attachments thereto pursuant to a subpoena without written authorization from the patient if the department and probable cause panel of the appropriate board, if any, find reasonable cause to believe that a health care practitioner has submitted a claim, statement, or bill using a billing code that would result in payment greater in amount than would be paid using a billing code that accurately describes the services performed, requested payment for services that were not performed by that health care practitioner, used information derived from a written report of an automobile accident generated pursuant to chapter 316 to solicit or obtain patients personally or through an agent regardless of whether the information is derived directly from the report or a summary of that report or from another person, solicited patients fraudulently, received a kickback as defined in s. 456.054, violated the patient brokering provisions of s. 817.505, or presented or caused to be presented a false or fraudulent insurance claim within the meaning of s. 817.234(1)(a), and also find that,

within the meaning of s. 817.234(1)(a), patient authorization cannot be obtained because the patient cannot be located or is deceased, incapacitated, or suspected of being a participant in the fraud or scheme, and if the subpoena is issued for specific and relevant records.

4. Notwithstanding subparagraphs 1.-3., when the department investigates a professional liability claim or undertakes action pursuant to s. 456.049 or s. 627.912, the department may obtain patient records pursuant to a subpoena without written authorization from the patient if the patient refuses to cooperate or attempts to obtain a patient release and failure to obtain the patient records would be detrimental to the investigation.

Section 9. Subsection (4) of section 456.072, Florida Statutes, is amended to read:

456.072 Grounds for discipline; penalties; enforcement.--

(4) In any ~~addition to any other discipline imposed through~~ final order, or citation, entered on or after July 1, 2001, that imposes a penalty or other form of discipline pursuant to this section or ~~discipline imposed through final order, or citation, entered on or after July 1, 2001,~~ for a violation of any practice act, the board, or the department when there is no board, shall assess costs related to the investigation and prosecution of the case, including costs associated with an attorney's time. The amount of costs to be assessed shall be determined by the board, or the department when there is no board, following its consideration of an affidavit of itemized costs and any written objections thereto. In any case in which ~~where the board or the department imposes~~ a fine or assessment of costs imposed by

the board or department ~~and the fine or assessment~~ is not paid within a reasonable time, such reasonable time to be prescribed in the rules of the board, or the department when there is no board, or in the order assessing such fines or costs, the department or the Department of Legal Affairs may contract for the collection of, or bring a civil action to recover, the fine or assessment.

Section 10. Subsection (5) of section 456.073, Florida Statutes, is amended to read:

456.073 Disciplinary proceedings.--Disciplinary proceedings for each board shall be within the jurisdiction of the department.

(5)(a) A formal hearing before an administrative law judge from the Division of Administrative Hearings shall be held pursuant to chapter 120 if there are any disputed issues of material fact. The administrative law judge shall issue a recommended order pursuant to chapter 120. If any party raises an issue of disputed fact during an informal hearing, the hearing shall be terminated and a formal hearing pursuant to chapter 120 shall be held.

(b) Notwithstanding s. 120.569(2), the department shall notify the Division of Administrative Hearings within 45 days after receipt of a petition or request for a hearing that the department has determined requires a formal hearing before an administrative law judge.

Section 11. Subsections (1) and (2) of section 456.077, Florida Statutes, are amended to read:

456.077 Authority to issue citations.--

(1) Notwithstanding s. 456.073, the board, or the department if there is no board, shall adopt rules to permit the issuance of citations. The citation shall be issued to the

subject and shall contain the subject's name and address, the subject's license number if applicable, a brief factual statement, the sections of the law allegedly violated, and the penalty imposed. The citation must clearly state that the subject may choose, in lieu of accepting the citation, to follow the procedure under s. 456.073. If the subject disputes the matter in the citation, the procedures set forth in s. 456.073 must be followed. However, if the subject does not dispute the matter in the citation with the department within 30 days after the citation is served, the citation becomes a public final order and does not constitute ~~constitutes~~ discipline for a first offense. The penalty shall be a fine or other conditions as established by rule.

(2) The board, or the department if there is no board, shall adopt rules designating violations for which a citation may be issued. Such rules shall designate as citation violations those violations for which there is no substantial threat to the public health, safety, and welfare or no violation of standard of care involving injury to a patient. Violations for which a citation may be issued shall include violations of continuing education requirements; failure to timely pay required fees and fines; failure to comply with the requirements of ss. 381.026 and 381.0261 regarding the dissemination of information regarding patient rights; failure to comply with advertising requirements; failure to timely update practitioner profile and credentialing files; failure to display signs, licenses, and permits; failure to have required reference books available; and all other violations that do not pose a direct and serious threat to the health and safety of the patient or involve a violation of standard of care that has resulted in injury to a patient.

Section 12. Subsections (1) and (2) of section 456.078, Florida Statutes, are amended to read:

456.078 Mediation.--

(1) Notwithstanding the provisions of s. 456.073, the board, or the department when there is no board, shall adopt rules to designate which violations of the applicable professional practice act are appropriate for mediation. The board, or the department when there is no board, shall ~~may~~ designate as mediation offenses those complaints where harm caused by the licensee is economic in nature, except any act or omission involving intentional misconduct, ~~or~~ can be remedied by the licensee, is not a standard of care violation involving any type of injury to a patient, or does not result in an adverse incident. For the purposes of this section, an "adverse incident" means an event that results in:

(a) The death of a patient;

(b) Brain or spinal damage to a patient;

(c) The performance of a surgical procedure on the wrong patient;

(d) The performance of a wrong-site surgical procedure;

(e) The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition;

(f) The surgical repair of damage to a patient resulting from a planned surgical procedure, which damage is not a recognized specific risk as disclosed to the patient and documented through the informed-consent process;

(g) The performance of a procedure to remove unplanned foreign objects remaining from a surgical procedure; or

(h) The performance of any other surgical procedure that breached the standard of care.

(2) After the department determines a complaint is legally sufficient and the alleged violations are defined as mediation offenses, the department or any agent of the department may conduct informal mediation to resolve the complaint. If the complainant and the subject of the complaint agree to a resolution of a complaint within 14 days after contact by the mediator, the mediator shall notify the department of the terms of the resolution. The department or board shall take no further action unless the complainant and the subject each fail to record with the department an acknowledgment of satisfaction of the terms of mediation within 60 days of the mediator's notification to the department. A successful mediation shall not constitute discipline.In the event the complainant and subject fail to reach settlement terms or to record the required acknowledgment, the department shall process the complaint according to the provisions of s. 456.073.

Section 13. Section 456.085, Florida Statutes, is created to read:

456.085 Duty to notify patients.--Every physician licensed under chapter 458 or chapter 459 shall inform each patient, or an individual identified pursuant to s. 765.401(1), in person about unanticipated outcomes of care that result in serious harm to the patient. Notification of outcomes of care that result in harm to the patient under this section shall not constitute an acknowledgement or admission of liability, nor can it be introduced as evidence in any civil lawsuit.

Section 14. Paragraph (t) of subsection (1) and subsection (6) of section 458.331, Florida Statutes, are amended to read:

458.331 Grounds for disciplinary action; action by the board and department.--

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(t) Gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of$50,000~~$25,000~~ each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the physician. As used in this paragraph, "gross malpractice" or "the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances," shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that a physician be incompetent to practice medicine in order to be disciplined pursuant to this paragraph.

(6) Upon the department's receipt from an insurer or self-insurer of a report of a closed claim against a physician

pursuant to s. 627.912 or from a health care practitioner of a report pursuant to s. 456.049, or upon the receipt from a claimant of a presuit notice against a physician pursuant to s. 766.106, the department shall review each report and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply. However, if it is reported that a physician has had three or more claims with indemnities exceeding$50,000~~$25,000~~ each within the previous 5-year period, the department shall investigate the occurrences upon which the claims were based and determine if action by the department against the physician is warranted.

Section 15. Section 458.3311, Florida Statutes, is created to read:

458.3311 Emergency procedures for disciplinary action.--Notwithstanding any other provision of law to the contrary:

(1) Each physician must report to the Department of Health any judgment for medical negligence levied against the physician. The physician must make the report no later than 15 days after the exhaustion of the last opportunity for any party to appeal the judgment or request a rehearing.

(2) No later than 30 days after a physician has, within a 60-month period, made three reports as required by subsection (1), the Department of Health shall initiate an emergency investigation and the Board of Medicine shall conduct an emergency probable cause hearing to determine whether the physician should be disciplined for a violation of s. 458.331(1)(t) or any other relevant provision of law.

Section 16. Paragraph (x) of subsection (1) and subsection (6) of section 459.015, Florida Statutes, are amended to read:

459.015 Grounds for disciplinary action; action by the board and department.--

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(x) Gross or repeated malpractice or the failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar osteopathic physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $50,000~~$25,000~~ each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the osteopathic physician. As used in this paragraph, "gross malpractice" or "the failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar osteopathic physician as being acceptable under similar conditions and circumstances" shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that an osteopathic physician be incompetent to practice osteopathic medicine in order to be disciplined pursuant to this paragraph. A recommended order by an administrative law judge or a final order of the board

finding a violation under this paragraph shall specify whether the licensee was found to have committed "gross malpractice," "repeated malpractice," or "failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized as being acceptable under similar conditions and circumstances," or any combination thereof, and any publication by the board shall so specify.

(6) Upon the department's receipt from an insurer or self-insurer of a report of a closed claim against an osteopathic physician pursuant to s. 627.912 or from a health care practitioner of a report pursuant to s. 456.049, or upon the receipt from a claimant of a presuit notice against an osteopathic physician pursuant to s. 766.106, the department shall review each report and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply. However, if it is reported that an osteopathic physician has had three or more claims with indemnities exceeding$50,000~~$25,000~~ each within the previous 5-year period, the department shall investigate the occurrences upon which the claims were based and determine if action by the department against the osteopathic physician is warranted.

Section 17. Section 459.0151, Florida Statutes, is created to read:

459.0151 Emergency procedures for disciplinary action.--Notwithstanding any other provision of law to the contrary:

(1) Each osteopathic physician must report to the Department of Health any judgment for medical negligence levied against the physician. The osteopathic physician must make the report no later than 15 days after the exhaustion of

the last opportunity for any party to appeal the judgment or request a rehearing.

(2) No later than 30 days after an osteopathic physician has, within a 60-month period, made three reports as required by subsection (1), the Department of Health shall initiate an emergency investigation and the Board of Osteopathic Medicine shall conduct an emergency probable cause hearing to determine whether the physician should be disciplined for a violation of s. 459.015(1)(x) or any other relevant provision of law.

Section 18. Paragraph (s) of subsection (1) and paragraph (a) of subsection (5) of section 461.013, Florida Statutes, are amended to read:

461.013 Grounds for disciplinary action; action by the board; investigations by department.--

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(s) Gross or repeated malpractice or the failure to practice podiatric medicine at a level of care, skill, and treatment which is recognized by a reasonably prudent podiatric physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the standards for malpractice in s. 766.102 in interpreting this section. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $50,000~~$10,000~~ each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the podiatric physicians. As used in this paragraph, "gross

malpractice" or "the failure to practice podiatric medicine with the level of care, skill, and treatment which is recognized by a reasonably prudent similar podiatric physician as being acceptable under similar conditions and circumstances" shall not be construed so as to require more than one instance, event, or act.

(5)(a) Upon the department's receipt from an insurer or self-insurer of a report of a closed claim against a podiatric physician pursuant to s. 627.912, or upon the receipt from a claimant of a presuit notice against a podiatric physician pursuant to s. 766.106, the department shall review each report and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply. However, if it is reported that a podiatric physician has had three or more claims with indemnities exceeding $50,000~~$25,000~~ each within the previous 5-year period, the department shall investigate the occurrences upon which the claims were based and determine if action by the department against the podiatric physician is warranted.

Section 19. Subsections (7), (8), and (9) are added to section 627.062, Florida Statutes, to read:

627.062 Rate standards.--

(7) Notwithstanding any other provision of this section, in matters relating to professional liability insurance coverage for medical negligence, any portion of a judgment entered as a result of a statutory or common-law bad faith action and any portion of a judgment entered that awards punitive damages against an insurer may not be included in the insurer's rate base and may not be used to justify a rate or rate change. In matters relating to professional liability

insurance coverage for medical negligence, any portion of a settlement entered as a result of a statutory or common-law bad faith action identified as such and any portion of a settlement wherein an insurer agrees to pay specific punitive damages may not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees that is identified as being related to the bad faith and punitive damages in these judgments and settlements may not be included in the insurer's rate base and may not be utilized to justify a rate or rate change.

(8) Each insurer writing professional liability insurance coverage for medical negligence must make a rate filing under this section with the Office of Insurance Regulation at least once each calendar year.

(9) Medical malpractice insurance companies shall submit a rate filing to the Office of Insurance Regulation no earlier than 30 days, but no later than 120 days, after the date upon which this act becomes law.

Section 20. Section 627.0662, Florida Statutes, is created to read:

627.0662 Excessive profits for medical liability insurance prohibited.--

(1) As used in this section:

(a) "Medical liability insurance means insurance that is written on a professional liability insurance policy issued to a health care practitioner or on a liability insurance policy covering medical malpractice claims issued to a health care facility.

(b) "Medical liability insurer means any insurance company or group of insurance companies writing medical liability insurance in this state and does not include any

self-insurance fund or other nonprofit entity writing such insurance.

(2) Each medical liability insurer shall file with the Office of Insurance Regulation, prior to July 1 of each year on forms prescribed by the office, the following data for medical liability insurance business in this state. The data shall include both voluntary and joint underwriting association business, as follows:

(a) Calendar-year earned premium.

(b) Accident-year incurred losses and loss adjustment expenses.

(c) The administrative and selling expenses incurred in this state or allocated to this state for the calendar year.

(d) Policyholder dividends incurred during the applicable calendar year.

(3)(a) Excessive profit has been realized if there has been an underwriting gain for the 3 most recent calendar-accident years combined which is greater than the anticipated underwriting profit plus 5 percent of earned premiums for those calendar-accident years.

(b) As used in this subsection with respect to any 3-year period, "anticipated underwriting profit means the sum of the dollar amounts obtained by multiplying, for each rate filing of the insurer group in effect during such period, the earned premiums applicable to such rate filing during such period by the percentage factor included in such rate filing for profit and contingencies, such percentage factor having been determined with due recognition to investment income from funds generated by business in this state. Separate calculations need not be made for consecutive rate filings

containing the same percentage factor for profits and contingencies.

(4) Each medical liability insurer shall also file a schedule of medical liability insurance loss in this state and loss adjustment experience for each of the 3 most recent accident years. The incurred losses and loss adjustment expenses shall be valued as of March 31 of the year following the close of the accident year, developed to an ultimate basis, and at two 12-month intervals thereafter, each developed to an ultimate basis, to the extent that a total of three evaluations is provided for each accident year. The first year to be so reported shall be accident year 2004, such that the reporting of 3 accident years will not take place until accident years 2005 and 2006 have become available.

(5) Each insurer group's underwriting gain or loss for each calendar-accident year shall be computed as follows: the sum of the accident-year incurred losses and loss adjustment expenses as of March 31 of the following year, developed to an ultimate basis, plus the administrative and selling expenses incurred in the calendar year, plus policyholder dividends applicable to the calendar year, shall be subtracted from the calendar-year earned premium to determine the underwriting gain or loss.

(6) For the 3 most recent calendar-accident years, the underwriting gain or loss shall be compared to the anticipated underwriting profit.

(7) If the medical liability insurer has realized an excessive profit, the office shall order a return of the excessive amounts to policyholders after affording the insurer an opportunity for hearing and otherwise complying with the requirements of chapter 120. Such excessive amounts shall be

refunded to policyholders in all instances unless the insurer affirmatively demonstrates to the office that the refund of the excessive amounts will render the insurer or a member of the insurer group financially impaired or will render it insolvent.

(8) The excessive amount shall be refunded to policyholders on a pro rata basis in relation to the final compilation year earned premiums to the voluntary medical liability insurance policyholders of record of the insurer group on December 31 of the final compilation year.

(9) Any return of excessive profits to policyholders under this section shall be provided in the form of a cash refund or a credit towards the future purchase of insurance.

(10)(a) Cash refunds to policyholders may be rounded to the nearest dollar.

(b) Data in required reports to the office may be rounded to the nearest dollar.

(c) Rounding, if elected by the insurer group, shall be applied consistently.

(11)(a) Refunds to policyholders shall be completed as follows:

1. If the insurer elects to make a cash refund, the refund shall be completed within 60 days after entry of a final order determining that excessive profits have been realized; or

2. If the insurer elects to make refunds in the form of a credit to renewal policies, such credits shall be applied to policy renewal premium notices which are forwarded to insureds more than 60 calendar days after entry of a final order determining that excessive profits have been realized. If an insurer has made this election but an insured thereafter

cancels his or her policy or otherwise allows the policy to terminate, the insurer group shall make a cash refund not later than 60 days after termination of such coverage.

(b) Upon completion of the renewal credits or refund payments, the insurer shall immediately certify to the office that the refunds have been made.

(12) Any refund or renewal credit made pursuant to this section shall be treated as a policyholder dividend applicable to the year in which it is incurred, for purposes of reporting under this section for subsequent years.

Section 21. Subsection (10) of section 627.357, Florida Statutes, is amended to read:

627.357 Medical malpractice self-insurance.--

(10)(a) An application to form a self-insurance fund under this section must be filed with the Office of Insurance Regulation.

(b) The Office of Insurance Regulation must ensure that self-insurance funds remain solvent and provide insurance coverage purchased by participants. The Financial Services Commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this subsection ~~A self-insurance fund may not be formed under this section after October 1, 1992~~.

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 $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 assessments; 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 or assessments. 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; ASSESSMENTS.--

(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) In the event that the premiums for a particular year, together with any investment income or reinsurance recoveries attributable to that year, are insufficient to pay claims arising out of claims accruing in that year, the facility shall levy assessments against all of its policyholders in a uniform percentage of premium. Each policyholder's assessment shall be such percentage of the premium that policyholder paid for coverage for the year to which the insufficiency is attributable.

(c) The policyholder is personally liable for any assessment. The failure to timely pay an assessment is grounds for suspension or revocation of the policyholder' s professional license by the appropriate licensing entity.

(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, except that, in recognition of the fact that its ability to levy assessments against its own policyholders is a substitute for

the protections ordinarily afforded by such statutory requirements, the facility is exempt from statutory requirements relating to surplus as to policyholders.

(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.

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) and paragraph (a) of subsection (10) of section 766.106, Florida Statutes, are amended, and subsections (13), (14), and (15) are 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.

(10) If a prospective defendant makes an offer to admit liability and for arbitration on the issue of damages, the claimant has 50 days from the date of receipt of the offer to accept or reject it. The claimant shall respond in writing to the insurer or self-insurer by certified mail, return receipt requested. If the claimant rejects the offer, he or she may then file suit. Acceptance of the offer of admission of liability and for arbitration waives recourse to any other remedy by the parties, and the claimant's written acceptance of the offer shall so state.

(a) If rejected, the offer to admit liability and for arbitration on damages is not admissible in any subsequent litigation. Upon rejection of the offer to admit liability and for arbitration, the claimant has 60 days from receipt of the rejection of the offer to admit liability and for arbitration, 60 days from the date of the declaration of impasse during presuit mediation conducted pursuant to s. 766.1065, or the remainder of the period of the statute of limitations, whichever period is greater, in 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.

(14) Failure to cooperate on the part of any party during the presuit investigation may be grounds to strike any claim made, or defense raised, by such party in suit.

(15) In all matters relating to professional liability insurance coverage for medical negligence, and in determining whether the insurer acted fairly and honestly towards its

insured with due regard for her or his interest during the presuit process or after a complaint has been filed, the following factors shall be considered:

(a) The insurer s willingness to negotiate with the claimant;

(b) The insurer s consideration of the advice of its defense counsel;

(c) The insurer s proper investigation of the claim;

(d) Whether the insurer informed the insured of the offer to settle within the limits of coverage, the right to retain personal counsel, and risk of litigation;

(e) Whether the insured denied liability or requested that the case be defended; and

(f) Whether the claimant imposed any condition, other than the tender of the policy limits, on the settlement of the claim.

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 an occurrence of 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. Subsections (2) and (3) of section 766.203, Florida Statutes, are 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.

(3) Prior to issuing its response to the claimant's notice of intent to initiate litigation, during the time period for response authorized pursuant to s. 766.106, the defendant or the defendant's insurer or self-insurer shall conduct an investigation to ascertain whether there are reasonable grounds to believe that:

(a) The defendant was negligent in the care or treatment of the claimant; and

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

Corroboration of lack of reasonable grounds for medical negligence litigation shall be provided with any response rejecting the claim by the defendant's submission of a verified written medical expert opinion from a medical expert as defined in s. 766.202(5), at the time the response rejecting the claim is mailed, which statement shall corroborate reasonable grounds for lack of negligent injury sufficient to support the response denying negligent injury. This opinion and statement are subject to discovery.

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.

(f) In submitting its report with respect to (a)-(c), the Department should identify at a minimum:

1. The percentage of medical malpractice claims submitted to the panels during the time period the panels were in existence.

2. The percentage of claims that were settled while the panels were in existence and the percentage of claims that were settled in the 3 years prior to the establishment of such panels or, for each panel which no longer exists, 3 years after the dissolution of such panels.

3. In those state where panels have been discontinued, whether additional safeguards have been implemented to avoid the filing of frivolous lawsuits and what those additional safeguards are.

4. How the rates for medical malpractice insurance in states utilizing such panels compares with the rates in states not utilizing such panels.

5. Whether, and to what extent, a finding by a panel is subject to review and the burden of proof required to overcome a finding by the panel.

(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.

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.