By the Committees on Judiciary; Health, Aging, and Long-Term Care; Banking and Insurance; and Senators Saunders and Peaden

308-2317-03

1 A bill to be entitled
2 An act relating to medical malpractice
3 insurance; providing legislative findings;
4 amending s. 624.462, F.S.; authorizing health
5 care providers to form a commercial
6 self-insurance fund; amending s. 627.062, F.S.;
7 providing that an insurer may not require
8 arbitration of a rate filing for medical
9 malpractice; providing additional requirements
10 for medical malpractice insurance rate filings;
11 providing that portions of judgments and
12 settlements entered against a medical
13 malpractice insurer for bad-faith actions or
14 for punitive damages against the insurer, as
15 well as related taxable costs and attorney's
16 fees, may not be included in an insurer's base
17 rate; providing for review of rate filings by
18 the Office of Insurance Regulation for
19 excessive, inadequate, or unfairly
20 discriminatory rates; requiring insurers to
21 apply a discount based on the health care
22 provider's loss experience; amending s.
23 627.0645, F.S.; excepting medical malpractice
24 insurers from certain annual filings; amending
25 s. 627.4147, F.S.; revising certain
26 notification criteria for medical and
27 osteopathic physicians; requiring prior
28 notification of a rate increase; amending s.
29 627.912, F.S.; increasing the limit on a fine;
30 requiring the Office of Insurance Regulation to
31 adopt by rule requirements for reporting

1 financial information; creating s. 627.41491,
2 F.S.; requiring the Office of Insurance
3 Regulation to require health care providers to
4 annually publish certain rate comparison
5 information; creating s. 627.41493, F.S.;
6 requiring a medical malpractice insurance rate
7 rollback; providing for subsequent increases
8 under certain circumstances; requiring approval
9 for use of certain medical malpractice
10 insurance rates; creating s. 627.41492, F.S.;
11 requiring the Office of Insurance Regulation to
12 publish an annual medical malpractice report;
13 creating s. 627.41495, F.S.; providing for
14 consumer participation in review of medical
15 malpractice rate changes; providing for public
16 inspection; providing for adoption of rules by
17 the Office of Insurance Regulation; providing
18 for a mechanism to make effective the Florida
19 Medical Malpractice Insurance Fund in the event
20 the roll back of medical malpractice insurance
21 rates is not completed; creating the Florida
22 Medical Malpractice Insurance Fund; providing
23 purpose; providing governance by a board of
24 governors; providing for the fund to issue
25 medical malpractice policies to any physician
26 regardless of specialty; providing for
27 regulation by the Office of Insurance
28 Regulation of the Financial Services
29 Commission; providing applicability; providing
30 for initial funding; providing for tax-exempt
31 status; providing for initial capitalization;

1 providing for termination of the fund;
2 providing that practitioners licensed under ch.
3 458 or ch. 459, F.S., must, as a licensure
4 requirement, obtain and maintain professional
5 liability coverage; requiring the Office of
6 Insurance Regulation to order insurers to make
7 rate filings effective January 1, 2004, which
8 reflect the impact of the act; providing
9 criteria for such rate filing; amending s.
10 456.049, F.S.; requiring the Department of
11 Health to report certain liability claims to
12 the Office of Insurance Regulation; amending s.
13 627.357, F.S.; providing guidelines for the
14 formation and regulation of certain
15 self-insurance funds; creating s. 627.9121,
16 F.S.; requiring certain claims, judgments, or
17 settlements to be reported to the Office of
18 Insurance Regulation; providing penalties;
19 requiring the Office of Program Policy Analysis
20 and Government Accountability to study and
21 report to the Legislature on requirements for
22 coverage by the Florida Birth-Related
23 Neurological Injury Compensation Association;
24 authorizing health care facilities to apply to
25 the Department of Financial Services for
26 discounts in insurance rates after reducing
27 adverse incidents and serious events at the
28 facility; requiring health care facilities to
29 apply to the Department of Financial Services
30 for the certification of programs recommended
31 by the Florida Center for Excellence in Health

1 Care; requiring the Department of Financial
2 Services to develop criteria for the
3 certification; requiring insurers to file rates
4 with the Department of Financial Services for
5 review under specified circumstances; creating
6 s. 627.3575, F.S.; creating the Health Care
7 Professional Liability Insurance Mutual
8 Facility; providing purpose; providing for
9 governance by a board of governors; providing
10 for the facility to provide excess liability
11 insurance for certain health care
12 professionals; providing for premiums;
13 providing for regulation by the Office of
14 Insurance Regulation of the Financial Services
15 Commission; providing applicability; providing
16 for debt and regulation thereof; authorizing
17 the Office of Insurance Regulation to adopt
18 rules; providing for application of s.
19 627.3575, F.S., to medical malpractice
20 insurance policies issued after January 1,
21 2004; creating s. 627.0662, F.S.; providing
22 definitions; requiring each medical liability
23 insurer to report certain information to the
24 Office of Insurance Regulation; providing for
25 determination of whether excessive profit has
26 been realized; requiring return of excessive
27 amounts; amending s. 766.106, F.S.; providing
28 for application of common law principles of
29 good faith to an insurance company's bad-faith
30 actions arising out of medical malpractice
31 claims; providing that an insurer shall not be

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1 held to have acted in bad faith for certain
2 activities during the presuit period and for
3 120 days after that period; requiring
4 facilities licensed under ch. 395, F.S., to
5 install a computerized prescription system by a
6 specified date; providing for severability;
7 providing a contingent effective date.
8
9 Be It Enacted by the Legislature of the State of Florida:
10
11 Section 1. Findings.--
12 (1) The Legislature finds that Florida is in the midst
13 of a medical malpractice insurance crisis of unprecedented
14 magnitude.
15 (2) The Legislature finds that this crisis threatens
16 the quality and availability of health care for all Florida
17 citizens.
18 (3) The Legislature finds that the rapidly growing
19 population and the changing demographics of Florida make it
20 imperative that students continue to choose Florida as the
21 place they will receive their medical educations and practice
22 medicine.
23 (4) The Legislature finds that Florida is among the
24 states with the highest medical malpractice insurance premiums
25 in the nation.
26 (5) The Legislature finds that the cost of medical
27 malpractice insurance has increased dramatically during the
28 past decade and both the increase and the current cost are
29 substantially higher than the national average.
30 (6) The Legislature finds that the increase in medical
31 malpractice liability insurance rates is forcing physicians to

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1 practice medicine without professional liability insurance, to
2 leave Florida, to not perform high-risk procedures, or to
3 retire early from the practice of medicine.
4 (7) The Governor created the Governor's Select Task
5 Force on Healthcare Professional Liability Insurance to study
6 and make recommendations to address these problems.
7 (8) The Legislature has reviewed the findings and
8 recommendations of the Governor's Select Task Force on
9 Healthcare Professional Liability Insurance.
10 (9) The Legislature finds that the Governor's Select
11 Task Force on Healthcare Professional Liability Insurance has
12 established that a medical malpractice insurance crisis exists
13 in the State of Florida which can be alleviated by the
14 adoption of comprehensive legislatively enacted reforms.
15 (10) The Legislature finds that making high-quality
16 health care available to the citizens of this state is an
17 overwhelming public necessity.
18 (11) The Legislature finds that ensuring that
19 physicians continue to practice in Florida is an overwhelming
20 public necessity.
21 (12) The Legislature finds that ensuring the
22 availability of affordable professional liability insurance
23 for physicians is an overwhelming public necessity.
24 (13) The Legislature finds, based upon the findings
25 and recommendations of the Governor's Select Task Force on
26 Healthcare Professional Liability Insurance, the findings and
27 recommendations of various study groups throughout the nation,
28 and the experience of other states, that the overwhelming
29 public necessities of making quality health care available to
30 the citizens of this state, of ensuring that physicians
31 continue to practice in Florida, and of ensuring that those

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physicians have the opportunity to purchase affordable professional liability insurance cannot be met unless comprehensive legislation is adopted.

(14) 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.

Section 2. Subsection (2) of section 624.462, Florida Statutes, is amended to read:

624.462 Commercial self-insurance funds.--

(2) As used in ss. 624.460-624.488, "commercial self-insurance fund" or "fund" means a group of members, operating individually and collectively through a trust or corporation, that must be:

(a) Established by:

1. A not-for-profit trade association, industry association, or professional association of employers or professionals which has a constitution or bylaws, which is incorporated under the laws of this state, and which has been organized for purposes other than that of obtaining or providing insurance and operated in good faith for a continuous period of 1 year;

2. A self-insurance trust fund organized pursuant to s. 627.357 and maintained in good faith for a continuous period of 1 year for purposes other than that of obtaining or providing insurance pursuant to this section. Each member of a commercial self-insurance trust fund established pursuant to this subsection must maintain membership in the self-insurance trust fund organized pursuant to s. 627.357; ~~or~~

3. A group of 10 or more health care providers, as defined in s. 627.351(4)(h); or

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4.~~3.~~ A not-for-profit group comprised of no less than 10 condominium associations as defined in s. 718.103(2), which is incorporated under the laws of this state, which restricts its membership to condominium associations only, and which has been organized and maintained in good faith for a continuous period of 1 year for purposes other than that of obtaining or providing insurance.

(b)1. In the case of funds established pursuant to subparagraph (a)2. or subparagraph (a)4.~~subparagraph (a)3.~~, operated pursuant to a trust agreement by a board of trustees which shall have complete fiscal control over the fund and which shall be responsible for all operations of the fund. The majority of the trustees shall be owners, partners, officers, directors, or employees of one or more members of the fund. The trustees shall have the authority to approve applications of members for participation in the fund and to contract with an authorized administrator or servicing company to administer the day-to-day affairs of the fund.

2. In the case of funds established pursuant to subparagraph (a)1. or subparagraph (a)3., operated pursuant to a trust agreement by a board of trustees or as a corporation by a board of directors which board shall:

a. Be responsible to members of the fund or beneficiaries of the trust or policyholders of the corporation;

b. Appoint independent certified public accountants, legal counsel, actuaries, and investment advisers as needed;

c. Approve payment of dividends to members;

d. Approve changes in corporate structure; and

e. Have the authority to contract with an administrator authorized under s. 626.88 to administer the

1 day-to-day affairs of the fund including, but not limited to,
2 marketing, underwriting, billing, collection, claims
3 administration, safety and loss prevention, reinsurance,
4 policy issuance, accounting, regulatory reporting, and general
5 administration. The fees or compensation for services under
6 such contract shall be comparable to the costs for similar
7 services incurred by insurers writing the same lines of
8 insurance, or where available such expenses as filed by
9 boards, bureaus, and associations designated by insurers to
10 file such data. A majority of the trustees or directors shall
11 be owners, partners, officers, directors, or employees of one
12 or more members of the fund.
13 Section 3. Paragraph (a) of subsection (6) of section
14 627.062, Florida Statutes, is amended, and subsection (7) is
15 added to that section, to read:
16 627.062 Rate standards.--
17 (6)(a) After any action with respect to a rate filing
18 that constitutes agency action for purposes of the
19 Administrative Procedure Act, except for a rate filing for
20 medical malpractice,an insurer may, in lieu of demanding a
21 hearing under s. 120.57, require arbitration of the rate
22 filing. Arbitration shall be conducted by a board of
23 arbitrators consisting of an arbitrator selected by the
24 department, an arbitrator selected by the insurer, and an
25 arbitrator selected jointly by the other two arbitrators. Each
26 arbitrator must be certified by the American Arbitration
27 Association. A decision is valid only upon the affirmative
28 vote of at least two of the arbitrators. No arbitrator may be
29 an employee of any insurance regulator or regulatory body or
30 of any insurer, regardless of whether or not the employing
31 insurer does business in this state. The department and the

1 insurer must treat the decision of the arbitrators as the
2 final approval of a rate filing. Costs of arbitration shall be
3 paid by the insurer.
4 (7)(a) The provisions of this subsection apply only
5 with respect to rates for medical malpractice insurance and
6 shall control to the extent of any conflict with other
7 provisions of this section.
8 (b) Any portion of a judgment entered or settlement
9 paid as a result of a statutory or common-law bad-faith action
10 and any portion of a judgment entered which awards punitive
11 damages against an insurer may not be included in the
12 insurer's rate base, and shall not be used to justify a rate
13 or rate change. Any common-law bad-faith action identified as
14 such and any portion of a settlement entered as a result of a
15 statutory or portion of a settlement wherein an insurer agrees
16 to pay specific punitive damages may not be used to justify a
17 rate or rate change. The portion of the taxable costs and
18 attorney's fees which is identified as being related to the
19 bad faith and punitive damages in these judgments and
20 settlements may not be included in the insurer's rate base and
21 may not be utilized to justify a rate or rate change.
22 (c) Upon reviewing a rate filing and determining
23 whether the rate is excessive, inadequate, or unfairly
24 discriminatory, the Office of Insurance Regulation shall
25 consider, in accordance with generally accepted and reasonable
26 actuarial techniques, past and present prospective loss
27 experience, either using loss experience solely for this state
28 or giving greater credibility to this state's loss data.
29 (d) Rates shall be deemed excessive if, among other
30 standards established by this section, the rate structure
31 provides for replenishment of reserves or surpluses from

1 premiums when the replenishment is attributable to investment
2 losses.
3 (e) The insurer must apply a discount or surcharge
4 based on the health care provider's loss experience, or shall
5 establish an alternative method giving due consideration to
6 the provider's loss experience. The insurer must include in
7 the filing a copy of the surcharge or discount schedule or a
8 description of the alternative method used, and must provide a
9 copy of such schedule or description, as approved by the
10 office, to policyholders at the time of renewal and to
11 prospective policyholders at the time of application for
12 coverage.
13 Section 4. Subsections (1) and (2) of section
14 627.0645, Florida Statutes, are amended to read:
15 627.0645 Annual filings.--
16 (1) Each rating organization filing rates for, and
17 each insurer writing, any line of property or casualty
18 insurance to which this part applies, except:
19 (a) Workers' compensation and employer's liability
20 insurance; or
21 (b) Commercial property and casualty insurance as
22 defined in s. 627.0625(1) other than commercial multiple line,
23 ~~and~~ commercial motor vehicle, and medical malpractice,
24
25 shall make an annual base rate filing for each such line with
26 the department no later than 12 months after its previous base
27 rate filing, demonstrating that its rates are not inadequate.
28 (2)(a) Deviations, except for medical malpractice,
29 filed by an insurer to any rating organization's base rate
30 filing are not subject to this section.
31

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1 (b) The department, after receiving a request to be
2 exempted from the provisions of this section, may, for good
3 cause due to insignificant numbers of policies in force or
4 insignificant premium volume, exempt a company, by line of
5 coverage, from filing rates or rate certification as required
6 by this section.
7 Section 5. Section 627.4147, Florida Statutes, is
8 amended to read:
9 627.4147 Medical malpractice insurance contracts.--
10 (1) In addition to any other requirements imposed by
11 law, each self-insurance policy as authorized under s. 627.357
12 or insurance policy providing coverage for claims arising out
13 of the rendering of, or the failure to render, medical care or
14 services, including those of the Florida Medical Malpractice
15 Joint Underwriting Association, shall include:
16 (a) A clause requiring the insured to cooperate fully
17 in the review process prescribed under s. 766.106 if a notice
18 of intent to file a claim for medical malpractice is made
19 against the insured.
20 (b)1. Except as provided in subparagraph 2., a clause
21 authorizing the insurer or self-insurer to determine, to make,
22 and to conclude, without the permission of the insured, any
23 offer of admission of liability and for arbitration pursuant
24 to s. 766.106, settlement offer, or offer of judgment, if the
25 offer is within the policy limits. It is against public policy
26 for any insurance or self-insurance policy to contain a clause
27 giving the insured the exclusive right to veto any offer for
28 admission of liability and for arbitration made pursuant to s.
29 766.106, settlement offer, or offer of judgment, when such
30 offer is within the policy limits. However, any offer of
31 admission of liability, settlement offer, or offer of judgment

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1 made by an insurer or self-insurer shall be made in good faith
2 and in the best interests of the insured.
3 2.a. With respect to <u>physicians licensed under chapter</u>
4 <u>458 or chapter 459 or</u> dentists licensed under chapter 466, a
5 clause clearly stating whether or not the insured has the
6 exclusive right to veto any offer of admission of liability
7 and for arbitration pursuant to s. 766.106, settlement offer,
8 or offer of judgment if the offer is within policy limits. An
9 insurer or self-insurer shall not make or conclude, without
10 the permission of the insured, any offer of admission of
11 liability and for arbitration pursuant to s. 766.106,
12 settlement offer, or offer of judgment, if such offer is
13 outside the policy limits. However, any offer for admission of
14 liability and for arbitration made under s. 766.106,
15 settlement offer, or offer of judgment made by an insurer or
16 self-insurer shall be made in good faith and in the best
17 interest of the insured.
18 b. If the policy contains a clause stating the insured
19 does not have the exclusive right to veto any offer or
20 admission of liability and for arbitration made pursuant to s.
21 766.106, settlement offer or offer of judgment, the insurer or
22 self-insurer shall provide to the insured or the insured's
23 legal representative by certified mail, return receipt
24 requested, a copy of the final offer of admission of liability
25 and for arbitration made pursuant to s. 766.106, settlement
26 offer or offer of judgment and at the same time such offer is
27 provided to the claimant. A copy of any final agreement
28 reached between the insurer and claimant shall also be
29 provided to the insurer or his or her legal representative by
30 certified mail, return receipt requested not more than 10 days
31 after affecting such agreement.

(c) A clause requiring the insurer or self-insurer to notify the insured no less than 90 ~~60~~ days prior to the effective date of cancellation of the policy or contract and, in the event of a determination by the insurer or self-insurer not to renew the policy or contract, to notify the insured no less than 90 ~~60~~ days prior to the end of the policy or contract period. If cancellation or nonrenewal is due to nonpayment or loss of license, 10 days' notice is required.

(d) A clause requiring the insurer or self-insurer to notify the insured no less than 60 days prior to the effective date of a rate increase. The provisions of s. 627.4133 shall apply to such notice and to the failure of the insurer to provide such notice to the extent not in conflict with this section.

(2) ~~Each insurer covered by this section may require the insured to be a member in good standing, i.e., not subject to expulsion or suspension, of a duly recognized state or local professional society of health care providers which maintains a medical review committee.~~ No professional society shall expel or suspend a member solely because he or she participates in a health maintenance organization licensed under part I of chapter 641.

(3) This section shall apply to all policies issued or renewed after October 1, 2003 ~~1985~~.

Section 6. Subsections (2) and (4) of section 627.912, Florida Statutes, are amended to read:

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

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

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1 (a) The name, address, and specialty coverage of the
2 insured.
3 (b) The insured's policy number.
4 (c) The date of the occurrence which created the
5 claim.
6 (d) The date the claim was reported to the insurer or
7 self-insurer.
8 (e) The name and address of the injured person. This
9 information is confidential and exempt from the provisions of
10 s. 119.07(1), and must not be disclosed by the department
11 without the injured person's consent, except for disclosure by
12 the department to the Department of Health. This information
13 may be used by the department for purposes of identifying
14 multiple or duplicate claims arising out of the same
15 occurrence.
16 (f) The date of suit, if filed.
17 (g) The injured person's age and sex.
18 (h) The total number and names of all defendants
19 involved in the claim.
20 (i) The date and amount of judgment or settlement, if
21 any, including the itemization of the verdict, together with a
22 copy of the settlement or judgment.
23 (j) In the case of a settlement, such information as
24 the department may require with regard to the injured person's
25 incurred and anticipated medical expense, wage loss, and other
26 expenses.
27 (k) The loss adjustment expense paid to defense
28 counsel, and all other allocated loss adjustment expense paid.
29 (l) The date and reason for final disposition, if no
30 judgment or settlement.
31

(m) A summary of the occurrence which created the claim, which shall include:

1. The name of the institution, if any, and the location within the institution at which the injury occurred.

2. The final diagnosis for which treatment was sought or rendered, including the patient's actual condition.

3. A description of the misdiagnosis made, if any, of the patient's actual condition.

4. The operation, diagnostic, or treatment procedure causing the injury.

5. A description of the principal injury giving rise to the claim.

6. The safety management steps that have been taken by the insured to make similar occurrences or injuries less likely in the future.

(n) Any other information required by the office ~~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 in its analysis and evaluation of the nature, causes, location, cost, and damages involved in professional liability cases reported by insurers under this section.

(4) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any insurer reporting hereunder or its agents or employees or the department or its employees for any action taken by them under this section. The department shall ~~may~~ impose a fine of $250 per day per case, but not to exceed a total of $10,000 ~~$1,000~~ per case, against an insurer that violates the requirements of

1 this section. This subsection applies to claims accruing on or
2 after October 1, 1997.
3 Section 7. Section 627.41491, Florida Statutes, is
4 created to read:
5 627.41491 Medical malpractice rate comparison.--The
6 Office of Insurance Regulation shall annually publish a
7 comparison of the rate in effect for each medical malpractice
8 insurer and self-insurer and the Florida Medical Malpractice
9 Joint Underwriting Association. Such rate comparison shall be
10 made available to the public through the Internet and other
11 commonly used means of distribution no later than July 1 of
12 each year.
13 Section 8. Section 627.41492, Florida Statutes, is
14 created to read:
15 627.41492 Annual medical malpractice report.--The
16 Office of Insurance Regulation shall prepare an annual report
17 by October 1 of each year, which shall be available to the
18 public and posted on the Internet, which includes the
19 following information:
20 (1) A summary and analysis of the closed claim
21 information required to be reported pursuant to s. 627.912.
22 (2) A summary and analysis of the annual and quarterly
23 financial reports filed by each insurer writing medical
24 malpractice insurance in this state.
25 Section 9. Section 627.41493, Florida Statutes, is
26 created to read:
27 627.41493 Insurance rate rollback.--
28 (1) For medical malpractice insurance policies issued
29 or renewed on or after July 1, 2003, every insurer, including
30 the Florida Medical Malpractice Joint Underwriting
31

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1 Association, shall reduce its rates and premiums to levels
2 that were in effect on January 1, 2001.
3 (2) For medical malpractice insurance policies issued
4 or renewed on or after July 1, 2003, and before July 1, 2004,
5 rates and premiums reduced pursuant to subsection (1) may only
6 be increased if the director of the Office of Insurance
7 Regulation finds that an insurer or the Florida Medical
8 Malpractice Joint Underwriting Association is unable to earn a
9 fair rate of return. Any such increase must be approved by the
10 director of the Office of Insurance Regulation prior to being
11 used.
12 (3) The provisions of this section control to the
13 extent of any conflict with the provision of s. 627.062.
14 Section 10. If, as of July 1, 2004, the director of
15 the Office of Insurance Regulation determines that the rates
16 of medical malpractice insurers have been reduced to the level
17 in effect January 1, 2001, but have not remained at the level
18 for the previous year beginning July 1, 2003, and that the
19 medical malpractice insurers have proposed increases from the
20 January 1, 2001, level that are greater than 15 percent for
21 each of the next 2 years beginning July 1, 2004, then the
22 provisions of section 11 shall take effect.
23 Section 11. Florida Medical Malpractice Insurance
24 Fund.--
25 (1) FINDINGS AND PURPOSES.--The Legislature finds and
26 declares that there is a compelling state interest in
27 maintaining the availability and affordability of health care
28 services to the citizens of Florida. This state interest is
29 seriously threatened by the increased cost and decreased
30 availability of medical malpractice insurance to physicians.
31 To the extent that the private sector is unable to maintain a

1 viable and orderly market for medical malpractice insurance,
2 state actions to maintain the availability and affordability
3 of medical malpractice insurance are a valid and necessary
4 exercise of the police power.
5 (2) DEFINITIONS.--As used in this section:
6 (a) "Fund" means the Florida Medical Malpractice
7 Insurance Fund, as created pursuant to this section.
8 (b) "Physician" means a physician licensed under
9 chapter 458 or chapter 459, Florida Statutes.
10 (3) FLORIDA MEDICAL MALPRACTICE INSURANCE FUND
11 CREATED.--Effective October 1, 2003, there is created the
12 Florida Medical Malpractice Insurance Fund, which shall be
13 subject to the requirements of this section.
14 (a) The fund shall be administered by a board of
15 governors consisting of seven members who are appointed as
16 follows:
17 1. Three members by the Governor;
18 2. Three members by the Chief Financial Officer; and
19 3. One member by the other six board members.
20
21 Board members shall serve at the pleasure of the appointing
22 authority. Two board members must be doctors licensed in this
23 state and the Governor and the Chief Financial Officer shall
24 each appoint one of these doctors.
25 (b) The board shall submit a plan of operation, which
26 must be approved by the Office of Insurance Regulation of the
27 Financial Services Commission. The plan of operation and other
28 actions of the board shall not be considered rules subject to
29 the requirements of chapter 120, Florida Statutes.
30
31

1 (c) Except as otherwise provided by this section, the
2 fund shall be subject to the requirements of state law which
3 apply to authorized insurers.
4 (d) Moneys in the fund may not be expended, loaned, or
5 appropriated except to pay obligations of the fund arising out
6 of medical malpractice insurance policies issued to physicians
7 and the costs of administering the fund, including the
8 purchase of reinsurance as the board deems prudent. The board
9 shall enter into an agreement with the State Board of
10 Administration, which shall invest one-third of the moneys in
11 the fund pursuant to ss. 215.44-215.52, Florida Statutes. The
12 board shall enter into an agreement with the Division of
13 Treasury of the Department of Financial Services, which shall
14 invest two-thirds of the moneys in the fund pursuant to the
15 requirements for the investment of state funds in chapter 17,
16 Florida Statutes. Earnings from all investments shall be
17 retained in the fund, except as otherwise provided in this
18 section.
19 (e) The fund may employ or contract with such staff
20 and professionals as the board deems necessary for the
21 administration of the fund.
22 (f) There shall be no liability on the part of any
23 member of the board, its agents, or any employee of the state
24 for any action taken by them in the performance of their
25 powers and duties under this section. Such immunity does not
26 apply to any willful tort or to breach of any contract or
27 agreement.
28 (g) The fund is not a member insurer of the Florida
29 Insurance Guaranty Association established pursuant to part II
30 of chapter 631, Florida Statutes.
31

1 (4) MEDICAL MALPRACTICE INSURANCE POLICIES.--The board
2 must offer medical malpractice insurance to any physician,
3 regardless of his or her specialty, but may adopt underwriting
4 requirements, as specified in its plan of operation. The fund
5 shall offer limits of coverage of $250,000 per claim/$500,000
6 annual aggregate; $500,000 per claim/$1 million annual
7 aggregate; and $1 million per claim/$2 million annual
8 aggregate. The fund shall offer such other limits as specified
9 in its plan of operation.
10 (5) PREMIUM RATES.--The premium rates for coverage
11 offered by the fund must be actuarially sound and shall be
12 subject to the same requirements that apply to authorized
13 insurers issuing medical malpractice insurance, except that:
14 (a) The rates shall not include any factor for
15 profits; and
16 (b) The anticipated future investment income of the
17 fund, as projected in its rate filing, must be approximately
18 equal to the actual investment income that the fund has
19 earned, on average, for the prior 7 years. For those years of
20 the prior 7 years during which the fund was not in operation,
21 the anticipated future investment income must be approximately
22 equal to the actual average investment income earned by the
23 State Board of Administration for the moneys available for
24 investment under ss. 215.44-215.53, Florida Statutes, and the
25 average annual investment income earned by the Division of
26 Treasury of the Department of Financial Services for the
27 investment of state funds under chapter 17, Florida Statutes,
28 in the same proportion as specified in paragraph (3)(d).
29 (6) TAX EXEMPTION.--The fund shall be a political
30 subdivision of the state and is exempt from the corporate
31 income tax under chapter 220, Florida Statutes, and the

1 premiums shall not be subject to the premium tax imposed by s.
2 624.509, Florida Statutes. It is also the intent of the
3 Legislature that the fund be exempt from federal income
4 taxation. The Financial Services Commission and the fund shall
5 seek an opinion from the Internal Revenue Service as to the
6 tax-exempt status of the fund and shall make such
7 recommendations to the Legislature as the board deems
8 necessary to obtain tax-exempt status.
9 (7) INITIAL CAPITALIZATION.--The fund shall enter into
10 an agreement with the Florida Birth-Related Neurological
11 Injury Compensation (NICA) Fund for a loan of $100 million to
12 the fund. Repayment of the loan by the fund shall commence no
13 earlier than 3 years following the date of the agreement. In
14 the interim prior to the beginning of repayment, interest
15 shall accrue at a rate described in the agreement. The rate of
16 repayment shall be based on assumptions that ensure the proper
17 operation of the fund. The moneys loaned to the fund pursuant
18 to this subsection shall be considered admitted assets of the
19 fund for purposes of chapter 625, Florida Statutes.
20 (8) RULES.--The Financial Services Commission may
21 adopt rules to implement and administer the provisions of this
22 section.
23 (9) REVERSION OF FUND ASSETS UPON TERMINATION.--The
24 fund and the duties of the board under this section shall
25 stand repealed on January 1, 2013, unless reviewed and saved
26 from repeal through reenactment by the Legislature. Upon
27 termination of the fund, all assets of the fund shall revert
28 to the General Revenue Fund.
29 Section 12. Notwithstanding any law to the contrary,
30 all practitioners licensed under chapter 458 or chapter 459,
31 Florida Statutes, as a condition of licensure shall be

1 required to maintain financial responsibility by obtaining and
2 maintaining professional liability coverage in an amount not
3 less than $250,000 per claim, with a minimum annual aggregate
4 of not less than $500,000, from an authorized insurer as
5 defined under section 624.09, Florida Statutes, from a surplus
6 lines insurer as defined under section 629.914(2), Florida
7 Statutes, from a risk retention group as defined under section
8 627.942, Florida Statutes, from the Joint Underwriting
9 Association established under section 627.357(4), Florida
10 Statutes, or through a plan of self-insurance as provided in
11 section 627.357, Florida Statutes, or from the Medical
12 Malpractice Insurance Fund.
13 (b) Physicians and osteopathic physicians who are
14 exempt from the financial responsibility requirements under
15 section 458.320(5)(a),(b),(c),(d),(e) and (f) and section
16 459.0085(5)(a),(b),(c),(d),(e), and (f), Florida Statutes,
17 shall not be subject to the requirements of this section.
18 Section 13. Section 627.41495, Florida Statutes, is
19 created to read:
20 627.41495 Public hearings for medical malpractice rate
21 filings.--
22 (1) Upon the filing of a proposed rate change by a
23 medical malpractice insurer or self-insurance fund, which
24 filing would result in an average statewide increase of 25
25 percent, or more, pursuant to standards determined by the
26 office, the insurer or self-insurance fund shall mail notice
27 of such filing to each of its policyholders or members. The
28 notices shall also inform the policyholders and members that a
29 public hearing may be requested on the rate filing and the
30 procedures for requesting a public hearing, as established by
31 rule, by the Financial Services Commission.

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1 (2) The rate filing shall be available for public
2 inspection. If any policyholder or member of an insurer or
3 self-insurance fund that makes a rate filing described in
4 subsection (1) requests the Office of Insurance Regulation to
5 hold a hearing within 30 days after the mailing of the
6 notification of the proposed rate changes to the insureds, the
7 office shall hold a hearing within 30 days after such request.
8 Any policyholder or member may participate in such hearing.
9 The commission shall adopt rules implementing the provisions
10 of this section.
11 Section 14. (1) The Office of Insurance Regulation
12 shall order insurers to make a rate filing effective January
13 1, 2004, for medical malpractice which reduces rates by a
14 presumed factor that reflects the impact the changes contained
15 in all medical malpractice legislation enacted by the Florida
16 Legislature in 2003 will have on such rates, as determined by
17 the Office of Insurance Regulation. In determining the
18 presumed factor, the office shall use generally accepted
19 actuarial techniques and standards provided in section
20 627.062, Florida Statutes, in determining the expected impact
21 on losses, expenses, and investment income of the insurer.
22 Inclusion in the presumed factor of the expected impact of
23 such legislation shall be held in abeyance during the review
24 of such measure's validity in any proceeding by a court of
25 competent jurisdiction.
26 (2) Any insurer or rating organization that contends
27 that the rate provided for in subsection (1) is excessive,
28 inadequate, or unfairly discriminatory shall separately state
29 in its filing the rate it contends is appropriate and shall
30 state with specificity the factors or data that it contends
31 should be considered in order to produce such appropriate

1 rate. The insurer or rating organization shall be permitted to
2 use all of the generally accepted actuarial techniques, as
3 provided in section 627.062, Florida Statutes, in making any
4 filing pursuant to this subsection. The Office of Insurance
5 Regulation shall review each such exception and approve or
6 disapprove it prior to use. It shall be the insurer's burden
7 to actuarially justify any deviations from the rates filed
8 under subsection (1). Each insurer or rating organization
9 shall include in the filing the expected impact of all
10 malpractice legislation enacted by the Florida Legislature in
11 2003 on losses, expenses, and rates. If any provision of this
12 act is held invalid by a court of competent jurisdiction, the
13 department shall permit an adjustment of all rates filed under
14 this section to reflect the impact of such holding on such
15 rates, so as to ensure that the rates are not excessive,
16 inadequate, or unfairly discriminatory.
17 Section 15. Subsection (3) is added to section
18 456.049, Florida Statutes, to read:
19 456.049 Health care practitioners; reports on
20 professional liability claims and actions.--
21 (3) The department must forward the information
22 collected under this section to the Office of Insurance
23 Regulation.
24 Section 16. Subsection (10) of section 627.357,
25 Florida Statutes, is amended to read:
26 627.357 Medical malpractice self-insurance.--
27 (10)(a)1. An application to form a self-insurance fund
28 under this section must be filed with the Office of Insurance
29 Regulation ~~A self-insurance fund may not be formed under this~~
30 ~~section after October 1, 1992~~.
31

1 2. The Financial Services Commission must ensure that
2 self-insurance funds remain solvent and provide insurance
3 coverage purchased by participants. The Financial Services
4 Commission may adopt rules pursuant to ss. 120.536(1) and
5 120.54 to implement this section.
6 Section 17. Section 627.9121, Florida Statutes, is
7 created to read:
8 627.9121 Required reporting of claims;
9 penalties.--Each entity that makes payment under a policy of
10 insurance, self-insurance, or otherwise in settlement or
11 partial settlement of, or in satisfaction of a judgment in, a
12 medical malpractice action or claim that is required to report
13 information to the National Practitioner Data Bank under 42
14 U.S.C. section 11131 must also report the same information to
15 the Office of Insurance Regulation. The Office of Insurance
16 Regulation shall include such information in the data that it
17 compiles under s. 627.912. The office must compile and review
18 the data collected pursuant to this section and must assess an
19 administrative fine on any entity that fails to fully comply
20 with the requirements imposed by law.
21 Section 18. The Office of Program Policy Analysis and
22 Government Accountability shall complete a study of the
23 eligibility requirements for a birth to be covered under the
24 Florida Birth-Related Neurological Injury Compensation
25 Association and submit a report to the Legislature by January
26 1, 2004, recommending whether or not the statutory criteria
27 for a claim to qualify for referral to the Florida
28 Birth-Related Neurological Injury Compensation Association
29 under section 766.302, Florida Statutes, should be modified.
30 Section 19. Patient safety discount.--A health care
31 facility licensed pursuant to chapter 395, Florida Statutes,

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1 may apply to the Department of Financial Services for
2 certification of any program that is recommended by the
3 Florida Center for Excellence in Health Care to reduce adverse
4 incidents, as defined in section 395.0197, Florida Statutes,
5 which result in the reduction of serious events at that
6 facility. The department shall develop criteria for such
7 certification. Insurers shall file with the department a
8 discount in the rate or rates applicable for insurance
9 coverage to reflect the effect of a certified program. A
10 health care facility shall receive a discount in the rate or
11 rates applicable for mandated basic insurance coverage
12 required by law. In reviewing filings under this section, the
13 department shall consider whether, and the extent to which,
14 the program certified under this section is otherwise covered
15 under a program of risk management offered by an insurance
16 company or exchange or self-insurance plan providing medical
17 professional liability coverage.
18 Section 20. Section 627.3575, Florida Statutes, is
19 created to read:
20 627.3575 Health Care Professional Liability Mutual
21 Insurance Facility.--
22 (1) FACILITY CREATED; PURPOSE; STATUS.--There is
23 created the Health Care Professional Liability Insurance
24 Facility. The facility is intended to meet ongoing
25 availability and affordability problems relating to liability
26 insurance for health care professionals by providing an
27 affordable, self-supporting source of excess insurance
28 coverage. The facility shall operate on a not-for-profit
29 basis. The facility is self-funding and is intended to serve a
30 public purpose but is not a state agency or program, and no
31 activity of the facility shall create any state liability.

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1 (2) GOVERNANCE; POWERS.--
2 (a) The facility shall operate under a seven-member
3 board of governors consisting of the Secretary of Health,
4 three members appointed by the Governor, and three members
5 appointed by the Chief Financial Officer. The board shall be
6 chaired by the Secretary of Health. The secretary shall serve
7 by virtue of his or her office, and the other members of the
8 board shall serve terms concurrent with the term of office of
9 the official who appointed them. Any vacancy on the board
10 shall be filled in the same manner as the original
11 appointment. Members serve at the pleasure of the official who
12 appointed them. Members are not eligible for compensation for
13 their service on the board, but the facility may reimburse
14 them for per diem and travel expenses at the same levels as
15 are provided in s. 112.061 for state employees. The board
16 shall form a claims committee consisting of individuals having
17 experience in the management and disposition of medical
18 malpractice claims.
19 (b) The facility shall have such powers as are
20 necessary to operate as an excess insurer, including the power
21 to:
22 1. Hire such employees and retain such consultants,
23 attorneys, actuaries, and other professionals as it deems
24 appropriate.
25 2. Contract with such service providers as it deems
26 appropriate.
27 3. Maintain offices appropriate to the conduct of its
28 business.
29 4. Take such other actions as are necessary or
30 appropriate in fulfillment of its responsibilities under this
31 section.

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1 (3) COVERAGE PROVIDED.--The facility shall provide
2 excess liability insurance coverage for health care
3 professionals licensed under chapter 458 and chapter 459. The
4 facility shall allow policyholders to select from policies
5 with deductibles of $100,000, $200,000, and $250,000; excess
6 coverage limits of $250,000 per claim and $750,000 annual
7 aggregate; $1 million per claim and $3 million annual
8 aggregate; or $2 million and $4 million annual aggregate. To
9 the greatest extent possible, the terms and conditions of the
10 policies shall be consistent with terms and conditions
11 commonly used by professional liability insurers. Since it is
12 the intent that the facility operate in all respects as an
13 excess insurer, the health care provider that elects to
14 self-insure for the chosen deductible shall be responsible for
15 the costs associated with the defense of a claim, including
16 attorney's fees. If the chosen deductible is to be satisfied
17 through commercial insurance, a self-insurance trust, or other
18 authorized insurance program, that entity shall be responsible
19 for the costs and fees associated with the defense of a claim.
20 (4) COVERAGE REQUIRED.--
21 (a) All health care professionals licensed under
22 chapter 458 or chapter 459 may purchase coverage provided by
23 the facility as a condition of licensure.
24 (b) Such professional shall at all times maintain:
25 1. An escrow account consisting of cash or assets
26 eligible for deposit under s. 625.52 in an amount equal to the
27 chosen deductible amount of the policy;
28 2. An unexpired, irrevocable letter of credit,
29 established pursuant to chapter 675, in an amount not less
30 than the chosen deductible amount of the policy. The letter of
31 credit shall be payable to the health care professional as

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1 beneficiary upon presentment of a final judgment indicating
2 liability and awarding damages to be paid by the physician if
3 no appeal has been taken or if an appeal has been finally
4 disposed of, or upon presentment of a settlement agreement
5 signed by all parties to such agreement when such final
6 judgment or settlement is a result of a claim arising out of
7 the rendering of, or the failure to render, medical care and
8 services. Such letter of credit shall be nonassignable and
9 nontransferable. Such letter of credit shall be issued by any
10 bank or savings association organized and existing under the
11 laws of this state or any bank or savings association
12 organized under the laws of the United States that has its
13 principal place of business in this state or has a branch
14 office which is authorized under the laws of this state or of
15 the United States to receive deposits in this state; or
16 3. Professional liability coverage in an amount not
17 less than the chosen deductible amount of the policy offered
18 pursuant to this act from an authorized insurer as defined
19 under s. 624.09, from a surplus lines insurer as defined under
20 s. 626.914(2), from a risk retention group as defined under s.
21 627.942, from the Joint Underwriting Association established
22 under s. 627.351(4), or through a plan of self-insurance as
23 provided in s. 627.357.
24 (5) PREMIUMS.--The facility shall charge the
25 actuarially indicated premium for the coverage provided and
26 shall retain the services of consulting actuaries to prepare
27 its rate filings. The rate filings shall have no more than
28 three rating categories by specialty and shall apply a
29 discount or surcharge based on the provider's loss experience.
30 The facility shall not provide dividends to policyholders,
31 and, to the extent that premiums are more than the amount

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1 required to cover claims and expenses, such excess, as
2 determined by the consulting actuaries, shall be retained by
3 the facility for payment of future claims. If it is determined
4 by the consulting actuaries that the premiums collected are
5 more than sufficient for the payment of future claims, such
6 excess funds may be distributed to the participants. In the
7 event of dissolution of the facility, any amounts not required
8 as a reserve for outstanding claims shall be transferred to
9 the policyholders of record as of the last day of operation.
10 (6) REGULATION; APPLICABILITY OF OTHER STATUTES.--
11 (a) The facility shall operate pursuant to a plan of
12 operation approved by order of the Office of Insurance
13 Regulation of the Financial Services Commission. The board of
14 governors may at any time adopt amendments to the plan of
15 operation and submit the amendments to the Office of Insurance
16 Regulation for approval.
17 (b) The facility is subject to regulation by the
18 Office of Insurance Regulation of the Financial Services
19 Commission in the same manner as other insurers and is exempt
20 from laws relating to a required surplus. Any required surplus
21 shall be determined by the Office of Insurance Regulation.
22 (c) The facility is not subject to part II of chapter
23 631, relating to the Florida Insurance Guaranty Association.
24 (7) STARTUP PROVISIONS.--
25 (a) It is the intent of the Legislature that the
26 facility begin providing excess coverage no later than January
27 1, 2004.
28 (b) The Governor and the Chief Financial Officer shall
29 make their appointments to the board of governors of the
30 facility no later than July 1, 2003. Until the board is
31 appointed, the Secretary of Health may perform ministerial

1 acts on behalf of the facility as chair of the board of
2 governors.
3 (c) Until the facility is able to hire permanent staff
4 and enter into contracts for professional services, the Office
5 of Insurance Regulation shall provide support services to the
6 facility.
7 (d) In order to provide startup funds for the
8 facility, the board of governors may incur debt or enter into
9 agreements for lines of credit, provided that the sole source
10 of funds for repayment of any debt is future premium revenues
11 of the facility. The amount of such debt or lines of credit
12 may not exceed $50 million.
13 (e) The Office of Insurance Regulation is authorized
14 to adopt rules to implement the provisions of this act.
15 Section 21. Any policy issued under section 627.3575,
16 Florida Statutes, shall take effect January 1, 2004, except
17 that if a health care provider holds a liability insurance
18 policy that commenced in 2003 and does not terminate until
19 after January 1, 2004, such provider must purchase coverage
20 under this act upon the termination date of that policy.
21 Section 22. Section 627.0662, Florida Statutes, is
22 created to read:
23 627.0662 Excessive profits for medical liability
24 insurance prohibited.--
25 (1) As used in this section:
26 (a) "Medical liability insurance" means insurance that
27 is written on a professional liability insurance policy issued
28 to a health care practitioner or on a liability insurance
29 policy covering medical malpractice claims issued to a health
30 care facility.
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1 (b) "Medical liability insurer" means any insurance
2 company or group of insurance companies writing medical
3 liability insurance in this state and does not include any
4 self-insurance fund or other nonprofit entity writing such
5 insurance.
6 (2) Each medical liability insurer shall file with the
7 Office of Insurance Regulation, prior to July 1 of each year
8 on forms prescribed by the office, the following data for
9 medical liability insurance business in this state. The data
10 shall include both voluntary and joint underwriting
11 association business, as follows:
12 (a) Calendar-year earned premium.
13 (b) Accident-year incurred losses and loss adjustment
14 expenses.
15 (c) The administrative and selling expenses incurred
16 in this state or allocated to this state for the calendar
17 year.
18 (d) Policyholder dividends incurred during the
19 applicable calendar year.
20 (3)(a) Excessive profit has been realized if there has
21 been an underwriting gain for the 10 most recent
22 calendar-accident years combined which is greater than the
23 anticipated underwriting profit plus 5 percent of earned
24 premiums for those calendar-accident years.
25 (b) As used in this subsection with respect to any
26 10-year period, "anticipated underwriting profit" means the
27 sum of the dollar amounts obtained by multiplying, for each
28 rate filing of the insurer group in effect during such period,
29 the earned premiums applicable to such rate filing during such
30 period by the percentage factor included in such rate filing
31 for profit and contingencies, such percentage factor having

1 been determined with due recognition to investment income from
2 funds generated by business in this state. Separate
3 calculations need not be made for consecutive rate filings
4 containing the same percentage factor for profits and
5 contingencies.
6 (4) Each medical liability insurer shall also file a
7 schedule of medical liability insurance loss in this state and
8 loss adjustment experience for each of the 10 most recent
9 accident years. The incurred losses and loss adjustment
10 expenses shall be valued as of March 31 of the year following
11 the close of the accident year, developed to an ultimate
12 basis, and at nine 12-month intervals thereafter, each
13 developed to an ultimate basis, to the extent that a total of
14 three evaluations is provided for each accident year. The
15 first year to be so reported shall be accident year 2004, such
16 that the reporting of 10 accident years will not take place
17 until accident years 2012 and 2013 have become available.
18 (5) Each insurer group's underwriting gain or loss for
19 each calendar-accident year shall be computed as follows: the
20 sum of the accident-year incurred losses and loss adjustment
21 expenses as of March 31 of the following year, developed to an
22 ultimate basis, plus the administrative and selling expenses
23 incurred in the calendar year, plus policyholder dividends
24 applicable to the calendar year, shall be subtracted from the
25 calendar-year earned premium to determine the underwriting
26 gain or loss.
27 (6) For the 10 most recent calendar-accident years,
28 the underwriting gain or loss shall be compared to the
29 anticipated underwriting profit.
30 (7) If the medical liability insurer has realized an
31 excessive profit, the office shall order a return of the

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1 excessive amounts to policyholders after affording the insurer
2 an opportunity for hearing and otherwise complying with the
3 requirements of chapter 120. Such excessive amounts shall be
4 refunded to policyholders in all instances unless the insurer
5 affirmatively demonstrates to the office that the refund of
6 the excessive amounts will render the insurer or a member of
7 the insurer group financially impaired or will render it
8 insolvent.
9 (8) The excessive amount shall be refunded to
10 policyholders on a pro rata basis in relation to the final
11 compilation year earned premiums to the voluntary medical
12 liability insurance policyholders of record of the insurer
13 group on December 31 of the final compilation year.
14 (9) Any return of excessive profits to policyholders
15 under this section shall be provided in the form of a cash
16 refund or a credit towards the future purchase of insurance.
17 (10)(a) Cash refunds to policyholders may be rounded
18 to the nearest dollar.
19 (b) Data in required reports to the office may be
20 rounded to the nearest dollar.
21 (c) Rounding, if elected by the insurer group, shall
22 be applied consistently.
23 (11)(a) Refunds to policyholders shall be completed as
24 follows:
25 1. If the insurer elects to make a cash refund, the
26 refund shall be completed within 60 days after entry of a
27 final order determining that excessive profits have been
28 realized; or
29 2. If the insurer elects to make refunds in the form
30 of a credit to renewal policies, such credits shall be applied
31 to policy renewal premium notices which are forwarded to

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1 insureds more than 60 calendar days after entry of a final
2 order determining that excessive profits have been realized.
3 If an insurer has made this election but an insured thereafter
4 cancels his or her policy or otherwise allows the policy to
5 terminate, the insurer group shall make a cash refund not
6 later than 60 days after termination of such coverage.
7 (b) Upon completion of the renewal credits or refund
8 payments, the insurer shall immediately certify to the office
9 that the refunds have been made.
10 (12) Any refund or renewal credit made pursuant to
11 this section shall be treated as a policyholder dividend
12 applicable to the year in which it is incurred, for purposes
13 of reporting under this section for subsequent years.
14 Section 23. Present subsections (5) through (12) of
15 section 766.106, Florida Statutes, are redesignated as
16 subsections (6) through (13), respectively, and a new
17 subsection (5) is added to that section, to read:
18 766.106 Notice before filing action for medical
19 malpractice; presuit screening period; offers for admission of
20 liability and for arbitration; informal discovery; review.--
21 (5)(a) In regard to insurance company bad-faith
22 actions arising out of medical malpractice claims, common law
23 good-faith principles shall apply and not statutory good-faith
24 principles.
25 (b) An insurer shall not be held to have acted in bad
26 faith for failure to timely pay its policy limits if it
27 tenders its policy limits and meets the reasonable conditions
28 of settlement prior to the conclusion of the presuit screening
29 period provided for in subsection (4); during an extension
30 provided for therein; during a period of 120 days thereafter;
31 or during a 60-day period after the filing of an amended

1 medical malpractice complaint alleging new facts previously
2 unknown to the insurer.
3 Section 24. By July 1, 2006, each facility licensed
4 under chapter 395, Florida Statutes, must install a
5 computerized system for ordering and prescribing medications
6 which is linked to software designed to prevent prescribing
7 errors. This requirement shall be a condition of licensure for
8 each facility. As a condition of hospital privileges, each
9 health care practitioner authorized to order or prescribe
10 medications must use the facility's computerized system when
11 ordering or prescribing medications in a facility licensed
12 under chapter 395, Florida Statutes.
13 Section 25. If any provision of this act or its
14 application to any person or circumstance is held invalid, the
15 invalidity does not affect other provisions or applications of
16 the act which can be given effect without the invalid
17 provision or application, and to this end the provisions of
18 this act are severable.
19 Section 26. Except as otherwise provided in this act,
20 this act shall take effect upon becoming a law.
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STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
Senate Bill CS 0560

Provides that act relates to medical malpractice insurance;

Contains elements of CS/SB 2080, relating to insurance, including the roll-back of medical malpractice insurance rates and public participation in rate reviews;

Establishes the Florida Medical Malpractice Insurance Fund, a primary medical malpractice insurance carrier;

Creates a trigger by which the Fund comes into operation if medical malpractice rates are not rolled-back to January 1, 2001, levels and remain at that level for a period of one year and that no rate is proposed for an increase of greater than 15 percent;

Renames the Health Care Professional Liability Mutual Insurance Facility and increases its debt ceiling from $10 million to $50 million;

Provides for application of common law principles of good faith against medical malpractice insurer actions when settling claims;

Requires each facility licensed under chapter 395, F.S., to install a computerized system for ordering and prescribing medications which is linked to software designed to prevent prescription errors;

Prohibits excessive profits gained from medical malpractice underwriting and provides for a mechanism for refunding or rebating excessive profits to policy holders.